TALANOA ILE I'A: TALKING TO PACIFIC ISLAND YOUNG PEOPLE IN WEST AUCKLAND ABOUT HEALTH

A thesis presented in partial fulfilment of the requirements for the degree of

Master of Social Work

At Massey University, Albany, New Zealand

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2003

ABSTRACT

The present study explores the health issues surrounding Pacific Island youth health development. The present study conducted a literature review on youth health issues in New Zealand and found that most are cultural and social related. A second literature review of theoretical dispositions to account for the emergence of youth heath issues found that Pacific Island concepts, medical sociology theory and youth health theory were relevant explanations for the emergence of Pacific Island youth health issues. The present study conducted focus groups with Pacific Island young people about youth health issues to see if the information from the literature review corresponded with the participants' responses and whether the theoretical explanations were consistent with the participants' responses. The present study found that a correlation exists between the literature review and the participants' responses. The present study maintains through the participants' responses that the key to addressing Pacific Island young people health issues is to involve their families throughout the process of assessment and in the development of response plans. This means the perspectives of those in youth health policy arenas, the perspective of service managers and the perspective of professionals are required to recognise that the perspective of the young person is an essential domain for understanding the cause of and for resolving Pacific Island youth health issues.

'Talanoa ile I'a' is the story of Pacific Island young people living in West Auckland. It is based on responses to questions posed to participants of the study in relation to Pacific Island youth health development issues. The present study contends that in order to understand, identify and resolve Pacific Island youth health issues it is important to talk to Pacific Island young people themselves. The present study did not conduct any research with youth policymakers, youth health services or health professionals but preferred to explore youth health with Pacific Island young people themselves. The present study is built on the participants' responses and provides both warning signs and building blocks for youth health policy, youth healthcare services and youth health professionals. The present study is a Pacific Island approach to Pacific Island youth health issues; it is 'by Pacific for Pacific'.

DEDICATION

TO MY BELOVED PARENTS

FATHER – LEAULA MOSE FALEOLO

MOTHER – PEPE TALATAINA FALEOLO

ACKNOWLEDGEMENT

I would like to express my sincere thanks to all my supervisors at Massey University Albany who have been involved and supported me from the start of my thesis proposal through to its conclusion. These people include Mark Henrickson, Tafa Lauta-Mulitalo, Marilyn Waring and Mike O'Brien. Thank you for your patience, encouragement, guidance and ongoing support throughout my post graduate learning.

I would like to acknowledge West Auckland Pacific Island Health Fono and its operating arm, Pasifika Healthcare, who have supported me throughout my postgraduate learning. In particular Annie Tito-Nekaere, Marie Ah Leong, Doreen Arapai, Mareto Timo, Ruth Safole and David Lui. Special thanks to Jenifer Tuagalu and Moera Douthett both mentored me and introduced me to the importance of youth health issues in West Auckland and subsequently the construction of this thesis.

I would like to acknowledge the following organisations and people who have participated directly and indirectly to the shaping of this thesis. They include Geoff and Sina Mead (Engineering Industry Training Limited), Michelle Karaka (Target Education), Robyn Andrews (Henderson High School) and Elei Faraimo (Massey High School. Special thanks to Ruth Safole, Marjorie Suafa Leatua, and Lingi Pulesea for facilitating the female focus groups and thank you to Rangi Takaa for transcription services.

Finally, but definitely not the least, my sincerest thanks to my family, especially my sister Alice who ran errands for me and to my partner and soul mate, Leilani Osborne, thank you for putting up with twelve months of thesis conversations, thank you for your support and for being there for me.

TABLE OF CONTENTS

LIST OF TABLES

List of Diagrams

List of Appendices

CHAPTER ONE

THE STUDY

1.0 WHAT IS THE STUDY ABOUT?

The study is an exploratory study about Pacific Island youth health issues. The study contends that it is not sufficient to rest one's understanding of Pacific Island youth health issues with policymakers, service managers and health professionals alone. Instead the study proposes that in order to understand and identify key important health issues for Pacific Island young people we need to ask them directly. By talking to Pacific Island young people we gain insight into the world of Pacific Island youth culture and discover the causes and solutions to Pacific Island youth health issues.

The study raises awareness and understanding about key Pacific Island youth policy, service and workforce capacity building issues. It emphasises the importance of acknowledging the cultural and intergenerational values and diversity that exists amongst Pacific Island young people. It proposes that Pacific Island perspectives on health must be fully understood if the needs of Pacific Island people are to be better met by those working with and for Pacific Island youth

health issues in New Zealand. The Pacific Island view on youth health is intrinsically bound to the holistic view of health. It is therefore important that future planning of Pacific Island youth health policy, health services and health professionals are fully informed of this world-view in their planning of responses for Pacific Island peoples.

The study proposes a Pacific Island model, 'Talanoa ile I'a' (TII model), to incorporate the values and beliefs that many Samoans, Cook Islanders, Tongans, Niueans, Tokelauans, Fijians and Tuvaluans hold, which represent the world-views of Pacific Island young people. The TII model is also used to provide contextual and conceptual background information that underpins Pacific Island youth health development. It is used as a basis for determining an appropriate research approach for Pacific Island young people. It is therefore proposed as a means of identifying youth health issues and for establishing appropriate responses to these health issues.

1.1 PURPOSE OF THE STUDY

The purpose of the present study is to ascertain from Pacific Island young people themselves their views, opinions and knowledge of youth health issues that are important to Pacific Island youth in West Auckland. There are seven Pacific Island nations that Pacific Island young people living in West Auckland originate from Samoa, Cook

Island, Tonga, Niue, Fiji, Tuvalu and Tokelau, and the purpose of the study is to present their Pacific Island perspectives on youth health by drawing on Samoan examples to represent Pacific Island epistemologies and Pacific Island medicine science.

Pacific Island young people grow up under many conditions. Most Pacific Island young people in West Auckland have a dual heritage, learning both the language and practices that are unique to the culture they are born into, as well as learning the language and culture of the country they are growing up in. In terms of health issues, Pacific Island young people are taught traditional medicine and treatment by their parents but are also exposed to Western knowledge of medicine and treatments taught in schools and in heath care services.

Added to this dilemma are other contentious issues such as the influence of religion, biological and psychosocial changes. For instance Pacific Island young people are taught to refrain from premarital sex but this belief or value is constantly tested by peer pressure. Pacific Island young people undergo immense changes in their body as well as mental health and social changes that all young people in general undergo. However, 'looking big' is a sign of good health in Pacific Island cultures but observed by non-Pacific Island cultures as the opposite. Similarly, reciting a family chant in a public place to warn off evil spirits is a common Pacific Island cultural practice but is also interpreted by non-Pacific Island cultures as a

psychological problem. Another example is shown when Pacific Island young people who prefer not to contribute in classroom discussions as a sign of respect are interpreted by non-Pacific Island cultures as meaning something else.

Pacific Island cultures maintain and sustain their identity, language and practices through the use of oral teachings including sharing of folklore and storytelling. Through the use of the oral medium, knowledge and understanding is passed down from one generation to another. Pacific Island cultures have only recently resorted to alternative mediums introduced through teachings by missionaries such as reading and writing. Today, Pacific Island young people face the enormous task of coping with two ways of living: Pacific Island and non-Pacific Island, which is dependent upon where they live. Consequently the conditions that many Pacific Island young people in New Zealand grow in is a major factor in affecting Pacific Island youth health development.

Therefore the study aims to accomplish the following objectives:

1. Identify through the use of a Pacific Island construct (‘talanoa ile I’a’), viewpoints, opinions and knowledge of Pacific Island youth health issues according to Pacific Island young people in West Auckland.

2. Provide insight into an understanding of Pacific Island perspectives on health knowledge and traditional methods of treatment and its implications on health outcomes for Pacific Island young people.

3. Identify factors that influence Pacific Island youth health development, such as biopsychosocial changes, and explain their significance.

4. Comment on the influence of social health issues including the implications of Pacific Island culture and spiritual beliefs for Pacific Island young people.

5. Describe the effectiveness of health services for Pacific Island young people including access and workforce factors.

6. Assess the value of public health promotions materials and their value for Pacific Island young people.

7. Add value to Pacific Island health research and other associated disciplines such as policymaking, service orientation, workforce and community development.

1.2 SIGNIFICANCE OF THE STUDY

This study is significant for many reasons. First, the study is significant because it highlights the formation of concepts of health according to Pacific Island young people. Reinforcing the validity of Pacific Island perspectives, paradigms and models as a means for outlining issues that are particular to Pacific Island young people.

Secondly, the study documents Pacific Island young people's perceptions, opinions, ideas, concerns and views that are not normally sought but provide important considerations for policymakers, service providers and their workforce. For example, the perceptions of Pacific Island young people are important markers for improving health care service utilisation rates and doctor-patient relationships.

Thirdly, the study is significant because it explores controversial issues among Pacific Island cultures such as the role of culture and spirituality in Pacific Island young peoples health development and provides an account of significant implications. For example, why is talking about sex an uncommon practice in Pacific Island family homes? Is ill health a result of not pleasing God or sin? Why is it young people use traditional forms of treatment over Western medicine science?

Fourthly, the study is significant because it attempts to 'fill the gaps' in areas that are associated with Pacific Island youth development. For

example, most Pacific Island young people's relationships with their parents are often strained due to a lack of understanding between all parties. The study hopes to assist Pacific Island families to understand what their son or daughter undergoes as a young person growing up in New Zealand as opposed to back in the Pacific Islands. The study will help to answer questions raised in the workforce by non-Pacific Island professionals and practitioners such as how to work effectively with Pacific Island young people. The study also addresses the 'gaps' in the development of health services for young people by recommending specialist services for Pacific Island young people because they are a distinct population group with special needs.

Fifthly, the study is significant because it is based on the researcher's experience in working with Pacific Island young people. The researcher has been a Social Worker/Youth Worker for ten years and a volunteer youth leader for his local church for five years. Workplace and volunteer experiences have built up concerns on the part of the researcher regarding Pacific Island youth health development.

Lastly, the study is significant because it is based on the Pacific Island approach, 'by Pacific for Pacific', and exists to ensure Pacific Island youth health needs are accurately assessed and effectively responsive. By producing a study under Pacific Island terms and conditions ensures authenticity and validity of Pacific Island approaches for the purpose of studying Pacific Island people. Therefore, 'Talanoa ile I'a'

model is an outcome of this philosophy that is employed in this study to identify and resolve Pacific Island health issues for Pacific Island young people.

1.3 DEFINITION OF TERMS

In order to be clear how various terms are used in this study this section outlines a number of terms that appear frequently throughout the study and are used interchangeably. This section is provided to establish clarity around the use of the terms as well as reducing ambiguity and complexity in the nature of the terms. The terms are: 'adolescence', 'Pacific Islander', 'culture', 'health', and 'medical-sociology'.

1.3.1 ADOLESCENCE

Adolescence is the stage between a childhood development and adulthood development. United Nations Convention on the Rights for the Child (U.N.C.R.O.C.) defines childhood development as the period of life between 0-18 years (Action for Children and Youth Aotearoa, 2003). World Health Organization (W.H.O.) defines adolescence as the period of life between 10-19 years, youth as between 15- 24 years and young people, as those between 10-24 years. The present study is an 'adolescent', 'youth', 'young person' health study and not a

children's health study. Problems of interchanging the definition of youth and adolescence have also been countered by accepting that the dynamic transitions of this stage of life have as much to do with biological aspects as with socio-cultural conditions. Therefore, the health of both youth and adolescents are often taken together (Watson, 2001, p. 23; World Health Organization, 2000).

Youth health theorists also define adolescence in terms of age groups, because as they progress from childhood to adulthood various stages of development occur, which are marked in different age groups. Adolescence is the only population group that undergoes significant changes in terms of physical, mental, cultural and social development. As Radzik, Sherer and Neinstein (2002) describe early adolescence as approximately, 10-13 years (middle school years); middle adolescence as approximately, 14-17 years (high school years); and late adolescence as approximately 17-21 years (university or employment). Within each developmental phase are physical, mental, and social changes as the child develops into an adult. Adolescence is the stage in between childhood and adulthood (Radzik, Sherer & Neinstein, 2002, p. 53).

The study is therefore using the term, 'adolescent' to also mean 'youth' and 'young person'. The study uses these terms frequently and interchangeably. The study believes that an adolescent is characterised by different age groups because of varying developmental phases. The

study defines the term ‘adolescence’ as a young person aged between 10-24 years and somebody who is going through transitional changes; from childhood to adulthood.

1.3.2 PACIFIC ISLANDER

The terms, ‘Pacific Islanders’, ‘Pacific Nations People’ and ‘Pasifika’ are also commonly used to describe Pacific Island culture. ‘Pacific Islanders’ was used to describe those who migrated from the Pacific Islands such as Cook Islands, Niue and Tokelau (all who have free immigration access to New Zealand. ‘Pacific Nations People’ emerged from New Zealand-born Pacific Islanders who rejected the label of ‘Pacific Islander’ and expressed a preference to be called by their specific island nation, for example, Samoan, Tongan, Niuean, Cook Islander, Fijian, Tuvaluan and Tokelauan. ‘Pasifika’ has replaced the term, ‘Pacific Islander’, to describe where Pacific Islanders originated in a collective sense.

The study will refer to the term ‘Pacific Island’ instead of ‘Pacific peoples’, ‘Pacific Nations Peoples’, and ‘Pasifika’, when referring to Pacific Island young people living in New Zealand. The term ‘Pacific Island’ will be used frequently and interchangeably throughout the course of the present study.

1.3.3 CULTURE

Mulitalo-Lauta's (2000) definition of culture is embodied in a concept called, 'Fa'aSamoa' or the Samoan way of life, being a combination of two factors. The first factor is the visible features of 'Fa'aSamoa', the structures and institutions of Samoan culture such as aiga/family; lotu/religion; and matai/chiefly politics. The second factor is the 'invisible' features of 'fa'aSamoa', namely, the 'Samoan Heart' and the 'Samoan way'. The 'Samoan Heart' component consists of ideas, beliefs, values, skills, attitudes, moods, feelings, to name a few, and the 'Samoan Way', concerns the manner, style, method or fashion that Samoan people act out throughout the course of their daily lives (Mulitalo-Lauta, 2000, p. 15).

The study has adopted this definition of 'culture' to represent what the study refers to when discussing issues related to Pacific Island culture. Mulitalo-Lauta's (2000) definition of culture incorporates the essence of Pacific Island culture being things that you can see and things that you cannot see.

1.3.4 HEALTH

According to World Health Organisation (W.H.O.) health is defined as a positive state of mental, physical, and social well-being and not merely the absence of disease or infirmity, but this definition is not

entirely accepted universally (Goldstein, 1983). For Pacific Island cultures, the term 'health' is holistic, incorporating cultural and spiritual elements as well physical, mental and social well-being (Finau, 1996). Table 1 below outlines the Pacific Island definition of health as States of Well-Being and emphasises how the individual, the healer and the community at large, all play an important part in maintaining good health standards and minimising ill health and disease.

Table 1: Pacific Island Definitions and States of Health

Four States of Well-Being	
Physical well-being	e.g. sickness (morbidity), death (mortality), life expectancy, work satisfaction, happiness and other "feel good" indicators
Social well-being	e.g. housing, literacy, employment, poverty, and population growth
Mental well-being	e.g. mental illness, abuse, crime, violence, and delinquency
Spiritual well-being	e.g. religiosity and creed

(Source: Pollock & Finau, 1999, p. 283)

The study adopts the Pacific Island definition of health as intrinsically holistic. According to Pacific Island medical beliefs, health and well being is dependent on physical, social, mental and spiritual factors

functioning in tune with one another ensuring the Pacific Island individual stays healthy.

1.3.5 MEDICAL SOCIOLOGY

Medical sociology is a critical examination of medicine science by emphasising the role of social factors as a necessary perspective for explaining and resolving youth health issues. It provides the social context of health and illness such as social epidemiology, the distribution of disease and death various parts of the population (for example, sex, ethnicity and socio-economic status), and in relation to social factors (for example, stress, unemployment, and social inequality). Medical sociology is important because it links together many components: biomedical data; professional practice; service structures; economics and financing; demographics of disease and death, and the individual experience of health, illness, and medical care. Medical sociology offers a way to make the linkages to compose and focus the whole picture, to make social sense of the varied manifestations of health and illness. Therefore, in this sense, the study adopts the definition and arguments of medical sociology.

1.4 OVERVIEW OF THE STUDY

The purpose and significance of this study is therefore essential and timely. With the use of a Pacific Island construct ‘Talanoa ile I’a’ the

study explores youth health issues with Pacific Island young people in West Auckland to ascertain the degree of severity and establish ways of improving conditions for Pacific Island young people and their health issues.

Research and work to date with and about Pacific Island young people is still in its infancy stage. Hence, it is considered appropriate to use an exploratory form of research design, the purpose of which would determine the magnitude of the problem and recommend ways of reducing these, as well as ascertain common patterns themes.

The study is divided into seven chapters (including this one). The next chapter (Chapter Two), 'Talanoa ile I'a', is a breakdown of the significance of this Pacific Island model and its implications for research. Chapter Three, 'the Contextual Framework' is the first of two parts of the literature review undertaken to provide a background of youth health issues nationally, provincially and locally that are affecting Pacific Island youth health development. The second part of the literature review is presented in Chapter Four, 'the Conceptual Framework', which provides a theoretical explanation for the emergence of youth health issues and clarifies different ways of interpreting phenomenon.

Having established the context and theory for the 'Talanoa ile I'a' model, the next stage of the study is to develop a research

methodology (Chapter Five) to test a number of factors. Are the health issues in Chapter Three consistent with the participants' responses? Do the theoretical explanations (Chapter Four) provide a better understanding as to the cause of youth health issues particularly for Pacific Island youth health development? What role do cultural and spiritual elements of Pacific Island life have in affecting health outcomes for Pacific Island young people? Thus these questions and others are the focus points of Chapter Five, which leads to adopting a focus group research methodology because talking to young people is far more conducive.

In Chapter Six is a summary overview of the findings based on the research methodology developed in the previous chapter. The findings were sorted into four categories: responses regarding the background of the participants; responses regarding knowledge base; responses regarding opinions and value statements; and responses to do with experiences. This would ensure that all the information collected was used and made for simpler analysis.

In Chapter Seven is the discussion and conclusion. The discussion is based on identifying three important themes, which accounts for the emergence of youth health issues. Hence the important health issues for Pacific Island young people in New Zealand were physical, mental, social, cultural, health care service provision and the health workforce. From this insight, the conclusion recommends improvement in all

levels of health: health policy, health care service and its workforce. The strengths and limits of the study are also outlined in chapter seven.

CHAPTER TWO

TALANOA ILE I'A

2.0 INTRODUCTION

This study is based on a Pacific Island (Samoan) parable. We begin by analysing the significance of the terms, 'Talanoa' and 'I'a', because both carry symbolic and philosophical meanings outlined in section 2.1. After establishing the translation of the phrase, 'Talanoa ile I'a' (TII), we shift our focus from its origins as a parable defining Samoan culture and Samoan society as three perspectives. This discussion appears in section 2.2 and highlights another important feature, the transformation of the concept of TII into a model based on three dimensions. However, the study reconstructs the original TII model described in the previous section and draws on two theories (Brofenbrenner, 1979, and Finlayson, 2000) to provide additional components in section 2.3. Section 2.4 is a discussion that follows from the reconstruction process outlined in the previous section and raises relevant aspects such as conceptual, structural and procedural changes. Section 2.5 is the summary, which features the 'new' TII model and its implications for research.

2.1 WHAT IS 'TALANOA ILE I'A'?

'Talanoa ile I'a' (TII) is a Samoan phrase that literally means 'talk to the fish'. In the Samoan language there are two words that describe talking: '*tautala*' and '*talanoa*'. For example, one day the mother turned to the father and said, "Tatou *talanoaga* fa'aleaiga nani" ("Tonight we will have a family talk"), the father replied, "O le a le mea tatou te *talanoa* iai?" ("What are we going to talk about?"). The mother responded saying, "O nisi o le fanau e *tautala* i taimi o le lotu" ("Some of the children are talking during prayer"). The example above describes the term, '*talanoa*', as an event or forum for discussing issues as in family talks, whereas, the term, '*tautala*', describes the action of talking such as sharing of opinions and knowledge in family talks. The mother wanted to have a family talk ('*talanoa*') regarding the talking ('*tautala*') that occurs during prayer time.

The word, 'I'a', is the Samoan word for, 'fish'. The study utilizes the creature to symbolize the Pacific Island youth population group. The characteristics and attributes of fish are used as personifications of Pacific Island young people. For example, fish are slimy and slippery creatures, easily slipping through hands unless experienced fishermen handle them. Pacific Island young people are not slimy and slippery

creatures but are young people who undergo tremendous turmoil in their lives as they move from childhood to adulthood via adolescence. Fish roam the vast oceans in schools and live a relatively quiet lifestyle but when fishermen catch them, fish struggle to break free and are unable to voice their resistance. Pacific Island young people congregate in groups and move about in this big world keeping their problems a secret because generally they are afraid to express what is wrong or speak out for themselves.

Therefore the concept of 'Talanoa ile I'a' is about two things. Firstly, it is about the type of talking that will take place such as family talks or focus groups. In Chapter Five, 'the research framework', the choice of using focus groups was employed because this approach promoted listening, sharing, expression of ideas and knowledge in learning and understanding important health issues for Pacific Island young people. Secondly, it is about the 'fish' or Pacific Island young people and the attributes of 'fish', which are similar to the experiences of Pacific Island youth. For example, fish are silent aquatic creatures, even when they are captured; they struggle but their protests are voiceless. Most Pacific Island young people are the same; they find it difficult to disclose their sexual health problems because of fear and embarrassment. In Chapter Seven, 'the discussion', this is a significant finding, fear and embarrassment, because most Pacific Island young people access health services as a last resort. So in order to find out what are the important health issues for Pacific Island young people we

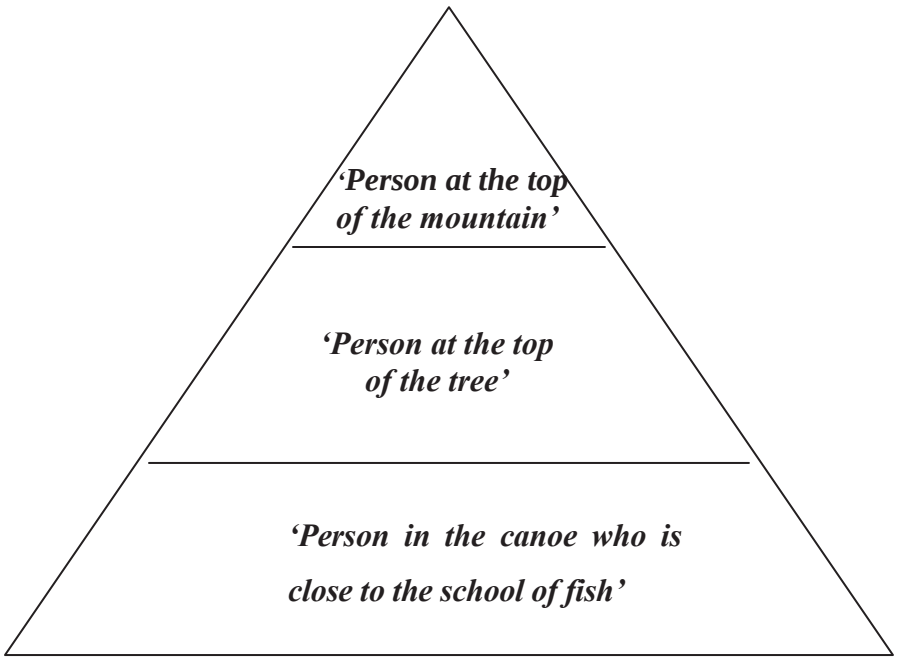
simply ask them. We talk to them and not around them. We treat them as people and not as an object. By talking to Pacific Island young people we gain important insights into their world such as how they think, what they value and believe in, and who they trust the most.

2.2 ORIGINS OF TALANOA ILE I'A

The origins of the 'Talanoa ile I'a' concept stems from the work by Tamasese, Peteru and Waldegrave (1997) and Tamasese (1997) on Pacific Island people and poverty. At the beginning of that report is a description of culture by Tui Atua Tupua Tamasese Taisi Efi, former Prime Minister of (then) Western Samoa and one of the paramount matai of Samoa. Tui Atua uses a parable to define Samoan culture as three perspectives: 'O le faautaga I tumutumu o mauga' (the perspective of the person at the top of the mountain); 'O le faautaga I tumutumu o la'au' (the perspective of the person at the top of the tree); and 'Ma le faautaga o le pii ama' (the perspective of the person in the canoe who is close to the school of fish). In any big problem the three perspectives are equally necessary. The person fishing in the canoe may not have the long view of the person on the mountain or the person at the top of the tree, but they are closer to the school of fish (Tamasese, Peteru, & Waldegrave, 1997, p. 1; Tamasese, 1997: p.1).

Diagram 1 represents the 'Talanoa ile I'a' model in its original form, made up of three perspectives, all of which represent views from different levels of Samoan society. The original TII model shows a hierarchical and foundation-based framework. There are three perspectives that define Samoan culture as well as a structural representation of Samoan society.

Diagram 1: Original 'Talanoa ile I'a' model



(Source: Writers reconstruction, 2003).

2.3 RECONSTRUCTING TALANOA ILE I'A

If the 'school of fish' is the most important component of this study then the original TII model fails to distinguish this factor. According to the original TII model (Diagram 1), 'the school of fish', is not

represented by a separate dimension but attached to the third perspective of Samoan culture, 'the person on the canoe close to the school of fish'. This invites a reconstruction of the original TII model. There are three interpretations that provide clues regarding the construction of a fourth dimension. The study adopts all three interpretations. Firstly, in the parable 'Talanoa ile I'a' are audience sites for consultations: 'the person at the top of the mountain' represent policy makers and government officials; 'the person at the top of the tree' stand for service managers and are regional commissioners; 'the person on the canoe close to the school of fish' analogous to practitioners and professionals. Secondly, in the parable 'Talanoa ile I'a' are also environments: microsystem, mesosystem, exosystem and macrosystem. Thirdly, 'Talanoa ile I'a', is a 'process' model, either things constructed from the 'top-down', or, things constructed from the 'bottom-up'.

However, the study focuses on the 'school of fish' as the target audience for consultation and the main environment of attention (microsystem). The study subscribes to the 'bottom-up' approach and puts forward the idea that the main stakeholder is the young person ('fish') whereby policy-making processes should start with in terms of consultation. The 'school of fish' is the main environment (microsystem) for investigation and exploration such as the relationships young people have with health services and health professionals and practitioners. In this sense, the parable that defined

Samoan culture is reconstructed and the end result is a fresh interpretation called the new 'Talanoa ile I'a' model.

The parable can be interpreted in other ways as well as a description of Samoan culture. Tamasese, Peteru, & Waldegrave (1997) interpreted the three perspectives as audiences for consultation. Their report included consultations with government-level representatives ('the person at the top of the mountain'); with representative from the service-level ('the person at the top of the tree'); and with professionals and practitioners ('the person in the canoe').

Another way of interpreting the parable, 'Talanoa ile I'a', is through an ecological analysis (Brofenbrenner, 1979). The parable, 'Talanoa ile I'a', is made up of four domains or environments. Brofenbrenner's (1979) ecological approach to human development identifies four different levels of environmental influence, extending from the most intimate environment to the global. Thus, to understand individual development, we must understand each person within the context of multiple environments. First, the *microsystem* is the everyday environment of home or school or work, including relationships with parents, siblings, caregivers, classmates, and teachers. Pacific Island young people are in contact with these people everyday in their lives, whether in the family home or at school, they are the people they trust the most. Within the *microsystem* domain Pacific Island young people develop trusting relationships and interact mostly with family members

and friends. The 'school of fish', in the 'talanoa ile I'a' parable represents the *microsystem* domain.

Second, when Pacific Island young people come into contact with professionals and practitioners they become clients, consumers and customers. They are introduced to public services by their linkages to youth workers, social workers, youth nurses and other people who are assigned to them. The *mesosystem* is the interlocking of various systems a young person is involved with – the linkages between home and school (student-teacher), home and service provider (client-youth worker), service provider and community (referral-specialist), and so on; represented by 'the person in the canoe who is close to the school of fish', in the 'Talanoa ile I'a' parable.

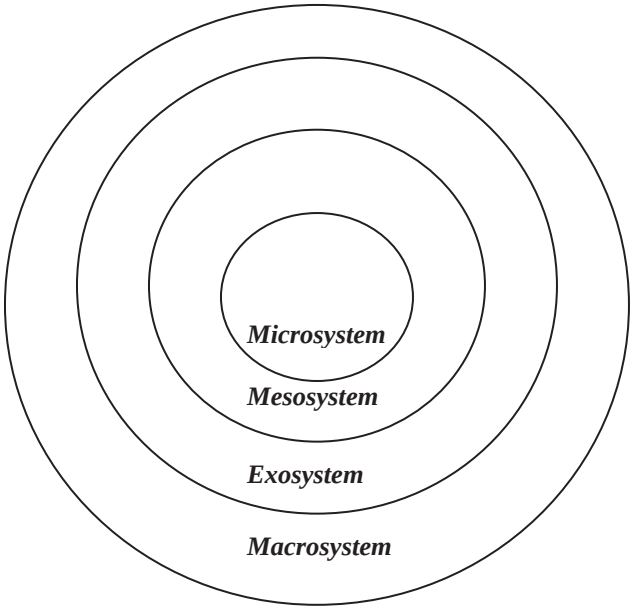
Third, each professional and practitioner is a representative of an organization. Collections of organizations become larger institutions, for example, Pasifika Healthcare, Southseas Healthcare and Healthstar Pacifica are Pacific Island health services from West Auckland and South Auckland respectively who have merged to form a Primary Health Organization called 'Ta Pasefika' (Ministry of Health, 2002a). Similarly, child and youth protection agencies such as Child Youth and Family services have offices scattered throughout New Zealand but when collectively grouped together they form a national organization. Hence the Chief Executive Officer of Ta Pasefika and the Director of Child Youth and Family services are representatives of larger institutions where these larger institutions interact with each other by

sharing resources and services. This is the domain of the *exosystem*; represented by 'the person at the top of the tree', in the 'Talanoa ile I'a' parable.

Finally, the collection of agencies to form national organizations is underpinned by overarching cultural patterns of government, religion, education, and the economy. For example, laws set by the legislative assembly in parliament are designed to ensure that persons living in New Zealand are protected. Another example of overarching cultural patterns is found in social and economic policy changes in New Zealand over the last century (Boston, Dalziel & St.John, 1999; Cheyne, O'Brien & Belgrave, 2000; Gauld, 2001). From 1935-1980, New Zealand social policy was based on universalism or free access to education and healthcare for everyone in society. However, economic policy concerns such as over the amount of money being spent on social policy goals (universalism) sparked a reorientation of national social policy from the 1980s onwards, replacing universalism with targeting policies or limiting access to those who really needed help. Lawmakers and policymakers are representatives from institutions such as legislative council and policy units, who have the widest-ranging influence by setting the overall cultural pattern for the rest of society to follow. This environment is known as the *macrosystem*; represented by 'the person at the top of the mountain', in the 'talanoa ile I'a' parable.

Diagram 2 demonstrates the combination of Brofenbrenner (1979) ecological model and the original TII model. Both have the same view of society in terms of how society is structured.

Diagram 2: Integration of 'Ecological model' and the 'Original Talanoa ile l'a model'



Microsystem – Young people and interpersonal relationships ('the school of fish')

Mesosystem – Young people and relationships with professionals ('the person on the canoe')

Exosystem – Young people and relationships with service sectors ('the person at the top of the tree')

Macrosystem - Young people and their relationship with overarching cultural patterns ('the person at the top of the mountain')

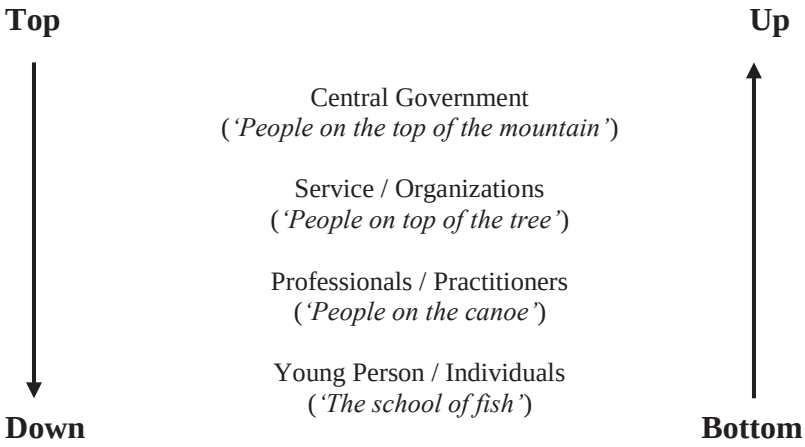
Diagram 2 highlights the way the parable TII is reconstructed by interpreting the perspectives outlined by Tui Atua Tupua Tamasese as environments or domains as in the ecological analysis.

Another interpretation of the parable, TII, is linked to Finlayson (2000) analysis of policymaking process. Finlayson describes two distinct ways of policymaking during the implementation stage: 'top down' and 'bottom up'. During the implementation stage of the policymaking process, where policy initiatives are put into practice, this can either occur at the top end or higher levels of society ('top down') or occur at the bottom end of society ('bottom up') or local community levels. For example, during the construction of the Pacific Health and Disability Action Plan (Ministry of Health, 2002b), a team of senior policy analysts from the Ministry of Health paid a visit to Pasifika Youth Health services (PYHS). The policy analysts were interested in views from the General Practitioner and Social Worker who founded and operated PYHS. As representatives of a national health body, the team of policy analysts sought information to better inform the policy they were developing. Basically undertaking consultations with people including a general manager, a general practitioner, social worker and community support workers; representatives of 'the person on the tree' and 'the person on the canoe'.

By contrast, the other way of policymaking is generating information from the 'bottom up'. The key difference in this approach is its starting point, revolving around building a policy from what people have to say, whereas the top down approach build policy from already existing policies such as 'Youth Health: A Guide to Action' (Ministry of Health, 2002c), which builds on information already reported in other similar policies, namely, 'Youth Development Strategy Aotearoa' (Ministry of Youth Affairs, 2002)) and the 'Pacific Health and Disability Action Plan' (Ministry of Health, 2002b).

However, the West Auckland Child Youth Health and Disability Strategy (WACYHDS) (Waitemata District Health Board and WestKids, 2002) is built from the community level by inviting key people from the community, health service sector and government services, to develop a West Auckland health and disability policy for its child and youth populations. The people who put the WACYHDS together were key stakeholders and recruited based on whether they work with or for children and young people. WACYHDS grew out of consultations with the community including Pacific Island, with consumers or clients, practitioners and professionals, and managers and directors. Diagram 3 shows the relationship of 'top-down' and 'bottom-up' approaches with regards to the 'new' 'Talanoa ile I'a' model.

Diagram 3: ‘Top-down’ approach and ‘Bottom-up’ approach as proposed by Finlayson (2000)



The ‘Talanoa ile I’a’ model is the same as the ‘Top-down’ and ‘Bottom up’ approach, in terms of describing a ‘process’ as in the policy making. Policy is made by ‘the people on the mountain’ and feedback is drawn from other levels of society: ‘the people on top of the tree’ and ‘the people on the canoe’, a ‘top down’ policymaking process. Policy can also be catalysed from the ‘school of fish’ or the community level and drawing feedback from ‘people on the canoe’; ‘people on the tree’; and ‘people on the mountain’; an illustration of a ‘bottom up’ policymaking process. However, the TII model, as a policymaking model need not necessarily begin at the ‘top-down’ or from the ‘bottom-up’. It is possible for policy to originate and be manufactured by the ‘centre up’ or ‘centre down’, in other words, by the ‘person at the top of the tree’ or by the ‘person on the canoe’. WACYHDS originated from the community level but it was mainly

practitioners, managers and directors who developed strategy. Irrespective of where policymaking is started from, 'top down', 'bottom up', 'centre up' or 'centre down', the perspectives outlined by Tui Atua Tupua Tamasese are reconstructed and translated into the TII model. The TII model either signals a course of action, as in the consultation process, or represents a series of stages, as in the policymaking process, 'bottom up'.

2.4 SUMMARY

The concept of TII is transformed into a model that resembles structural analysis of society in the ecological model (Brofenbrenner, 1979) and adopts from Finlayson (2000) a 'bottom-up' approach to demonstrate its mechanics. The original TII model had three dimensions but the new TII model has an added dimension, 'the school of fish' (microsystem). In addition, the new TII model is a tool for analysis such as the policymaking process, and it is based on generating outcomes to explain causes and effects as well as developing appropriate responses to Pacific Island youth health issues.

The new interpretation of the TII model began as a Samoan phrase that was part of a parable about defining Samoan culture. It indicated that talking would be invaluable when sourcing information and that Pacific Island young people was the main target audience for

consultations. As Table 2 illustrates, the new interpretation of the TII model contains an identifiable structure and a series of stages for constructing an accurate view of Pacific Island youth health issues.

Table 2: A new interpretation of 'Talanoa ile I'a' model

Existing Models	Talanoa ile I'a (2003)	Brofenbrenner (1979)	Finlayson (2000)
Mechanics	Concept	Structure	Process
Metaphors	People on the top of the mountain	Macrosystem	Up Bottom
	People on the top of the tree	Exosystem	
	People on the canoe	Mesosystem	
	The school of fish	Microsystem	

The new TII model rests on the belief that the 'school of fish' or Pacific Island young people and what they have to say on health issues is the most important concept. The microsystem is the structural element that the study focuses its attention mostly, the remaining dimensions are important because Pacific Island young people are influenced by things that are outside of the microsystem such as practitioners (mesosystem), service managers (exosystem) and policymakers (macrosystem). The study subscribes to the 'bottom-up' approach because its development origins commence with discussions with Pacific Island young people who are mostly found at the community level (ground level).

However, the new TII model requires further refining, in the sense it requires contextual information (chapter three) and a conceptual framework (chapter four). The new TII model requires a frame of reference or an exploration of relevant circumstances so the context of Pacific Island young people growing up in New Zealand and West Auckland emerges. When we arrive at chapter four, the new TII model consists of a conceptual framework made up of three theoretical perspectives so an in-depth understanding of Pacific Island young people and their world is gained before the TII model is put into action in chapter five.

CHAPTER THREE

THE CONTEXTUAL FRAMEWORK

3.0 INTRODUCTION

Context is a set of facts or background information that provides relevant circumstances to a proposed course of inquiry. The contextual framework or setting for the 'Talanoa ile I'a' model is based on factors surrounding Pacific Island youth health issues. Consider the following questions: how much do we know about Pacific Island young people in New Zealand? What is their current health and socio-economic status? Is it better or worse for Pacific Island young people living in a specific region? Are their particular health issues for Pacific Island young people that are significant over other ethnic groups?

The study conducted a review of youth health literature to find answers to these question and others, paying particular attention to information that reported on Pacific Island youth health status. The review looked at what health issues were frequently reported on and how the authors responded in literature published by government, service sector and practice organisations. Section 3.1 provides a national overview of

youth health status in New Zealand. Section 3.2 moves on from the broad-based approach in the previous section and limits the scope of exploration to specific regions in New Zealand such as Auckland and West Auckland respectively. Sections 3.4, 3.5 and 3.6 are responses to adolescent need from health policy ('the person at the top of the mountain'), health sector ('the person at the top of the tree') and health workforce ('the person on the canoe') positions. Finally, section 3.7 provides insight into what adolescents think of healthcare in New Zealand ('the school of fish')

Pacific Island populations, particularly Pacific Island youth populations, are projected to double over the next couple of decades (Statistics New Zealand, 2003). This trend is consistent with New Zealand's overall population growth, which in demographic terms, will look and host a large proportion of the population that is mainly young. If this is the case, then the current health issues facing Pacific Island young people today will be inherited by the next generation.

3.1 NATIONAL OVERVIEW

3.1.1 Youth Population in New Zealand

The youth population (those aged 12-25 years) is ethnically more diverse than the rest of the New Zealand population. In 1996 two-thirds (66.8 percent) of youth belonged to European ethnic groups

while one-fifth (19.9 percent) were New Zealand Maori. Asian and Pacific Islands groups apiece made up 6.4 percent of the youth population compared with 4.6 percent and 5.0 percent respectively of the total New Zealand population. Over the past three censuses, the proportion of young people who were European fell from 77.2 percent to 66.8 percent, while the proportion of Maori, Pacific Islands, Asian and other young people increased (Statistics New Zealand, 2003).

3.1.2 Causes of Mortality: Youth Aged 10-24 Years

The majority of young people in New Zealand die from a limited range of causes, which vary between males and females and among young people of different ages. In 1994, four causes of death: motor vehicle accidents, other accidents such as sport injuries, cancer and suicide or self-inflicted injury; accounted for just over three-quarters of all deaths of people aged 10 to 24 years. The leading cause was motor vehicle accidents, which accounted for 33.5 percent of the deaths of young people (New Zealand Health and Information Service, 1997).

The three other leading causes were suicide and self-inflicted injury, which accounted for 26.8 percent of deaths, non-motor vehicle accidents (10.1 percent) and cancer (7.1 percent). A higher proportion of young men (81.3 percent) died from these leading causes than of young women (68.5 percent). Young people aged 15 to 24 were also more likely to die from these causes (79.8 percent) than those aged 10

to 14 years (54.9 percent) (New Zealand Health Information Service, 1997).

Young people in the 10 to 14-year age group were more likely to die of cancer and a range of diseases, which afflict various sites and systems of the body (nervous system, sense organs and endocrine system). In 1994, 62.7 percent of deaths of 10 to 14-year-olds were the result of chronic illnesses or diseases, while 77.9 percent of 15 to 24-year-olds died from external causes, particularly due to accidents, suicide and self-inflicted injury, and non-motor vehicle accidents (New Zealand Health Information Service, 1997).

The extent of issues facing young people are widespread, mostly health and socially related risk factors, including car accidents, alcohol, drug issues, and poor sexual health care. Specific population groups such as Pacific Island youth show a health status that is even more alarming (Ministry of Youth Affairs, 2002).

3.1.3 Youth Health Issues in New Zealand

Over the last three years, more and more attention has grown regarding the state of youth health in New Zealand. Recent evidence have demonstrated that young people in New Zealand are becoming more sexually active, experimenting with drugs earlier and few resort to suicide. The amount of literature available was immense regarding youth health issues in New Zealand. The issues outlined below have

been selected to illustrate that poor health for Pacific Island young people is related to social factors such as unemployment, poverty, easy access to drugs and lack of role models. There were thirteen youth health issues identified: alcohol and drugs; abortion; contraception; dental care; driving; depression; disability; exercise; food; menstruation; obesity; sexually transmitted infections (STI) and suicide.

Dental care

The health issue of dental care is an emerging problem for Pacific Island young people in New Zealand. A series of reports have identified dental or oral health as a priority issue in terms of improving access to services and developing more skilled dental health professionals (see Action for Children and Youth Aotearoa, 2003; Ministry of Health, 2002b; Ministry of Health, 2001a). However, public dental services in New Zealand have been under pressure over the last 10 years. Reorganisation has led to fragmentation, and work pressures have meant some child and adolescent dental services have not maintained the levels of access and the provision of preventive services that were available in the past. In the New Zealand Health Strategy (Ministry of Health, 2001a; Ministry of Health, 2000a) is a response from the Government in the form of an Oral Health Implementation Plan, which will introduce new changes such as re-establishing a nationwide dental health system for children and adolescents, improve access particularly in secondary high schools and

allows for dental therapists to conduct broader tasks (Ministry of Health, 2001a; Ministry of Health, 2000a).

Disability

One in five New Zealanders has a long-term disability (Ministry of Health, 2000a). This prevents many from reaching their full potential or participating fully in the community. The aim of the New Zealand Disability Strategy (Ministry of Health, 2001b) is to eliminate these barriers wherever they exist. It proposes a vision of a non-disabling society that will enable people who have experienced disability to feel that their capacity to contribute and participate in every aspect of life is continually being extended and enhanced. For Pacific Island young people, the 'Pacific Health and Disability Action Plan (Ministry 2002b), aim to review Pacific Island youth disability issues to enable Pacific Island youth to participate and access dental services more regularly and concentrates on improving disability information and research.

Physical health issues (exercise; food and obesity)

The 2001/01 Hillary Commission Physical Activity Survey results analysed by Sports and Recreation New Zealand (SPARC) found that sixty eight percent of New Zealand adults were active (that is, 32 percent were inactive) (Sports and Recreation New Zealand, 2002). Substantial improvements are needed to reduce the risks of serious

illness and deaths attributed to physical inactivity, especially given the increasing levels of overweight, obesity and diabetes among Pacific Island young people. SPARC (2002) reports that the results from their own database (1997, 1999 and 2001) confirm that the percentage of 5-17 year olds doing at least two and a half hours physical activity per week has declined from sixty-nine percent to sixty-six percent, especially in Pacific Island young men. In addition, there has been an increase in the proportion of sedentary Pacific Island young people – those who do not undertake any sport or active leisure – the figure has increased from six percent in 1997 to thirty-three percent in 2001 (SPARC, 2002).

The Ministry of Health (2003) warns that a lack of physical activity increases the risk of death or ill health from many non-communicable diseases and conditions, especially obesity and mental health (depression and anxiety). In relation to obesity, the Ministry of Health (2001c) found that this health issue featured strongly in lower economic groups such as Pacific Island people. Obesity in Pacific Island adults was very high compared with the general population: twenty six percent were males and forty seven percent were females. An estimated seventy five percent of Pacific Island peoples in New Zealand are overweight.

Mental health issues (alcohol and drugs; depression; driving and suicide)

The Alcohol and Public Health Research Unit found adolescent usage relatively high in all categories as a result of a drug use survey of over 5,500 people in 2002 (Alcohol and Public Health Research Unit, 2002). The number of young people who have tried alcohol has remained stable (compared to a similar 1998 survey, although in 2000 there is an increase in the proportion of young males and females, aged 15-17 years, who consumed enough to feel drunk on a monthly basis. In the 'more frequent' use category is marijuana (10 or more times in the last month), by 15-17 year olds, which has increased from 1% in 1998 to 4% in 2001. For young females, aged 15-17 years, it was zero in 1998 to 4% in 2001 ('more frequent' use category); in the 'trying marijuana' for the first time category, it rose from 26% in 1998 to 38% in 2001; in having used marijuana in the month preceding the survey, the figure increased from 6% in 1998 to 15% in 2001. In the 'other' drugs category (hallucinogens, stimulants, opiates and 'needle' usages) there were increases as well as young people trying a combination of drugs or multiple drug use category.

A sample of 626 young people aged between 12-17 years old were interviewed regarding alcohol drinking habits and found a number of interesting trends (Kalafatelis, McMillen & Palmer, 2003). A high proportion of 14-17 year olds were drinking regularly and Pacific Island young people (18 percent) admitted to drinking a quantity of ten

or more glasses of alcohol in one sitting. Most of the Pacific Island young people who participated in the interview also admitted that their parents were unaware of their alcohol drinking patterns.

Alcohol and speed are the major contributing factors for young drivers involved in fatal crashes according to Land Transport and Safety Authority (2001). Twenty nine percent of 15-24 year olds died on New Zealand roads between 1998 and 2000 due to loosing control of the vehicle and crashing head-on. Of all young drivers involved in fatal crashes between 1998 and 2000, seventy six percent were males.

Suicide is the second leading cause of death in the 15-24 year old age groups according to the Ministry of Health (2000b). In 1998, one hundred and thirty eight young people died by suicide compared with 142 in 1997, 143 in 1996, and 156 in 1995. Of these 138 people, 35 were female and 103 were male. The youth suicide (15-24 year old) ratio in New Zealand is about 3 male suicides to every female suicide. This appears to be a common pattern in most countries. For Pacific Island young people, in 1998 there were 6 male and 2 female Pacific Island youth suicides.

The Suicide Prevention Intervention New Zealand organisation reported in 2001, that '…New Zealand has one of the highest rates of youth suicide in the world (22.4 per 100,000 populations), which means 119 young people died by suicide in 1999' (Suicide Prevention

Intervention New Zealand, 2001, p.3). Beautrais (2000) reported that the most common form of suicide for Pacific peoples in 1996 was hanging (Beautrais, 2000, p.16).

Sexual health issues (abortion, contraception and sexually transmitted infections)

Ortega, O'Rourke and Badkar (2003) found the group at high risk in terms of contracting sexual transmitted infections were Pacific Island young people aged 25 years and under. The researchers analysed data from sexual health clinics (SHCs) and family planning agencies (FPAs) and found chlamydia and gonorrhoea were high amongst Pacific Island young people especially males. SHCs warned that rates of chlamydia were considerably higher in Pacific Island peoples (8.1 percent than in Europeans (3.1 percent). SHCs also reported that 532 young people (15-24 years old) visited them for gonorrhoea problems and 65 (12 percent) were Pacific Island young people. FPAs report similar trends and patterns for Pacific Island young people.

Fenwick and Purdie (2000) found in their survey of fourth form students from the Hawkes Bay that Pacific Island peoples have teenage birth rates almost five times higher than Europeans in New Zealand and three times higher than populations in other Organisation for Economic Cooperation and Development (OECD) countries. The researchers added that their survey also revealed that Pacific Island

young people were not accessing sexual health services because of fear and embarrassment.

The Institute for Environmental Science and Research Unit reported in 2000, that early sexual behaviour is associated with lower socio-economic status, poverty, poor educational opportunities, being born to a teenage mother and high rates of unemployment (Institute for Environmental Science and Research Unit, 2000). Further, data suggests young New Zealanders' rates of sexually transmitted infections (STI) are considerably higher than other countries, for example, the most common reason for hospitalisation in females over 15 years is associated with pregnancy; over 60% of gonorrhoea, chlamydia and genital warts cases occur in people under 25 years; and young people are more likely to be diagnosed with multiple infections.

3.1.4 PROVINCIAL OVERVIEW - AUCKLAND

According to the 2001 Census of Population and Dwellings, the cities where most of the Pacific Island population are in the provinces of Auckland and Wellington. For example, in Auckland they are the territories of Manakau City (72,378 people), Auckland City and Waitakere City, and in Wellington, Porirua City (Statistics New Zealand, 2003). Two thirds of the Pacific people reside in the Greater Auckland region; hence the Auckland region has the highest number of Pacific people residing in the province. In addition, the Pacific Island population is characterized with a young population (where the median

age is 21 years), and 65 % of Pacific Island young people reside in the Auckland region. Therefore, with more than half of the Pacific teenagers residing in the Auckland region, it is imperative to study the perspective on health of this population group.

3.2 WEST AUCKLAND OVERVIEW

3.2.1 Why West Auckland?

The background information provided by section 3.1 sketched out above is prevalent in specific regions around New Zealand. For example, in West Auckland, sexual health, drug abuse, suicide and others are prominent youth health issues as for the whole of the country. There are three reasons why West Auckland was selected as a region of interest. Firstly, there is limited study about Pacific Island young people conducted by Pacific Island researchers particularly on Pacific Island young people living in West Auckland. Secondly, the present study operates on a limited budget and tight timeframe; consequently, other areas were not included in its research framework but tabled for further academic endeavours. Lastly, the region of West Auckland was selected in the present study because it provided a convenient sample as resources and participants were readily available

3.2.2 West Auckland Child Youth Health and Disability Strategy (WACYHDS)

The aim of the West Auckland Child Youth Health and Disability Strategy (WACYHDS) were to document children and youth health issues as a means for responding to children and youth health problems in West Auckland (Waitemata District Health Board & WestKids, 2002). The WACYHDS provided three important sources of information: firstly, epidemiology or current health status of children and youth in West Auckland; secondly, a review of existing national and local strategies; and lastly, the WACYHDS was developed from discussions with service providers, the community and young people and their family as to what they consider to be important issues. Representatives including service managers, practitioners and members of the community put the WACYHDS together by literature reviews, interviews and consultations, subsequently, responses were collected, analysed and resulted in a regional strategy. The information that is outlined below is a selection of WACYHDS findings that focuses on specifically on Pacific Island youth health status in West Auckland.

3.2.3 Demographics

There were over 43,000 children and over 25,000 15-24 year olds in West Auckland. Nearly 25% of West Aucklanders were children. Ethnicity data show that 12% of young people in West Auckland are

Pacific Island people. Table 3 summarises the demographic picture for West Auckland Child and Youth Populations as of 1996.

Table 3. Child and Youth Populations of West Auckland 1996

	Ages 0-14	Ages 15-19	Ages 20-24
European	23,988 *(55.6%)*	6,705 *(54.4%)*	7,734 *(60.8%)*
Maori	8,511 *(19.7%)*	2,205 *(17.9%)*	2,031 *(16%)*
Pacific	5,772 *(13.4%)*	1,623 *(13.2%)*	1,440 *(11.3%)*
Asian	2,880 *(6.7%)*	1,119 *(9.1%)*	681 *(5.4%)*
Others	1,962 *(4.6%)*	663 *(5.4%)*	831 *(6.5%)*
Total	43,113 *(100%)*	12,315 *(100%)*	12,717 *(100%)*

(Source: Waitemata District Health Board & WestKids, 2002, p.13)

A higher proportion of births in West Auckland in 2000/2001 were Pacific children and Pacific women in West Auckland tend have higher fertility rates compared to the rest of the West Auckland population. Therefore, it is likely that in the future a higher proportion of children in West Auckland will be of Pacific Island origin (Waitemata District Health Board & WestKids, 2002, p.14).

3.2.4 Hospitalisation

Some hospitalisations are thought to be potentially avoidable – for example by avoidance of injury or harmful behaviours, or by early care in the community. In terms of injury, around 40% of young people are

hospitalised when the injury could have been avoided. For non-injury conditions such as glue ear, respiratory infection and asthma, Pacific Island young people have higher rates of non-injury avoidable hospitalisations than other ethnic groups. Table 4 highlights the main concerns for Pacific Island young people including 'ENT infections', 'cellulitis', 'other potentially avoidable hospitalisations', 'pneumonia', and, 'asthma'.

Table 4. Top ten causes of potentially avoidable hospitalisation (PAH) 1999, 0-24 years (rates per 1000 population)

	North Auckland	West Auckland	Maori WA	Pacific WA	Others WA	New Zealand
ENT infections	5.2	6.9	5.9	6.1	7.4	6.5
Asthma	2.1	2.6	1.9	4.4	2.4	3.9
Gastro-enteritis	1.9	1.7	1.4	2.0	1.7	3.3
Dental	2.2	2.1	1.4	3.1	2.1	2.9
Acute bronchitis	1.1	2.3	3.1	5.1	1.2	2.8
Pneumonia	1.3	2.0	2.0	4.7	1.4	2.6
Cellulitis	2.2	2.9	3.1	5.7	2.2	2.5
Other respiratory infections	0.5	0.7	0.5	1.1	0.6	2.4
Epilepsy & febrile convulsion	0.7	0.9	0.6	1.0	1.1	2.0
Kidney/urinary infection	1.0	1.3	1.3	0.8	1.4	1.2
Other PAH	2.4	3.2	2.3	4.9	3.1	3.6
Total PAH	20.6	26.6	23.6	38.7	24.5	33.7

(Source: Waitemata District Health Board & WestKids, 2002, p.14).

WACYHDS review of the literature found 34 health related issues of concern in the Pacific Island population in West Auckland. One of the issues, youth health, contained concerns over primary healthcare and public health issues. WACYHDS found that alcohol and drug usage, cigarette smoking and teenage pregnancy were the main issues that were affecting Pacific Island youth health development.

Many Pacific Island families may be unaware of their teenagers drinking alcohol and taking drugs. Table 5 outlines the extent of alcohol and drug abuse among young people in New Zealand.

Table 5. Adolescent Drug Use in NZ of 15-17 year olds and 18-19 year olds in NZ who had used other drugs in the last 12 months, 1998.

	Men		Women	
	15-17 year old	18-19 year old	15-17 year old	18-19 year old
Marijuana	25	44	24	32
Hallucinogens	7	21	6	10
Stimulants	3	10	3	5
Kava	4	7	3	4
Solvents	1	2	2	0
Opiates	3	2	4	0

(Source: Alcohol & Public Health Research Unit, 2002).

Two reports by Scragg and Laugesen (2001) and Scragg (2001) about fourth form students in secondary schools and smoking behaviour.

Table 6 and 7 provides some insight into the growing problem of smoking for young people in Waitakere when a survey questionnaire about cigarette smoking was distributed to students from Waitakere College. The survey found that 'daily' smokers were 21 percent and higher than the rest of Auckland at 13.4 percent for fourth form female students. For the fourth form male students the pattern was the same, 'daily' cigarette smokers were 15.5 percent compared with the rest of Auckland at 12.2 percent. Only 31.1 percent of female students and 39.9 percent of male students indicated that they have never tried cigarette smoking (Table 6 and Table 7). This was the same with the rest of Auckland at 38.1 percent of female students and 39.6 percent of male students indicated that they have never tried cigarette smoking.

Table 6. Smoking amongst 4th form female students 1999 and 2000

Smoking category	Waitakere City	Rest of Auckland
(n)	1036	6958
Smoker		
Daily	21%	13.4%
Weekly	8.1%	7.4%
Monthly	7.0%	6.9%
Less often	11.5%	13.9%
Non-Smoker		
Previous	21.4%	20.3%
Never	31.1%	38.1%

(Sources: Scragg & Laugesen, 2001; Scragg, 2001).

Table 7. Smoking amongst 4th form male students 1999 and 2000

Smoking category	Waitakere City	Rest of Auckland
(n)	830	7172
Smoker		
Daily	15.5%	12.2%
Weekly	4.2%	5.1%
Monthly	5.2%	4.8%
Less often	12.1%	13.0%
Non-Smoker		
Previous	23.1%	25.3%
Never	39.9%	39.6%

(Source: Scragg & Laugesen, 2001; Scragg, 2001).

Finally, the WACYHDS reported high fertility rates among Pacific Island young women aged between fifteen to nineteen years living in West Auckland. Table 8 shows that Pacific Island young women have much higher rates of teen pregnancy in West Auckland compared against other ethnic groups except Maori. Even in some remote regions such as areas around North Auckland, the Pacific Island teenage pregnancy rate is higher than most other ethnic groups except Maori.

Table 8. Average fertility rates 15-19 years 1996-1998 (3 year average)(rates per 1000 women).

	Total	Maori	Pacific	Other
North Auckland	14	53	42	9
West Auckland	31	68	57	15
New Zealand	31	76	53	15

(Source: Waitemata District Health Board & WestKids, 2002, p. 29)

3.3 HEALTH POLICY RESPONSE TO ADOLESCENT NEEDS

The Ministry of Health (2002b) produced a specific health plan for Pacific Island people. It concentrates mainly on child health issues. However, it warns that Pacific Island young people are losing their cultural heritage and highlights problems of youth alienation. The health plan promotes the establishment of Pacific Island youth health service to address mental health, sexual and reproductive health, suicide prevention, alcohol, drug and tobacco consumption issues particular to Pacific Island young people (Ministry of Health, 2002b, p. 4-5).

On September 2002, the Ministry of Health launched a specific action strategy for young people alone. In particular, Goal Eight is a specific

action plan for Pacific Island young people which concentrates on addressing a number of issues. The action plan seeks to encourage more active participation by Pacific Island young people in the development of policy, design and delivery of youth health services. It also aims to improve access to primary health care services for Pacific Island young people, provide a wide range of health services, improve its health promotions strategy, reinforce working relationships with other youth health services and provide workforce development initiatives such as train more skilled staff on how to work with Pacific Island young people (Ministry of Health, 2002c, p. 43).

3.4 HEALTH ISSUE POLICIES

Recently, there have been a host of policies focusing on young people and specific health issues. In March 2001, the Alcohol Advisory Council of New Zealand and the Ministry of Health released a national strategy on reducing alcohol and drug consumption (Alcohol Advisory Council of New Zealand & Ministry of Health, 2001). The same year, in October, the Ministry of Health, produced a youth health policy that focused on sexual health issues (Ministry of Health, 2001d). And in November 2002, the Problem Gambling Foundation of New Zealand released a discussion document that had Goal 5 as a priority for Pacific Island people (Problem Gambling Foundation, 2002).

A national survey on youth health issues conducted with young people from secondary schools all over New Zealand reported three major findings (Adolescent Health Research Group, 2003).

> 1. Most New Zealand secondary school students are healthy. More than 80% of students feel healthy, do not engage in multiple risky behaviours and report positive connections to family, schools and peers.
>
> 2. Health services are not meeting the needs of today's youth. About half of surveyed youth have not sought assistance from health services (even though they knew they needed to) due to a wide range of perceived barriers.
>
> 3. There are concerning numbers of youth whose health development is at risk. A significant number of youth ride in cars with potentially intoxicated drivers, grow up in unsafe environments and experience emotional health problems.
>
> (Adolescent Health Research Group, 2003, p.3).

3.5 HEALTH SECTOR RESPONSE TO ADOLESCENT NEEDS

Youth health professionals have suggested a number of ways when working young people. Watson (2001) provides five key ways: firstly,

generate ‘rapport’ and build trust; secondly, have an understanding of adolescent physical, mental and social development; thirdly, have ‘sound clinical skills’ for assessing; fourthly, have good ‘networks’ to access more help; and lastly, utilise appropriate tools such as H.E.A.D.S.S and risk / resiliency frameworks to ‘build resilient youth’ (Watson, 2001, p. 26).

Shaw (2001) highlights other factors especially during health professional-adolescent interaction. She emphasises the importance of the health professional conducting conversational dialogues with young people. In addition, she suggests that environmental factors such as people in the waiting room or the look of the waiting room can be important factors in attracting young people to youth health services. Young people hold ‘privacy’ and ‘confidentiality’ as important issues for service providers and health professionals to understand because they discourage young people from visiting health services.

Adolescent healthcare settings, in terms of design and layout, are effective in attracting adolescent usage if young people themselves are involved in the planning. This initiative will encourage young people to access a health service that is youth friendly, ‘visible’, ‘available’, ‘flexible’ and ‘coordinated’. A holistic approach is recommended that includes ‘the context of their family’ and a practice that refrains from ‘instructing’ the adolescent so the adolescent and the health

professional develop realistic goals and plans 'together' (Coupey, 1997).

3.6 WHAT DO ADOLESCENTS THINK OF HEALTH CARE IN NEW ZEALAND?

Gray (1994) used focus groups and questionnaires with 234 young people aged between ten to twenty four years old to gather information about their perceptions of primary health services. For example Pacific Island young people in the study shared that they did not seek help because they felt embarrassed or wanted to avoid a fuss. Gray (1994) found that ten to fourteen year olds saw biomedical problems as the key health issues for their age group; the concerns of the fifteen to twenty-four year olds were largely psychosocial and behavioural.

Gray presented a five point criteria, which the Ministry of Health adopted in 1995 regarding effective services for young people. The criterion brings together the particular primary health service features, which young people identified, in the study as important to them. They included: first, access, that is affordable, located close by informative; second, acceptability, that is culturally appropriate and confidential; third, quality of care is good, that is timely and approachable; fourth, care is on and off-site; lastly, that the health service is evaluated regularly (Ministry of Health, 1995, p. 6).

3.7 SUMMARY

Pacific Island youth populations are projected to double over the next couple of decades. Primary healthcare rates such as potentially avoidable hospitalisations and mortality are alarming. A large number of mortality causes are related to social factors such as unemployment and poverty. Youth health issues also extend into other factors such as underutilisation of youth health services by young people and a lack of health professionals capable of working with young people and their needs.

Responses to young people's health issues have largely originated from central government, service providers and health professionals. Policies such as Youth Health: A Guide to Action (Ministry of Health, 2002c) and Pacific Health and Disability Action Plan (Ministry of Health, 2002b) are central government initiatives targeting healthcare services and workforce development. WACYHDS (Waitemata District Health Board and WestKids, 2002) was developed by service providers and health professionals to address children and young peoples health issues in West Auckland. However, some responses were derived from young people themselves such as New Zealand Youth: A Profile of Their Health and Wellbeing (Adolescent Health Research Group, 2003) and 'Effective Health Services for Young People' (Ministry of Health, 1995).

Therefore the contextual framework of the ‘Talanoa ile I’a’ model (TII) is based on the context of youth health issues and youth health responses particularly those that are affecting Pacific Island young people.

CHAPTER FOUR

THE CONCEPTUAL FRAMEWORK

4.0 INTRODUCTION

Theory is a set of assumptions or a system of ideas, which are formulated to explain a phenomenon. As previously stated in Chapter Three, youth health issues are diverse (or multifarious), from primary healthcare to public health concerns, and responses to these problems generally focus on targeting health care providers and the practices of health professionals. This provides an overview of the Pacific Island youth health context. The conceptual framework constitutes a combination of three theoretical approaches to explain why youth health issues are an emerging concern and to explain how the responses were shaped to address youth health issues.

Firstly, the study rests on the belief that understanding Pacific Island culture is very important in working with and for Pacific Island young people. A literature review was undertaken to shed light on existing descriptions of what a Pacific Island perspective may be, as well as to identify any implications on Pacific Island young people. Section 4.1

draws on examples from Samoan formation of concepts and ideas of health as illustrations of a Pacific Island perspective.

The second theoretical perspective is derived from a review of literature that traces significant advances sociology contributes to youth health issues. The present study ascribes to medical-sociology theory (section 4.2) because sociology provides a social context of health and illness whereby biomedical factors are often eclipsed by social factors such as ethnicity and access to care. In addition, medical knowledge alone does not provide sufficient understanding of the underlying causes of morbidity (disease) and mortality (death) such as the role of stress in illness – generally underutilized by medical professionals in explaining health status. Accordingly, medical-sociology theory is important because of its emphasis on social determinants of health as an underlying cause of poor health outcomes in young people health development.

The third theoretical perspective originates from literature about youth health theory. The study found that biomedical and psychosocial factors are the most important health issues for young people in the previous chapter. Section 4.3 provides an explanation by describing the immense and tumultuous changes young people undergo as they transform from child to teenager. Added to this dilemma, Pacific Island young people are also coping with cultural identity formation and spirituality issues. Growing up in New Zealand for a Pacific

Island young person is more than just biomedical changes but are also psychosocial, such as trying to 'fit in'; cultural, such as learning two languages and cultures; and spiritual, such as Christianity and traditional religious beliefs. The benefits of youth health theory for the 'Talanoa ile I'a' model are in the role biomedical and physical changes exact in the lives of Pacific Island young people.

4.1 PACIFIC ISLAND THEORIES

4.1.1 The Role of Pacific Island culture and health knowledge

MacPherson and MacPherson's (1990) ten-year longitudinal research on Samoan society described an alternative notion of health, illness and injury, to those proposed by the dominant conceptions of western medicine science. Western medical science generally relies on factors such as evidence, laboratory experiments, technology, pure chemical compounds to create tablets and formulas, and, it looks at the structure and function of the body parts. Samoan medicine and treatment differ in many ways. Samoan medicine science is grounded on experiences, clinical observation summaries, using herbs and natural agents, and looks at the behaviour of the system as a whole.

According to MacPherson and MacPherson (1990), Samoans believe that supernatural agencies determine the human condition and various

gods were often called upon to ensure that illnesses did not manifest itself upon Samoan society. Samoans also believed that if an individual became sick it represented many things: firstly, that the individual was sick and it had something to do with the spiritual elements; or secondly, that the individual became sick because the gods were punishing him/her because of wrongdoing (MacPherson and MacPherson, 1990, p. 38-9).

Samoan society possesses traditional knowledge, such as which herbs and plant life would provide cures and how to apply them. Samoan medical knowledge extended into the art of healing and practiced body-healing techniques such as fofo. If prayer failed to heal the sick member then special potions and herbal remedies are concocted to heal the sick or heal the injury. Essentially, the development of a secular-biological paradigm (western medicine science) was unnecessary because the supernatural paradigm (Samoan medicine science) was available.

4.1.2 The role of religion / spirituality and health

Tupou (2001) believes that the church, religion and spirituality have a significant impact on well-being. As a Tongan Methodist minister, he describes three essential concepts: the body, the soul, and the spirit, and their roles in keeping individuals healthy. The body is the physical part of the person: flesh, blood and bones. The soul is comprised of

the intellect, emotion and the will. It includes the power of reasoning, feeling and decision-making. The spirit is the communication channel with God that influences man's beliefs and behaviour. The integration and harmony of all three is vital for maintaining good health.

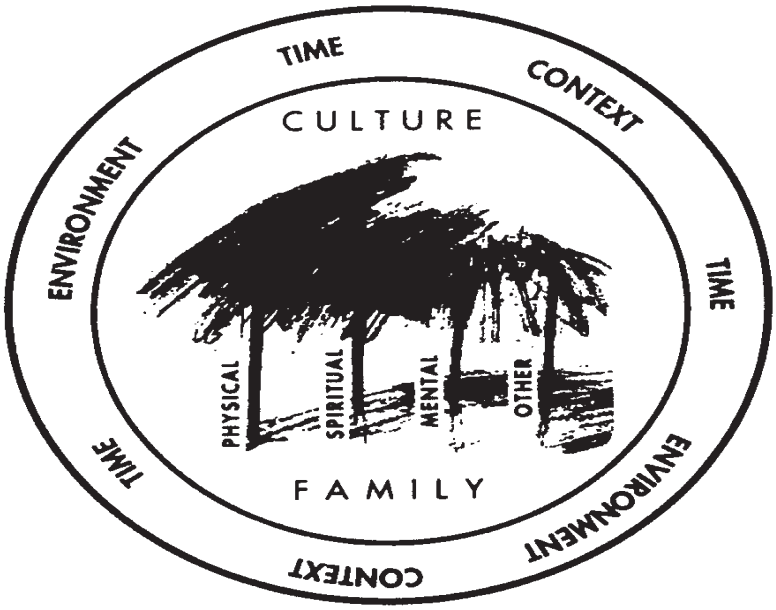
Tupou (2001) also describes two other important concepts that have a significant impact on well being: culture versus health and church versus health. The first concept is a cultural belief that 'Big is beautiful' and a person's mana is proportionally increased in relation to an individual's physical size. Because Pacific Island people are naturally big in their bone structure, 'bigness' is a sign that one is a true Pacific Islander and not some "half-baked foreigner". 'Bigness' is also associated with noble connections because nobility is linked to prestige and authority. The second concept, church versus health, relates to church events, which are stocked with large quantities of food, drinking of kava and heavy cigarette smoking. Despite the dangers of eating, drinking kava and smoking cigarettes too much, these church events have become customs and rituals played out by high-ranking officials, village chiefs and ministers in front of women, children and young people.

4.1.3 FONOFALE MODEL

Another model in working with Pacific Island people is the 'Fono Fale' model. The 'Fonofale' model is important to the TII model

because it outlines the multitude of influences Pacific Island young people have to contend with, and shows that each influence is channelled through different levels of Samoan society. Karl Pulotu-Endemann developed the 'Fonofale Model' from past work experiences (Mental Health Commission, 2001). Pulotu-Endemann used the metaphor of a Samoan to represent the different aspects of Samoan life. Diagram 4 outlines the components of the 'Fono Fale' model that the study highlight as factors impacting on Pacific Island youth health development: 'time', 'environment', 'context', 'culture', 'physical', 'spiritual', 'mental', 'social' and 'family'.

Diagram 4: Fonofale Model



(Source: Lui, (2000) with permission).

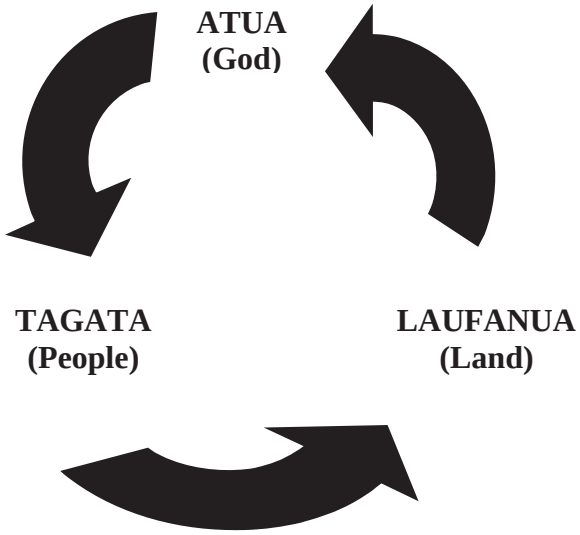
Each component of the 'Fonofale' model constitutes the various aspects of Pacific Island youth life. The roof represents cultural values and beliefs that are the shelter of life. These can include traditional methods of healing as well as Western methods. Culture is dynamic and therefore constantly evolving and adapting. The foundation represents the core of Pacific Island existence beginning through the family institution, which forms the fundamental basis of Pacific Island social organization.

Between the roof and the foundation are four posts: spiritual, physical, mental and other (for example, social factors such as age, gender, social class, educational status and employment). Spirituality is the sense of well being that stems from a belief system, which includes the values adopted from Christianity and traditional religious convictions. This post also accommodates language and history. The posts, 'physical' and 'mental' represent biological and psychological well being respectively. The post called, 'other', represents variables such as gender, sexual orientation, age, and social class, to name a few. The remaining components, 'environment', 'time', and 'context' are additional parts to reflect the uniqueness of Pacific Island people living in New Zealand.

If all these factors including the posts, the roof, the foundation, environment, time and context are in tune with one another, the individual is of good health. If any one of these factors is not in tune

with one another, then the individual is believed to be not healthy. This is the belief of Lui (2000) who presented a Samoan concept called, 'Soifua Maloloina', at the tenth annual Mental Health Services Conference held in Australia. 'Soifua Maloloina' means 'Life Wellness'. The 'Soifua Maloloina' model (Diagram 5) is adapted from the Fonofale Model and an illustration of Pacific Island health theory that intrinsically views health as holistic and functioning harmoniously, shaping one's health positively.

Diagram 5: 'Soifua Maloloina' Model



(Source: Lui (2000) with permission)

According to Lui (2000) the 'Soifua Maloloina' model is about maintaining good, safe and balanced relationships between: 1) the person and God 2) the person and land (environment) and 3) the person and other people are necessary to achieve good health. Every

relationship is sacred (tapu). Every relationship has boundaries. These boundaries are defined and governed by *tapu* or *sa*. The breaking of the tapu or sa may result in the person being punished and finding his or herself outside of the relational arrangement (unbalanced relationship). The punishment can be a fine (pigs, fine mats, food, other valuables), banished from village, curse or even death. The breaking of a tapu or sa can also result in a curse being placed on that person. Curses can cause illness of a physical nature (sores, disfiguration of body), mental/spiritual illness (hearing voices, hallucinations) or both. Traditional treatment of mental/spiritual illness involves use of herbs, massage and talking treatment or a combination. The herbs and leaves are rubbed on or mixed with water, strained and taken orally. The treatment is done by a *taulasea* (healer). This is generally how Pacific Island view health, not just about an injury or the biomedical circumstances but also about cultural, social, spiritual and environmental factors and the role they play in Pacific Island youth health development.

The TII model and its conceptual framework are based on the importance of sociological perspectives in redefining medicine science. The concept 'by Pacific for Pacific' is a Pacific Island perspective that is self determining and ethnically driven. The 'Fonofale' model is a Pacific Island perspective that describes Pacific Island health as holistic. The TII model is a by-product of the concept 'by Pacific for Pacific' and utilises the 'Fonofale' model to show the range of

pressures that impact on Pacific Island young people. The TII model has a conceptual framework based on Pacific Island theory and models to portray a Pacific Island perspective that is very different to non - Pacific Island perspectives. Overall, just being born a Pacific Islander is a social factor because already the young person requires specialist support in the form of a Pacific Island youth worker or Pacific Island youth service. The 'social' factor is the subject of the next section and explaining Pacific Island youth health issues always leads back to sociological factors to determine the cause.

4.2 MEDICAL-SOCIOLOGY THEORY (MST)

4.2.1 THE 'SICK ROLE' CONCEPT

Talcott Parson (1951) began the reorientation of American medical-sociology in a theoretical direction. From observing interactions between the doctor-patient medical consultations, he developed a concept called 'the sick role', which describes the many actions and behaviours that arises from the exchange. Parson noted things such as the way patients behave when they see their doctor or vice versa, he noted that when someone is sick they behave in different ways. For example, some patients avoid health care because they can't afford it and others seek help as the last resort. In addition, the 'sick role' theory also exposes the actions and behaviours of the health

professional as another social factor. For example, some health professionals overlook the importance of social factors as a determinant of ill health and rely on medicine science alone. From patient-health professional interactions Parson was able to formulate a theory of health that recognised the value of social factors for determination and assessment of health issues.

Cockerham (1998) notes that 'the merit of the concept is that it describes a patterned set of expectations defining the norms and values appropriate to being sick, both for the sick person and those who interact with that person' (Cockerham, 1998, p.11). In other words, patients adopt a number of certain behaviours such as compliance, concealment or resistance (social deviance). Patients can either accept what the doctor advises, or pretend to be sick, or after the consultation with the doctor throw the prescription away. At the same time, doctors respond either by using authority or negotiation (social control). Cockerham explains that patients who fall sick are removed from their social responsibilities and doctors are charged with the role of alleviating the sickness and returning the patient back to society (equilibrium).

This pattern of patient-doctor relationships is relevant in Pacific Island youth health issues. Pacific Island young people are often shy and diffident when they feel unsure of their surroundings, and for some language is a barrier. Pacific Island young people access health care

services only as a last resort, and when they do they take on different behaviours. This variation of behaviour originates from a range of social factors such as the environment, the staff member and the type of response offered by the health care service. Good communication skills, the ability to relate to Pacific Island young people and good advice is essential in Pacific Island young person-health professional relationships.

A healthy Pacific Island young person returns to society after accepting the treatment prescribed by the health professional. However, compliant behaviour is only one expression; some Pacific Island young people may pretend or reject medical advice (social deviance). Health professionals who are authoritarian may influence Pacific Island young people to pretend or reject medical advice, if they are negotiating and approachable, Pacific Island young people may accept the medical advice (social control). When social compliance and social control are controlled, an 'equilibrium' is achieved, however, when social deviance sets in, social control is difficult and subsequently upsetting the 'equilibrium'.

The emergence of MST challenged the conservative ideas of medicine science that culminated in the medical model. The medical model focuses on curative medicine. Its fundamental assumptions are threefold: firstly, all disease is caused by a specific aetiological agent ('the disease entity') such as viruses; secondly, the patient is regarded

as the passive target of medical intervention because the human body is metaphorically compared to a machine that has malfunctioned, rather than a person in a complex social environment; and lastly, rehabilitation requires the use of medical technology and, scientific procedures alone (see Cohen, 1961; Reise, 1953).

Mishler (1989) argues that the medical model 'dehumanises' the process of recovery, because it justifies the use of medical technology precluding alternative therapies and procedures, and the patient is simply regarded as an organism, excluding social and psychological needs. Mishler notes,

> 'Essentially…the biomedical model strips away social contexts of meaning. Illness is then viewed as an autonomous entity, defined by standard universal criteria, isolated from the lives and experiences of patients and physicians. Although symptoms and illnesses occur in people who live within sociocultural frameworks of beliefs and action, these contexts tend to be ignored in the biomedical approach' (Mishler, 1989, p. 153).

Mishler suggests that the medical model is only effective when it accommodates sociological perspectives. For example, during doctor-patient interactions, health professionals should assess patients for primary health and social related health issues. The advantage of social factors in health assessments is that it provides a wider causal

explanation of illness and the means to formulate a responsive recovery plan. Social factors such as class, age, ethnicity, gender, social structures (family, schools, church and workplaces), environmental influences (housing conditions and weather), and state institutions (policy and regulatory devices), are prevailing influences in Pacific Island youth health development.

4.2.2 TWO STRANDS OF MEDICAL-SOCIOLOGY THEORY

There are two main strands in MST: sociology *in* medicine and sociology *of* medicine (Brown, 1989; Cockerham, 1998). The first strand, sociology *in* medicine, involves work conducted by a sociologist in consultation with the health professional such as presenting relevant social factors towards the diagnosis and prognosis of a patient's ill health. It involves the use of sociological perspectives to clarify medically defined problems and objectives, such as the nature of patient compliance to medical advice.

By contrast, the sociology *of* medicine has been more concerned with issues of power between doctors and patients, and between medical fraternity and the state. Viewed from outside of the health sector, this strand looks at issues such as 'medicalization', which has produced dependency on antibiotics and amphetamines. The sociology *of* medicine strand emphasises gender issues as in Feminist theory (Bryson, 1992; Williams, 1989) such as the disparities between men

and women who work for health sector. At the same time, the sociology *of* medicine looks at ethnic-specific issues as in Anti-Racist theory (Spoonley, 1988; Spoonley, Pearson & MacPherson, 1991; Williams, 1989), which highlights the importance of ethnicity and culture such as Pacific Island health knowledge and treatments.

4.3 YOUTH HEALTH THEORY

Adolescents are not a homogenous group but display wide variability in biological, emotional and social growth. Each adolescent responds to life's demands and opportunities in a unique and personal way. Furthermore, adolescents must meet the challenges that arise from their own high-risk behaviours as well as the many social factors that affect their lives. The transition from childhood to adulthood does not occur by a continuous, uniform synchronous process. In fact, biological, emotional, intellectual, and social growth, occur at different times for each adolescent as well as overlap (Crockett & Petersen, 1993).

4.3.1 EARLY ADOLESCENCE

According to the literature on adolescent biopsychosocial development there are three main phases. The first phase, early adolescence (ten to fourteen years), is marked by a series of changes such as moving from

dependence on parents to independent behaviour. Anderson and Sabatelli (1998) argue that restoring the gradual lessening of social and emotional ties to family and parents is essential for adolescent development because imbalances between 'separatedness' and 'connectedness' often leads to psychological functioning problems. Another change is increased hormonal activity and the onset of puberty. This results in sexual development of genitalia, growth in weight and height, and changes in voice (Biro, 1998; Finkelstein, 1998), which vary in terms of ages and ethnicity (Herman-Giddens, Slora & Wasserman, 1997). This can be problematic as well; research has shown that boys who develop earlier than others tended to be more athletic, popular, and smarter than their peers, whilst those boys who had not reached this stage were socially maladjusted, insecure, and susceptible to peer pressure (Clausen, 1975). For girls, those showing signs of sexual development well before the next phase of adolescence were more confident about themselves, while other girls who had not, felt more negatively about their bodies and their appearance (Brooks-Gunn & Peterson, 1983).

4.3.2 MIDDLE ADOLESCENCE

The next phase, middle adolescence (fifteen to seventeen years), is characterised by consolidation of the multiple changes and transition of the early adolescence pubertal period and preparation for the major

transition to next phase of development. Autonomy becomes the central issue, formation of gender identity, and differential gender roles between boys and girls (Galamos, Olmeida & Petersen, 1990; Josselson, 1994; Josselson, 1987). Peer group involvement increases and family interaction decreases. Adolescents begin to model themselves after their peers (in some instances, parents or other adults) and some argue that this process is significant because peers can influence behaviours such as smoking. Smoking allows the adolescent to show allegiance to a particular peer group (Rich Harris, 1998; Rich Harris, 1995).

In adolescence, puberty and hormonal activity should have been completed but other adolescence may still be undergoing pubertal and hormonic changes. However, the development of formal operational thought that includes increases in the capacity for abstract reasoning, hypothetical thinking, and formal logic is more apparent in middle adolescence (Inhelder & Piaget, 1958; Jessor, 1993). Significantly, some adolescents living in economically disadvantaged families may not be exposed to the full range of abstract reasoning, decision making and future planning, as some studies on teenage pregnancy reveal (Franklin, 1988; Franklin, 1987).

Smoking, teenage pregnancy, drugs, alcohol, gang violence, car racing and other risk taking behaviours are more prevalent than the early adolescence phase, and perhaps permanently set in the adolescent

lifestyle before reaching late adolescence (Dinges, 1993; Kirby, 1997; Peterson, Richmond & Leffert, 1993; Werner & Smith, 1992).

4.3.3 LATE ADOLESCENCE

The last phase, late adolescence (eighteen to twenty four), depends on whether the individual has proceeded fairly well in early and middle adolescence, including the presence of a supportive family and peer group. If so the adolescent will be well on his or her way to handling the tasks and responsibilities of adulthood. If previously identified tasks (phase one and two) have not been completed, however, then problems such as independence-dependence struggle, coping difficulties with puberty, mental health problems such as addiction and depression, sexual health issues such as teenage pregnancy, and suicide ideation, may develop further into the late adolescence phase.

Developmental changes alone do not explain variations in health behaviours during adolescence. The complex interactions of the developmental changes are also compounded by social context factors. Those who work with and for adolescents are reminded of the challenges presented by adolescent developmental transitions. For Pacific Island young people these changes, from early adolescence to late adolescence are significant turning points in their lives.

4.4 SUMMARY

The study is grounded on three theoretical perspectives: Pacific Island theories, Medical-Sociology theory, and, Youth Health theory. For Pacific Island theories, the role of Pacific Island culture, religion and spirituality and wellbeing, and the 'Fono Fale' model represent a distinct theoretical orientation that is uniquely Pacific Island. The growth of Pacific Island knowledge and ideas of health can only add value to Western notions and widen the field of Western medicine science that has dominated health formulations and treatment for a long time. Both models provide an understanding of who a Pacific Islander is and what sort of world they come from, particularly Pacific Island young people. In addition, both models account for the varying influences that are part of the Pacific Island youth world and evidence that health issues are social related health issues as well.

The importance of social factors is emphasised by the Medical-Sociology theory as an important theoretical component for health because the use of sociology within medicine science means health issues are more clearly explained, clarified and responsive. Medical-Sociology theory can link together many components: biomedical data; professional practice; institutional structures; economics and financing; demographics of disease and death and the individual experience of health, illness, and health care, into one. This linkage is possible through the recognition of the two strands of MST sociology *in*

medicine and sociology *of* medicine. Both strands represent a growing use and acceptance of sociology in health research, health services, health professional training, health knowledge, health policy and health assessments of individuals.

The third theoretical perspective, Youth Health theories, emphasises the importance of acknowledging the biological, psychological, social and cultural challenges adolescents face as they move from being a child to teenager to adulthood. The shift in Youth Health theory from a reliance on medical permutations and formulations to accommodating psychosocial and cultural factors has only strengthened the work of those working with and for adolescents. Two factors in particular have been driving this change: firstly, a recognition that family, culture and context shape the young person including biological processes; secondly, findings from studies that have highlighted different factors that are associated with health development signal a shift away from traditional human development works such as Freud's psychosexual theory (1953), Erikson's psychosocial theory (1968), and Piaget's cognitive development theory (1952) to more contemporary works.

In relation to the 'Talanoa ile I'a' model, the three theoretical perspectives outlined in this chapter are relevant and significant. The concept 'by Pacific for Pacific' and the 'Fono Fale' model introduce Pacific Island thinking and formulating as a distinct theoretical

orientation. These Pacific Island theories also provide insight into Pacific Island culture, which is capable of managing and operating health services independently. The TII model is also an exponent of explaining the causes of youth health issues as related to social factors, which the analysis of MST outlines in section 4.2. Finally, the TII model is about explaining the causes of youth health as related to physical and mental changes, which is outlined in section 4.3.

Overall, the three theoretical perspectives are woven together to provide a conceptual framework for the study. Having established key youth health issues and responses as well as setting a theoretical explanation based on Pacific Island theories, medical-sociology theory and youth health theory, the situation sets the study in motion towards applying a method (Chapter 5) to depict what Pacific Island young people consider as important health issues (Chapter 6).

CHAPTER FIVE

THE RESEARCH METHODOLOGY

5.0 INTRODUCTION

Health evaluation literature has stressed the use of 'listening' to participants' perceptions of needs and priorities and has been argued to be a more ethical research process (MacDonald & Davies, 1998). The main research question of this study is what are the important health issues for Pacific Island young people in West Auckland? In order to answer this question the present study requires a research methodology that is exploratory and investigative. The present study proposes that it is not sufficient to talk to those who work with young people and those who work for young people. Instead, the study emphasises that talking directly to young people is far more important especially when it comes to understanding ethnic-specific or Pacific Island youth health needs and working out ways to addressing these needs.

This chapter outlines the research process and research design the researcher employed in order to answer the main research question. The first process involved preplanning, which included obtaining permission from Massey University Human Ethics committee. On the 30th of April, 2003, the study was approved and the researcher set about the next step, negotiating access. The research design had two main stages: a pilot study to test the interview schedule and then focus groups were staged live to collect data. The final research process was the conversion of the data collected as a preliminary analysis phase

into a summary form that included transcribing and preparation of the data. This was essential in order to sift and filter out common themes, patterns and trends for Chapter 6.

5.1 THE PARTICIPANTS

The participants were Pacific Island young people who are students of secondary high schools and training providers from West Auckland. There were twenty-four participants altogether and all resided in West Auckland. Table 9 below is a summary of the sites where participants were recruited.

Table 9. Recruitment Sites for Participants

Research Sites	Male	Female
*Engineering Industry Training Limited	0	6
Henderson High School	3	3
Massey High School	5	1
*Target Education	3	3
total	**11**	**13**

(**Denotes participants from training providers in West Auckland)*

Ethnicity

Over half of the participants identified themselves, as Samoans and most were able to recall their father and mother village names. Table

10 below is a summary of the participants' ethnicity including whether they knew their father and mother village names.

Table 10. Pacific Island Ethnicity backgrounds for Participants

Participant mostly identified	Father's ethnicity	Mother's ethnicity
Fijiian	Indian	Fijian
Samoan	German	Samoan
Palagi	Palagi	Cook Island
Cook Island	Tahitian	Cook Island
Samoan	Samoan	Samoan
Samoan	Samoan	Samoan
NZ born Samoan	Samoan	Samoan
NZ born Samoan	Samoan	Samoan
Samoan	Samoan	Samoan
Samoan	Samoan	Maori
Tongan	Tongan	Tongan
Samoan	Samoan	Samoan
Niuean	Samoan	Niuean

5.2 THE RECRUITMENT PROCESS

The participants were recruited on the basis of gender, ethnicity, age, and lived in West Auckland. Gender is important as it necessarily

includes the perspectives and experiences of both male and female Pacific Island youth in this study. Ethnicity is also important because it highlights the perspectives and experiences of what it is like to be a Pacific Islander, an essential component to understanding a Pacific Island youth perspective. Pacific Island ethnicity plays a central role in the study; the 'Talanoa ile I'a' model is a Pacific Island construct for the benefit of Pacific Island youth health. Understanding the world of the Pacific Islander is based on understanding the symbolism in Pacific Island models such as the 'Fonofale' model and 'Soifua Maloloina' model, which represents Samoan life and characterised by different influences including spirituality, mental, environment, context and time (Lui, 2000; Mental Health Commission, 2001).

Location is equally important because some questions posed to participants required responses in terms of knowledge and experience of health services for young people in West Auckland. Participants were recruited in they were living in West Auckland for more than one year. The importance of West Auckland and reasons for its inclusion in the study were outlined in section 3.2.1.

Hence, the following procedure was applied to the manner of recruiting participants for the study. The researcher produced an information sheet (Appendix 1), confidentiality agreement (Appendix 2) and consent form (Appendix 3). These forms were subsequently distributed to each prospective recruitment site identified in section

4.1. The researcher also developed a recruitment advertisement that was posted up in all the prospective recruitment sites (see Appendix 5).

Then the researcher contacted each prospective research site (outlined in Table 8) and negotiated access to prospective participants. The researcher did not target other sites such as child protection agencies (for example, Child Youth Family services), residential programmes (for example, Youth Horizons Trust), and recreational outlets (for example, video game places) because of the complexities involved in gaining access. Instead the researcher relied on those staff members that were familiar to the researcher and from the work the researcher had conducted in secondary high schools and training providers in the past. In this sense, then the choice of sites was a convenience sample.

The study undertook a non-probability sampling procedure by purposively recruiting subjects that were considered relevant to the research topic (Sarantakos, 1998). Sarantakos defines non-probability sampling as a form of research activity that places less emphasis on the sample size and more on the judgement of the researcher. Purposive sampling is one form of non-probability sampling because the researcher deliberately seeks certain types of elements judged to be typical (Davidson & Tolich, 2001, p. 111). In other words, if the study is only interested in listening to the views of Pacific Island young people, then only Pacific Island young people will be sought in the sample. Other criterion put forward by the researcher included a

certain age group (sixteen years and over); both genders; Pacific Island ethnicity or descent; and living in West Auckland.

In all instances those research sites that agreed to participate in the study depended on staff members to gain permission from their superiors who subsequently received approval from their Boards of Governors. In some instances, the researcher waited for four weeks before the study could be implemented. On other occasions approval was received immediately.

Staff members from each educational institution assisted in various ways. Some staff asked for volunteers during their teaching and posted posters on their notice boards that called for volunteers. A staff member at Massey High School sent correspondence to the parents of those students who volunteered to participate in the study so their parents were aware of their children's involvement. Attached to the correspondence were the Information Sheet and a letter from Massey High School. Another staff member provided a roll and together with the researcher discussed prospective participants in accordance to their age, ethnicity, gender and location. The same staff member then approached each student regarding interest and participants were sought in this way.

5.3 THE INTERVIEW SCHEDULE

The research methodology employed a qualitative framework using focus groups and an interview schedule (see Appendix 4). Questions and response categories were determined in advance so responses were relatively fixed and the respondents' answers were filtered accordingly. Data analysis was simplified because responses could be directly compared and easily aggregated.

Questions were based on a similar format described in Quinn Patton's (1990) text on designing an interview schedule. In Quinn Patton's interview schedule he designed questions to collect four main types of information. His interview schedule contained four categories: experience/behaviour questions; opinion/value questions; knowledge questions; and background questions. The interview schedule for the study adopts the idea of preparing response categories such as Quinn Patton to make data collection and analysis simplistic but does not adopt its structural design.

The questions in the interview schedule were designed to collect experiences, behaviours, opinions, values, knowledge, and background information from the participants in relation to the research topic Pacific Island youth health. Firstly, experience/behaviour questions, for example, "What is your experience of using health services?, secondly, opinion/value questions, for example, "Do you think fofo (massage) is good for your health?, thirdly, knowledge questions, for

example, questions about what is fofo? Or knowledge questions about Pacific Island medicine and treatment; and lastly, questions that provide background information such as ethnicity and socio-economic status.

In relation to the 'Talanoa ile I'a' (TII) model this questionnaire design feature is significant. The broad based approach in the interview schedule meant information collected provided a variety of experiences. Some of these experiences were reactions by the participants with regards to health service care and other experiences revolved around health workforce issues. These are domains in the TII model such as the perspective of 'the person at the top of the tree' (service provider) and the perspective of 'the person on the canoe', (professional or practitioner). However the perspective of the 'school of fish' is the basis of the study and not the other perspectives. What the participants had to say about the other perspectives is anticipated in this interview schedule design.

After the pilot test of the interview schedule was conducted further changes were made. The pilot test was conducted with six participants from a training provider. A host of issues emerged that eventually led to changes in the interview schedule. The first issue was to do with the way the questions were phrased and composed. For example, questions such as 'Is illness a result of not pleasing God?' Many participants did not understand the question; the question was

originally composed as a close-ended question so responses were more direct and not explanatory. As a result statement questions were developed to introduce the participants to the topic and the relationship between two concepts, health and religion, in relation to Pacific Island youth health development.

The second issue was the length and time it took to complete the interview schedule. The original interview schedule took two hours from start to finish and participants began to lose interest after one hour. The quantity of questions were shortened, the number of health promotions publications were limited to three handouts. These changes reduced the length and time of the interview schedule from two hours to one and a half. More breaks for the participants were also introduced.

The interview schedule was semi-structured and unstructured. It was structured because the interview schedule was designed to collect responses around specific youth health issues. At the same time it was unstructured because the interviewer freely probed beyond the answers in a manner seeking both clarification and elaboration on the answers given. The questions were designed with a specific focus on health but also designed to enable the respondent to elaborate on the topic (see Gerson & Horowitz, (2002); Mason, (2002); May, (2001)).

Therefore the changes outlined above provided the facility for respondents to challenge the preconceptions of the researcher, as well as enable the respondent to answer questions within their own frames of reference. The changes allowed the respondents to freely express their opinions and viewpoints even if it meant that their answers diverged from the main focus. As Opie (2001) describes, instead of being determined by a formalised, pre-decided, structure, the content of 'unstructured' interviews is shaped by what the respondents tell the researcher. The researcher guides the respondent into particular areas, but the interviewee decides what path is actually followed. Thus, the interview schedule was changed from semi to unstructured as a result of the pilot test, which meant the focus was based on reproducing the world of the person being interviewed, not attempting to make sense of it from some predetermined perspective.

5.4 FOCUS GROUPS

Focus groups enabled participants to share their experiences and knowledge collectively. Focus groups provide the means for gaining insight into the opinions, beliefs and values of a particular segment of the population. Their strength lies in the relative freedom that the group situation provides for participants to discuss issues and reflect on problems. Furthermore, the group situation allows participants to prompt as well as to 'bounce ideas' off one another. In a focus group

the researcher introduces the topic of interest and then ensures that the discussion runs smoothly – that is everyone contributes to the discussion and that no one person attempts to dominate it. The focus group allows researchers to explore group norms and dynamics around topics that they wish to investigate (see, Greenbaum, (1993); Krueger, (1988); May, (2002); Sarantakos, (1998); Waldegrave, (2001)).

A total of four focus groups were staged in the venues where the participants attended either formal schooling or trade skill training. Focus groups were separated by gender. The separation allowed for females and males to air their views on the questions asked of them openly and freely. Had the focus groups been mixed then some of the questions may have made males and females uncomfortable (For example, questions about sexual health issues such as menstruation could prevent openness for female participants if males were present). Similarly, questions about sexual relationships, where a male participant boasts about multiple partners and the way he treats them could offend female participants.

During the implementation of the focus groups there were breaks to offset, 'silent' periods, and long pauses. Before the breaks occurred, participants were reminded about their obligations in terms of confidence and privacy. The researcher reminded the participants that they had signed a confidentiality agreement preventing them from sharing information discussed in the focus groups with their peers and

others who were not part of the study. At the end of the focus groups, participants were treated to meals such as pizza, Kentucky Fried Chicken, pies, fish and chips, and fizzy drinks as a reward for their participation. These meals were bought by the researcher and arranged prior to each session. Focus groups were audiotaped, which where securely stored and passed on to professional transcribers for transcription purposes culminating in the next section of the research design and process.

5.5 DATA ANALYSIS

The designated typists transcribed the data collected on Microsoft Word Processing Program 7.0. The transcriber was instructed to lift the responses from the audiotaped recordings of each focus group and sort these under each question asked by the researcher. The transcriber utilised the structure outlined in the interview schedule and sorted the responses under each category. For example, if the participants were asked about their ethnicity, a total of twenty-four responses were anticipated. Some participants came from mixed backgrounds such as half-Samoan and half-Tongan. The researcher also advised the transcribers that it was not important for transcription to identify each participant. This would prove later on to be a mistake because it became very difficult for transcribers to sift and filter the information

as they did not know who said what and what was this particular participant talking about or in relation to.

Using Quinn Paton (1990) categories (behaviour, values, knowledge and background), the researcher sorted the participants' responses accordingly. Quinn Paton's categories were useful for sorting huge amounts of detail into an analytical framework. For example, participants' responses regarding background information such as ethnicity, beliefs and current living arrangements were sorted into the category, 'background'. Similarly, participants' responses regarding experiences with health services were sorted into the category, 'experiences'. Participants' responses to do with knowledge such as descriptions of Pacific Island traditional medicine and treatment were categorised under 'knowledge' and the same with participants' responses regarding value statements such as opinions about public health promotion materials were categorised as 'values'.

Sorting participants' responses in this way proved to be useful in the analysis stage. This method reduced the multitudes of information into manageable broad based categories to make in-depth analysis easier. Having the Quinn Paton categories provided details and insights into how Pacific Island young people behave, perceive, know about health service care and health workforce issues. Under this preliminary analytical framework, each entry highlighted important analytical information such as common themes, patterns and trends. For

example, the role of ethnicity in the methodology is significant because it influenced the criteria for recruitment, it was one of the main themes during the focus groups discussions and it influences the design of the interview schedule as a topic, one of the causes of Pacific Island youth health issues. Another example is the role of gender influencing the composition of questions and the cause of separating male and female participants into gender-specific focus groups so male and female youth health issues are compared. In Chapter 6, the researcher found that the data could be further categorised into themes such as 'health issues' and 'social related' health issues including cultural and spiritual related health issues.

5.6 ETHICAL CONSIDERATIONS

The staff members who participated in the study, in terms of recruitment and selection, had an established professional relationship with the researcher. The researcher is a trained social worker and youth worker who had opened a youth health service in the area, specialising in Pacific Island youth health and social related issues, and had gained access to the research sites in the past. The researcher staged outreach sessions on various youth health topics at all the venues that the focus groups attended. Since the researcher had already established relationships with the students of the sites where he practiced earlier, it was decided between the researcher and the staff

representatives, that the recruitment and selection of participants for this study would entail students who did not know the researcher or were not familiar with the researcher's youth health service or had not participated in any of the outreach sessions the researcher had conducted.

During the preplanning stage, the interview schedule for the focus group sessions was being put together. There were questions that had to be eliminated. Questions that identified the participant in any way were omitted. Questions regarding the participants' background were refined. Questions about sensitive health issues, particularly for female participants, were carefully scrutinised with the help of the researcher's supervisory team and staff members of the respective research sites. This was done to minimise any discomfort and avoid triggering any event in the past that the participant concealed or recently recovered from.

Focus groups were divided into two groups based on gender. Since the researcher is a male, it would be possibly unsafe for a male researcher to facilitate a female focus group. Therefore by having a female facilitator to question the female participants it would reduce unnecessary interviewer effects such as misinterpreted body language and discomfort on the part of female participants due to a specific-gendered question that a female researcher should be asking.

The female facilitator chosen for the study was an experienced youth health nurse and has worked with Pacific Island young people for more than five years. She was recruited based on her ability to generate discussions, because of her Pacific Island background that included speaking a Pacific Island language, because her interest in youth health work support the philosophies and ideas behind the study, and because of her work with Pacific Island young women particularly sexual health issues. The female facilitator was trained on three aspects. Firstly, the aims and objectives of the study and her role within it such as focusing her interviewing style on the main research topic, Pacific Island youth health issues. Secondly, the female facilitator was trained in communication and interviewing skills in order to avoid interviewer bias. Lastly, the female facilitator was also trained by the researcher conducting a dummy focus group in front of her so she could visualise what the researcher and the study expects. After three weeks of training the female facilitator the study moved on to staging live focus groups.

During the staging of the focus group, discussions and the sharing of experiences were mainly expressed in the language that the participants were familiar and comfortable with. For example, in many of the audiotaped conversations, most participants used vulgar and colloquial language, and this was allowed by the researcher because it was a sign that the participants were comfortable. In many instances

the researcher used the same language so participants could understand the questions.

All the participants were aged sixteen years and over. In some instances, permission was still sought from the parents, mainly so that the parents were aware of the whereabouts of their son or daughter. Permission for the female participants was more common than for the male participants. A consent form was issued to secure the participants attendance despite all of the participants aged sixteen years and over (see Appendix 3).

All the participants were issued confidentiality agreements (see Appendix 2) to ensure that no information that was shared in the focus group would be passed onto non-participants of the study outside of the focus group. All the participants signed and agreed that they would not divulge any information or material to their fellow classmates, friends, boyfriends or girlfriends.

All materials, documents, and audiotaped cassettes conversations were secured after each focus group in a secure case that was kept overnight by the researcher. Then these items were passed on to the team leader of the researcher's supervisory group to be secured in a filing cabinet. This was done until the data collection stage was completed. When the preliminary data analysis stage started, the audiotaped cassette conversations were passed on to a designated transcriber for

transcribing. A transcriber's agreement (see Appendix 6) was issued to safeguard the confidentiality of the participants and the information that was collected from them during the focus group. A recruitment advertisement was produced to minimise the role of staff members who volunteered to help out. Having an advertisement meant that participants were self-selecting or they chose to participate; no approaches were made by the researcher or the staff member.

5.7 THE SUPERVISORY TEAM

The researcher was assigned a supervisory team to assist in the research process and construction of this thesis. The supervisory team was made up of two very experienced people: Mark Henrickson and Pa'u Tafaogalupe Mano'o Tilive'a Mulitalo-Lauta. The key to the success of this study is due to the background and expertise both individuals brought to the research team. Dr Henrickson's expertise in Health issues such as HIV-related and mental health as well as programme design and evaluation is invaluable. Mr Mulitalo-Lauta's extensive knowledge of Samoan and Pacific Island issues as well as being the author of the first book to offer a view of social work in the context of the Samoan ethnic group in Niu Sila was equally invaluable. The combinations of Western and Indigenous ideas highlight the importance of 'culture' and scientific interrelationships as essential considerations for social research processes. Western contributions

such as regulation and procedure coupled with Pacific Island offerings such as indigenous knowledge and the use of key informants provides a more stable research framework. For example, when the researcher made a suggestion, Dr Henrickson would remind the researcher of ethical considerations, and, Mr Mulitalo-Lauta contributed 'cultural' safety issues.

Within this process, the study began to take shape through various meetings and various forms of triangulation. As Laing and Mitaera (1994) describes: data triangulation (the use of a variety of data sources), investigator triangulation (the use of several different researchers or evaluators), theory triangulation (the use o theory triangulation (the use opret a single set of data), and methodical triangulation (the use of multiple methods to study a single problem or program) give the study validity and quality (Laing and Mitaera: 1994, p. 66-7).

5.8 SUMMARY

The research process followed a systematic and chronological framework. The preplanning phases included establishing the extent of youth health problems nationally and locally (Chapter 3) and a conceptual framework (Chapter 4) through a literature review. This provided the researcher with the grounds to prepare a proposal and

develop a research methodology with the assistance of a supervisory team. Chapter 5 outlines the next stage, from preplanning to implementation phase, which a research design in the form of focus groups to collect data using a semi – to – unstructured interviewing schedule was developed. The 'Talanoa ile I'a' model has a contextual framework, a conceptual framework and a research methodology framework. Having equipped itself with a context, theory and research approach, the next stage for the 'Talanoa ile I'a' model is to ask Pacific Island young people what they think are the most important health issues.

After the implementation phase was complete, the next stage of the research methodology was activated, data analysis. Before the data collected from the focus groups could be analysed in-depth, the information had to be transplanted from audiotape records into an analytical framework. Part of the preliminary data analysis also meant the researcher had to further refine the information provided by the transcribers and prepare the data for in-depth analysis.

From using a Pacific Island construct called, 'Talanoa ile I'a (Chapter 2), the study successfully achieved part of its purpose by talking directly with Pacific Island participants. The next chapter will present findings and identify the important health issues for Pacific Island young people (Chapter 6).

CHAPTER SIX

THE FINDINGS

6.0 INTRODUCTION

The following summary of the findings from the research described in Chapter Five is based on responses provided by fourteen participants. The quality of playback from the audiotaped focus group session masked the responses of the remaining ten participants. The findings have been refined from the preliminary data analysis and categorized into four sections. The idea was adopted from Quinn Patton's (1990) interview schedule, which featured four types of questions: experience/behaviour questions; opinion/value questions; knowledge questions; and background questions, and used by the author to group the information provided by the participants' responses. This framework for sorting and categorising responses has been adopted into this chapter in four sections. Each section represents how the participants' responses were categorised and summarised below.

The chapter has four sections. First, section 6.1, 'Background', is findings from questions that uncovered information relating to the participants' background. Second, Section 6.2, 'Knowledge/Experience/Behaviour', is findings from questions

relating to the participants' knowledge of key terms such as 'health', 'culture', 'Pacific Island', 'youth', and 'ill health'. This section also included participants' opinion regarding how much effort Pacific Island young people put towards staying healthy as well as experiences with handling a crisis. Section 6.3, 'Health Issues', contains participants' responses around experiences, opinions, and knowledge of 'health', 'health care services', and 'health workforce'. Sections 6.4 are findings from questions that looked at the participants' opinions or values with regards to the public health publications.

6.1 BACKGROUND INFORMATION

6.1.1 Demographics

The recruitment of the participants for the research project yielded a variety in Pacific Island ethnicities. Six participants indicated that they were full-blood Pacific Islanders (Samoan) and the remaining eight participants indicated that they were from mixed-blood origins. The eight participants originated from the following ethnic breakdowns: Fijiian-Indian, German-Samoan (2), European-Cook Island, Tahitian-Cook Island, Samoan-Maori, Samoan-Niuean and Maori-Niuean. The mean age of the participants was seventeen years of age, seven of them were females and seven were males. All of the participants lived in West Auckland for more than a year.

6.1.2 Values and Beliefs

In terms of what the participants valued and believed in the most, two influences emerged: family and religion. When the researcher asked why, most of the participants expressed emotions such as loyalty and obligation. When the researcher asked for clarification in terms of religion, nine participants indicated they were Christians, three indicated they were atheists and the remaining two participants indicated that they had no exposure to any religious teachings in their family household.

Participants indicated a strong affiliation with family because it is in the family home where they are taught values and beliefs. For example, one participant commented, 'my mother taught me to respect my elders and to say excuse me when I walk past them…my mother also taught me to believe in God to help me when I am in a jam'. Participants also attributed their values and beliefs to God and religious instructions. For example, one participant shared, 'um my beliefs…I love being Christian…oh I'm Catholic actually and I'm fairly strong with my religion, um, and yeah that's what I believe in, my religion um a lot'. Another participant shared that he valued and believed in a combination of influences, namely, 'church', 'upbringing', 'God' and 'family'.

6.1.3 Awareness of services for Pacific Island young people in West Auckland

Out of the fourteen participants, only ten participants were aware of services for Pacific Island young people that were available in West Auckland. The most common categories of services that they mentioned they could go to for help included church-based, ethnic-specific and social services. However many could not name the services in West Auckland that specifically cater for Pacific Island youths.

6.1.4 Living arrangements

The number of family members ranged from two in the family to nine people, as some participants indicated they lived with members of their extended family (2) or lived with foster parents (2). However, a majority of the participants lived with both parents, with only two participants living with their extended family because of family issues. Two participants indicated that they were the only children in the family.

When the researcher asked the participants whom they trusted the most, a significant portion of the participants mentioned their family members, including mother, father, sister, brother, and grandfather. Some participants also mentioned their peers, only one participant

indicated that he trusts no one and prefers to keep to himself. Another participant said the opposite and commented that she trusts everyone.

6.1.5 Future plans

Female participants more often outlined a clear plan to achieving their goals, compared with the male participants who felt that taking one day at time was a better approach. Plans included: getting an education to achieve their career goals (e.g. pharmacy, dentistry); getting a job (e.g. mechanic, airforce); and being a professional sportsman (e.g. basketball, rugby player). Three participants did not identify goals.

6.2 KNOWLEDGE / EXPERIENCE / BEHAVIOUR

6.2.1 Definition of Concepts

Culture

Three participants defined culture as something to do with 'your background', 'religion' and 'race'. Three other participants referred to the way they were 'being brought up', two alluded to traditions e.g. 'we can say that we're Samoan so we do this and that', which was further illustrated when two other participants expanded on this definition by saying culture is being able to speak two languages and

practice customs that are different to other cultures such as non Pacific Island people.

Pacific Islander

There was a wide range of descriptions and characteristics in the information that the participants used when defining what a Pacific Islander is. These have been sorted into two categories, the first category is outlook, for example, one participant mentioned, "colour of skin and wearing lavalavas, jandals and afros". The second category is attitude and behaviour, as one participant noted, "it's their attitude, the way they eat, walk and talk".

Young Person/Youth

In relation to defining the terms, 'young person' or 'youth', the participants hold a consistent view. Two categories were identified: outlook and attitude and behaviour. Outlook refers to responses that describe characteristics such as the way young people dress or what music youth populations listen to. Attitude and behaviour include expressions, style and the way they act. Five participants indicated that young people could be distinguished by the way they dress, the type of music they listen to, their hairstyle unwrinkled, no facial skin problems, and usually short. Participants described behaviours such as acting immature, acting 'gangstard' (macho), watches too much

television, copying other people, and someone who is ‘still learning about life’.

Health

In terms of how the participants define the word, ‘health’, the data show that twelve participants indicated that health is something to do with the human body such as looking after your body by eating the right foods. One participant defined health as the ‘well-being, spiritual and emotional stuff’, in other words, mental health and influences such as religion on health. Two participants referred to health as looking after yourself by practicing regular personal hygiene.

6.2.2 Comments on illness, injuries and accidents

In terms of how much effort Pacific Island young people place towards staying healthy, the most common response from the participants was ‘it depends’. For example, one participant noted, “…depends on what they want to be, if they want to be healthy, then they want to be healthy but it’s up to them”. This suggests there is no widely accepted standard of health.

Some participants also linked the idea with their culture, such as the food they eat and the physical activities they engage in, one female participant noted, “Yeah, I reckon um, Pacific Islanders put a lot of effort trying to stay healthy because a lot of Pacific Islanders like

playing their sports. They like rugby, playing games that got pain in it".

6.2.3 What to do in emergency situations

When asked about what they will do in emergency situations, most of the participants know what to do, for example, **"**Call the ambulance"; or "Yeah, oh get someone else to come in like an adult or something to come in for help". A few participants had no idea, as one female participant puts it, "I'll panic… because I don't know what I'd do because that's never happened to me. Nothing like that has ever happened… I wouldn't know how I'd act but all I know is that I'd just panic and cry". Despite many of the participants acknowledging what they would do, they were not confident to carry out the procedure themselves. Only one participant felt confident to carry out the actions: "I feel confident too so if you guys dropped and stopped breathing I think I could do it but um they said the number one rule was don't panic…and um, but call for help, like tell someone to ring and then you do it."

6.2.4 Not feeling well and seeking help

Participants were asked to define 'not well' and 'unhealthy'. Their responses can be narrowed down to two categories: physical and

psychosocial health. The majority of the participants regarded 'not well' as in physically sick, such as "Maybe um, you don't feel well, you're sick, you're breathing might be difficult, um just unusual things that um occur to your body…" Some participants explained that not feeling well can affect school work and daily routines, "You know how everything is linked together and if one thing isn't going then another thing can be affected by that like if your school work is not going well and you can't eat and so that's all tied in… that's when you know you're not healthy. When everything is not going well… you're not concentrating properly… you fall asleep in class…"

Some participants mentioned the psychosocial factors of being 'unwell'. Responses ranging from personal pressure such as, "I think the most unhealthy you can get is when your stressed, that's when it really affects", to external pressure as in, "Yeah, something is happening at home or yeah, depression!"

The most common help-seeking approach participants mentioned are 'counsellors' and 'youth services'. However, participants did not mention they had utilised these services previously.

6.3 EXPERIENCE / BEHAVIOUR / KNOWLEDGE

6.3.1 Health Issues

The researcher identified an assortment of different health issues. These issues created much discussion. These issues were: alcohol and drugs; abortion; contraception; dental care; driving; depression; disability; exercise, food; menstruation; obesity; sexual transmitted infections (STIs); and suicide. The responses from the participants regarding each health issue are outlined below.

Alcohol and Drugs

Participants expressed a range of experiences. One participant said he started ‘drinking, smoking cigarettes and dak’ when he was eleven years old. Another participant felt a sudden urge to eat when he woke up the next morning after binge drinking last night. Another participant shared a personal moment when he linked beer drinking to frequent toilet visits and assumed this would be a turn off for girls. Thus he decided to drink alcohol spirits instead of beer.

When the researcher asked the participants how they accessed alcohol and drugs, the participants nominated friends and from ‘tinny houses’. The male participants in particular admitted that they found it hard to give up alcohol and drug use because of their friends. Some female participants drank alcohol and smoked drugs but the majority of the participants disliked the practice totally.

Abortion

Most participants agreed that abortion was ‘murder’. One participant commented that if young people practice safe sex then they would not have an unplanned pregnancy. The participants advised that courting and courtship is an important youth development stage for early intervention approaches to preventing abortions. Few participants remarked that abortion was not ‘murder’ because sometimes abortions are necessary for circumstances such as rape-pregnancy cases. For example, ‘I feel that it’s the peoples choice that made it, but then again if they were ready to have sex and they didn’t use protection they should be ready to have a baby and not kill a life because it will be a choice to do that and they have the consequences to use protection and they obviously didn’t use protection and they had a baby…yeah’.

Contraception

Participants have a good knowledge of what contraception is and what it does. Participants were able to call out types of contraception such as ‘condoms’ and ‘pill’ but had no idea how to apply a condom or even used other forms of contraception. A male participant shared openly a personal experience between him and his girlfriend about contraception and how they decided on what role each would play before participating in sexual activity. At least three other participants

reiterated that contraception ‘don’t work’. But most of the participants indicated that they would use a ‘rubber’ or contraception all the time.

Dental care

Participants indicated that they practiced dental care at least once a day. Participants’ responses were varied. One participant feared having false teeth later on life so he brushes his teeth daily. Another participant shared he kept his teeth clean to ‘look good for the chicks’. Some participants suggested that there should be no dental fees for young people and that dental services should be a regular routine like it was in primary and intermediate schooling. For some participants, they shared that they have not visited a dentist since primary school or in the last ten years.

Driving

Female participants felt that driving was not a necessary skill to learn because there are alternative modes of transport to choose from such as bus, train or family car. One participant pointed out that transportation is essential but it is also controversial, saying, ‘you know driving is good but the more cars there are, the more road pollution’. Another participant described safe driving tips to ensure an enjoyable driving experience occurs, saying, ‘get a licence, drive sober, don’t drink and drive, no cell phone…um seatbelts on especially when you get people

in the car'. The male participants shared different views and experiences about the issue of driving. The discussion consisted of a lesson on how to steal a car, and about the different road acrobats that can be performed by cars.

Disability

Participants had very little to share in terms of what they thought about the issue of disability other than they felt sorry for young people who are disabled and were relieved themselves that they were not disabled. However there are two experiences that provide an interesting insight into disability issues. One participant (P1) shared a personal experience about his cousin who is disabled and how this cousin became disabled. P1 said, 'They're normal, 'cause I've got a cousin that's handicapped, his mum, she was like she lives with the older sister and um she got pregnant behind um her back and stuff and um when she got pregnant, she was too scared um like go to the doctor, she was too scared to tell the older sister and she didn't tell no-one and she tried to wear a belt to squeeze it in. And then after that, one day when she went for a shower, my aunty, the sister um walked in the shower to grab a towel or something and saw her stomach was big. She saw the little sister's stomach was big. And when it came out it was handicapped'.

When the researcher asked P1 about his relationship with his cousin he described it as 'brotherly'. For example, P1 shared an experience at a recent family beach trip where he felt sorry for his cousin who could do nothing else but watch other people enjoy themselves from the comfort of his wheelchair. P1 shared, 'sometimes if feel sorry for him cause all he does is sit there and play toys on that same spot or he just watch tv. And I feel stink when um we go to the beach he's watching all the other kids go swim. And he's sitting on his wheelchair by himself, that's why I feel uncomfortable and I go off and play with him. Pretty cool and he's fun.'

Another participant (P2) added that the she feels sorry for her cousin who is twenty years old and unable to look after himself. P2 response emphasises the important role family members play in caring for disabled young people. For example, P2 shared, '…well I have a cousin that's disabled and he's like twenty-something aye, but he acts like a little kid and his mum man she's like…oh man, sometimes I feel really sorry for him cos she's like always with him, takes care of him…like he's really happy and that, but we still have to be like watch ourselves around him yeah…cos even though he's like twenty-something he could do something stupid…so we always look out for him.'

Exercise

The researcher asked the participants about their thoughts on exercise, fitness and staying healthy. The general consensus was that exercise was not an issue for most Pacific Island young people because participants believe Pacific Island young people are 'born' athletic and fit. When the researcher asked for clarification, the participants pointed out that Pacific Island young people become lazy or they drift into other interests such as 'drinking and drugs' when they get older and therefore fitness and looking good is not important anymore. Overall, the participants felt that exercise is important but realise that to maintain fitness and exercise requires being proactive and eating the right foods on a consistent basis. The participants commented that they either did not have the time or could not be bothered because 'it's easier to be lazy'.

Food

This issue proved very popular among the participants and generated a lot of response. The responses were mainly similar to the following examples. For example, participants acknowledged that they eat mostly 'junk' food such as McDonalds and Kentucky Fried Chicken and prefer these types of foods to others. Another example, participants added that eating Pacific Island food was also appealing such as taro and pig because 'it makes us hard'. One participant did not mind eating fattening foods because he wanted to 'bulk-up' and 'muscle-up' so he could compete on the rugby field with other players.

Menstruation

This issue was discussed with female participants alone and generated very little response apart from two reactions. One participant did not have any problem with sharing sexuality issues with her mother. The participant disclosed '…personally um my mum was really cool. This doesn't leave this room but like I had my period and I went home. I went to the toilet, pulled down my pants and like I had my period and I came out and I ran to my mum with my pants down…and she was fine with it…she was like okay get in the shower…I wasn't scared or anything, I just didn't know what to do.'

Another participant mentioned she was frustrated because her menstrual cycle was irregular and unpredictable. She added that she thought that menstruation was a monthly event but her menstrual cycle was two or three months apart. She understood the irregularities to be tied with her emotions, for example, 'I can go two or three months without having my period, its always been like that, my period is tied with my emotions, when I look forward to something it comes, it tries to spoil my fun. Cos when I get excited, it comes.'

Obesity

Most of the participants understand the meaning of obesity, especially female participants. One participant had an in-depth understanding of the issue compared to other participants. She noted, "One in seven pre-teens in general are overweight. But then it went to PI's statistics and it was 1in 4. And I was like oh my… you know". Other participants expanded the idea to the food issue in terms of how they access food, "I'm really aware now of what I eat. We discussed this in student council of how when you come in third form and its really weird when jumping from… to this dairy here and its got chocolate and everything. In third form we just go hard out". Occasionally, participants mentioned about how obesity relates to recreational sports, this is more evident in the male focus groups, "But this year I've been really conscious, I just really think about what I eat now and I actually like, when we started the rugby season, I love training. I actually enjoyed it".

Sexually Transmitted Infections (STI)

Most of the participants have some knowledge of what STI is, only one male participant asked, "What does STI stand for?" Many participants regarded STI as an issue for young people and perceive it as "makes people scared of doing it. I think that's a good thing". A majority of the participants also relate STI to protection issues, as one participant puts it, "They should just use protection and take the consequences and be prepared for what they get".

Suicide

Participants commented on suicide through many instances. Some participants had experiences of trying to kill themselves or had friends who had committed suicide. For example, one male participant remembered, “Yeah my mate committed suicide, no-one knows why. He’s like the least person that you would never thought that would do it, and the happiest guy ever, the friendliest yeah and out of the blues he hung himself. I didn’t believe it at first, my mate rang me up and told me and like nah whatever. Yeah, not him, yeah it’s too late, I was pissed off hard”.

Other ways to combat depression and suicidal thoughts, according to one participant are, “If I feel like depressed and stuff, I’ll just go for a drink, yeah, or go and do something funny to get my mind off it”. One participant also noted that suicide is a sin, its “a one-way ticket to hell, and yeah, nothing else for that”.

There are some subtle gender differences when participants comment on a personal experience with suicide ideation or hear of one of their attempt at suicide. Female participants are more likely to engage their family or peers when experiencing depression, as one participant mentioned, “family, friends, students at this school, it just makes us realise why do they do that? If they think that they’re gonna die

because that will answer get rid of all their problems… think of the people that they're doing this to… family."

One participant remembered her suicide attempt, "That's just like last year I had major problems with my family, and I felt like they were always… the way they were talking to me was like they don't trust me at all. And so I was in bed writing my suicidal note and my little niece, she's a baby she was sleeping right next to me, and I kept looking at her and I was thinking if I do this, my little niece will grow up not knowing who I was, can't remember who I was, so she was the one that made me realise that no I can't do this."

For male participants, they are more likely to express their emotions through explicit behaviour, as one participant recalled his suicide attempt, "I was going around smashing all the shop windows, didn't give a shit, walk across the road nearly get hit". The way he got over his suicide attempt was self-reflection, "And if you want to go through it, it's your own life you're just wasting own life where you can make something out of your life and you can do something with your life". Another male participant shared an experience when he was rejected by a girl whom he had liked for a long time and finally decided to approach her after one of his friends lied that the girl liked him.

6.3.2 Socially related health issues

Crime

Most of the respondents had not committed any crimes previously. However, a male respondent commented on feeling excited because he enjoyed the thrill of committing a crime and getting away with it. He adds that even when the store detective approaches him after knowingly having stolen and stashing the item down his pants, he enjoyed the chase but when he was caught he was sent to hospital after his parent disciplined him. As he recalls, "Yeah, I got caught and I was wondering what's gonna happen next, am I gonna go to jail or am I gonna get the bash when I get home. You know what? I got both".

Poverty

In relation to how poverty affects health outcomes, many participants mentioned that the lack of financial resources limits the choices people make, especially when seeking health professionals, one participant puts it, "You can't seek help with doctors and stuff or buy the medicine that you need to make you better and you can't buy clothes and stuff… that's your health".

Family

During the discussion, many participants indicated the influence of family and health by stating that family is an important part of their

life. This view is consistent with the earlier finding where participants mentioned family as one of the most important values they hold. Family influences the way participants view life. One participant commented about her father, "Yeah and like you know how people keep you happy, I reckon that's important for health and my dad's the funniest man that I've ever met and that's…"

Another participant commented on the influences family have on him especially lifestyle, for example, "My brother has lots of influence, he's just like, cos he trains and he eats the right food and he always influences me to do the same". However, not all influences are positive. As one participant revealed, "Young people are also exposed to anti-social behaviours such as intoxication and threatening language". Overall, participants generally accepted their family, as one participant recalled, "Its funny cos if my dad's drunk, and he goes off and if our whole families there backing up my mum and then in the morning he's all quiet, he doesn't say anything and he'd be like… so what happened last night? And he doesn't talk at all, but then that night he lets it all out and he takes it out on everyone its so funny man. And we just, all we do is just laugh, but we have attitude towards that. But then we just laugh it off, and yeah its normal, its normal! Get used to it".

6.3.3 Culturally-related health issues

Pacific Island Medicine and Treatment

According to some of the respondents, Pacific Island young people are not familiar with remedies and treatment that are unique to their cultural origins; other respondents named some medicines and described how these traditional medicines were applied. Some of the traditional medications they mentioned included: fofo, aloe vera leaves, and lauki. Some participants can describe how to use these traditional medicines. One participant noted, "We go um, what's that green thing, the um the plant, got a lauki or something with um it's like you get ah plants. You mush it all up and use it like a cloth and you stick it in and turn it around".

There are also some discussions on fofo as some participants commented that they would seek fofo as a last resort if Western medication didn't work, and others suggested that Western medicine is better. However, one participant also recalled an experience with her (Western) doctor that discouraged her from visiting her doctor again, she states, "if you go to a Palagi doctor, they don't understand what you're talking about".

6.3.4 Spiritually related health issues

When asked about whether being sick was a result of not pleasing God,

only one participant thought it was related, the rest of the participants had no idea. Likewise, when asked about whether ghosts or curses cause health issues, only a few participants believed evil spirits causes ill health. For example, a female participant recalled, "my sister like, I think it had some kinda way like she was dressed and then um, she said she felt something like sitting on her and like trying to strangle her, and she tried to call out to my grandma but grandma couldn't wake up, and when she finally did wake up my grandma started yelling like all these you know in Samoan". In addition, some participants shared what they had heard from their parents and friends regarding folklore, myths and ghost stories. For example, one participant said, "I cover my mirror, um I try not to whistle at night, yeah, I've heard of stories and stuff but um, I don't actually know if they're true but I just do it you know, just for the safety path".

6.3.5 Health Services experience

In relation to participants' perception of Pacific Island youth utilising health services, the results are rather mixed. Participants either had utilised health services with conditions, or they felt there are barriers to access health services. For participants who had utilised health services, they mentioned they seek health professionals' advice as the last resort, as one female participant noted, "I don't… not many (I only hear palagi girls that go)… I only go to the doctors and stuff, only when we're sick and all but only as a last resort aye…" Others also had

mentioned they utilised traditional medicine, “Pacific Island young people use health services because they have to, it’s the last resort but other young Pacific Island young people are getting their own medicine at home”.

In relation to accessing health services some participants raised the issue of cost, as one male participant noted, “Nah not really. The cost, it’s a rip off. Can’t pay for it”. Other participants mentioned that the explanation given to them by health professionals was unclear, for example, “Can’t translate what the doctor is talking about”. However, a majority of the participants regarded shame as the major reason why they don’t utilise health services, one female participant noted, “Sometimes. Because I get shamed, and because sometimes the health nurse or whatever, they can be mean and look at me funny and that just makes me don’t wanna go”. Some of the participants were also aware of confidentiality issues where “they might not want their parents to find out”.

6.3.6 Most Important health issues for Pacific Island young people

Finally, when asked about what are the most important health issues for Pacific Island young people, the participants mentioned (not in priority order) fighting, fitness, obesity and suicide. One participant mentioned the language barrier he experienced when he accessed health services. Another participant mentioned the frustration that he experienced when he migrated to New Zealand. A few of the participants took an eclectic approach; as one of the male participants put it, "Not to drink, smoke and do drugs as much as they probably would do. To exercise, to eat good food and to take care of your body and…like protection wise, like if you're having sex, take care of what you're doing and use protection if you can, or try use contraception although that doesn't always work".

6.4 OPINION / VALUE

In this section, participants were shown an assortment of public health promotion materials and were asked to 1) explain the message printed in the pamphlet; 2) discuss the possibility of utilising that resource or health service; 3) explain whether they would refer the resource to peers who might need it; 4) give their opinion in relation to the pamphlet; and 5) suggest possible changes they would like to make in those pamphlets.

A significant proportion of the participants correctly identified the message printed in the resources. However, many of them would not utilise the health services but would read the information. About half will refer the information to peers to the service who might need it and the other half would not. In regards to the participants' opinions of the health pamphlets, comments generally referred to the layout of the pamphlets or the content of the pamphlets. For participants who commented on the layout of the pamphlets, they would like to have more pictures, "make it more colourful", "have some more young people in it". In relation to the content, participants commented that there were "too many words" and recommended to, "just put the main points in".

Other additional interesting observations emerged. The female participants commented that they would avoid touching the pamphlets because they were afraid their friends would see them and this would suggest that they had a health problem. One participant said, "especially if its about pregnancy or drug addiction". However, the male participants indicated that they would pick up the pamphlet mainly because they would be attracted to the pictures. For example, one participant said, "If it has heaps of pictures of drug, you know, real pictures, then, yeah …I like pictures of naked people too".

Another observation related to the language of the pamphlet, most of the participants commented on the 'big words' used in health

promotions materials, on the other hand, another participant felt that the 'big words' were necessary so you can learn more about what is being advertised. Finally, another observation was the way the participants preferred the smaller pamphlets to the bigger ones. The participants added that booklet style promotional material would be a deterrent because not many young people want to 'stand there and read it'. All of the participants preferred single sheet information, posters, and pocketsize promotional materials.

6.5 SUMMARY

The principal findings centre on the health issues because the main research question of the study is to identify important health issues for Pacific Island young people. There are four main health issues for Pacific Island young people. First are health issues that are biomedical and social related to Pacific Island youth health development such as obesity, sexual transmitted infections and suicide. Second are social related health issues such as poverty, family, culture and religion. Noticeable, participants were responsive to discussions about culture and health but unclear about spirituality and health. Third are health issues to do with health care services and health professionals. Most participants expressed that they were afraid and ashamed of accessing health services because they might know someone in the same waiting

room. Even when young people do visit health services they sometimes find the staff members are unapproachable.

Overall nearly forty health issues and related health issues were identified. These health issues have been grouped into four types of responses: background, knowledge, experience and opinion. Hence the principal health issues for Pacific Island people are biomedical issues, social related health issues and health issues related to health care services and health professionals. Discussion on the principal findings and how it relates to the 'Talanoa ile I'a' model will be examined in the next chapter.

CHAPTER SEVEN

THE DISCUSSION AND CONCLUSION

7.0 INTRODUCTION

From the findings in the previous chapter there are three main themes the study identifies as important health issues for Pacific Island young people. These themes are: health issues (section 7.1), cultural and spiritual related health issues (section 7.2), and health issues regarding health services and health professionals practice (section 7.3). The study have emphasised the importance of social factors in health issues for young people. In section 7.1 the participants nominated nine important health issues that underpin Pacific Island youth health development and most of the health issues identified are socially related causes. Section 7.2 is an analysis of social factors such as the role of Pacific Island cultural and spiritual elements in affecting Pacific Island youth health development. Section 7.3 explores the role of health care services and professionals in responding to Pacific Island youth health needs. In section 7.4 is a discussion in terms of the significance of these health issues in relation to the 'Talanoa ile I'a' model.

Section 7.5 is the limitations of the study that were mostly to do with the research framework (Chapter 5) and section 7.5 is the strengths of the study that were linked to section 1.1, the aim and objectives of the present study. Finally, the present study concludes with a series of recommendations for youth health care services and health professionals working with young people (section 7.7).

7.1 IMPORTANT HEALTH ISSUES FOR PACIFIC ISLAND YOUNG PEOPLE

The main research question for the study was to identify important health issues for Pacific Island young people. The present study identified nine important health issues for Pacific Island young people according to the participants' responses. They were: cigarette smoking, depression, drugs and alcohol, fighting, fitness, obesity, stress, and suicide. These youth health issues have been grouped into three broad groups: physical, mental, and social health related issues to represent important health issues for Pacific Island youth health development.

7.1.1 Physical health (fitness and obesity)

The present study explored Pacific Island adolescents' understanding of physical health and nutrition in affecting health outcomes for Pacific

Island young people. From the findings in the previous chapter, participants' responses regarding obesity indicated participants were self conscious about their weight, which changed their eating habits and motivated them to exercise more regularly. However, other participants noted that the level of effort Pacific Island young people put towards staying healthy is dependent on attitude; whether they choose to be healthy or not. Moreover, the participants admit that generally some Pacific Island people are idle and rarely keep a regular physical exercise routine like the participants because its not part of their lifestyle choice. On the one hand, participants consider regular physical exercise and eating the right foods as important health issues; on the other hand, participants admit that many Pacific Island young people are not exercising regularly and not eating properly.

Apart from exercising regularly and eating the right foods, another physical health issue is sexual, height and weight development. The advent of puberty and the onset of hormonal activity in early and middle adolescence physical development phases mark the beginning of sexual development and sexual identity in youth health development (Biro, 1998; Finkelstein, 1998; Galamos, Olmeida & Petersen, 1990; Josselson, 1994; Josselson, 1987). The impact of biological processes and physiological changes is an important health issue for Pacific Island young people because it is a tumultuous period, which most are struggling to cope with rapid physical changes to their bodies. As one participant observed in her menstrual cycle rotating every three months

instead of monthly rotation and how this situation made her feel different from the rest of her friends. Effectively, the physical changes that Pacific Island young people undergo are demanding and sudden. Nonetheless the important physical health issues identified by the participants are regular physical exercise, good nutrition and dietary standards, and support during pubertal phases.

7.1.2 Mental health (cigarette smoking, depression, drugs and alcohol, fighting, stress, and suicide)

The present study examined the impact of lifestyle activities on Pacific Island youth mental health development. The findings in the previous chapter show that all the participants consider drug and alcohol abuse important because of its influence on the thinking and actions of young people. Most participants described unusual behaviour patterns such as heavy consumption of food the next morning and going to the restroom regularly. Some participants shared that they enjoyed the 'buzz' alcohol, drugs and cigarettes give off and the habit became an addiction. Some participants shared that they resorted to drinking alcohol as a means to temporarily distract them from their problems. These situations highlight what alcohol, drugs and cigarettes do to young peoples thoughts and behaviours. Substance abuse is a growing problem amongst youth populations and many young people are caught up in the drug culture.

Drugs, alcohol and cigarettes are vices that most young people indulge in to help them relax and for pleasure. Most of the participants commented that young people take drugs or drink heavily because they are depressed or stressed. Sometimes drugs and alcohol is not enough, participants describe young people trying more extreme methods such as committing suicide to escape their problems. The mental health of Pacific Island young people is an important health issue because drug and alcohol usage and cigarette smoking usage among Pacific Island young people is increasing (Alcohol Public Health Research Unit, 2002; Scragg & Laugesen, 2001; Scragg, 2001). Similarly, since 1998 there have been eight Pacific Island successful suicide attempts (Ministry of Health, 2000b). These trends and behaviour patterns represent the struggle Pacific Island young people undergo in coping with changes such as physical transformations. Participants added Pacific Island young people are very sensitive and can become upset quite easily when someone close to them (parent) picks on them and makes them feel worthless. Pacific Island young people are also likely to be depressed or stressed over being rejected or feeling unwanted. Access to cigarettes, drugs, and alcohol would be physically and mentally destructive.

7.1.3 Social related health issues

The present study explored adolescents' perceptions of social factors impacting on health outcomes for Pacific Island young people. There

were four examples of social factors presented for exploration: peer pressure, crime, poverty and family. All except crime were important health issues for Pacific Island youth health development. Most of the participants describe peer pressure as affecting their health by attracting their attention to participate in peer group activities hazardous to health such as drinking alcohol and smoking marijuana. However some participants argue that young people prefer this type of peer group activity because it provides a sense of belonging and connectedness. Nonetheless, peer pressure is an important health issue for Pacific Island young people because most of what they learn about sex, music, fashion and life are from their peers.

Participants considered poverty as an important health issue for Pacific Island young people. From the findings in the previous chapter, most participants highlighted that being poor prevented people from buying food and medicine. Some participants observed people reaching into rubbish bins and were relieved that they were not poor. Participants shared that young people are discouraged from accessing health care services because of cost. According to the participants the lack of money is an important health issue for Pacific Island youth health development.

The participants also considered family as an important health issue for Pacific Island young people because family form the greatest influence on Pacific Island young people. Participants' responses confirm a

definite relationship between aspects of the 'Fonofale' model and the family institution. The 'Fonofale' model (Lui, 2000; Mental Health Commission, 2001) depicted in chapter five, notes the family as the foundation of Samoan social organisation and a key component for understanding important influences in Pacific Island young peoples lives.

7.2 CULTURAL AND SPIRITUAL RELATED HEALTH ISSUES

The present study explored adolescents' perceptions of culture in affecting health outcomes. The findings in the previous chapter show most participants have a good understanding of Pacific Island culture. One participant remarked that he was aware of which plants Pacific Island people use and how they make medicine out of the leaves to soothe headaches and small injuries. Another participant mentioned fofo was good for healing a sty near the eye and for mending fractures. In this sense, the participants' perception of traditional medicine knowledge and treatment is a strong indicator of cultural affiliation to the Pacific Island way of life.

However, when the present study explored adolescents' perceptions of spirituality in affecting health outcomes, surprisingly, most of the participants responded that they had no idea that religion played an

important role in Pacific Island youth health development. Most participants thought sicknesses were caused by biological and sociological factors, not spiritual. Few participants contradicted these participants by arguing that the spiritual factor is an important health issue because some religions forbid followers from eating meat and inadvertently cause a spiritual related health issue.

The role of culture in affecting health outcomes is apparent in the traditional medical knowledge and practices described by the participants. Pacific Island medicine science provides an alternative option for Pacific Island youth health issues. However, no evidence emerged from adolescences' responses that spiritual elements are important health issues. For example, there was no reference on the part of the participants to health issues such as the role of curses and evil spirits in affecting health development. One participant shared a haunting tale of being physically touched by a ghost while holidaying in Samoa. But no participants mentioned the impact of curses and evil spirits as a factor for health issues affecting Pacific Island youth health development. This is a surprising finding because spirituality is very much part of the Samoan life and not fully described by the participants in relation to health (Mental Health Commission, 2001; Tupou, 2001).

7.3 HEALTHCARE SERVICE RELATED HEALTH ISSUES

The present study explored adolescents' perceptions of health care services in affecting health outcomes for Pacific Island youth health development. There were three main factors identified by the participants explaining the underutilisation of healthcare services by Pacific Island young people. The first factor the participants expressed were to do with the staff members of healthcare services. One participant shared that she had an unfortunate first time experience in a healthcare setting and decided will never visit a healthcare service ever again. Another participant added that her first time experience was not good because she did not understand what the health professional was saying. The second factor the participants expressed about health care service provision relates to cost. Most participants agreed that a fee is a deterrent to accessing health care services. The last factor is a significant health issue and that is embarrassment and fear. Nearly three-quarters of the participants emphasised the importance of confidentiality because it discourages young people from accessing health care services. One participant shared that when she noticed a familiar face in the waiting room and she slipped away before being noticed because she did not want anyone to know she was in a sexual health clinic.

The present study examined adolescents' responses in relation to public health promotions materials. These materials are booklets,

pamphlets and fliers outlining important health information and services for young people. There were six public health promotions materials: 'Body Piercing and Tattooing', 'Cannabis', 'Speed', 'Safe Sex', 'Cigarette Smoking' and 'Food and Adolescence'. Most participants would not use the publications because they do not want to be caught reading the publication in front of their friends. It might suggest that the young person reading the publication has a health problem. Other participants remarked that young people never stop and read the information because it lacks appeal and interesting information.

Although most of the participants would not use public health promotions materials, they were very vocal about the design and contents of the publication. Most of the participants suggested that designers should use realistic pictures, simple language formats and less text but more visual content. Participants commented that young people prefer face-to-face contact with health professionals who teach youth about health issues. According to the participants, publications are an important health issue for Pacific Island youth health development. Participants recommended that publications be available in the different Pacific Island languages and accompanied with a parent's kit so the participants' family share in the development of their children.

7.4 CONCLUSION: TALANOA ILE I'A REVISITED

Overall the 'Talanoa ile I'a' model has successfully produced an account of important health issues for Pacific Island young people. The important health issues have been a combination of physical, mental and social related issues. Other important health issues have been cultural factors but not spiritual factors and participants' responses were critical of health care services and health professionals including public health publications. In relation to the TII model, the public health publications represent the perspective of 'the person at the top of the mountain' because they are published by central government and participants' responses were critical. Most participants recommended many changes and overhaul of the publications. The adolescents' responses regarding the health care service sector and its staff members are critical examinations of the perspectives of 'the person at the top of the tree' (service provider) and the perspective of 'the person on the canoe' (staff member). Most participants recommended many changes in health care service delivery such as separate health clinics for young people and specially trained staff for youth health matters.

From talking to Pacific Island young people the study have identified health issues that are consistent with the other frameworks of the TII model. The contextual framework (Chapter Three) outlines a national-provincial-local overview of youth health status for Pacific Island young people and its issues are the same as the health issues outlined

above. The context was built from a literature review of central government, city council and community approaches to youth health issues as in the ecological model (Brofenbrenner, 1979). The context constituted findings from the macrosystem (central government), exosystem (city council) and mesosystem (community) (Brofenbrenner, 1979). Thus the contextual framework identified similar health issues for youth health development that the participants also identified.

From talking to Pacific Island young people the study also tested the validity of theoretical explanations for youth health issues. The conceptual framework (Chapter Four): Pacific Island perspectives, medical-sociology, and youth health theory were assembled to provide clues as to how youth health issues emerge. For example, a popular Pacific Island people belief is that looking 'big' represents good health and children and young people are likely to believe in this Pacific Island value and consume large quantities of food (Tupou, 2001). Hence some Pacific Island cultural beliefs can influence youth health development negatively.

However, most of the health issues identified in the study are social related health issues. The importance of sociology is critical to illuminating Pacific Island health issues that are caused by social factors such as poverty and overcrowded housing conditions. Similarly, youth health theory emphasise the importance of biological

processes such as puberty as an important health issue for Pacific youth health development. Accordingly the theory framework argued cultural, spiritual, social and physical factors explain the causes of youth health issues and the findings from the previous chapter confirms this situation except for spiritual factors.

7.5 LIMITATIONS OF THE STUDY

There were many limitations in the study. Most revolve around the research framework (Chapter Five); its design and process were problematic. The first limitation lay in the design flaws of the interview schedule. The interview schedule were designed with too many questions, which meant some focus groups ran overtime and participants were introduced to too many topics and concepts. Some questions in the interview schedule were difficult for the participant to understand. The interview schedule contained over twenty questions and most was a mixture of close-ended and open-ended questions. Consequently, the interview schedule was flawed.

The second limitation relates to sample size of the study. Initially twenty-four participants were recruited but only thirteen participants' responses were analysed. The original sample size was too big because participants' responses produced large quantities of information and sorting this data into a coherent analytical framework would be difficult. However, the sample size was too small in terms of

participation to offer any generalisable conclusions. There were some patterns related to gender, ethnicity and age in the data collected, but few conclusions can be drawn.

The third limitation refers to resource shortages and equipment failure issues. The tape-recorders used for the focus groups were borrowed from friends. During one focus group the tape-recorder jammed and delayed the focus group by ten minutes. Another problem emerged when the recording instruments of the tape-recorder damaged some audiotapes. This greatly affected the data in terms of quantity by erasing parts of the data collected and in terms of quality by the prevalence of background noises such as static. Transcribers reported listening difficulties and frequently asked for clarifications and explanations. A total of twenty-four blank cassettes and approximately one hundred twenty hours of battery life (including transcription) are essential resources to budget. Consequently, failure to maintain resources such as spare batteries and spare blank cassettes can hamper data collection activities and affect the data being collected.

7.6 STRENGTHS OF THE STUDY

The first strength of the study is that it is groundbreaking work exploring a lesser-known phenomenon, Pacific Island youth health development.

Secondly, the study has demonstrated through the use of a new Pacific Island construct ('Talanoa ile I'a') a tool that reveals important information regarding Pacific Island youth health issues. At the same time, it has provided insight into Pacific Island young people, and identified important factors such as biophysical and social influences, which underpins Pacific Island youth health development.

Thirdly, the study also highlighted challenges of acculturation, Pacific Island young people growing up in New Zealand with a 'dual' heritage, Pacific Island and European, at home and school, at church and at the local rugby club.

Lastly, the study has reinforced regularly the importance of social factors as a determinate of health outcomes for Pacific Island adolescents. Family, religion and culture are the most valued and treasured elements of Pacific Island perspectives. In relation to the 'Talanoa ile I'a' model, family, religion, and culture represent social factors that interact and interrelate with Pacific Island young people daily and inadvertently affect Pacific Island youth health development. The TII model is a process model; it provides insight into relationship formation and young people, particularly, between young people and family, between young people and church and between young people and health services. Evidently, the present study provides the perspective of the young person and their relationships with three key

domains of the TII model: young people and 'people on the canoe'; young people and 'people at the top of the tree'; young people and 'people at the top of the mountain'. However the present study also brings the perspectives of the 'person at the top of the mountain', the 'person at the top of the tree', and the 'person on the canoe' together and measures the impact of each perspective on affecting health outcomes for Pacific Island youth by listening to Pacific Island young people.

7.7 RECOMMENDATIONS

7.7.1 Considerations for Adolescent Health care providers

The Society for Adolescent Medicine promotes a seven-point criterion for health service providers aimed at improving adolescent utilization rates. To encourage adolescents to access health services, services should consider the following: availability, visibility, quality, confidentiality, affordability, flexibility and coordination (Klein, Slap, Elster & Schonberg, 1992).

Availability means providing a wide range of services: physical examinations, counselling, social services, as well as each service being free of cost. A host of surveys corroborate the provision of diverse service orientations (Jacobson & Wilkinson, 1994; Oppong-Odiseng & Heycock, 1997; Parcel, Nader & Meyer, 1977, Sternlieb &

Munan, 1977; Williams, Kirkman & Elstein, 1994).

Quality depends on the background and experience level of the health professional. The ideal is a person who is a trained adolescent specialist, sensitive and understands the complexities of adolescence life including the impact of biopsychosocial factors. And the ideal health service provider is one that has a workforce with these competencies and a separate unit specialising in adolescent needs (Blum & Bearinger, 1990; Blum, Bearinger & Daniel, 1986; Graham & Jenkins, 1985).

Confidentiality is essential for adolescence in order to gain their trust and cooperation. Confidentiality allows practitioners to fulfil their moral duty to benefit the adolescent, and it respects the adolescent by recognising their right to privacy (Bagshaw, 2001; Cheng, Savageau, Sattler & De Witt, 1993). However, it is up to the health professional to decide how much information should be disclosed if requested from a parent or agency, especially if the adolescent is aged fifteen years and under.

Lastly, coordination between various 'types' of adolescent healthcare services is another essential requirement to improving utilization rates. For example, 'traditional' healthcare services such as hospitals and family planning; 'indigenous' healthcare services (reflecting the characteristics of the adolescent social context) such as drop in centres

and cross cultural organizations; 'support' services such as Police, Schools and local government; are all equally important when each are sharing information and collaboratively working towards addressing adolescent biopsychosocial needs (MacKenzie, 1994).

7.7.2 Considerations for the workforce

Another key factor for effective and responsive adolescent health care service provision are the competency and ability of the health professional to work with adolescents. When health professionals such as doctors, nurses, receptionists, counsellors and youth workers are working with young people, a more personal approach through empathy and sensitivity is important (Boekeloo, Schamus, Cheng & Simmens, 1996; Sanci & Young, 1995; Schneider, Friedman & Fisher, 1995).

For Pacific Island young people, there are other considerations such as cultural sensitivity, that the age of the health professional is closer to their age, ethnic-matching and the ability to speak a Pacific Island language, confidentiality, and the ability to work with Pacific Island families because Pacific Island youth work is not a focus on the individual alone.

Apart from a personal approach, when health professionals are interviewing adolescents, the tools that they utilise for profiling and assessment, should have a holistic focus. When an adolescent visits a

health care service, the medical model is the main tool for profiling and assessment that health professionals rely on. However, the focus of this approach is to diagnose medically defined problems and therefore medical technology is applied to adolescent issues. This process fails to include psychological and sociological factors, which are equally important in building a case management plan for addressing adolescent needs.

7.7.3 The H.E.A.D.S.S. profiling tool

In light of our findings above it may be helpful for the helping medical professional to have a simple tool to help appropriately structure interviews with Pacific Island youth. Two examples of such tools follow: The H.E.A.D.S.S. profiling tool and The Risk / Resiliency framework for case management planning. The H.E.A.D.S.S. (an acronym for Home, Education, Activities, Drugs and Alcohol, Sexual health, and, Suicide identification and prevention) tool generates a more holistic approach than the medical model (Cohen, Mackenzie & Yates, 1991; Goldenring & Cohen, 1988). The medical model is important for identifying biological factors such as diseases and viruses but the H.E.A.D.S.S. tool widens its scope to incorporate other important information such as causal or contributory explanations. The H.E.A.D.S.S. tool accounts for mental and social related causes of illness and provides an interview guideline for health professionals working with adolescent health issues.

Diagram 6 shows how the H.E.A.D.S.S. psychosocial profiling tool can used as instrument for interviewing adolescents. H.E.A.D.S.S. provides an overview and a framework for health and education professionals to structure sessions in a way that can promote a relationship of safety and trust. Some examples that the tool can illuminate are: psychiatric disorders including psychosis, depression (which may present as irritability), behaviours problems, alcohol or drug abuse, anxiety, stressful life events e.g. relationship break up, unemployment, death of someone close; family difficulties or dysfunction; sexual abuse; physical abuse or neglect; exposure to suicidal behaviour.

Diagram 6: H.E.A.D.S.S. sample questionnaire

HOME: How are things going at home? Who lives with you? What's good about home? What's not so good?

EDUCATION: What do you like about school? How are you doing in school? What are you favourite subjects?

ACTIVITIES: What do you do after school/work/course? What do you do in the weekends? Do you go to church?

DRUG & ALCOHOL: Do you drink/take drugs? What are they? How often? Where did you get it?

SEXUAL HEALTH: Most young people have become interested in sex at your age. Have you talked about safe sex at home/school? Have you had a sexual experience?

SUICIDE RISK: Everybody has good days and bad days. What is you mood like? Do you ever feel like you want to end it all? How do you plan to?

(Source: Writers reconstruction, 2003)

The information obtained from the H.E.A.D.S.S. interview presents a holistic view of the circumstances surrounding the adolescent as well as key background information. However, another tool is required to filter the key information provided in interview so health professionals have an overview of priorities and tasks are needed to address the adolescent health issues.

7.7.4 The Risk / Resiliency Framework tool

In Table 11 is an illustration of another tool for working with young people called, 'Risk / Resiliency' framework, which filters and summarises the information obtained from a H.E.A.D.S.S. interview (Blum, 1998; Resnick, 2000). The main focus of the 'Risk / Resiliency' framework concentrates on enhancing the resiliency factors to minimise the risk factors. As Table 11 shows, the information on the left-hand column are risk factors and there is a temptation to prioritise and set tasks on this information. However, the 'Risk / Resiliency' framework focuses on priorities and tasks set by the right-hand column. So the health professional builds a case management care plan based on working with the family, the adolescent's love for basketball and writing rap lyrics, and, making contact with prospective course providers preferably one that connects the adolescent to Police training. Accordingly, the most crucial element of this tool is its holistic-focus, accommodating biological (the

medical model) psychological, social and cultural factors (H.E.A.D.S.S and Risk / Resiliency framework) as a means to understand, conceptualise, analyse and construct a management care plan to meet the needs of the adolescent's health and socially-related issues

Table 11: Demonstration of H.E.A.D.S.S translated into Risk / Resiliency Framework for Case Management tasks.

RISK FACTORS	RESILIENCY FACTORS
Poor nutrition	Family support
Dislikes school	Loves sports e.g. basketball
Consumes alcohol and smokes	Loves to write rap lyrics and hip hop music
Has had unprotected sex recently	Wants to do a course or be a police officer

The information gained from Table 11 allows the health professional to focus on the resiliency factors such as 'family support', 'loves basketball', 'loves to write lyrics for rap songs', and 'wants to be a Police Officer'. By focusing one's practice on the resiliency factors the end goal is for the risk factors to wither away and gradually replaced by the resiliency factors.

These recommendations originate from the use of a Pacific Island construct, 'Talanoa ile I'a' model. The important health issues for Pacific Island young people are physical, mental, social and cultural factors. Moreover, the important health issues for Pacific Island young people also extend into health care service and health professional

health issues. These conclusions are consistent with the contextual and conceptual frameworks (Chapters Three and Four). These conclusions have emerged because of a qualitative approach in the form of focus groups (Chapter Five).

Talanoa ile I'a emphasises the importance of talking to Pacific Island young people about Pacific Island youth health development. There were three significant issues identified from the findings outlined in the previous chapter. The important health issues for Pacific Island young people are physical, mental, and social related health issues. The present study also identified that culture played an important role in influencing Pacific Island youth health development. In addition the present study identified health issues related to health care service provision and health professionals. Through the use of a Pacific Island construct these issues have been identified and are generally consistent with the contextual and conceptual framework of Talanoa ile I'a. This

Talanoa ile I'a has revealed that health issues for Pacific Island young people are widespread and not only biologically determined. Talanoa ile I'a adopted focus groups to substantiate the predominance of social related health issues over and above biological determinants. Talanoa ile I'a found in Chapter 6 that the role of social related health issues is prevalent in the participants' responses. Talanoa ile I'a recommends a broad base approach for Pacific Island youth health issues such as health care services and health professionals adopting a holistic

approach to health issues as in the H.E.A.D.S.S. and Risk / Resiliency tools. Talanoa ile I'a represents the voices of Pacific Island young people and provides critical information for future youth health developments particularly for Pacific Island young people. Talanoa ile I'a is the story of Pacific Island young people; their concerns and solutions for Pacific Island youth health development in New Zealand.

(**Appendix 1)**

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Title What Pacific Young People Say on Health? An Exploratory Study of Pacific Youth Health Issues through talking directly to Pacific Young People in West Auckland.

INFORMATION SHEET

Researcher Information

TALOFA LAVA – MALO E LELEI – KIA ORANA – FAKAALOFA LAHI ATU – NI SA BULA – TALOHA NI & WARM PACIFIC GREETINGS TO YOU ALL

My name is Moses Maalo Faleolo. I am a postgraduate student at Massey University, enrolled for a Master of Social Work (Social Policy) Degree in the School of Social and Cultural Studies. My supervisor is Senior Lecturer Mark Henrickson. I am interested in finding out what Pacific Island young people consider as important health issues. I believe the best way to getting this information is to listen to young people. That is why I will be running a focus group session and invite volunteers to step forward and have their say. This would help many people understand what young people are going through. I am working as a Youth Worker from Pasifika Youth Health Services based at 199 Lincoln Road, Henderson. I have worked with young people for over ten years both in the community and for the government. It would be really great if you decided to be part of this study I am doing. You will be speaking on behalf of Pacific Island Youth and your knowledge would assist many others understand what Pacific Island young peoples needs are and ways to meet these.

My Study

I will be making contact with staff at four different places. I will be looking for volunteers to attend a focus group session. I need 24 volunteers, aged between 16-22 years old, a Pacific Islander, live in West Auckland, male or female and is enrolled at where they go to learn. Selections will take place from two high schools and two training providers. Volunteers are asked to attend two sessions. The first is a briefing session lasting half an hour so the volunteers can ask questions before the study begins. The second is a focus group session for two hours where the volunteers are

asked a series of questions. For accuracy a tape recorder will record the volunteers answers in case I miss some important information and so I can concentrate on running the focus group. Each volunteer will receive a certificate for attending and refreshments will be made available

The focus group session aims to invite any comment, opinion or viewpoint. However, the topic may be very sensitive such as sexual health and young people may choose to avoid speaking freely on this issue. Boys will be interviewed separately from the girls and will attend separate focus group sessions; one conducted by a male and the other by a female youth worker. Some comments, opinions or viewpoints may be hurtful and cause distress to others or to the speaker. A list of follow up counseling contacts is available for any volunteer who during the course of the focus group session has been affected some way or another. Please see me if you are not feeling comfortable as soon as possible so I can help you. Everything that is recorded during the focus group session is private and confidential. Only my supervisor, a transcriber (someone who will transfer the recorded information onto paper) and I will have access to this information. However, it is up to the volunteers to be responsible for all information that is shared during the focus group session, to make sure it is not passed on to others who are not part of the study.

The information that is collected is used for understanding what Pacific Youth consider as important health issues. Without identifying who said what, this information is important so other people and services can also understand Pacific Youth Health issues. The findings of the study will be made available to all the volunteers and participating institutions. After five years, the data that is locked in a filing cabinet will be shredded and disposed.

Volunteers Rights

All participants have the following rights:

You have the right to:
decline to participate before the study begins;
decline to answer any particular question;
withdraw from the study after the briefing session only;
ask any questions about the study at any time during participation;
provide information on the understanding that your name will not be used unless you give permission to the researcher;
be given access to a summary of the project findings when it is concluded.
ask for the audio/video tape to be turned off at any time during the interview.

If volunteers have any questions regarding the study they can contact Moses Faleolo on 021 905 326 or Senior Lecturer Mark Henrickson on (09) 443 9700 extn 9050.

Committee Approval Statement

This project has been reviewed and approved by the Massey University Human Ethics Committee, ALB Protocol 03/026. If you have any concerns about the conduct of this

research, please contact Associate Professor Kerry P Chamberlain, Chair, Massey University Campus Human Ethics Committee: Albany, telephone 09 443 9700 x9078, email K.Chamberlain@massey.ac.nz.

(Appendix 2)

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Researcher Moses Maalo Faleolo

CONFIDENTIALITY AGREEMENT

I ..... (Full Name - printed)

agree to keep confidential all information concerning the project .....

I ..... (Full Name - printed)

agree to keep confidential all information that other participants have disclosed during the focus group sessions.

Signature: ..... **Date:** .....

Full Name - printed .....

(**Appendix 3)**

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Researcher Moses Maalo Faleolo

CONSENT FORM

THIS CONSENT FORM WILL BE HELD FOR A PERIOD OF FIVE (5) YEARS

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree/do not agree to the interview being audio taped.

I agree that the information exchanged by participants in the focus group will be totally confidential and not divulged to any other person at any time.

Signature: ..... **Date:** .....

Full Name - printed .....

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Researcher Moses Maalo Faleolo

Format For Focus Group Sessions

A. First Activity

(Facilitator: *This section are close-ended questions designed to ensure the participants have a Pacific Island heritage, they reside in West Auckland, and a brief background about them to provide a context for the study)*.

Ethnicity / Cultural ties

Which Pacific Island nation does your parents come from?

Can you name the villages your mother and father left behind?

Which Pacific Island nation do you identify more closely with?

Geographic location

Do you live in West Auckland?

Do you think West Auckland has services for young people and can you name some of them? (If you do not live in West Auckland, does the area you are from have services for young people and can you name some of them?

Brief background

What are you currently doing in your life? (A course, working or nothing).

How many people are in your family?

Who do you trust the most and why?

What are your goals and visions for your life?

What are your beliefs and what do you value the most?

B. Second Activity

Definition of Concepts according to Pacific Youth

What does the word, 'Culture', mean?

What is a 'Pacific Islander' and how do you know this information?

How would define a young person or youth? Why?

What does the word, 'Health', mean?

Comments on illness, injuries and accidents

How much effort do you think Pacific Island young people put towards staying healthy? Why do you say this?

Do you know what to do when someone close to you has an accident and is not breathing?

How do you know if you are unhealthy?

Health services awareness / experience.

Do Pacific Island young people visit health services? If so, why? If not, why not?

Who would you go to see if you were depressed and why?

If your friend tells you that she is feeling suicidal what would you do and why?

Why is it that some Pacific Island young people don't use health services and other Pacific Island young people do use health services?

If you are in charge of making hospitals look more appropriate for young people where would you start and what changes (if any) would you make? Why?

What is your experience of using health services? Why do you say this? If you don't have one then imagine what that experience might feel like.

Health Issues

Facilitator – *this section requires you to call out each health issue one by one and invite participants to respond to each according to their understanding of what the issue is about, whether they consider the issue to be important and why, and, who would they go to see for help if one or more of the issues listed below affected some way or another.*

Alcohol and drug abuse
Abortion
Contraception
Dental Care
Driving
Depression
Disabled or handicapped
Exercise
Food
Menstruation
Obesity
Parenthood
STI's
Suicide

Related Health Issues.

Facilitator – *this section covers topics that are issues but have a connection to health, for example, peer pressure is a social determinant of health because the impact of peer pressure on individual young people can sometimes lead to health issues such as depression or trying to 'fit in'. So you are to call each related health issue out one by one and repeat the process in Question 4.*

Social determinants related to health (Peer pressure, crime, poor, and family).

Why is peer pressure a social determinant of health?

How does peer pressure cause ill health?

How does crime cause ill health?

Why is being poor a cause of ill health and sickness?

How much influence does your family have on your health and give examples?

Cultural determinants related to health

What types of traditional medicine does your Pacific Island nation use to cure sick people?

Do you think fofo (massaging) is good for your health? Why?

Spiritual or faith based determinants related to health

Do you believe that being sick is a result of not pleasing God? Why?

Christianity teaches Pacific Island peoples against eating particular foods. What do you think of this and why?

What roles do ghosts and spirits play in causing poor health particularly curses?

Workforce development.

What is a youth worker?

What is youth work?

Is there a difference between youth work and social work?

Concluding questions:

So tell me, what are the most important health issues for Pacific Island Young people?

What do you think would improve your health in the future?

C. Third Activity

Facilitator – for this section you will need to select up to ten different public health publications and ask the following questions:

What do you think the message is? What do you know about this health service?

Would you use this health service? If so, why? If not, why?

How would you design a publication so other young people would find it informative?

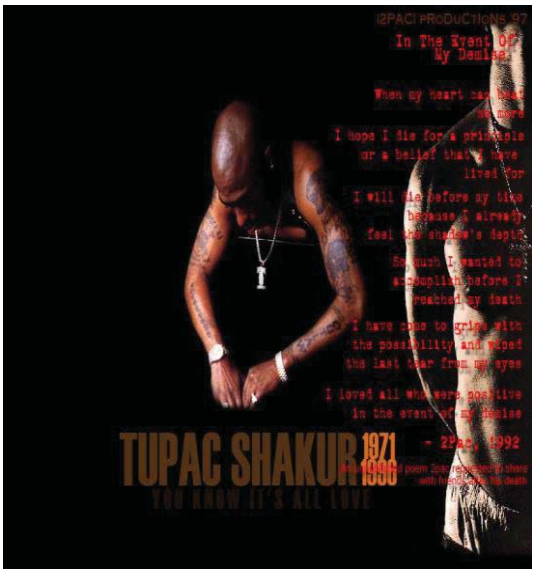
Media Type	*Public Health Category*	*Public Health Message*
Wall Poster Sticker	Sale of Cigarettes Legislation	It is against the law to sell cigarettes under the age of 18.
Pamphlets	Sexual Health	Being Safter Sexually.
Wall Poster	Road Safety	Look out when X are about.
Fold out pamphlet	Dance Party Safety	What you should know.
Booklet	Career Services	Take off to Tertiary!
Coaster	Problem Gambling	Pub Charity Inc.
Signage	Smoking	'Aua le ulaula'
Booklet	Food and Nutrition	A teenager's guide to healthy eating.
Pamphlet	Lifestyle	Body-piercing and tattooing: protecting your health.
Pamphlet	Mental Health	Anger, conflict, bullying : What to do.

Wassup!

R U Pacific Island?

16-22 years old?

I need some volunteers to help me with my study. It takes one day after school for two hours.



All you need to do is tell me what you think are important health issues for Pacific Island young people.

You'll get a feed and a certificate to go just for participating.

WADDA YA RECKON?

IF THIS IS YOU CONTACT (insert name of staff member or researcher) ON (insert phone or cell phone number).

(Appendix 6)

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TRANSCRIBER'S AGREEMENT

I ..... (Full Name - printed) agree to transcribe the tapes provided to me.

I agree to keep confidential all the information provided to me.

I will not make any copies of the transcripts or keep any record of them, other than those required for the project.

TRANSCRIBER

Signature: ..... **Date:** .....

WITNESS

Signature: ..... **Date:** .....

Full Name - printed .....

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