

Background evidence



Migration to the Pacific and New Zealand

Current thinking is that waves of migrants from South-East Asia first reached the islands of the South Seas between 5000 and 1500 BCE. In highly sophisticated ocean-going vessels, these voyagers reached Micronesia, then Fiji, Tonga and Samoa. They then travelled eastward to the Cook, Society and Marquesas Groups, and from there crossed thousands of miles of open ocean to colonise the islands of Hawai'i in the north, Easter Island in the southeast, and New Zealand in the southwest.¹⁴

Pacific peoples in New Zealand

Pacific peoples first migrated to New Zealand some 1200 years ago, becoming the indigenous Māori.³ In modern times, the most significant arrival of Pacific peoples to New Zealand was between the 1950s and 1970s when immigration controls were relaxed, and the post-war economy provided work.

In 1968, the Department of Māori and Island Affairs was formed. One of its chief responsibilities was to work with Pacific Island immigrants.⁴⁷

The oil crisis in the 1970s caused an economic downturn in New Zealand. Despite the tightening of immigration policy and high unemployment rates, Pacific peoples continued to work in the manufacturing and service sectors. During the 1976 government election campaign, Pacific peoples were labelled 'overstayers', resulting in 'dawn raids' where police and immigration officials executed searches through their homes looking for people who had overstayed their work permits. This had a deep impact on the community and today is still seen as a decisive event in New Zealand–Pacific relations.

Partly because of these issues, in the 1970s Pacific peoples in New Zealand developed as an organised political force and the 'Pacific voice' was presented to Government. The first Minister of Pacific Island Affairs was appointed in 1984, and the joint Department of Māori and Island Affairs was disbanded in favour of separate organisations for each group. This move gave each group its own voice and enabled programmes and interventions to be specifically targeted.

In New Zealand, 'Pacific' usually refers to people of Samoan, Tongan, Cook Islands, Fijian, Niue, Tokelauan, or Tuvaluan descent, although there are also people from French Polynesia, Kiribati, Papua New Guinea and the Solomon Islands in the country. The term is also used to refer to people of mixed ancestry, including multiple Pacific cultures, as well as Pacific-non-Pacific backgrounds.³³

While this document uses the term 'Pacific peoples' as a broadly accepted convention to refer to those whose cultures originate among the islands of the South Pacific and share certain attributes, it is important to remember that the act of grouping tends to mask the differences amongst those who have been grouped.

Like the term 'Asians', 'Africans', and 'Muslims', the inclusive term 'Pacific peoples' or terms such as 'Pacific Nations people', 'tangata pasifika', 'tagata pasefika', 'Pasifika peoples', 'Pacific Islanders', and 'PIs'⁶¹ misleadingly group together a wide range of people with distinct languages, heritages, national origins, and ethnic affiliations. This grouping,⁷ creates a false impression of uniformity within and amongst the different groups.³³ Pacific communities within New Zealand are diverse. Inter-marriage among these groups, as well as with the broader New Zealand population, has provided a further level of complexity.³³

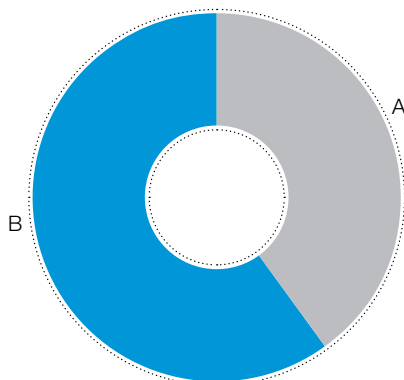
Statistics – living in New Zealand

The majority of Pacific peoples living in New Zealand were born here.

According to the 2006 census, more than half of the Pacific children born between 2002 and 2004 had more than one ethnicity and nearly a quarter had more than one Pacific ethnicity.¹¹ In addition, 7 percent of Māori also claimed Pacific ancestry in the same census.⁵⁷ This means that every person must be approached as a unique individual, rather than as the representative of a larger, homogeneous group.³³

In the 2006 census, nearly 7 percent (300,000) of the total New Zealand population identified themselves as Pacific. This was a 15 percent increase from the 2001 census, and the second-biggest increase amongst all ethnicities.

Pacific People Living in New Zealand: Birth Location

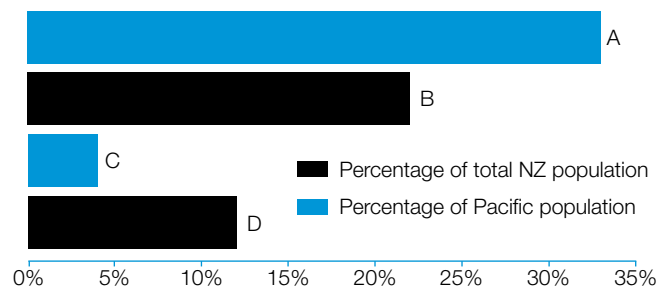


- A Born in New Zealand – 40%
- B Born overseas – 60%

Our Pacific population is projected to continue growing faster than the European population, with the Pacific population estimated to increase from 300,000 in 2006 to 480,000 by 2026. The composition of the Pacific population is also changing because of the community's higher fertility rates and younger age structure. The median age among Pacific peoples is 21 years – 14 years below the median age for the general population.⁵⁸

Two-thirds of Pacific peoples live within the area of DHBs in the Auckland region, whilst another 11 percent live in Capital and Coast, Hutt Valley, Waikato or Canterbury DHB areas.²⁹

Age Distribution of Total NZ vs Pacific NZ Population



- A Pacific under 15 years – 33%
- B Total under 15 years – 22%
- C Pacific over 65 years – 4%
- D Total over 65 years – 12%

Summary points – history of Pacific peoples in New Zealand

- The most significant modern movement of Pacific people to New Zealand was between the 1950s and 1970s.
- Economic woes in the mid-1970s led to tightening of immigration policies, prosecution of 'overstayers', and the emergence of Pacific peoples as a political force within New Zealand.
- The majority of Pacific peoples now living in New Zealand were born here.
- Nearly 7 percent of the total New Zealand population identify themselves as Pacific and most live in the Auckland region.

Summary point – Pacific cultures are diverse

- Exercise caution in grouping all Pacific peoples together and making assumptions about 'Pacific' preference.

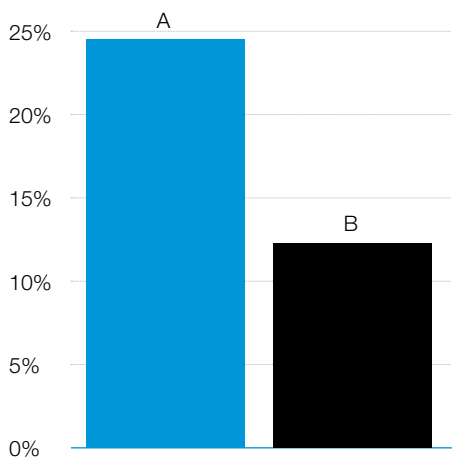
Pacific health

The health outcomes of Pacific peoples are worse when compared with the general population in New Zealand. These outcomes are reflected in lower life expectancy, higher rates of chronic disease, and premature disability.^{33,34}

For example, Pacific peoples:

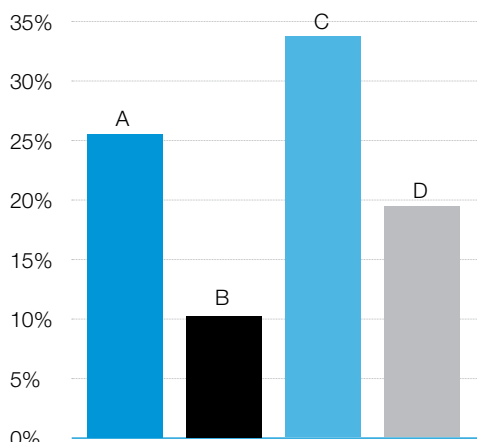
- are three times more likely to have diabetes than the general population²⁹
- are more likely to be severely disabled, with a higher proportion of disabled children or young adults
- have nearly twice the rate of avoidable mortality and ambulatory-sensitive hospitalisations as other New Zealanders³⁷
- have a higher incidence of mental health disease than the general population, yet access mental health services, even for serious disorders, at a much lower rate.

Disabled Population with Severe Disability



- A Pacific people – 24%
- B Non Pacific People – 12%

Disabled Population with Severe Disability



- A Children Pacific – 25%
- B Children European – 10%
- C Young Adult Pacific – 33%
- D Young Adult European – 19%

Pacific children have higher hospitalisation rates (compared to non-Pacific, non-Māori children) for multiple diseases, including:

- respiratory diseases (2.5 times higher)
- asthma (3 times higher)
- cellulitis (5.5 times higher)
- gastroenteritis (1.3 times higher)
- dental conditions (3 times higher)
- kidney and urinary infections (over 2 times higher).

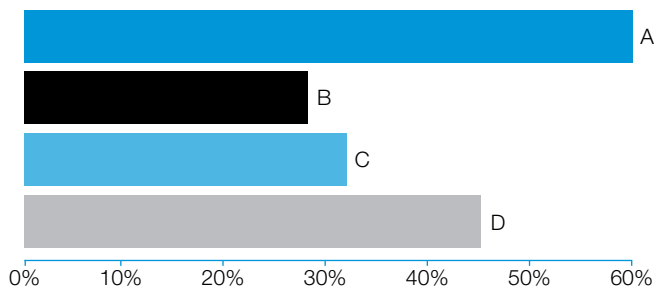
Effects on the community

The burden of illness and disability is reflected in less than ideal outcomes for individual Pacific people, as well as for communities as a whole. Because of the community-oriented nature of traditional Pacific culture, one person's negative experience is likely to be shared with their extended family, as well as the broader community. This influences the entire group's perceptions and future behaviours.^{17,22,63}

Negative experiences may also reinforce stereotypes within the health practitioner community. If a practitioner doesn't understand the cause of a Pacific patient's confusion or dissatisfaction, he or she cannot prevent similar experiences with other patients.²⁵

Although demographic information often refers to ‘Māori and Pacific peoples’, there are significant differences between Māori and Pacific communities. For example, teenage smoking rates are quite different between the two communities.^{32,36}

Teen Smoking Rates by Ethnicity & Gender

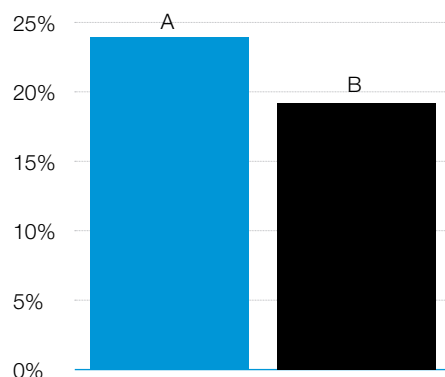


- A Māori Girls – 60%
- B Pacific Girls – 28%
- C Māori Boys – 32%
- D Pacific Boys – 46%

There are also differences between Pacific communities; Schaaf et al demonstrated that compared with Tongan women, Samoan and Cook Island Māori women had higher ten-year cardiovascular risk scores. For men, individual risk factors varied, with Cook Island Māori having significantly higher total cholesterol, blood pressure and urinary microalbumin than other Pacific Island ethnic groups, while Tongan men had lower HDL levels.⁴⁸

There are also different patterns for how Pacific populations use mental health services. These are due to different ethnic backgrounds and differing migrant experiences. Historically, Pacific peoples were thought to have low rates of mental disorder, but *Te Rau Hinengaro: The New Zealand Mental Health Survey* in 2006 showed that this is not the case.³⁹

Mental Disorders: 12 month prevalence



- A Pacific people – 24.4%
- B Non Pacific People – 19.3%

Pacific peoples born in New Zealand or those who have moved here before the age of 12 years have twice the rate of mental disorders as people who moved after the age of 18 years.³⁹ Among those with serious mental disorders, Pacific peoples accessed services at a significantly lower rate.³⁹

Summary points – differences in health between Pacific populations

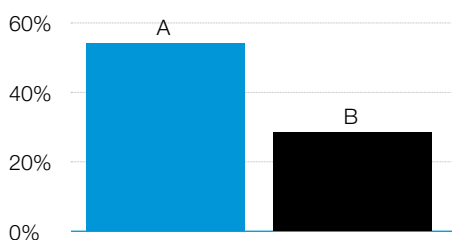
- The health of Pacific peoples is worse than that of the general population.
- Māori and Pacific populations can differ significantly in many measures of health; there are also differences within and between different Pacific populations (for example, cardiovascular risk scores for Tongan and Samoan populations).

Pacific health inequalities

Pacific peoples are disproportionately represented in lower socioeconomic brackets.

- Compared to 8 percent of the total population, 27 percent of Pacific peoples meet the criteria for living in severe hardship.
- 15 percent live in significant hardship.
- Only 1 percent report ‘very good living standards’.²⁸
- Home ownership rates are much lower in the Pacific community and Pacific peoples are more likely to experience overcrowding in their homes.²⁸
- Unemployment rates are almost twice as high within Pacific communities.²⁸

Home Ownership Rates



- A Total NZ – 55%
- B Pacific People – 26%

While all of these factors contribute to the health status of Pacific peoples,²⁸ disparities in overall health persist even when factors such as poverty, education, and location are eliminated. This difference demonstrates that culture determines health status independently of socioeconomic factors.^{27,50}

Common health disparities in Pacific communities

Health disparities are noticeable throughout Pacific communities. Overall, the life expectancy for Pacific peoples is nearly five years less for men and just over four years less for women when compared with men and women in the New Zealand population.³³ Although there is some evidence² that ethnic inequalities in mortality may no longer be widening, the recent improvement in mortality for New Zealanders overall has been less apparent for Pacific groups.

The leading cause of death in Pacific communities is cardiovascular disease. The mortality rates for both cardiovascular and cerebrovascular disease are consistently higher among Pacific peoples than in the rest of the New Zealand population.^{12,29} Among adults, Pacific peoples have three times the risk of death from stroke compared to the general New Zealand population and twice the rate of ischemic heart disease.³⁷

Over the past 25 years, disparities in cancer survival rates have increased. Pacific men have higher rates of lung and liver cancer, and Pacific women have higher rates of breast and cervical cancers, compared with the rest of the New Zealand population.²⁹

Infant mortality is higher among Pacific peoples, even though Pacific infants have a good distribution of birth weight. Pacific children have above-average risks of infection, including serious infections such as meningococcal meningitis and rheumatic fever. Pacific children are more likely to be admitted to hospital for asthma and are at higher risk for burns and pedestrian injuries.^{29,37}

Other measures of health, such as avoidable mortality, participating in screening programmes, and access to specialists, are significantly worse than for non-Pacific populations.³³ Despite having access to primary health-care services, Pacific peoples present less frequently for breast and cervical cancers screening, have lower than average rates of surgical admission to hospital, and lower rates of specialist visits.³⁷

Healthy lifestyle choices, as well as targeted public awareness campaigns, are also disproportionately poor in Pacific communities. Pacific children and adults are more likely than non-Pacific peoples to be physically inactive and to smoke. There are higher obesity rates in the Pacific community for both adults and children, contributing to the higher incidence of diabetes.³⁷

In the disabled community, Pacific peoples are disproportionately represented in the most socioeconomically deprived areas.³⁵ Yet parents or caregivers of disabled Pacific children are less likely to receive the child disability allowance than their non-Pacific peers.³⁵ This lower use of entitlements (despite higher levels of financial need) is consistent with the lower ACC claim rates also seen in the Pacific community.³⁵

Summary points – health disparities

- Health disparities exist in all parts of the Pacific communities, even after socioeconomic status and other factors are controlled for, especially in rates of cardiovascular disease, cancer, and infant mortality.
- Despite being more likely than any other group to enrol in the national diabetic programme Pacific peoples have lower than average results.
- Pacific peoples turn up for GP appointments at higher rates but experience worse outcomes and receive fewer referrals, despite having a higher burden of disease.

Different approaches to treatment



There is compelling evidence³⁷ that although Pacific peoples access the health system, they do not achieve the same benefits as other groups.

Different patients have different expectations of their providers that, if not appreciated, can lead to miscommunication and poor outcomes. Several studies have demonstrated the importance of doctors asking about their Pacific patients' health-related beliefs.^{8,33,40}

Pacific patients generally expect to spend time building a close rapport with their general practitioner (GP). If this does not happen, or if the patient feels rushed, then Pacific patients may develop a negative picture of their doctor, which in turn can affect their use of the health system.^{33,40}

Health care and Pacific patients

Studies have consistently demonstrated that some doctors treat patients differently based on ethnicity. Examples of this include the findings of the 2001–2002 *National Primary Medical Care Survey (NatMedCa), Report 7*.¹⁶ General practitioners reported that they were less likely to have a high level of rapport with their Pacific patients, ordered fewer tests, and referred patients to specialists less often, despite their greater and more complex health needs.

Although Pacific peoples have a high enrolment rate with Primary Health Organisations (PHOs) and high attendance rates with their GPs, many measures show that the health-care system is not as effective in providing care to Pacific peoples. For example:

- Pacific children are less likely to be fully vaccinated at two years of age than the national average

- Pacific women used cervical and breast screening services one-third less often³⁷
- Pacific peoples are less likely to have received counselling or advice about stopping smoking³⁷
- Pacific peoples are referred to specialists at lower rates (20 percent versus the national average of 30 percent), with access to surgical care particularly problematic³⁷
- Pacific peoples with disabilities are also less likely to have received a needs assessment than their non-Pacific peers.³⁷

Although Pacific communities are familiar with and do seek care from primary care services, they continue to have less than ideal outcomes. This suggests that they are not receiving the most 'appropriate treatment' from these services.³⁷

One aspect of appropriate treatment is to provide information in a form that the Pacific patient finds both understandable and acceptable, so that they can keep to treatment recommendations. Two percent of Pacific peoples reported being treated unfairly by a health professional because of their ethnicity (compared with 0.6 percent of European/others, 1.3 percent of Asian, and 2 percent of Māori people). Research strongly links self-reported experience of racial discrimination with a range of negative health outcomes in New Zealand adults.^{21,33}

Cultural misunderstanding and unconscious bias have contributed to the state of Pacific health. Integrating cultural with clinical competence should lead to better outcomes by:

- improving communication
- making treatment more acceptable
- improving adherence to treatment plans
- measuring of doctor performance in delivery of services to Pacific peoples.^{1,6,15,24}

Summary points – the New Zealand health-care system does not always meet the needs of Pacific patients and their families

- Despite seeking care appropriately, Pacific people often don't receive the high quality, timely services they need.
- Pacific patients and their families may expect different things from their doctor than non-Pacific families; for example, they may place a high value on spending time getting to know the doctor.
- Cultural misunderstanding by doctors can contribute to Pacific health disparities.

Cultural competence and clinical competence



Research shows that health professionals who are familiar with their patients' cultural heritage are likely to offer improved patient care,²⁵ making cultural competency 'essential for high quality healthcare'.⁹ The Health Practitioners Competence Assurance Act 2003 requires all registration bodies, including the Council, to establish standards for clinical and cultural competence.

In a series of articles in 2004, Dr Ian St George described how to establish and assess competency standards in the health-care setting. Current recertification requirements incorporate many of these ideas.^{51-56 52-56 †}

EXPLODING MYTHS

A case study about conventional wisdom

Dr Smith and Dr Manning are friends from medical school who have met up at an annual medical conference. They sit down to talk shop and share some of the problems they face in their practices.

'To be honest, I'm finding it really hard to avoid getting callous,' Dr Manning sighed. 'Some patients are so uninterested in taking care of themselves that it's hard for me to feel concern for them. It's terrible to say, but sometimes I feel like, if they can't be bothered to care, then why should I?'

Dr Smith nodded vigorously. 'I know exactly what you mean. And the obesity numbers – it looks like things are getting worse, not better. The Pacific patients in my practice are all so unmotivated and unhealthy! What's worse, when I try to talk to them about it, to tell them what they need to do differently, they always agree with me, but then they never change! It's enough to make me give up. I catch myself spending as little time with them as possible, since I know I'm wasting my breath. It's really sad, but I suppose there's nothing we can do about it. It's just a cultural thing.'

'Really? I don't agree. I don't think Pacific people want to be unhealthy any more than other groups do,' Dr Manning objected, frowning. 'I used to have problems with my Pacific patients, too, but since I changed how I do things with them, I've been really pleased.'

'If you've figured out the secret, share it with me,' Dr Smith replied sarcastically. 'I can't get anywhere with those people.'

'Well, first off, I realised that if I wasn't having any effect, then doing the same old thing wasn't going to work.'

The other man nodded grudgingly. 'Okay, that makes sense.'

[†] Branch advisory bodies such as the Australasian Faculty of Public Health Medicine (AFPHM) and the Royal New Zealand College of General Practitioners (RNZCGP) have begun to address the need to assess cultural competence alongside clinical competence in their recertification requirements.

'So I decided to get to know the community better and see if they really were as uninterested as I thought. I was surprised to find a lot of interest out there – I work in an area with mostly Samoans and Tongans. I worked with two of the local churches and a community group, and I gave some talks on diabetes and heart disease. Then they asked me back for a sort of free-form question and answer session. Boy, did that open my eyes.'

'How so?'

'A lot of people came, and they all had lots of questions. I'd thought Pacific people were really fatalistic about their health and didn't want us to give them much information, but they were all eager to learn more. They said they find it really frustrating not to be told more, and when I checked in the literature, I found that really was the case – patients want information, but in a way they can understand.'

'I explain things very well!' Dr Smith argued. 'My patients never ask me any questions.'

'Well, a lot of Pacific patients won't ask questions unless you ask them to. I realised I was often explaining things to patients the same way I'd talk to another doctor, so they really didn't understand me half the time. I didn't even figure out I was doing that until I started asking patients to explain things back to me.'

'What? Why would you do that? That would take forever!'

'It doesn't really, and it lets me make sure that I explained things to them clearly. I've caught a lot of misunderstandings since I started doing that. I also find that by 'politely demanding' that they tell me what they think, I get past the "yes, Doctor" polite answer.'

'Aha! You get that too!'

'I used to. I didn't realise it was just my patients' way of being polite and not contradicting someone who they hold in high regard.'

'You? Obviously they haven't heard about the time in uni when you –'

'Yes, me. You can stop laughing. You know – a doctor's high status is true in most Pacific cultures, so my patients were uncomfortable telling me "no" or that my treatment plan wouldn't work for them. When I started building better relationships with them and asking them to tell me what they thought of my recommendations, it made it easier for them to express concern or dissatisfaction. Once they started doing that, then we could work out a plan that they would actually follow and start to see results.'

'You make it sound simple. It can't possibly be that easy.'

'It is and it isn't. I mean, it takes time at first, when you need to get to know the people – making social small talk about them and their families as well as sharing stuff about yourself.'

'That's unprofessional! I don't feel comfortable talking about myself and my family with patients. Besides, why would they care about my life? I'm their doctor, not their friend. I shouldn't take up time from their consultation for non-essential chit chat, let alone talking about myself instead of them.'

'No, no. I know what you're saying, but in a lot of cultures, until the patient knows who you are, who your people are, and what kind of person you are, they don't feel comfortable with you. That means they won't be able to express their concerns or tell you when they have a problem. Once you connect with them, they trust you and will follow your advice. I used to think that communication was easy – just talking – but believe me, it's pretty complicated. Still, I find that if you make the effort, it really pays off.'

'Well, I'm still not convinced, but I guess I'll give your method a try. I'm certainly not having much success and I'm tired of having my patients contributing to these health inequalities.'

'Give it a try – isn't there someone else in your practice who can help, like your partners or practice nurse? And there are a bunch of online resources available too. Good luck!'

The impact of culture on health



Because culture plays an important role in health, health providers should be aware of their patients' specific cultural preferences. With Pacific peoples, key issues need to be addressed so that the patient can achieve the best possible outcome.

Doctors who recognise that their Pacific patients provide a unique opportunity to learn about a variety of Pacific cultural values, can use this understanding in working with all patients and their families.¹⁹

A GOOD OUTCOME

A case study about asking questions

Mr Toleafoa, a 32-year-old Samoan man, tried to prevent a fight at a social gathering and was punched in the face, falling backwards onto a concrete floor. He was unconscious for about five minutes, but regained consciousness shortly before Emergency Medical Services (EMS) arrived. He was assessed at a Glasgow Coma Scale (GCS) of 15 by EMS at 02.20 and taken to the local emergency department (ED).

He was first assessed by a doctor at 03.45 – one hour after presenting to the ED. His GCS was then a 12. When the physician, Dr Sinclair, heard that Mr Toleafoa was Samoan and was injured in a fight at a party, he decided that Mr Toleafoa was intoxicated

and may have a head injury. He decided not to order any imaging studies and admitted Mr Toleafoa for observation.

Due to overcrowding, the only available bed was in the urology ward. While Mr Toleafoa was waiting to be sent to the ward, he became very agitated. Mrs Toleafoa was worried by her husband's uncharacteristic behaviour.

Mr Toleafoa doesn't drink alcohol and he is normally extremely pleasant and easy-going. He doesn't use vulgar language and is a lay preacher at his church. In the ED, however, he was combative and cursed the staff in extremely rude language. Now he was mumbling nonsense and Mrs Toleafoa wasn't sure what to do. The ED was very hectic, and staff members were all obviously busy, so she was hesitant to bother them. She felt embarrassed that her husband was acting so strangely and didn't know why. She decided to stay quiet – after all, Dr Sinclair and the nurses had examined Mr Toleafoa, and they must know what they're doing.

Nurse Fong was keeping an eye on Mr Toleafoa while his own nurse took a quick break. He went in and noted a restless patient with a bruised face who was apparently talking to his wife. He saw that Mrs Toleafoa looked scared and worried.

'How are you feeling, Mr Toleafoa?' he asked, but the patient ignored him, keeping his eyes closed. He looked at Mrs Toleafoa, who looked at the ground.

'Mrs Toleafoa, how are you doing?'

'I – I'm all right, thank you.'

'We're going to be taking Mr Toleafoa upstairs to a room soon. I'm sorry it's taken so long.'

'Oh, that's all right, I know you're taking good care of him and that you're very busy.'

'It's certainly busy tonight! Still, we should get you upstairs where it's quieter soon.'

'That will be good. I think the noise is upsetting my husband.'

'Yes, it can have that effect. Tell me, how much did Mr Toleafoa have to drink tonight?'

'He had about six cans of Coke, and I think he had some coffee with dinner.'

'No, no. I mean, how much alcohol did he have?'

'Oh, my husband doesn't drink.'

'Ever?'

'No, never.'

'Hmm.' Nurse Fong checked the chart again. No blood alcohol level was drawn. It looked as if someone had assumed that since Mr Toleafoa was at a party, he must have been drinking. Nurse Fong was now concerned that Mr Toleafoa's behaviour wasn't alcohol-related.

'Mr Toleafoa? Mr Toleafoa?' The patient continued to ignore him and to mumble.

'Mrs Toleafoa, what is he saying?'

Mrs Toleafoa looked surprised, 'I don't know.'

'Don't you speak Samoan?'

'Yes, I speak Samoan, but my husband isn't speaking Samoan. That's just nonsense what he's saying.'

Now Nurse Fong was very alarmed. 'Mrs Toleafoa, is your husband acting in his normal way?'

'No, ever since we got here, he's been very odd. He's normally very polite and quiet, yet he's been shouting and swearing. I'm very sorry – it's not at all like him to be this way. He will be very ashamed of himself when he feels better.'

'Did anyone tell you about the signs of a head injury and ask you to let us know if Mr Toleafoa displays any of them?'

'No.'

'I'll be right back.'

Nurse Fong hurried over to Dr Sinclair and explained what he had just learnt. Dr Sinclair returned to the patient, alarmed to find that his GCS was now 10. He confirmed that Mr Toleafoa had had no alcohol that night, nor any other mind-altering substance, and that he was acting in a very uncharacteristic fashion. He too had assumed that Mr Toleafoa was speaking Samoan when he couldn't understand him, and was worried when Mrs Toleafoa assured him that the patient was simply rambling.

A computed axial tomography (CAT or CT) scan was immediately performed and an epidural haematoma diagnosed. Mr Toleafoa was taken to the operating room and eventually made a full recovery.

NOTE: This case is based on an actual Health and Disability Commissioner report. In that case, however, no one checked whether the patient was speaking Samoan or acting characteristically, and the diagnosis was not made until it was too late. The patient died. (HDC Canterbury Report, full report at: http://www.hdc.org.nz/files/hdc/publications/other_canterburyreport.pdf)

Key concepts for Pacific peoples



The key to understanding health behaviours of Pacific peoples is to see issues from their worldview. In this section, we highlight common and important concepts that continue to guide many of the Pacific peoples in New Zealand.

Relationships – family, community, environment

The family is the basic unit of organisation in Pacific society, with individualism less of a focus and less celebrated than in non-Pacific society.

‘Family’ refers not only to the nuclear family, but – more often than not – to the extended family. For many Pacific people, each person’s role is defined by the family, so personal contribution to the family in turn defines the individual. Family conveys interconnectedness a system of interrelated obligations, responsibilities and benefits.

For many Pacific peoples, it is important to create and maintain good relationships within the family, and beyond to other families, friends and community. Pacific peoples often work to balance relationships between people and with the surrounding environment.

Holistic health and spirituality

In Pacific societies, good health is a holistic concept that extends beyond the physical world. Pacific peoples see life and wellness as gifts, and as incorporating physical, mental, social, and spiritual wellbeing. One’s ability to fully participate in family and community life is directly associated with being ‘fully healthy’. Being healthy is associated with being a more

productive member of family and community, whereas being unhealthy or unwell is associated with the shame and embarrassment of not being able to contribute fully to one’s family and community.

Contribution and responsibility

Because one’s contribution is a key aspect of wellbeing, responsibility has a huge influence on the way a Pacific person conducts their life. This creates a desire and duty to provide for and support family and community financially, emotionally, practically, and spiritually.

This responsibility begins with taking care of family, and revolves around ensuring the future of children. Relationships with friends, professionals and community are characterised by integrity, the ability to give, generosity and mutual benefit, so that a Pacific person can meet all their obligations.

Correctness and respect

For Pacific peoples, the way things are done is important. An example is Fa’a Samoa, the Samoan Way. This is an all-encompassing concept dictating how Samoans should behave. It refers to the obligations a Samoan owes to their family, community and church, and a person’s sense of Samoan identity.

Respect is also very important. Samoans are expected always to show respect for those of higher social status; this includes older people, matai (those with chiefly authority, hereditary village leaders), ministers, politicians, doctors and teachers.

Faith

Spiritual faith (the belief that there is a greater power than oneself, namely God) is important throughout the Pacific. Since the 1700s, Christianity and the church have played a central role in Pacific culture and life. For example, Pacific churches act as a meeting place and an organising force for community projects.

FAITH AND FATE

A case study about religion

Dr Chin's patient, Mrs Pukapuka, is a 39-year-old Tokelauan woman with breast cancer. Dr Chin is very concerned that Mrs Pukapuka has 'given up', because when they discuss her different treatment options, she frequently says, 'It's in the Lord's hands. I know He will take care of me.'

Dr Chin interprets this as Mrs Pukapuka having decided there's nothing medicine can do to help her. He therefore doesn't discuss very aggressive treatment options with her, focusing more on helping with quality of life issues.

At the next visit, Mrs Pukapuka's sister, Mrs D comes with her, and she surprises Dr Chin with a question about enrolling Mrs Pukapuka in a clinical trial. 'My neighbour has breast cancer too, and her doctor put her in this new study. She had to have surgery and now she's on this new drug, and they say it might cure her.'

'Well, that's the hope of every new drug,' Dr Chin explains, 'but the trial takes a very aggressive approach to the treatment. There would be surgery, chemotherapy, and it is a very gruelling regimen. I don't think your sister would be interested in that.'

'Why not?'

'Mrs Pukapuka has a more fatalistic approach. She says that it's in the Lord's hands and –'

'But, Doctor, we believe that everything is in the Lord's hands. That doesn't mean we don't try to help Him out! The Lord brought us to you so that you could give my sister the best treatment possible. If you think this new drug might help her, of course

we want to try it, and the Lord will help our family get through the struggle.'

Now that Dr Chin understands that Mrs Pukapuka's faith doesn't prevent her from being interested in any and all treatment options, including those with a high degree of intervention, he is able to discuss treatment more effectively and comprehensively with Mrs Pukapuka and her family, so that they can make the most informed choices possible.

With the encouragement of Mrs D and the rest of her family, Mrs Pukapuka decides to enrol in the clinical trial. With the support of her family, her church, and Dr Chin, she tolerates the treatment very well.

Integrity and dignity

This concept includes both the formal, solemn processes that Pacific peoples observe when meeting and interacting with others, as well as a sense of individual poise and pride. Both reflect the importance of keeping to proper behaviour.

Dignity can also play an important part in medical experiences for Pacific peoples. A person's concern for their dignity may, in cases, outweigh concerns about their health, especially if health issues are not explained properly. If a doctor doesn't reassure the patient that their dignity will be respected, the patient may refuse certain procedures. This is particularly true of invasive medical interventions, such as a digital rectum examination for prostate cancer.

Dr Mason Durie has commented:

“The degree of comfort individuals feel with seeking health services impacts on their use of services and, in turn, health outcomes... The delivery of care in a culturally appropriate manner is an important element in determining both the willingness of people to access services and the success of any treatment or care then delivered.¹⁸”

The most effective and enjoyable way for providers to understand the communities they serve is to have an open mind. This, coupled with a commitment to effective communication and a desire for helpful feedback, will lead to an educational approach that extends beyond the moment to a lifetime of learning.

Summary points – cultural competence will improve health care

- Beware of over-generalisations, especially when dealing with Pacific peoples; always treat patients as individuals and verify any assumptions you make about them.
- The extended family is the basic unit of organisation in Pacific society, and reciprocal obligations to and from the family are very important. Because of this, Pacific people often bring family members to their medical appointments and/or may want to consult with them before accepting treatment recommendations.
- Health is a holistic concept for Pacific peoples and is not limited to physical illness (or the lack thereof).
- Many Pacific people value respect and spiritual faith, as well as proper behaviour and conduct. Pacific people may interpret informality, especially in the absence of a long-standing relationship, as disrespect or discourtesy.