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Sexual and reproductive health education in the Pacific: the role of family life education

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ABSTRACT

Background: Young people have the right to comprehensive sexual and reproductive health and education; yet Pacific Island countries continue to grapple with inadequate understanding of sexual and reproductive health education and provision. A lack of timely access to accurate information and resources exacerbates the risks of unintended pregnancies, unsafe abortions, childbirth complications, and the transmission of sexually transmitted infections, including Human Immunodeficiency Virus. Introduced in the 1970s, Family Life Education is a school-based initiative aimed at supporting youth development and provides a curriculum for sexual and reproductive health education for young people. Since its introduction, questions regarding its suitability for the delivery of sexual and reproductive health education within the Pacific have been raised especially considering its impact beyond the school setting, including within the home and the wider community. This paper reviews the historical delivery of sexual and reproductive health education within the Family Life Education ethos in the Pacific and considers how it can be improved to better meet the needs of Pacific communities.

Key words: Sexual and reproductive health; education; Family Life Education; school systems, youth, adolescent

INTRODUCTION

Sexual and reproductive health (SRH) rights are fundamental to achieving sustainable development goals (SDG 3, SDG 5); however, young people in Pacific Island Countries (PICs) continue to experience a lack of awareness and uptake of SRH services.[1-3] Addressing the lack of SRH knowledge is necessary for accessing appropriate services and reducing adverse SRH outcomes amongst adolescents,[4-6] such as high rates of teenage pregnancy[7-8] and sexually transmitted infections (STIs)[9] resulting from low rates of contraceptive use.[10-12]

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While the Asia and Pacific region, as a whole, reports an adolescent birth rate (24 births per 1,000 girls aged 15–19) that is lower than the global average (38 per 1,000), there is significant variation across PICs that is masked at the regional level. In several PICs, adolescent birth rates are markedly higher than both the regional and global averages. For example, Vanuatu records an adolescent birth rate of 81, more than double the global rate, while Samoa (55), Kiribati (51), and the Solomon Islands (49) also demonstrate elevated rates.[13] These figures underscore the uneven distribution of adolescent reproductive health outcomes across the Pacific and suggest that regional averages may obscure country-specific vulnerabilities that require targeted policy and programmatic responses. Meanwhile, Fiji has experienced a sharp rise in STIs, including one of the fastest increases in Human Immunodeficiency Virus (HIV) in the region. In 2024, 1,583 new HIV cases were reported—a thirteen-fold increase compared to the previous 5-year average. Of these cases, 41 involved children aged 15 years or younger.[14] These data indicate a clear gap in the application of current culturally relevant SRH education programs at the grassroots level and a pressing need to reevaluate how SRH education is delivered in PICs.

Originating in the 1900s, the Family Life Education (FLE) program was designed to assist young people in their physical, emotional, and moral development as they prepare for adulthood, marriage, parenthood, ageing, and social relationships.[15] FLE topics include human growth and development, adolescence, responsible parenting, relationships, and sexuality.[16] Initially, FLE was positioned as a program to address SRH issues within broader, holistic framings that centred on the well-being of the family. Within the Pacific, this approach aligned with traditional and Christian values surrounding SRH in the early 1960s, particularly emphasising moral expectations and the central role of women within the family.[15]

Given the current shift in social norms around sexuality, high fertility rates, low contraceptive use, and the rise of HIV and other STIs in PICs, a re-evaluation of the SRH curriculum within FLE is needed. The term FLE-SRH is used to distinguish the SRH component of the FLE curriculum, as opposed to the program in general. We begin with a discussion of how FLE-SRH education was introduced in the Pacific, followed by a discussion of key features of the FLE-SRH program. Areas for improvement, or which could be included for more Pacific-centric SRH education, are then explored.

FLE-SRH education in the Pacific

In the 1970s, in the Pacific, fertility rates were high, contraceptive use was low but increasing, and STIs were a significant public health issue. HIV was essentially non-existent, with the HIV/AIDS epidemic in PICs not beginning until the mid-1980s.[17] It was in this context that FLE was introduced in the Pacific in 1973. Held in Nuku'alofa, Tonga, a joint seminar organised by the World Health Organization and the United Nations Educational, Scientific and Cultural Organization ,UNESCO, brought together international/regional experts, Pacific church leaders, teachers, youth workers, and church members from the Cook Islands, Australia, Papua New Guinea, Tonga, Fiji, and American Samoa[15] to discuss the potential challenges facing parents and youth and to prepare them for the "conditions of life". [15]

Seminar participants reached a consensus that the first 'school' was home (parents are the first teachers)—what may be considered an 'informal' environment that supported their cultural and immediate context. Seminar outcomes highlighted the importance of understanding the central role of the family unit in both formal and informal learning contexts, particularly in shaping how SRH topics are introduced, discussed, and supported.[17] Thus, health education within the context of family structures and values was seen as the appropriate approach to take when educating adolescents on SRH. Participants' collective aspirations resulted in the conception of FLE, defined as a curriculum-based process of teaching and learning about the cognitive, emotional, physical and social aspects of sexuality. It aims to equip children and young people with knowledge, skills, attitudes and values that will empower them to: realise their health, well-being and dignity; develop respectful social and sexual relationships; consider how their choices affect their own well-being and that of others; and, understand and ensure the protection of their rights throughout their lives.[18]

Early Pacific discussions on FLE underscore several core features that continue to define effective SRH-FLE programs in the region. These include a focus on grounding education within family, culture, and values; recognising learning as both informal and formal; and ensuring that adolescents are supported by trusted adults and institutions.

In PICs, the family unit includes extended family, uncles, aunties, and grandparents. While the family unit may promote the continuation of learning outside of formal school systems, for many young people a lack of discussion in the home regarding SRH has created a void that has been difficult to fill.[19,20] Addressing this gap has been a challenge for both educators and policymakers. It raises ongoing questions about the extent to which schools should support the messaging and information needed to prepare adolescents for sexual relationships and intimacy, and where the boundary lies between what should be taught in schools and what should remain the responsibility of families.

Within this context, schools are often viewed as a more 'formal' channel for delivering sexual health information, particularly to support young people who may not be receiving such information at home. However, while teachers generally recognise schools as an important setting for SRH education, FLE-SRH is not always delivered effectively, largely due to personal discomfort and inadequate training.[20,21] Cultural taboos limiting discussions of SRH within the home contribute to minimal parental engagement and are often mirrored within school environments, especially where curricula fail to adequately reflect cultural understandings of SRH.[22] These experiences highlight the importance of SRH-FLE programs that are culturally responsive, values-aligned, age-appropriate, and delivered by confident,

well-trained facilitators. When accompanied by meaningful engagement with families and communities, learning is more likely to be reinforced at home.

Key features of the FLE-SRH program

Appropriate content and delivery of FLE-SRH

A central strength of the FLE program is its commitment to being scientifically accurate, removing biased or misleading information often obtained from untrusted sources such as the internet or peer misinformation. The curriculum is designed on evidence-based, medically accurate information about human development, relationships, and health. However, this approach does not account for 'how' the information then gets delivered.

Research from Fiji has detailed the difficulty female teachers have sharing information with male students and vice versa. Furthermore, these teachers reported receiving little or no training for the skills, knowledge, and strategies required to deliver the FLE-SRH program; and limited resources for sharing content.[21] The inconsistent incorporation of SRH policies into national strategies across PICs[23] may indirectly impact the lack of teacher training.

Sequence of SRH topics in FLE

FLE is intended to be incremental and age- and developmentally- appropriate, recognising that learners' cognitive, emotional, and social capacities evolve over time. Incremental learning allows gradual introduction of concepts, starting with foundational ideas in early years and building toward more complex topics in later years. Recent research examining Pacific youth education in Aotearoa New Zealand showed that the timing and sequencing of SRH-related topics are critical when aligning SRH education with the lived realities of Pacific youth.[24] The study found that deferring sensitive and developmentally relevant topics to later stages of curricula can leave young people in early adolescence underprepared for sexual experiences and/or challenges.

Currently, the sequencing of SRH topics is not always clear, and, at times, concepts appear to be introduced randomly.[21] Some higher-level concepts are presented in lower grades, while more basic concepts are deferred until later years. Such inconsistencies may limit learners' understanding and readiness.

Tensions balancing individualised models and family-based cultural frameworks

Although FLE emphasises family growth and development, it is fundamentally implemented at the individual level. By focusing on the learner's needs and lived experiences, the program is designed to support behaviour change, personal development, and long-term well-being. However, in PICs where individual well-being is closely embedded within family and community relationships, efforts to align individual-focused approaches with prevailing socio-cultural norms can create tensions for educators and policymakers, further exacerbating uncertainty about what topics should be taught and at what stages.

Accordingly, some SRH information is either not communicated at all, or education is limited to scientific discussions that avoid direct reference to sex, sexuality, or sexual relationships,[25] and delivery lacks an engaged participative learning approach. Such omissions undermine the impact of FLE-SRH delivery.

Advancing SRH education in the Pacific

Pacific language and SRH knowledge systems

To achieve better learning outcomes for FLE-SRH education requires consideration of family and cultural contexts. Thaman[26] argued that many of the curriculum frameworks implemented in Pacific Island countries have been developed by curriculum experts, hired by donor partners, who are less likely to consider Pacific knowledge systems. Thaman[26] contended that locally developed frameworks should consider 'Pacific knowledge systems and Pacific languages' in schools and universities. Recent interviews with the Fiji Ministry of Education, curriculum development specialist advisors, and other subject matter specialists, such as Mr Biu Colati, revealed that none of the early childhood, primary, secondary, and tertiary curricular are in the three vernacular languages**:** iTaukei, Hindustani, and Urdu.

Pacific scholars have emphasised that the learning and teaching of Pacific knowledge systems affects everyday living; hence the need to vernacularise concepts in local languages that make sense to the people living in these contexts.[26-27] Doing so would provide both the student/child and teacher/family member a better understanding of their language and culture and notions of *veiwekani* (relationships) in their younger years.

Understanding of concepts like *Tabu* (in the Fijian language) or sexual taboo within cultural settings can also provide insight into what might constitute safe boundaries within which discussions of sexual health, intimacy and relationships can occur.[28]

Incorporating holistic cultural values that empower families

Recent research[28] exploring the need for a re-centring of Fijian values within research assessment and investigation draws on the need for approaches to provide holistic understanding that empower family and community. This need is even more pronounced within Pacific sexuality education, given the intergenerational impact of SRH on both the individual and the family. Although the current FLE–-SRH curriculum is delivered in formal school environments, parents, community leaders, and church leaders continue to be key drivers for SRH implementation beyond the school setting. Therefore, it is important that the use of Pacific knowledge and systems extend beyond the school setting to include parents at home[22] and stakeholder groups at the community level.[16]

Originally, within FLE discourse in the 1970s, family life was positioned as something that started in the home with family activities, livelihood programs, sanitation, health, and well-being. Traditionally, such knowledge was transmitted within the home and community rather than through formal schooling. However, in contemporary socio-cultural contexts, this mode of intergenerational learning has become increasingly challenging, as shifting social norms have altered attitudes toward sexuality.

These emerging norms often emphasise sexual autonomy and exploration, diverging from traditional values and practices that historically structured sexual socialisation. The coexistence of these contrasting attitudes and value systems can generate ambiguity and uncertainty for young people. Consequently, youth may increasingly seek SRH information beyond the family and school contexts, relying instead on peer networks and digital or online sources as alternative sites of learning and validation.[24] This shift highlights the limitations of narrowly framed SRH education and underscores the need for more holistic and culturally grounded models.

Accordingly, future FLE-SRH curriculum development could intentionally draw on the roles and responsibilities of family and community members. For example, in the Fijian context, a sex education framework could be informed by the holistic values of the *vuvale* (family), including *vuvale raraba* (extended family networks), and *tavi vakavanua* (social and cultural roles within the community). These roles could be meaningfully integrated into the national FLE-SRH curriculum to strengthen understanding of how cultural structures and values might aid SRH awareness.

SRH in community-based contexts

Advancing SRH education in PICs requires intentional strategies that reach young people who are excluded from formal schooling. High school dropout rates represent a critical missed opportunity, as young people who leave school early are often among the most vulnerable to early marriage, unintended pregnancy, gender-based violence, and limited access to SRH information and services.[18,29] When SRH education is delivered primarily through schools, these young people are systematically excluded, reinforcing cycles of marginalisation and poor health outcomes. Thus, SRH education must be extended into non-formal and community-based learning spaces. Churches, youth groups, vocational training centres, women's groups, sports clubs, and village gatherings provide culturally legitimate platforms for engaging young people who are no longer in school.[26-27] In many PICs, these spaces are already sites of intergenerational learning, mentorship, and moral guidance, making them appropriate settings for culturally grounded SRH discussions.[30] Training community facilitators—including youth leaders, church representatives, nurses, and social workers—to deliver age-appropriate and culturally sensitive SRH education can ensure that messages are consistent with local values while remaining developmentally appropriate.[18]

Finally, advancing FLE-SRH in PICs requires supportive policy environments and sustained investment in locally driven curriculum development, research, and monitoring. Governments and donor partners should prioritise co-design approaches with Pacific educators, youth, parents, and community leaders from the outset.[26] Doing so aligns with long-standing calls by Pacific scholars to decolonise education and health interventions by centring Indigenous knowledge systems, languages, and values.[27,31]

Moving Forward

Looking ahead, several interrelated considerations are critical to strengthening the future of FLE–SRH in Pacific Island countries. Table 1 summarises key considerations for the future of FLE–SRH in PICs, including the cultural framing of SRH concepts using Indigenous knowledge; the cultivation of safe spaces and learning environments for young people; and increased attention to the experiences of marginalised and underserved populations, including those in rural and remote settings and young people living with HIV/AIDS.

Table 1: Developing Family Life Education-Sexual Reproductive Health (FLE-SRH) in the Pacific.

Area	Current Approach	Advancing SRH in PICs
Content and delivery of SRH	Biomedical messaging with strong emphasis on knowledge/behaviour change. Classroom lectures; didactic sessions; separate from community institutions; often using Western, technical, medical language.	Develop content using local metaphors/language and deliver it using storytelling, workshops, Talanoa. Utilise communal and participatory settings to deliver education (e.g., church, village meetings, sports events, youth programs in urban/peri-urban communities)
	Facilitators lack confidence and have little training on delivery of SRH.	Provide extended training on facilitation, cultural knowledge and translation of FLE-SRH material.
Sequence of SRH topics in FLE	Age- and grade-segmented curricula structured around formal schooling systems, with linear and standardised progression of topics. Sequencing often aligned with Western developmental models rather than local lived realities.	Curriculum focussed on life events and transitions are fluid and community centred. Modules looking at Pacific life stages, transitions, and social roles (e.g., puberty, menstruation, courtship, marriage, parenthood) rather than school year levels alone. Use virtual communications (e.g., Instagram/Facebook) to promote local content and human-interest stories of survivors (e.g., success stories of young teenage pregnancy and transition to navigating life and lessons learnt within community contexts. (Facebook, Instagram)
	Sensitive topics (e.g., sexual relationships, sexual violence, contraception) are frequently delayed or omitted altogether.	Introduce sensitive topics in developmentally appropriate ways, using culturally safe and relational approaches to ensure timely knowledge.
	English language with minimal Local language interpretation	Translation of materials in the Pacific vernacular language for better understanding of parents/families members in the villages/communities where English is the second language.
Balancing individualised models and family-based	Emphasis on individual learner	Reframe FLE-SRH to emphasise relationality by promoting greater family and community engagement through family modules, caregiver workshops, and safe intergenerational dialogues

cultural frameworks	School-based delivery often disconnected from home and community value systems. Minimal/ad-hoc engagement with parents, caregivers, and community or church leaders.	Offer separate and joint sessions for youth and family. Support educators and community facilitators on culturally responsive pacing and delivery of SRH topics.
	English language with minimal Local language interpretation	Work with existing NGOs or faith-based communities already in the communities to promote advocacy materials in English or the vernacular language.

Monitoring Impact of FLE Programs in the Pacific

Research consistently shows that SRH education strengthens knowledge and awareness, particularly in relation to contraception, HIV prevention, and healthy relationships.[32,33] School- and community-based initiatives have been effective in increasing young people's understanding of sexual health concepts, with these gains commonly captured through pre- and post-intervention assessments.[34] A systematic review of SRH education interventions in Nigeria reported improvements in knowledge and attitudes toward SRH-related topics, increased utilisation of SRH and HIV/STI services, enhanced parental and societal support, and reductions in risky sexual behaviours.[35]

A review of the FLE curriculum from UNFPA[36] found that all six PICs—Fiji, Solomon Islands, Tonga, Kiribati, Samoa, and Vanuatu—provided a component of SRH education. However, only Fiji, in 2023, has reviewed their offering of FLE-SRH.[18] Regional reports have consistently highlighted the limited availability of data on SRH outcomes and the inadequate monitoring of the impact of FLE programmes across the Pacific. This gap underscores the need for PICs to strengthen how SRH education outcomes are assessed and understood, using monitoring frameworks that are both robust and reflective of Pacific values, relationality, and collective well-being.

Improving monitoring also requires stronger alignment between education and health systems. In many PICs, SRH education outcomes are not routinely connected to health indicators such as adolescent pregnancy, STI trends, or use of youth-friendly services. Pacific-framed assessment would support more integrated monitoring that tracks learning across multiple spaces—schools, homes, churches, and health services—while remaining attentive to cultural safety, confidentiality, and community trust.

Capacity building is central to sustaining improved assessment practices. Teachers, health workers, and community facilitators often lack training in culturally responsive evaluation.[38] Strengthening local capacity to design, interpret, and use data—drawing on both Indigenous knowledge systems and formal monitoring tools—can enhance local ownership and relevance of evaluation processes.

At the same time, FLE-SRH data systems must be sufficiently developed to meet relevant international standards, including the benchmarking of performance across educators, learners, families, and other key stakeholders, as well as broader community engagement. Aligning culturally grounded assessment approaches with international best-practice monitoring standards would support more effective and sustained implementation of FLE-SRH education and community-based initiatives, while ensuring accountability and coherence across all SRH stakeholders in the Pacific.

CONCLUSION

This paper has highlighted the limitations of externally designed, biomedical models of SRH education that insufficiently account for Pacific knowledge systems, languages, and holistic understandings of well-being. Strengthening SRH education requires the meaningful integration of Indigenous languages and concepts, the re-centring of family and community as foundational sites of learning, and the extension of SRH education beyond formal schooling into community-based contexts. Equally important is ensuring that SRH education within FLE reaches marginalised young people, including those no longer in school, those living in rural and remote communities, and young people living with HIV/AIDS. Achieving these goals will require sustained investment in locally driven curriculum development, robust monitoring and evaluation systems, and active engagement

between Pacific educators, youth, families, and community leaders.

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