

***Organisational pre-requisites to fund, implement
and sustain Māori health promotion in a primary
care setting.***

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ATTESTATION OF AUTHORSHIP

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree of diploma or a university or other institution of higher learning.

Signed

Date.....

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ABSTRACT

Māori are the indigenous people of New Zealand. As a population group Māori have on average the poorest health status of any ethnic group in New Zealand (Ministry of Health, 2007). Much of this disproportionate ill-health is linked to manageable and/or preventable conditions. Given this, there is much scope for effective Māori health promotion in particular, as the Māori population is relatively young.

The primary objective of the case study research was to determine the organisational pre-requisites necessary to fund, implement and sustain Māori health promotion within a primary care setting. Secondary aims were to; identify how health promotion is perceived within a 'Māori' primary health care setting, identify existing health promotion practice, and test the feasibility of implementing a current Māori health promotion framework.

The case study research was informed by 19 key informant interviews and two focus group sessions. A literature review including an organisational document review was also undertaken. Findings indicated that many of the pre-requisites necessary for effective Māori health promotion implementation sat outside the scope of the organisation and needed to come from a variety of sources including the Ministry of Health, District Health Board's (DHB's), community organisations and health providers, whānau (family), hapū (sub tribe) and iwi (tribe), including support from other sectors. The research also found a number of underlying issues that impacted greatly on the health of the Māori population within the PHO. These issues need to be addressed at a number of levels and given high New Zealand priority.

In testing the feasibility of a current Māori health promotion model (Kia Uruuru Mai a Hauora) it was considered by participants to fit well with the goals, principles and values of the case study site and within primary health care in general, complementing critical health care service delivery components that already exist.

The study's conclusion found that there was much scope for Māori health promotion that was fully supported, recognised, and adequately and appropriately resourced by the New Zealand Government, Ministry of Health and DHB's in order to provide long term cost effective and sustainable health benefits.

CHAPTER ONE: INTRODUCTION

Modern health promotion is considered the process through which people gain greater control over decisions and actions affecting their health (Koelen & van den Ban, 2004; Nutbeam & Harris, 1998; World Health Organisation, 1986). Empowerment strategies are seen as complementary strategies for advocacy and support in encouraging people to take control of their own health and become partners in the system that can help them lead healthy lives (WHO, 1994). Inter-sectoral collaboration and community participation are considered to be key strategies leading to empowerment. The absence of empowerment leads to powerlessness, learned helplessness and alienation (Koelen & van den Ban, 2004).

Māori are the indigenous people of New Zealand. As a population group Māori have on average the poorest health status of any ethnic group in New Zealand (Ministry of Health, 2007). Much of this disproportionate ill-health is linked to manageable and/or preventable conditions. Given this, there is much scope for effective Māori health promotion in particular, as the Māori population is relatively young.

Whilst broad health promotion approaches in the past have led to Māori health gains (Ajawani, Blakely, Robson, Tobias, & Bonne, 2003; Ratima, 2001), they have not been sufficient enough to address Māori health status disparities (Ministry of Health, 2006; Ratima, 2001). Recent research such as Lea and Chambers (2007) points to ethnic differences in genetic makeup as a primary cause of these disparities. As a result much criticism of this view has been expressed by opponents stating that “*gene hunting is a new form of colonialism*” (Pearce, Foliaki, Sporle, & Cunningham, 2004). Although genetic

factors do contribute to disease causation they can be excluded as a major explanation for health disparities (Ellison-Loshmann, 2004). Disparities are largely related to differences in the social, economic, cultural and political determinants of health (Ministry of Health, 2002; 2007; Robson & Reid, 2001). Evidence shows that wider societal factors such as low educational attainment, unemployment and low income alongside poor housing, all contribute to a range of health problems (Reid, Robson, & Jones, 2000; Te Puni Kokiri, 2000). Structural barriers impact negatively on access to health care services as increasing evidence highlights inequitable access to health care services for Māori (Cormack, Ratima, Robson, Brown, & Purdie, 2005; Crengle, 2000; Robson & Reid, 2002). Population groups with high health care needs should have high exposure and greater access to medical care and treatment. However, recent New Zealand studies show that exposure to primary health care is higher among Europeans than Māori despite their high health need (Crampton, Jatrana, Lay-Yee & Davis, 2007).

Māori have long called for health services and approaches that are appropriate to meet their needs. Māori concepts of health contribute to greater understanding of a Māori worldview of health and provide guidance for health providers to deliver services that are at the very least appropriate and culturally responsive to Māori. The role of Māori health promotion will be key in reducing disparities, promoting and facilitating health gains and improving health outcomes for all New Zealander's.

Research question

The research question for this thesis came about as a result of discussions with Māori health workers from differing providers in particular, those who work in the area of health promotion. Discussions were held in relation to Māori health needs and the lack of effective Māori health promotion activity and appropriate models being implemented at

the primary health care level. Conversations raised issues in relation to where and with whom the problem may lie. This brought about differences of opinion with Māori health workers highlighting issues such as funding, workforce, access to training and the acknowledgment of the need for different processes, services, and programmes aimed at Māori.

This research set out to gather information that could be used to contribute to comprehensive community-based strategies in order to provide effective health promotion aimed at Māori including the implementation of a Māori health promotion framework.

The primary research question asks; what are the organisational pre-requisites necessary in order to fund, implement and sustain Māori health promotion within a primary health care setting?

Issues surrounding the health of Māori are not new and the causes are complex, with no one size fits all answer. Primary health care is seen as the ‘first port of call’ for many Māori who utilize health services and therefore it has an important role to play in the successful and effective implementation of health promotion activity. In order for effective health promotion to occur we first need to identify the pre-requisites necessary to create an environment that will be conducive in implementing and sustaining effective Māori health promotion delivery.

Secondary aims were to identify existing health promotion activity and then compare it with the themes that underpin the Māori health promotion framework ‘Kia Uruuru Mai a Hauora’ developed by Dr Mihi Ratima (2001) as part of her doctoral thesis whilst testing the feasibility of the model’s implementation within the PHO.

In summary the objectives of the research were to;

1. identify how health promotion is perceived within a 'Māori' primary health care setting;
2. identify existing health promotion practice;
3. identify the organisational pre-requisites for effective Māori health promotion in a primary health care setting; and,
4. test the feasibility of implementing a current Māori health promotion model within a primary care setting.

Positioning of the researcher

Research findings are influenced according to the particular worldview or lens through which the researcher analyzes the findings. This study will be influenced and shaped by my worldview which has been fashioned by my upbringing, personal experiences, education and cultural background, alongside the values that I uphold.

I am of Te Atiawa and Ngāi Tahu descent. My parents had me at the young age of 18. Due to my parents work commitments I was brought up by my Māori paternal grandparents and lived between Otautahi (Christchurch) and Wharekauri (The Chatham Islands). The Chatham Islands was home to both my grandparents where they lived and met also at a young age. I am the oldest of sixteen grandchildren some of whom were also raised alongside me under my grandparents care. My grandparents were both fluent in te reo but I never heard them speak a word. My grandfather in particular was not supportive of things Māori which influenced the way his children and subsequently his grandchildren lived and viewed te ao Māori (the Māori world).

Growing up I remember through both primary and secondary school being asked if I was Māori in which I remember reluctantly replying yes in fear of some sort of repercussion. Throughout the various stages between primary and secondary school I tried my hand in the then termed 'Māori club' now appropriately named kapa haka group. I distinctly remember my grandfather's reaction and his exact words when I told him. "*Why do you want to learn that bloody rubbish for? it will never get you anywhere*". With his reaction and those of other members where I was told I was too white to be Māori I left and dabbled in drama with the white kids where I was told to go join the Māori club. For many years I was left wondering where I would fit in as I never did quite fit into either box.

I eventually grew up and left the nest heading overseas at 17 years of age, I came home to Christchurch and by chance ended up heading to Auckland for a weekend with two friends. Since then I have never left and have been residing here for over twenty years. After working in retail I decided to try out tertiary education where I completed my social work qualification and there a whole new journey started. This is where I learnt about the Treaty of Waitangi, being Māori and all the injustices that had and continue to occur. I also learnt the reason why my grandfather was so anti of things Māori. Social work linked me to my husband who is of Cook Island descent and we have been married for 12 years. Today I am a mother to seven children (two of my own) and five wonderful step children. I am also a grandmother of two lovely baby boys. My grandparents have now passed away due to various health issues, all preventable so I have since learnt with adequate care, information and appropriate assistance.

A few years ago my mother who always claimed she was Pakeha found out she was a descendent of Ngāi Tahu. We both remember my maternal grandfather who liked to drink at the Workingmen's' Club always saying he had Māori land. He tended to tell a

few porkies after a beer or two so we never believed him, as well both he and my mother had blonde hair and blue eyes. After he died my aunty stumbled on a book that incorporated some of our family history that showed the Ngāi Tahu links and names of all our Māori family on that side. This then began another journey for both my mother and I.

I took some well needed time out from social work and was employed at the Ministry of Health, where I discovered more about Māori health issues, I then became employed at AUT University in the Māori Health Research Centre, (later launched as Taupua Waiora, Centre for Māori Health Research) for just under five years where my journey began into researching Māori health issues. Papers towards this master's qualification helped me to understand the impact of dominant discourses in shaping perspectives including my own Māori identity. I had always wanted to learn te reo but was discouraged and outraged that I would have to pay for something that should have been rightfully mine in the first place. Once te reo became free I could no longer complain. I took classes over three years and found it both exhilarating and frustrating at the same time. I vowed that my children would never go through the struggle of learning their own language and as a result I made it my mission to bring them both up in kohanga reo (total immersion pre-school) and kura kaupapa (total immersion primary-secondary school). Today both of my children can speak and understand both te reo Māori and Cook Island languages.

Māori health research has contributed to who I am today, how I see the world and in particular where I now stand as a Māori woman. Knowing and feeling comfortable in my own skin as a Māori has enriched my life and of those around me. As a result I want to contribute to Māori health gains and be part of a solution that results in positive impacts for Māori. Hence, the undertaking of this research and the associated qualification. Today I no longer feel apprehensive in regards to informing people that I am Māori. I

now know it is my whakapapa (genealogy) that determines who I am and not other people's perceptions of who they think I should be.

Health issues for Māori cannot be viewed in isolation (Koelan & van den Ban, 2004; Ministry of Social Development, 2006). There are many factors that contribute to the high rates of ill-health within this population group in particular, social, economic, cultural and political factors (Smith & Jackson, 2006). There is an urgent need for both the Government, health sector and other sectors of New Zealand society to be more responsive as a Treaty partner to improving Māori health disparities. Firstly, by recognising and incorporating Māori concepts and processes within the various structures and by providing adequate resources in order to support and sustain effective programmes/services and delivery mechanisms.

To set the context for this thesis the following chapter is based on the review of literature and contextualises the study by highlighting the history and background knowledge to health promotion drawing on many of the Western concepts that continue to shape health promotion activity today. The chapter concludes by defining the research question and the position of the researcher. The thesis also highlights the state of Māori health pre and post colonisation and includes the impacts of the Treaty of Waitangi, the determinants of health and incorporates a snapshot of Indigenous models of health. A large focus of the thesis is on current Māori health promotion and in particular, Kia Uruuru Mai a Māori a health promotion model developed by Dr Mihi Ratima (2001) as part of her doctoral thesis.

CHAPTER TWO: WESTERN CONCEPTS OF HEALTH

Background

World Health Organisation

In 1948, The World Health Organisation (WHO) was formed as the health agency of the United Nations with the ultimate aim to make possible by all people the attainment of the highest possible level of health (WHO, 1994). Over time it became clear that health could not be achieved without improvements in social and economic conditions (WHO, 1978). Three years later the WHO launched the Global Strategy – ‘Health for All by the year 2000’ (WHO, 1981b) which was unanimously adopted by The World Health Assembly in 1981. The Global Strategy is based on the principles of the Declaration of Alma-Ata on primary health care, which implies an integrated approach to the solution of health care problems and requires the fullest support and involvement of all economic and social development sectors (WHO, 1981a). According to the WHO, ‘health for all’ does not imply an end to all disease and disparities but rather that resources for health are evenly distributed and that essential health care is accessible to everyone (Koelen & van den Ban, 2004). The Strategy’s task was to ensure that by the year 2000 all people in all countries should have at least such a level of health that they are capable of working productively and are able to actively participate in the social life of the community in which they live (WHO, 1981b). The Strategy’s underlying intention was that each country and regions within countries should develop their own health for all strategy (Koelen & van den Ban, 2004).

The WHO has been the cornerstone of the health promotion and new public health movements, the principles of which have been built on throughout numerous health related conferences (Lloyd, Handsley, Douglas, Earl, & Spurs, 2007), commencing with Alma-Ata (1978) and the Ottawa Charter (1986). The WHO and the United Nations International Children's Emergency Fund (UNICEF) are the world's largest formal agencies formulating both global policy and action plans on health, which are reflected in regional, national and local policies (Koelen & van den Ban, 2004).

The WHO's definition of health is "*a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*" (WHO, 1994). This definition highlights the importance of understanding health and disease within the personal, social and cultural context specific to the person or community whose health is being considered.

The health sector among government agencies has always taken a leading role in advocating for health. Health professionals, technical experts, administration and planning divisions in health and health related ministries and their advisory committees play an important role in helping policy makers, government readers and the public identify priority health issues (WHO, 1994). However, over the years it became apparent that the achievement of health could not be the responsibility of the health care sector alone. In order to tackle problems a broader approach was necessary addressing the endogenous (biological or hereditary) and exogenous (physical or social environment or lifestyle) determinants of health as well as, review of the system of health care. A new concept was soon formed known as health promotion. There are several major documents that have helped inform the development of health promotion principles these are outlined in the following sections.

The Lalonde Report

A key turning point in the history of the health promotion movement was the publication in Canada 1974 of the Lalonde report: A new perspective on the health of Canadians. This was widely acknowledged as a pioneering statement by a national government. It explicitly recognised that health was created by the complex inter-relationship between four health fields; biology, environment, lifestyle and the system of health care (Davies & Macdowall, 2006).

The World Health Assembly

In 1977, the World Health Assembly decided the major social goal of governments and the WHO for the coming years should be '*the attainment by all people by the year 2000 of a level of health that would permit them to lead socially and economically productive lives*'. This goal is commonly known as '*Health for All by the Year 2000*' (HFA2000). The international conference on primary health care held in Alma-Ata in 1978 helped further define the idea of 'health for all' (HFA) and was seen to be the beginning of a world wide HFA movement (WHO & UNICEF, 1978).

The Declaration of Alma-Ata

The Declaration of Alma Ata (1978) recognised that health improvements would not occur just by developing more health services or by imposing solutions aimed at public health. This heralded a significant movement creating a shift in power away from the providers of health services to the consumers of those services and the wider community. The Declaration stated that an acceptable level of health for all people can be attained through a fuller and better use of the world's resources.

Unfortunately, according to the WHO (1994), a considerable part of the world's resources is now spent on armaments and military conflicts.

The Alma Ata Declaration paved the way to formulate a future global strategy for public health and health for all by the year 2000 (Koelen & van den Ban, 2004). It formally adopted primary health care as the principle mechanism for health care delivery (International Union for Health Promotion and Education, 2007) and is credited with making a distinct difference between primary health care and primary medical care. According to the Declaration, primary health care is a philosophy of practice rather than a type or level of health service. The Declaration's philosophy incorporates principles of equity, community, participation, self determination and social justice. It provides important guidance toward professional and scientific development in the field as well as the blueprint for the development of policies in different countries (Koelen & van den Ban, 2004).

The concepts and principles of HFA have a number of implications including moral, political and social implications. These not only affect national and political systems but have aided in providing a framework both for health development and for developing and dealing with inequities in health care. Health conditions in developing countries according to the WHO (1994) must be viewed in a wider social economic context. The philosophy and strategies underlying the Declaration have continued to evolve serving as an important foundation for further progress.

The Ottawa Charter

At the first international conference of health promotion in Ottawa in 1986 a Charter was presented (WHO, 1986) which describes health promotion as “*the process of enabling individual and communities to increase control over and to improve their health*”, thus ensuring empowerment at the core of the health promotion movement. The Charter built on many sources including the Declaration of Alma Ata (1978) and in particular the work of Thomas McKeown (1980). The Charter established that health is created in the context of everyday life where people live, love, work and play (International Union for Health Promotion and Education, 2007). The key achievement of the Ottawa Charter was to legitimise the vision of health promotion by suggesting key concepts, highlighting conditions and resources required for health and identifying key actions and basic strategies. The Charter also identified pre-requisites for health including peace, a stable ecosystem, social justice and equity, and resources such as education, food and income (International Union for Health Promotion and Education, 2007). It also identified the various roles of organisations, systems and communities as well as individual behaviour and capacities in creating choices and opportunities for better health.

Alongside providing an internationally common understanding the Charter also provides standards of sound logic and structure to health promotion (Frankish, Moulton, & Gray, 2000). The Ottawa Charter is now an international model on which health promotion planning is based.

The five key action strategies of the Ottawa Charter are to;

- build healthy public policy;
- create supportive environments;

- strengthen community action;
- develop personal skills; and,
- re-orient health services.

Building healthy public policy was an exhortation to put health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health.

Creating supportive environments stresses the link between people and their environments in order to improve health. It involves addressing the cultural values, social norms, physical surrounds, political and economic structures that make up the home, workplace and community environments in which people live.

Strengthening community action involves the empowerment of communities through strengthening social networks and support for social change by providing information, learning opportunities and resources.

Developing personal skills focuses on supporting personal and social development through providing information, education for health and enhancing life skills. By doing so it increases the options available to people to exercise more control over their own health and over their environments and to make choices conducive to health.

Re-orienting health services shares the responsibility for health promotion among individuals, community groups, health professionals, health service institutions and governments. They must work together towards a health care system which contributes to the pursuit of health in addition to treatment of disease and illness. Re-orienting health

services also requires stronger attention to health research as well as changes in professional education and training. This was aimed at a change of attitude and organisation of health services designed to refocus on the total needs of the individual as a whole person (Health Promotion Forum of New Zealand, 2008).

Much progress and development has been made over the past decade in regard to health promotion yet according to The International Union for Health Promotion and Education (2007) there are two important challenges that still remain; to demonstrate and communicate more widely to developing countries that health promotion policies and practices can make a difference to health and quality of life, and that health promotion action can achieve greater equity in health and can close the health gap between population groups. Table 1 shows the succession number of WHO conferences that have continued to develop the Ottawa Charter principles and themes that drive health promotion activity.

Table 1: WHO International Conferences on Health Promotion

Conference venue	Theme
First International Conference on Health Promotion, Ottawa, Canada, 1986	Ottawa Charter principles
Second International Conference on Health Promotion, Adelaide, South Australia, 1988	Healthy public policy
Third International Conference on Health Promotion, Sundsvall, Sweden, 1991	Supportive environments for health
Fourth International Conference on Health Promotion, Jakarta, 1997	Leading health promotion into the 21st Century
Fifth International Conference on Health Promotion, Mexico City, 2000	Bridging the equity gap
Sixth International Conference on Health Promotion, Bangkok, 2005	Policy and partnership for action

Health promotion principles

Health promotion is a term given to planning, implementing and evaluating activities that promote health and well-being in communities (Ministry of Health, 2003b). It draws upon many principles including those of social and physical change, policy development, empowerment, community participation, equity and health and accountability. It is seen as working with people rather than on them and starts and ends with the local community. Moreover, the population needs to be actively involved. Health promotion addresses both the underlying and the immediate causes of health whilst balancing concerns with the individual and the environment. It places emphasis on the positive dimensions of health concerns and should at the very least involve all sectors of society and environment (Health Promotion Forum of New Zealand, 2007). The field of health promotion continues to develop drawing on knowledge and methodologies of diverse disciplines and being informed by new evidence about health needs and their underlying determinants (Smith, Tang, & Nutbeam, 2006).

Ashton and Seymour (1998), state that health promotion needs to actively involve the population in everyday life settings taking into account places of social context. These are where people engage in daily activities and where environmental, organisational and personal factors interact to affect health and well-being (Nutbeam, 1998), for example, schools within the community. They further state that health promotion is directed towards action on the causes of ill-health including information, community development, organisation, health advocacy and legislation.

Inter-sectoral collaboration is a necessary part of health promotion and refers to a means of working together (collaboration) between sectors at all levels of governance and society (Koelen & van den Ban, 2004). An ideal inter-sectoral approach is to have active

information sharing and dialogue with the target populations. Health is increasingly moving away from being the responsibility of individuals alone instead the social factors determining health are taken into account and health is now viewed as a collective responsibility of society (Naidoo & Willis, 2000; Smith & Jackson, 2006). Health promotion aims to bring together actions directed at strengthening the skills and capabilities of individuals alongside actions directed towards changing social, environmental and economical conditions that may have an impact on public and individual health (Koelen & van den Ban, 2004).

Health promotion was initially defined by the WHO (1986), as the most ethical effective, efficient and sustainable approach to achieving good health. It has since been refined to take into account new health challenges and a better understanding of economic, environmental and social determinants of health and disability (Davies & Macdowall, 2006).

Western models of health promotion

Many health promotion models derive from the behavioural and social sciences and tend to borrow from disciplines such as psychology and sociology as well as activities such as management, consumer behaviour and marketing (Davies & Macdowall, 2006). There are many models that are commonly used in regard to health promotion with many not yet highly developed or rigorously tested. The range and focus of health promotion models has expanded over the last two decades, emerging from a focus on the modification of individual behaviour to recognition of the need to influence and change a range of social and environmental factors that influence health alongside individual behavioural choices (Davies & Macdowall, 2006).

Choosing an appropriate health promotion model that fits well can depend upon many factors including; the nature of the problem at hand, its determinants and the opportunities for action. Programmes that operate at multiple levels such as described in the Ottawa Charter for health promotion (WHO, 1986) are most likely to address the full range of determinants of health problems in populations and therefore give the greatest effects (Davies & Macdowall, 2006). The following sections contain summaries of Western-derived health promotion models.

The ecological-social environmental model of health promotion

The ecological – social environmental model argues that the community should be the centre of health promotion efforts (Davies & Macdowall, 2006). The concept of community is based on the geographic locality and recognition that people and groups are diverse. It also considers the relationships between the two classifications which range from (a) community as a setting or community based health promotion (where health promotion is done to the community); and, (b) community as an agent or community development (where the community is in control). There is continual strong support for community development within the Treaty of Waitangi from a Māori health promotion perspective particularly the element of self-determination.

The main critique of community development is its failure to address social, economic and political determinants that impact on communities. However, this can be minimised to some degree through a focus on community empowerment. Community participation and empowerment are key concepts for health promotion, community development and primary health care (Koelan & van den Ban, 2004; Rae, 2007; WHO, 1994).

The medical model in relation to health promotion

The medical model consists of activity that aims to reduce morbidity and premature mortality targeted towards whole populations of high risk groups. It seeks to increase medical interventions that will prevent ill-health and premature death and consists of three levels; primary prevention, where there is activity that aids in the prevention of the onset of disease through risk elimination for example, immunisation; secondary prevention, which is also preventative consisting of activities aimed at preventing the progress of the onset of the disease through avenues such as screening and lastly, tertiary prevention where activity is aimed at reducing future disease and suffering for those already ill for example, rehabilitation, palliative care and education (Naidoo & Willis, 2000). Māori access to primary, secondary and tertiary prevention strategies continue to be considerably low relative to their high health need (Crampton, Jatrana, Lay-Yee & Davis, 2007).

Health promotion and the behaviour change model

The behaviour change model aims to encourage individuals to adopt health behaviours which are seen as key to improving health. It views health as the property of individuals where people can choose to make improvements and ultimately they are to blame if they do not choose to look after themselves. It recognises the complex relationship between individual behaviours, social and environmental factors. It also acknowledges that behaviour may be a response to the conditions in which people live and the causes of these conditions for example, unemployment and poverty which are outside the control of the individual (Naidoo & Willis, 2000).

The educational model in relation to health promotion

There has been much discussion in regard to health education and its role within health promotion. The educational model provides knowledge and information to develop the

necessary skills so that people can make informed choices about their behaviour. It is based on a set of assumptions about relationships and knowledge and assumes that a change in attitude may lead to a change in behaviour. This approach facilitates the ability to increase knowledge and is seen as easy to measure (Naidoo & Willis, 2000). Naidoo and Willis (2000) argue that education is central to health promotion however, education alone has not proven to be successful. In order for health education to be effective it needs to be an integrated component within health promotion activity rather than a stand alone measure in itself (Tones & Tilford, 2001).

Health promotion takes into account a broad context whilst health education focuses on individual behaviour (Koelen & van den Ban, 2004). Traditionally health education was based on the medical practice at the time being prescriptive and unidirectional based on the conceptualisation of health as the absence of disease and health workers providing a treatment to a passive patient. Health education aimed to make individuals aware of the negative consequences of their behaviour on health for example, much emphasis is placed on the individual and on single behaviours such as smoking or eating. Strategies at that time aimed to improve health and were based on helping people to form sound opinions and make good decisions (Koelen & van den Ban, 2004).

In order to implement effective health education the focus has shifted to the determinants of behaviour other than knowledge such as social influences, skills, opportunities and the possibility of changing such behaviour. This marked an important shift as it considers health as the property of individuals and makes it possible to assume that people can improve their health by choosing to change their lifestyle. Health education today is defined as '*a consciously constructed opportunity for learning*', involving some form of communication designed to improve health literacy including improving knowledge and

developing life skills which are conducive to individuals and community health (Koelen & van den Ban, 2004; WHO, 1998b).

Health promotion and the empowerment model

The Oxford dictionary states empowerment is “*to give power or authority to act*” (Koelen & van den Ban, 2004). Empowerment strategies should complement strategies for advocacy and support by encouraging people to take control of their own health and become partners in the system that can help them lead healthy lives (WHO, 1994). Empowerment is concerned with changes in power relationships. It takes an ecological perspective, that is, it approaches health issues at multiple levels emphasising integration and interaction between those levels (Glanz & Rimer, 1995). The empowerment model helps people obtain the skills and knowledge to gain control over their own lives (Naidoo & Willis, 2000).

The social change model

The social change model is sometimes referred to as radical health promotion and acknowledges the importance of socio-economic and the environment in determining health (Naidoo & Willis, 2000). Social change is targeted towards group and populations and involves a top down approach. The skills that are seen as essential include that of lobbying, policy planning, negotiating and implementation. Evaluation includes outcomes such as legislative, organisational or regulatory changes which promote health such as safer play grounds or speed bumps to promote safer driving and safety for pedestrians (Naidoo & Willis, 2000).

Health promotion and clinicians

The role of clinicians undertaking health promotion is still widely debated (Winnard, 2006). There is a constant and on-going tension for practitioners to balance and respond to demands for the treatment of symptoms and ill-health and the pressure to be proactive in preventing ill-health or promoting health. Koelen and van den Ban (2004) identify that health professionals have an important part to play in nurturing health promotion. They believe that the health sector needs to move beyond its responsibility for providing clinical and curative services and further state that change in attitudes from professionals alongside the organisation of health services is required. In particular, changes in participatory approaches which require recognition of downstream transfer of information (from professional to the public) which is dominant over the upstream transfer of information (from the public to professional). The shift mainly reflects the intention to take the characteristics of the target population into account, as professionals are educated to be the experts and are trained in top down approaches.

A number of barriers have been identified in regard to undertaking health promotion within general practice. These include; lack of time, need for specific skills, limits of the current clinical role and lack of knowledge regarding community (Naidoo & Willis, 1998). The need for General Practitioner's (GP's) to have dedicated time and training to be able to fully endorse health promotion is well recognised. In a New Zealand study by Rae (2007), GPs interviewed acknowledged the importance of health promotion but felt strongly that it was not part of their duties or within their role to provide it as a service, clearly defining their role as purely healing and intervention and not prevention. Health promotion is identified as being undertaken by GPs but is restricted to the provision of health information on how to improve health on a daily basis. This alone has proven to be relatively ineffective with a need for information to be integrated as part of a wider

programme or action plan (Tones & Tilford, 2001). Although within Rae's study, GPs saw the value in health promotion they acknowledged that it is not their area of expertise and should be left to those trained and skilled in the area. GP's preferred to stick to the treatment of patients and not be part of sorting out the broader health and social issues.

Health policies

According to the WHO (2008) poor and unequal living conditions are the consequence of poor social policies and programmes, unfair economic arrangements and bad politics. In addressing the determinants of health there must be involvement from the whole of government, civil society, local communities, businesses, global fora and international agencies. Policies and programmes must embrace all the key sectors of society not just the health sector.

One of the five defining guidelines of the Ottawa Charter is the production of healthy public policy. Koelen and van den Ban (2004) describe policy as a set of objectives and rules that guide the activities of an organisation or an administration. Healthy public policy defines priorities and parameters for action in response to health needs, available resources and political pressures. Health should be on the agenda of policy makers in all sectors and at all levels highlighting the health consequences of decisions being made. It also holds policy makers and governments to account in accepting responsibility for health (Koelen & van den Ban, 2004).

Much work is still needed in order to align health public policy with the needs of the population. There is also much recognition in New Zealand and around the world that health public policy needs to acknowledge and accommodate indigenous people providing policies that are flexible, equitable, accessible and responsive to indigenous cultures.

Health public policies for indigenous communities need to be developed with indigenous health professionals and communities contributing at each stage of development and implementation (Australian Indigenous Health Promotion Network, 2006). Likewise in New Zealand policies need to recognize, acknowledge, and reflect the marginalized position of Māori and their continual requests for services and programmes that meet their needs.

Determinants of health

Health is not distributed equally within or across countries with vast differences existing in the health status of populations in various parts of the world (Smith & Jackson, 2006). There are a broad number of determinants that affect health with the more common being; social, cultural and economic factors which have been internationally accepted and promoted (Health Promotion Forum of New Zealand, 2002; Smith & Jackson, 2006; WHO, 2008).

Conditions where people live and work affect their health and longevity. It is recognised that the health and well-being of people is influenced by a range of factors both within and outside of the individual's control (Lalonde, 1974; WHO, 1998a). While each of the determinants is important in its own right, health is determined at every stage of life by complex interactions in particular, between social economical factors, the physical environment and individual behaviour (Dahlgren & Whitehead, 1991; Davies & Macdowall, 2006).

In New Zealand the primary causes of health inequalities are attributed to uneven distribution of, and access to, income, education, employment, health care and housing (Ministry of Health, 2002; Smith & Jackson, 2006). These groups of determinants do not

occur in isolation but interact with each other and together they influence the health status of individuals and populations. For example, socio-economic variables such as income, education and occupation affect in-activity, diet and tobacco use. These variables influence physical condition, increased blood pressure and cholesterol levels that lead to cardio-vascular disease, cancer and/or other health related issues (Davies & Macdowall, 2006; Howden-Chapman & Tobias, 2000; Wilkinson & Marmot, 2003).

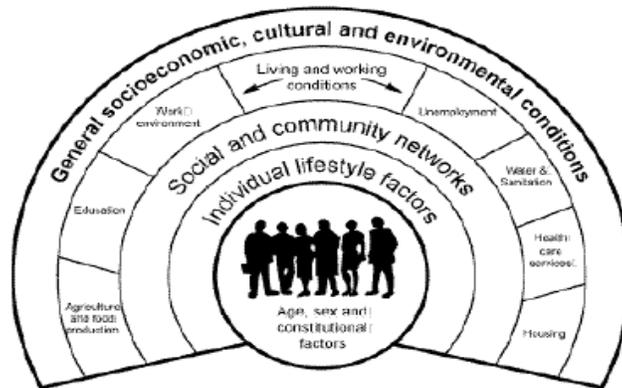


Figure 1: Social and economic model of health and its inequalities (Dahlgren & Whitehead, 1991)

Dahlgren and Whitehead (1991) identified determinants of health ranging from the individual to societal and global. This model has often been used to flag issues pertaining to inequalities in health. The model makes clear the constraints on individuals arising from social, cultural, economic and environmental factors whilst identifying the need for structural interventions that impact on the causes of health and ill-health.

Individual characteristics and behaviour influence health statistics but continue to be significantly determined by different social, economic and environmental circumstances of individuals and populations. Naidoo and Willis (2000) state that disease prevention, life experience and behaviour risk gradients are linked to socio-economic status as well as sex, age and ethnicity. People who live in different socio-economic environments face

different risks of ill-health and death. Employment is important to consider as a social determinant as it determines income levels, affects self esteem and the type of employment can also adversely affect health (Blakely, Collings, & Atkinson, 2003; Ministry of Social Development, 2006; Naidoo & Willis, 2000; WHO, 2008). Social and environmental determinants indirectly influence the individual characteristics that constitute the risk. For example, Māori are at greater risk of injury and disease due to different lifestyle factors (Reid, Robson, & Jones, 2000; Te Puni Kokiri, 2000). In many countries poverty affects the health of many populations for example, the least affluent have much poorer health than the most affluent (Davies & Macdowall, 2006). Naidoo and Willis (2000) also make note that the impact of scientific medicine on health seems marginal when compared to major structural features such as distribution of health, income, housing and employment.

Determinants of health are intertwined in all sectors of society. Improving individual and community health cannot be the sole responsibility of the health sector and therefore requires a collective effort (Koelen & van den Ban, 2004; WHO, 1978; 2008). Health promotion programmes are most likely to be successful when the determinants of a health problem or issues are well understood, where the needs and motivations of the target population are addressed, the context in which the programme is being implemented has been taken into account and at the very least when the programme fits the problem (Davies & Macdowall, 2006).

More recently the WHO (2008) commissioned report highlighted the need to address the social determinants of health including the social conditions in which people are born, live and work. It is these that are the single most important determinant of good health or ill health. The report identified the great discrepancies that occur along the social scale –

from marginalization and deprivation to privilege and power, the main reasons for the vast differences seen throughout the world in health outcomes and life expectancy. The report focuses on the upstream causes of ill health creating new opportunities for prevention, greater efficiency and sustainability. It treats these upstream preventive options as matters to be addressed by government policies and regulations and it also places the responsibility for taking action on political leaders and policy-makers. At the same time it acknowledges the power of civil society and the activist community to generate grassroots pressure that can ignite policy change. The report concludes that nearly all social determinants of health fall outside the direct control of the health sector and as a response there is a strong call for a whole-of-government approach in which policies in all sectors are assessed in terms of their impact on health. Addressing these social determinants of health will be the most effective way to improve health for all populations and reduce inequalities (WHO, 2008).

Health inequalities

Health inequalities are described as differences in health between different population groups according to socio-economic status, geographical area, age discrimination, sex or ethnicity (Ajwani et al., 2003; Davies & Macdowall, 2006; Ministry of Health & University of Otago, 2006; Reid & Robson, 2006). Disparities are found world wide and are considered ‘unfair and unjust’ (Reid & Robson, 2006; Whitehead, 1992). In some countries disparities have increased despite improvements in welfare provision. This suggests that while health policies, interventions and initiatives have led to some improvements in health for many segments of society they still remain inadequate (Davies & Macdowall, 2006).

Health equity is described by Braveman and Gruskin (2003) as the absence of systematic disparities in health (or in the determinants of health) between different social groups who have different levels of underlying social advantages and disadvantages. It is the difference in opportunities for different population groups which result in unequal access to health services, nutritious food and adequate housing for example, which can lead to inequalities (Davies & Macdowall, 2006). This concept of health equity focuses attention away from the individual and his or her health and instead it monitors how resources including health services are distributed to and within the community.

Different approaches to health promotion are reflective of different political positions. Politics may be defined as the distribution and effects of power in society. Power according to Naidoo and Willis (2000) includes not only material or physical resources but psychological and cultural aspects which maybe equally effective in limiting or channelling people. Different groups of people hold different amounts of power. Power is also unequally distributed and is often determined by factors such as gender, race, age, social class, wealth and power between groups of people, all of which significantly affect health. Structural factors such as class and gender affect power relationships in an institutionalized and patterned manner. Naidoo and Willis (2000) further state that in general people in the lower social classes and women have less control over their own lives and the lives of others compared to men in higher social classes. According to Reader (2003) reducing health inequalities is slowly moving up on the policy agenda of national governments and international agencies.

Summary

Chapter two has provided a background to this thesis, highlighting the history of health promotion activity undertaken across many countries. It has identified the critical role that the WHO has played in shaping health promotion in particular in providing support and the environment for the Ottawa Charter which is now considered the key framework that underpins Western-derived health promotion. The WHO definition of health and the principles within the Ottawa Charter (1986) are now widely accepted. Stemming from the Ottawa Charter a number of models for health have been articulated and continue to be refined to fit with addressing the determinants of health that impact on populations across the world. It is clear from the literature that health cannot be the sole responsibility of the health sector and whilst the health sector has a critical role to play it will be up to governments worldwide to implement appropriate preventative measures and regulations for taking action to address a broad range of determinants in order to improve health outcomes for all.

CHAPTER THREE: MĀORI HEALTH

Chapter three introduces the reader to te ao Māori (the Māori world). Relating who Māori are as a people, how they once lived, recognising their strength and vitality highlighting how they managed their own health prior to colonisation in relation to customary Māori public health systems. It concludes with the impacts of colonisation highlighting some of the contributing factors to poor Māori health status.

Māori

Māori self identify as the indigenous people of New Zealand and are recognised as such by the New Zealand Government, in both policy and legislation and by the wider New Zealand society. Māori refer to themselves as ‘tangata whenua’ literally translated as ‘people of the land’, which highlights that land and the wider environment are considered by Māori as a fundamental source of their identity (Ratima, 2001), as well as an integral part of their health and well-being.

Customary Māori public health systems

Pre-colonisation, Māori lived in a well developed society that contained tribal structures and systems of health, education, justice, spirituality and a common language (Orange, 1987). At the time of colonisation Māori public health systems were well established, having developed over many generations (Ratima, 2001). These systems were based on widely accepted Māori conceptions of health and understandings of disease causation. Pool (1991) describes early British explorers commentary on the good health of the Māori people, which is most likely attributed to the set up and beliefs in their public health systems. Māori public health systems were based on concepts that clearly defined safe

and unsafe practices within a framework of Māori beliefs and values which regulated certain behaviour (Durie, 1998a).

‘Tapu’ and ‘noa’ are examples of regulatory mechanisms that contributed to Māori disease prevention and health protection systems (Buck, 1950; Ratima, 2001). ‘Tapu’ in practical terms refers to restriction of access and enabled regulation of daily activities. Making sites tapu was often for protection or contamination purposes, or so food would not be depleted. Designated fishing areas for example, were prohibited at certain times of the year so the fish supply had sufficient time to replenish. The application of tapu provided a safety mechanism and a sense of caution (Durie, 1998a). Māori believed transgressions of tapu would result in negative consequences such as disease, disability or even death (Buck, 1950). The state of tapu was not always permanent and where there was a lesser need for caution ‘noa’ would be applied. ‘Noa’ signalled a more relaxed ability to access areas previously termed ‘tapu’. These could include, people or resources such as when food growth was at its peak, or when the contamination precaution was over then access would be resumed (Barlow, 1994; Durie, 1998a). Other practices contributed directly to Māori good health including the location of Māori villages, designated or separate quarters within the whare (house) or village and tohunga (spiritual healers, medicine men or women) oversight.

Māori villages were often located on hilltop sites providing not only a strategic military purpose, but also minimising dampness and cold, whilst providing access to good drainage. Separation of various quarters for specific purposes enabled for healthier environments for example, te pataka (food storage) would be elevated, the whare kohanga (birthing house) where expectant mothers would reside prior to birth would be located a short distance from the village and would involve specific rituals and rules associated with

entry. The whare mate was a house where the very sick and/or dying and their whānau would reside. It provided separation from the wider community allowing the whanau (family) to grieve. It would also prevent contamination if there was risk of disease. Separation enabled the everyday activities of village life to continue without disruption (Durie, 1998a; Ratima, 2001).

Tohunga were significant to customary Māori public health systems and were recognized as a group of people who had specialist customary knowledge and ‘mana’ (high esteem and of great importance). Tohunga provided leadership in all aspects of Māori society and their selection was usually based on whakapapa (genealogy) and proven ability. They were very skilled at identifying environmental causative factors related to ill-health and practiced specific ceremonies to prevent or treat resulting conditions (Buck, 1950; Rolleston, 1998).

The effectiveness of customary Māori public health systems relied heavily upon having confidence in the concepts that framed the system as well as respect for tohunga as health specialists. According to Ratima (2001) trust in the concepts that underpin the system was instilled in the population which then behaved according to the rules associated.

The impact of colonisation on Māori health

Colonisation saw the deterioration of Māori public health systems. With the introduction of infectious disease, political oppression, guns and land alienation came the reduction of Māori confidence in their own health and other social systems. Lack of immunity to conditions such as influenza, measles, mumps, whooping cough, tuberculosis and venereal disease (McLean, 1964; Owens, 1972; Webster, 1979) aided in the reduction of the Māori population. Māori were estimated to number 100,000 at the time of colonial contact

however by the 20th century this was reduced by half to approximately 50,000 (Durie, 1998a; Pool, 1991). Over the years the loss of land, language and culture led to rapid changes. Māori were forced to adapt to a new and very foreign environment, were cut off from their economic base, food sources, social networks and were constantly battling against the introduction of new diseases. The Māori population rapidly declined as all these conditions took effect (Durie, 1998b).

Māori strength and integrity is reflected in their capacity to adapt to change, survive and be resilient in the face of the adversity of colonisation. However, colonisation has had devastating effects for Māori who continue to be marginalised socially, economically, politically and culturally (Ajwani, Blakely, Robson, Tobias, & Bonne, 2003; National Health Committee, 1998; Ratima, 2003; Reid et al., 2000). This is reflected across a spectrum of indicators in areas such as employment, education and health (Ministry of Health, 2007; Reid & Robson, 2006; Robson & Reid, 2001).

Māori health inequalities

Ethnic inequalities between Māori and non-Māori are the most consistent and compelling inequities in health (Ajwani et al., 2003; Ministry of Health & University of Otago, 2006; Reid & Robson, 2006). There are wide disparities between the health status of Māori and non-Māori which is reflected in for example, mortality and chronic disease rates (Ajwani, Blakely, Robson, Tobias, & Bonne, 2003; Baxter, 2002; Cormack et al., 2005; Ministry of Social Development, 2005). The disparities are largely a reflection of the impact of the broader determinants of health (Robson, 2003), alongside the underperformance of the health sector (Durie, 2001), and therefore, much of the ill-health experienced by Māori is preventable.

According to Reid and Robson (2006), Māori have suffered and continue to experience consistent comprehensive and compelling disparities in health outcomes, including exposure to the determinants of ill health, lack of health system responsiveness and the under representation of Māori in the health workforce as well, Māori have become an expected and accepted feature of mental health services.

Differential access or exposure to the determinants of health leads to differences in disease incidence. New Zealand evidence includes the very different profile of Māori to non-Māori with respect to the determinants of health such as education, employment, income, housing, welfare support and dealing with the criminal justice system (Ministry of Social Development, 2006). These factors also pattern exposures to other risks such as tobacco use, poor nutrition, over crowded and sub-standard housing, unsafe work places, problem gambling and binge patterns of alcohol use, social position and social exclusion (Howden-Chapman & Tobias, 2000; Wilkinson & Marmot, 2003). All of these have direct impacts on health as well as having inter-related and cumulative effects over lifetimes (Cormack, 2007).

In all countries there is evidence of a social gradient in health and mortality (Wilkinson & Marmot, 2003), alongside growing acknowledgement that disparities in health between different ethnic groups are a consequence of the way in which determinants of health are distributed in society (Robson, 2004). In New Zealand, there is clear evidence of the differential distribution of social, environmental, economical and political determinants of health for Māori and non-Māori (Robson, Cormack, & Cram, 2007). There is an abundance of evidence linking poverty and disadvantage to poor health (Ajwani et al., 2003; Cormack et al., 2005; Smith & Jackson, 2006), and evidence continues to point toward inequalities between income groups as a direct cause (Davies & Macdowall, 2006).

The Treaty of Waitangi

The Treaty of Waitangi (the Treaty) is the founding constitutional document in New Zealand and it is the primary mechanism in which Māori have sought to have their unique rights addressed. The Treaty is an agreement that was signed between Māori chiefs and the British Crown in 1840 and set the foundation for the British to formally settle in New Zealand. The intention of the Treaty was to lay the ground rules for the relationship between Māori and the British settlers. The Treaty as a whole had a basis of protections and concerns, however, discrepancies between the Māori and English versions have been the cause of ongoing debate.

The three Articles within the Treaty can be analysed for their health implications (Health Promotion Forum of New Zealand, 2002), but need to be considered in conjunction with each other rather than separately. One example of contention is Article One of the English version which provides for transfer of sovereignty from Māori to the Crown, whilst in the Māori version the same Article provides for transfer of kawanatanga (translated as governance, or administrative authority), which falls short of sovereignty (Ratima, 2001).

Article one kawanatanga (governance) outlines the obligations of the Crown. Kawanatanga allows the Government to govern and provides for the Crowns right to make laws and its obligations to govern in accordance with a constitutional process which directly applies to all agencies which draw their authority from the Crown (Health Promotion Forum of New Zealand, 2002). Māori gave up governship of their lands but in return expected to receive benefit from the Government.

Article two shows that the Queen of England agrees and consents to give the chiefs, hapū and all the people of New Zealand the full chieftainship (tinorangatiratanga) over their lands, villages and possessions. This article provides for Māori to exercise tinorangatiratanga control, authority and responsibility over their affairs including health. It guarantees to Māori the control of their resources and taonga (those things sacred and precious). One government response to crown obligations has been to support the development of Māori health funders and providers (Health Promotion Forum of New Zealand, 2002).

Article three addresses issues of equity and equality and constitutes a guarantee of legal equity between Māori and citizens of Aotearoa (New Zealand). Māori should experience equity in the enjoyment of all benefits of New Zealand citizenship including health. Provision requires the Crown to actively protect and reduce disparities between Māori and non-Māori (Health Promotion Forum of New Zealand, 2002).

The Treaty of Waitangi and the Articles are strongly associated with determinants of health. Treaty articles provide good government and protection, Māori self determination and control over their affairs and equity with other people in Aotearoa New Zealand. Despite the importance of the Treaty of Waitangi as a founding document in New Zealand's political system, most organisations tend to identify more with incorporating the principles of partnership, participation and protection that reside within the document. The principles are recognised as interpreting the intentions and spirit of the Treaty arising from the interpretative differences (Ministry of Culture and Heritage, 2005). The right to good health is implicit under the Treaty of Waitangi and health inequalities are considered to be a breach of the Treaty (Robson & Reid, 2001).

Determinants of health

The major determinants of health across many countries are recognised as social, cultural and economic factors, more specifically, the health impact of income and poverty, employment and occupation, culture and ethnicity, education and housing (Ministry of Health, 2007; National Advisory Committee on Health and Disability, 1998; Ratima, 2001; Smith & Jackson, 2006). Social and economic policies have a determining impact on the growth and development of populations. Increasingly the nature of the health problems countries have to solve is converging. The development of a society whether it is rich or poor, can be judged by the quality of its population's health, how fairly health is distributed across the social spectrum and the degree of protection provided from disadvantage as a result of ill-health (WHO, 2008).

During the past 20 years educational qualifications have become increasingly critical determinants of employment and occupational status (Robson et al., 2007). Occupational gradients in health have been well-described with poorer health among those in unsafe, insecure and poorly paid jobs (Shaw, Dorling, Gordon, & Davey-Smith, 1999). Redundancy and unemployment are associated with poorer health outcomes (Blakely, Collings, & Atkinson, 2003; Keefe et al., 2002; Robson et al., 2007). This confirms the relationship between income and health. In general, lower incomes are associated with higher morbidity and mortality for many illnesses and injuries (Robson et al., 2007), therefore the lower the socio-economic position, the worse the health (WHO, 2008).

The marginalisation of Māori is clearly reflected in the disproportionate ill-health they experience compared to the general population, in particular, preventable and/or manageable conditions. Disparities are largely attributed to the differences within the social, economic, cultural and political determinants of health. It is well documented that

as a population group, Māori have on average the poorest health status of any ethnic group in New Zealand (Ministry of Health, 2000; 2007; Ministry of Health & University of Otago, 2006), and extensive disparities exist between the health status of Māori and non-Māori. In some areas health status disparities are widening (Ajwani, Blakely, Robson, Tobias, & Bonne, 2003). There is international evidence that indigenous peoples have poor access to and/or utilisation of health services and that even when they do access health care the quality of care received is low compared to the general population (Crampton, Jatrana, Lay-Yee, & Davis, 2007; Smedley, Stith, & Nelson, 2003). There is New Zealand evidence that supports the position that Māori have poor access to health services relative to their high need (Cormack et al., 2005; Crampton et al., 2007).

Over the years a number of health promotion approaches have been developed. Whilst some approaches have led to increasing health gains for Māori and evidence has shown a reduction of disparities in some areas (Ministry of Health, 2005), they still remain insufficient to adequately address the majority of existing health status disparities. Given that the disproportionate ill-health of Māori is linked to preventable and manageable conditions, there remains much scope for effective Māori health promotion.

Summary

This chapter has highlighted the health of Māori pre-colonisation, identifying Māori customary health systems that aided Māori in their good health. It also outlined their strength and vitality as a people in overcoming the devastating consequences brought about by colonisation. Importantly, this chapter shows that culturally appropriate interventions are most effective if they are adequately supported, developed in conjunction with the needs of the target audience, use culturally relevant tools including traditional resources

and set in the right environment can have profound affects on the health of a population, as seen pre-colonisation.

CHAPTER FOUR: INDIGENOUS CONCEPTS OF HEALTH

This chapter describes indigenous concepts of health and health promotion. It focuses on common elements across indigenous models and approaches in particular the holistic approach to health.

Indigenous peoples' concepts of health are varied however, they do share some general features that are distinct. A range of models have been put forward by indigenous peoples' that describe ways in which they conceptualise health. These models generally incorporate the notions of holism and balance between interacting dimensions. They also incorporate a spiritual dimension (Alderete, 1999), and like Māori have a relationship with the land which is described as a fundamental aspect of well-being (Cobo, 1987; Daes, 1996). Elements of indigenous health promotion models include; community ownership, leadership, empowerment, consultation and partnerships. Local culturally appropriate interventions and preventions are essential to improving health status in aboriginal communities. The Ministry of Health (2003b) outlines some key principles for indigenous programmes including; the need for them to be holistic, culturally appropriate, use Western and traditional methods, undertaken in a familiar environment, use believable community methods, promote traditional activities, address underlying social issues and treatment of abuse, have recognition of history, comprise a realistic timeframe and understand community restraints.

Principles for better Australian Aboriginal health promotion were also agreed upon at a national workshop held in Sydney in 2002. These principles include; the acknowledgement of Aboriginal cultural influences alongside the historical, social and

cultural context of communities, they should be based on available evidence, building the capacity of community, government, services systems, organisations and the workforce ensuring equitable resource allocation, cultural security and respect in the workplace, promote ongoing community involvement and consultation, practically apply Aboriginal self determination principles, adhere to the holistic definition of health and that primary health care incorporate Aboriginal health promotion and the establishment of effective partnerships and programmes that are aimed at being sustainable and transferable whilst demonstrating the transparency of operations and accountability (NSW Department of Health, 2002).

The National Native Addictions Partnership Foundation (NNADAP) summarises current prevention activity for First Nations people in Canada as approximately 550 prevention programmes with over 700 workers (NNADAP, 2008). The programmes share a variety of elements based on the size and needs of each community and the availability of skilled workers. Programme elements fall into three primary areas; prevention activities, intervention activities and aftercare activities (Gifford, 2009; NNADAP, 2008). Whilst these activities are not solely based on traditional methods of delivery, they do suggest further refinement of an appropriate paradigm for social-cultural development. NNADAP describes traditional healing practices for First Nations people as “*experimenting with and applying methods to improve both physical and mental health*” (NNADAP, 2008, pg 38). Whilst there is agreement that there is no common indigenous pedagogy there is an acknowledgment between cultures of diverse ways of knowing and a pluralism of knowledge-gathering across diverse geographic and cultural groups that needs to be respected (NNADAP, pg 39).

The Medicine Wheel

Contemporary indigenous healing and wellness strategies are now being informed by concepts such as the Medicine Wheel. The Medicine Wheel is a circular conceptual framework for knowing and understanding. It emphasizes an attempt on the part of individuals and communities as a whole to see balanced styles of living that benefit both themselves and others (NNADAP, 2008). The philosophy of the Medicine Wheel presumes that lives of all individuals are oriented in four separate but equal spheres from which they can potentially receive purposeful direction in terms of managing their lives. The spheres include spiritual, emotional, physical and cognitive or intellectual components. When spheres co-exist in harmonious balance then that is reflected within the individual's life. When these spheres are out of balance then disharmony and ill-health will be apparent (Gifford, 2009). Many Aboriginal communities have different versions of the Medicine Wheel.

The Circle of Health

The Circle of Health (1996) was developed in Prince Edward Island, Canada. This tool has a wide range of applications and is constructed using the theoretical frameworks of the determinants of health, the Ottawa Charter, and the First Nations Medicine Wheel. It is relevant to community, health, justice, economic, business and environmental issues which intersect with, and influence individual and community well-being. The Circle provides a picture of the components of health promotion at a glance. By moving the various rings you can line up many possible interactions within and between the components. The Circle helps people to understand health promotion as a very dynamic process which involves many people and strategies (Circle of Health, 1996).

Concepts of interconnectedness or interdependence, balance in all things, and the concept that a person is responsible for his or her actions in relation to the larger community is reinforced by indigenous writers such as Graveline (1998). Other concepts deemed important include; the incorporation of indigenous practices and the use of oral tradition (Wardman & Quantz, 2006). The Assembly of First Nations (2006) identifies a number of principles that they would like to see incorporated into intervention models these include;

- self government and self determination;
- acknowledging the role of First Nations governments and their role in providing a formal public health system infrastructure;
- a holistic approach with a focus on community;
- public health data on which to base interventions and strategies;
- data ownership, control, access and possession is exercised in all surveillance;
- capacity development in particular, funding health human resources, enabling legislation, and a collaborative approach among all levels of provincial, territorial, federal and First Nations governments; and,
- an approach that addresses the broader determinants of health and allowing individual community flexibility in the provision of services (Assembly of First Nations, 2006).

Whilst these principles derive specifically from the Assembly of First Nations, many apply to other indigenous communities.

Māori concepts of health

Early influences

Instrumental to Māori health was the role of Maui Pomare since he first graduated as the first Māori medical practitioner in 1899. Appointed as the first Māori medical officer at age twenty five he brought about significant change to Māori health development in the many years to follow (Durie, 1999; Ratima, 2001). Durie (1999) outlines Pomare's five point plan for Māori health promotion which is described as a pre-cursor to today's modern approaches. The five points include; health leadership (drawing on professionals and Māori community leaders), recognition of the link between health and socio-economic factors (acknowledging issues such as housing and water supply affect disease), the connection between Māori health and Māori culture, the importance of political commitment to health and the development of a strong health workforce. Even though Pomare's five point plan was developed over 100 years ago key elements continue to have significant relevance today.

Emerging more recently are forms of health promotion that are distinctly Māori (Ratima, 2001), for example, its 'all about whānau' stop smoking campaign. Māori approaches that link to customary systems and infrastructure that support Māori health initiatives alongside a variety of Māori driven health promotion interventions are now well established. Initiatives such as these are diverse in nature and seek to address a range of issues from nutrition and physical activity to mental health. Initiatives are being implemented across a number of different domains ranging from the marae to the classroom and include a range of different activities from prevention to education. They utilise different processes from advocacy to cultural responsiveness and generate a number of diverse strategies ranging from capacity building to collaboration (Ratima,

2001). Although these approaches are diverse they share a number of common goals including; situation improvements for Māori, retaining cultural approaches to health and increasing Māori control.

Māori models of health consist of similar characteristics in that they have a holistic approach, have interacting dimensions and utilise both Western and traditional aspects. Although many models are being used in different health settings the following sections describe the most common models currently used.

Te Whare Tapa Wha

Durie's (1982) Te Whare Tapa Wha model for Māori health has gained widespread recognition and is used across many health settings (Figure 2). The model views health as holistic with four interacting dimensions; te taha tinana (physical), te taha wairua (spiritual), te taha hinengaro (thoughts and feelings), and te taha whānau (family and community). According to the model in order to achieve well-being there must be a balance between these interacting dimensions. On the other end of the spectrum ill-health is seen when one of the interacting dimensions is out of balance, which affects the other dimensions in a negative way.

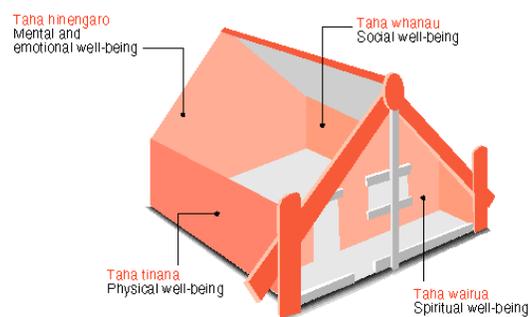


Figure 2: Te Whare Tapa Wha (Durie, 1982)

Te Wheke

Pere (1984) takes Durie's model a step further using Te Wheke (the octopus) as a metaphor with each tentacle representing a dimension of health while the body and head symbolise a whole family unit. These dimensions complement Te Whare Tapa Wha with the addition of further elements at a community level. These dimensions are wairuatanga (spirituality), taha tinana (the physical side), hinengaro (the mind), whānaungatanga (the extended family), mana ake (unique identity), mauri (the life-force in people and objects), ha a koro ma a kui ma (the breath of life that comes from fore bears), and whatumanawa (the open and healthy expression of emotion).

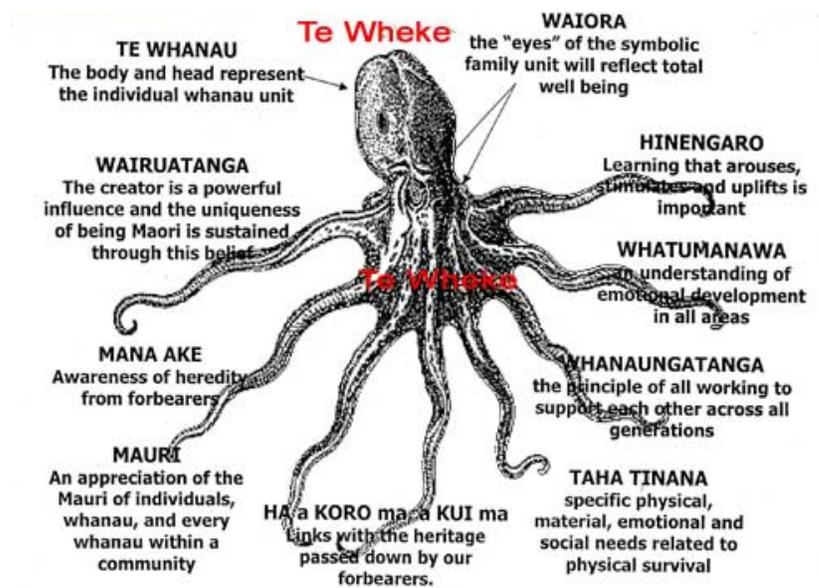


Figure 3: Te Wheke (Pere, 1984)

TUHA-NZ

In 1988 the Health Promotion Forum of New Zealand began a consultation process to discuss the Treaty of Waitangi and Ottawa Charter for health promotion and their

application to health promotion practice in Aotearoa. The objective of the consultation process which involved four workshops around New Zealand was to invite the health promotion workforce to participate in discussions of the remit that came out of the forums in 1997 on 'Creating a Future Conference'. Members involved in the consultation process strongly supported the development of a framework document based on the Treaty of Waitangi to guide health promotion action in New Zealand. The consultation process identified how the framework should look in that it should be Treaty based, explain what health promotion is, clarify the relationship between the Treaty and health promotion, reflect values and issues relevant to New Zealand as well as having international relevance particularly in relation to the rights of indigenous and First Nation peoples. Commitment to and actioning of the Treaty would role model New Zealand experience and process, represent a clear developmental step on from the Ottawa Charter which will require commitment to monitoring and evaluation. In summary the call was heeded for a practical framework to help health promotion organisations and practitioners further understand and apply the Treaty in everyday work. The Memorandum links a Treaty principle with each Article and its associated provision. Following on from this, three goals for New Zealand health promotion were derived;

- to achieve meaningful Māori involvement in all aspects of health promotion;
- to actively support the advancement of Māori health aspirations; and,
- to prioritise health promotion action that improves Māori health outcomes.

TUHA-NZ has proven to be a useful starting point in seeking to operationalise the Treaty of Waitangi within New Zealand health promotion. The Memorandum is now commonly referred to TUHANZ (two hands) (Health Promotion Forum of New Zealand, 2002).

Te Pae Mahutonga

Te Pae Mahutonga articulates Māori health promotion as “*creating a climate within which human potential can be realised*” (Durie, 1999). This model emerged from the work of Maui Pomare and the Ottawa Charter and is conceptually based on the Southern Cross. Te Pae Mahutonga incorporates access to te ao Māori (the Māori world), environmental protection, healthy lifestyles and participation in society. The two pointers (large stars pointing to the Southern Cross grouping) represent pre-requisites for Māori health promotion that include ngā manukura (leadership) and te mana whakahaere (autonomy) (Ministry of Health, 2003a). Within the model, health promotion leadership referred to by Pomare is a key factor in health promotion. Health promotion leadership refers to a number of levels including community, health and tribal leadership. Also incorporating within its components is open communication and co-operative relationships between leaders and key groups.

Autonomy refers to the need for control of health promotion interventions to ultimately rest with communities, be consistent with community aspirations, be driven by communities and be carried out in a way that is consistent with local preferences. The model also outlines four key tasks of health promotion. These tasks are; mauiora (access to the Māori world), waiora (environmental protection), toiora (healthy lifestyles) and te oranga (participation in society). Access to the Māori world in this context is associated with Māori language and knowledge, culture and cultural institutions, economic resources (e.g. land) and Māori social resources (e.g. access to Māori networks).

Environmental protection recognises the spiritual connection between Māori wellness and the environment, whilst protection of the physical environment is central to Māori health

promotion it is also important that there are opportunities for Māori to interact with the natural environment.

Māori health promotion has an important role in facilitating healthy lifestyles by looking at individual lifestyle behaviours and taking into account macro-level influences. Durie (2000) identifies five areas of focus for promotion of healthy lifestyles. They are; harm minimisation, targeted interventions, risk management, cultural relevance and positive development.

Participation in society relates to Māori access to society's goods and services and as a result, fair opportunities for Māori participation in New Zealand society. According to Ratima (2001) Māori health promotion has an obligation to increase Māori participation in the economy, education, employment, the knowledge society and in decision making. Te Pae Mahutonga was ground breaking as it is the first to attempt to conceptualise Māori health promotion in a comprehensive way.

Summary

Indigenous models presented reinforce the importance of a holistic approach with the inclusion of family and community in order to sustain health and well-being of the individual. The models and approaches outlined in this section highlight the many important aspects to consider alongside the physical aspects of health.

Indigenous approaches share a number of commonalities including the concern to better their situation, retainment of their own culture and approaches to health, as well as the desire to increase control over their own health and lives.

The Decade of Māori Development (1984-1994) stimulated the re-emergence of distinctly Māori approaches to their own health development. As a result increasing numbers of Māori community organisations and tribal groups are now providing health promotion interventions that draw on customary systems. Many Māori driven health promotion interventions have been established which are diverse in the sense that they seek to address a range of issues for example, mental health, smoking, physical activity and/or nutrition. Many are set in a variety of domains such as marae, community halls, and sports venues and tend to differ in activities for example, health, prevention and education. Interventions also function through a variety of processes, such as advocacy and cultural responsiveness and utilise diverse strategies such as workforce capacity and inter-sectoral collaboration.

Access to Māori resources is vital including te reo, Māori leadership and Māori environments. Māori health promotion facilitates shared meaning and enhanced communication. It can be used as a guide to practice and encourages transparency and accountability as a basis to justify actions. The main aim of Māori health promotion is to build a solid Māori foundation that emerges from taha Māori (a Māori perspective) and te ao marama (the natural world) incorporating values that lead to Māori development.

CHAPTER FIVE: A MODEL FOR IMPLEMENTATION

Chapter five presents the Māori health promotion framework ‘Kia Uruuru Mai a Hauora’ and its defining characteristics in relation to health and health promotion.

Kia Uruuru Mai a Hauora

Ratima (2001) incorporated three case studies pertaining to Māori health promotion interventions as part of her doctoral thesis. The characteristics of Māori health promotion were identified as a result of her study and presented in ‘Kia Uruuru Mai a Hauora’ a framework for Māori health promotion. The term ‘framework’ has been applied and used in regard to Kia Uruuru Mai a Hauora until such time as it has been validated in practice and research. The term framework emphasises a less precise meaning in terms of an organising structure. The framework is used to organise the elements and constructs that are integral to health promotion to explicitly show connections with the intention to inform practice. The framework conceptualizes and makes explicit the defining characteristics of Māori health promotion. According to Ratima (2001) Māori health promotion utilises a range of contemporary tools, methodologies and frameworks, but influences the ways in which they are applied in order to ensure that they are relevant to Māori. Māori health promotion has a dual focus on ‘health’ and ‘Māori’ and it is this that shapes the defining characteristics of Māori health promotion. The defining characteristics of ‘Kia Uruuru Mai a Hauora’ are outlined in table 2.

Table 2: Characteristics of Kia Uruuru Mai a Hauora

Characteristics	Māori health promotion
Concept	<ul style="list-style-type: none"> The process of enabling Māori to increase control over the determinants of health and strengthen their identity as Māori, and thereby improve their health and position in society.
Concept of health	<ul style="list-style-type: none"> A balance between interacting spiritual, mental, social, and physical dimensions.
Purpose	<ul style="list-style-type: none"> The attainment of health, with an emphasis on the retention and strengthening of Māori identity, as a foundation for the achievement of individual and collective Māori potential.
Concept Paradigm	<ul style="list-style-type: none"> Māori worldviews.
Theoretical base	<ul style="list-style-type: none"> Implicit.
Values	<ul style="list-style-type: none"> Māori identity, collective autonomy, social justice, equity.
Principles	<ul style="list-style-type: none"> Holism, self-determination, cultural integrity, diversity, sustainability, quality.
Processes	<ul style="list-style-type: none"> Empowerment, mediation, connectedness, advocacy, capacity-building, relevance, resourcing, cultural responsiveness.
Strategies	<ul style="list-style-type: none"> Reorienting health systems and services towards cultural and health promotion criteria. Increasing Māori participation in New Zealand society. Iwi and Māori community capacity-building. Healthy and culturally affirming public policy. Intra and inter-sectoral measures to address determinants of health. Effective, efficient, and relevant resourcing of Māori health.
Markers	<ul style="list-style-type: none"> Secure Māori identity, health status (positive and negative), health determinants, and strengthening Māori collectives.

Source: (Ratima, 2001)

Table 2 summarises the defining characteristics of the framework Kia Uruuru Mai a Hauora. The following sections outline more detailed information pertaining to each characteristic.

Māori health promotion

According to Ratima (2001), Māori health promotion focuses on shared meaning and communication. The focus is less about adapting practice to the preferences of Māori in order to avoid offending Māori cultural sensibilities and is more concerned with developing and maintaining a strong Māori foundation. Māori health promotion starts with Māori beliefs, values and preferences. It incorporates Māori needs and is securely rooted in Māori worldviews in which Māori values, beliefs, processes and preferences are implicit.

Purpose

The purpose of Māori health promotion is that it will lead to health gains facilitating retention and strengthening of Māori identity (Durie, 1999) as a foundation for the achievement of individual and collective Māori potential.

Paradigm

Māori health promotion origins are traced back to customary Māori public health systems. These systems were based upon concern for the collective with particular attention paid to the determinants of health namely the supernatural, social, and environmental determinants. Examples have been identified through the literature including the concepts of 'tapu' and 'noa', where certain food, people and processes were prohibited or limited for a period of time (long or short term). This was for various reasons such as safety, hygiene, risk of contamination or to enable replenishment of resources. Fish, plants, designated areas and/or livestock are examples of resources that may have been tapu. The separation and designation of certain quarters enabled village life to continue without disrupting other important rituals and processes such as birthing, sickness or death. The

role of tohunga was recognised and well respected and advice and remedies sought and given were well adhered to.

Theoretical base

Theories of health enable the identification and prioritisation of certain issues to be addressed and can give credibility and provide sound theoretical grounding. For example, workforce theories can help clarify the role of the Māori health promoter. Māori health promotion is based on a Māori world view therefore as Ratima points out it is more familiar with Māori concepts such as manaakitanga (caring for one another) and whānaungatanga (kinship or connection) rather than specifically identified health theories. Māori health models such as Te Whare Tapa Wha (Durie, 1982) and Te Pae Mahutonga (Durie, 1999) are steps towards the development of a macro-theory that include concepts and common themes such as interconnectedness and collectivity which are more familiar with Māori. Theories of Māori health promotion will draw from a number of sources including Western derived health promotion and other disciplines, as well as Māori sources rather than stemming from one particular field.

Values

Values are seen to provide moral guidance. Māori health promotion is ideologically motivated and political, challenging existing power relations. Values identified within the framework include; Māori identity, collective autonomy (looks at changes in power relationships), Māori control over determinants of health (uses Māori specific approaches that emphasise holism and the needs and aspirations of the group above the individual), social justice (sees that all people are equal worth and have the right to equal consideration in relation to development opportunities), equity (deals with fairness).

Ratima draws on two examples of Māori values which include Māori heritage (inherited from ancestors) and wairua (spirituality).

The principles of health promotion

Principles are used to provide practical direction for Māori health promotion work. A number of principles are identified within 'Kia Uruuru Mai a Hauora' and include; holism, self determination, cultural integrity, diversity, sustainability and quality.

Holism

Holism in regards to Māori health promotion deals with a number of elements and can include time (past and present) realms (spiritual and physical), as well as sectors and focus. It can also refer to an alternative treatment system that focuses on the whole person rather than on specific diseases or disorders. Holism takes into consideration physical, emotional, social, environmental and spiritual factors. A Māori worldview encompasses the interconnection of the past, present and future with emphasis on how actions today influence future generations (Business Research Centre Marketing and Social Research & Te Pūmanawa Hauora, 2000). Examples of holism within health promotion include; health promotion programmes that target smoking and the impacts on the collective and/or inter-generational impacts (e.g. it's about whānau), healthy pregnancies and the passing on of knowledge.

Self determination

Self determination is described as Māori asserting their right to control their own future in all domains including health. Self determination is seen as central to Māori health promotion in that it should take a by Māori for Māori approach that emphasises tribal or

Māori community group initiation, ownership, management and delivery of interventions.

It should also increase greater control over the determinants of health.

Cultural integrity

A critical role of Māori health promotion will be to ensure that Māori health promotion is culturally appropriate and that it affirms and strengthens Māori identity and reinforces cultural values and practices. Examples include; a culturally competent workforce and programme delivery, Māori health promotion undertaken in Māori domains such as marae and motivation to develop or up skill including cultural skills such as te reo.

Diversity

The principle of diversity shows that although Māori share a number of commonalities they are not a homogenous group. Māori live in diverse socio-economic and cultural realities. Examples include; diversity in health status, lifestyles, tribal affiliations and income levels.

Sustainability

Kia Ururu Mai a Hauora outlines two important aspects of sustainability and includes; durability of solutions and well-being of future generations (Business Research Centre Marketing and Social Research & Te Pūmanawa Hauora, 2000). Māori health promotion cannot rely on quick fix solutions that do not take into consideration durability. Funding timeframes need to allow for planning and be of a reasonable length whilst the political durability of interventions also needs to be regarded as important. The recognition that future generations will not be compromised by the interests of the current generation is

also a vital aspect of sustainability and aligns with the interconnectedness of the past, present and future.

Quality

Māori health promotion will need to consist of high levels of technical and cultural principles and criteria. These principles and criterion need to be consistent and be informed by accurate up to date, relevant and appropriate information from those that are best qualified (not necessarily in academic terms) and/or experienced. Interventions that are culturally appropriate need to be credible in Māori terms, and operate in ways that are consistent with Māori expectations. Culturally competent interventions would ideally have input from Māori with the appropriate knowledge and skills which are relevant not only to the intervention but to the population and community. These would include for example, Māori institutions, Māori community including leaders and Māori health promoters.

Processes

Processes are applied across a number of settings and a variety of issues. The central processes of Māori health promotion within this framework are; empowerment, mediation, connectedness, advocacy, capacity-building, relevance, resourcing and cultural responsiveness.

Empowerment

Empowerment within Māori health promotion refers to the process of enabling Māori to increase control over the determinants of health and therefore strengthen their identity whilst improving their health and position in society. It includes a focus on both the

individual and Māori collectives and enhances Māori community capacity and raising awareness.

Mediation

Māori health promotion mediation is the process of facilitating intra and inter-sectoralism. *Intra-sectoralism* is referred to as the co-ordination of approaches at all levels within the health sector and works to achieve consistency between government and Māori health policies and practices at local levels. It promotes co-ordination between stakeholders encouraging an integrated approach between health services within communities. *Inter-sectoralism* recognises key determinants of Māori health may lie outside the immediate influence of the health sector and due to this there is a role for Māori health promotion in mediating between stakeholders and providers. Examples include; setting up appropriate delivery of services, sourcing adequate funding and addressing issues that are relevant across different sectors such as social, financial, educational and justice issues that impact significantly on health.

Connectedness

Connectedness is referred to as a process that is central to Māori health promotion and includes; intergenerational transfer of knowledge, inter-sectoral approaches, locating health within the broader context of Māori development, whānau focused services, strengthening of whānau relationships and use of tribal and Māori community networks.

Advocacy

Māori health promotion needs adequate and appropriate support from a wide range of stakeholders at all levels. Advocacy pertains to all levels including, local, national and

international and has taken many forms over the years. Advocacy is about ensuring Māori participation and Māori having control over their own processes, resources and health. Advocacy is a process for lobbying for public, political and other stakeholder commitment to the goals of Māori health promotion. Advocacy can take many forms and ensures Māori participation at all levels which is integral to well-being.

Capacity building

Māori health promotion capacity building will need to recognise the marginalised position of Māori. Increasing Māori community capacity will enable communities to lead their own health development, enhance community readiness to take on benefits from interventions and to ensure sustainability of improvements in health outcomes. It will require attention to the conventional as well as more broadly defined dimensions of capacity, including not just financial and material resources but cultural resources such as drawing on whakapapa and the use of te reo.

Relevance

Relevance ensures Māori health promotion interventions are appropriate to Māori in that they are accessible, addressing Māori priorities and meeting the perceived needs of Māori communities.

Resourcing

Māori are not at the same level as the general population they are marginalised in social, cultural, economical and political terms. Additional developmental resources will be required to achieve realistic and equitable health outcomes. As well, there needs to be recognition of the different types of resources that will be needed. In order for Māori to

fulfil their potential for good health they will need to have access to Māori resources such as Māori health promoters and relationships with Māori institutions.

Cultural responsiveness

Cultural responsiveness ensures that health promotion interventions are culturally competent and affirm Māori beliefs, values and practices. Māori health promotion interventions will need to meet high cultural standards that operate in a way that is consistent with Māori beliefs, values and preferences. For example, cultural skills of workers and the provision of services in Māori domains.

Strategies

Strategies of Māori health promotion derived from the framework have been identified as overlapping between the three key areas of Māori health promotion, Māori development and Western derived health promotion activity. Strategies within the Kia Uruuru Mai a Hauora framework have been identified as; reorienting health systems and services towards cultural and health promotion criteria, increasing Māori participation in New Zealand society, iwi and Māori community capacity building, healthy and culturally affirming public policy, intra-sectoral and inter-sectoral measures to address the determinants of health and effective, efficient and relevant resourcing of Māori health.

Reorienting health systems and services towards cultural and health promotion criteria

The strategy of services being of a high technical and cultural standard complements that of reorienting health systems and services. It is an important strategy given that the disproportionate ill-health of Māori is largely preventable as well as Māori underutilisation of and/or Māori not accessing health care services relative to their high

need. This strategy according to Ratima requires consistency with cultural competence criteria and should result in health systems that are responsive to and appropriate given Māori preferences.

Increasing Māori participation in New Zealand society

The participation of Māori in New Zealand society is marginal and is reflected in a range of areas including education, unemployment rates and through low levels of income. This shows that Māori are not receiving society's benefits at the same extent as other New Zealanders. Identified in Durie's (1999), Te Pae Mahutonga model of health promotion is the provision for greater opportunities for Māori participation in New Zealand society and includes areas identified such as, the economy, education, employment, knowledge and decision making. Durie's model also highlights that it is not only about increasing Māori participation in society, but the terms under which Māori participate and the confidence that they have in accessing society's goods and services.

Iwi and Māori community capacity building

There are fundamental differences between tribal and community groups these differences include; criteria for membership, status within Māori society and access to Māori resources. For Māori health promotion increasing iwi and Māori community capacity is concerned with taking a developmental approach where by iwi and Māori communities are better positioned to lead and benefit from health promotion interventions. An important feature of capacity building is also to sustain those benefits.

Healthy and culturally affirming public policy

This strategy calls on public policies that promote health and are conducive to a secure Māori identity. It is consistent with the Western derived health promotion strategy of ‘building healthy public policy’.

Intra-sectoral and inter-sectoral measures to address determinants of health

This strategy aims to deal with the social, economic, political and cultural determinants of health through the co-ordination within and between sectors. This approach is consistent with the Western derived health promotion strategy of ‘creating supportive environments’.

Effective, efficient and relevant resourcing of Māori health

There are a number of issues to consider when resourcing Māori health. The holistic definition of health is one such issue and having resources that take into account addressing the determinants of health. Consideration of community credibility and local iwi support is necessary when working with Māori communities. The funding required should be in line with an equity based approach whereby the greater need of Māori in terms of their marginal health status is recognized in resource levels. Current evidence-based approaches need to take into account indigenous peoples.

Markers

Markers in relation to Kia Ururu Mai a Hauora act as measures or indicators. In general Māori health promotion programmes are measured by conventional indicators such as morbidity and mortality or changes in health risk behaviours. Ratima suggests that Māori health promotion can also be measured by alternative markers including; secure Māori

identity, health status (positive and negative), health determinants and strengthening of Māori collectives.

Māori health promotion therefore plays a critical role particularly as it is derived from a Māori conceptual base, tailored to the specific concerns of Māori in addressing wide and longstanding disparities and improving Māori health outcomes.

Summary

This chapter has conceptualised Māori health promotion within the framework ‘Kia Uruuru Mai a Hauora’ developed by Ratima (2001) as part of her doctoral thesis. The framework was derived through a process consistent with Māori worldviews and was guided by empowerment theory. Previous chapters have outlined the distinctness of both Western-derived and Māori health promotion concepts. Kia Uruuru Mai a Hauora is unique in that it draws upon both these concepts showcasing a combination of the two.

CHAPTER SIX: PRIMARY HEALTH CARE

This chapter showcases primary health care in relation to public and population health, providing an overview, background and context in regard to the setting (Waiora Healthcare PHO) in which data was collected. Equally important this chapter highlights some of the changes past and present in primary health care and within the New Zealand health system as a whole.

Primary health care (PHC) first emerged out of the Declaration of Alma-Ata (1978). Contained in the Declaration's ten principles was the blueprint which was promoted as the key to achieving an acceptable level of health throughout the world (WHO, 1994).

Primary health care refers to the first tier of health provision provided at local community settings. It is the first level of contact between individuals, families, communities, and the national health system. The idea was to bring health care as close as possible to where people lived and worked. As such, PHC constitutes the first element of a continuing health care process (MacDonald, 1993; Naidoo & Willis, 2000) and according to Wass (2000), it is in this first point of contact where the level of care should be the most comprehensive including both personal health care and health promotion/population health services. PHC aims to work with people to enable them to make decisions about their needs alongside how best to address them using approaches that are affordable, appropriate and sustainable. PHC has been highlighted as a key setting in both international and national health promotion policies (WHO, 2008).

A strong primary health care system is central to improving the health of all New Zealanders and reducing health inequalities between different groups.

The primary health care strategy

The New Zealand Primary Health Care Strategy (King, 2001) was introduced by the New Zealand Labour Government and aimed to establish a primary health care structure that would provide comprehensive coordinated services to enrolled populations. This was to be achieved through the development of Primary Health Organisations (PHO's). Implicit in the Primary Health Care Strategy (PHCS) was a community development approach that supported community members to be a part of PHO governance structures. It also placed emphasis on inter-sectoral work at both the population and individual levels. A key feature of the PHCS was the requirement for primary health care services to focus on improving the health of a population by also undertaking health promotion.

The Labour Government at the time, also introduced a set of primary care reforms aimed at improving health and reducing disparities by reducing payments, moving from fee for service to capitation, promoting population health management and development and establishing a not for profit infrastructure with community involvement to deliver primary care (Berghan, 2007; Hefford, Crampton, & Foley, 2005). Many aspects of the reforms emphasized access to and the design of primary health care as a means of reducing health disparities (Berghan, 2007; Hefford et al., 2005).

Primary health organisations

Primary Health Organisation's (PHO's) are the local structures for delivering and co-ordinating primary health care services under the PHCS (Ministry of Health, 2001). PHO's were designed to bring together general practitioners (GP's), nurses and other

health professionals such as Māori health workers, health promotion workers, dieticians, pharmacists, physiotherapists, psychologists and midwives in the community to serve the needs of their enrolled populations. Currently in New Zealand most GPs belong to a PHO. PHO's vary widely in size and structure. The first PHO were established in July 2002 and there are now 82 PHO's around the country.

There have been huge challenges for both Non Government Organisations (NGO's) and Māori and mainstream PHO's in attempting to implement population health strategies and health promotion within a primary care setting (Health & Disability Sector NGO Working Group, 2005). A key feature of the PHCS was the requirement for primary health services to focus on improving the health of a population by undertaking health promotion and other public health initiatives. This was a new concept for most primary care providers, with philosophical differences raised in relation to public health and primary health paradigms (Ministry of Health 2003b). Although the new focus on population health, health promotion and wellness was welcomed, one of the major concerns among many was whether health promotion would be sufficiently understood, supported, sustained and promoted within a PHO environment. Health promotion and disease prevention have been important components of many Māori health provider contracts (Crengle, 1999) and while it could be argued that population health as a concept is well understood by Māori, several issues continue to arise from attempting to implement population health strategies within primary health settings (Abel, Gibson, Ehau, & Tipene Leach, 2005).

Governance requirements were one such issue. Many GP's at the time were involved in private practice and therefore had some reluctance to include community members in governance structures. In order to gain GP buy in to the new structures, community participation imperatives become watered down in successive versions of the PHCS policy

(Neuwelt & Crampton, 2004). One of the biggest threats to health promotion was seen as the GP capture of PHO's and the subsequent dominance of the medical model. Provider relationships within PHO's have also posed difficulties. A few PHO's have collapsed and in others some partner providers have left due to member provider-groups who have not been able to work together (New Zealand Doctor, 2005). There are still valid concerns raised in regard to Māori who are still trying to understand the complexities of the PHO system (Health & Disability Sector NGO Working Group, 2005).

Funding

PHO's currently receive set per capita funding from the Government to provide a range of health services. The funding is based on the numbers and characteristics (age, sex and ethnicity) of people enrolled within them. Funding pays for; the provision of care and treatment when people are ill, helping people stay healthy and reaching out to those groups in their community who have poor health or who are missing out on primary health care. All PHO's receive per capita funding for health promotion and are able to also access Services to Improve Access (SIA) funding to provide new services or improved access to reduce health inequalities among high need groups that are known to have the worst health status. Most PHO's deliver on very low cost access to primary health care and have been instrumental in reducing health inequalities, with many having chosen to forgo revenue that was previously acquired from patient fees. For PHO's health promotion funding is allocated at \$1.90 per enrolled person with slight weighting to \$2.29 for Māori, Pacific or persons who live in quintile five areas (Ministry of Health, 2006). Funding is used to resource PHO's so they can engage in population based health promotion services for example, smoking cessation campaigns, teen suicide awareness, physical activity and nutrition awareness (Berghan, 2007; Hefford et al., 2005).

The size of a PHO varies from 5000 enrolled to 300,000. PHO's also vary in origin with some that are ethnic specific, Māori or Pacific Island focused and Māori led linked to iwi (Ministry of Health, 2006). There are many factors that significantly contribute to the diverse arrangements of PHO contractual provision of health promotion services. PHO's with small numbers of enrolments have subsequently smaller budgets and may only be able to employ a part time health promoter or programme whilst larger PHO's have a health promotion team and access to considerable health expertise.

There has been limited guidance from the Ministry of Health regarding expectations of health promotion funding. A one off grant of \$50k has been offered to DHB's alongside health promotion funding related to the number of patients enrolled in a PHO to provide support for the development of health promotion however, DHB's vary in their arrangements in delivering this support (Ministry of Health, 2006).

Implementation

The provision of health promotion education opportunities for the health promotion workforce is seen as nurturing leadership by giving greater credibility to promoters. According to the Ministry of Health (2006) qualifications and increased training opportunities will improve the quality of health promotion work offered within PHO's. Training about the role of health promotion for those in management and on the boards of PHO's has the potential to support the growth of health promotion leadership by validating it as an important component of PHO services to achieve the vision of the PHCS. While there has been general support from providers for the overall direction of the reforms, some of the implementation processes have been challenged, including the inconsistencies in contracting and monitoring between the 21 DHB's with whom PHO's obtain contracts (Austin, 2003; Perara, McDonald, Cumming, & Goodhead, 2003). While

some DHB's are happy to contract with small PHO's, others are not (New Zealand Doctor, 2005).

The future of PHO's

More recently under the new National Government PHO's are currently the subject of yet another reform. According to the new Government the PHCS has failed to achieve its goal of revolutionizing primary care services (Ryall, 2007). The current National Government points out that the achievements of the PHCS to date have been lower fees and the formation of 82 PHO's, with limited progress in achieving the Strategy's more quality-focused goals. According to Health Minister Hon Tony Ryall (2007) the PHCS has failed to deliver on quality improvements offered by multidisciplinary teams, wider range of services and strong and expanded involvement of nurses.

To aid in the reform a Government initiative *Better, Sooner, More Convenient* Primary Health Care has been launched to deliver a more personalised primary health care system that provides services closer to home with the aim to make New Zealander's more healthier (Ryall, 2007).

The initiative recognises that primary health care has a critical part to play in helping reduce acute demand pressure on hospitals by better managing chronic conditions and proactively supporting high need populations. The Government has proposed a package of services to make significant improvements. This includes multiple Integrated Family Health Centres (IFHC), nurses acting as case managers for patients with chronic conditions, providing a wider range of care and support for patients and shifting some secondary care services into primary care.

At the same time Associate Minister of Health, Tariana Turia has been instrumental in establishing the Whānau Ora Taskforce Group to look at how to more effectively use existing public sector resources to improve the social and economic standing of Māori and address inequalities. The Whānau Ora Taskforce is tasked with constructing an evidence-based framework that will “*lead to strengthened whānau capabilities; an integrated approach to whānau well-being; collaborative relationships between state agencies in relation to whānau services; relationships between government and community agencies that are broader than contractual and improved cost-effectiveness and value for money*” (Whānau Ora Taskforce Terms of Reference). Whānau Ora is an innovative direct strategy and call for action. It incorporates building upon the existing strengths inherent in Māori social structures such as whānau through adopting a more direct whānau empowerment strategy that provides multidimensional health and social support that is identified, directed and acceptable by those that need it (The National Māori PHO Coalition, 2009).

In September 2009, the Ministry of Health issued an Expression of Interest (EOI) in order to get proposals from eligible primary health care providers, to implement *Better, Sooner, More Convenient*. More than 70 EOI's were received and nine have been selected to move through to the next stage of development including a submission from the National Māori Coalition (NMC) made up of 11 Māori PHO's. The NMC aims to devolve services and government-held resources for the empowerment of Māori communities as a pathway to greater Māori social, economic development and self responsibility. The Coalitions' proposal is based heavily on the Whānau Ora Strategy, a systemic model of health and social service development. The Coalition aims to develop a national network of Whānau Ora models of care including IFHC's, new care pathways along with the integration of health and social services.

The NMC outlines its key transformational changes to include;

- service integration, with Whānau Ora Centres moving from service fragmentation to service integration through a mix of technology, co-location and shared management system based approaches;
- accessible and high quality service delivery through Whānau Ora Centres and robust clinical governance at a national level;
- interdisciplinary teamwork, with team members working together to address the health needs of their patients and whānau;
- devolution of DHB Māori health services to Whānau Ora Centres;
- the development of Whānau Ora centres in the Auckland region, Tairāwhiti and Eastern Bay of Plenty in the first year;
- using a ‘commissioning’ approach to funding and contracting.

Business cases will be submitted to the Ministry of Health in mid February of 2010.

Summary

Primary health care in New Zealand has taken on much transformation in particular, in relation to the implementation of the Primary Health Care Strategy (2001) and with the formation of PHO’s which set a new direction for primary health care services in New Zealand.

There have been huge challenges both for NGO’s and PHO’s alike in adapting to the changes for implementing population health strategies and health promotion within primary care settings. Resources, in particular, the allocation and the amount of funding per capita has been widely criticised leaving some NGO’s and smaller PHO’s struggling to continue health service provision. There has been limited guidance from the Ministry of Health regarding funding and therefore funding allocated differs between PHO’s.

Health practitioners have also been the subject of much debate, combining practitioners who are use to the realms of private practice with those who are use to the public system. Merging the two has had its share of difficulties and within some PHO's this continues to be addressed. In order for health promotion activity to be effective it will be vital for practitioners to work together in an environment that is conducive to their and the communities needs.

The New Zealand health system as a whole is currently under review and it is likely that other radical changes will occur within it given the new change in government. These new changes bring with it uncertainty for many providers in particular, as this Government has been explicit with its focus on economic growth and cost effectiveness. It is not uncommon for Māori initiatives to be the primary target when a government is looking to reduce its expenditure. It will be interesting to see how the reforms take place and whether changes will truly address issues that impact greatly on high needs population groups.

CHAPTER SEVEN: RESEARCH APPROACH

This chapter describes the research approach and methods giving reasons for their selection. It includes descriptions of methodology outlining methods utilised in the research and concludes with a description of how data was analysed.

Objectives of the research

This study was driven by a kaupapa Māori approach stemming from a Māori worldview (Bishop, 1999; Ratima, 2001; Royal, 1992; Smith, 1999), the research was Māori led, and undertaken within a Māori PHO, Waiora Healthcare Trust. The study was designed to investigate health promotion activity within the PHO and test the feasibility of implementing a current Māori health promotion framework. The research had four primary objectives which were to;

1. identify how health promotion is perceived within a ‘Māori’ primary health care setting;
2. identify existing health promotion practice within the PHO;
3. identify the organisational pre-requisites for effective Māori health promotion; and,
4. testing the feasibility of implementing Kia Uruuru Mai a Hauora, a current Māori health promotion framework within a primary health care setting.

It was anticipated that the findings would contribute to Māori health promotion theory development, provide policy advice to support the implementation of health promotion in a primary care setting, support organisational capacity-building for Māori health

promotion and potentially provide a model for health promotion that may be generalised to a number of primary care settings for diverse population groups. The research also had the potential to contribute to the tools available in primary care to address chronic disease among Māori, such as diabetes and heart disease.

Methodology

An inquiry paradigm always guides the researchers' practice (Patton, 1990). The paradigm defines acceptable methodologies, research priorities, problem conceptualisation, appropriate methods and the standards by which the quality of research is assessed (Phillips, 1987).

Over the past two decades there has been a shift in New Zealand health research towards employing more culturally sensitive research and increasing utilization of kaupapa Māori research processes (Smith, 1999). While there is not yet agreement as to the full detail of a Māori inquiry paradigm, a number of themes have emerged indicating essential features of a Māori inquiry paradigm (Ratima, 2003). Those themes are; interconnectedness, Māori potential, Māori control, collectivity and Māori identity. Bishop (1998) further adds the establishment of relationships which assists in the research process by outlining connectedness and demonstrating an unspoken but implicit commitment to other people.

Whilst a Māori inquiry paradigm is yet to be fully articulated and affirmed there is agreement in the Māori research community that Māori health research should be Māori led, owned and pursues priorities set by Māori.

Ethical considerations

Prior to any data being collected ethical approval was granted by AUTEK – the AUT Ethics Committee on 31st January, 2008 application number 07/228, as shown in Appendix A.

According to Hudson (2004), Māori understandings of research ethics is at a basic level of people, as individuals and members of committees. It features respect, control and reciprocity. These ideas were integrated throughout the study and within various research processes and activities.

Methods

The study utilized multi-methods that included a literature review, document review, key informant interviews, additional stakeholder interviews and focus group sessions with staff in a diverse range of roles across Waiora Healthcare Trust PHO.

Document review

A document review was undertaken as part of the study which consisted of drawing upon administrative documents, evaluation reports, newsletters and brochures, annual reports and health promotion plans. Documents were obtained through the CEO, Operations Manager, Funding and Planning Manager as well as other staff across the PHO within the different practices. The documents were used for three main purposes; to provide background information, to corroborate information from other sources and in some instances as a primary source for example, in identifying the general strategies for the PHO in regard to health promotion. Documents as a source of information has the advantage of being able to be repeatedly referred to and deemed to be precise, and do not

need to be specifically created for the study. According to Yin (1994) the limitation in their usage is that they can be difficult to source and access may be blocked or denied resulting in bias.

Data analysis

An informal content analysis (Denzin and Lincoln, 1994) was undertaken as part of the document review. A series of categories were formed based on the key informant interview themes that emerged (see following section). Content obtained through various documents were then coded against the same categories. Data triangulation (Patton, 1990), was also carried out where data was drawn from the document review, key informant and focus group interviews helping to corroborate research findings.

Key informant interviews

Fifteen in-depth semi-structured key informant interviews were undertaken with a range of staff across the PHO utilizing an interview schedule attached as Appendix B. Interview data collection took place between 11th of February and 18th of April, 2008. The aim of the key informant interviews was to identify three key areas; how health promotion is perceived within a primary health care setting, existing health promotion practice, and the organisational pre-requisites necessary to provide effective Māori health promotion.

A draft interview schedule (Appendix B) was developed and piloted by asking three health professionals from different disciplines to undertake a ‘dummy interview’ utilising the schedule. Based on their feedback, the interview schedule was then changed and refined to better suit the research.

Sampling is the act, process, or technique of selecting a suitable sample, or a representative part of a population for the purpose of determining parameters or characteristics of the whole population. Participants interviewed were deemed to hold expert knowledge with regard the research (Patton, 1990).

In-depth semi-structured key informant interviews were undertaken with a range of staff across the PHO. Fifteen participants were interviewed who were deemed as being rich sources of information. The CEO, alongside the Operations Manager aided the researcher by identifying suitable candidates for the research. Participants were identified representing each of the following roles; CEO, Operations Manager, Practice Nurses, Administrators, Health Promoter, Community Support Workers, Nurses including the Disease State Management Nurse (DSM), Research Manager, General Practitioners (GP), Practice Managers, Mental Health Support Workers (MHSW), Team Leaders and Clinical Care Co-ordinator. Key informants stemmed from a variety of roles, were of both Māori and non-Māori descent, had various levels of experience and number of years within the contributing practices and across the PHO and were selected on the basis of their knowledge and experience in regard to health promotion, funding and contracting and health service delivery. Key informants were notified firstly, through management and secondly, by a formal letter which contained relevant information pertaining to the study. The researcher then followed up on interview times by email and telephone and an information sheet (Appendix C) and consent form (Appendix D) was sent to participants prior to interviews proceeding. Interviews took place at a time and venue convenient to the participant and ranged from 15 – 45 minutes in length. Some interviews took place within practice settings whilst others took place in surrounding environments such as local cafeterias, libraries, and shopping malls.

All interview data was recorded by way of dictaphone with permission from each participant and written notes were also taken by the researcher. Transcripts were given back to each interviewee within a two week timeframe to ensure accurate information was captured. All interviewees confirmed information was correctly captured and no changes were put forward. In-depth semi-structured interviews allowed for the collection of direct quotes about key issues. The advantage of using in-depth semi-structured interviews as a data source is that they are able to focus directly on the topic of interest and provide insight into informant perceptions. Data gathered through key informant interviews helped to address each of the research objectives. All participant information, interview recordings and transcripts have been stored safely and securely in a locked filing cabinet at AUT, Faculty of Environmental and Health Sciences, Northcote, Auckland.

Data analysis

The data from key informant interviews was transcribed and analysed using categorical content analysis which included; coding the data, then placing coded data into categories of similarity to identify categorical themes (Patton, 1990). In this particular instance the researcher read all the transcripts highlighting common themes across interviews for example, all issues that related to staff shortages and workloads were labelled in the first instance under the category 'workforce'. The researcher then went back and re looked at the categories. Where common themes emerged or data was deemed to fit elsewhere it was then moved under new headings such as 'training'. In some circumstances the same set of data would sit in multiple categories. The data analysis software package NVivo was used by putting identified themes into categories which was then compared with the manual coding categories to identify and categorical differences if any.

Investigator triangulation (Patton, 1990) took place via another researcher also classifying data into the same themes or categories. Through discussion some themes were refined, confirmed and where necessary new themes were developed. There was high agreement on the validity of initial themes and only four new categories were created.

Additional stakeholder interviews

Further in-depth semi-structured interviews were also carried out with three of the original stakeholders and one new key informant (Research Manager). Additional stakeholder interviews were undertaken between 16th – 25th of June, 2009. These interviews provided clarity on certain aspects of the data and filled potential gaps in information as identified by the researcher and supervisor after the data analysis of both phase one (key informant interviews) and phase two (focus group sessions). The four additional stakeholder interviews took place with the Operations Manager, Funding and Planning Manager, Research Manager, and one Practice Manager. Participants were selected for their knowledge and expertise within the areas identified as needing more information in the research study. Additional stakeholders were notified through follow up phone calls from the researcher where verbal consent was obtained. Signed consent was deemed unnecessary for the three original interviewees due to participants already having been interviewed at phase one (the key informant interview stage). However, an information sheet (Appendix G) and consent form (Appendix H) was provided for the additional interviewee. Interviews took place within clinical settings, such as medical centre offices, staff room and head office. Interviews ranged from 15-30 minutes. Data from additional stakeholder interviews was incorporated throughout the document review and key informant interview section of this thesis.

Focus group sessions

Initially the research plan had intended to incorporate a training programme on Kia Uruuru Mai a Hauora, a Māori health promotion framework (Ratima, 2001), however, as identified in the focus group analysis this was not a feasible option at the time due to reasons outlined below;

- a number of staff shortages across the PHO and therefore until positions were filled existing staff were covering an increased workload;
- due to the high needs population staff felt time taken away for training is time taken away from cliental;
- due to the above the training would have had to proceed at different times to capture the numbers of staff necessary for the model to be implemented, which was not feasible; and,
- as key informant interviews took place in staff personal time i.e. tea breaks, lunch or after hours so not to take time away from the working day, a training programme would have had to be run in a similar matter and was clearly practically infeasible.

The researcher felt at the time the conditions were not suitable to undertake training to implement the framework. Focus groups were therefore used to present the framework and identify characteristics (from key informant interviews). The researcher outlined characteristics that were currently utilised within the PHO and that were consistent with the framework. Focus group participants then had the opportunity to discuss and add additional information. Additional themes that had emerged from stakeholder interviews were also fed back to focus group participants. Themes are listed in the key informant findings section.

Focus groups are most useful for exploring an issue that has not previously been dealt with in a way that recognises an essential perspective of a particular population group (Morse, 1995). Two focus group sessions were held at Wai-health, Henderson, in Waitakere City on the 3rd and 10th of September, 2008. Participants were recruited by the researcher through the PHO using purposeful sampling based on perceived richness as a data source and coverage of a range of health related fields, age groups and experience. The researcher built a good relationship with all participants at the key informant interview phase across the PHO and was trusted by the CEO to make contact for the focus group sessions with relevant staff. Focus group participants were notified by phone and/or email.

The research was explained to participants and informed consent was sought using information sheets (Appendix E) and consent forms (Appendix F). Information presented at focus group sessions was tailored with input from supervisors. Data was recorded using a dictaphone and written notes were taken by the researcher and a note taker to summarise discussions. Both focus groups took place at differing times and dates in order to capture and cater for differences in working hours. One focus group took place during the day between 12:00 noon and 2:00pm and the other in the evening between 4:00pm – 6:00pm.

The framework Kia Uruuru Mai a Hauora was not fully implemented within the PHO but instead it was presented and explained in an indepth and detailed way to participants with particular emphasis on the breakdown and summaries of its components. The researcher then presented a table with the framework component headings, highlighting some examples that had been documented through the key informant interviews, observation at the case study site and through various PHO documentation. Participants were informed

that not all the components were evident or explicit in the timeframe of the research and therefore the focus group forum may be a way of identifying missing components. The focus groups were also a way of gauging whether a framework like the one presented would fit with the practice, Māori-world views and current work undertaken within the PHO.

Focus group participants

According to Morgan and Krueger (1993) focus groups are mainly used for the purpose of drawing upon respondents' attitudes, feelings, beliefs, experiences and reactions in a way in which would not be feasible using other methods for example, observation, one-to-one interviewing, or questionnaire surveys. They further state that a focus group enables the researcher to gain a larger amount of information in a shorter period of time and are particularly useful when there are power differences between the participants and decision-makers or professionals, when the everyday use of language and culture of particular groups is of interest and when one wants to explore the degree of consensus on a given topic.

Focus group participants represented the following health service delivery roles; health promotion, community work, management, administration, nursing and mental health. Initially the researcher only requested 6-8 attendees (MacIntosh 1981) however, due to the overwhelming response 12 participants took part in one session and 15 in the other. All except four participants were Māori.

Data analysis

Data from the focus group sessions was recorded using a dictaphone and a note taker was present to help summarise participant comments. Data was then categorized (Patton, 1990) using the breakdown of characteristics from Kia Uruuru Mai a Hauora (Ratima,

2001) as categories. This was deemed a good process as focus group sessions were tailored using the same categories. The researcher and the note taker analysed the content of the sessions and in agreement confirmed the data that focus group participants put forward was in the relevant characteristic category of the framework (Patton, 1990).

Summary

The research was undertaken within Waiora Healthcare Trust PHO. Data was collected from 19 stakeholder interviews (15 key informant interviews and a further three re-interviews and one additional interviewee) and two focus groups. Data was analysed using categorical content analysis and data and investigator triangulation in order to identify themes relevant to the research. Participants on reflection of the information presented confirmed the content and although the framework was not fully implemented as originally planned within the PHO. Participants validated Kia Urururu Mai's framework components as likely to fit with the PHO structure and current work undertaken as well as Māori worldviews.

CHAPTER EIGHT: FINDINGS

This chapter provides a description of research findings in order to answer the research question; what are the organisational pre-requisites necessary in order to fund, implement and sustain Māori health promotion within a primary care setting? Findings are presented from the document review, key informant interviews and additional stakeholder interviews. Focus group session findings related to testing the feasibility for implementing the Māori health promotion framework Kia Uruuru Mai a Hauora are provided in a separate section at the end of the chapter.

The document findings section summarizes the PHO background, structure, objectives, and overall health promotion activity. Key informant interview findings address objectives one to three, outlining health promotion perceptions, identification of existing practice and organisational pre-requisites for effective Māori health promotion. Focus group session data addresses objective four, testing the feasibility of the implementation of a Māori health promotion framework within a primary care setting. Focus group session data has been summarised using Kia Uruuru Mai a Hauora framework characteristics.

Document review

Background

Waiora Healthcare Trust PHO (Waiora) is based in Henderson, Waitakere City. The Trust is community owned and operated and was originally formed as a PHO through incorporation as a Charitable Trust in March 2003. Formally known as Waiora Amataga Trust, it is an amalgamation of three existing organisations; Pasifika Healthcare, Wai

Health and Waitakere Union Health Centre. In August 2003, Pasifika Healthcare exited and the PHO was reconstituted as Waiora Healthcare Trust in December 2003 (Waiora Healthcare Trust PHO, 2007).

Ownership and Governance

The Trust is governed by a Board of Trustees consisting of a Chairman and five Trustees from each of the two appointing bodies (Te Whānau o Waipareira and Waitakere Union Health Centre). A Clinical Advisory Group with membership from each of the providers sits alongside the Board and provides the Board with Clinical expertise. The Clinical Advisory Group is made up of representatives from Māori providers, general practice teams and the PHO clinical team (Waiora Healthcare Trust PHO, 2007, 2008).

PHO structure

Figure 4 outlines Waiora Healthcare PHO's current structure which is designed to focus on functions of the PHO rather than specific roles. Population health services including health promotion comes under the clinical co-ordination line structure and includes; quality, needs analysis, referred services, clinical protocols, peer review, multi-disciplinary teams and SIA and health promotion funding.

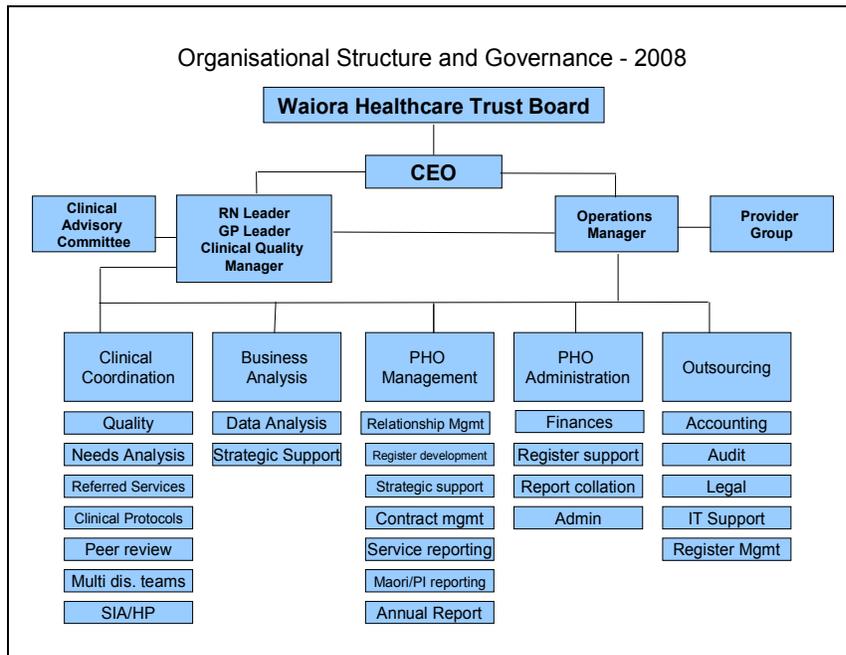


Figure 4: Waiora Healthcare PHO organisational structure

Practices within the PHO

Waiora head office is situated in Lincoln Road, Henderson, Waitakere City. At the time of the research there were five member practices under the PHO. Three practices participated in the research, Wai-health, The Doctors New Lynn and Waitakere Union Health Centre. The other two practices Rathgar Medical and McLaren Medical Centre were just becoming incorporated into the PHO and it was not feasible to include them in the research.

Wai-health at the time of the research was the largest practice under Waiora PHO with the highest number of Māori patients enrolled (see table 5). It is located in Ratanui Street, Henderson, Waitakere City. Wai-health provides a range of GP services including doctor and nurse consults, minor surgery, immunizations, diabetes get checked, cervical smear clinics and CVD screening to name a few of its services. The practice caters for diverse population needs and has a high percentage of Māori staff employed.

The Doctors New Lynn is situated in Delta Avenue, New Lynn. It is the PHO's second largest practice with a population base of a large number of long term New Zealand residents in the older population bracket, as well as catering for a high number of recent immigrants in particular those from Asian communities. The ethnicity of staff is diverse with 10 different languages being spoken across the practice. To cater for specific patient needs, The Doctors New Lynn has recently incorporated Chinese acupuncture alongside their GP and nursing services.

Waitakere Union Health Centre is located in the Waitakere Hospital grounds, Lincoln Road, Henderson, Waitakere City. Waitakere Union Health Centre provides low cost services to patients of mixed ethnicities and has a high number of Pacific peoples including recent immigrants enrolled within its practice. It has a smaller number of staff employed compared to Wai-health and the Doctors New Lynn but equally caters for a diverse range of patient needs.

Geographical positioning

Waiora PHO works with the population of Waitakere City. Waitakere City is in the Western part of Auckland which has a population of 201,400. The population is made up of 59% European, 13% Māori, 15% Pacific Peoples, 16% Asian and 10% Other (including "New Zealander"). Thirty four percent of the population is born overseas (Henderson Community Board, 2008).

Waitakere City is classed as having a young population with the lowest life expectancy which reflects high proportions of Māori and Pacific people. It encompasses a high percent of people reliant on income support, who are without transport or modes of

communication and who earn lower incomes and attain lower levels of education compared to the rest of the DHB district (Statistics New Zealand, 2005).

PHO Objectives

Waiora PHO prides itself on its goal of becoming a leading Māori health care organisation in Aotearoa. The objectives of the PHO are laid out in the following table.

Table 3: Waiora PHO objectives

Objectives
Improve, maintain and restore the health of people living in the Auckland region.
Provide or ensure the provision of accessible primary health care services to the community of the Auckland region.
Provide or ensure the provision of effective, high quality integrated health services for the community of the Auckland region.
Assist members of the community of the Auckland region (particularly those on low incomes and with high health care needs) who have difficulty gaining timely and appropriate health services.
Support any institution, society or other body of persons whether incorporated or not, whose objectives are similar to the objectives of the Trust.
Understand and respond to the health needs of people living in the Auckland region.
Promote and/or facilitate the education and dissemination of health information to the people of Auckland.
Support the promotion of healthy communities.
Recognise the Treaty of Waitangi as the founding document of New Zealand and to recognise and respect the importance of the Treaty in carrying out the objectives of the Trust.

Source: (Waiora PHO Annual Report)

Enrolments

As of 31st of August 2008, Waiora PHO had approximately 26810 enrolled patients spread across its five practices. Of the total PHO population 44% are European, 22% are Māori, 17% Pacific Island 13% Asian, 3% Other, and 1% is classed as unknown. The PHO health centres remain free for anyone to join and costs are kept low to ensure all can afford to see a doctor or nurse. The PHO qualifies for Low Cost Access Funding (LCAF) which aligns with the Ministry of Health's philosophy of providing

affordable primary health care to the community. LCAF contributed to half of the PHO's enrolled population with a total of 13405 patients accessing funding as outlined in table 4.

Table 4: Breakdown of ethnicity and funding categories across Waiora PHO

Ethnicity	Numbers
Māori	6448
Pacific	4058
Non-Māori and non-Pacific	2899
LCAF	13405

Source: (Waiora PHO Breakdown of ethnicity document)

Table 5: Breakdown of ethnicity by practice

Practice	Māori	Pacific	Non-Māori Pacific
McLaren Park	322	751	559
Rathgar Medical Centre	102	141	209
The Doctors New Lynn	915	1301	1161
Wai Health	3837	450	451
Waitakere Union	1272	1415	519

Excludes low cost funding. Source: (Waiora PHO Breakdown of ethnicity document)

Service delivery mechanisms

Waiora PHO has a number of services directed at improving the health of Māori, Pacific and other high needs groups within the Waitakere City area. Primarily based on contractual obligations, the PHO undertakes the following types of activities; GP and nursing services, podiatry, physical activity and nutrition, dietetics, maternity services,

transportation, community health, family and whānau support, advocacy, individual and group health education, health promotion, well-child checks, research partnerships, building relationships with health professionals and other support services, referral to a range of health and social support services and facilitation of follow up of care. Waioira PHO supports a number of partnership initiatives with academic institutions, government agencies and has recently introduced a research-based position within the PHO.

Health promotion within the PHO

The PHO has a health promotion plan drawn up dated 2005 – 2006 which provides strategy and direction for achieving the PHO community health objectives whilst identifying priority areas and a framework for community interventions. The plan supports initiatives targeting community organisation, community action and community development approaches. At the time of the research the health promotion plan was primarily focused to meet the objectives of the Ministry of Health's - Healthy Eating Healthy Action (HEHA) Implementation Plan. Within the plan a number of PHO interventions are identified alongside the priority areas, projected budget and performance indicators. In particular, interventions addressed the following five areas;

- strengthening community action;
- healthy beverages;
- reorient the PHO and support primary health care clinician skills and knowledge;
- resource development; and,
- workforce development.

Currently the health promotion plan 2007 – 2008 incorporates additional areas for intervention aimed at engaging low income workers in an eight week group health promotion programme. The PHO's health promotion programme is targeting healthy lifestyles, family violence and workplace safety. It also incorporates a 'healthy kai on the marae' programme emerging from activity originally supported by ¹Te Hotu Manawa Māori. The PHO is supportive of a collaborative inter-sectoral approach to addressing lifestyle risk factors that impact on the health of the community. It is committed to working with key community providers and groups to facilitate success specifically for Māori and Pacific peoples.

At the head office level, a part-time health promoter has been employed and is responsible for co-ordinating certain initiatives alongside community workers that align with DHB and Ministry of Health priority areas as well as liaising and supporting within the practices and community. Current initiatives that have been undertaken with local schools have included campaigns that target healthy eating, drinking water, washing hands and physical activity.

The PHO hosts health promotion event days, Pacific health in the community and open clinic days. Health promotion/health expo event days are where services under the PHO are promoted in ways that engage different ages utilising the promotion of different service elements such as children's health, women's health or men's health alongside celebrity appearances, prizes and giveaways, entertainment and activities.

¹ Te Hotu Manawa Māori is an independent organisation delivering health services 'by Māori for Māori' aiding health workers in their treatment of Māori heart health conditions www.tehotumanawa.or.nz.

Open clinic days provide people with free health checks such as eye and hearing tests, diabetes checks, blood pressure, as well as providing information about health care such as screening and practice-based services.

Health promotion within the practices

Wai-health is the largest practice within the PHO having the largest population base of Māori. The majority of the PHO's health promotion services and programmes were contracted to Wai-health, with many of these intentionally set up to target, but not restricted to, Māori. The Community Health team within Wai-health are a large contingent and have the primary role for health promotion within the practice. This includes programmes and services such as smoking cessation, nutrition, health education, physical activity and healthy lifestyles including healthy pregnancies.

The Doctors New Lynn is the second largest practice within the PHO. Health promotion activity identified within the practice mainly occurred as one to one health information and education provided by nurses. In many instances information is given to the patient in regard to screening including cervical, immunisation and diabetes. Health promotion and information giving within this practice has proven difficult at times with the many ethnic differences, however this is being addressed by information being translated and the employment of new staff who speak different languages.

Similarly, at the Waitakere Union Health Centre, the majority of health promotion activity identified was also one on one consultation by the nurses. Both the Doctors New Lynn and the Waitakere Union Health Centre referred a majority of their patients to Wai-health for Māori-specific services and/or health promotion programme and activities.

At the time this research was undertaken a new initiative was due to be implemented across the PHO which specifically targeted GPs and nurses. Breakfast meetings were being set up to facilitate discussion and action regarding health promotion in a wider context. This was in recognition that health promotion needed to involve looking outside current PHO health promotion activity in particular, within certain practices which were mainly focused on screening and education. These meetings would give GPs and nurses a chance to discuss ideas and have first hand input into further development of health promotion within the PHO. It was also a chance to give management insight into hearing what the constraints and concerns may be for both GPs and nurses in undertaking both current and future health promotion activity.

A free diabetes self-management course is also run by the PHO which incorporates elements of health promotion aimed at patients enrolled across all the practices. Course participants are of mixed ethnicities and vital information is tailored to meet individual needs (such as information on food and nutrition pertaining to different cultures). The course is nurse-led, designed and initiated and has been set up to ensure self-management principles can be easily understood by all who attend. The course is currently run on concurrent Saturdays over a four week period and to date there has been high participation rates and consistent attendance. Course booklets are currently being re-developed and refined to specifically cater for Pacific and Māori attendees. It is anticipated in the future these courses will also be run in different languages such as Māori, Samoan and Tongan.

Summary

Waiora Healthcare PHO in relative terms is a small PHO with five constituent practices serving a large Māori population base in Henderson, Waitakere City. The PHO's goal of becoming the leading Māori health care organisation in Aotearoa is well underway incorporating a number of health service delivery mechanisms. It was clear from the documentation reviewed that health promotion activity, services and programmes across the PHO were wide-ranging and stemmed across all three settings as well as at head office. Health promotion activities varied between the settings and ranged from one to one consultation such as promoting breast screening, to group activities, for example, promoting physical activity and healthy eating programmes. Health promotion activities were also held outside of practice settings within communities such as community centres, aquatic centres, parks and recreational facilities as well as within individual homes. Health promotion features as a key initiative throughout relevant documentation and is deemed as a high priority with an obvious clear focus for future activity.

Key informant interview findings

A total of 19 interviews took place over the course of the study. Fifteen interviews were with key informants and four interviews were later undertaken with three of the original interviewees and one additional stakeholder to fill in perceived gaps. Key informants stemmed from a variety of roles, levels of experience and number of years within the PHO.

The major themes that emerged from the key informant interview findings included, health promotion prioritisation (how the PHO prioritises health promotion), frameworks for health promotion (what frameworks are currently being used in regard to health promotion within the PHO) and collaboration for effective health promotion (partnerships

and relationships formed to effectively implement and undertake health promotion within the PHO). Within each of the major themes a number of sub-themes emerged and are integrated throughout the findings.

Health promotion prioritisation

Participants were unanimous from both a personal and PHO perspective that health promotion was a critical component of health and health care delivery. It was also clear from interviews that health promotion was classed as a priority and examples of this prioritisation were given from all levels of the PHO. Indications include the employment of a part-time health promoter situated at the head office. The majority of participants interviewed identified that the health promoter was a critical position in particular as the position was based at the head office. The role comprised of liaising with management and community teams and in addition the health promoter provided a supporting role within the community. One participant identified the location of the health promoter as being strategically positioned providing reciprocal pathways for information to and between the CEO, management team, practice staff and the community. They went further to say that positioning enabled easier access for input into the PHO policies whilst being able to gain knowledge and understanding that can be shared in regard to Ministry and DHB strategic planning and priority setting. Whilst all participants valued the position of the health promoter, an issue raised by one participant was in regard to the role only being part-time.

Health promotion priority within contracts

Participants were consistent in their views that they perceived health promotion was a low priority of the Government, Ministry of Health and DHB's despite all the policy hype expressed in government documentation such as the PHCS. They felt this was reflected

through a number of PHO contracts with those institutions and in particular, the amount of funding associated with health promotion activities which in some cases were non-existent.

We are guided by the DHB and by the Ministry. The funding is minimal... I guess people would say that it reflects the level of priority that the Government places around health promotion which is not very high (Key informant 1).

Another issue raised was that health promotion is often 'tacked on' to existing contracts with an outputs rather than an outcomes focus.

The ways in which contracts are constructed, is that health promotion is like a bit of an add on. some of the messages I get from that is that it's not actually taken seriously. It's about saving dollars and cents and about where they're putting their money and trying to get the biggest bang for their buck (Key informant 1).

Patient and provider priority

Participants from the Doctors New Lynn raised issues regarding health promotion priority at both the patient and provider levels. They indicated that the older population that they serve have a preference for where their health information comes from.

Some patient's prefer to see the doctor for all their health needs rather than a nurse, and are explicit in regards to verbalising this. That has its challenges both for the patient, the doctor and the nurse (Key informant 2).

GPs interviewed from two different practices highlighted concerns in regard to the time it takes to do health promotion.

GP's tend to be the busiest people within a practice in terms of the actual number of patients coming in. There are a number of constraints for example 15 minutes maybe spent on dealing with the injury and I know she is due for a smear or would benefit from some advice or information on other activity. I will then refer her to the nurse which then impacts on their workflow as well. So it is something that falls over from being short staffed and health promotion is usually the last thing that we tend to do (Key informant 4)

Similarly, a number of other participants also raised concerns in regard to not having the time on top of their already busy schedules or the necessary skills to undertake health promotion. Some further indicating that it was not their role to do so. Comments reiterated points raised by GPs that in some cases health promotion was often left until last or missed out altogether.

I know its [health promotion] important, but with staff shortages and high workloads its easy to put it to the bottom of the pile, in some instances I don't feel I am the right person to be doing it (Key informant 3).

Others indicated that they felt ill-equipped holding a limited understanding of what exactly health promotion was, recognizing health promotion utilises specific knowledge and skills. One participant commented on when this had been raised with their superior there was an expectation that it should have already been incorporated within specific and specialised health related training such as nursing training. Throughout the fifteen interviews only one participant identified that she had a formal qualification being a certificate in health promotion.

Workforce issues

One of the biggest issues raised from participants was in regard to workforce. Retention issues were particularly evident at Wai-health in regards to nursing staff. At the time of the research the participants indicated that the practice was short by five nurses. According to two interviewees this is due to nurses choosing to be employed under an agency which pays a substantial amount more money for nurses than a PHO could afford. There was also commentary in regards to many nurses hired at the practice who did not last long as they were dealing with too many patients with very high health and social needs which wears new people out too quickly. Staff shortages such as these impacted on

all levels of the PHO. One participant identified that those that live and work in the geographical area seem to last the longest as they have a tie to the community.

Getting those that are appropriately trained or qualified is probably the biggest issue and then with that comes their level of understanding of what health promotion entails. Now for us because engagement is a real issue here, engagement of the high needs whānau we tend to swing toward people on the basis of their previous experience of working in the community, as opposed to the more formal qualification (Key informant 5).

Health promotion training opportunities were noted through interviews and were provided by the PHO and other health services.

We are so fortunate to be able to have Hapai they come in and run a number of different sorts of health promotion sessions (Key informant 3).

²The Health Promotion Forum of New Zealand, ³Hapai Te Hauora Tapui Ltd and DHB's, as well as local community based initiatives were also identified as providing different levels of health promotion training across the organisation. However, a consistent response from participants within the three practices was a personal feeling of not being able to attend due to workload and time commitments, whānau commitments, timing of the courses and the costs associated. Other issues were also raised in regards to limited staff availability to cover for those seeking to attend training courses. Current high caseloads meant that much of the health promotion training had to be done on top of their already busy roles.

Its hard to get fill-ins or replacements so we can do training, because of the shortage in staff we have to work extra hours to catch up sometimes and people

² The Health Promotion Forum of New Zealand is made up of over 150 organisations committed to improving health. It builds leadership, relationships and the workforce in health promotion consistent with the principles of Te Tiriti o Waitangi and the Ottawa Charter. It is an Incorporated Society and a registered charity. www.hpforum.org.nz

³ Hapai Te Hauora Tapui is a Regional Māori Public Health Provider based in Auckland. www.hapai.co.nz

feel that its just not worth the energy doing that so the training gets left (Key informant 6).

Although a number of participants identified specific health promotion knowledge and skills were needed, others felt that the necessary knowledge and skill could be obtained by attendance at training provided, or by advocating for the time to upskill and gain health promotion qualifications. Participants also raised that it would be better to upskill staff at the broader level then having to solely rely on the employment of a specific health promoter or health promotion role to undertake necessary health promotion activity.

If we were able to attend training we would be better off as staff and a PHO in the long run. We will all be equipped to do health promotion opposed to waiting and relying on one person which may take a long time to employ the right one (Key informant 8).

Health promotion and whānau

The majority of participants interviewed understood the need for health promotion and its benefits not only for the individual but for the whānau and community. However, many recognised in regard to their patients that health promotion had a lower priority due to the number of other pressing priority health and social issues that individuals and whānau were facing.

Sometimes its about advocating for the weakest, poorest, ugliest and the least likely to earn some bread and its then you know your working with the bottom of barrel. There is limited understanding of what is impacting on our whānau. Things like social issues, lack of transport, transient lifestyles, no family support, poverty, overcrowding lack of employment, domestic violence to name a few. These issues all need to be dealt with first as they all impact on the health of our people, then we can undertake effective health promotion (Key informant 9).

Summary

In summary participants generally perceived that health promotion was a priority and that its importance in the PHO was reflected at a strategy/policy level. However, it was evident from the interviews that participants found it difficult at an individual level to

effectively provide health promotion as a priority due to a number of issues raised in regard to contracts and funding, including time and resources, workforce issues including recruitment, retention, roles, expectations, lack of expertise and limited opportunities for health promotion training, as well as dealing with the pressing priority health and social needs of the population. These issues were identified as significant obstacles to implementing effective health promotion practice.

Frameworks for health promotion

Throughout interviews participants identified a number of frameworks that they utilize for health promotion. Participants made it clear that framework components were eclectic and emerged from many sources in contrast to utilising formal health promotion-specific models and approaches. A number of Māori-based frameworks were cited and stemmed from commonly known health models such as Te Whare Tapa Wha, Te Wheke and Te Pae Mahutonga, as well as other frameworks stemming from Te Ao Māori (the Māori world).

The majority of the whānau recognise and understand Te Whare Tapa Wha and although staff know about Te Wheke we also use components of other Māori models some that are used outside of health and some that are used in our everyday life as Māori (Key informant 2).

Māori frameworks

Consistently referred to from a number of participants was the guidance of kaumatua and kuia. Informants indicated a great respect for using advice and support from kaumatua and kuia at all different levels and capacities within the PHO and in particular within the practice of Wai-health.

Interviews highlighted that the community response to kaumatua and kuia as implemented at Wai-health has been most effective specifically in dealing with cultural and other difficult issues relating to Māori whānau. This structure utilises the knowledge, skills, qualifications and practical experience relevant to the issues of the population and community. Kaumatua and kuia have the ability to fit into both one on one type roles and also being part of different initiatives within the community including at the kohanga level right through to the Ministry and government levels. Staff indicated that having kaumatua and kuia associated with the practice has been most valuable at all levels. Kaumatua and kuia provide cultural advice, expertise on specific issues, as well as providing a grounded knowledge-base of the geographical area including its history and knowledge in regard to the population within it. They also provide guidance in relation to working in the current political environment.

A lot of our young workers don't seek guidance from kaumatua or kuia anymore but rely on Western theories and wonder why our whānau don't fit the theory or the model. Now we have kaumatua and kuia sitting right there in our teams and only now are they realising how valuable that resource is. Today we learn a lot of information and come out with knowledge and that's it. It becomes so easy to lose sight of the things Māori. A lot of our young people today don't take that on board, but our whānau as well as our workers respect their guidance, its real and it works (Key informant 9).

Three of the interviews highlighted framework components being utilized that arise from the process of firstly, being Māori and secondly, as a Māori health worker. These components were identified as whakawhānaungatanga, whakapapa and tikanga.

We use an integrated health model, a public health model its called whānaungatanga and its all about we know you, we probably know your uncles and aunties, and we're interested in how they are and you and how the rest of your whānau is working and how can we get in there and help support that. So, it's an organic type model (Key informant 5).

Some participants went further to discuss whānaungatanga frameworks and how patients themselves were effectively implementing them within their own communities in their own ways with no organisational support to do so.

We have somebody, whose been with one of the programmes for a while now all of those people in the programme know this person now has cancer, so they're going through that part of their journey, but everybody on that programme is going round and helping to look after them, taking kai, making sure that they're comfortable, taking them out for walks. That to me is effective health promotion, empowering communities to take control (Key informant 10).

A number of participants commented on utilizing Māori-specific approaches to ensure better uptake for Māori. Māori-specific components that were expressed as important include; Māori staff dealing with Māori whānau, speaking te reo, utilizing Māori resources such as people, stories and tools.

Good Māori health promotion models come from a different perspective. Good Māori health promotion models come from the perspective of trying to protect whakapapa, and in doing that using what we know best will work best, that is, our own tools and resources (Key informant 5).

Whānau was also a framework identified throughout interviews. Participants expressed that everything that relates to Māori involves whānau including health promotion. Participants highlighted whānau as a great resource and a great motivation and prevention tool as used in previous media campaigns such as 'its all about whānau', stop smoking and 'do it for your whānau', cervical screening campaigns.

We talk about it, we need to help your heart to get better so that you can make a difference in your whakapapa, we want you to be around to look after your mokopuna, to see them, we want you to be the person who role models these things so that their whakapapa is preserved. When we involve the whānau, in what ever shape or form physically or hypothetically things usually start to change (Key informant 10).

Alternative frameworks

Alternative models were also mentioned by participants that stemmed from Western frameworks for example the 'Navigator model' (Northwest Portland Area Indian Health Board, 2002). This model is currently being implemented into various organisations in the USA to aid and support cancer patients in and through the alternate pathways associated with cancer services. The use of navigators was also being implemented within Waioira PHO in particular within Wai-health. The two main aims for using the navigator model within Wai-health includes service improvement and service utilisation. Participants identified that although this type of model did not directly relate to health promotion, indirectly it did help deal with a number of barriers impeding on patient health and therefore dealt with issues that would bring staff a step closer to providing health promotion for the patient.

Where possible and where we can, we're trying to use a model whereby we have navigators in our clinics, we've got an ACC navigator in the clinic at present, which will go out there and link people into the service. They are based in our clinic for certain times and days of the week and they talk to our community, they are visible and verbal, and they are representative of our whānau within a service. They provide access to necessary services that our people would otherwise not utilise or even know about, with navigators they aid the whānau and provide a confidence to use the service that they are entitled to use (Key informant 1).

The Ottawa Charter principles were also referred to frequently by participants in particular; reorienting services. For example, access improvements and creating supportive environments such as; applying cultural elements and mobile services. Holistic approaches that incorporated physical, spiritual and mental aspects were also commonly referred to taking from different indigenous frameworks such as the Medicine Wheel (NNADAP, 2008), Circle of Health (1996) and Te Whare Tapa Wha (Durie, 1982).

There was a strong preference from some participants to be able to use a framework that would guide the PHO in their health promotion work in particular a framework that had been recognized as being ‘best practice’ for Māori and/or other indigenous populations. Whilst participants recognised the more commonly known models it was identified that a model that was specifically tailored to fit with the work and priorities of the PHO would be ideal.

We would be keen to implement a programme of activity that's clearly defined and is considered to be best practice in terms of dealing with the indigenous population. These are the things that says that its... a strong set of guidelines about what to do and what not to do and its kind of proven its worth (Key informant 11).

Framework enablers

Participants across the PHO took great pride in identifying the uniqueness of being a small PHO in that it enabled flexibility with exploring a number of creative opportunities especially in utilising and promoting health promotion framework components whilst addressing contractual obligations.

One of our contracts allows us to actually undertake community team building and to ensure that the community can actually participate in the initiatives being proposed. This allows us to implement different ideas in relation to health promotion and the community. It also enables us to physically and wholeheartedly support those ideas (Key informant 5).

The majority of participants identified the need to use an integrated approach incorporating different models and cultural aspects as well as different roles and experiences of those at the interface. Some identified due to the small size of the PHO that this was made possible and was being incorporated across all practices.

We make the most of our small size in that we incorporate both mainstream and Māori-specific components in our services and activities alongside using different people in different roles. Sometimes we make the most of opportunities with patients who may see three of us at the same time, podiatrist, GP and the DSM nurse. They like it as they get a very comprehensive service in the same amount of

time and get many issues dealt with in one go opposed to coming back for three different appointments (Key informant 12).

Participants highlighted that using an integrated type framework enables the service or activity to be tailored to the specific needs of the population, saves on patient time, travel and cost.

Summary

In summary framework components utilised in relation to health promotion across the PHO were not necessarily health promotion-specific nor health sector specific and came from a number of sources including, Western and indigenous models, as well as tools and resources that stemmed from the Māori world. Overall participants felt that the PHO used a variety of frameworks that worked well as they were tailored to the needs of the population.

Interviews highlighted that although there were some clear indications of health promotion elements within the services and programmes across the PHO there was no systematic or co-ordinated approach directed at or used in undertaking these elements. Participant understanding of health promotion was more at a clinical level with much of the health promotion activity identified by key informants as one to one health care, health education and activities that targeted a reduction in morbidity and mortality alongside service utilisation and activity aimed at better access for patients. Although an eclectic mix of framework components utilised to meet patient needs were specifically tailored for the activity and seem to work well for patients, many were not specifically aimed at the provision of health promotion and indeed cannot be, given the overwhelming high priority health care needs of the population. Participants did identify health promotion framework components such as the Ottawa Charter strategies however, PHO health promotion

activity seemed more assimilated to the medical and educational models of health promotion with a primary focus on individual health behaviour change.

Collaboration for effective health promotion

Internal collaboration

Participants noted the importance of collaboration in their every day work highlighting the significance of working in and being part of a quality team in order to meet patient and whānau needs.

Collaboration enables Wai-health to be seen as a one stop shop where patients can get all their health needs in one place (Key informant 6).

Participant's revealed good internal collaboration enabled effectiveness in a number of areas including; office based work both at an individual level and working as a team as well as community and whānau centred work outside of the office. Interviewees identified collaboration at a number of different levels within the PHO including management, provider, individual, patient and whānau levels.

It's nice being in a small PHO we all get on quite well and share resources it's all about whānau and the community we serve. The clinics are well known as is the staff so it makes things a lot easier. We know the roles, job and staff across all the PHO and what we're looking at is the sharing of resources. We have all the clinics and Wai-health and if you need stuff or help or you know any health promotion stuff going on we can all jump on board due to the good relationships (Key informant 7).

Participants identified how the internal networking system within the PHO is set up plays an important role when considering referrals. A shared view was that networking and knowing staff and their expertise allowed for ease of referrals into specific programmes and services. Staff felt that good collaboration and close professional working relationships enabled for better shared holistic care of the patient.

I work quite closely with everybody. I work with the clinical teams, the nurses, social workers etc so referrals can come to us from all over, its great we feedback to each other so everyone knows where the families are at, the GP who doesn't get to go into the homes gets a feel for inside information, i.e. what is happening for the whānau in the home, he can then tailor his care toward treatment that will actually work in with the whānau which is better for all in the long term (Key informant 10).

External collaboration

All participants agreed that developing and maintaining quality external relationships is vital for the organizations credibility within the community. One participant identified collaboration as the next step to undertake once a relationship is formed.

We are constantly forming new and maintaining existing networking relationships that is not only diverse but also wide-ranging. Networks formed include; kohanga reo, primary, intermediate and secondary schools, other practices and PHO's, tertiary institutions, community-based programmes aimed at different cultures, DHB's, Ministry of Health, alongside other key agencies such as WINZ and ACC to name a few. Once the relationship is established you need to move to the next level and start forming some specific and effective collaboration that will benefit the people (Key informant 7).

Participants identified that they bring their own networks and relationships to the job including whānau, hapū and iwi networks alongside any long standing relationships they had with other services. Others recognize that this has been positive for the PHO in the development of new programmes, implementing projects, recruitment and retention of staff, as well as gaining additional resources needed at limited or no cost to the PHO. Two participants identified that linking in with tertiary institutions such as AUT University has proven beneficial for the PHO in providing support for the PHO's podiatry clinic and research partnership initiatives.

I think our direct links that we are forming with many organisations and universities are working really well, community centres, like the arts and crafts market that we've been involved in. We actually are giving a positive message and that is always something that's going to work well (Key informant 14).

Participants who worked at Wai-health identified the success of at least two external collaborations in that they provide a service that meets the population needs across sectors.

Wai-health has Work and Income New Zealand (WINZ) and Accident Compensation Corporation (ACC) representatives now based at Wai-health on certain days (Key informant 2).

Participants highlighted through interviews the benefit this collaboration has had for patients in making it easier to access the help required without the usual additional barriers. One participant highlighted the significant decrease in non-attendance (DNA) rates over the past year and believes the collaboration nature of Wai-health has been a significant contribution. A number of key informants highlighted the need for inter-sectoral collaboration in order for Māori health promotion to be truly effective. One participant identified this as an ideal approach due to many Māori whānau being involved or known by the different sectors such as justice, education as well as health. Another highlighted that health promotion is not only about health in the physical sense but health of the whānau and individual as a whole therefore, other sectors have a lot to contribute.

Being caught up in the Justice system, and lack of education attainment or even motivation impacts on the person and their family it causes something,... something that is not healthy and then it spirals.... We need to work together for whānau across sectors (Key informant 16).

Whilst the majority of participants agreed that inter-sectoral collaboration has worked on a small scale within the PHO, others remain sceptical commenting on the time it would take to set up and whether it would be truly effective due to other sectors not wanting to take responsibility for health related issues.

It might work and work fine, but I cant see Justice for instance putting money towards health or even making themselves accountable, its been hard enough getting education and health to collaborate for the sake of more Māori in the universities studying health (Key informant 1).

Summary

In summary collaboration across the PHO and with some outside agencies appears to have been successful making a difference for patients. Inter-sectoral collaborations have been more opportunistic with a targeted focus on addressing population access barriers to many services including, podiatry services, WINZ and ACC. It is optimistic to assume that the same approach may be equally applied to health promotion activity until such a time as health promotion has been well grounded, well resourced and well understood firstly, within the health sector secondly, within the PHO and lastly, with outside organisations and other sectors. This is a major concern considering the high priority health needs of the population, workforce issues and low priority for health promotion funding from Ministry and government. Inter-sectoral collaboration related to health promotion whilst maybe an ideal strategy for the future, there is still some way to go before it will be fully integrated into the study's setting.

Organisational pre-requisites for effective Māori health promotion

Interview data highlighted a wide range of organisational pre-requisites considered important for effective Māori health promotion within a primary care environment. These have been grouped into themes that emerged from interviews.

Funding

Funding was regarded as a primary resource and was high on the list of priorities identified by participants as a pre-requisite for effective Māori health promotion. Participants expressed frustration at some of the limitations of the current funding sources for health promotion in that to get the required funding the PHO needs to consider and go

with the priorities that have been set by the Ministry of Health or DHB rather than addressing more locally apparent priorities.

In some instances funding sources can limit us as their priorities may not align with PHO or the individual practice priorities and more specifically, priorities relevant for the Māori population (Key informant 1).

One participant noted that Waiora PHO regularly evaluates funding mechanisms available for specific health promotion related activity that is driven by the PHO. An example given by another participant related to contracts that have allowed slight flexibility therefore discretionary money could be used to tailor a programme to the specific needs of the population as seen by the PHO.

We will fund it through other means. We have contracts that have a wee bit of discretionary money so we'll use that money to top up and tailor the activity so it fits with both the contract output and our kaupapa and community (Key informant 13).

Resources

Participants identified that limited funding for health promotion had a ripple effect on the amount of quality resources that are within the PHO. According to many participants in order to effectively undertake high quality health promotion adequate funding for resources are needed that are specifically tailored to the target population. Although some participants acknowledge the limits this has on providing health promotion to the highest standard they identify some unique ways of getting the basic resources required for their patients. A number of participants identified their reliance on innovation and creativity when it comes to utilising the resources that they have. In some situations staff have made their own resources, designed information so it is simple, effective, understandable and appropriate to the audience. On occasion some participants have utilised their

contacts and networks both within and outside of the practice to obtain resources that are relevant and effective.

Having fewer resources makes us more innovative around the way things are done, we make our own, re-design what we have or borrow from other departments and/or other organisations (Key informant 12).

Others tell of getting resources translated or tailoring them to include for example, foods that are relevant to Māori. Totally new resources have also been designed such as small badges with slogans in te reo, sipper bottles that contain relevant provider information and/or health check reminders, Tamariki Ora (Plunket books) with stickers and photos at milestones and tailoring aspects of programmes so it meets the needs across communities. Other staff have secured resources at no cost to the practice. These include posters, training, booklets and pamphlets as well as syringes and diabetic needles for patients.

Sometimes our health promotion is dependent on how good we are at accessing all the free stuff and being able to get to it. Especially at a regional level (Key informant 12).

Whilst some participants commented on the creativity that emerges through lack of resources others found it frustrating and time consuming in having to design and track down the most basic of resources. All participants agreed that funding for development of adequate resources was seen as essential to health promotion.

Unless you've got the resource behind the health promotion to come in pretty quickly you're wasting your time. So again the whole thing of resource development, I don't think we need flash resources I think we just need simple things that are plain speaking and clear. Having the funding to develop the resources and the concepts for the delivery of some of those messages is key (Key informant 12).

Māori specific-elements

The way health promotion messages are delivered to the intended target audience was a significant issue for all the participants. This was a particularly passionate topic for those dealing with Māori patients with high health and social needs especially within the practice of Wai-health.

Those that were in roles that delivered health promotion messages shared their experience of different delivery style implications. Delivery style in regard to Māori went wider than how messages were put across to individuals. For Māori, the environment, credibility of person delivering the message and content of messages were all important factors. Also of significance were Māori images, use of Māori language and relevant examples such as healthy Māori kai (food). One participant identified that if Māori were unable to deliver the messages then at the very least there needs to be a knowledgeable and credible Māori walking beside them.

The way the messages are delivered is vital for our people. Holding on to things Māori within those education packages and once again it's the presenting, having the right people and Māori do work better with Māori. And it's not putting down anyone else but I have seen it. If you can't have Māori delivering it you must have Māori involved if it's to work. If you can't get a Māori person to do the presentation/education or promotion then let them have Māori walk side by side (Key informant 10).

Participants identified that the message itself needs to be encouraging alongside an empowering process that enables Māori to take control of their health and their lives. Others identified that many health promotion messages aimed at Māori in the past have been put forward in a blaming manner.

When you start to bash people over the head for what they're doing that's when they switch off. So it's been really good giving positive messages (Key informant 17)

Four interviewees highlighted that they had utilised people in the community to get a specific message across. Others identified having to simplify and change relevant health promotion information in order to break it down so the intended audience could understand it fully. Information often had to be re-created in a way that suited. One participant talked about how she transformed written information into visual imagery and that it has been a very popular tool. Two key informants highlighted the success of using Māori patient experience and knowledge in order to get the message across to others.

One man that I've got coming to my support group meetings, he's a double amputee he has renal failure, just about to go in to hospital for the week, and he was really good, when I got him coming along he started telling the group, "well if you fellas don't listen, this is what's going to happen to you, look where are my legs? I don't have any now why, because I never listened". Māori can talk that way to their own and it's not offensive (Key informant 12).

Collective versus individual process

Staff were evenly divided in regard to whether group sessions compared to individual work best. Patient preference seemed to differ depending on circumstances, confidence and understanding of information.

You have to tailor the programme and you do the best you can, I am constantly learning all the time from my clients. Some cultures would prefer one on one self management course or other cultures would prefer to do a marae situation. It really depends to be honest on the actual way that health promotion is pitched to them. So that's something that we have been looking at (Key informant 17).

Others commented on the importance of the collective being part of education, health solutions and visits to health providers in particular, whānau involvement. This facilitates support for the patient if changes in areas are necessary as well as patients gaining a better understanding of treatment, diagnosis and processes that maybe associated. It is important to note however, that not all patients want immediate whānau support at the time of diagnosis and there is acknowledgment that there needs to be a lead in time in

order for the patient to come to terms with their own health issue prior to the whānau becoming aware of it.

I encourage whānau to come on board but then that's depending on whether this person wants their whānau to sit there. I always try to encourage whānau to be part of the korero. And it's normally about the third time that they will let the other ones sit down and listen. But they realize how the health issue impacts on everyone (Key informant 10).

I think it's really important to include the whole family as the disease not only affects that one person, it's the whole family and they all need to know what to do (Key informant 12).

Accountability and responsibility back to the community

Participants who lived and worked in the community expressed their commitment and 'self imposed' role of going beyond their working role for the community and the people that they serve.

Whānau and community responsibility and accountability. it's all about whānau and the community we serve (Key informant 2).

Many staff identified their responsibility not only to the patients but to whānau, hapū, and iwi.

I'm, mana whenua to this place, so it doesn't matter whether or not my boss fires me, I'm not worried about that, what I am worried about is my family will deal to me they would absolutely deal to me and they hold me responsible for what happens within my work environment (Key informant 13).

Many participants identified the need for more accountability back to the local community from all levels. Two participants expressed wanting to see more Māori at the high levels within ministries to keep policy makers aware of community needs.

We need more Māori working in high places like the Ministry of Health, as it will be them that will give our communities a voice (Key informant 10).

One participant raised accountability in the form of a statutory committee.

The Government needs to be accountable for what they put in place but it needs to align with our population needs. Maybe they should form some sort of a committee with statutory powers that they have to consult and report to (Key informant 3).

Leadership

Other participants also identified the difficulty in getting other sectors involved recognising that it will take some strong leadership in order for changes to take effect. Three participants identified that good leadership was seen as essential to effective Māori health promotion. Participants highlighted how leadership took on many forms and needed to occur at all different levels and included those that were willing to advocate and drive appropriate health promotion activity as well as influence policy by implementing change. Leadership was identified at many levels including government and ministry levels and within management of the PHO. Interviews highlighted the importance of community leadership in particular role models who will influence and drive change from the bottom up starting within whānau.

If we haven't got good leadership starting at Government to advocate for appropriate and effective health and health promotion, how can we be effective on the ground? We can only do so much at the grass roots level (Key informant 9).

Training

Interviews indicated a number of workforce issues that impact on training provided throughout the PHO. Participants identified specific health promotion training opportunities available however, some were unclear exactly how the training was immediately relevant to their current work. Others although grateful for training opportunities wanted it to be more regular leading to a qualification of some sort.

The training would be great if it was tailored to what we do and have to face on a daily basis. Sometimes training is very irregular and you cannot plan ahead to attend (Key informant 3).

Work environment

Interviews identified the working environment within the PHO as playing a huge part in delivering effective health care services to the population. Many participants were consistent in their satisfaction in regards to their work environment in particular the relationships formed across the PHO.

Understanding of the determinants of health

There was strong consensus from key informants that the PHO has a large population with high social, economic and health needs.

My clients with diabetes can't even afford to buy their new needles let alone healthy food (Key informant 3).

Key informants across the PHO agree that with a majority of patients who come into clinics for health care needs also have numerous social issues. These were seen as pertinent to deal with as they impacted significantly on their health and well-being. Many expressed frustration in regard to funders and contracts not taking into consideration the determinants that impact on health. Examples of social issues being dealt with include; lack of transportation, transient lifestyle, limited or no family support, poverty, overcrowding, no power, limited food, domestic violence and safety issues.

Participants also made comment on how undertaking the work associated with their role is already quite difficult without dealing with the other issues that impact on the health of the patient or whānau. Two participants expressed the difficulty in just getting to the stage where you provide health promotion as it is long and hard. One participant highlighted that it is a constant ongoing battle that many funders fail to understand.

It's not just the health promotion its how you integrate it with the high needs the service and the high risk population. Funders don't understand this and expect things to be done A, B, C..... if they would only come out with us they may understand what we deal with and how long it takes (Key informant 16).

Health promotion evidence

The need for evidence based health promotion activity was mentioned in order to prove that it is effective if properly funded, targeted and utilized. Issues were consistently raised in regard to the focus funders have on outputs rather than outcomes and the tick box systems associated with reporting on contracts which fail to capture the true impact health promotion is having on peoples lives.

The key thing for me is evidence, which is what this is about. People say that this programme has worked and this service is doing great but they have no evidence to support that something works. Most times MoH or the DHB only want particular information so evidence something works is not captured (Key informant 18).

Two participants commented on how they have been encouraging their team members to write narratives that support the evaluation or end of contract reports for funders so there is additional evidence that the contract has worked. Others commented on tracking and recording systems such as databases and testimonies from patients that are stored within each of the practices to form part of their own evidence base.

Summary

A number of organisational pre-requisites for effective Māori health promotion were identified throughout interviews. Pre-requisites varied in nature and included; material requirements such as funding and resources whilst others required a change or transformation to occur at a number of organisational levels including cross sectoral and policy levels, attitudes and beliefs alongside practical implications such as gaining health promotion knowledge and up skilling.

Some of the pre-requisites identified seemed more geared at personal health care in general with a focus on support for the patient such as whānau involved in health activity or an avenue where participants get satisfaction from their work. Although this is a good framework to create change for the patient and may fertilise the ground for health promotion to occur at a late stage it cannot be mistaken as a pre-requisite for health promotion in itself.

Training is a pre-requisite for health promotion however, it is difficult to clearly articulate health promotion theory and skills however well intentioned through the current number of limited, ad-hoc training sessions currently provided. In order for the true essence of health promotion to be explicit it will need to be delivered in an environment and style that is conducive to trainee needs which may be outside of the PHO setting and away from busy working activity. It will also need to be structured according to the PHO activity and agreement for attendance given priority by PHO management otherwise it may prove to be a wasted opportunity.

Overall the work environment was clearly satisfying for participants who had built up good relationships over the time employed. This is important considering the overwhelming needs of the population and issues relating to staff shortages, funding and resources. Although there were clear benefits from this for patients, if other issues are not addressed at the strategy and policy levels then health promotion is unlikely to be most effective.

Testing the feasibility of a Māori health promotion framework

The research provided an opportunity to investigate the feasibility of implementing a current Māori health promotion framework (Kia Ururu Mai a Hauora) and discuss how it could be developed and implemented within primary care. Training sessions were also going to be undertaken on the framework ready for implementation in one practice (Wai-health). However, in testing the feasibility and drawing on the analysis of data from the key informant interviews, the researcher identified a number of constraints that would not enable the implementation to proceed. In brief these include; staff shortages, high workload, impact on patient time and staff personal time constraints.

The researcher felt at the time the conditions were not feasible to undertake training to implement the health promotion framework as had been originally planned in the study. Instead focus group sessions were undertaken to introduce the framework - Kia Uruuru Mai a Hauora Māori and then compare its components with existing health promotion practice identified throughout interviews. The following sections include a comparison of practice identified by participants with the individual characteristics of the framework Kia Uruuru Mai a Hauora. Due to time constraints not all characteristics outlined in the framework were discussed.

Concept	The process of enabling Māori to increase control over the determinants of health and strengthen their identity as Māori, and thereby improve their health and position in society
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Focus group participants readily identified areas of practice that enabled Māori to increase control over the determinants of health, however more emphasis was placed on constraints including an urgent need to address the wider determinants that impact on health particularly associated with the communities they work in. Areas identified included; poverty, access to food, electricity, affordable and appropriate housing and education. Participants identified ways in addressing the determinants as; collaboration with other organisations and sectors (WINZ), providing culturally appropriate and specifically tailored programmes, and flexibility of delivery style.

In strengthening their identity as Māori, the majority of participants agreed that they chose to work for a Māori Provider and that their preference was to work with Māori communities. Most of the participants identified living in the same community. Non-Māori participants identified and agreed that it was appropriate for Māori staff to deal with Māori patients. Participants also acknowledged that in working with Māori patients and utilising Māori processes and resources such as kaumatua and the use of te reo also strengthened Māori patient identity. Focus group participants who worked in other practices made comment that they would refer to Wai-health as a first option regarding Māori health promotion programmes if the patient was Māori. Māori participants within focus groups highlighted the non-Māori support throughout the PHO toward culturally appropriate frameworks and ways of working.

Concept of health	A balance between interacting spiritual, mental, social, and physical dimensions
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The focus group participants acknowledged the importance of the balance between interacting links and utilising a holistic approach. Models of health drawn upon with these

dimensions included Māori models of health and health promotion, indigenous concepts, whānau ora and whakapapa-based frameworks as well as tikanga, whānaungatanga, and wairua processes. One participant identified using a model called ‘Te Pae Heretia’ through her role in addictions and raised the point of utilising many models and components dependent on the client and the situation. Māori participants reiterated that this was not something new and that the concept of interacting dimensions is intrinsic in their everyday life. They identified the difficulty associated with this as having to continually justify or get validation for the tools and frameworks that they knew to be naturally appropriate at the higher DHB and Ministry levels.

Purpose	The attainment of health, with an emphasis on the retention and strengthening of Māori identity, as a foundation for the achievement of individual and collective Māori potential
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Throughout interviews and focus groups there was a great emphasis on improving health for Māori using Māori processes, tools and resources. Within Waiora this was primarily identified as working in a ‘Māori PHO’, which is led by a Māori CEO. This was deemed as a very important issue for many staff. Others commented on having input into hiring and working alongside other Māori and non-Māori staff that understood and respected Māori patients and different ways of working. For many, the attainment of health and strengthening Māori identity came via promoting and respecting kaumatua and kuia. The Kaumatua Roopu (group) set up and based out of Wai-health is a valid and an integral part of the PHO. Others commented on the inclusion of whānau in consults, programme and service design, and health education as critical to the attainment of health and strengthening Māori identity. Much discussion was held in regard to working within Waiora PHO and with staff that are focused on the same goal for whānau. Working in a

Māori environment with other staff that support Māori processes and different ways of working was seen as validating their Māori identity.

Values	Māori identity, collective autonomy, social justice, equity
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Participants felt strongly about equity and the right to good health for Māori. Discussions included the rights of their patients to adequate and appropriate resources including; space for consults and appropriate tools for education. Conversations led to looking at the differing needs of Māori and the recognition of rights and obligations under the Treaty. The main issue that arose was the number of staff working outside of their roles and responsibilities to ensure the quality of service for their patients as the current health system is not meeting their needs. Many agreed that their role was not about the money but about accountability and responsibility back to their own people. As many lived and worked in the same community this was highlighted as an important issue.

Principles	Holism, self-determination, cultural integrity, diversity, sustainability, quality
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The impact of one sick individual affecting the whole whānau was raised consistently as a theme within the focus groups. Workers noted that in their role they tried to get the additional whānau members on board to educate them about medications, medical terminology, and about raising awareness about the sickness and what needed to be done in order for the individual to get well. Others raised the importance of whānau being part of programme and/or intervention design and not just being on the receiving end of services. Many gave account of examples where this had been successful leading to improvement in programmes, taking services to marae, utilising whānau with relevant

experience and knowledge of health as examples in programmes, and for getting resources translated in te reo. The ability for staff to tailor their programmes and services appropriately to different whānau was identified in particular, as Māori and whānau are diverse. Sustainability was raised as an issue within the different practices including recruitment and retention of staff, services and programmes which lack workforce, resources and funding all of which continue to be on-going issues.

Processes	Empowerment, mediation, connectedness, advocacy, capacity-building, relevance, resourcing, cultural responsiveness
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Participants highlighted their motivation to work to provide choices for whānau, to build up communities and to be an advocate on their behalf. Staff felt that they had input into programmes and services and in a few instances had input into contracts to ensure that they were relevant to the population. They identified that within each practice and across the PHO processes work well due to it being relatively small. Staff felt they knew each other well enough with many shifting practices within the PHO over time.

Strategies	Reorienting health systems and services towards cultural and health promotion criteria
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Participants highlighted the choice to work in a Māori provider environment and recognised the urgent need for Māori workforce development although they identified not being sure where to start. Some participants identified that the secondary health services provided within the PHO (optometry, podiatry), aligned with the need of the population. It was also highlighted that Wai-health was slowly orientating toward being a one stop shop and included such services as addictions, mental health, community health, GP and nursing services. A number of campaigns were mentioned that were now facilitated more

toward cultural and health promotion criteria. One was aimed at kohanga children in regards to reducing waiting times for glue ear at the Remuera clinic and catering services towards whānau in particular the inclusion of dads. As well, changing the environment where programmes and services take place e.g. on the marae or community hall rather than at a clinic. One participant identified their senior manager being on national radio and in the media advocating on behalf of Māori, contributing to reorienting service delivery to better suit the needs of Māori and their community, including advocating for a funding stream to suit the population and service delivery needs.

Strategies	Increasing Māori participation in New Zealand society
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Focus group participants highlighted that some patients stop coming to programmes for positive reasons such as engaging in employment or academic courses. Others identified that having a Māori employed is better than having them on a programme. Whilst others stated that small changes that have occurred through health education has led to big changes in whānau, hapū, iwi, (e.g. no smoking on marae, change of food, offering different health programmes, glue ear campaign through the kohanga helps children learn better at school). Others commented that by providing tailored programmes that utilise Māori resources (Māori staff, te reo, Māori food, and landmarks) has created a better understanding for Māori whānau in changing their view and behaviour around food and lifestyle choices to better their health and provide guidance and role modelling for future generations. Therefore, many felt they have the ability and the confidence to participate in societal activities such as, sport, learning new skills for employment and furthering their education where they once felt they were not able or even entitled to do so.

Strategies	Iwi and Māori community capacity-building
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The group highlighted that there are now more Māori clinicians who are developing skills and taking the skill sets back to their iwi. They also raised the point of health promotion not having set hours in that it never stops. Although more clinicians are going back to their iwi they are also recognising their limits and what they cannot provide. Group members expressed a definite need for more male health workers and health promoters. At times it was identified by focus group participants that the gaps in workforce seemed to be overwhelming making work seem like a daunting task. Some are working at all different levels of society including whānau, schools, local council and kohanga to make the necessary changes.

Strategies	Healthy and culturally affirming public policy
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Participants identified a number of examples relating to PHO input into healthy and culturally affirming public policy. Participants highlighted that some resources are now put out in te reo and there have been changes in how the younger generations are raising issues with the older ones (e.g. grandchildren and grandparents). There have been significant changes with the acknowledgement of the use of traditional healing methods and medicines, alongside supporting the change of food at school tuck shops, and no smoking at kohanga and marae. There are also more physical activity programmes being implemented through schools, health services and within the home environment by whānau.

Strategies	Intra- and inter-sectoral measures to address determinants of health
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The PHO works closely with services such as WINZ and ACC. Within Wai-health access to these services are now within the practice. Implementation within the Wai-health environment and under their kaupapa has been far less intimidating for whānau with easier access to addressing their needs. Systems have been implemented that allows for timely updating of databases each time a patient presents at the practice. This has enabled the PHO to stay in touch as best as possible especially with transient families. The IT system that is utilised allows all staff to access patient records so each knows when the patient presents and the changes that are occurring with patients due to different programmes/services. The flexibility of allowing time for double consults so whānau get to see the GP, nurse and/or a podiatrist within the same timeframe has proved to work effectively.

Participants did raise the issue of not having the time to always feedback to colleagues face to face (usually this is done by email) and not realising the ripple effect this has.

Strategies	Effective, efficient and relevant resourcing of Māori health
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Interviews highlighted that those involved with contracting stand quite firm to ensure as best as possible that contracts fit with the practice and/or PHO priorities. Sometimes this occurs by the renegotiation of contracts and having to be creative and look at flexible funding aspects. The PHO requires more funding representative of their high needs population and staff have already realised that information in reports are not being captured as evidence for effective funding. Contracts have tended to focus on the quantity

rather than the quality of services. Many participants identified wanting the person who writes up the contract to come and see what is needed versus them dictating what they think may be needed. Others highlighted the need for sufficient space, computers and cars, reducing time and energy spent on being creative due to limited resources and funding to make resources. Some participants also highlighted the need to wear different hats within their role (nurse, counsellor, social worker and budgeter) and having to go outside their job description due to the high needs population.

Markers	Secure Māori identity, health status (positive and negative), health determinants, strengthening Māori collectives
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Many raised the point of collecting additional data over and above what is required by funders in regards to contracts. Participants highlighted that contracts were output focussed rather than having a focus on the quality of the outcome. One person stated that at a clinical level there is limited capacity to collect information on Māori identity and that what is collected is tick box type of information. Others reiterated that they are fortunate that their IT system is set up so that they can measure their own outcomes. This has been a strategy used in the past to request additional funding. Many commented on now they use the system to keep informed such as being party to relevant information pertaining to funding that they previously did not know about.

One participant suggested that in the future measures to collect data may need to be balanced with qualitative information. The stories behind the numbers were also being recorded as part of additional data to highlight the quality of outcomes. For example, the number of people on a programme may reduce when one gains employment which is seen

as positive. However, funders will only see that the numbers have reduced therefore so should the funding.

Participants highlighted the importance of having voices at all levels within the DHB, the Ministry of Health, and Māori health organisations and government to advocate for Māori. Participants also discussed the need for more funding to sit at the provider level which will mean that providers are more accountable to their communities, stating the closer you are to the ground the more accountable you need to be.

Participants raised the issue measuring a secure Māori identity with one participant stating it is something that they choose. Some acknowledged that it comes down to diversity, feeling strengthened and being positive in saying that you are Māori. Others agreed that being Māori is diverse and means different things for different people including knowing your whakapapa. Others reiterated Māori identity as being very important and that not having a strong sense of identity was often a big part of patient problems. Participants were impressed with the markers within the framework in particular, that it dealt with the importance of Māori identity.

Summary

Interview findings affirm that health promotion is perceived as a critical component to health service delivery across the PHO. This was evident across all three practices and in particular at management level by the annual documentation of the health promotion plan, current and future delivery of health promotion activity throughout the PHO, strategic positioning of the health promoter and the alignment of priorities with DHB and the Ministry of Health for better access to funding. Whilst the PHO appears to be doing all that it can to make health promotion a high priority and there is a hive of current activity,

it seems that if the priority is not driven from the top firstly, emerging from government and the Ministry of Health then support for health promotion at the ground level will soon become redundant. The staff at Waiora PHO are working with very limited resources that impact on all areas and all levels of the PHO including workforce capacity, availability and access to training. Lack of these resources create difficulty in dealing with the most basic of health care issues putting aside all the other social determinants and other priority issues that come with the territory of working in this area.

Although health promotion activity across the PHO is presented as varied and wide-ranging much time appears to be spent by well meaning, supportive and committed staff at getting better access to health care services and service utilisation for individual patients. This was seen as a critical issue in particular, for Māori who for many reasons outlined in this thesis do not access and/or under-utilise health services. Health promotion tends to get left until last or left out altogether especially when staff are overwhelmed with dealing with primary health care needs of a population that has such high health and social needs. It was evident that many if not all staff involved in the research went well beyond their paid role to serve their population by taking on extra work, going the extra mile and using their own resources, whilst at the same time putting their own personal and training needs aside. Although staff did this to benefit the population they serve, long term this will be difficult to maintain and could become counter productive. Changes will therefore be necessary so not to cause at the very least staff burnout, which may be a contributing factor to some of the workforce issues raised.

There were clear indications from interviews of a variety of health promotion training needs. A number of avenues were identified where training was provided through the PHO however, attendance was difficult due to heavy workloads and staff shortages. It

was also apparent that formal health promotion training was minimal among staff with only one person having a formal health promotion qualification. As noted in several interviews in this particular community it was important to hire someone with broad experience in the community and to deal with a number of issues rather than hire someone with expertise in one particular area. Often, such people were not always those who were the most qualified. However, if training was more accessible there is much potential for the PHO to eventually have a number of staff on hand who would be better skilled in the area of health promotion. In the longer term this would benefit both the PHO and the community by being able to focus more on preventative strategies. It would be cost effective by focusing on prevention rather than treatment or cure. Health promotion activities could then be more specifically tailored to the needs of the population. Staff skill and experience would be enhanced which would add positively to their regular work activities.

There was no one consistent health promotion model that was reported across the PHO. Frameworks were wide-ranging taking from a number of Western and Māori-specific frameworks and were reported as working well, although there did not seem to be a cohesive and co-ordinated approach to how and when participants were using them. This is consistent with a number of interview themes in regard to using spontaneous ad-hoc approaches due to the urgent high needs of the population, lack of training opportunities and the limited pool of staff trained in health promotion.

A number of organisational pre-requisites for effective health promotion were identified from the findings. The most prominent being adequate funding and resourcing in order to undertake health promotion effectively. Lack of adequate funding impacts on other pre-requisite areas such as workforce, training, implementation and developing an evidence-

base for health promotion. All of these are fundamental areas when building capacity to make changes at a population level. The pre-requisites identified are critical challenges for any effective change.

The Kia Uruuru Mai a Hauora framework was well received and appeared very well suited to the PHO. However, due to restrictions (staff, time and resources), the framework could not be fully implemented and therefore validated as an effective health promotion tool within the PHO. The presentation however, of the framework outlining its characteristics was identified as being easy to understand, very relevant to the current working environment, the PHO's different roles and the community. It was seen to fit with current framework components used and identified by participants as an avenue that could provide an over arching structure that delivered a systematic co-ordinated approach to health promotion across the PHO. Kia Uruuru Mai a Hauora was also identified as being a helpful tool in order to address elements of health including the social, economical, cultural and political determinants of health.

CHAPTER NINE: DISCUSSION AND CONCLUSION

Chapter nine concludes the thesis by presenting discussion in relation to the findings that set out to answer the research question; what are the organisational pre-requisites necessary in order to fund, implement and sustain Māori health promotion in a primary care setting. The findings from the research highlighted general themes including; the need for Māori health promotion to have priority within primary health care and the urgency to address underlying priority issues that effect Māori health promotion implementation such as, training and staff shortages. Apparent pre-requisites for effective Māori health promotion are presented and discussed in relation to the literature reviewed. The chapter concludes by outlining the limitations, future research needs and the implications of the study.

Māori health promotion priority within primary care

In general the perception towards health promotion from participants was that it was a critical component of health care and health service delivery. Participants felt that Waiora's health promotion plan (Waiora Healthcare PHO, 2007; 2008), which outlines the PHO's strategic direction for health promotion supported initiatives that targeted community organisation, community action and community development approaches. This, alongside the employment and strategic positioning of the health promoter, the broad range of health promotion activity delivered in different environments, cultural approaches and the commitment from staff that go beyond their paid role confirmed that health promotion was considered a priority at both an organisational and an individual level across the PHO.

Waiora PHO staff take an active role within the community that they serve. Health services and health promotion are delivered in different environments such as clinics, community centres, home environments and schools (Ashton & Seymour, 1998). According to Nutbeam (1998) it is in these settings where environmental, organisational, and personal factors interact and affect health and well-being. Although the majority of participants perceived that they were undertaking extensive health promotion activity it appeared that a large extent was more focused on one to one health care consultations, service access and utilisation issues, chronic disease management, information and education. Some participants raised concerns at their lack of knowledge and confidence to take part in health promotion whilst others considered it not being part of their designated role. This confirmed a concern raised by the Health & Disability Sector NGO Working Group (2005) in regard to health promotion being lost within some PHO's due to it not being sufficiently understood, resourced and/or supported.

Health promotion activity was evident in selected areas of the PHO. However, participants spent the bulk of their time dealing firstly, with the overwhelming high health and social care needs of the PHO's population. Participants were fully aware that until these needs are adequately addressed health promotion effectiveness and implementation will be hindered. Whilst all participants identified health promotion as important and knew it was part of various contracts, there seemed to be unclear direction as to who was responsible and what the expectations were. Some put the responsibility solely on nurses and others such as the community workers and DSM nurse took it upon themselves to undertake it as part of their current role. There would appear to be clearer direction needed from government and the Ministry on what is required, as well as clearer strategic direction from providers as to their role in health promotion. Clinicians also have a huge role to play in regards to health promotion, if not undertaking it themselves, by fully

supporting its importance. Without clear direction and support health promotion will always be left until last or not undertaken at all.

Consequently, until these issues which are common to many primary health care organisations are addressed at policy levels, health promotion in general and more specifically, Māori health promotion will still be in an emergent form.

The Ottawa Charter reflects in its action strategy of ‘producing healthy public policy’ the priorities and parameters for action in response to health needs, available resources, and political pressures (Koelen and van den Ban (2004). Healthy public policy is important as it guides the activities of different organisations that align their internal policies and strategies to those at DHB, Ministry and government in order to meet the priorities set and access associated funding. However, the findings raised concern about how participants perceived the way the New Zealand Government prioritizes health promotion given the identified lack of understanding at the Ministry and government levels in regard to priority targets and contractual outputs aligning with population needs and in particular, the needs of Māori. It also highlighted that health promotion was often added on to existing contracts and therefore not seen as a priority. More importantly, a number of PHO contracts and outputs failed to consider the wider social, economical, cultural and political determinants of health (Cormack, 2007; Robson, 2003; Smith & Jackson, 2006). The study raised how low funding associated with health promotion contracts led to inadequate access to resources, only allowed for a narrow scope for health promotion activity and provision of a very limited pool of trained health promotion workforce. It further highlighted that poor contractual arrangements which focus on outputs restricted the gathering of necessary information to provide an evidence-base for health promotion.

Therefore, funding agencies failed to capture pertinent data that would feed into policies that could ultimately determine New Zealand health priority areas.

At the provider level, Māori have long called for policies and services that are appropriate to meet their needs and whilst there have been some broad changes in the health sector which have led to increasing health gains for Māori (Ministry of Health, 2005), Māori health still remains an extreme concern. Key informants highlighted the many factors that contribute to the health status of Māori including; unequal distribution of resources and the disparities that exist for Māori compared to non-Māori in particular, the differences in the social, economic, cultural and political determinants of health (Ministry of Health, 2007; 2001; Robson & Reid, 2001). Participants were well aware that issues such as these limit providers to adequately and appropriately deal with health issues in accordance with funding associated to service contracts. Alongside the narrow scope and framework that is directed from DHB, Ministry and government officials who in most cases according to participants are far removed from the target population. Participants were consistent in their views that contracts do not take into account contributing factors that affect and impact on health such as poverty. High numbers of Māori are in the lower socio-economic bracket and are forced to prioritize health care along with other pertinent household, family and social issues that often take precedence. As a consequence Māori health status is worse having higher morbidity and mortality rates for many illnesses and injuries (Robson et al., 2007) compared to those that are financially better off and who have greater access to health care and its ongoing resources such as information, insurance, specific medication and alternative treatments such as various surgeries (Koelen & van den Ban, 2004; Naidoo & Willis, 1998; Smith & Jackson, 2006).

This has not always been the case for Māori. Pre-colonisation Māori were in good health utilising Māori customary public health systems and concepts such as ‘tapu’ and ‘noa’ to guide and protect the health and behaviour of the individual, whānau, and hapū members. Systems and concepts set up were appropriate for the time, were well established and supported by those in leadership who were a trusted part of the community. Decisions made involved the whole community and were strictly adhered to as there was an overall understanding by all of the benefits, and, subsequently the consequences to the collective of failing to do so (Buck, 1950; Durie, 1998a; Ratima, 2001).

Waiora PHO’s health promotion targeted areas of community organisation, community action and development aligns with Ratima’s (2001) framework confirming that by taking a community development approach Māori communities are better positioned to lead and benefit from health promotion interventions. Empowering the community to participate is a key concept for both health promotion and community development (Koelen & van den Ban, 2004; Rae, 2007; Ratima, 2001; WHO, 1994), however, it is important to note that the community needs to be in a place where they are ready to participate and therefore contribute to their own development. Often communities already know where the problems lie and in most cases usually have their own answers. However, they are often weighed down by other pressing issues that override their ability to address them such as lack of food, not enough money or having to make a choice over what takes priority at a given time.

The WHO Social Determinants Report (2008) states that people living in poor conditions is a direct result of poor social policies and political processes. The majority of the population that Waiora PHO services are Māori who have overwhelming high health and social needs and are living in very low socio-economic conditions. Therefore staff at

Waiora PHO are forced to place priority on dealing with immediate health care issues. Much work is still needed in order for Māori health promotion to be a firm and robust priority at all levels of New Zealand society and ensure public health policy aligns with the broader social determinant needs of the population. In the long term public policies on health are needed that are flexible, equitable, accessible, and ensure that they are particularly responsive to Māori given their marginalised position in society and high health need.

Māori health promotion pre-requisites

Pre-requisites are the fundamental conditions and resources required in order for good health to occur. Ratima (2001) describes pre-requisites as being the ideal conditions for the achievement of good health. Research points to a range of pre-requisites for health promotion including; peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity (WHO, 1986; 2008). Whilst Durie (1999) further outlines leadership, autonomy, access to cultural resources and the understanding and use of holistic approaches as key pre-requisites for Māori health promotion.

This study identified a number of pre-requisites deemed necessary for the effective implementation of Māori health promotion within a primary health care setting. Many of the pre-requisites identified were found to lie outside the organisations responsibility and needed to come from a variety of sources including DHB, Ministry of Health, government, community and whānau. Pre-requisites identified include; appropriate and adequate levels of funding, Māori-specific components of health promotion including; processes that strengthen Māori identity, Māori leadership, accountability, and responsibility, workforce training and development, supportive work environments and policies and strategies that address the broader social determinants of health.

Funding

Participants consistently raised issues of inadequate funding for health promotion as reflected through contracts and by per capita funding which is used for population based health promotion services such as smoking cessation campaigns and physical activity programmes (Berghan, 2007; Hefford et al., 2005). PHO's get a one off grant for health promotion but there is little direction in how that can be adequately used. Health promotion funding sources such as these are meant to provide appropriate staffing, however, programmes, services and resources for health promotion afforded by this grant are minimal considering the huge issues and the large numbers of diverse populations PHO's have to cater for. Adequate funding for effective Māori health promotion also needs to take into account the greater need of Māori in terms of their marginal health status in order to achieve realistic and equitable health outcomes (Ratima, 2001; Robson & Reid, 2001).

Ratima (2001) further states that Māori health promotion should not be seen as a quick fix solution and that funding timeframes in particular need to allow for appropriate planning, training and resourcing. Participants within the study agreed that in dealing with populations with such high social and health needs Māori health promotion planning will need to take into consideration the time it takes to deal with their associated issues. Issues such as dealing with a transient population and patients having no access to phone or transport not only makes health promotion difficult but impacts on the basic steps needed to be done beforehand such as, making initial and on-going contact, identifying all the issues that impact on health, accessing up to date and relevant information, gaining acceptance and ongoing commitment in regard to appointments, care and treatment. Issues such as these are difficult to adjust for with the limited funding associated with Māori health promotion.

The DHB and Ministry provide overarching strategies directed at priority areas of health however, participants raised that such strategies do not necessarily cater for the issues that they as providers are faced with on a daily basis. Although health promotion funding is well appreciated and provides some guidance and direction, it seems it may be worth considering additional avenues and criteria for accessing health promotion funding. The study highlighted that funding for health promotion needs to be appropriate and adequate and more importantly align with community understood and driven needs. These needs differ greatly between providers and practices within providers as well as across communities and regions. The health of Māori in the far north for example, may differ from the health of Māori in the Chatham Islands although there may be areas that overlap between the two. Health promotion funding that comes from DHB and the Ministry of Health is meant to cater for different population needs, however, there is huge competition between providers in applying for well needed funds. Better targeting of resources such as more resourcing at a provider level may be better utilised for population and provider initiated health promotion activity. DHB's could still provide overall direction but the community and provider could determine specific health promotion needs. Better resourcing for providers will better address community driven activity. Health promotion needs that are community identified and utilize frameworks that take into consideration cultural aspects including appropriate resources and environments are expected to be far more productive and cost effective in the long term. This process may even result in the communities sustaining health promotion activity themselves, leading to maintaining a healthy lifestyle whilst gaining control over their own lives (Naidoo & Willis, 2000; WHO, 1994).

Resources

The provision of adequate health promotion funding will also greatly impact on the ability to access well needed quality resources. Resources for Māori health promotion will need to be diverse and stem from a variety of sources.

Participants consistently raised the issue of limited funding and its affect on appropriate resources that aid health promotion activity. Whilst the majority of participants identified their creative ability to seek out, re-design or develop material resources from scratch in order to make them appropriate for their Māori patients, others expressed constant frustration in not having the basics. Participants identified the need for basic resources such as, pamphlets and brochures explaining health issues, prevention and treatment and in particular, resources written in relevant languages that are culturally appropriate and easy to understand. Ratima (2001) earlier identified that additional resources will be required for Māori health promotion in order to achieve realistic and equitable health outcomes.

The importance of access to Māori resources such as activities undertaken in te reo, access to Māori workers, Māori imagery, health promotion activity being undertaken in Māori environments, use of Māori landmarks, Māori role models, teachers and/or health experts within clinics and programmes was also raised. Participants consistently highlighted that activity, programmes and services were much more successful in achieving their desired goal when one or more of these Māori resources had been incorporated.

Access to Māori resources also came by participants identifying that they chose to work for a Māori provider, utilise Māori philosophies and processes such as karakia (prayer)

and waiata (songs). Many highlighted that they felt connected to other staff members throughout the PHO and all expressed a liking for working at Waiora due to relationships formed. This is consistent with Durie (1999) who confirms that access to the Māori world and the resources within it will be a key task of Māori health promotion. Similarly, Ratima (2001) identifies in her study that distinct Māori approaches used in Māori domains and link to customary systems and infrastructure, utilising cultural approaches will be needed in order for Māori to fulfil their potential and gain control over their health. The Ottawa Charter describes a similar process under its strategy ‘creating supportive environments’ where links are established between people and their environments in order to improve health (WHO, 1986). Access to resources, in particular, Māori resources are strongly considered to be an important part of the development of Māori health promotion practice.

Māori health promotion key components

Throughout the findings participants commonly referred to framework components used that emerged distinctly from being Māori. The majority of participants interviewed were strongly grounded in Te Ao Māori by having good connections to their whānau, hapū and iwi, were strong in their identity and tikanga (customs), maintaining fluency in te reo and a drive for Māori processes to be used as a health service delivery mechanism.

Being Māori and having shared knowledge of the Māori world and Māori processes enabled the establishing of greater engagement between Māori patient and Māori staff, creating trust and building up patient confidence to access the programmes, services, and treatment at the practices within the PHO. Literature points to Māori health promotion being more familiar with concepts such as manaakitanga (caring for one another) and whānaungatanga (kinship or connection) rather than being specifically theory driven and

based (Ratima, 2001). According to Durie (1998a) Māori health promotion is founded on Māori worldviews which share common themes of; interconnectedness, Māori potential, self determination, collectivity and Māori identity. Māori health promotion allows for a dual focus on health but also on Māori and it is this focus that shapes its defining characteristics (Ratima, 2001). Durie (1999) also outlines that the purpose of Māori health promotion is that it will lead to health gains, facilitate retention and strengthen Māori identity.

Strengthening Māori identity

The majority of participants interviewed identified a number of ways that they strengthened their Māori identity. One way was by choosing to work for a Māori Provider. Waiora PHO is classed as a 'Māori' PHO as it is Māori led (has a Māori CEO), has Māori Board members, a Māori name, utilizes Māori philosophies that underpin activity, employs a significant number of Māori staff who deal with large numbers of Māori cliental. Non-Māori staff were seen as being supportive of Māori processes acknowledging the need for more culturally appropriate service and environment. Strengthening staff identity and utilising Māori processes had a flow on effect to many patients and their whanau. Processes and resources used were deemed comfortable, appropriate, and/or familiar to whānau which enabled for better relationships, good uptake of services and in some cases a radical change of circumstances.

Durie (1999) outlined Maui Pomare's five point plan for Māori health promotion that included the connection between Māori health and Māori culture, the importance of political commitment to health, and the development of a strong workforce. Participants within the study recognise and respect their respective leadership and speak highly of the Board, CEO, team leaders and kaumatua and kuia. Participants identified that health is

influenced by many factors including Māori culture (Durie, 1999). This is evident across teams and throughout services and programmes by the utilisation of Māori processes and Māori resources. Participants acknowledged that they felt strengthened in their identity through their work, relationship with colleagues, whānau, and community as well as their relationship with other agencies in particular other Māori based organisations.

Leadership

The Te Pae Mahutonga model identifies leadership (ngā manukura) as a key pre-requisite for Māori health promotion (Durie, 1999; Ministry of Health, 2003a). Participants agreed that leadership was a critical driver of Māori health promotion. Increased leadership was identified as necessary at all levels from government, Ministry, DHBs, within communities, and most importantly within whānau.

Within whānau, leadership should entail initiating, supporting and role modelling relevant changes necessary for the health of the whānau. Whānau leadership should take many forms and activity will be varied such as growing a vegetable garden, exercising, breast feeding, banning smoking in the home, car and marae, or by visiting medical centres for regular check ups and immunisation. At the provider level leadership should include provision of an overarching health promotion plan or strategy, clear frameworks, role modelling the importance of support for health promotion throughout organisations, providing clear health promotion roles and expectations and the implementation of innovative, relevant and appropriate health promotion activity. Leadership at the policy/strategy levels would include recognising and acknowledging the importance of health promotion, provision of clear frameworks, expectations and guidance, as well access to adequate funding and resourcing. In order for health promotion to be well supported there is a pressing need for strong leadership in order to provide appropriate

health promotion training that can be accessed by all workers undertaking health promotion roles. Participants highlighted a need for strong Māori leadership at all levels in order to effectively make positive changes to Māori health.

Leadership is an established part of Māoridom. Prior to colonisation leadership came in many forms such as tohunga (medicine man, healer), kaumatua and kuia (elders), matriarchal positions (mothers, aunties, nannies) and the likes of Ariki (chiefs). Strong Māori leadership in today's modern society still exists and takes on different forms such as the use of kaumatua and kuia, recognising and respecting the Māori King and Queen, prominent political and local leaders and through different avenues such as kohanga reo, kura kaupapa, kapa haka and whānau. For many, strong leadership may be more scarce with many Māori now living overseas, or in more urban settings isolated away from their whānau and land-base. Some Māori have very limited funds and are unable to return home, others are now failing to even know where they come from resulting in close positive Māori leadership and role modelling to be non-existent in their lives.

Waiora PHO utilises Māori leadership within different practices as previously outlined. Many staff within the PHO are also well known in the community with some holding leadership positions on different trust, school and marae boards. Durie (1999) confirms leadership plays a critical role in health promotion at a number of levels including community, health and tribal leadership. He further outlined the leadership of Maui Pomare in making significant changes for Māori health that have continued to play an important part in Māori health promotion today. Māori health promotion will clearly require strong Māori leadership at all levels if it is going to be effective and sustainable.

Community accountability and responsibility

Participants felt that being Māori and working in health required more accountability and responsibility back to the community that they serve. Other participants expressed quite vividly that their accountability and responsibility went wider than just the local community and firstly, belonged to their own whānau, hapū, and iwi. It is important to note that all Māori participants interviewed also felt a sense of accountability and responsibility to Māori as a people in general. There was agreement that the more involved participants were in the community the more accountable they felt in particular, if they were part of that specific community. Other indigenous workers share similar values in that they too felt a sense of greater responsibility in relation to the larger community (Graveline, 1998), especially their own.

The Ottawa Charter (1986) stresses the link between people and their environments as outlined in strategy 'strengthening community action'. This strategy emphasises strengthening support for social change by providing information, learning opportunities and resources. The Ottawa Charter, Declaration of Alma-Ata, and the WHO itself express accountability on both a small scale at a local level but also globally by provision of strategies that support diverse population needs whilst trying to lobby for individual governments to take responsibility towards health issues especially those in underdeveloped countries.

Participants expressed frustration as they felt the same sense of responsibility and accountability was not obviously reflected at a New Zealand policy level. Some participants stressed the importance of having Māori at all levels of society especially in high level positions as advocates for reflecting a community voice. Others wanted to see more statutory type committees connected to communities being implemented whereby

government and the Ministry are better advised and therefore held accountable in relation to community and population needs. Whilst having Māori in senior policy positions is a positive step, there are implications that are not always positive. Often Māori at these levels are isolated, over worked and in addition to their normal working role are expected to provide cultural advice and assistance to their colleagues. In many circumstances they are also expected to be ‘the’ Māori representative at certain meetings and committees. These roles although important carry with it skills that are not often recognised or regarded highly enough to warrant payment or recognition as a specialised skill set. Statutory committees whilst closer to the ideal often host only one or two Māori representatives on a committee of eight or so, and these are expected to carry the voice of all Māori for committee matters. Too often Māori in these positions tend to burnout due to the expectations placed on them by their colleagues, their community and by their own whānau.

The Treaty of Waitangi, New Zealand’s founding document has been a primary mechanism where Māori have tried to seek accountability from the Crown in regard to their right to good health (Health Promotion Forum of New Zealand, 2002). However, there have been a number of historical and contemporary breaches, with some politicians trying to remove any sense of the agreement altogether. A Treaty Understanding of Hauora in Aotearoa-New Zealand formally known as TUHA-NZ (1988) has been an avenue that has been instrumental in trying to establish a framework that operationalises the Treaty of Waitangi within New Zealand health promotion. TUHA-NZ is a practical framework that aims to provide health promotion organisations and practitioners with practical tools to understand and apply the Treaty of Waitangi in everyday work (Health Promotion Forum of New Zealand, 2002). Māori frameworks such as these will be most valuable for the implementation of Māori health promotion and to provide a mechanism

that will enable government and providers to be accountable back to local communities. Accountability may incorporate many forms such as informing communities of new initiatives, advising them of changes to funding or programmes, but more importantly it will take into account their feedback, their views and their needs.

Building the health promotion workforce

The implementation of the Primary Health Care Strategy (2001) and the establishment of PHO's were intended to provide greater emphasis on health promotion and the strengthening of the health promotion workforce. Increased training opportunities alongside qualifications were also suppose to improve the quality of health promotion work offered within PHO's (Ministry of Health, 2006). Whilst training about the role of health promotion for those in management and on the board of PHO's has the potential to support the growth of health promotion it was perceived that a lack of support at these and policy levels has promoted an opposite effect. The under representation of Māori in the health workforce (Reid & Robson, 2006) is not a new phenomenon and participants confirmed a number of workforce issues affecting health promotion activity at all levels of the PHO. Consistent implications of staff shortages in general were; heavy workloads, no cover for training opportunities and health promotion priorities being down graded or not being undertaken at all.

Whilst a health promotion specific role was clearly established within the PHO and was classed as a critical position, concerns were raised at there only being enough funding for it to be a part time position. Currently there is heavy reliance on existing staff within the PHO to undertake health promotion which is unrealistic given that the high personal health care needs of the population take precedence. There seemed to be an understanding that staff such as nurses have already had health promotion training as part of their nursing

qualification and that health promotion was not seen as a specialised skill area by some. In the future health promotion may even be better placed as a totally separate service within the primary health care. It may also require a separate base away from the dominance of medical approaches that can hinder the effectiveness of health promotion activity. This aligns with Ashton and Seymour (1998) where they agree that health promotion needs to take place in settings and places of social context such as being based at a local school for example. A larger portion of resources will be required such as; funding and training in order for this to be achievable. In addition to mainstream health promotion concepts and practices Māori health promotion will require a specific skill set that takes into account adequate and culturally relevant health promotion training and qualifications as well as community based initiatives that will better meet the needs of the Māori population.

Training

Training opportunities were identified through the study and were well supported by the PHO. Hapai Te Hauora Tapui Ltd was identified as providing health promotion training and support to workers within the PHO. As well, participants identified the Health Promotion Forum of New Zealand, DHB and community based health promotion training which took place outside of the organisation. Participants identified these as great opportunities but raised issues about the reality of training accessibility due to staff shortages, heavy workloads and associated costs. Although training was seen as critical and the community based providers identified as credible and well experienced, some participants voiced concerns in that courses tended to be sporadic and ad-hoc undertaken within short timeframes with a focus on topical issues and framework components. This highlighted that staff within the PHO were at varying levels in their understanding and experience of health promotion. While some training was well suited for those with

previous health promotion knowledge and experience, others needed a more foundational level of education. Some participants raised the issue that although training was helpful, it did not make much of a difference considering the overriding priority health care issues that the practices were facing at the time.

While formal health promotion training has increased over the years there is still much work to be done. There are still a very limited number of institutions incorporating health promotion into current curriculum. Responsibility at other levels and sectors will be required such as the education sector for supporting such opportunities for health promotion workers to undertake formal health training and gain necessary qualifications through various institutions (Berghan, 2007; Ratima et al; 2006). Having more formal avenues and qualifications in health promotion may enhance health promotion by lifting the perception and increasing its acceptance by other health professionals and those in other sectors. Liaison with other sectors and support from providers to facilitate better set up of training institutes including community based venues will be critical. Developing the capacity and capability of a Māori health promotion workforce will be necessary in order to sustain it. However, having a well trained workforce will not make much of a difference until all the underlying priority issues are addressed that health promotion is currently faced with.

Supportive work environments

The majority of participants identified Waiora PHO as being unique in that it was small compared to others, that good relationships and collaborations were formed with other organisations and sectors and that they felt supported and valued in their work. This aligns with the Ottawa Charter (1986) 'creating supportive environments' which addresses the cultural values, social norms, physical surrounds, political and economic structures

that make up the workplace and community environments in which people live and work. This also meets the 'reorienting health services' guideline where there is a shared responsibility for health promotion. Others felt that everyone within the PHO was striving for the same goals and that the PHO provided an environment where Māori processes were valued at all levels. Non-Māori support for Māori processes was also reiterated and confirmed by non-Māori staff participants through the interviews. Flexibility, autonomy and support was seen a vital component in trialling and implementing Māori processes alongside Western models such as the valid use of kaumatua and kuia and the inclusion of whānau in consults and programmes. Participants identified that components such as these helped to build solid foundations and relationships and at the same time strengthened their Māori identity. Supportive work environments were seen as a key pre-requisite for Māori health promotion implementation.

Addressing the determinants of health

The broad number of social determinants that affect health are well documented (Health Promotion Forum of New Zealand, 2002; Smith & Jackson, 2006; WHO, 2008). The conditions where people live and work are known to affect their health and longevity and in New Zealand the primary causes of health inequalities are uneven distribution of, and access to, income, education, employment, health care and housing (Ministry of Health, 2002; Smith & Jackson, 2006).

Davies and Macdowell (2006) raise that social and environmental issues have an indirect influence on constituting risk with many poorer populations having much worse health than their affluent counterparts leading to differential access to health services, food and housing. Durie (1999) also alludes to risks being highest where poverty is greatest. Research participants consistently reiterated such views that in these circumstances it is

not unusual for health promotion to take a back seat to other pertinent issues that take priority. There is much recognition of the social determinants that effect health. The recent WHO (2008) commissioned report highlighted the need to address the social determinants of health. Whilst this seems like a huge undertaking, the report tasks different levels of society with responsibilities for taking action. The report outlines to government, political leaders, and policy makers to look at preventative options to the upstream causes of ill-health. At the grass roots level it tasks communities to be active in creating pressure to create an environment for policy change. It also calls upon a whole-of government approach concluding that determinants are intertwined in all sectors of society, therefore improving individual and community health will require a collective effort moving outside the sole responsibility of the health sector (Koelen & van den Ban, 2004; WHO, 1978; 1991; 2008).

Waiora PHO provides an integrated approach to health and has recently established links with other sectors such as the Ministry of Social Development-Work and Income New Zealand (WINZ). Whilst PHO inter-sectoral collaboration has so far been more opportunistic it has improved some of the pertinent issues that have impacted heavily on health such as lack of food, no electricity, phone or money. Internal collaboration within the PHO has enabled better staff relationships and a more efficient and effective referral process for patients. Whilst most participants agreed with Koelen & van den Ban (2004) in that collaboration is a necessary part of health promotion, others within the study felt that inter-sectoral approaches would take a long time to implement and buy in from other sectors would prove to be difficult. Naidoo and Willis (2000) suggest that an ideal inter-sectoral collaboration would entail small but effective steps such as active information sharing and dialogue with target populations. The Ottawa Charter supports inter-sectoral collaboration and there is agreement that it will be critical in order to effectively address

the social, economic, political and cultural determinants of health (Ratima, 2003; WHO, 1994). Whilst an effective inter-sectoral approach in the long term may work, in the short term collaboration at all levels of (government, ministries, community and whānau) will need to be addressed in order for health promotion at the provider and ground levels to be adequately catered for. Participants raised the urgent need to address the wider determinants of health in particular issues of poverty, access to affordable and appropriate housing, employment, and education. Issues such as limited money to buy healthy food needed to address diabetes and obesity, overcrowded housing or living in damp conditions affecting chronic disease and limited education opportunities leading to low paid, or, no, employment impact heavily on the health of Māori. It is only recently been accepted that health can be influenced by many factors or determinants. The Lalonde Report (1974) and WHO (1998a) recognise the two-fold focus that determinants can have of both being able to promote and also damage health. Participants within this research agree with Naidoo and Willis (2000) perception of the marginal impact medicine has compared to the equal distribution of health, income, housing, and employment. It is pertinent that issues such as these be recognised and addressed prior to implementing the contractual health and health promotion obligations as outlined by funders if health promotion is to be effective.

A framework for Māori health promotion

Health promotion practice across the PHO is currently being undertaken in a number of ways and at varying levels and is currently underpinned by models and frameworks that utilise both Māori-specific and Western derived components. Participants identified a number of framework components that were not evident in literature or accessed through training provided by the PHO or universities but rather emerged from frameworks used as a natural part of being Māori. These included; karakia, (prayers), kaumatua and kuia leadership, the process for whakawhānaungatanga (gathering together and getting to know

each other), te reo Māori (Māori language), waiata (songs or hymns), by Māori by Māori approaches, programmes taking place in Māori environments and utilizing Māori resources.

Although no one consistent framework was used across the PHO, the multiple approaches identified were varied, culturally appropriate, relevant to the population and were very well integrated. The role of kaumatua and kuia aligns with Te Pae Mahutonga model where leadership (ngā manukura) is identified as one of the key pre-requisites for Māori health promotion (Durie, 1999; Ministry of Health, 2003a). Kaumatua and kuia leadership is seen as vital by Wai-health staff and has been incorporated as a practice philosophy which is explicitly laid out in the entrance of the clinic. Pomare's five point plan (Durie, 1999) placed great respect with community leaders recognising community leadership as a key factor in health promotion creating links with the people and their environments (World Health Organisation, 1986).

Components of Te Whare Tapa Wha and Te Wheke frameworks were utilised by participants and held resonance for Māori patients and their whānau due to their holistic dimensions and interacting links. Māori are very familiar with these concepts knowing that if one dimension such as hinengaro (mental well-being) is not right it will affect all the other dimensions. Consistent with Te Whare Tapa Wha and Te Wheke models the impact of health or rather ill-health affects not only the individual and their whānau but how they interact with the environment. Participants commonly referred to impacts on the whole whānau and not just the individual in particular, in trying to obtain the most basic needs for their patients such as food and/or medical supplies. The Navigator model (Northwest Portland Area Indian Health Board, 2002) also commonly referred to in the findings utilises people that aid patients in the navigation of the health system. This is

still being explored within Wai-health but there are a number of people who currently undertake this as part of their existing role. According to the WHO (1986) choosing the right approach is important taking into account factors such as the nature of the problem, its determinants and the opportunities for action.

Health promotion is not a new phenomenon to Māori with health promotion practice stemming back pre-colonisation (Ratima, 2001). This is also evident within Māori communities today and highlighted through the findings where community participants took it upon themselves to contribute to the care of a fellow participant diagnosed with cancer. It was also evident with staff who would go outside of their role to provide additional means of support to patients utilising the concept of 'whānaungatanga' and 'manaakitanga'. Participants were empowered to undertake different roles and tasks in order to lessen the load on the others. These approaches are consistent with the ecological-social environmental approach identified by Naidoo and Willis (2000) where the community is in the centre of health promotion efforts. These approaches highlight the community as receiving benefits and also having control over providing benefits to others. Elements of the behaviour change approach were also evident within the PHO, where staff would provide programmes and/or activities relating to adopting a change in behaviour in order to improve their health. Health education was incorporated into consults as well as having separate group and individual sessions set up to varying degrees throughout the practices.

Although a full Māori health promotion framework is yet to be articulated and defined, as identified by Durie (1998a; 1998b) and Ratima (2001) common themes have emerged and include interconnectedness, Māori potential, Māori control, collectivity, and Māori identity. Many of these themes are currently evident across the PHO. Approaches used

confirm that Māori health promotion can incorporate both Western and Māori approaches and at times the two are used in unison. Māori health promotion frameworks need to take into account that Māori are not a homogenous group and that they are diverse in many ways. Therefore, no single approach or one size fits all theory will cater for all people. According to Davies and Macdowell (2006) a multi-level approach will have the greatest effect taking into consideration the relevance of different theories depending on the type and level of intervention or programme, the determinants of health as well as the community or population being served.

Kia Uruuru Mai a Hauora

The Kia Uruuru Mai a Hauora framework was well received and appeared very well suited to the PHO. Whilst the framework was not fully implemented, participants highlighted their strong acceptance for it to be used within the PHO in particular, as it was identified as being easy to understand and very relevant to the current working environment, different roles within the PHO and the community. Participants identified that the framework opened their eyes to the broad spectrum that Māori health promotion encompasses, creating in-depth detail of its characteristics signifying its critical importance and relevance to both their professional and personal lives.

Components were identified as sitting well with the PHO objectives and with Waioara's health promotion plan, as well as the goal to have a Māori-led framework. Kia Uruuru Mai a Hauora seemed to fit easily with all the frameworks identified and utilised by participants both Māori-specific and Western derived. It had the potential to fit with all elements of health including addressing the social, economical, cultural and political determinants of health. The framework not only addressed activity at a PHO level but also iwi, hapū and whānau as well as providing very clear connections for participants at an

individual level, relating to cultural identity, empowerment and capacity building. Kia Uruuru Mai a Hauora also provided a sense of validity to participants work with many highlighting it encompassed everything they felt, used and worked toward. Participants felt the work they did was understood and was clearly outlined within framework components alongside providing affirmation for who they were physically (in their role), personally (as Māori) and where they stood spiritually (taking into account past, present, and future implications and influences that impact on their work and their lives). If the framework were to be taken up by the PHO, it could also provide a means for an overarching co-ordinated, systematic and culturally appropriate approach to health promotion practice that would see long term benefits for both staff and patients, whilst providing a cost effective service that will produce significant health outcomes for Māori.

Limitations of the study

The scope of the study was restricted by a number of contextual influences such as time and resources of both the researcher and participants. Interviews were undertaken over a longer period than expected due to cancellations and re-scheduling of participants who were balancing high workloads and many family demands. Although the number and range of interviews undertaken was adequate, the researcher would have found it beneficial to interview the person in the public health specific role within the PHO. However, at the time of the research the key person was absent from the PHO. The researcher would have also liked to engage with patients and gain their perspective of health promotion if time and consent was possible. In writing up the study and drawing near completion the researcher realised a number of other avenues that would have been good to explore with participants in regard to their understanding of health promotion as it was assumed that all participants working within this environment would have a full understanding alongside training in the area. The final limitation was in regard to

undertaking the training in relation to the framework Kia Uruuru Mai a Hauora. It was not feasible to undertake training given the overwhelming work demands of staff and the time it would take away from meeting patient needs. Therefore in substitution at the focus group sessions the framework was presented to test its feasibility and was found to be useful.

Health promotion future research needs

The participants in this study have provided a snap shot of the realities of undertaking health promotion within a Māori primary health care setting. Participants provided critical information about their professional and personal worlds highlighting that for health workers who are Māori the two are not separate. To have a broader understanding in providing effective health promotion within a primary care setting it would be beneficial to contrast at least one other primary health care organisation. This would enable insight to see whether vast differences exist in areas such as funding, resources and workforce. It would also be useful to undertake similar research within a mainstream organisation that caters for a different population mix. This would then build a more comprehensive description of the influences and/or barriers surrounding the implementation of effective health promotion in general.

Implications of the study

The state of Māori health needs to be a public health priority. Māori have the worst health of all New Zealanders. There is huge potential for health promotion to be effective within primary health care and have long term benefits for Māori and all New Zealanders. Public health strategies aimed at reducing morbidity and mortality rates of Māori need to include appropriate programmes and services that incorporate adequate funding in order for health promotion to be of any serious benefit.

Understanding health promotion and building the health promotion workforce will be vital and will require sectors in particular, health and education to continue a co-ordinated collaborative approach in order to provide adequate training and qualifications for health workers. Associated institutions (academic, marae and community organisations) will be instrumental in the delivery of health promotion curriculum.

Inter-sectoral collaboration and a multi-level approach will be needed in order to address the wider social, cultural, political and economic determinants of health. All sectors and levels of society will need to take responsibility for providing appropriate and timely solutions that will reduce many of the underlying issues that impact on the health of all New Zealanders.

Conclusion

The study set out to answer the research question; what are the organisational pre-requisites required to fund, implement and sustain Māori health promotion within a primary health care setting. The major pre-requisites identified included; appropriate and adequate levels of funding, Māori-specific components of health promotion including processes that strengthen Māori identity, Māori leadership, accountability and responsibility, workforce training and development, supportive work environments and policies and strategies that address the broader social determinants of health. The main finding was that pre-requisites did not solely lie at an organisational level but needed to come through a variety of sources including; government, ministries, DHB's, providers, community, whānau, hapū and iwi. There were four main additional findings that emerged from the study.

Firstly, in order for the effective implementation of Māori health promotion to occur underlying priority issues that impact greatly on the health of a population need to be addressed at a number of levels by;

- provision of adequate and appropriate funding and resources for health promotion;
- strategic support for both formal and informal health promotion training and qualifications, undertaken within a number of environments (academic institutions, marae, providers);
- building up the health promotion workforce and in particular, the Māori health promotion workforce including support for Māori leadership at all levels of society (policy, DHB, community, whānau, hapū and iwi);
- recognising and acknowledging that Māori health promotion will need to rely on Western-based resources alongside Māori processes, Māori resources and tools;
- ensuring that community involvement occurs at all stages (identifying needs, input into processes, activity, provision of relevant and timely information, inclusion of their views and most importantly being accountable back to the community), through information sharing, input into policies and identification of community needs, processes and solutions; and,
- providing a supportive environment for both staff and patients that promotes, understands and provides clear direction in regard to health promotion using Māori processes and strengthening Māori identity.

By addressing these underlying priorities will enable facilitation of a suitable environment that is conducive to the provision of Māori health promotion which will in itself promote

specific long term advantages that impact not just physically on the health of one Māori individual but also holistically on Māori as a collective.

Secondly, health promotion in general needs to be made a New Zealand priority that is reflected at all levels of society including government, the Ministry of Health, DHBs, providers, community and whānau.

Thirdly, there needs to be recognition and responsibility from other sectors such as education and justice by way of an inter-sectoral approach to address the wider social, economic, political and cultural determinants intertwined in all sectors of society that impact on health.

Lastly, the incorporation of the framework Kia Uruuru Mai a Hauora was considered to be advantageous to primary health care and in particular Waioira PHO as it complemented the critical components that already exist alongside providing support for additional components deemed necessary as outlined in this study.

Overall; there is much scope for Māori health promotion within Waioira PHO. Māori health promotion that is recognised and acknowledged as a primary prevention strategy and that is adequately and appropriately supported and resourced will provide long term cost effective and sustainable health benefits.

These benefits will reduce the burden of disease, hold governments and ministries to account and provide better opportunities for providers in undertaking health promotion that is community identified, driven and supported. It will also aid in building the health promotion workforce whilst affecting significant change in the health status of Māori by addressing chronic conditions that are preventable and manageable. With adequate

support and clear direction through good strong leadership primary health care organisations including Waioira Healthcare PHO have huge potential to provide an effective co-ordinated approach to Māori health promotion that can be delivered professionally, appropriately and competently by skilled and experienced workers. This will ultimately lead to Māori health gains and positive Māori health outcomes.

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GLOSSARY OF TERMS

Aotearoa	New Zealand/Land of the long white cloud
Ariki	Chief
Hapū	Sub tribe or clan
Iwi	Tribe
Karakia	Prayer/incantation
Kaumatua	Elder/elderly man
Kohanga Reo	Māori language pre-school
Kuia	Elder/elderly woman
Kaupapa	Topic, discussion, plan or agenda
Kura kaupapa	Total immersion school
Manaakitanga	Hospitality/ kindness
Māori	Indigenous people of New Zealand
Noa	to be free from restriction/less restricted
Tangata whenua	People of the land
Tapu	Sacred, prohibited or protection
Te Pataka	Store house
Tohunga	Expert, skilled or chosen leader
Waiata	Song or him
Whānau	Family or kinship
Whakawhanaungatanga	Mentoring, sharing, coming together
Whare kohanga	Birthing house
Whare mate	House for the sick/dying
Whenua	Land

APPENDICES

APPENDIX A – ETHICAL APPROVAL

M E M O R A N D U M
Auckland University of Technology Ethics Committee (AUTEC)

To: John F Smith
From: **Madeline Banda** Executive Secretary, AUTEC
Date: 31 January 2008
Subject: Ethics Application Number 07/228 **Organisational prerequisites to fund, implement and sustain a Māori health promotion model in a primary care setting.**

Dear John

I am pleased to advise that the Auckland University of Technology Ethics Committee (AUTEC) approved your ethics application at their meeting on 21 January 2008. Your application is now approved for a period of three years until 21 January 2011.

AUTEC noted that it is not always possible to withdraw all information about a participant in a focus group and suggests that the researcher may wish to submit a revised Consent Form that is worded similarly to the one in the Consent Form exemplar on the Ethics Knowledge Base (accessible online via <http://www.aut.ac.nz/about/ethics>).

I advise that as part of the ethics approval process, you are required to submit to

AUTEC the following:

- A brief annual progress report using form EA2, which is available online through <http://www.aut.ac.nz/about/ethics>. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 21 January 2011;
- A brief report on the status of the project using form EA3, which is available online through <http://www.aut.ac.nz/about/ethics>. This report is to be submitted either when the approval expires on 21 January 2011 or on completion of the project, whichever comes sooner;

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are reminded that, as applicant, you are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

Please note that AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to make the arrangements necessary to obtain this.

When communicating with us about this application, we ask that you use the application number and study title to enable us to provide you with prompt service. Should you have any further enquiries regarding this matter, you are welcome to contact Charles Grinter, Ethics Coordinator, by email at charles.grinter@aut.ac.nz or by telephone on 921 9999 at extension 8860.

On behalf of the AUTEC and myself, I wish you success with your research and look forward to reading about it in your reports.

Yours sincerely



Madeline Banda
Executive Secretary
Auckland University of Technology Ethics Committee
Cc: Rachel Brown

APPENDIX B – INTERVIEW SCHEDULE

Health promotion interview schedule

Participant role

1. Brief description of role and what it entails

Health promotion and participants role

2. Does your current role involve any aspects of health promotion?
 - If so please describe what aspects of health promotion you are involved in.
3. Approximately what % of your weekly time would be spent on some of these aspects of health promotion?
4. In relation to your role are there particular barriers in regard to undertaking health promotion? If so what are they?

- if not do you feel health promotion should be a part of your role? Please explain

Health promotion and other staff

5. How does health promotion impact on other staff and their time in the area that you work in?
 - what are some of the barriers for other staff in regard to health promotion?
 - is there specific times allocated for the health promotion aspect of work?
 - is there specific training staff attend? Internal/external

Funding for health promotion

6. How does funding impact on the health promotion aspect of both your role and or other staff that you work with?
 - is there specific funding allocated for certain roles?
if so please explain?
7. Can you tell me anything about the contracting process for health promotion?
- 8 What is your view on the level and type of funding?

Health promotion programmes/services

9. What programmes/services are currently in place in your specific area of work?
 - PHO/Provider/Role
10. Where are the programmes/services delivered?
 - within the home/provider/community
11. Do you know what health promotion models are currently being used or underpin the service or programme?
12. How are these programmes determined?
 - a. by need
 - b. by funder
 - c. provider identified
13. How are the programmes/services evaluated?
 - documentation
14. What components of health promotion do you think work well?
15. What, if anything could be improved?
 - a. in PHO/provider/service or programme

Māori specific health promotion

16. Are there any specific Māori health promotion services/programmes currently being run in your area of work?
 - a. if so please explain
17. How are these funded?
 - a. Māori specific funding or general
18. Are there Māori staff involved in the services/programmes?
 - how many?

Participant views

19. In your opinion what is needed to provide optimal health promotion
 - a. in general?
 - b. For Māori

General

- c. numbers enrolled in the PHO/practice
- d. breakdown by ethnicity
- e. geographical area covered

APPENDIX C - KEY INFORMANT INFORMATION SHEET

Key informant Interviews



Pre-requisites to successful Māori health promotion

Date and version 17th December, 2007, Version 1

Invitation

You are invited to take part in this research study which explores organisational pre-requisites to successful Māori health promotion in a primary care setting.

What is the purpose of the study?

The purpose of the research is to use an evidence based Māori framework for health promotion in order to help the services make more of a difference to Māori health. The research will identify the organisational conditions that are necessary to put into action a Māori health promotion framework in these settings (e.g. type of workforce, level of funding). This project is intended to support the development of more effective Māori health promotion policies and services.

Who are the researchers?

Taupua Waiora, Centre for Māori Health Research, AUT University and Whakauae Research Services.

Researcher contact details:

Rachel Brown,
Research Officer
Tel. (09) 921 9999 ext 7237
rachel.brown@aut.ac.nz

Project Supervisors:

Dr Heather Gifford
Whakauae Research Services
Tel. (06) 347 6772 Tel.
h.gifford@massey.ac.nz

Assoc Prof John F Smith
AUT University
(09) 921 7753
jfsmith@aut.ac.nz

What happens in the study?

You will be asked to participate in an interview, either over the telephone or face to face at a location and time that suits you.

How are people chosen to be part of the study?

You are being asked to participate as we consider you to be an important source of information in regards to this research and we would value your contribution. You have been recommended by a member of our research team, advisory group, the community, a health provider and/or another stakeholder.

What will I be asked to do?

We will be asking for your views on a range of issues related to Māori health promotion in a primary care setting.

How long will it take?

We anticipate that the interviews will take up to and no more than one hour.

What are the benefits?

This research project will contribute to the evidence-base for planning and action to develop an effective Māori health promotion model to help services make more of a difference to Māori health as a whole.

How will my privacy be protected?

Only the researchers will have access to identifying data. Identifying data will not be included in reports and you will not be named.

If you take part in the study, you:

- Can refuse to answer any questions or stop at any time
- Can ask any questions you want about the study
- Can ask another person to be present at the interview
- Can request a copy of notes taken at the interview
- Will receive a summary of findings at the end of the project
- Will not be identified and your responses will remain confidential

Participant concerns

If you have any queries regarding your rights as a participant in this research study, you can contact an independent Health and Disability Advocate. This is a free service provided under the Health and Disability Commissioner Act: Telephone (NZ wide 0800 555 050) Fax (NZ wide 0800 2787 7678 or 0800 2 support) Email: advocacy@hdc.org.nz

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor Heather Gifford, h.gifford@clear.net.nz. or (06) 347 6772.

There is no obligation for you to take part in this study and you have the right to decline.

Approved by the AUTEK on 31st January, 2008. Reference number 07/228

APPENDIX D – KEY INFORMANT CONSENT FORM

Consent to participate in key informant interviews

Title of Project: **Organisational pre-requisites to successful Māori health promotion in a primary care setting.**

Project Supervisor: **Dr Heather Gifford**

Researcher: **Rachel Brown**

1. I have read and I understand the information sheet for taking part in the research which explores organisational pre-requisites to fund, implement, and sustain a Māori health promotion model in a primary care setting.
2. I have had the opportunity to discuss this research study and I am satisfied with the answers I have been given.
3. I understand that taking part in this interview is voluntary (my choice) and that I may withdraw from it at any time.
4. I understand that my participation is confidential and that no material that could identify me will be used in any reports regarding this research.
5. I know whom to contact if I have any questions about the research.

6. I agree to take part in this interview session

7. I would like the chance to view my interview transcript on completion yes no

Verbal consent given? yes no

Signature: _____

Name:.....
.....

Org and Role: _____

Date: _____

Date and version 17th December, 2007
Approved by the AUTEK on **31st January, 2008**. Reference number **07/228**

APPENDIX E – FOCUS GROUP INFORMATION SHEET

Focus group interviews

Implementing a Māori health promotion model into a primary care setting

Invitation

You are invited to take part in this research project which explores organisational pre-requisites to fund, implement, and sustain a Māori health promotion model in a primary care setting.

What is the purpose of the study?

The purpose of the research is to use evidence based Māori framework for health promotion in order to help the services make more of a difference to Māori health. The research will identify the organisational conditions that are necessary to put into action a Māori health promotion framework in these settings (e.g. type of workforce, level of funding). This project is intended to support the development of more effective Māori health promotion policies and services. Information from the focus groups will also contribute towards a Masters of Health Science by the researcher.

Who are the researchers?

Taupua Waiora, Centre for Māori Health Research, Auckland University of Technology and Whakauae Research Services.

Researcher contact details:

Rachel Brown,
Research Officer
Tel. (09) 921 9999 ext 7237
rachel.brown@aut.ac.nz

Dr Heather Gifford
Whakauae Research Services
Tel. (06) 347 6772 Tel.
h.gifford@massey.ac.nz

Project Supervisors:

Assoc Prof John F Smith
AUT University
(09) 921 7753
Jfsmith@aut.ac.nz

What happens in the study?

You will be asked to participate in a focus group interview along with others to share your views. The focus group will take place at a specific location near you. You will be contacted by one of our researchers two weeks prior and have the information explained to you and any questions answered. Focus groups will be audio taped and transcribed and your consent to take part will be obtained in writing.

How are people chosen to be part of the study?

You are being asked to participate as we consider you to be an important source of information in regards to this research and we would value your contribution. You have been recommended by a member of our research team, advisory group, the community, a health provider and/or another stakeholder.

What will I be asked to do?

We will be asking for your views on a range of issues related to sustaining an effective Māori health promotion model in a primary care setting.

How long will it take?

We anticipate that the focus group interviews will take up to and no more than one and a half hours.

What are the benefits?

This research project will contribute to the evidence-base for planning and action to develop an effective Māori health promotion model to help services make more of a difference to Māori health as a whole. A \$20 voucher will be given as koha in recognition of each participants' time and knowledge towards this project.

How will my privacy be protected?

Only the researchers will have access to identifying data. Identifying data will not be included in reports and you will not be named.

If you take part in the study, you:

- Can refuse to answer any questions or stop at any time
- Can ask any questions you want about the study
- Can request a copy of notes taken at the session
- Will receive a summary of findings at the end of the project
- Will not be identified and your responses will remain confidential

Participant concerns

If you have any queries regarding your rights as a participant in this research study, you can contact an independent Health and Disability Advocate. This is a free service provided under the Health and Disability Commissioner Act: **Telephone (NZ wide 0800 555 050) Fax (NZ wide 0800 2787 7678 or 0800 2 support) Email: advocacy@hdc.org.nz**.

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor **Heather Gifford**, h.gifford@massey.ac.nz, or (06) 347 6772.

There is no obligation for you to take part in this study and you have the right to decline.

Approved by the AUTEK on 31st January, 2008. Reference number 07/228

APPENDIX F – FOCUS GROUP CONSENT FORM

Consent to participate in focus group session

Title of Project: **Organisational pre-requisites to successful Māori health promotion in a primary care setting.**

Project Supervisor: **Dr Heather Gifford**

Researcher: **Rachel Brown**

I have read and understood the information provided about this research project

- I have had an opportunity to ask questions and to have them answered.
- I understand that the focus group session will be audio-taped and transcribed.
- I understand that taking part in this research is voluntary (my choice) and that I may withdraw at anytime.
- I understand that I may withdraw myself from this project at any time prior to completion of data collection, without being disadvantaged in any way.
- I agree to take part in this research.
- I wish to receive a copy of the report from the research: tick one: Yes No
- Verbal consent tick one: Yes No

Participant signature:

Participant name:

Participant contact details (if appropriate):

.....

Date:.....

Date and version 17th December, 2007

Approved by the AUTEK on **31st January, 2008**. Reference number **07/228**

**APPENDIX G – ADDITIONAL STAKEHOLDER INTERVIEW
INFORMATION SHEET**

Additional Stakeholder Interviews

Implementing a Māori health promotion model into a primary care setting

Invitation

You are invited to take part in this research project which explores organisational pre-requisites to fund, implement, and sustain a Māori health promotion model in a primary care setting.

What is the purpose of the study?

The purpose of the research is to use evidence based Māori framework for health promotion in order to help the services make more of a difference to Māori health. The research will identify the organisational conditions that are necessary to put into action a Māori health promotion framework in these settings (e.g. type of workforce, level of funding). This project is intended to support the development of more effective Māori health promotion policies and services. Information from these interviews will also be used to contribute towards a Masters of Health Science by the researcher.

Who are the researchers?

Taupua Waiora, Centre for Māori Health Research, Auckland University of Technology and Whakauae Research Services.

Researcher contact details:

Rachel Brown, Research Officer
AUT University
Tel. (09) 921 9999 ext 7237
rachel.brown@aut.ac.nz

Project Supervisors:

Dr Heather Gifford
Whakauae Research Services
Tel. (06) 347 6772
h.gifford@massey.ac.nz

Assoc Prof John F Smith
AUT University
Tel. (09) 921 7753
jfsmith@aut.ac.nz

What happens in the study?

You will be asked to participate in an interview, either over the telephone or face to face at a location and time that suits you.

How are people chosen to be part of the study?

You are being asked to participate as we consider you to be an important source of information in regards to this research and we would value your contribution. You have been recommended by a member of our research team, advisory group, the community, a health provider and/or another stakeholder.

What will I be asked to do?

We will be asking for your views on a range of issues related to sustaining an effective Māori health promotion model in a primary care setting.

How long will it take?

We anticipate that the interviews will take up to and no more than one hour.

What are the benefits?

This research project will contribute to the evidence-base for planning and action to develop an effective Māori health promotion model to help services make more of a difference to Māori health as a whole.

How will my privacy be protected?

Only the researchers will have access to identifying data. Identifying data will not be included in reports and you will not be named.

If you take part in the study, you:

- Can refuse to answer any questions or stop at any time
- Can ask any questions you want about the study
- Can ask another person to be present at the interview
- Can request a copy of notes taken at the interview
- Will receive a summary of findings at the end of the project
- Will not be identified and your responses will remain confidential

Participant concerns

If you have any queries regarding your rights as a participant in this research study, you can contact an independent Health and Disability Advocate. This is a free service provided under the Health and Disability Commissioner Act: Telephone (NZ wide 0800 555 050) Fax (NZ wide 0800 2787 7678 or 0800 2 support) Email: advocacy@hdc.org.nz).

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor Heather Gifford, h.gifford@massey.ac.nz, or (06) 347 6772.

There is no obligation for you to take part in this study and you have the right to decline.

Approved by the AUTEK on 31st January, 2008. Reference number 07/228

**APPENDIX H – ADDITIONAL STAKEHOLDER INTERVIEW
CONSENT FORM**

Consent to participate additional stakeholder interview

Title of Project: **Organisational pre-requisites to fund, implement, and sustain a Māori health promotion model in a primary care setting.**

Project Supervisors: **Dr Heather Gifford and John F Smith**

Researcher: **Rachel Brown**

I have read and understood the information sheet dated 17th December 2007.

- I have had an opportunity to ask questions and to have them answered.
- I understand and agree to interview information being used toward a Masters of Health Science which will be available to the public.
- I understand that the focus group session will be audio-taped and transcribed.
- I understand that taking part in this research is voluntary (my choice) and that I may withdraw at anytime.
- I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- I agree to take part in this research.
- I wish to receive a copy of the report from the research: tick one: Yes No
- Verbal consent tick one: Yes No

Participant signature:

Participant name:

Participant contact details (if appropriate):

Date:

Approved by the AUTECH on **31st January, 2008**. Reference number **07/228**