


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

A report prepared for Nga Pae o te Maramatanga



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model in a primary care setting.**

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MIHI

Me mihi ka tika ki ngā kaihautū o te kaupapa, koutou katoa i whai wā ki te tautoko i ngā mahi kia hua ai ēnei kitenga. Koinei te otinga atu o ngā mahi ā, ko tā tātou, hei tautoko hei whakatīnana kia whai mana a tātou tikanga. Hei whakakapinga ake kia tīkina atu ngā kōrero a o tātou tūpuna. 'E hara taku toa i te toa takitahi engari, he toa takitini.' Nō reira, e ngā mana, e ngā reo, rau rangatira mā, hau-nui hau-ora hau-pai-marire.

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LIST OF ABBREVIATIONS

CEO	Chief Executive Officer
DHB	District Health Board
DSM	Disease State Management
GP	General Practitioner
LCAF	Low cost access funding
PHO	Primary Health Organisation

EXECUTIVE SUMMARY

Health Promotion was traditionally delivered within a Public Health setting in New Zealand. With changes to Primary Care delivery, health promotion is increasingly delivered within the primary care setting due to national strategy changes aimed at improving health outcomes. Rather than dealing primarily with the individual in a treatment and support role, primary care is now also tasked with providing preventative and health promotion activities.

This research was focussed on what organisational pre-requisites are necessary for implementing and funding a Māori health promotion framework in a primary care setting. The Māori health promotion framework chosen for this research was 'Kia Uruuru Mai a Hauora'. Recommendations for implementing a Māori health promotion framework within mainstream and Māori contexts was also part of the research brief.

Within indigenous and Māori health promotion, common themes have been identified in the literature in regards to requirements of indigenous frameworks of health promotion delivery. These requirements are:

- Cultural context
- Importance of cultural identity
- Community context and collectivity
- Active community participation and partnerships
- Wider family/whānau involvement
- Broad holistic nature of indigenous concepts of health
- Importance of community/iwi networks
- Access to resources

The framework 'Kia Uruuru Mai a Hauora' (Ratima 2001) addresses these themes within the framework's boundaries and sets out a structure for the co-ordination of Māori health promotion activities.

Waiora Healthcare Primary Health Organisation (Waiora Healthcare PHO) was selected as the primary care setting in which to explore how to implement the framework because it has both mainstream and Māori services and straddles a wide population group as five practices serve the PHO. A number of interviews and two focus groups were carried out to gather information.

Given the nature of the local population that Waiora Healthcare PHO serves, the framework fit well into existing health promotion activities co-ordinated and run by the PHO and the philosophy and values of the practice with regard to Māori health and Māori health promotion more specifically. Waiora Healthcare PHO had invested in a strategic plan for health promotion and have committed to health promotion activities.

The framework provided a structure with which health promotion activities would be able to be co-ordinated and organised, providing transparency and accountability. The information provided by Waiora Healthcare PHO was crucial for identifying organisation pre-requisites, and identifying recommendations for aiding the implementation of a health promotion framework.

In the course of interviews and the focus groups several organisational pre-requisites were identified as being necessary for the implementation of a Māori health promotion framework.

The funding organisational prerequisites identified for funding a framework were:

- Adequacy of funding
- Flexibility of funding
- Health promotion priority
- Good communication

The organisational prerequisites identified for implementation of a framework were:

- Adequate contracts for effective health promotion
- Specialist workforce values
- Organisation support and leadership
- Workforce Development Requirements
- Key health promotion person or team
- A process for determining the communities key health priorities
- Access to adequate resources
- Appropriate message delivery requirements
- Health promotion marketing and advertising
- Importance of a multi-disciplinary team
- Developing networking and inter-agency protocols
- Health promotion evaluation development
- Development of feedback mechanisms

These interviews have also led to recommendations for the implementation of Māori practice models within mainstream and Māori primary care contexts. The recommendations set out in this report are primarily aimed at the primary care setting. However there were things that a funding DHB or the Ministry of Health could also do to help implement a health promotion framework with more ease. The main facilitators to this have been listed as recommendations under the headings 'Regional level' and 'National Level' respectively.

The local level recommendations were:

- Establish communication pathways with staff, funding DHB, other health organisations, intersectorally and with the community.
- Delivery services that are client whānau and community focussed.
- Have regular, clear feedback channels and opportunities for review and discussion.

- Have a clear contract strategy with experienced personnel, who also consult the staff delivering the services to make sure all needs are being met as effectively as possible.
- The contracts entered into should, where possible, fit with the practice philosophy.
- Have a workforce development and capacity strategy.
- Develop a clear implementation plan for a Health promotion framework.
- Monitoring and evaluation of the framework after implementation to ensure that the desired outcomes are achieved.
- Establish flexible service delivery development and be open to new ideas and technology.
- Establish the communities and PHO priorities for health promotion and align with regional and national priorities where possible.
- Development of outcomes measures in partnership with the community and funder.
- Develop Health Information Systems in line with National strategies.
- Establishing and maintaining network processes and protocols at the internal and external level.
- Develop interagency protocols, and referral pathways and contacts with other agencies to better support their clients where necessary
- Develop multi-disciplinary teams.
- One single model will not work for everybody, hence a framework that is workable will be broad in nature but still able to co-ordinate and plan services and delivery.
- Culturally appropriate delivery of services should be developed and consulted upon with the local community, this would include whānau involvement.
- Cultural policies for individual PHOs should be developed with protocols for delivery of services.
- Existing community resources should be utilised where possible such as local kaumatua and kuia.
- Health promotion marketing and advertising should be incorporated into any strategic planning.
- Implement a health promotion framework and document the barriers and facilitators to that process leading to a developed Māori health promotion model and pathway.
- Staff required:
 - Contract manager
 - Health promotion facilitator.
- Staff Development needs:
 - Health promotion training
 - Contract management training
 - Relationship management training.

The recommendations identified at the regional and national level included developing flexible funding mechanisms, developing flexible reporting structures, developing communication pathways, providing funding for advertising and marketing, and resources.

The research will aid in the optimal implementation of a Māori health promotion framework within a primary care setting. Using an existing health promotion framework that incorporates principles and values present in successful health promotion activities and is flexible to allow for many different responses and models is vital for the co-ordination and planning of health promotion within primary care. Organisation prerequisites that will aid in the success of implementation and funding and allow an organisation to capitalise on the strengths it contains are identified. The recommendations will solidify the success of implementing a Māori health promotion framework that achieves the desired health outcomes and works for the community the primary care organisation serves.

INTRODUCTION

This research was designed to take a Māori health promotion framework and explore how best to implement it in a case study site. The research was intended to identify what conditions are needed to develop and operationalise a Māori health promotion model.

There are wide disparities between the health status of Māori and non-Māori that are reflected in mortality and chronic disease rates (Baxter 2002; Ajwani, Blakely et al. 2003; Cormack, Ratima et al. 2005; Ministry of Social Development 2007). 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). Much of the ill health experienced by Māori is preventable.

Māori health promotion is the process of enabling Māori to increase control over the determinants of their health and strengthen their identity as Māori, thereby improving their health and engagement in society.

There is a critical role for Māori health promotion, which is derived from a Māori conceptual base and tailored to the specific concerns of Māori, in addressing these wide and longstanding disparities and improving Māori health outcomes. 'Kia Uruuru Mai a Hauora' was used as the Māori health promotion conceptual framework in this research project.

With the introduction of the Primary Health Care Strategy (Ministry of Health 2001), the New Zealand Government aimed to establish a primary health care structure that would provide comprehensive coordinated services to enrolled populations and reducing inequalities in health status.

This was to be achieved through the development of PHOs. Implicit in the strategy was a community development approach and an emphasis on intersectoral work at both the population and individual levels. A key feature of the Strategy was the requirement for primary health services to focus on improving the health of a population by undertaking health promotion.

This was a new dimension for many providers of primary care services, which had previously focussed mainly on clinical treatment and support of the individual. There have been challenges for both Māori and mainstream PHOs in attempting to implement population health strategies and health promotion within a primary care setting.

The research provided an opportunity to investigate the feasibility of implementing a Māori health promotion framework, and discuss what organisational pre-requisites are necessary for the implementation in primary care settings.

The research findings will contribute to Māori health promotion theoretical 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.

METHODOLOGY AND RESEARCH OBJECTIVES

Objectives of the research

1. To compare existing health promotion practice with the Māori health promotion model, 'Kia Uruuru Mai a Hauora'
2. Identify the organisational pre-requisites necessary to fund and implement a Māori health promotion framework in a primary health care setting.
3. To make recommendations for the implementation of Māori practice models within mainstream and Māori contexts to inform Māori policy and practice across sectors.

Theoretical framework

While there is not agreement as to the detail of a Māori inquiry paradigm, a number of themes have been identified in the Māori health research literature as providing an indication of the essential features of a Māori inquiry paradigm and can together be used as a theoretical framework for Māori health research projects (Ratima, 2003). Those themes are: interconnectedness, Māori potential, Māori control, collectivity, and Māori identity. Those themes provided the theoretical framework for this research project. It is the themes, rather than any particular methodologies, that led the Māori research approach used in this study.

Method

This project utilised multiple qualitative methodologies within the Māori-centred theoretical framework (Minichiello, Sullivan et al 2004; Health Research Council of New Zealand 2008). The research included a literature review, key informant interviews and focus group sessions with staff in a diverse range of roles across the PHO. The research project was carried out in three phases over a two-year period.

The sampling technique employed was 'purposeful sampling' (Minichiello, Sullivan et al 2004), interviewees were selected who were considered to be rich information sources with regard to Māori health promotion (Health Research Council of New Zealand 2008). The Advisory Group (see Appendix one) provided input into the development of the interview schedule and Waiora Healthcare PHO head office staff helped inform the selection of key informant interviewees.

In-depth semi-structured key informant interviews were undertaken in October 2007 (see Appendix two). Interview issues included health promotion training, framework funding and implementation questions (see also Appendix two). Data gathered through key informant interviews informed each of the research objectives.

Fifteen key informant interviews were conducted by the researcher with PHO staff covering the following positions: CEO, operations manager, practice nurses, administrator, health promoter, community support workers, nurses, Disease State Management (DSM) nurse, general practitioner (GP), practice managers, mental health support worker, team leader and clinical care coordinator. The data was collated using NVIVO then analysed by two researchers using thematic analysis (Richards 1999; Browne 2004).

Two focus groups were planned as part of this project incorporating a range of staff within the different practices within Waiora Healthcare PHO. Focus group sessions were held in February 2008. Participants were recruited via the PHO, using purposeful sampling based on perceived richness as a data source and coverage of a range of health promotion related fields.

The aim of the focus groups was to provide feedback based on the interviews back into the PHO and to look at the 'Kia Uruuru Mai a Hauora' framework in the context of current PHO operations.

Ethics approval was obtained from Northern X Regional Ethics Committee on 10th April 2007. The research was explained to all participants prior to interview or focus group, and informed consent was obtained using consent forms (see Appendix three) and information sheets (see Appendix 4).

HEALTH PROMOTION IN PRIMARY CARE SETTINGS

At a national level the Ministry of Health has released the strategic document the *New Zealand Health Strategy* (Ministry of Health 2000) that sets the overall direction of health services and delivery. The aim of this document is to reduce inequalities in health and improve overall health status of the population. The *Primary Health Care Strategy* sets out how this will happen in a primary health care setting (Ministry of Health 2001).

The Ministry of Health identified 13 population health objectives and eight key priority areas for Māori Health (Ministry of Health 2000), which would improve health outcomes for the general population and in particular Māori.

The population health objectives that were chosen were from areas where there was a significant burden of disease for New Zealand as a whole but also those that have the potential to reduce Māori health disparities (Ministry of Health 2000; Ministry of Health 2002a). They population health objectives are:

- Reducing smoking
- Improving nutrition
- Reducing obesity
- Increasing the level of physical activity
- Reducing the rate of suicides and suicide attempts
- Minimising harm caused by alcohol and illicit and other drug use to individuals and the community
- Reducing the incidence and impact of cancer
- Reducing the incidence and impact of cardiovascular disease
- Reducing the incidence and impact of diabetes
- Improving oral health
- Reducing violence in interpersonal relationships, families, schools and communities
- Improving the health status of people with severe mental illness
- Ensuring access to appropriate child healthcare services including well child, family healthcare and immunisation.

The eight Māori health-gain priority areas identified were:

- Immunisation
- Hearing
- Smoking cessation
- Diabetes
- Asthma
- Mental health
- Oral health
- Injury prevention

Health promotion aims to reduce the impact of the wider determinants of health, including those factors listed above, by changing behavioural patterns, addressing social circumstances and reducing the impact of environmental exposures (Ministry of Health 2001; Ministry of Health 2003b). The *Primary Health Care Strategy* (Ministry of Health 2001) included health promotion that was to be delivered in primary care settings.

Primary care is the first tier of health care in New Zealand. Its main focus traditionally is to improve the health of the individual, with comprehensive care delivered by doctors, nurses and associated staff (Wass 2000). The services delivered in primary care settings include community pharmacies, physiotherapy, dental health, family planning and sexual health (Ministry of Health 2001; Ministry of Health 2003b).

Traditionally health promotion has been delivered through public health systems where care is focused on collective action to improve the health of populations rather than treatment of the individual. This led to very separate developments of the two spheres – population health and primary health (Ministry of Health 2003b).

The *Primary Health Care Strategy* brought in a new direction for health services to work together to improve health outcomes (Ministry of Health 2001). Rather than a focus on the treatment and support of the individual, there was to be an increased focus on population health and a more preventative, health promotion approach within primary care settings.

This was a change in direction, a focus on the collective rather than only the individual. As part of this change new skills and approaches had to be developed in the Primary Care Sector, including the development of Primary Health Organisations (PHOs) that were established to deliver health services to their local populations (Ministry of Health 2003b).

PHOs are vehicles for the implementation of the *Primary Health Care Strategy* (Ministry of Health 2001). They endorse a comprehensive view of primary health care based on principles that include community participation and empowerment.

A community focus is increasingly emphasised in the primary sector and health more generally. Empowerment and community development are evident in many regional health reforms. Many of these changes incorporate community-centred health care approaches in their design and delivery of services (Frankish, Moulton et al 2000).

PHOs bring together GPs, 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.

PHOs vary widely in size and the structure is that of a non-profit organisation. The first PHOs were established in July 2002 and there are

now over 81 PHOs in New Zealand with six PHOs listed in the Waitemata DHB catchment (Ministry of Health 2009).

PHOs are charged with working to decrease health inequalities between groups and improve health outcomes of the population whilst re-orienting the sector towards a population health approach. Health promotion is seen as a key component of the population health approach to be used by PHOs to achieve these goals (Ministry of Health 2006a).

The Ministry of Health has identified seven principles of health promotion that are important in developing strategies and programmes that are successful (Ministry of Health 2003a). These principles are present in 'Kia Uruuru Mai a Hauora' framework (Ratima 2001) that is the focus of this research. The seven principles are:

- Address the wider determinants of health
- Base activities on the best available data and evidence
- Act to reduce inequalities in health
- Ensure active consumer and community participation
- Empower individuals
- Explicitly consider difference in gender and culture
- Facilitate intersectoral co-operation

PHOs get a set amount of funding from the government to subsidise a range of health services. The funding is based on the numbers and characteristics (for example: age, sex, and ethnicity) of people enrolled with the PHOs. The funding is for clinical care and treatment of people when they are ill as well as health promotion activities.

All PHOs receive additional funding for Health Promotion based on their enrolled local population, and are able to access other 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, including Māori.

Implementing health promotion strategies in primary care settings requires a degree of organisational support, which includes capacity building as defined in the "WHO Health Promotion Glossary". This includes development of knowledge, skills, structures, leadership, organisational commitment to enable effective health promotion. This requires actions at three levels, the training of practitioners, health promotion support and infrastructure within in the primary care organisation and the development of networks and partnerships within the community (Praire Region Health Promotion Research Centre 2004; Smith, Tang 2006).

MĀORI HEALTH

As a population group Māori have on average the poorest health status of any ethnic group in New Zealand (Ajwani, Blakely et al 2003; Ministry of Health 2002b; Ministry of Health 2006c).

Like other indigenous models of health, Māori models of health are largely holistic in nature and include a balance in physical health, and thoughts and feelings, spirituality and the extended family (Durie 2004). The most widely quoted Māori health model is Whare tapa wha, which describes the balance of te taha tinana (physical dimension), te taha wairua (spiritual dimension), te taha hinengaro (thought and feelings) and te taha whānau (family dimension) (Durie 1998).

There are other models such as Te Wheke (Pere 1991) and Te Pae Māhutonga (Durie 1999). The common thread within these models is their holistic nature, the wider family/community context as opposed to a focus on the individual, wider focus on broader determinants of health in broader social, political and economic spheres, environmental and ecological factors and the importance of culture. The development of Māori health models provides a working framework for a Māori specific approach.

MĀORI HEALTH PROMOTION

Māori health promotion will lead to health gains among Māori as well as facilitating the retention and strengthening of Māori identity. The ultimate purpose is the attainment of good health with an emphasis on the retention and strengthening of Māori identity as a foundation for the achievement of individual and collective Māori potential (Ministry of Health 2006b).

Māori health promotion origins can be traced back to customary Māori public health systems. Customary Māori public health systems were based upon concern for the collective and particular attention paid to the supernatural, social and environmental determinants of health (Ratima 2001).

Māori health promotion starts with Māori beliefs, values, preferences, needs and is securely rooted in Māori worldviews in which Māori values, beliefs, processes and preferences are implicit. Māori worldviews are not always clearly articulated but they have common themes of interconnectedness, Māori potential, self-determination, collectivity and Māori identity (Ratima 2001).

The Māori health promotion model Te Pae Mahutonga (Durie, 1999) conceptualises Māori health promotion in relation to facilitating healthy cultures, natural environments, lifestyles and participation in wider society. Māori health promotion can be defined as 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 in general (Durie 2000).

It is important to note that a Māori centred approach does not exclude the use of the range of contemporary methods and tools, but rather influences the ways in which they are applied in order to ensure that they are acceptable to Māori communities (Durie 1999; Ratima 2001).

Further, a Māori-centred approach requires the service to meet high quality standards in both technical and cultural terms, and therefore enables the provision of enhanced services for Māori clients (Ratima 2001).

Māori Health promotion is based on acknowledging people's circumstances and needs. For example health promotion is unlikely to succeed when people are more concerned with issues relating to poverty and surviving than their personal health (Cram, Smith 2003). Important factors in Māori Health promotion have been identified as including:

- Talking and learning from others including kuia and koroua
- Hearing information that is understandable
- Receiving follow up and support when accessing services or attempting to change behaviour (Ratima 2001).

Principles of Māori Health Promotion

The principles of health promotion identified within the Kia Uruuru Mai a Hauora framework (Ratima 2001) are:

- Holism
 - The past, present and future are interconnected and our actions today influence future generations. Māori health promotion is not only about health but also the other dimensions that are interrelated and connected to a person's wellbeing.
- Self determination
 - Deals with Māori asserting their right to have control over their own future in all domains including health utilising a 'for Māori by Māori' approach.
- Cultural integrity
 - Ensuring health promotion is culturally appropriate and that it affirms and strengthens Māori identity as well as reinforcing cultural values and practices.
- Diversity
 - Māori are not a homogenous group, though there are a number of commonalities, Māori live in diverse socio-economic and cultural realities.
- Sustainability
 - Solutions need to be robust and long-lasting and should not be based on short term solutions. It is not only about what is happening today but what happens in the future as well. Funding timeframes need to allow for planning and it is preferable for consistency between governments.
- Quality
 - Māori health promotion needs to meet high technical and cultural standards. The messages need to be consistent and be informed by accurate and relevant quality information. Though it is recognised that evaluation for health promotion programmes incorporates many forms and is often an amalgamation of different types of evaluation (Tang, Ehsani et al 2003).

Processes of Māori Health Promotion

The processes by which Māori health promotion is achieved as identified within the 'Kia Uruuru Mai a Hauora' framework (Ratima 2001) are:

- Empowerment
 - The process of enabling Māori to increase control over the determinants of health. A system should strengthen an individual's identity as Māori and improve their health and position in society. The focus is on the individual and the wider whānau/iwi/community.
- Mediation
 - There needs to be processes for facilitating intrasectoralism and intersectoralism. Intrasectoralism is the co-ordination of approaches at all levels within the health sector. Co-ordination between stakeholders is promoted encouraging an integrated approach between health services within

communities. Intersectoralism recognises key determinants of health also lie outside the immediate influence of the health sector and there is a role within Māori health promotion across sectors.

- Connectedness
 - Locating health within the broader context of Māori development, whānau focused services, strengthening of whānau relationships and use of iwi and Māori community networks.
- Advocacy
 - There needs to be a process for lobbying for public, political and other stakeholder commitment to the goals of Māori health promotion.
- Capacity building
 - Increasing Māori community capacity will be necessary to enable communities to lead their own health development, and enhance community ability to capitalise on benefits from interventions.
- Relevance
 - Māori health promotion interventions should be appropriate to Māori realities. They need to be accessible and address Māori priorities that Māori have identified.
- Resourcing
 - Māori are often marginalised in social, cultural, economical and political terms. Additional development of resources is required to achieve realistic, equitable health outcomes. There needs to be recognition of the range of resources required in order to deliver messages effectively.
- Cultural responsiveness
 - Health promotion interventions need to be culturally competent and consistent with Māori beliefs, values and practices.

INDIGENOUS HEALTH PROMOTION

In order for indigenous public policy to be effective, it needs to reflect, accept, acknowledge and accommodate indigenous people. For this to take place meaningfully, the policies need to be flexible, accessible and responsible to indigenous culture. To achieve this requires communication and for indigenous people to be actively involved in the design and implementation of policy to increase community ownership of the policy (Australian Indigenous Health Promotion Network 2006). Elements that are perceived as essential in an indigenous health promotion framework (Australian Indigenous Health Promotion Network 2006) are:

- Community ownership and leadership
- Empowerment
- Consultation
- Partnerships

Indigenous health promotion involves more than merely making a mainstream health promotion model culturally acceptable. An indigenous health promotion lens needs to focus on more than just the behaviour of individuals but to look at the wider context within which the behaviour is occurring and to look at the strengths within communities to solve these problems themselves. These strengths include the wider family network, community commitment, community organisations and community events (Brough, Bond et al 2004).

In Australia the principles for Aboriginal Health Promotion have been declared (NSW Department of Health 2004) as:

- Acknowledge Aboriginal Cultural Influences and the context of the communities
- Health Promotion practice should be based on the best available evidence
- Build the capacities of the communities, government, organisations and workforce ensuring equitable, flexible resource allocations
- There should be ongoing community involvement and consultation
- There should be a practical application of Aboriginal self-determination principles
- Aboriginal health promotion should adhere to the holistic nature of aboriginal health concepts
- Effective partnerships with communities should be established

Indigenous models of health promotion intrinsically link health to indigenous world-views and indigenous development (Durie 2004). Marginalised people are less likely to participate in programmes unless actively involved in the design and implementation of programmes and actively supported in their involvement (Laverack, Labonte 2000).

Local, culturally appropriate interventions and preventions are essential to improving health status in aboriginal communities. Programmes need to

be holistic, culturally appropriate, use western and traditional methods, in a familiar environment, use believable community methods, promote traditional activities, address underlying social issues, recognition of history, realistic timeframe and understand community restraints (Ministry of Health 2003) . The 'Kia Uruuru Mai a Hauora' framework (Ratima 2001) incorporates these values within the framework's structure.

THE FRAMEWORK – KIA URUURU MAI A HAUORA

The Māori health promotion framework ‘Kia Uruuru Mai a Hauora’ was developed by Dr Mihi Ratima, as the product of her doctoral research programme (Ratima 2001), and in response to the relative dearth of empirically and theoretically sound work to conceptualise Māori health promotion.

A Māori health promotion framework enables shared meanings to develop and results in enhanced communication. A framework will guide practice and facilitates both transparency and accountability. It also provides a basis of justifying actions. Māori health promotion is less about adapting practice to the preferences of Māori in order to avoid offending Māori cultural sensibilities but about building a Māori foundation from which to deliver an effective message (Ratima 2001).

The term ‘framework’ has been applied and used in regard to Kia Uruuru Mai a Hauora until it has been applied and validated in practice and research. A framework has a less precise meaning as an organising structure than a model. It is used to organise elements and constructs which are integral to health promotion so that their relationships are explicit. A model is grounded in theory and empirical knowledge, and is intended to inform practice (Ratima 2001)

Theoretical Foundation

Theories of health enable identification and prioritisation of issues to be addressed. Sound theoretical grounding provides a basis for common understandings and consistent approaches and aids in clarity and credibility (Ratima 2001).

Māori health promotion utilises concepts such as manaakitanga (caring for one another) and whānaungatanga (kinship or connection) rather than high-level academic theories. Māori health models such as Te Whare Tapa Wha and Te Pae Mahutonga are steps towards the development of a macro-theory (setting boundaries as to what or is not legitimate Māori health promotion action) (Ratima 2001).

Theories of Māori health promotion draw from mainstream health promotion, and other disciplines, utilising Māori and western sources together. The theories are often ideologically motivated and challenge existing structures. Values identified as important in this framework include: Māori identity, collective autonomy (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 and equity.

In implementing Kia Uruuru Mai a Hauora several strategies are suggested (Ratima 2001). These are expanded on below:

Reorienting health systems and services towards cultural and health promotion criteria

Services need to meet high technical and cultural standards. Priority must be placed on the disproportionate ill health of Māori that is largely a reflection of preventable/manageable conditions. Māori often under-utilise health care services and/or do not have access to health care services relative to their high need and this must be taken into account.

Emphasis should be aimed toward health promotion, primary health care and disease prevention rather than tertiary care. Health systems must be responsive to Māori needs and appropriate services provided. This requires collaboration between all health sector stakeholders and a shift in the culture of the health sector.

Increasing Māori participation

Māori do not participate to the same extent in society as other New Zealanders in some crucial areas, though gains have been made in recent years.

In 2006/07 20.3 percent of Māori aged 15 years and older were in tertiary education, as opposed to the national figure for the population as a whole of 13.7 percent. The proportion of Māori students moving directly onto higher-level study was 25 percent compared to 18 percent for the total population (Ministry of Education 2007). These positive gains are tempered by statistics such as the highest suspension rates are held by Māori (Ministry of Education 2007)

Increasing Māori participation and engagement in health services and health promotion will be important in improving health outcomes for Māori as they will be more likely to hear and act upon the messages depending on how they are delivered (Ratima 2001).

Iwi and Māori capacity building

Memberships of iwi are based on genealogical criteria. Membership to Māori communities is less clearly defined but is generally task-centred with the basis of being of Māori ethnicity. Building capacity occurs at two levels – individual and collective level. At the individual level skills are developed through information provision, education and enhanced life skills. At the collective level a structural change is required that is conducive to creating contexts in which iwi and Māori community groups are better able to achieve their potential. It is important to take a developmental approach whereby iwi and Māori communities are better positioned to lead and benefit from health promotion and to sustain those benefits.

Culturally affirming health and public policy

There is a need for public policies that promote health and are also conducive to supporting a secure Māori identity. It requires policy makers to be cognisant of and accountable for health outcomes and cultural implications of their policies for Māori when developing policy.

Intra sectoral and intersectoral measures to address determinants of health

Given the broad holistic nature of Māori health, there needs to be co-ordination within and between sectors to deal with social, cultural, economic and political determinants of health. Stakeholders must be engaged in all sectors and co-operation and co-ordination within the health sector should be encouraged.

Effective, efficient and relevant resourcing of Māori health

There needs to be increased access to resources, and actions that address all health determinants. Priority should be given to health and resources being allocated across sectors with a broad holistic health focus towards Māori needs. Resourcing in this context includes:

- Financial
- Access to Māori resources
- Environmental protection – land and wider environment
- Maintaining community credibility
- Gaining support of local iwi.

The Kia Uruuru Mai a Hauora framework is summarised and set out below in Table 1.

Table 1 Kia Uruuru Mai a Hauora framework

Characteristics	Māori health promotion
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.
Concept of health	A balance between interacting spiritual, mental, social, and physical dimensions.
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.
Paradigm	Māori worldviews
Theoretical base	Implicit
Values	Māori identity, collective autonomy, social justice, equity
Principles	Holism, self-determination, cultural integrity, diversity, sustainability, quality
Processes	Empowerment, mediation, connectedness, advocacy, capacity-building, relevance, resourcing, cultural responsiveness
Strategies	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	Secure Māori identity, health status (positive and negative), health determinants, strengthening Māori collectives

WAIORA HEALTHCARE PRIMARY HEALTH ORGANISATION

Background

Waiora Healthcare Trust was originally formed as a PHO through incorporation as a Charitable Trust in March 2003. It has gone through some changes since inception and currently incorporates five practices with the additions of Rathgar Medical Centre and McLaren Medical Centre in 2007. It is a part of the Waitemata DHB catchment area. Within the catchment area Waitemata DHB has 6 established PHOs, including Waiora Healthcare PHO (Ministry of Health 2009).

The five practices comprising the Waiora Healthcare PHO are:

- Waitakere Union Health Centre
- Wai Health
- The Doctors New Lynn
- Rathgar Medical Centre
- McLaren Medical Centre

Waiora Healthcare PHO works within the population of Waitakere City. Within this area there are 12.7% Māori, 12.2% Pacific people, 9.8% Asian, 59.1% European and 5.2% classified as other. This is only a segment of the Waitemata DHB catchment area where overall there are 9.2% Māori, 6.2% Pacific people, 9.4% Asian, 69.8% European and 5.3% classified as other (Waitemata DHB 2004).

West Auckland is classed as having the youngest population in Waitemata, which reflects high Māori and Pacific populations. Waitakere City has the lowest life expectancy in Waitemata with higher percentages of people on income support, lower income levels, and higher percentages for people without cars and phones and lower education levels that the rest of the DHB district (Waitemata DHB 2004).

As at 31st of August 2008 Waiora Healthcare PHO had 22853 enrolled patients spread across five practices. Of the total PHO population 33% are Māori, 15% Pacific Island and 11% are classed as non-Māori Pacific. Table 2 shows patient breakdown by ethnicity and table 3 highlights ethnicity breakdown by each practice (Waitemata DHB 2004)

Each practice at Waiora Healthcare PHO undertakes health promotion differently inline with its own community and resources for example health promotion at the Waitakere Union Health Centre and the Doctors New Lynn mainly occurs on a one to one consultation type basis by nurses and/or doctors in regards to specific health activity such as cervical smears and diabetes.

Participants interviewed for this research explained that they refer patients to Wai-Health for a number of health promotion related programmes and services. Table 3 identifies Wai Health practice as having the largest Māori and Pacific Island enrolled population across the practices in the PHO.

Participants interviewed across the practices noted that being in a smaller PHO environment was great for networking, being able to refer patients to alternative services in other practices and knowing staff expertise in specific areas including cultural needs.

Table 2 Breakdown of ethnicity across PHO

Waiora Healthcare PHO Population Breakdown	
Ethnicity	Numbers
Māori	6448
Pacific	4058
Other Dep 5	2899
LCAF	13405
Non LCAF	9448
Total	22853

NB: LCAF stands for Low Cost Access Formula, which is the total patients that qualify as “high need” (Māori, Pacific Island and Dep 5) for funding purposes, including health promotion

Table 3 Ethnicity breakdown by practice

Practice	Māori	Pacific	Other Dep 5	LCAF	Non LCAF
McLaren Park	322	751	559	1632	1067
Rathgar Medical Centre	102	141	209	452	576
The Doctors New Lynn	915	1301	1161	3377	4133
Wai-Health	3837	450	451	4738	1267
Waitakere Union	1272	1415	519	3206	2405

Funding

All PHOs receive additional funding for Health Promotion programmes, and are able to access Services to Improve Access 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 (Hefford Crampton et al 2005).

A low cost access payment for PHOs and practices that charge low fees to patients was introduced on 1 October 2006. The very low cost access payment was introduced as a way to support, encourage, and reward PHOs and their practices as recognition that in order to deliver on low cost access to primary health care and reduce health inequalities, many have forgone revenue from patient fees (Hefford Crampton et al 2005). This is utilised by Waiora Healthcare PHO.

PHO Targeted Services

Waiora Healthcare PHO have a number of services directed at improving the health of Māori, Pacific Island people, and other high needs groups within the Waitakere City area. These include access to Care Plus funding, dietician, diabetes and podiatry, nursing, family/whānau support, immunisation and health promotion services.

- Care Plus is provided to patients that have chronic health problems such as Diabetes, Asthma, and respiratory conditions.
- Dietician
 - A clinical nutrition/dietician support service is based in each of the member clinics and is designed to provide dietary advice and support to chronic disease clients or those at risk of developing/exacerbating chronic disease conditions.
- Free Diabetes Checks
 - Waiora Healthcare PHO provides a free yearly check up to help improve and monitor patients' conditions.
- Podiatry Service
 - The podiatry service is aimed at improving lower limb status of all enrolled patients with diabetes and other chronic conditions, with particular emphasis on high need patients. The service also aims to provide preventative measures when necessary, provide podiatric management as appropriate and develop self-management strategies by encouraging independence with foot care.
- Nursing Outreach
 - Waiora Healthcare PHO provides nursing home visits for enrolled patients, referred by the GP. Tasks include: provision of health education, nursing, assessment in the home, and palliative care.
- Family / Whānau Support Services
 - This service provides education on health and child development issues including; parenting skills, identification of "high needs" families / whānau, planning and implementation of appropriate strategies together with the "high needs at risk" families/whānau, and referral to appropriate agencies if necessary
- Outreach Immunisation Service
 - Identification and immunisation of children so as to ensure that Māori, Pacific and other priority groups have access to a service that enables informed decision-making, and also offers flexible delivery of services.
- Health Promotion
 - Health promotion prioritisation areas; and planning and developing a strategic approach to better health outcomes for Waiora Healthcare PHO's enrolled population.

CURRENT PRACTICE WITHIN WAIORA HEALTHCARE PHO

Māori Focus

Although the PHO as a whole did not subscribe to one particular model it was not uncommon for different streams and practices within the PHO to utilise components from a range of models that best fit with their practice, role and target client group. Common Māori models of health identified by participants were Mason Durie's Te Whare Tapa Wha model (Durie 1998) and Rose Pere's Te Wheke model (Pere 1991).

It's just you know if you can get a good grasp of it, then it's a lot easier to put it out there and the majority of the whānau recognise and understand Te Whare Tapa Wha (Key informant 15)

Other models were identified that incorporated elements of whakawhānaungatanga and whakapapa, as well as frameworks containing tikanga-based components.

Some participants went further to discuss these components and how whānau themselves were implementing them within their own communities.

Alternative models were also mentioned that stemmed from international ideas, for example the 'navigator model', which is currently being implemented into various organisations within New Zealand (Van Wallegghem, MacDonald et al 2008). This involves a support person who accompanies the patient to appointments and is of general emotional support as well as acting as an advocate if that becomes necessary.

We have somebody who has been with the programme for a while now, all of those people in the Waikaukau 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 you know looking after them, taking kai, making sure that they're comfortable, taking them out for walks. That to me is health promotion (Key informant 16)

An existing framework that was consistently referred to from a number of staff participants was the importance of traditional kaumatua and kuia roles. Staff identified the appropriateness and relevance of utilising kaumatua and kuia at all different levels and capacities within the PHO and in particular within the practice of Wai-Health.

Community response to this model implemented at Wai-Health has been effective specifically in dealing with both cultural and difficult whānau issues. The framework 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 both individual direct roles and part of collective group roles from kohanga to ministry and government level.

Participants indicated that kaumatua and kuia associated with Wai-Health has been most valuable for staff at all levels for providing cultural advice, expertise on specific issues, a well grounded knowledge-base of the area and population as well as guidance in relation to working in the current environment. Participants also stated that some people do not fully appreciate the importance their role can have.

A lot of our young workers don't seek guidance from kaumatua or kuia. Now you have got one sitting right there, they don't know how valuable she is. You know today they have learnt the information, have got that knowledge. They lose sight of the things Māori and she is right there and a lot of our young people today don't take that on board (Key informant 29)

The focus group supported the importance of having a Māori model and reiterated that different teams utilised models differently depending on client needs. A range of models were identified, Te Whare Tapa Wha (Durie 1998) and Te Pae Mahutonga (Durie 1999), and it was noted that clinicians emphasized how the appropriate model to use often differed from client to client and individual health needs. The lack of a co-ordinated model which everyone can use and reference can be problematic. The framework 'Kia Uruuru Mai a Hauora' (Ratima 2001) proposes a framework that enables a collation of concepts from a number of popular models for Māori health into a health promotion framework.

Current health promotion within the PHO

Waioara Healthcare PHO had incorporated *Health Promotion Plan 2005 – 2006* (Waioara Healthcare Trust PHO 2005), which provides a strategy and direction for achieving the PHO community health objectives whilst identifying priority areas and a framework for community interventions. Waioara Healthcare PHO supports initiatives targeting community organisations, community action and community development approaches. All the practices across the PHO undertook health promotion initiatives in various forms and degrees at different levels.

Health promotion activity occurred in the form of both one to one consultations and set group sessions for example set physical activity programmes. Health promotion activity within the PHO was not restricted to being held at the individual practices but occurred within the

community at community centres, aquatic centres, park and recreational facilities, as well being implemented within the home environment.

The majority of services and programmes were contracted to Wai-Health, which is the largest practice within Waiora Healthcare PHO and has the largest population base associated with it. Wai-Health has a large population base of Māori patients therefore many of the programmes and services are set up to target, but are not restricted to, Māori.

At the time this research was undertaken a new initiative was being implemented across the PHO involving GPs and nurses. Breakfast meetings that were specifically set up to facilitate discussion and action regarding health promotion in a wider context were planned. This would involve looking outside the current health promotion activity within the practices that mainly focused on immunisation and screening.

Waiora Healthcare PHO runs a free diabetes self-management course, which incorporates elements of health promotion. 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 principals 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 turned into a Pacific Island and a Māori manual.

Participants were consistent in talking about the clinic open days and mobile clinics that the PHO organise. They are popular with the community and are usually full. The clinic is open and provides free health checks such as eye and hearing tests, diabetes checks, blood pressure checks as well as providing information about practice-based services.

Health promotion/health expo event days are also popular with the community. Services under the PHO are promoted in ways that engage different groups of people such as attracting younger people by utilising the promotion of healthcare messages alongside celebrity appearances and music.

Time constraints

Issues concerning time constraints in regards to health promotion practice were raised. Clinicians noted that health promotion was critical for patient wellbeing, although concerns were expressed in regards to incorporating that within the consultation time period.

When you think of the standard consultation, you are supposed to do four things in every consult... treat the presenting complaint, treat the long term problems, do a bit of health promotion and change what we call health seeking behaviour. This is to either encourage them to

either come in earlier or not to come in at all and to know/understand their problems better, so we are supposed to do that at every patient contact (Key Informant 28).

Priorities are then set and usually the health promotion part of the consult is left to the nurse or left out altogether as the presenting problem takes up the most time.

I think the main barrier is time and that is because of the cost perhaps. It would be great if we could have more nurses and more doctors and you could spend more time with people who do come in, we could be a little bit more proactive and get out into the community. We just can't afford it in either time or money (Key Informant 28).

The focus group reiterated the time constraints that existed, and the need to be opportunistic with the time available. This had led to new initiatives such as the nurse-led clinics, and also doubling up on consults so that when people were coming in for other needs the appointments were co-ordinated.

ACCEPTANCE OF THE MODEL

Participants were in agreement with the presented framework. The framework fit with the Māori Health action plan that Waiora Healthcare PHO was currently utilising and the general practice at Waiora Healthcare PHO.

Participants stated that Māori identity is important and often part of a client's problem is that they have lost their identity, so a framework that affirms Māori was seen as a positive step.

'Being Māori' has different meanings and implications for people and it was identified that any framework had to be supportive of this. There is a diversity of experience and this has to be taken into account for any framework to be successfully implemented.

Participants noted that to some, 'being Māori' is being able to speak te reo Māori and knowing your whakapapa, to others it may be something else. Māori identity and the importance of that to people was seen as crucial in a framework, but where people fell on that spectrum was seen as less important in order that the model was inclusive of all Māori.

Participants were in consensus that the fact that they choose to work for Wai-Health demonstrates their commitment to Māori and their community. There was also consensus that results are achieved through a Māori way of doing things, for instance taking the time to build a relationship, and identify client needs and priorities rather than a single focus on disease management. Working alongside kaumatua and kuia, understanding the individual client, as well as their role within their whānau was important in effecting lasting change.

Participants indicated that they were well aware of a number of health promotion frameworks that currently exist and were being used within the wider health arena.

There was a strong preference from some participants to use a framework that guided 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 and used 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 its... a

strong set of guidelines about what to do and what not to do and its kind of proven its worth (Key informant 27).

Participants stated that in order for health promotion to be effective it needs to have an integrated approach incorporating different models, cultural aspects as well as different roles and experiences of those at the interface of health promotion. Some participants identified that health promotion needs to incorporate both mainstream and Māori specific components.

I think the integrated health model, the public health model that we use, is a whānau based model, it's about we know you, we probably know your uncles and aunties, and we're interested in how they are and you and we're interested in how the rest of your whānau is working and how can we get in there and help support that (Key informant 17).

You have to tailor the programme and you do as best as you can, I am constantly learning all the time from my clients. Some people would prefer one on one self-management course or other people would prefer to do a marae situation. It really depends to be honest on the actual way that the education is pitched to them. So that's something that we have been looking at in the last two years (Key informant 47).

Whilst a number of participants agree on an integrated approach others believe that a Māori-specific approach is needed in order for better uptake of Māori health promotion. Māori specific components that were important included Māori staff dealing with Māori whānau, speaking te reo Māori, utilizing te ao Māori (the Māori world) such as people, stories, tools and resources.

Good Māori health promotion models come from a different perspective. Good Māori health promotion models come from the perspective of trying to protect whakapapa (Key informant 17)

The 'Kia Uruuru Mai a Hauora' framework (Ratima 2001) was further developed in order to fit the practice within the organisation by the organisation. This is set out below in Table 4:

Table 4 Organisational Ownership of the Model in Practice

Concept	<p>The process of enabling Māori to increase control over the determinants of health and strengthen their identity as Māori, thereby improving their health and position in society.</p> <p>Waiora Healthcare PHO recognises the need to address wider issues as well as health such as the need for food, power, housing, and education.</p> <p>Staff working at Waiora Healthcare PHO work in a ‘for Māori, by Māori’ environment and in the community.</p>
Concept of Health	<p>A balance between interacting spiritual, mental, social and physical dimensions, based on a Māori worldview.</p> <p>Waiora Healthcare PHO utilise Māori models of health including:</p> <ul style="list-style-type: none"> • Te whare tapa wha • Te pae mahutonga • Whānau ora and whakapapa based frameworks • Tikanga, whānaungatanga and wairua processes
Purpose	<p>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.</p> <p>At Waiora Healthcare PHO there is a focus on improving health for Māori through Māori ways (Māori staff, kaumatua and kuia, whānau involvement in consults, programmes and health education). A priority is placed on reinforcing identity and valuing Māori values and beliefs.</p>
Values and Principles	<p>Māori identity (including diversity), collective autonomy, just and equitable, cultural integrity, sustainability, quality</p> <p>Waiora Healthcare PHO recognises and supports the rights of Māori to resources, and places emphasis on the separate needs of Māori, treaty obligations and rights.</p> <p>Waiora Healthcare PHO staff work outside of their roles and responsibilities to ensure quality.</p>
Processes	<p>Empowerment, mediation, connectedness, advocacy, capacity-building, relevance, resourcing, cultural responsiveness</p> <p>Waiora Healthcare PHO staff work to provide choices for whānau, work well as a team and work to build up communities and networks as well as advocating on behalf of Māori.</p>
Strategies	<p>Reorienting health systems and services towards cultural and health promotion criteria</p> <p>Waiora Healthcare PHO is a Māori provider environment, and recognise the need for Māori workforce development. Secondary health services aligned with Waipareira (optometry, podiatry); one stop shop at Wai-health with other services – addictions, mental health, community health, clinic etc; there is support for outside initiatives such as kohanga glue ear campaign; first referral access to Remuera clinic with a 6wk wait compared to public system 3mth wait.</p> <p>Waiora Healthcare PHO changing programmes and services to cater other scenarios such as currently changing programmes for dads as well as mums as more fathers become involved.</p> <p>Increasing Māori participation in New Zealand society</p> <p>Waiora Healthcare PHO has found small changes through health education has led to big changes in whānau, hapu, iwi, (no smoking on marae, change of food, offering different health programmes), glue ear campaign through the kohanga helps children</p>

	<p>learn better at school.</p> <p>Iwi and Māori community capacity-building</p> <p>At Waiora Healthcare PHO there are more Māori clinicians, developing skills and taking back to iwi, health promotion is a priority. There is no restriction on hours.</p> <p>Waiora Healthcare PHO has found increasingly more Māori make the choice to work for their iwi and take skills back.</p> <p>Waiora Healthcare PHO does recognise limits on what they can provide. There is also a need for more male health workers/providers that they acknowledge.</p> <p>Healthy and culturally affirming public policy</p> <p>Waiora Healthcare PHO recognises a need for resources in te reo, there is acknowledgement of the use of traditional healing methods and medicines.</p> <p>Waiora Healthcare PHO actively promotes changing food at school tuck shops, kohanga and marae, more physical activity through different programmes – school, health service and home environment.</p> <p>Intra- and inter-sectoral measures to address determinants of health</p> <p>Waiora Healthcare PHO work with WINZ, ACC, and other agencies as required. They have found that it is less intimidating for whānau if it is through them.</p> <p>Waiora Healthcare PHO updates databases each time patient presents, double consults, having IT system that all staff can access to see when patient presents.</p> <p>Effective, efficient, and relevant resourcing of Māori health</p> <p>Waiora Healthcare PHO stands firm with what fits with practice, and as well as contract renegotiation, there is a recognition that they have to be creative and innovative in their practice.</p> <p>Waiora Healthcare PHO are actively looking at flexible funding options, that is more representative of a high needs population as well as actively promoting the work that is carried out at Waiora Healthcare PHO.</p> <p>Waiora Healthcare PHO has programmes aimed at the whole whānau and a multi-disciplinary team.</p>
Markers	<p>Secure Māori identity, health status (positive and negative), health determinants, strengthening Māori collectives</p> <p>Waiora Healthcare PHO recognises the need to collect evidence around these markers that is co-ordinated as it leads to Māori returning to the service, better health outcomes, and more effective changes. Waiora Healthcare PHO also actively encourages whānau to become involved.</p>

ORGANISATIONAL PREREQUISITES

In implementing the framework and through interviews and the focus groups organisational prerequisites necessary to fund and implement a Māori health promotion framework in a primary health care setting have been identified. The prerequisites have been organised under ‘funding organisational prerequisites’ and ‘implementation organisational prerequisites’.

The funding organisational prerequisites identified were:

- Adequacy of funding
- Flexibility of funding
- Health promotion priority
- Good communication

The organisational prerequisites for implementation are:

- Adequate contracts for effective health promotion
- Specialist workforce values
- Organisation support and leadership
- Workforce Development Requirements
- Key health promotion person or team
- A process for determining the communities key health priorities
- Access to adequate resources
- Appropriate message delivery requirements
- Health promotion marketing and advertising
- Importance of a multi-disciplinary team
- Developing networking and inter-agency protocols
- Health promotion evaluation development
- Development of feedback mechanisms

Funding Organisational Prerequisites

Funding to enable implementation of health promotion services and programmes primarily come from the Ministry of Health and DHBs.

District Health Boards have been charged with the task of distributing allocated funding within districts by way of contracting to health providers including PHOs in order to meet the ongoing needs of priority populations. Contracts are a key-funding source for PHOs and are specifically tailored to meet the needs and demands within different geographical areas (Hefford Crampton et al 2005).

Adequacy of funding

Health promotion funding per enrolled patient was raised as a consistent issue. Funding was noted to be minimal. What money there is, is often saved and grouped together by the healthcare provider in order for it to be used as part of a ‘bigger resource’ that will enhance one part of a health promotion aspect of the PHO.

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 27).

Its only a couple of dollars per patient per year to develop a health promotion plan and to undertake some level of health promotion activity. That money effectively gets grouped up and we write a plan budget, and what we have done is to hire a part-time health promoter (Key Informant 27).

The focus groups were in agreement, and also suggested other methods of more direct funding may better meet local priorities.

Flexibility of funding

Since the establishment and development of PHOs health promotion funding was introduced by way of a capitation formula. Funding is paid to the PHO per enrolled patient. Funding per patient is deemed to be minimal by participants. Participants stated that the Waiora Healthcare PHO tends to group and direct funding toward health promotion-specific activity.

Waiora Healthcare PHO regularly evaluates specific funding mechanisms and where and when applicable and available additional funding is applied for through other means.

Health promotion funding is actually part of the capitation formula, so actually is tied directly to your register. So each of the practices has an enrolled population and according to their age, ethnicity and gender, it attracts certain amount of funding. So we get monthly allocated amounts according to our practice's register (Key informant 22)

In some circumstances contracts have allowed slight flexibility in regards to funding, and Waiora PHO have had some access to discretionary monies. This has been used to fund elements of health promotion services and programmes.

Well we fund it through other means. You know we have contracts that have a wee bit of discretionary money to do it and so we'll put that discretionary money in (Key informant 16).

The focus groups noted that a more direct source of funding would allow the PHO to better focus on the priorities that their population has, rather than a focus on priorities set elsewhere that are not always reflective of the requirements with their clients.

Health Promotion Priority

Key informants commented that the perception existed that the government viewed health promotion as low priority. Participants

considered that this was reflected in the level and types of funding offered and emphasis put on areas other than health promotion.

Actually government ...tick all the boxes in terms of saying oh yeah we do health promotion in every contract. But actually every contract they add another clause that says, oh by the way, as well as doing dah, dah, dah, you will give educational health promotion about these five things (Key Informant 18).

The focus groups also supported the view that the perception of health promotion is seen as a low priority by the government.

Good communication

Some interviewees identified the need for funders to promote better communication in regard to contracts. In some circumstances the same contract has gone out to two different practices in order to service the same population in the same small area. This has proven difficult as it creates competition for service providers and service repetition for the population affected.

Other people are already in some of those schools that we are contracted to, doing the same work sometimes we cant get in so we have to go outside our contract because other people another service is already in funded to do the same mahi (Key Informant 25).

Implementation Organisational Prerequisites

Adequate Contracts for Effective Health Promotion

Contracts within the Waiora Healthcare PHO covered a broad range of programmes, services and outcomes. According to participants involved in the contracting process very few contracts are health promotion specific but instead many have differing requirements that contain at least one element of health promotion within each contract.

Relationship management and negotiation

Whilst most of the PHO contracts may have a DHB or Ministry influence, participants did identify scope for change. Contract negotiators within practices went to great lengths to meet and discuss with contractors and in some instances redraft specifications so that it had a better fit with the practice, staff and most importantly the community.

The fit between contracts and the practice philosophy was an important issue for many participants. Some highlighted past issues with contractual arrangements, not being able to meet the specified outputs due to outputs not working with practice philosophy and the community they serve.

I guess from my point of view of my roles, I need to make sure that, whatever health promotion, activities we're doing, fits in, with, the actual practice and that it makes sense. There are a lot of great ideas

about health promotion but at the end of the day if they don't fit back in with the clinic, then, they're pointless (Key informant 20).

The focus groups noted there is a need to explain and educate funders about what is required to generate positive outcomes with whānau, a need to show funders the way to work with whānau. It was suggested that the funders should actually come and see what is needed. The focus groups believed there was an onus on PHO managers to work harder to negotiate on behalf of the staff.

The focus group reiterated that in renegotiation of contracts, depending on where the funding had stemmed from, there is some room for flexibility. One example given was that of a programme that only came about when the original contract didn't fit with practice, therefore management went back and the money was approved to be used toward this programme which continues effectively.

Flexible Contract Specifications

Flexibility around contract specifications was also highlighted as an important issue as participants identified the need to be able to be creative and flexible in delivering specific services and programmes that meet the required outcomes. This was particularly evident with practices dealing with such high needs population areas. In order to meet the outputs associated with the contract, many staff often worked above and beyond their role in order to address issues of basic need prior to servicing those outlined in the contract specifications.

Participants consistently commented on the time it takes to do health promotion especially in regards to Māori whānau. Most contracts specify a timeframe or number of funded visits, however interviews highlighted the need for more flexible time arrangements due to a high non-attendance rate, transient populations and other high needs being dealt with prior to health promotion occurring.

Sometimes I can be seeing the same client everyday for a week, the contract is only for 11 face to face contacts but that's so not realistic. It's not. It's definitely ongoing. I mean I can see a client and use that up within two weeks and they still haven't got to doing health promotion or any education. You need to take them by the hand, and lead them (24).

The focus groups supported the need for contract flexibility. Examples were given where a contract outlines a specific number of visits a client is entitled to, for example three, however sometimes it may take three visits to establish the relationship. Other examples were provided including programmes requiring a certain number of people attending, however a lesser number of people may end up attending the programme in reality, though those that did attend often achieved great success. The focus groups agreed that there should be an emphasis on quality rather than quantity.

Health Promotion Focus

Issues were raised throughout interviews regarding the different types of contracts that incorporate elements of health promotion. Issues raised are mainly aimed at the broader DHB and Ministry of Health level and are not isolated to only Waiora Healthcare PHO. Issues include contracts lacking specific details on health promotion, and a perception that health promotion is a lower priority than other services.

The ways in which contracts are constructed, is that health promotion is 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, basically (Key Informant 18).

The focus groups also believed that there was not an emphasis on health promotion within some contracts, and that it was often viewed as low priority. This was reflected in how contracts are evaluated and the emphasis on outputs such as number of visits allowed per client that often bear no reflection on the reality of a client's needs.

Specialist Workforce Requirements

Community accountability and responsibility

Participants who live and work in the community demonstrated a commitment and 'self imposed' role of going beyond their role for the community that they serve.

Whānau and community responsibility and accountability as for us its all about whānau, it's all about whānau and the community we serve (15).

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

I'm manawhenua to this place, so doesn't matter whether or not my bosses fire 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 at Waipareira (Key informant 25).

The focus groups reiterated the importance of certain values when working in the community. Examples were given of health professionals who had values that were different to the community and they had left the practice.

Commitment to Health Promotion

The majority of participants when asked about what percentage of their time was spent on health promotion seemed to under-estimate the time they utilised, until they broke it down during the interview, most were

surprised at how much time they actually did spend on different aspects of health promotion activity.

The focus groups emphasised that staff work to deliver to the needs of the whānau, therefore if the whānau needs two hours to get a message across, and gain understanding, then staff will take whatever time is needed. There is an acknowledgement that there is a commitment to the community and kaupapa.

The focus groups supported the commitment necessary to be able to undertake health promotion successfully. Often people had to work outside of their roles to increase the quality of the service that patients receive, and a perception exists that it isn't just about collecting a pay cheque.

Team Interconnectedness

Key informant interviews highlighted the significance of working and being part of a team. This enables effectiveness and efficiencies in a number of areas including office-based work both at an individual level, working as part of a team as well as community and whānau centred work outside of the office.

Participants identified team members to include colleagues, management, patients and whānau as well as other individuals from other services across the entire PHO, as well as within the individual practices.

It's nice being in a small PHO, we all get on quite well and share resources, its all about whānau and the community we serve. The clinics and staff are well known so it makes things a lot easier. We know the roles/job/staff across the PHO (Key informant 15).

Participants revealed a number of staff had initiated a change in role and/or practice but had remained loyal staying within the same PHO. They further identified that this could be due to a number of reasons including: the PHO supportive environment, being a smaller and therefore more intimate team, and supportive employment provision and flexibility to move across the PHO.

A lot of staff stay in the PHO but move around the clinics, by moving of course I'm going to go out of my comfort zone but still have the luxury of being under the same PHO and with the same people just a different practice or clinic (Key Informant 15).

The team environment was seen as important especially in relation to serving the community and whānau. Good team relationships ensured effectiveness in relation to client/whānau issues, including consistency in relationships; work being undertaken and knowing the issues so whānau do not feel overwhelmed, unsupported and unheard.

Good feedback from other staff is important especially when there is more than one of you working with the same whānau (Key Informant 29).

Trying to be consistent having the same worker go in if possible, if that still works for the whānau or have someone else go in that knows the issues but works in a similar way that whānau are used to (Key Informant 25).

Organisation Support

There is a need for organisational system support, for the entire organisation to provide visible support for the model, including in the values and mission statements and organisational strategies, as well as management support through the CEO, Board and Leadership teams. This is critical for the successful implementation of any model.

It takes a whole practice involved to ... do that. That's one of the key things, actually everyone involved and knowing what's going on and talking about the vision of the nurses looking beyond, I think maybe the whole practice needs to have the same vision (Key Informant 23).

But my role really is to find out how to position health promotion in the middle of the organisation and make health promotion one of our core activities rather than a extraneous activity (Key Informant 27).

Supportive and Innovative Leadership

A strong theme in the interviews conducted with management was the innovation and looking to outside sources for inspiration for new ways of operating, including international experience and best practice. An example was given of sending the nurse manager to Texas to look at successful clinic interventions.

The focus groups commented on the CEO being supportive in the media to the needs of the PHO and directly tackling the funding issues. The support and leadership of the CEO was seen as important to the development of the PHO.

It was believed that senior managers should be advocating on behalf of Māori, and contributing to reorienting service delivery to better suit the needs of Māori and their community. It was stated that managers should be looking at the next step in Māori development and to reorient the funding stream where necessary to better reflect population and service delivery needs.

Workforce Development Requirements

Capacity

A number of concerns were raised through interviews pertaining to workforce capacity. These concerns were in regard to attendance of health promotion training sessions and lack of time to undertake health promotion with whānau members due to high needs population, high caseload numbers and limited staff availability.

It is hard to get fill-ins or replacements so we can do training but the PHO does provide training and we did jump on our health promotion training (Key Informant 15).

Workforce Development

One of the biggest issues raised in terms of health promotion has been workforce development and the recruitment and retention of staff with the appropriate qualifications and experience.

Getting those that are appropriately trained or qualified, is probably the biggest issue and then with that comes their level of understanding regarding what health promotion entails. Now for us because engagement is a real issue here, engagement of the high needs whānau we tend to swing people on the basis of their previous experience of working in the community, as opposed to the more formal qualification (Key informant 18).

As well as finding the right people with health promotion experience and qualifications that fit with the team and community environment.

So, the issue with that is of course is their own world view in terms of the kind of idea, of what health promotion is which is usually very limited and I hear that certain people who are going in to the community I actually cringe. And it's not because, they just don't know I just think it could be done a lot better 18).

Health promotion training opportunities

Participants identified a number of health promotion training opportunities provided within both the PHO and other health service providers such as the DHB, Hapai, Health Promotion Forum as well as local community based initiatives.

However, a consistent participant response was one of not being able to attend training due to workload commitments, commitment to patients and whānau, timing of the courses and cost associated.

Training and money for training is a major issue as a lot of health promotion is hands on (Key informant 15).

We are fortunate to have Hapai and they've come in and run a number of different sorts of health promotion sessions. But it can be quite ad hoc. Actually what would be better is if there was, short courses that ran three times a year that you could actually, plan to go and or agree to employ someone, but on the basis that they did the course. Send them off to a course and then bring them back (Key Informant 18).

In some circumstances staff utilised networks and resources to attend various training provided in the community.

I look within the community in regard to training and find that sometimes I am able to attend as a consumer so I go and support somebody (patient) and do the training with them, then I am only paying like \$20 (Key informant 18).

Issues regarding patient training opportunities were also highlighted throughout interviews with issues being raised in regards to waiting lists for courses, and timing of courses coinciding with whānau commitments such as children, schooling and transport issues.

They do they all get really busy and there's sometimes a long waiting list. That's actually a real shame because when there's that waiting list, they can be waiting for ages. Once they get on the programme nobody wants to get off (Key Informant 24).

Some participants perceived health promotion training was seen as an expected incorporation of their training for their current role even if this does not reflect reality. For instance there was a presumption identified by the focus groups that health promotion was incorporated into nursing training, and training was therefore not as necessary for nurses although this is not the case.

The focus groups highlighted training and that training for community health workers was missing, most training geared at clinical needs rather than health promotion skills. It was identified that some community health workers have to attend presentation days as a consumer to learn about health problems and gather information. A need to have a more formal training programme with formal recognition and possible certification was identified by the focus group.

Specialist Training Manager

The focus group identified a need for a person to be in charge of research what courses are available for staff, and looking at the content and costs of courses as well as ensuring staff can attend. It was noted that currently managers are required to investigate all the options and look at the content and costs, as well as how staff are able to attend which takes up time identifying the right training for individual staff.

Key Health Promotion Person or team

Waiora Healthcare PHO undertakes health promotion initiatives at the head office level and employs a part-time health promoter who liaises with the community and implements programme activities. The health promoter utilises her skill and network knowledge to get community-based initiatives implemented using creative techniques to gain support, obtain sponsorship of products and engage communities specifically targeting primary to intermediate school aged children.

There has been good uptake by local schools, communities alongside children and their whānau. Health promotion activities implemented at the head office level have included campaigns aimed at drinking healthy beverages, reducing obesity, and hygiene in schools (washing hands). These initiatives are in line with DHB strategic planning priorities.

What I'm interested in is campaigns doing scoping exercises, going into schools, talking to the public, the school nurse or the principal, or the public health nurse who works for that school. Going into low decile schools and talking about what are the issues that they have with the students (Key informant 26).

A number of participants identified the need to have the right person to do the health promotion job and there was a general consensus that not just anyone could carry out effective health promotion. The right person is needed who would have at the very least some sort of health and community experience, knowledge, skill and/or qualification. The ability to co-ordinate health promotion activities was seen as important in any strategic plan or framework.

A Process for Identifying the Communities Key Health Priorities

Regional Priorities

Participants confirmed that the majority of the contracts within the PHO are specifically aligned with the priorities of wider district and region strategic planning. It was noted that the overarching consistency was useful at a regional level that had wide variations in the catchment population. However, participants identified that this often dictated priorities for the PHO practices. In order to get the required funding the PHO needs to align with the priorities set by the DHB, although in some instances these may not align with individual practice priorities of the local population.

Local Practice Variations Across the PHO

Participants across the different practices identified priority differences depending on the population-base of their practice. Populations varied across practices including Māori, Pacific, Asian, Middle Eastern and European. The location of the practice and the makeup of staff contributed to the population base of the practice for example mandarin speaking doctors attracted more mandarin speaking patients.

The primary function of the practice also influenced the type of populations for example whether the practice was mainly GP services, community based services and/or mental health.

It is all based on our population, the health stats, of course a lot of it comes from stats but also, it is about us all working and getting together and including other cultures (Key informant 15)

There was strong consensus from key informants regarding the high-needs population that the PHO currently serves in some areas. In particular staff from Wai-Health identified the tremendous impact of social needs that surround the patients within the community.

Participants across the PHO note that a large number of patients that attend clinics for health needs also have social issues that need to be dealt with before they are able to focus on their health and wellbeing. Examples of social issues include: lack of transportation, transient lifestyles, limited or no family support, poverty, overcrowding, no power, limited food and domestic violence and safety issues.

For a number of reasons they don't have the transport. (Key Informant 25)

Some of our whānau become transient as they do. And that's their choice, one minute they're there, the next minute they're gone, they become transient you can't find them. Or you ring up, schedule home visits and you go there and they're not there (Key Informant 25).

My clients with diabetes cant even afford to buy their new needles (Key Informant 24).

Access to Adequate Resources

Limited funding for health promotion has 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 and resources are needed that are specifically tailored to the target population.

Lack of resources was a consistent theme that emerged from interviews. Participants commented on utilising the making of their own resources to educate patients or use for promotional purposes. Even basic resources were needed such as posters in offices, appropriate pamphlets in different languages and the inclusion of sufficient space in order to work effectively.

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 things that are plain speaking but clear and you know what I mean, have all those things (Key Informant 18).

When I go over to the diabetes health specialist clinics at Waitakere hospital and I look around their offices and all the good posters and models. Yeah. I mean I've got to make my own (Key Informant 24).

Funding for adequate resources was seen as essential to good health promotion.

It's not only the funding it's developing, we're usually funded to develop the resources and to develop the concepts for the delivery of some of those messages (Key Informant 18).

Innovation and Creativity

Participants acknowledged the limits that access to resources has on providing health promotion to the highest standard, and they identified some unique ways of getting the basic resources required for their patients.

Having fewer resources makes us more innovative around the way things are done (Key informant 18)

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, and on occasion have utilised contacts and networks both within and outside of the practice to gain better resources.

A lot of the educational resources and stuff are my own, or I make some (Key informant 24).

Participants noted spending a lot of time and energy on redesigning resources to make them fit with the intended population. Others recognise the need for this to happen and tell many stories of different teams innovative use of resources that have had a positive affect on community members.

One of the things we've implemented is a baby book; you know the well child books? We have a camera now and at all the milestone checks, our nurse takes a photo, so she puts the photo there and then we stick it in the books. When our community health workers go in to the house, they don't take the photo but they've got stickers in books ... now our mums don't lose their books (key informant 25).

Others tell of getting resources translated or tailoring existing resources to include for example foods that are relevant to each ethnicity. New resources have also been created such as small badges with slogans in te reo, sipper bottles that contain relevant provider information and tailoring programmes so they meet the community needs.

A lot of the educational resources and stuff are my own (Key Informant 24).

Participants also noted that there were staff who ensured that all available resources that can be accessed at no cost to the practice and PHO are obtained. These include posters, training, booklets and pamphlets as well as syringes and diabetic needles for patients.

The focus group reiterated that in an environment of limited resources this has resulted in staff working smarter and coming up with clever initiatives such as cardboard cut outs or using their own resources.

Adequate Physical Space

The focus groups emphasised the importance of having adequate space, both office and clinic space. Some double consults were a result of lacking space for the patient to be able to see health professionals separately.

Consults take place in a variety of spaces because there is no specialised area. So for example some consults take place in a whānau room, others in a tearoom or in a space shared with other clinicians. There is no individual space that is dedicated for health promotion.

Appropriate Message Delivery Requirements

The way health promotion messages are delivered to the intended target audience was a significant issue for all the participants interviewed. This was a particularly passionate topic for those dealing with a high case of Māori patients given the specific needs of Wai-health Māori clients..

The focus groups reiterated the importance of having messages that are culturally appropriate and are delivered in such a way that the message is heeded. According to focus group participants, it is important to take into account the form that messages take as well as the messages themselves if programmes are to succeed.

Māori Paradigm

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. For Māori the environment, credibility of person delivering the message and content of messages were important factors.

Also of significance were Māori images, use of Māori language and relevant examples such as Māori food. One participant identified that if Māori were unable to deliver the messages there should be a knowledgeable and credible Māori walking beside non-Māori.

The way the messages are delivered are as important the messages themselves. All hold onto things Māori you know 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 then have Māori walking side by side. You must have Māori. And just being humble. Being humble and knowing your stuff and knowing health information. If you can't get a Māori person to do the presentations then let them have Māori walk side by side (Key informant 29).

Focus groups reiterated the importance of the Māori paradigm and the importance of knowing the audience. An example was given of a young nurse telling a kuia about cervical screening, and the limitations of that message being received as opposed to a PHO-based kuia been brought in to disseminate the information. The PHO acknowledges the value of working with kaumatua and kuia and how that support works in getting the community on board.

The focus group also supported having Māori staff available where that often led to a greater understanding of what a client's needs are and gives staff an added insight that non-Māori may not have.

Supportive and flexible delivery

Participants identified that the message itself needs to be encouraging alongside an empowering process that enables Māori to take control. Many messages aimed at Māori in the past have been put forward in a blaming manner.

When you start to try bashing 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 22)

Participants also recognise that in some instances patients may not be ready to hear information being presented. This can be for many reasons including the need for time to come to terms with their illness and the radical change in lifestyle needed in order to maximise their quality of health.

Some of the health promotion programmes within the PHO have utilised other community members to get a specific message across. Others have had to simplify and change relevant health promotion information in order to break it down so the intended audience could understand it fully. Information often has to be re-created in a way that suits the needs of the population.

Two participants highlighted the success of using patient experience and knowledge in health education and health promotion in order to get the message across to others.

But one man that I've got coming to my support group meetings, he's a double amputee he is in 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 got any now. Why? Because I never listened" (Key informant 24).

Participants were evenly divided in regard to whether group sessions compared to individual work best. There was consensus that patient preference seemed to differ depending on circumstances, confidence and understanding of the information.

The focus group supported the need for flexible programmes and health promotion approaches, from individual consultations to group activity-based programmes.

There was consensus from the focus groups that there is a need for the right person that can work with the particular client groups and acknowledgement that that is not the same for every individual, even within the same client group.

The focus groups also emphasised the time that health promotion takes to be effective, and that it is also about knowing the client so their needs can be assessed appropriately and acted upon. With limited time available health promotion is often opportunistic and whatever moments are available are taken. Health promotion is not formulaic, and different clients have different needs that have to be met before health promotion becomes effective.

The focus groups identified that directly working with the client individually did not always achieve the best results, sometimes health promotion activity achieve better results when implementing changes at a policy level, such as programmes through schools.

Whānau Involvement

Some participants commented on the importance of whānau involvement in education, health promotion and visits with patients. This facilitates support for patients if changes in particular areas are necessary as well as patients gaining a better understanding of treatment, diagnosis and processes that maybe associated. It was noted 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.

And I do 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 apart of this korero. And it is normally about the third time that they will let the other ones sit down and listen (Key informant 29).

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 24).

Many staff also highlighted the time it takes to motivate whānau to attend appointments. This can be a time consuming process but according to participants perseverance is crucial as with whānau involvement health promotion is more likely to be successful.

Health promotion marketing and advertising

The way health promotion is marketed and advertised was a common theme across interviews. A number of participants identified particular interest and concern in regard to how to effectively reach certain populations and what would work best. Advertising avenues were identified such as through the medium of television with particular emphasis on adverts and reality type shows.

Other avenues were also identified such as radio and hui. Many participants believed that the key to health promotion messages getting through to people is repetition or a creative way that makes people remember different slogans and health advice. Some also highlighted the lasting effect of hearing and/or seeing other people's personal experiences.

We're wanting to improve our communications and being able to communicate directly to our communities of interest via traditional communication mediums television and radio in particular, to try and sway opinion or sway attitudes about certain activities or lifestyle choices that people make that might not be good for them (Key informant 27).

Importance of a Multi-disciplinary Team

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

We have taken advantage of opportunities, because our organisation is quite opportunistic (Key informant 27).

One of our contracts allows us to do community team building to ensure that the community can actually participate in these things. So we can implement different ideas in the community and we can support those ideas (Key informant 16).

Given the transient nature of some clients, protocols have been developed whereby teams work together to meet client needs. For instance, a patient may be booked into see the doctor and allowances are also made to see the DSM nurse and the podiatrist if necessary. Many staff valued the ability to be able to work together for the greater health of the patient.

Over half of the participants commented on the ease of clinical input, access and support from other colleagues specifically the doctors when working closely with patients. Staff believed that being a small PHO and having a close professional working relationship enabled better holistic care of the patient.

The majority of participants understood the need for health promotion and its benefits not only for whānau members but the organisation and the health sector as a whole. Most of the participants identified health promotion as part of their role regardless of whether it was part of their intended contract.

The focus groups emphasised the importance of double consults where more than one health specialist may consult with a patient at the same time. This allows for information to be delivered to the patient in a cohesive manner with shared expertise, and a solution-focussed approach providing the patient with in-depth information within one consult. To achieve this patient information is often tracked so appointments can be co-ordinated.

The focus group also made comments regarding GP consults where there was limited time to fit in health promotion because of clinical needs and health promotion was therefore left out or sent to the nurse. This is what led to the development of Nurse led clinics, as all clinical components have some aspect of health promotion and it was important that this aspect was prioritised. The focus group reiterated the fact that health professionals wear many hats during the day to help support the client, and whānau.

Developing Networking and Inter-agency Protocols

Internal Networking

How the internal networking system within an organisation is set up plays an important role when considering referrals, working in collaboration in and across teams, and for the general betterment of fostering excellent working relationships at all levels.

Waiora Healthcare PHO staff worked hard to maintain good internal networks and relationships that are reflected in the quality of care for their patients as well as for each other.

Participants were consistent across the PHO in expressing their satisfaction in being part of a small PHO compared to others. A shared view was that networking and knowing staff and their expertise allowed for easier referrals for patients into specific programmes and services.

We know the roles/job/staff across all the PHO and what we're looking at is the sharing of resources within this PHO. We have all the clinics at Wai-Health and if you think or need stuff or help or you know any health promotion stuff going on we can all jump on board (Key informant 15).

One participant who facilitated a course for patients found that the main barrier was actually getting the referrals from workers to attend or that there was limited knowledge being generated about the course.

What we have found is it has, taken it a long time for people to get on board with actually referring. So the biggest barrier is actually getting the practice staff to refer clients it does take time to think through their clients and decide which meet the criteria and its easy to forget to actually do, because it's a new programme for Waiora (Key Informant 47).

The focus group emphasised the importance of internal networks, and having access to a multi-disciplinary team that made referrals to appropriate services easier and increased access. One of the benefits of internal networking was identified as knowing the system better and knowing the service available so being able to navigate the system with ease for the benefit of the patient.

External Networks

Gaining and maintaining quality external networks was seen as vital for the organisation's credibility within the community. Waiora Healthcare PHO has formed new networks and maintained existing networking relationships that are not only diverse but also wide-ranging. Networks formed include: kohanga reo, schools, other practices and PHOs, tertiary institutions, community-based programmes aimed at different cultures, DHBs, Ministry of Health, alongside other key agencies.

Staff employed within the PHO utilise their own existing networks as well as forming new ones relative to the position they hold. This was seen as positive for the PHO in 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.

In maintaining contact with the community at large and keeping up with the latest technology Waiora Healthcare PHO have an official website. The website is updated on a regular basis and contains relevant

information pertaining to staff, practices and location, fees, services and other associated information.

Many value the work undertaken by the staff at Wai-Health and were assured of what services are on offer because of good professional working relationships within the practice that patients were getting the most appropriate care when making referrals.

I refer to Wai-Health because that's where I know, that's what I know, but also the staff at Wai know the people here in West Auckland and we wouldn't refer if we didn't feel they were going to get good service (Key informant 15).

Waiora Healthcare PHO management are considering long term plans in regards to other forms of communication for networking and having direct communication with communities of interest by utilising traditional mediums such as television and radio.

The focus group reiterated the use of external networks in supporting a client if that is what is needed, and having those networks works to the advantage of the client and their whānau. Having external networks and knowledge of other pathways also helped support the client's more effectively so that they could be given an idea about processes, and supported to enter pathways that may be unknown to them.

Interagency Protocols

The Focus group supported having interagency protocols, and referral pathways and contacts with other agencies to better support their clients where necessary. Clients have many needs that are interrelated and it is sometimes necessary to involve other agencies to meet a client's needs.

Health Promotion Evaluation Development

Evaluating health promotion activity within the PHO occurs in a number of ways.

The focus group noted that the numbers rather than the quality of the intervention are often contract measures. This only tells a small part of the story and is not indicative of the success of a programme. Often only outputs or numbers are wanted rather than outcomes.

At the local level, staff utilise evaluation processes such as client feedback, high attendance rates for programmes and services as well as the number of participants. There is also an acknowledgment that success occurs on multiple levels and account should be taken between what is said and what is meant.

When our whānau tell us that they're good programmes, they don't mean that it's fixing their heart or it's losing weight, what they mean is they feel comfortable here (Key informant 16).

Other evaluation processes include meeting expected outputs, patient evaluation sheets, surveys and audits. A unique form of evaluation identified by two staff members was the use of photographic evaluation.

We have photographic evaluations where we'll use photos so in each of the programmes there's a camera, and there's a camera that we have in the unit now and it's just bringing my team up to scratch with okay what is an evaluation, what does it look like, and, these are the different ways you can do it (Key informant 16).

The focus groups identified that often there were requirements of what information was collected for contract evaluation and that this information was not always fed back into the practice. Contracts are often output focussed rather than focussed on the quality of the outcome, and often the information collected is not useful for planning purposes.

Health Information Systems

The participants identified that having their own information systems allowed them to measure their own outcomes. They have also had the benefit of using this data to request changes to, and in some cases additional funding. This information allows effective programme evaluation to take place with measures that contribute towards evidence-based best practice outcomes rather than been based on measures of quantity.

In the future, information collected may need to be balanced with qualitative information, the stories behind the numbers which is already being done to some extent, though it's not being fed to the Ministry of Health within the current Ministry reporting structure, where it was stated that the perception was that it was only about ticking boxes to some extent.

Development of Feedback Mechanisms

Participants identified it would be beneficial for staff to have the time to share feedback with managers and discuss the difficulties and different approaches required to achieve contract outcomes.

The need for evidence-based health promotion was also mentioned in order to prove that the activities are effective.

Key thing for me is evidence, which is what this is about, people say "oh yeah I did this" but no evidence to support that something works (Key Informant 18).

The focus group supported this where comments were made reiterating reporting and that the evidence exists but it is not captured by those in management or presented back to the funders. The initiatives that are unique or innovative are being written up but it isn't getting read although staff often put in time out of hours.

There is a standard reporting structure, and even though information is often collected, it is not often utilised at a higher level for reporting, as it does not fit into the standard forms and templates that are supplied.

RECOMMENDATIONS

Based on analysis of the interviews and focus groups there is some clear recommendations in implementing a Māori practice model within mainstream and Māori contexts to inform Māori policy and practice across sectors.

Local Level

- Establish communication pathways with staff, funding DHB, other health organisations, intersectorally and with the community. If people are involved at the outset there is increased ownership and increased effectiveness.
- Delivery of services that are client, whānau and family focussed, with appropriate messages and delivery methods.
- Have regular, clear feedback channels and opportunities for review and discussion of strategic plans and services.
- Have a clear contracting strategy with experienced personnel, who also consult the staff delivering the services to make sure all needs are being met as effectively as possible.
- The contracts entered into should, where possible, fit with the practice philosophy and community in order to aid meeting specified outputs.
- Have a workforce development and capacity strategy including appropriate training, career pathway development, recruitment and retention of staff.
- Develop an implementation plan for a Health promotion framework and then begin implementation.
- Monitoring and evaluation of the framework after implementation to ensure that the desired outcomes are achieved effectively and efficiently.
- Establish flexible service delivery development and be open to new ideas and technology to increase the scope and audience for the message and provide resources that aren't readily available.
- Establish the communities and PHO priorities for health promotion and align with regional and national priorities at a policy level to help ensure that the health promotion resources are going where they are needed and can be most effective.
- Development of outcomes measures in partnership with the community and funder to measure effectiveness of services and resources.
- Develop Health Information Systems to improve collection and analysis of information.
- Establishing and maintaining network processes and protocols at the internal and external level.
- Develop interagency protocols, and referral pathways and contacts with other agencies to better support their clients where necessary
- Develop multi-disciplinary teams.

- One single model will not work for everybody, a flexible approach with many options in mainstream and kaupapa Māori services would reach more people and meet Treaty of Waitangi obligations under Article 2.
- Culturally appropriate delivery of services should be developed and consulted upon with the local community, this would include whānau involvement.
- Cultural policies for individual PHOs should be developed with protocols for delivery of services.
- Existing community resources should be utilised where possible such as local kaumatua and kuia.
- Health promotion marketing and advertising should be incorporated into any strategic planning so it is co-ordinated with other activities.
- Implement a health promotion framework and document the barriers and facilitators to that process leading to a developed Māori health promotion model and pathway.
- Staff required:
 - Contract manager
 - Health promotion facilitator/team.
- Staff Development needs:
 - Health promotion training
 - Contract management training
 - Relationship management training
 - Team training/networking opportunities.

Regional Level

- Develop flexible funding mechanisms. It is important for funding bodies to establish a process for direct and adequate funding for health promotion model implementation within the PHO environment.
- Develop flexible contracting mechanisms.
- Develop flexible service delivery mechanisms.
- Develop flexible reporting structures.
- Have transparent and accountable funding practices.
- Develop and maintain communication pathways with the PHOs and their community.
- Be open minded to how services are delivered and measured with an emphasis on quality rather than quantity.
- Further development of outcome measures in participation with key stakeholders.
- Develop health information systems in the PHO sector.
- Funding should be available for advertising and marketing and providing resources.

National level

- Implementation of health information systems strategic planning documents.
- Review reporting structures and information collected and utilised.

- Provide funding for advertising and marketing and providing resources.

CONCLUSION

There is a worldwide shortage of health professionals and other resources. It is unlikely that this will change in the immediate future therefore changes need to be made to enable services to work more effectively and efficiently. There needs to be a co-ordinated strategy to the delivery of health services with limited resources and this extends to health promotion. Health promotion has the capacity to greatly reduce health spending in other areas and should be a co-ordinated effort, not adjunct add-ons.

The interviews and focus groups reiterated what organisational pre-requisites are necessary for implementing a health promotion framework. Many of these organisational pre-requisites are present already within organisations. Many could be developed.

Organisation pre-requisites identified as necessary for the successful implementation of a health promotion framework were divided into two categories – organisational prerequisites necessary for funding, and organisation prerequisites necessary for implementation. The funding organisational prerequisites identified for funding a framework were:

- Adequacy of funding
- Flexibility of funding
- Health promotion priority
- Good communication

The organisational prerequisites identified for implementation of a framework were:

- Adequate contracts for effective health promotion
- Specialist workforce values
- Organisation support and leadership
- Workforce Development Requirements
- Key health promotion person or team
- A process for determining the communities key health priorities
- Access to adequate resources
- Appropriate message delivery requirements
- Health promotion marketing and advertising
- Importance of a multi-disciplinary team
- Developing networking and inter-agency protocols
- Health promotion evaluation development
- Development of feedback mechanisms

Although primarily the report was on the implementation of a health promotion framework into a primary care setting there arose recommendations for not only the PHO, but also funding DHBs and the Ministry at a national level.

At the local level recommendations included:

- Establish communication and consultation pathways
- Service delivery that are client, whānau and community focussed
- Have a clear contracting strategy with experienced personnel
- Have a workforce development and capacity strategy.
- Establish the communities and PHO priorities for health promotion and align with regional and national priorities.
- Develop interagency protocols, and referral pathways and contacts with other agencies to better support their clients where necessary
- Develop single electronic client information,
- Develop electronic or SMS client reminder/recall systems
- Culturally appropriate delivery of services should be developed and consulted upon with the local community, this would include whānau involvement
- Cultural policies for individual PHOs should be developed with protocols for delivery of services
- Existing community resources should be utilised where possible such as local kaumatua and kuia

Recommendations to include the local community in planning and development as well as the involvement in service delivery will create ownership in the community and there is more likely to be buy in and better health outcomes. With limited resources creative means of getting results needs to be investigated. To improve Māori health outcomes, changes to the way services are currently delivered do need to be considered. Health promotion plays a part in many of the nationally identified priority areas for Māori health, in reducing the prevalence of chronic illnesses that are preventable if the information is not only given, but also received.

This study will aid in the optimal implementation of a co-ordinated system of health promotion within a supportive organisational context in which to gain the desired outcomes. In identifying the organisational pre-requisites, organisations can identify weaknesses and strengths to aid in strategic planning and to pre-empt challenges, leading to greater successes. The recommendations further solidify the potential success of implementing a framework to ensure successful co-ordination and implementation of a health promotion framework, and the funding that is required to support the process of gaining the desired health outcomes.

APPENDICIES

APPENDIX ONE – ADVISORY GROUP

Cinnamon Whitlock
Amohia Boulton
Megan Tunks
Dr Clive Aspin

APPENDIX TWO – INTERVIEWS

Health promotion interview schedule



Your role

1. Brief description of role and what it entails

Health promotion and your 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

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?

Your 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
20. Do you have anything you would like to add?

Documentation

Brochures
Website
Pamphlets
HP material/strategy/plan
Contracts/funding
Annual report
Needs assessment dox
HP models
Evaluation of programmes/services

APPENDIX THREE – CONSENT FORMS

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: _____

Office Use

Date and version

27th March 2007, Version 1

Interviewer name _____

Area session held _____

Interviewer signature _____

Participant code ____/____/____

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
27th March 2007, Version 1

APPENDIX FOUR – INFORMATION SHEET

Key informant Interviews



Pre-requisites to successful Māori health promotion

Date and version

27th March 2007, Version 1

Invitation

You are invited to take part in this research project 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:

Supervisor:

Rachel Brown, Research Officer
Gifford

Taupua Waiora, Centre for Māori Health Research, AUT

**Tel. (09) 921 9999 ext 7237
6772**

rachel.brown@aut.ac.nz

h.gifford@clear.net.nz

Project

Dr Heather

Whakauae
Research Services

Tel. (06) 347

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

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**.

Concerns regarding the conduct of the research should be notified to the Secretariat, neac@moh.govt.nz

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

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