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Can a participatory development approach  
contribute to the achievement of  
Sustainable Development Goal 3, target 3.8  
(universal health coverage)?

Lessons from the Whānau Wellness Resource Programme  
in Hawke's Bay

A thesis presented in partial fulfilment of the requirements for the Degree of  
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# Abstract

In Aotearoa, health inequities are a constant and growing concern for those in the primary health care sector. Barriers towards accessing primary health care services include the cost of treatment and prescription medication, access to a general practice and the lack of relationships with health professionals. Sustainable Development Goal 3 (ensure healthy lives and promote wellbeing for all at all ages), target 3.8 aims to address these barriers through a commitment to universal health coverage. This target seeks to ensure that everyone has access to affordable and quality health care, medications and vaccinations. Although not explicitly stated in this target, this research assumes that having people actively participate in their own health care decisions and treatment, will further enhance the impact of SDG 3, target 3.8 as participation in development has been proven to do in the Global South.

In Hawke's Bay, the Whānau Wellness Resource Programme was established in 2015 to combat issues surrounding inequity in health and provide free primary health care and medication for one year to whānau enrolled in the programme which is a predominately Māori population. This research seeks to investigate how the Whānau Wellness Resource Programme is utilising participation to contribute to the achievement of Sustainable Development Goal 3, target 3.8 of universal health coverage.

To answer this research question, field research was undertaken during a six-week period. Alongside the field research, a literature review examined relevant information regarding the research topic. The research methods consisted of semi-structured interviews and semi-structured observations of education sessions provided by the Whānau Wellness Resource Programme. Following analysis of the fieldwork data, five research themes of inequity, valuing relationships, partnership and participation, tokenism and empowerment were discerned. In relation to the Whānau Wellness Resource Programme, positive steps are being made to utilise participation in a way that reduces inequity in Hawke's Bay, while also providing an empowering environment for participants. The research showed Sustainable Development Goal 3, target 3.8 is relevant in Aotearoa, and the primary health care sector can learn from the Whānau Wellness Resource Programme, who have begun to embrace participation to contribute to the achievement of universal health coverage.

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# Abbreviations

<b>DHBs</b>	District Health Boards
<b>HBDHB</b>	Hawke's Bay District Health Board
<b>HHB</b>	Health Hawke's Bay -Te Oranga Hawke's Bay
<b>GP</b>	General Practitioner
<b>MDGs</b>	Millennium Development Goals
<b>MFAT</b>	Ministry of Foreign Affairs and Trade
<b>MoH</b>	Ministry of Health
<b>NGOs</b>	Non-Governmental Organisations
<b>PD</b>	Participatory development
<b>PHO</b>	Primary Health Organisation
<b>PHOs</b>	Primary Health Organisations
<b>SDG</b>	Sustainable Development Goal
<b>SDGs</b>	Sustainable Development Goals
<b>SIA</b>	Service to Improve Access Funding
<b>UN</b>	United Nations
<b>WHO</b>	World Health Organisation
<b>WWRP</b>	Whānau Wellness Resource Programme

# Glossary

<i>Kupu Māori (Word)</i> <sup>1</sup>	Definition
<b>Aotearoa</b>	Māori name for New Zealand.
<b>Hapū</b>	Kinship group, clan, tribe, subtribe.
<b>Hawaiki</b>	Ancient homeland - the places from which Māori migrated to Aotearoa/New Zealand.
<b>Iwi</b>	Extended kinship group, tribe, nation, people, nationality, race - often refers to a large group of people descended from a common ancestor and associated with a distinct territory.
<b>Karakia</b>	To recite ritual chants, say grace, pray, recite a prayer, chant.
<b>Māori</b>	Indigenous New Zealander, indigenous person of Aotearoa/New Zealand
<b>Mauri</b>	Life principle, life force, vital essence, special nature, source of emotions
<b>Oranga</b>	Survivor, food, livelihood, welfare, health, living.
<b>Pākehā</b>	English, foreign, European, exotic - introduced from or originating in a foreign country.
<b>Taha hinengaro</b>	The capacity to communicate, think and to feel mind and body are inseparable. Thoughts feelings and emotions are integral components of the body and soul. Also referred to as Mental Wellbeing
<b>Taha tinana</b>	Physical health - The capacity for physical growth and development.

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<sup>1</sup> Definitions for this glossary have been attained from the Māori Dictionary (2018) and the Ministry of Health (2017d).

<b>Taha wairua</b>	Spiritual health - The capacity for faith and wider communication. Health is related to unseen and unspoken energies. Also referred to spiritual wellbeing.
<b>Taha whānau</b>	Family health – The capacity to belong, to care and to share where individuals are part of wider social systems.
<b>Te Reo Māori</b>	Māori language.
<b>Te Whare Tapa Whā</b>	Māori health model that represents the four walls of a whare. With its strong foundations and four equal sides, the symbol of the whare illustrates the four dimensions of Māori well-being.
<b>Tikanga</b>	Correct, procedure, custom, habit, lore, method, manner, rule, way, protocol - The customary system of values and practices that have developed over time and are deeply embedded in the social context.
<b>Te Tiriti o Waitangi</b>	Also known as the Treaty of Waitangi - the founding document of New Zealand. It is an agreement entered into by representatives of the Crown and by Māori Chiefs.
<b>Waka</b>	Canoe or vehicle.
<b>Whare</b>	House, building, residence, dwelling, shed, hut, habitation.
<b>Whānau</b>	Extended family, family group.

# Chapter One:

## Introduction

*The tohunga had had a long life, filled with magic and knowledge of the universe, of constellations, sea navigation, natural phenomena, trees, plants, and medicines... the seeds of knowledge the old tohunga had shared had been planted in the minds of the young people... to ensure that the ways of the old people would live on into the future.*

(Grace, 2017).

### 1.1 Introduction

The Māori legend, ‘The Tohunga’<sup>2</sup>, shares the inspirational narrative that knowledge is power and that while it is relevant to adapt and evolve to changing environments, it is also important to remember your identity and origins. This legend speaks of the values and key messages of the Whānau Wellness Resource Programme (WWRP), the case study being researched in this thesis. WWRP embraces and shares with programme participants the importance of community participation to improve wellbeing. WWRP aims to do this by increasing health literacy levels and providing key messages which can be passed amongst whānau.

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<sup>2</sup> To refer to *The Tohunga* Māori legend see Appendix One

I have always had an interest in Aotearoa's<sup>3</sup> health system and the provision and funding of health care services. In 2016, I was able to gain experience and insight into the development, design and delivery of health programmes during a practicum experience at Health Hawke's Bay – Te Oranga Hawke's Bay (HHB) when I completed a course towards my Master of International Development (my positionality, a key consideration for this thesis, will be discussed in Chapter Five: Methodology). During my time at HHB, I was involved with WWRP, a programme that delivers free health care for one year, to those residing in quintile 5<sup>4</sup>, who are predominately of Māori and Pacific Island descent, and those of Māori and Pacific Island descent residing in quintile 4 with a Community Services Card<sup>5</sup>. To ensure that my practicum was related to development studies, I researched the Sustainable Development Goals (SDGs) in relation to health. While at HHB, I perceived that one of the aims of WWRP was to ensure healthy lives for whānau, which relates to Sustainable Development Goal (SDG) 3 "ensure healthy lives and promote wellbeing for all at all ages" (United Nations General Assembly, 2015, p. 20), and directly to SDG 3, target 3.8 of universal health coverage. This target has a focus on achieving universal health coverage through the provision of affordable and accessible health care, medication and vaccinations without having concern over financial burdens.

During my studies I was interested in the utilisation of participation by people and communities in their own development can ultimately lead to better development outcomes and I wondered if the same was true in Aotearoa, particularly in the provision of primary health care services.

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<sup>3</sup> I have chosen to use the word Aotearoa instead of New Zealand as my thesis is focused on a programme targeting Māori health and I felt the use of Aotearoa was more culturally respectful in this context.

<sup>4</sup> Deprivation levels are reported in quintiles developed from data collected through Statistics New Zealand Census, used a basis for additional funding for District Health Boards and Primary Health Organisations. The Deprivation Index is determined through area-based measures of socioeconomic deprivation. Quintile 1 is considered the least deprived and quintile 5 is considered the most deprived part. Nationally, each quintile represents 20 percent of the population (Ministry of Health, 2016b).

<sup>5</sup> A Community Services Card is available to low-middle income families to help support the costs of health care and prescriptions (Ministry of Social Development, 2017).

This sparked my interest in completing in-depth research into WWRP, focusing on the utilisation of how participation in this programme contributes to the achievement of SDG 3, target 3.8.

## 1.2 Background to research

The background to this research brings together three main ideas. Firstly, addressing health inequity in Aotearoa and improving Indigenous health and wellbeing. Secondly, the role of participation in helping communities to be actively involved in their health and health care journeys and thirdly Aotearoa as signatories to the SDGs. These three ideas will now be discussed.

Firstly, there is a body of literature that explores earlier research into health inequities in Aotearoa, particularly between Māori and non-Māori (Sarche & Spicer, 2009). Health inequity is defined as “differences in health outcomes that are avoidable or preventable and therefore unfair” (McElnay, 2016, p. 5). McElnay (2016) suggests that to ensure the improvement of equity and equality in health care, it is essential to focus efforts on the issues of concern surrounding health and wellbeing. While the terms inequity and inequality are often interchanged within the literature and everyday conversation, for the purpose of this research the term inequity will be utilised as WWRP does not offer the programme to the total enrolled population of HHB. By providing this resource to those who are eligible, this programme presents the opportunity to create equity in health statistics and outcomes.

Secondly, incorporating Māori culture and identity in partnerships allows Indigenous communities to actively participate in their own self-empowerment (Durie, 2006). With governments globally now having an increased focus on Indigenous health, participation, empowerment and partnership have been identified as key strategies for the improvement of Indigenous health and wellbeing (Chino & DeBruyn, 2005). Keleher (2002), and Chino and DeBruyn (2005) share similar perspectives on global Indigenous health, expressing the need to implement strategies to improve health inequity between Indigenous and non-Indigenous

populations. While this statement is on a global scale it can be related to Aotearoa and the growing concern over health inequity faced by Māori. Cram (2014) also supports this concept that Māori health and wellbeing is vital to improvements in the social and economic development Māori.

Participatory development (PD) emerged in development in the 1980s and provides a different perspective on how to engage people in development. PD can increase levels of engagement and participation of people while also providing an environment where they are able to feel safe to share their concerns, thoughts and feelings (Mansuri & Rao, 2011; Cornwall, 2008; Mohan & Stokke, 2000). While the use of participation can vary in terms of each project and participants involved, there is no definitive way of ensuring that participation will be effective (Cornwall, 2008; Mohan & Stokke, 2000). In terms of this study the intention is to gain a more nuanced understanding of participation as it relates to WWRP and in relation to the role of participation in the achievement of SDG 3, target 3.8<sup>6</sup>. Finally, in 2015 alongside 193 countries, Aotearoa agreed upon a global set of 17 development goals to achieve sustainable development, identified as the Sustainable Development Goals (SDGs). This will be discussed in detail in Chapter Two. The third SDG has a focus on the improvement of health with an emphasis of ensuring and promoting healthy lives and wellbeing for all (United Nations General Assembly, 2015). By the Government agreeing to these goals there is the responsibility to ensure that measures are in place to achieve the agreement. To achieve the SDGs, the Government needs to provide support and encouragement in all sectors to achieve the targets (Ministry of Foreign Affairs and Trade, 2017b). The Ministry of Foreign Affairs and Trade (2017b) recognise the

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<sup>6</sup> While I am aware that a full set of indicators has been developed to measure the levels of achievement of Sustainable Development Goal 3, target 3.8 globally, this is not the focus on my thesis. Instead, I have focused on participatory development as a lens through which to analyse the implementation of Sustainable Development Goal 3, target 3.8. A discussion on the indicators associated with Sustainable Development Goal 3, target 3.8 will take place in Chapter 2.

importance of the work that the private sector as well as Non-Government Organisations (NGOs) do to achieve the SDGs.

With this in mind, the research seeks to examine how HHB's programme, WWRP, is contributing to the achievement of SDG 3, target 3.8 through a PD approach. While WWRP was established in 2015, programme staff were unaware of the SDGs, even though they were delivering a health programme which seemingly contributed towards the achievement of SDG 3, target 3.8. The programme was developed with a focus on establishing a successful model of health care delivery for Māori and other targeted groups as opposed to the SDGs or in terms of the development agenda.

### 1.3 Study site and key concepts explained

Before we go further, a brief explanation of the study site will occur as well as clarification regarding as to what level of health care is being studied, how health is defined and the focus of WWRP.

WWRP is a new primary health care programme established in Hawke's Bay by the local Primary Health Organisation (PHO), HHB. Primary health care covers a broad range of health services delivered within the community (Ministry of Health, 2017e). These include services from a general practitioner (GP), nurse practitioner, registered nurse, and allied health services working within primary care. Allied health services include social workers, health education, pharmacists and health screening services (Ministry of Health, 2017e). In 2001, the Ministry of Health (MoH) founded the Primary Health Care Strategy that mandated for Primary Health Organisations (PHOs) to be established. PHOs have the responsibility for the delivery of primary health care services to enrolled patients (Ministry of Health, 2017e).

Health is defined most commonly by the World Health Organisation (WHO) as including the physical, mental and social wellbeing of an individual or community (World Health Organisation,

2006). The concept of health is expanded in Chapter Four of this thesis, however it is important to acknowledge that this definition includes more than being free from disease and harm. This definition is also reflected in the Māori concept of health which is a holistic view of wellbeing. Utilising the WHO definition of health represents the complex nature of wellbeing and this is demonstrated by WWRP providing care and being cognisant of various aspects of wellbeing.

WWRP has a selection criterion for the programme for people of Māori and Pacific Island descent and 'other' patients all residing in Quintile 5 as well as for people of Māori and Pacific Island descent residing in Quintile 4 with a Community Services Card (SHORE Whariki, 2017). While this is the community that WWRP services, this research is focusing on Māori within the programme as this group is more negatively represented in health statistics and inequity faced by Māori is of major concern. In placing emphasis on Māori participation in WWRP, I hope to gain a more nuanced understanding as to how participation contributes to the achievement of SDG 3, target 3.8 of universal health coverage amongst an underserved Indigenous community<sup>7</sup>.

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<sup>7</sup> While the focus is only on Māori participants, they will be referred to as participants within this research.

## 1.4 Research aim and questions

The aim of this research is to explore:

Is Sustainable Development Goal 3, target 3.8 relevant to Māori health and wellbeing in the Hawke's Bay region and does a participatory development approach can facilitate the achievement of this important global goal within the Aotearoa context.

Three research questions are posed:

1. Is a participatory development approach an effective mechanism in contributing to the achievement of Sustainable Development Goal 3, target 3.8 of universal health coverage?
2. Is the Health Hawke's Bay – Te Oranga Hawke's Bay, Whānau Wellness Resource Programme, using participation to contribute towards the achievement of Sustainable Development Goal 3, target 3.8 of universal health coverage?
3. Does Sustainable Development Goal 3, target 3.8 have value in the Aotearoa context?

Overall, this study seeks to gain an understanding of how participation can influence WWRP to achieve target SDG 3, target 3.8 which has a focus on achieving universal health coverage through the provision of affordable and accessible health care.

## 1.5 Structure of the thesis

This thesis is structured into nine chapters. Chapter one has introduced the background and rationale of the research. A brief introduction into the study site is given, and the research aim, and research questions are stated. The chapter concludes by outlining the thesis structure. Chapter two explores the SDGs with an emphasis on SDG 3, target 3.8 which is the focus of this thesis. Chapter three investigates the theoretical framework of PD, a framework that will be

utilised when reflecting on the research aim and questions later in the thesis. Through a literature review and a critical analysis, PD will be discussed, and diverse forms of PD will be presented.

Chapter four completes a literature review on Māori health. The relevance of this chapter is to establish an understanding of different health perspectives and determinants impacting on health. This chapter also establishes implications in health according to Te Tiriti o Waitangi and explores a Māori health model. Chapter five reflects on and describes my positionality as the researcher as well as the research design and ethical procedures that were considered when the research was being planned and discussed. The methods used to conduct the research as well as the selection of participants, data analysis and interpretation, credibility and trustworthiness of this study will be discussed. Chapter six explores the primary health care system in Aotearoa and the demographics of Hawke's Bay. An outline of WWRP case study and the PHO in Hawke's Bay will be given as well as a discussion surrounding SDG 3, target 3.8 and its relevance in this community.

Chapter seven reflects on the fieldwork findings and discusses the five themes identified and derived from interviews and observations. Chapter eight provides an in-depth discussion and review of the research findings in relation to the literature discussed in prior chapters. This analysis will draw together the information to debate the findings of the research. Chapter nine will provide conclusions, recommendations for further study and reflect on the process undertaken during this research. It will endeavour to discuss the key contributions of the study while also examining its limitations.

# Chapter Two:

## Sustainable Development Goals

*Reflecting on the MDGs and looking ahead to the next fifteen years, there is no question that we can deliver on our shared responsibility to put an end to poverty, leave no one behind and create a world of dignity for all.*

(Ki-Moon, cited in United Nations, 2015, p. 3).

### 2.1 Introduction

In 2015, world leaders agreed upon a revised set of global goals, known as the Sustainable Development Goals (SDGs), that continued and enhanced the work of the Millennium Development Goals (MDGs). The SDGs are universal and include 17 goals with 169 targets and stipulate a collective vision that embodies progress towards a sustainable future for all. They focus on embracing collective responsibility in the delivery of global wellbeing which ensures everyone is protected in the future (Osborn, Cutter & Ullah, 2015). SDGs provide a significant aspect to this research as I am seeking to examine how Sustainable Development Goal (SDG) 3, target 3.8 is relevant to Māori health and wellbeing in the Hawke's Bay region, and how a participatory development (PD) approach can facilitate the achievement of this important global target within the Aotearoa context. To gain a greater understanding of the goal and target, this chapter will also explore the formation of the SDGs and include a discussion of their history and significance, however before this occurs the concept of sustainable development

will be outlined with a focus on the three pillars: economic, social and environment needing to be considered.

## 2.2 Sustainable development

In 1987 the United Nations (UN) World Commission on Environment and Development published the report of 'Our Common Future' also known as the Brundtland Report (Elliot, 2013). This report is considered influential in establishing the relevance of sustainable development on a political and international stage (Elliot, 2013). The definition of sustainable development from this report included an insightful comment that environmental issues can be influenced through the development process of an economic, social and political perspective (Elliot, 2013). The Brundtland Report emphasised the necessity to fight environmental degradation and poverty by providing long-term sustainable solutions (McChesney, 1991). McChesney (1991) argued that while the report provided a focus on the impacts of economic growth, it was vague in the description on how to manage environmental burdens including population growth. Burns and Witoszek (2012) also criticised the Brundtland report and stressed that while the report does present sustainable development as a concept it lacks the understanding of how cultures can influence development. Burns and Witoszek (2012) maintain that there is a need to update the Brundtland Report to encompass what is occurring in the 21<sup>st</sup> century as there has been both positive and negative effects of economic growth and population movement.

A classic definition of sustainable development is "the ability to make development sustainable to ensure that it meets the needs of the present without compromising the ability of future generations to meet their own needs" (The World Commission on Environment and Development, 1987, p. 8). This definition of sustainable development has a focus on equity and has emphasis on the future and the importance of creating a world where the needs of forthcoming generations can be accomplished (Kates, Parris & Leiserowitz, 2005). While the

definition can be considered dated, many current resources still refer to it, including the International Institute for Sustainable Development (2017), Kates, Parris and Leiserowitz (2005) and Holden, Linnerud and Banister (2016).

The official document by the United Nations (UN) regarding the SDGs state that sustainable development focuses on economic, social and environmental dimensions (United Nations, 2015). These three dimensions are known as the pillars of sustainable development and will be discussed further in this chapter. The document by the United Nations (2015) does not specifically describe what they consider sustainable development is, however, these pillars are referred to throughout the document. The broadness of the description of sustainable development allowed the SDGs to be created and to progress where the MDGs were not able to achieve (United Nations, 2015).

## 2.3 The history of global goals

The concept of sustainable development has become a well-used term within the development sector since the Brundtland Report was released (Elliot, 2013). Kates, Parris and Leiserowitz (2005) describes literature regarding sustainable development implies there is a connection between what is to be sustained and what requires development, however, they debate that these concepts are not often intertwined. Due to deteriorating social and environmental conditions and to achieve sustainable development, ethical and universal global development goals have been established for the provision of improved wellbeing of future generations (Holden, Linnerud & Banister, 2016). In 2002, the World Summit on Sustainable Development established the pillars of sustainable development referred to as the economic, social and environment determinants (Kates, Parris & Leiserowitz, 2005). Whilst these three pillars were adopted within the development context, there was no agreement to the finer details due to the economic, environmental and social determinants being difficult to define (Kates, Parris & Leiserowitz, 2005).

“Spare no effort to free our fellow men, women and children from the abject and dehumanising conditions of extreme poverty” (United Nations, 2015, p. 3). These words, spoken in 2000, inspired the creation of the first set of global development goals with the purpose of eradicating extreme poverty, poor health and education (United Nations, 2015). Prior to the SDGs, the MDGs were developed through the agreement of 189 global leaders in the 1990s, deciding upon eight goals to be the focus of the first 15 years of the new millennium. (United Nations, 2015; CAFOD, 2015). Fukuda-Parr, Yamin and Greenstein (2014) explain that the MDGs opened a new chapter in development as they created a global movement towards the reduction of poverty and hunger. With the attention and awareness of the MDGs raised, it became essential to ensure social priorities were a focus for governments, development agencies and individuals globally (Fukuda-Parr, Yamin & Greenstein, 2014). With the global mobilisation occurring to achieve the MDGs, it became one of the most successful movements in tackling issues surrounding extreme poverty and hunger. The MDGs were integrated into many of the countries national development plans allowing for strategies to be implemented to ensure the targets of these goals were reached (CAFOD, 2015). Whilst the MDGs set targets to achieve their goals, there was concern they would distort priorities of other development initiatives or programmes already in place as they may be neglected to achieve these new goals (CAFOD, 2015).

The United Nations (2015) stressed that many of the issues regarding poverty needed to be addressed through integrating economic, social and environmental aspects of sustainable development. This section discusses how the MDGs were unable to integrate these three dimensions and includes further criticisms of these goals. While the MDGs had a positive effect in some countries, the MDGs did not allow for a comprehensive analysis of the development needs and this could have provided a narrow focus (Lomazzi, Borish & Lassser, 2014). While the MDGs were important, the influence on policy and key stakeholders and the consequences were not well understood (Fukuda-Parr, Yamin & Greenstein, 2014). Another criticism of the

MDGs is that they did not consider environmental, social and economic factors (Lomazzi, Borish & Lassser, 2014). While there was some consideration regarding environmental issues, they did not reflect key concerns that influences sustainable development (Lomazzi, Borish & Lassser, 2014). Fehling, Nelson and Venkatapuram (2013) argue that there were multiple reasons for the shortfall of the MDGs and quote former UN Secretary-General Ban-Ki Moon as saying that the lack of progress was due to “unmet commitments, inadequate resources, lack of focus and accountability, and insufficient interest in sustainable development” (United Nations, 2015, p. 1110). The reasoning behind the limited achievement of the MDGs is complex and this can be connected to shortfalls in the formulation, content and implementation of the MDGs (Fehling, Nelson & Venkatapuram, 2013). Having a complex understanding of the restrictions of the MDGs, however provided future goal writers an opportunity to assess and address issue of the past to ensure they do not occur in the future (Fehling, Nelson and Venkatapuram, 2013).

## 2.4 What are Sustainable Development Goals?

The United Nations Sustainable Development Conference, also referred to as Rio +20, occurred on 20-22 June 2012 in Rio de Janeiro, Brazil (United Nations, 2017). This conference focussed on providing governments with measures to implement sustainable development within their respective nations. During the conference it was agreed that governments should adopt sustainable development methods (Leggett & Carter, 2012). It was stated by Leggett and Carter (2012) that many stakeholders are resistant to ‘top-down’ decision making from government and international committees and welcomed the opportunity towards greater inclusion in the decision-making process. Literature suggests that in 1992 the Earth Summit in Brazil constructed the concept of the three pillars of sustainability and that the Rio +20 Summit embraced this form of development (Leggett & Carter, 2012).

During the Rio +20 Summit, members at the conference agreed to the formation of the SDGs to succeed the MDGs. During this conversation there was heavy debate between wealthier and

poorer countries who both viewed the role of these goals differently and in terms of who should take on the greater responsibility of ensuring the achievement of the SDGs (Leggett & Carter, 2012). Gaffney (2014) states that the SDGs do not provide a main focus on poverty in comparison to the MDGs, as it has a wider ambition that involves all nations. The SDGs cover a range of issues including poverty, health, education, hunger and gender equality, with additional issues being included to ensure that newly identified concerns are addressed (CAFOD, 2015). Since sustainable development can be considered an holistic approach between the relationship humans have with the environment (Egelston, 2013), the SDGs provide a broader engagement of issues to address concerns on energy, climate change, forests, oceans sustainable consumption and production, peace and security, inequality, cities, employment and economic growth (CAFOD, 2015).

Creating a wider focus and moving towards a sustainable future enables a role for all individuals to participate for the future of the planet. The SDGs hold relevance and are applicable to all countries, including the Global North<sup>8</sup>, with each goal providing differing challenges according to the country's situation and encourages transformation within their societies and economies (Osborn, Cutter & Ullah, 2015). Osborn, Cutter and Ullah (2015) stress that while Global North nations need to embrace the SDGs within their own country, they also have a role in providing support to countries such as the Global South. This can be considered a significant step forward on a global scale as these development goals are not targeted at a specific group of countries and the SDGs can be described as universal goals that every country needs to embrace to ensure a sustainable future is achieved.

The Ministry of Foreign Affairs and Trade (MFAT) states that Aotearoa will contribute to the SDGs on a global and local scale to ensure the achievement and success of the agreed global

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<sup>8</sup> First World, Third World, developed or developing countries terminology can be viewed as colonial constructs and thus can be derogatory and inappropriate (Connell, 2009). For this thesis the terms of Global North and Global South will be used.

goals (Ministry of Foreign Affairs and Trade, 2017b). For these goals to be achieved in Aotearoa, government agencies and Non-Governmental Organisations (NGOs) will be required to form an alliance on the implementation of methods. As Cooper (2016) explains “New Zealand, like many, is going through its own process to work out how we can use the agenda to make a real difference. We know that achieving the SDGs will require a whole of government effort – and have set up a cross-government mechanism to support decisions on how Aotearoa’s efforts can have the greatest impact” (Ministry of Foreign Affairs and Trade, 2017a). This quote demonstrates the need for Aotearoa to collaborate at both a local and national level to ensure that SDGs become of value to our society.

## 2.5 Sustainable Development Goal 3

When the SDGs were first examined by the World Health Organisation (2015a), they expressed concern that health was not as high of a priority in comparison to the MDGs. However, within the SDG framework, health is considered a key influence on human development and is integrated within these goals in a broader and more versatile way covering a wide spectrum of health issues and topics (World Health Organisation, 2015a). When the SDGs consider health, they observe it in relation to social, economic and environmental determinants which include education and income that affects and impacts the health of populations. It can be concluded that if a population is educated and has sufficient income, the health of the people is greater than those who cannot obtain similar opportunities to receive health care (World Health Organisation, 2015a).

The overall goal of SDG 3 is to “ensure healthy lives and promote wellbeing for all at all ages”. SDG 3 is underpinned by nine targets to ensure that the goal is met within a 15-year timeframe (United Nations General Assembly, 2015, p. 20). World Health Organisation (2015a) also express that the overall goal of SDG 3 identifies many issues regarding health and the targets for this goal recognise areas of concern. The term health inequity describes the differences in

health between different groups and is defined by the Oxford Dictionary (2017) as “a lack of fairness of justice”. To obtain health equity, it is required that full health is attained by all individuals regardless of their social position (Pulver, Haswell, Ring, Waldon, Clark, Whetung, Kinnon, Graham, Chino, LaValley, Compher & Sadana, 2010). Reid (2013) describes that equity is an ethical concept and is a model of justice which ensures resources are distributed to guarantee that people have the minimum requirements. It is vital to remember that when discussing equity, resources do not need to be equally distributed as some people require more resources than others for equity to be achieved. The World Health Organisation (2015a) expresses that inequity can occur when accessing health care due to factors including cost, geographical and cultural barriers. Whilst SDG 3 is aimed at developing countries, this target holds relevance in the Aotearoa context as many Māori suffer from poor health as compared to non-Māori populations (Ministry of Health, 2016a). Osborn, Cutter and Ullah (2015) consider this goal a low priority for developed nations although they agree that there are some in the population that suffer from poor access to health care.

## 2.6 Sustainable Development Goal 3, target 3.8

SDG 3, target 3.8 aims to achieve the implementation of “universal health coverage, including financial risk protection, access to quality essential health care services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all” (United Nations General Assembly, 2015, p. 20). The World Health Organisation (2015b) describes universal health coverage as everyone being able to access high quality and essential health care services without having to have huge financial struggles when accessing the services. To achieve universal health coverage can be difficult and health care providers need to adapt and expand services depending on current technology, demographics and patient expectations (World Health Organisation, 2015b). The concept of universal health coverage can be considered ambitious; however, as a target it can address constraints in the provision of health services

(World Health Organisation, 2015b). With SDGs providing a focus on equity, SDG 3, target 3.8 addresses the allocation of funding and equitable access with the aim of affordable health care to all. SDG 3, target 3.8 is the focus of this research as the Whānau Wellness Resource Programme (WWRP) aligns with this target as participants involved in the programme receive affordable and accessible health care and medication for a 12-month period. The WWRP will be discussed in greater detail in Chapter Six: Health Hawke's Bay Case Study.

To ensure the SDGs could be evaluated a set of indicators were established. In March 2017 the United Nations Statistical Commission agreed and refined a set of indicators to measure the SDGs formed by the Inter-Agency and Expert Group on SDG Indicators (United Nations Statistics, 2017). Inter-Agency and Expert Group on SDG Indicators (2017) proposed the indicators to United Nations Statistical Commission in March 2016 providing 232 indicators to measure the SDGs.

The Inter-Agency and Expert Group on SDG Indicators (2017) proposed that to measure SDG 3, target 3.8 there needs to be two indicators. The first indicator to measure SDGs is the measurement of the coverage of essential health services. This is defined by the "coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, new born and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population)" (p. 4). This examines any essential services and how they are accessed by marginalised populations. The second indicator for SDG 3, target 3.8 is the measurement of the "proportion of population with large household expenditures on health as a share of total household expenditure or income" (Inter-Agency and Expert Group on SDG Indicators, 2017, p. 4). The indicators provided by Inter-Agency and Expert Group on SDG Indicators state that they can be considered a strong way to measure, analyse and evaluate SDG 3, target 3.8 to determine if the target is met in 2030.

## 2.7 Concluding thoughts

This chapter has discussed the history of global development goals and the need to continue the work of the MDGs through the establishment of the SDGs. The SDGs strive to achieve beyond the MDGs by providing a framework which encompasses further issues representing the growing need to incorporate sustainable development in the Global North and Global South. SDGs are an important set of development goals that have been created to obtain a sustainable future for forthcoming generations. An holistic approach to sustainable development as agreed by 193 countries, enables the opportunity to achieve affordable and accessible health care for the population. Whilst the indicators to measure SDG 3, target 3.8 are finalised by the United Nations Statistical Commission, they tend to focus on health statistics and economic spending on health care per household which does not perhaps account for the need to take a participatory approaching to achieving affordable health care. To achieve affordable and accessible health care in the Hawke's Bay district, SDG 3, target 3.8 needs to become a focus for health care organisations by providing affordable health care to ensure equity occurs. SDG 3, target 3.8 is of value to the Aotearoa community as there is a percentage of the population who struggle to afford primary health care. The following chapter will explore the theoretical framework of participatory development.

# Chapter Three:

## Participatory Development

*Being involved in a process is not equivalent to having a voice. Voice needs to be nurtured. People need to feel able to express themselves without fear of reprisals or the expectation of not being listened to or taken seriously.*

(Cornwall, 2008, p. 278).

### 3.1 Introduction

The purpose of this chapter is threefold, to firstly critically review literature regarding the concept of participation as it relates to development thinking and practice. Secondly consideration will be given to participation in relation to Aotearoa's founding document Te Tiriti o Waitangi. In doing this I highlight the diverse conceptual definitions while also critically debating aspects of the participation paradigm. Through demonstrating a more nuanced understanding of participatory development (PD), I will endeavour to demonstrate how Whānau Wellness Resource Programme (WWRP) can contribute to the achievement of Sustainable Development Goal (SDG) 3, target 3.8. Thirdly, criticisms of participation will be discussed followed by the concluding thoughts.

### 3.2 Overview of participatory development

The notion of PD re-emerged in the 1980s when the realisation that traditional models of development that were insistent on using top-down development approaches focused on imposed expert opinions rather than embracing local knowledge and expertise (Elliot, 2013). The use of PD can result in a greater engagement and increased participation on issues of concern to participants (Mansuri & Rao, 2011). Providing a forum for people to share their thoughts and feelings is not a definitive way of creating effective participation as it is dependent on what the parties are willing to offer (Cornwall, 2008; Mohan & Stokke, 2000). While it appears simple to transfer ownership of a situation to the people participating, it is more complicated than it first appears as there needs to be resources and services in place to provide the support in the shift of power and control (Cornwall, 2008). Due to the framework of PD focusing on poor and vulnerable communities having to participate in development schemes, power and participation are often highly encouraged in these communities even if they do not perceive any benefit from it (Mohan & Stokke, 2000).

### 3.3 Defining participatory development

PD first occurred in the 1950s- 1960s when various aid agencies including the United States Agency for International Aid looked to implement participatory development (Mansuri & Rao, 2013). PD was funded by donors and created decentralisation, community-based development and promoted cooperative institutions (Mansuri & Rao, 2013). However, by the 1970s PD had fallen out of favour when the realisation occurred that government reform and cooperation had largely failed and was believed to be an unsustainable or viable option for development or aid agencies (Mansuri & Rao, 2013). Chambers (1995) expresses that the rise of PD is due to the recognised failures and dissatisfaction of top-down approaches to development resulting in a renaissance in the 1990s. This shift of development paradigm from a top-down development approach allowed for participation to be acceptable and acknowledged (Chambers, 1995).

Cornwall (2002) reiterates the ideas of Chambers (1995) while also expanding on how participation has now also gained legitimacy and respect. It is stated that community involvement and participation over the last few decades have allowed for improved governance and an increase in development outcomes (Gaventa & Barrett, 2010).

Mohan (2014) expressed that Robert Chambers, a prominent development thinker, believed that mutual learning was an important aspect of development, whereas participation involves all parties sharing their knowledge with one another to achieve better outcomes. Chambers was determined to challenge the way that development agencies and theories were approached when working with impoverished communities and individuals (Parnwell, 2006). Chambers (1995) argues that the way history has evolved determines how individuals view and perceive poverty and impoverished people in relation to being disadvantaged. Cornwall (2002) describes the uprising of participatory language and embracing participatory methods has allowed for a change in development practice.

It is perceived that those who implement and engage with development programmes are often removed from the situation and the reality that impoverished people are experiencing, thus creating a lack of understanding between the two parties (Chambers, 1995). Although Chambers theory concentrated on Global South farmers, it holds relevance to this research being undertaken, as it has a focus on how participation can be implemented in different contexts within a development framework. The proposed research is being undertaken in Hawke's Bay, Aotearoa, a Global North country, and there is still the need for people to be able to participate in their lives and community projects which can affect them personally.

Peet and Harwick (2009) described nine years ago that PD is a new and popular bottom-up approach that promises and embraces a new form of development where colonial views are not domineering. People tend to perceive PD in a positive light, however there tends to be many definitions and interpretations of PD resulting in confusion regarding what form of PD is

occurring (Mohan, 2014). Chambers (1995) states that there are three ways that participation can be implemented. The first use of the term participation can be to upscale proposals to ensure that they are appealing to donor agencies and governments. Most donor agencies and governments expect participation to occur. However, Chambers (1995) claims that top-down approaches can occur instead which follows the traditional style of development. The second intention of participation is that it is a co-operating practice. This ensures that the local community are included in the process while also reducing costs. The final intention of participation is that it is meant to be an empowering process that allows local participants to have control over the programme (Chambers, 1995).

Mohan (2014) poses the question “if people participate, what are they aiming to gain by participating?” (p. 132). This question can initiate debate over the purpose of engaging communities in development projects and the impact on the wider community. While citizen participation can produce positive effects on outcomes, these affects are dependent upon the situation where participation is occurring (Gaventa & Barrett, 2010). However, Gaventa and Barrett (2010) also express that it is important to note that while the use of participation has increased within the development field, it is difficult to measure and evaluate. For this research Cornwall’s (2002) definition of PD will be applied. Cornwall (2002) defines PD as “to give the poor a part in initiatives designed for their benefit” (p. 11). This definition of participation has been selected as the research focuses on involving multiple groups from diverse backgrounds in the health programme of WWRP to achieve affordable and accessible health care. This provides a focus on encouraging participants at all levels to be empowered by participating in decisions that affect their and their whānau’s future.

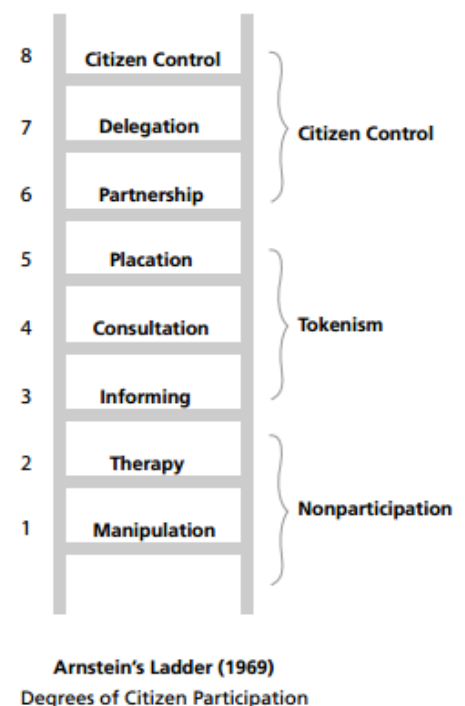
### 3.4 Types of participation

Participation has been theorised in varying ways. Popular frameworks seen in the development literature are Arnstein (1969), Pretty (1995) and White (1996). Arnstein’s Ladder of Participation

(1969), represented in a ladder with eight components, distinguishes between various levels of participation. Pretty Typology of Participation (1995), describes seven different forms of participation in differing environments. The final model of participation is White's Typology of Interest (1996) which examines the relation between participation, the implementing agency and those who are on the receiving end of participation.

In Figure 1 (Arnstein's Ladder of Participation image retrieved from The Citizens Handbook, 2018) below, Arnstein (1969) has divided participation into eight distinct levels and then grouped the levels into 1) Citizen's Control, 2) Tokenism and 3) Nonparticipation.

Nonparticipation is the "condition of not being involved with or participating in something" (Oxford Dictionary Online, 2017). Under this level, Arnstein (1969) states that there are two subcategories which are Manipulation and Therapy. The objective of these subcategories is to ensure that people are not able to participate in planning and allows for those who hold the power to 'educate' or 'cure' non-participants or vulnerable populations (Arnstein, 1969).



Tokenism is defined as "the practice of making only a perfunctory or symbolic effort to do a particular thing, especially by recruiting a small number of people from under-represented groups in order to give the appearance of sexual or racial equality within a workforce." (Oxford Dictionary Online, 2017). Informing and Consultation, when offered by those who hold power, may allow for peoples' voices to be heard and for information to be shared (Arnstein, 1969). However, while people are provided a platform to express their opinions, it is not guaranteed that they will be heard or considered (Arnstein, 1969). Placation is a higher level of tokenism and is a way to

appease those who have offered their opinions regarding the situation. While it allows for personal opinions to be expressed, those in charge retain power over the situation and decision-making process (Arnstein, 1969).

The final level, Citizen's Control, is where citizens have control and power over the relationship and decision-making process and can enter a more equal relationship (Arnstein, 1969). The first subcategory of citizen's control is Partnership which allows for negotiations and trade to those in charge. The last of the subcategories are Delegated Power and Citizens Control. These allow citizens to gain power and control over the decision-making process (Arnstein, 1969).

These eight subcategories and three levels of participation appear separate, when dealing with participation, however they are not easily distinguishable (Cornwall, 2008). While Arnstein's Ladder of Participation is a seminal model it was appropriate to discuss this model as it has relevance in the involvement of participation within the development context (Rodrigues, 2017). Cornwall (2008) states that Arnstein's Ladder of Participation views participation in terms of those who receive the help and differs from Pretty's Typology of Participation where it is viewed from various approaches. While both models strive to achieve clear approaches of participation which relate to the development context (Cornwall, 2008), it is important to review both models as they share commonalities on the shift of power and control.

Pretty's Typology of Participation (1995) was designed for agricultural development, however, the distinct types of participation identified by Pretty (1995) are applicable to different environments. Pretty identified seven types of participation and each are identified as distinct levels of engagement (Norwegian Agency for Development Cooperation, 2013). As demonstrated in Table 1 (Pretty's Typology of Participation image retrieved from Norwegian Agency for Development Cooperation, 2013) this model as determined by Pretty (1995) provides a range of participatory types that can be engaged when conducting PD.

*Table 1 Pretty's Typology of Participation (1995)*

Manipulative Participation is considered to have the least amount of participation with the nominated representative of a community having no validity or power (Pretty, 1995). Passive participation is when there are announcements or decisions without listening or consultation with the people they are working with. People only participate when decisions have been finalised and they are informed of what to do in the situation (Pretty, 1995). Participation by Consultation is defined as people asking questions. However, external agents provide the solutions and answers to the problems at hand. There is no sharing in the decision-making process and external agents are not required to acknowledge people's opinions and perspectives (Pretty, 1995). Participation for Material Incentives requires people participating by contributing resources in return for food, money or other material incentives. Functional Participation occurs when external agents see participation as a way to achieving goals and outcomes of a project whilst also managing to reduce costs (Pretty, 1995). While people may create groups to discuss decisions regarding the predetermined outcomes and goals, most groups will be established once external agents have determined the outcomes of the project (Pretty, 1995).

Interactive participation involves the joint analysis and development of plans and the strengthening of local institutions. In this type of participation, participation is determined as an entitlement, seeking multiple perspectives and is a learning process for all. As a group, they assume control over the situation and determine what resources are required to ensure they have a stake in controlling the situation (Pretty, 1995). Self-Mobilisation is the final type of participation, where people take initiative over a situation themselves without external agencies being in control or leading the project. While this group may contact external agencies for advice and resources, they have total control and the authority stays with them. Self-mobilisation can spread in a community if governments and Non-Governmental Organisations (NGOs) provide the required support and the resources to achieve this (Pretty, 1995). While Self-Mobilisation would be the ideal participation typology to have implemented in communities', it is however, an enlightenment that is difficult to obtain (Cornwall, 2008).

White's Typology of Interest (1996) is another model of participation relevant to understanding a PD framework. White (1996) states that sharing stories and ideas through participation does not mean that there is a shift in power. Table 2 (White's Typology of Interest image retrieved from White, 1996) demonstrates how White (1996) has divided up the forms of participation. It is stated as being an analytical device, however, in practice the utilisation of participation can vary. A development project will rarely identify with a pure form of participation, however White (1996) believes that this layout of participation provides some distinctions in the ambiguity of the concept of participation.

**Table 2** *White's Typology of Interest (1996)*

White (1996) describes four forms of participation. Cornwall (2000) expanded White's (1996) original model to provide a more in depth understanding of what each level of typology involves (Table 3, White's Typology of Interest adapted by Cornwall's (2000) image retrieved from Norwegian Agency for Development Cooperation, 2013).

*Table 3 White's Typology of Interest (Adapted by Cornwall, 2000)*

Nominal Participation describes how this level of participation is for display and it is about inclusion and legitimation (Cornwall, 2000). Cornwall (2000) describes that legitimation is to demonstrate that the agency is engaging in participation and this inclusion allows those on the receiving end to gain access to some benefits. Drawing on an example by White (1996) in Zambia, nominal participation can be best understood when the government looked to form a women's group. While the group is legitimate, and the government has looked to include women, they rarely meet, and participation is for display and increased involvement does not occur.

The second level of participation referred to as instrumental, focuses on efficiency and cost (White, 1996). This model of participation is about limiting funders input and by allowing the community to contribute to projects, they become more cost effective (Cornwall, 2002). The cost of instrumental participation for those on the receiving end is to contribute labour and time to the projects, providing a cost-effective delivery (Cornwall, 2002). White (1996) states that through this typology, people's participation is necessary to provide the labour. However, this level participation can be considered instrumental rather than the valuable (White, 1996).

The third typology according to White's (1996) is representative participation. This form of participation focuses on sustainability to ensure dependency is not created by the implementing agency. Leverage is to ensure that those on the receiving end can influence and shape the project and the management team (Cornwall, 2000). The use of this participation is to ensure that people have a voice when influencing their own development. When White (1996) discusses this typology, she mentions that the function of this is to allow locals to have their own voice and also allow the implementing agency to avoid any dependency and create sustainability.

White's (1996) final typology is Transformative Participation whereby there is a strong focus on empowerment (White, 1996). The implementing agency looks to strengthen people's capabilities enabling them to act and make decisions for themselves, thus they are empowered (Cornwall, 2000). White (1996) states that participation as empowerment is a practical component to being involved in decision making and collective action, which can lead to a greater awareness and questioning as to what keeps people in poverty and enables people to have greater confidence in their ability to make decisions and create a difference (White, 1996). White (1996) debates that empowerment can be perceived as an agenda 'from below' as it is essential that it involves action from below. It is important to consider that while implementing agencies can facilitate empowerment, they are not able to implement empowerment (White,

1996). This process is a never ending one and it continues to transform people's reality and their sense of what it is (White, 1996).

White's Typology of Interest (1996) provides understanding of participation that is less of a ladder and enables people to perceive participation as a way to identify ideas and how it is being utilised in particular stages (Cornwall, 2008). As participation has many definitions that can co-exist together, it is important to understand that participation will not be the same in any community or project (Cornwall, 2000).

### 3.5 Sustainable Development Goals and participation

The United Nations (UN) describes participation as a consultation process allowing for various voices to be heard (Honniball and Spijkers, 2014). To achieve the Sustainable Development Goals (SDGs) and specifically SDG 3, target 3.8, participation is required to ensure that division and inequality are not occurring (Servaes, 2016). Community participation is considered instrumental when addressing the SDGs as it provides an understanding of how discrimination and social orderings can be influential (Howard & Wheeler, 2015). The inclusion of participation at a governance level allows policy makers to work with marginalised populations which addresses power abuse (Howard & Wheeler, 2015). While there is a focus on participation to achieve the SDGs, people should not be forced to participate in any project where they do not feel comfortable.

Honniball and Spijkers (2014) state that while the Millennium Development Goals (MDGs) did not encourage participation in the formation of the goals, a different approach occurred for the SDGs. The transition from MDGs to SDGs is ongoing and still requires work and highlights the concept that to achieve the SDGs, governments and agencies need to work together rather than participate in a sector that highlights inequality and divisions (Servaes, 2016). The SDGs highlight that all cultures and ethnicities are required to participate and work together to be able to

achieve these goals and this is a shift in direction to what was previously used for the MDGs (Servaes, 2016).

### 3.6 Empowerment and participation

While PD is the focus of this research, it is also important to understand the concept of empowerment and how it relates to wider research. There has been a shift in development practice to ensure that participation and empowerment are equivalent with each other, and this has changed the relationship between locals and institutions (Mohan & Stokke, 2000). The use of participation aspires to reduce a top-down power approach and distributes power more equally (Kesby, 2005). While empowerment and participation are often referred to in the context of gender issues and equality, it is important to recognise that participation and empowerment play a role in other areas of society including vulnerable and/or Indigenous populations. Empowerment is a transformation and involves a focus on language, identities, cultural practices and meanings (Parpat, 2014). The importance of empowerment is to ensure that people enhance their power and enables them to act and fight for change.

Empowerment is considered a flexible concept that is generally applied in relation to gender or vulnerable populations (Parpat, 2014). In the mid-1990s mainstream development began to embrace the concept of empowerment, participation and partnership. Increased utilisation of these concepts enhances the efficiency and productivity of social transformation (Parpat, 2014). Empowering vulnerable populations in society is critical when the goal to improve sustainable development and welfare is apparent (Elliot, 2013). Empowerment is considered more than just participation in a decision-making process and should embrace the evolution of people being able to perceive themselves as capable and willing to make decisions regarding their future (Parpat, 2014).

The World Bank (2002) debates that creating openness and encouraging participation enables people to become empowered as they speak out when they believe it is required. The use of

inclusion and accountability can create empowerment and promote social cohesion and trust (World Bank, 2002). Good governance has been recognised as a requirement for effective development and can promote growth. Having good governance helps in the promotion of empowerment as it allows for transparency, accountability and participation from all parties and individuals.

McElnay (2016) uses the concept of empowerment throughout Hawke's Bay Health Equity report. Empowerment in the context of health reflects the idea of having control over personal health as well as valuing the changes that are required. Research suggests that in less well-off communities, empowerment is often lacking due to the belief that creating change is no longer possible (McElnay, 2016). Therein lies the challenge of being able to empower people in a positive way to ensure change in their health and wellbeing is occurring for the future of themselves, their whānau and the community. Whilst there are many health programmes in place in Aotearoa to support Māori wellbeing, the main theme throughout is allowing Indigenous people to have control over their own decision making and changes that are happening for their whānau.

While it is disputed how power is defined, there are various forms of power relations, such as 'power within' and 'power to' (Rowlands, 1997). Power is often considered having the ability to influence people, however this is not always the case (Willis, 2011). Within the dimensions of power described by Rowlands (1997) there is the ability to have the 'power within', whereby an individual has the strength inside them to allow for the growth of self-respect and self-acceptance (Rowlands, 1997). 'Power to' creates new forms of possibilities and actions without dominating the group (Rowlands, 1997). The purpose of this power dynamic is to ensure leadership which enables people to create change, allowing a group to achieve its potential. This is a form of power that allows for new possibilities (Rowlands, 1998).

In relation to development, power is still observed as being defined by sovereign terms, as being held by a few with a top-down approach (Kesby, 2005). This approach to power can lead to dominant ideologies and beliefs being imposed on vulnerable populations. In relation to participation and power, it is often referred to as the political activity of all parties. However, for this research the opinions formed of the relationship between participation and power can be incorporated, as participation is being observed between a health organisation, health professionals and a vulnerable population.

### 3.7 Participation and Te Tiriti o Waitangi

Te Tiriti o Waitangi is the founding document of Aotearoa, forming the relationship between Māori and the Crown, and in 1975 becoming an element of Aotearoa legislation (Orange, 2010). However former Aotearoa Prime Minister Sir Geoffrey Palmer (2013) has argued:

The difficulty with the Treaty is, we say it's constitutionally important but it's not even in the legal system. It's half in and half out of the legal system, let alone the constitution. So, you see there really has to be a systematic approach to deciding what its legal status is.

(Constitutional Advisory Panel, p. 5).

This confusion demonstrates that while Te Tiriti o Waitangi is open to interpretation, it is a long-standing document that remains relevant in supporting and mending the ways in which Māori have been treated in the past (Network Waitangi, 2016; Anaya, 2011).

Partnership, participation and protection are the core concepts, deriving from Te Tiriti o Waitangi for health professionals in Aotearoa when addressing Māori health (Ministry of Health, 2014c). Te Tiriti o Waitangi principles state that participation and partnership include working with the iwi, hapū and whānau and the wider Māori community to ensure appropriate strategies are created in the development of health services (Ministry of Health, 2014c). As

participation is often referred to in the health context, further discussion is continued in Chapter Four: Māori Health.

### 3.8 Criticism of participation

While PD is considered a reaction against top-down development, there are concerns over how it is implemented in practice (Enns, Bersaglio & Kepe, 2014). With PD becoming a more recognisable method of development, the UN prioritised participation as significant when consultation processes occurred for the SDGs. To ensure participation occurs in Indigenous communities, the UN has provided guidelines for countries to be facilitative and inclusive in the process (Enns, Bersaglio & Kepe, 2014). However, while there was the endeavour to provide an inclusive consultation and participatory process, the manner in which post-MDG era was discussed did not meet the expectation of the UN (Enns, Bersaglio & Kepe, 2014). Enns, Bersaglio & Kepe (2014) state that while groups-initiated conversation by means of participation, there is concern that the voices selected to represent the group supported the stakeholder's concerns, rather than represented what is actually occurring in the community as those voices often go unheard.

The participation discourse originally was based on NGOs participation in the community, however there has been a shift to have participation involved in political agendas where governments and international development agencies are utilising this discourse as a form of control (Williams, 2004). It was believed that for participation to become an integrated part of development practice, the concept needed to be depoliticised and reintroduced as a watered-down concept with a neo-liberal agenda (Leal, 2007). The question surrounding participation is often about whether participation should be adopted into different development frameworks. However, it is important to remember that the underlying principle of empowerment is to ensure social transformation (Leal, 2007). Kyamusugulwa (2013) debates that while participation is used in relation to the political context it also highlights power imbalances

between those who are being led and the leaders of a group or community. It has been identified that one of the main criticism of PD is that many practitioners treat PD as a social project rather than a political movement to create empowerment (Terry, 2008). Parfitt (2004) argues that while participation is designed to empower those at a grass roots level, participatory projects tend to sustain power imbalances and are not accountable to those they are serving.

Power relations are not only found in a community between leaders and the people, it also occurs between facilitators of development programmes and beneficiaries. This process tends to allow facilitators to have more power over the beneficiaries and this unequal power balance does not allow for true participation to occur (Kyamusugulwa, 2013). As Rowlands (1997) states 'power over' is a form of controlling power that people respond to in compliance. When there is an unequal balance of power between two parties, 'power over' can ensue and this can diminish the impact of participation occurring. Kyamusugulwa (2013) states that participation has been identified as affecting the social power in a community and can hide the true power dynamics. To ensure power relations are understood Norwegian Agency for Development Cooperation (2013) suggests that analysis of power relations is required before engaging in PD to gain a greater understanding of the community to enable participation to be used appropriately. This can be considered a time-consuming step in relation to participation, however it is important to understand the community being engaged with the process, as if not undertaken, community buy-in may not occur (Parfitt, 2004).

The conceptual definitions used in relation to participation have come under criticism due to the complexity and the rightness of the application of techniques (Kyamusugulwa, 2013). Cleaver (2001) debates that when conceptualising participatory approaches and definitions there is a need to have broader and more complex analysis to allow a greater understanding of how these interventions impact the community. Norwegian Agency for Development Cooperation (2013) supports Kyamusugulwa (2013) and Cleaver (2001) statements that

participation and concepts relating to this are often difficult to define and measure in a precise method.

Cleaver (2001) states that due to difficulty in defining and conceptualising who is advancing from participatory programmes, it is often unclear as to who is benefiting, and little is done to explore the limitations of these programmes. Another identifiable issue with definitions involved in PD is that when defining the community, one is working with, it is often assumed that these can be identified in simple organisational forms (Cleaver, 2001). This however is often not the case, especially as communities are growing and changing in relation to their environment. While a community may be open to participation there can be limitations in how receptive they are, and this can be unaccounted for when starting a participatory project (Cleaver, 2001).

### 3.9 Concluding thoughts

To conclude, an increasing rise in disparities creates a distrust in institutional organisations thus creating a sense of powerlessness and people wanting to change the status quo (Gaventa & Martorano, 2016). The use of PD in this research allows for a greater understanding of how participation is understood and what can occur if implemented to its full potential. For the thematic analysis occurring, a PD lens will be applied when analysing and discussing the research findings which will enable the research aim and questions to be answered. While there are different forms of participation, this research focuses on White's Typology of Interest (1996). This typology defines various level of participation that is representative of the different groups being researched. PD provides a lens in which participation can be viewed in terms of delivery and involvement of a health programme in Hawke's Bay. The following chapter discusses Māori health and determinates that influence and affect the health and wellbeing of this community.

# Chapter Four:

## Māori Health

*Health is about people and Māori health development is essentially about Māori defining their own priorities for health and then weaving a course to realise their collective aspirations. It requires an understanding of philosophical and cultural parameters, an appreciation of social and economic positions, and the ability to plait together the many strands that influence health status.*

(Durie, 1998, p. 1)

### 4.1 Introduction

Reflecting on Durie's (1998) quote, there is the requirement that Māori are empowered to define their own needs and health priorities to ensure they are receiving the care they require. The purpose of this chapter is to understand various perspectives on health and wellbeing, how Māori health is defined and the impacts of colonisation on health. Also discussed are the determinants of health and the implications in relation to Te Tiriti o Waitangi. To wrap up the chapter the Māori health model of Te Whare Tapa Wha will be explored. While this chapter focuses on Māori health, it is important to understand this topic as the research places emphasis on a health programme that targets Māori. By gaining an understanding on the obstacles of

health for Māori, the relevance of Sustainable Development Goal (SDG) 3, target 3.8 will be evident.

## 4.2 Understanding perspectives of health and wellbeing

Traditionally the biomedical model of health is the dominant paradigm which underpins western medicine that views any physical or mental illness because of physiological issues (Rohleder, 2012). When using the biomedical approach, the theory states that any illness is strictly caused by biological factors. However, the World Health Organisation Constitution (2006) defines health as a “state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity” (p. 1). This definition provided by the World Health Organisation (WHO) demonstrates that health requires an holistic approach and establishes how numerous factors can contribute to an individuals and a community’s wellbeing. As wellbeing has differing individual connotations, Cram (2014) states that in the United Kingdom the Health and Education Authority (1997) has defined wellbeing as being how we feel, think and our beliefs in our own and other individual’s dignity and self-worth.

Wellbeing for Indigenous people can be difficult to define and many assessments discount colonisation, racism or loss of culture and identity as impacting on health outcomes and health service assessments may need to consider historical and current issues which are affecting Indigenous communities (Cram, 2014). The situation for Māori is also common in other Indigenous people in Global North nations. Migiroy, Lama, Hansen, Maldonado, Tukuitonga, and Buranbaeva (2015) express concern over marginalised and vulnerable populations, including Indigenous communities on a global scale, where the majority face hardship when accessing affordable health care. Ring and Brown (2003) suggest that there should be a requirement to have a cultural change in the delivery of health care to ensure that good health is attainable for all.

To quantify objective wellbeing in an impartial method, socio-economic measures are assessed and examined to determine if people are living a good life (Cram, 2014). Durie (2006) states that socio-economic measures including standard of housing, health status and levels of education can be used to determine the wellbeing of an individual or a community as they are measures that can be applied to any age or ethnic group. With information surrounding Indigenous wellbeing often being obtained from the census or similar data collection techniques, true depiction and the opinion of individuals are often not well represented (Cram, 2014). Māori specific measures may be required as interpretation of approved education and housing is defined differently depending on cultural influence (Durie, 2006). Wellbeing can also be measured through subjective wellbeing and this approach examines how people experience their life (Cram, 2014). To assess subjective wellbeing individual reflections on feelings and experiences need to be recorded as this provides an efficient way to assess wellbeing, however it is often an unattainable way to measure wellbeing as it is a time-consuming and costly method (Cram, 2014).

### 4.3 Overview of Māori health

Prior to the colonisation of Aotearoa by the British Empire the Indigenous population, known as Māori, who had travelled via waka from Hawaiki, had an established and highly functioning society (Network Waitangi, 2016). The community was sustainable as it had its own health care, education, justice, welfare and spirituality sectors. For Māori, spirituality encompasses more than just religion, as they value relationships with the environment and tend to identify with surrounding land, water and mountains (Durie, 1998). These environmental spiritual connections are pivotal in providing a sense of identity and is fundamental in the provision of good health (Durie, 1998). As well as placing importance on the spiritual aspects of their lives, whānau also holds a special place. For Māori, whānau encompasses more than the extended family and is a network that provides support, responsibility and obligation within the

community (Durie, 1997). In modern times, the significance and value of the term whānau is considered to be lost, however there is a concrete attempt by many in the communities to reunite and redefine the term within current society (Durie, 1997)<sup>9</sup>.

The role of whānau in an individual's health care is vital. Due to the whānau structure and dynamics, the individual approaching a health care professional is not necessarily the patient and maybe the parent, grandparent, aunt, carer, or a whānau representative (Best Practice Journal, 2008). Though the role of the patient is to receive the required treatment, whānau provide the role of support whilst also being a champion with health care professionals. Best Practice Journal (2008) encourages whānau participation during patient consultations, in the decision-making process and in terms of implementing goals. Through health care professionals having a relationship and understanding with whānau and acknowledging the dynamics of their culture, health care solutions can be tailored to the individual (Best Practice Journal, 2008).

Empowering Indigenous communities to be in control of their health and wellbeing provides a positive step forward, however, this can only occur when suitable resources are culturally appropriate and readily available (Medical Council of New Zealand, 2008). The Medical Council of New Zealand (2008) states that when addressing concerns surrounding oranga for Māori, a whānau focused approach is an important requirement for health models. Aotearoa is no exception to the effects of colonisation with statistics representing that Māori suffer poorly in all areas of health compared to non-Māori. Over the past twenty years the Aotearoa Government has attempted to increase the emphasis on Māori health, however, even with this increased focus, statistics still represent negative indicators towards improvement (Anaya, 2011). Indicators demonstrate that Māori have a shorter life expectancy than other ethnicities residing in Aotearoa (King, Smith & Gracey, 2009; Durie, 2003; Pulver et al., 2010). For Māori

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<sup>9</sup> Regarding Durie's work, from the 1980s Mason Durie wrote seminal pieces of work on Maori health and many health professionals and literature still refer to his writing.

men in Hawke's Bay the life expectancy is 8.2 years less than non-Māori with the average age being 71.7 years old, and for Māori women in Hawke's Bay life expectancy is 7.7 years less than non-Māori with the average age of 75.9 years old (McElnay, 2016). In comparison to the rest of Aotearoa, the life expectancy for Māori is higher with Māori males having a life expectancy of 73 years old and Māori females having a life expectancy of 77.1 years (McElnay, 2016).

#### 4.4 Post-colonialism and health

In many Global North countries, Indigenous populations suffered when their land was colonised, and with lasting community impact it appears to be having long term effects on their health and wellbeing (Durie, 2003; MacDonald & Steenbeek, 2015; Paradies, 2016). Durie (1997) describes the colonisation process of Aotearoa as a comparatively recent experience compared to the colonisation experiences of other Indigenous groups, however the impacts of this event are similar to what other Indigenous communities faced before them.

As many Indigenous communities embrace a more westernised, urbanised, and modern aspect to their lifestyle, non-communicable diseases, for example obesity, diabetes, cardiovascular disease, drug and alcohol substance abuse, are becoming of greater concern (Gracey & King, 2009; Durie, 2003; Reading & Wein, 2013). Indigenous populations are considered to have a similar definition to health as the WHO. As Reading and Wien (2013) confirm, an Indigenous perspective on health embraces the holistic approach of incorporating the physical, spiritual, emotional and mental characteristics. There are many contributing factors that can affect the health and wellbeing of an Indigenous community. Gracey & King (2009) affirm that due to poor living conditions, socio-economic factors, malnutrition, overcrowding, poor hygiene, education and geological locations, Indigenous communities are at higher risk of contracting diseases than their non-Indigenous counterparts.

Whilst Māori openly welcomed representatives of the British Empire, Māori were portrayed in a negative way when racism became an issue and the traditional Māori lifestyle was not

accepted or tolerated (Durie, 1997). Rochford (2004) identifies that the effects of colonisation on Māori lead to loss and suffering of their identity, culture and land which were all components that provided a sustainable lifestyle. Māori also had an established economic and health system that disbanded when they were colonised by the British Empire. With over forty different Māori iwi throughout Aotearoa, everyone experienced and created a different history in terms of colonisation (Rochford, 2004). Durie (1997) explains that the implementations of new religions, social structures and hierarchies led to a huge change in the traditional Māori culture and customs. Anaya (2011) states that many Indigenous groups hold a strong connection to the land as it is a part of their cultural identity and is involved in spiritual and material wellbeing, and this is particularly true for Māori.

When traditional British schooling was implemented, the concept of assimilation was enforced as all education was taught in the English language which was of a disadvantage to Māori who spoke Te Reo Māori. Through education, the cultural and spiritual beliefs of Māori were also challenged and provided assumptions that European culture and beliefs were superior (Durie, 1997).

By Māori engaging in compulsory British education and having a new belief system enforced upon them, their language, ideological practices and culture were placed in danger (Durie, 1997). The deculturalisation of language has created the estrangement of Māori from their traditional way of life whilst also creating difficulty in becoming a part of the Pākehā society (Rochford, 2004). It has been noted that earlier research conducted on Māori have had a negative tendency towards the people. Without a positive and empowering environment for Māori, this can have a negative effect on the overall health and wellbeing of this population (Durie, 1997).

## 4.5 Determinants of Health

While section 4.3 provides a brief insight into Māori Health, this section explores issues that can create inequity in health for Māori. Within Aotearoa there is a different health profile between Māori and non-Māori concerning the determinants of health. Oxford Online Dictionary (2017) defines determinants as “a factor which decisively affects the nature or outcome of something”. In relation to this definition, the Ministry of Health (2017c) has identified that social, economic and cultural components can affect the outcome of health and wellbeing. The Ministry of Health (2017c) explains that to ensure inequity is reduced there needs to be a long-term intervention.

Socio-economic inequalities, occur in all countries and impact the health and wellbeing of the population, and this is evident for Māori within Aotearoa (McElnay, 2016). Observations have determined that there is a relationship between socio-economic status and health which is known as the health gradient. This gradient determines that if socio-economic status decreases, there is a high chance that the health of the individual and family will deteriorate, however it can be noted that this is a consistent gradient and people are able to move up and down (Rohleder, 2012).

Rohleder (2012) describes how traditional perspectives on poverty are related to income and gross national product, however there has been an increasing awareness on human rights and development issues. Rohleder (2012) refers to the work of Amartya Sen who argues that income disparity can affect the way in which people live their lives and in order to measure poverty, human capabilities need to be examined which include employment and health.

On an international scale, Aotearoa has had a positive growth in employment and income (Johnson, 2017). For those who can work, income levels have increased in a similar pattern to that of economic growth however those who are not a part of the labour market are not facing the same prosperity. There are 300,000 adults who receive the Working-age Benefit providing them with their main source or only source of income (Johnson, 2017). Low levels of income

can also affect the way in which people access health care. McElnay (2016) states that there is supporting evidence to suggest that unemployment can be correlated to poorer health outcomes. With approximately 12.5 percent of Māori unemployed in Hawke's Bay, this can have a negative outcome on the ora for Māori (McElnay, 2016).

Ministry of Health (2012) states that 14 percent of the Aotearoa adult population in 2011/2012 did not access primary health care due to cost. The cost of primary health care services prevented one in seven people from accessing required health care over a 12-month period from 2011-2012. Statistics from the Ministry of Health (2012) demonstrate barriers that Māori faced, with 39 percent of adults experiencing an unmet need in primary health care due to cost, not being able to access an appointment or lack of transport to appointments. This is a growing concern for the Government and medical professionals, with the primary health care sector being challenged to improve services and delivery of health care (Pulver et al., 2010).

#### 4.6 Implications of health according to Te Tiriti o Waitangi

While Te Tiriti o Waitangi was discussed in Chapter 3.7, this section will expand on it in relation to health. Pulver et al., (2010) expresses that Indigenous communities need to be included in partnership with all other stakeholders to ensure a positive impact on communities when change is occurring. In the health sector, there are three identifiable core principles of Te Tiriti o Waitangi that are recognised. These are participation, protection and partnership. Participation requires Māori to be participating at all levels of the health and disability sector including decision making, planning, development and the delivery of health programmes (Ministry of Health, 2014a; Pulver et. al., 2010). With Māori participation in the health sector increasing, there has been significant improvement in allowing cultural values and beliefs to be implemented into the health sector (Ministry of Health, 2014a). Pulver et. al., (2010) states the value and importance of acknowledging the involvement of whānau, hapū, iwi and Māori community support when encouraging participation.

A 2011 United Nations Human Rights report expressed concern regarding *Māori* health and wellbeing compared to the remainder of the Aotearoa population (Anaya, 2011). The Medical Council of New Zealand (2008) note that Te Tiriti o Waitangi is a representation of Aotearoa's goal of achieving universal wellbeing, as it ensures that Māori have access to equal health care that promotes equal health outcomes for all in Aotearoa.

Reid (2013) defines health equity as a measure of how a government distributes health resources and the influence this has over societal values. In relation to health, the aim of Te Tiriti o Waitangi is to provide equitable access to national resources ensuring Māori have the same level of health as non-Māori (Medical Council of New Zealand, 2008). Pulver et al., (2010) state that the majority of countries, where governments actively engage with the Indigenous populations believe that in order to implement solutions, partnership and empowerment need to occur. Partnership requires all participants to be on equal terms, and for this to occur all participants need to ensure that they develop their own capacities and skill to allow the wellbeing of the individuals to improve (Pulver et al., 2010)

With great emphasis being placed on partnership, Te Tiriti o Waitangi implies that the Government is willing to ensure that positive actions are undertaken to improve the wellbeing of the Māori community (Anaya, 2011). Although it is believed that colonisation in the early days impacted the future for Māori, there are ways in which society is trying to make amends. Anaya (2011) states that the Declaration on the Rights for Indigenous People articulates the need for any treaties between Indigenous communities and governments to be recognised as it will allow for partnerships to be strengthened between both parties. Māori representation in the Aotearoa Parliament has allowed for increased participation and action to occur. Having these influential positions enables Māori to have impact on decision making at a higher national level ensuring that the Māori voice is heard (Anaya, 2011). Consultation is another key component of Te Tiriti o Waitangi; however, this is not considered to be unconditional and

varies depending on the situation (Anaya, 2011). Even though there is mention of consultation in Te Tiriti o Waitangi, there is inconsistency as to when it occurs (Anaya, 2011).

#### 4.7 Te Whare Tapa Whā

When discussing Māori health, it is important to understand the holistic focus of their health beliefs through the Te Whare Tapa Whā model. For Māori the harmony between an individual and the wider environment regarding health is due to their perspective of being holistic, dynamic, healthy and having positive thinking (Durie, 1998). It is important to gain an understanding of Māori models of health to be able to relate other concepts of the research including participation and empowerment.

The Māori health model of Te Whare Tapa Whā was developed in 1982 by a Māori psychiatrist, Sir Mason Durie (Figure 2 Te Whare Tapa Whā image retrieved from Ministry of Health 2015). The establishment of this model created a unique perspective as to how health is recognised and valued within the Māori community (Ministry of Health, 2017d). Te Whare Tapa Whā is represented as a whare, a house, where the four core values of Māori health are each reflected as a wall of the whare. The four walls are necessary as they ensure strength and balance (Durie, 1998). The four values of the Te Whare Tapa Whā model are taha tinana (physical health), taha wairua (spiritual health), taha whānau (family health) and taha hinengaro (mental health). Whilst this model of health is not a formal approach to health it is becoming a more recognised method to engage Māori in



Figure 2 Te Whare Tapa Whā Model

health care as it was observed that ethnicity and culture has an implication on health (Durie, 1998)<sup>10</sup>.

Taha tinana can be translated to physical health. This definition observes how good physical health is required for ideal development (Ministry of Health, 2017d). For many health professionals, physical health is the main focus when discussing health related issues. Durie (1998) explains that taha tinana also embraces the growth and development of physical health and this is necessary for optimal development.

Taha wairua examines the importance of spiritual health in relation to the overall wellbeing of a person's health. This component of Te Whare Tapa Whā takes into consideration an individual's religious values and other unspoken energies and is believed to be a part of the life force (Ministry of Health, 2017d). When Māori observe issues surrounding physical health they also focus on the spiritual wellbeing of the individual. This provides a holistic approach to wellbeing that westernised forms of medicine may not consider. Durie (1985) emphasises that taha wairua is recognised to be the most basic and important aspect to require good health, as without any spiritual awareness or mauri, which is spirit or a life force, a person can be more susceptible to illness or misfortune. Durie (1998) explains the value and importance of taha wairua as it is an essential element of Māori health.

Taha whānau observes how the health and wellbeing of the family can impact on an individual. Māori believe that having the capacity to belong, to share and care whilst also being part of a wider community is an important aspect to wellbeing (Durie, 1998; Ministry of Health, 2017d). Whānau is considered a huge contributor to the health and wellbeing of Māori and is believed that the relationship people have with whānau can impact individual health outcomes in either a positive or a negative way (Ministry of Health, 2017d). The Medical Council of New Zealand

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<sup>10</sup> While this model of health care is widely used, the Ministry of Health acknowledge that the model was developed by Durie, they do not state the date it was developed or updated.

(2008) conveys that the concept of wellbeing includes being taken care of by the elders in the whānau. This statement is supported by Durie (1998) who expands the idea and articulates that whānau involvement is critical when illness occurs as a traditional and culturally appropriate attitude is required to improve the health and wellbeing of a patient.

Taha hinengaro places emphasis on the mental health and the thoughts and feelings of an individual and how the mind and body are one. The Ministry of Health (2017d) states that thoughts, feelings and emotions are an important aspect of the body and soul. Durie (1998) describes taha hinengaro as the capacity to communicate, think and feel as the mind and body are an inseparable part of health and wellbeing. For Māori, thoughts and feelings are located within the person. Whilst western medicine has embraced the advancement of mental health through psychology and psychiatry, Māori claim that they did not need the development of these health care services to treat mental health (Durie, 1998).

#### 4.8 Concluding thoughts

In relation to the Aotearoa context, the way in which health and wellbeing is examined needs to be redefined to ensure that the holistic concepts of spiritual, mental, physical and whānau health are incorporated (McElnay, 2016). These concepts can be demonstrated in the Te Whare Tapa Whā model of health that has been discussed in this chapter. In the next chapter discussions will surround the methodology undertaken for this research and the methods used to collect and collate data during the field research process.

# Chapter Five:

## Methodology

*I want to understand the world from your point of view. I want to know what you know in the way you know it. I want to understand the meaning of your experience, to walk in your shoes, to feel things as you feel them, to explain things as you explain them. Will you become my teacher and help me understand?*

Spradley (1979, p. 34).

### 5.1 Introduction

The overall purpose of this chapter is to discuss the methodology undertaken for this research, a qualitative design approach, the accompanying research methods and the fieldwork experiences. As I am a young Pākehā women conducting research on a programme involving Māori health outcomes, I will firstly reflect on my positionality as a researcher and how this can potentially impact the research process and findings. Secondly, the chapter discusses the research design, ethical considerations, research methods and analytical tools applied when conducting this research. The chapter concludes by discussing the concepts of trustworthiness and credibility seen to hold value in this study.

## 5.2 Positionality

When initially discussing my research ideas with my peers, I held concerns regarding my positionality as I am a young, female, Pākehā researcher. I discussed my proposed research with Health Hawkes Bay – Te Oranga Hawke's Bay (HHB) management, the Whānau Wellness Resource Programme (WWRP) Facilitator and Senior Māori Advisor following the completion of a practicum, as mentioned in Chapter One. The concept of a different approach to analysing WWRP was supported. While I have the support of HHB and received approval from the Massey University Ethics Board, there remains concerns that there may be barriers in conducting this research based on my positionality.

In accordance to the principles of Te Tiriti o Waitangi and the guiding values of Massey University Code of Ethical Conduct, when a non-Māori researcher proposes to research the concept of Māori health, consideration needs to be given to ensure there is participation between all parties and no harm occurs (Massey University Human Ethics Committee, 2015). These concerns were raised with the HHB Equity Manager and Senior Māori Advisor who gave support, advice and guidance in the Tikanga and the concepts of health and wellbeing to ensure I presented the cultural beliefs in an appropriate and respectful manner. While I did not see this affecting the research I wished to conduct, consideration was required when asking questions regarding cultural beliefs, values and traditions, as I do not wish to cause offense to those being interviewed or allow any actions I take to disrespect those I am observing. While researching Indigenous concepts and communities, it is important to ensure that reciprocity occurs and that there is recognition that Māori are custodians of their knowledge (Stewart-Withers, Banks, McGregor & Meo-Sewabu, 2014; Smith, 2012). There needs to be an understanding that whilst participants will be sharing their knowledge, this needs to be respectfully reflected within the research ensuring their voices and perspectives are heard and acknowledged (Banks & Scheyvens, 2014; Smith, 2012).

I was concerned that when conducting this research that I may be treated differently due to my age, ethnicity and gender. To ensure that this does not affect the research, reflexivity will occur. Reflexivity is the practice of reflecting on power relations and being aware of your positionality (Stewart-Withers, Banks, McGregor & Meo-Sewabu, 2014). I was able to reflect on who I was and interact appropriately with the different groups I encountered to ensure that I was able to build relationships with the participants through conversation, being humble and respecting those I was in engaging with (Smith, 2012). Smith (2012) argues the importance and value of respect and how it can impact on the relationship between participants and the researcher. By introducing myself at the beginning of each of the observations and interviews, stating the reasons for my presence and asking for consent, this will hopefully allow the participants and interviewees to feel at ease with me being there and for a relationship to occur. There is value in asking the participants for their consent to be involved as it is not only an ethical issue, it is a sign of respect and trust (Smith, 2012). I will be available during session breaks and following the WWRP third quarterly education session, where the observations will occur, for participants to ask any questions. By making myself available to participants, I am endeavouring to build a relationship and decrease bias that is not reflective on my age, gender and ethnicity. I believe that if I come across as genuine to the participants, they will accept me and by having support of the WWRP Programme Facilitator, I will feel welcome and there should be limited bias.

### 5.3 Research philosophy

O'Leary (2014) defines epistemology as "how we come to have legitimate knowledge; rules for knowing" (p. 5). When conducting research, it is important to understand that there are different perspectives and views on a topic and by keeping this in mind it provides an understanding of the best way to conduct data collection (O'Leary, 2014).

As the quote at the beginning of this chapter highlights, an interpretivist perspective allows for an understanding of how people have lived and their experience within a historical and social

context (Ormston, Spencer, Barnard & Snape, 2013). Interpretivism can be defined as knowledge being produced through the exploration and understanding of the social world and the people being studied (Ormston, Spencer, Barnard & Snape, 2013). This form of epistemology allows for the researcher to construct meanings and interpretations based on the participants views and understanding (Ormston, Spencer, Barnard & Snape, 2013). While there is a focus on interpretivism, the researcher has the positionality of social constructionism. Social constructionist theory was created during the enlightenment period and was influenced by different academic areas (Mercadal, 2017). Social constructionism holds the belief “theories of knowledge that emphasise that the world is constructed by human beings as they interact and engage in interpretation” (O’Leary, 2014, p. 7). Social constructionism identifies that human development occurs through social connections and knowledge is constructed through the interactions with others (Mercadal, 2017). Individual beliefs, expectations and behaviours are based on social systems and have created the way that society operates daily (Mercadal, 2017). Savin-Baden and Howell Major (2013) define social constructionism as a philosophy that embraces the interpretation of subjective meaning and shared knowledge through the interaction of a community. As the social constructionist epistemology viewpoint states researchers should remain focused on how knowledge develops, and that shared knowledge is occurring through interactions (Savin-Baden & Howell Major, 2013).

## 5.4 Research design

The research will utilise qualitative research. This is an approach which emphasises the requirement to focus on human experience, understand the social world while researching the details, context and experiences (Stewart-Withers, Banks, McGregor & Meo-Sewabu, 2014). O’Leary (2014) defines qualitative research in a simple form by stating qualitative data is “data represented through words, pictures, symbols, videos or icons” (p. 354). Qualitative research seeks to research and understand social occurrences in their natural setting. This helps to

explore how people interact, what their values and how they behave in an environment (Stewart-Withers, Banks, McGregor & Meo-Sewabu, 2014).

When using qualitative methodologies, it requires the search for a holistic meaning in research and is conducted in a natural setting often with a small number of hand-selected participants (O'Leary, 2014). The purpose of qualitative research is to gain an understanding of the people's places, culture and situations. There are debates surrounding the credibility of qualitative studies and to ensure that these studies are reliable, as qualitative research is often criticised for not engaging in scientific methods (Stewart-Withers, Banks, McGregor & Meo-Sewabu, 2014). The credibility and trustworthiness of qualitative research will be discussed further in this chapter. The next section will discuss ethical considerations and procedures undertaken for the research.

## 5.5 Ethics

Key ethical considerations in any research focuses on the experiences of people and includes informed consent, causing no harm to the participants and ensuring that privacy and confidentiality occur (O'Leary, 2014). When discussing proposed research and ethics, the needs and concerns of the research and participants are carefully considered rather than the potential success of the research (Banks & Scheyvens, 2014).

Before going into the field, ethical approval is required. I will adhere to the research ethics principles outlined by the Massey University Human Ethics Committee (2015) which highlights that when conducting research on Indigenous communities and their wellbeing, a strict ethical procedure must occur to ensure no harm is caused. Following the guidelines of the Massey University Human Ethics Committee, I have completed an in-house ethics review and attained a low-ethics approval. Informed consent is required from the participants of this research. Discussions occurred throughout the ethics process that interviewing vulnerable groups would not be undertaken as it was deemed that it may cause harm. An alternative non-intrusive

approach was proposed, of conducting observations during the WWRP quarterly education sessions for participants which gained approval.

#### *5.5.1 Ethics in practice*

For those whom I am conducting semi-structured interviews, I obtained and confirmed written and verbal consent prior to commencing the interviews (O’Leary 2014; Massey University Human Ethics Committee, 2015). Preceding the observations at the WWRP quarterly education sessions, I stated the purpose of attending at the commencement of each session and explained the research being undertaken and ensured people were comfortable and consented to my presence (O’Leary, 2014). If consent was not obtained I would leave the sessions and not conduct observations. To ensure privacy and confidentiality, I will not state any names when writing up my findings or release any personal information (O’Leary, 2014). Raw data will not be shared and participants and interviewees who wish to read the research, can have access to a summarised report where the identity of the people interviewed will be protected (Massey University Human Ethics Committee, 2015). The data will be stored on personal and private hard drives and online storage clouds, which are password protected. This will prevent the data being shared or accessed by others and that personal information is kept private. Once the research is completed and the finalised thesis submitted, all data will be destroyed (O’Leary, 2014; Massey University Human Ethics Committee, 2015).

I cannot foresee any harm to participants, myself or the university in conducting this research as cultural considerations and beliefs will be considered prior to commencing observations and developing questions for the semi-structured interviews.

### **5.6 Data collection processes and methods**

This section will continue the discussion on 5.4 qualitative research and focus on the data collection process and methods that will be utilised when conducting field research. Due to

relationships formed with HHB and staff members and reflecting on my positionality (discussed earlier in the chapter) I am able to conduct myself in a way that allows me to undertake this research. By being able to talk to a cultural advisor I was able to learn about the customs and traditions that occurred in a Māori setting, especially regarding Karakia and the way relationships work between various members of the community. The most common way to collect primary data in qualitative research is through surveying, interviews and observations (O'Leary, 2014). When primary data is collected it is data that does not exist independently of this research (O'Leary, 2014). This means that the primary data is owned by the researcher (O'Leary, 2014). This research has a focus on the Indigenous population in Aotearoa and knowledge shared in relation to their identity and culture belongs to the Indigenous population (Scheyvens, Scheyvens & Murray, 2014). While this contradicts what O'Leary (2014) has explained about data collection it is important to value the origins of the knowledge and that it is being utilised in a respectful manner.

#### *5.6.1 Semi-structured observations*

Observations are a form of qualitative research and is used to gain an understanding of what is occurring in the environment from utilising your senses (O'Leary, 2014). Conducting observations under a qualitative research lens, delivers a range of possibilities and outcomes as it provides an unfiltered way to see how participation is developing between participants and WWRP and staff. To ensure observations are conducted in the correct manner for this research non-participant observations will occur. A non-participant observation does not require the researcher to become involved or be a part of the observing group as this form of observation is unobtrusive and is best used in structured situations (O'Leary, 2014). Another component of observations is whether the research will be candid or covert. For ethical reasons, I will endeavour that my observations are candid. A candid observation is when those being observed

understand the reasoning for the researcher's presence, what the research is about and how these observations will impact on the research (O'Leary, 2014).

To ensure the relevant information is being drawn from these observations, a semi-structured observation technique will occur allowing the observer to have a pre-determined set of indicators as well as allowing flexibility to include additional indicators when required (O'Leary, 2014). With the research focusing on participation and relationships between various levels of people in the community, it is important to have semi-structured criteria to ensure information is being collected that will help to answer the research aims and questions.

#### *5.6.2 Semi-structured interviews*

An interview is a qualitative data collection method allowing the researcher to ask questions that will provide open-ended answers (O'Leary, 2014). A semi-structured interview is a flexible structure allowing some freedom when posing questions and can be framed as a conversation rather than a rigid interview. This provides the advantage of identifying information the researcher may not have been aware of prior to conducting the interview (O'Leary, 2014). While interviews can be a positive way of gaining information, recording data can be difficult. Not all participants will feel comfortable having their interview recorded. If this is the case transcribing may have to occur which can limit the amount of information obtained (Stewart-Withers, Banks, McGregor & Meo-Sewabu, 2014). The use of semi-structured interviews will provide a first-person perspective and informative opinions on how WWRP is utilising participation to ensure that primary health care is accessible and affordable to those in need.

### **5.7 Selection of programme and participants**

One of the most important aspects of conducting qualitative research is finding appropriate participants and this may be dependent on the questions posed, theoretical perspectives and evidence informing the research (Sargant, 2012). Consideration of sample size is a requirement

when conducting qualitative research, as it is not usually predetermined. It is dependent on data saturation, if the information that is obtained demonstrates data saturation, where no new data has been identified, there is no need to continue researching as it can be a time-consuming method to conduct interviews and the analysis (Sargant, 2012).

In 2016, I completed the course of 131.708 Development Practicum allowing me the opportunity to gain an understanding of how primary health care is implemented, while embracing development concepts and models, in the Hawke's Bay community including the values and beliefs of the organisation. This practicum was completed at HHB and provided the opportunity to form a relationship with the HHB staff. This provided me the opportunity to gain an understanding on the WWRP health programme and how it is implemented within the Hawke's Bay community. Having the opportunity to work with the Programme Facilitator of WWRP, provided a greater understanding of the implementation, management and challenges of the programme. Due to the nature of providing free primary health care for one year to improve the health and wellbeing of Māori and the vulnerable population in Hawke's Bay, there was interest from HHB to conduct research on this programme from a different academic field and perspective. There is hope that this research will be of value to HHB and will result in a greater understanding of how participation can benefit WWRP in the service delivery and for Māori participants.

This research was conducted during August and September 2017. It consisted of four observations that were conducted during the third quarterly education sessions provided for participants of WWRP. Also, to complete the research, six interviews with individuals involved in the design, delivery and implementation of the WWRP programme were undertaken. The comments and observations analysed during Chapters Seven and Eight are not directed or

criticising interviewees or participants. Figure 3 below demonstrates the format of the field research undertaken.

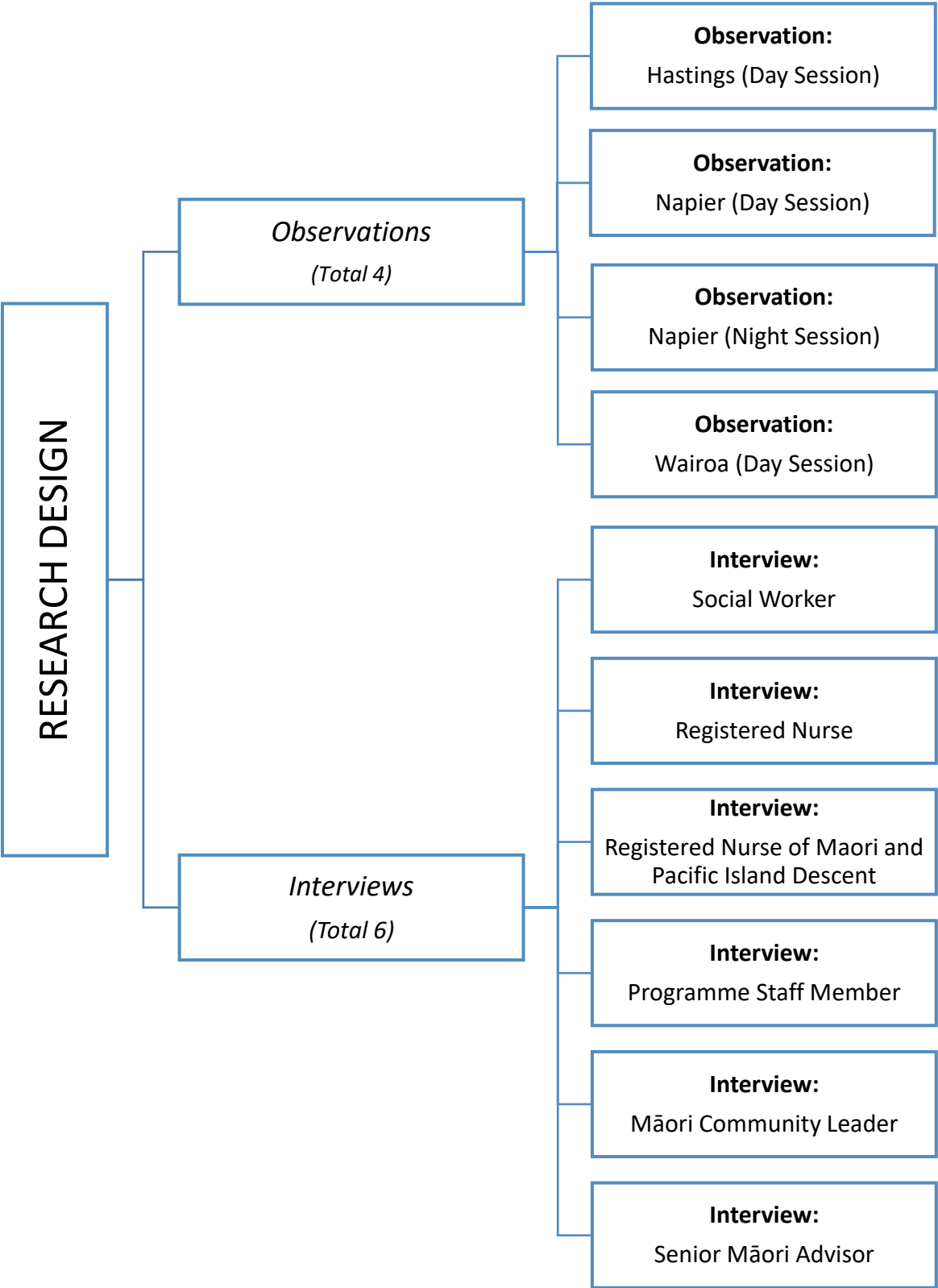
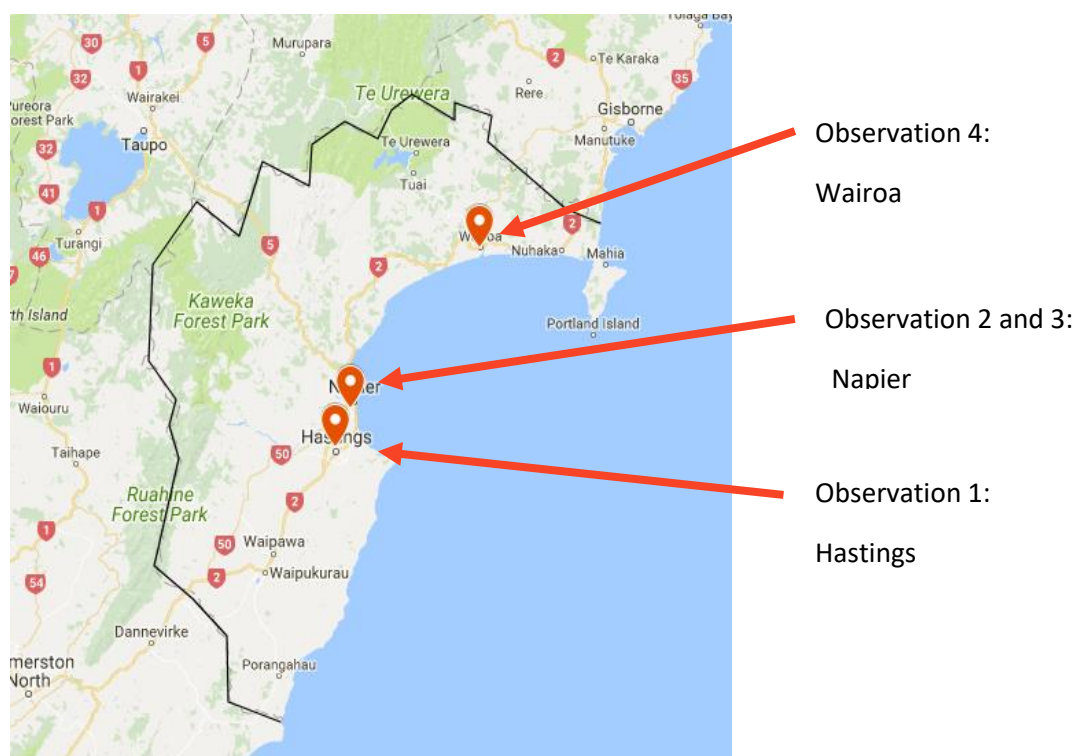


Figure 3 Research method process

### 5.7.1 Observations

In relation to the observations, four quarterly education sessions will be observed throughout Hawke's Bay, one is based in Hastings, two in Napier and one in Wairoa. The quarterly education session is the third session of the year for those on WWRP. These quarterly education sessions provide participants with knowledge and skills on improving health and wellbeing. The education sessions, delivered through HHB, provided the opportunity for the researcher to be able to be included, however permission of participants was unknown prior to attending each session.

The below map (Figure 4, obtained via Google Maps. All marks have been placed on the map by the researcher) demonstrates where the observations for this research were conducted and illustrates the vast area of Hawke's Bay and the region the programme serves. While funding is allocated to general practices, the region to be serviced is substantial in comparison to the funding assigned to this programme.



**Figure 4** Map of the Hawke's Bay Region

The observations were conducted in three locations. Informed consent from all participants for the observations to be undertaken was gained at the beginning of the session to ensure that they were comfortable with my presence during each quarterly education sessions. The first observation was conducted at the Red Cross Service Centre; Hastings, occurring between 10am – 2pm. This session commenced with 40 participants with 17 remaining by the end of the session.

The second observation occurred at a church in Napier between 10am – 2pm. This session commenced with 21 participants, with five remaining at the end of the session. Throughout the observation it appeared that many of the participants left due to boredom, lack of understanding or relevance of the content, or they asked the administrative staff if they could leave to attend appointments or family commitments. The third observation also held in Napier occurred between 5:30pm – 7:30pm, to ensure those who are employed during the day were able to attend a session. During the evening session there were 11 attendees, with many arriving at 6pm owing to work commitments. One participant was encouraged to go home by the Facilitator due to unwell children waiting in their car. In this session no presenters attended to deliver the health messages as per the morning session. It then became the responsibility of the Facilitator and administrator to deliver key messages, resulting in miscommunication if this was a topic they were unfamiliar with.

The final observation held in Wairoa at the local hospital, occurring between 10am – 2pm, with 12 attendees at this session. Two participants left during the education session, expressing their disappointment at leaving and their gratitude for being included in the programme. Only two of the seven presenters from previous sessions travelled to Wairoa due to the distance from Napier. The facilitator adapted this session by means of open conversation to enable participants to obtain the information they required.

During the observations I witnessed, participants demonstrating their appreciation for the opportunity of being included in this programme. Many participants expressed that through participating in WWRP the health and wellbeing for themselves and their whānau has changed. While there is no statistical analysis to support these statements, it can be validated by multiple participants expressing similar feelings. It is important to acknowledge the openness of the participants by allowing me to be included in the quarterly education sessions. I do not feel my presence during these sessions impacted on the way that they conducted themselves or interacted with the presenters and staff.

### *5.7.2 Interviews*

The selection of participants for this research was obtained through purposive sampling and was sourced primarily with the help of HHB, to ensure that those being interviewed are involved with WWRP. I then approached six individuals who were involved in different aspects of the programme and asked if they would be interested in being a part of this research. These interviewees understand the challenges and opportunities that are encountered with WWRP. There can be considered two groupings of participants involved in the interviews. This first group is those who are involved in the design, formation and oversight of the programme and the other group are those involved in the delivery. For the semi-structured interviews HHB staff and a board member were interviewed. This allowed for different perspectives of how HHB and the WWRP work, as well as the relevance it holds when implemented in the community. These different perspectives will also allow an understanding of how participation is used to form partnerships between the HHB, general practice and WWRP participants. The second group of interviewees can be categorised as health professionals and involved in the delivery of WWRP. By interviewing these professionals, insight will occur to how the programme works on a practical level and whether they were involved in consultation, design and improvement of the programme.

The six interviewees will be referred by their given titles and include a Social Worker; Registered Nurse; Registered Nurse of Māori and Cook Island descent; a Programme Staff Member; Senior Māori Advisor and a Māori Community Leader. The titles given to the interviewees were confirmed by each individual during the informed consent process to ensure that they were given generic titles that would be appropriate to maintain confidentiality, and to confirm that they were not offended with the given title. While some were content for more disclosing titles to be used, this did not occur due to confidentiality. All interviews occurred in a neutral setting where participants could feel relaxed and comfortable when sharing their experiences. The opinions given by the interviewees are that of their own and do not represent the opinions of their employers or HHB.

## 5.8 Data analysis and interpretations

Whilst quantitative data is considered an easy form of material to analyse due to the numerical information collected, the same cannot be said for qualitative research (O'Leary, 2014). Raw data can be difficult to examine and interpret however there are methods to ensure this is completed properly (O'Leary, 2014; Berg & Lune, 2017; Savin-Baden & Howell Major, 2013). Transitioning raw data from interviews and observations to ascertain connections and patterns can be challenging. For this to be achieved, inductive or deductive reasoning should occur. Deductive reasoning places emphasis on using an overarching principle or theory to draw conclusions on the data provided (O'Leary, 2014; Ormston, Spencer, Barnard & Snape, 2013). Whereas inductive reasoning uses the facts and information provided to draw conclusions and theory (O'Leary, 2014; Ormston, Spencer, Barnard & Snape, 2013). While the theory of participatory development (PD) has been selected for this research, themes were not pre-determined as it was perceived that it was more beneficial to form these once the semi-structured interviews and semi-structured observations were completed.

To analyse and interpret the data collected, the utilisation of thematic analysis will occur. Thematic analysis comprises of searching through collected data to identify interconnections and patterns (O’Leary, 2014). As the interconnections and patterns are further analysed, potential themes emerge and are explored allowing for theories and conclusions to be drawn (O’Leary, 2014). A thematic analysis of the collated data allows for participants opinions, feelings and experiences to be represented. The application of triangulation utilises more than once source to verify the data and eliminate bias (O’Leary, 2014).

A content analysis provides a way to interpret speech and can involve linguistic quantification (O’Leary, 2014; Savin-Baden & Howell Major, 2013). This form of analysis can identify how many times a word or phrase is spoken. Savin-Baden & Howell Major (2013) explain that while content analysis was originally used for written text it has been adapted to ensure that the content from other various forms of communications were able to be analysed. By highlighting phrases or words, trends can be identified, and themes established to ensure that the data collected, is understood (Sargant, 2012).

Narrative analysis identifies with stories being told and examines the common themes that are occurring to construct an agreement of different accounts (Spencer, Ritchie, Ormston, O’Conner & Barnard, 2014). As the interviews will ask personal questions about participation, the use of storytelling and narratives best represent the situations interviewees are highlighting. In the observations, stories may be told by the leaders of the WWRP quarterly education sessions to portray messages. Listening and understanding stories can identify key messages and themes that will provide answers to the research aim and questions.

## 5.9 Credibility and trustworthiness

The use of credibility and trustworthiness for qualitative research is to ensure that participants answers have been captured and interpreted correctly. Credibility takes into consideration the extent that the findings are believable (Stewart-Withers, Banks, McGregor & Meo-Sewabu,

2014). For qualitative research and data collection methods to produce credible and trustworthy information there is a process required to ensure that the information is reliable (Attride-Stirling, 2001). The triangulation effect is a method used to verify the relevance of the data and information collected. Triangulation assumes that with the collected data, the information will improve clarity and verify the opinions that each person holds will be similar (Lewis, Ritchie, Ormston & Morrell, 2014).

The use of triangulation through multiple analysis utilises observations and interviews to ensure that data can be adequately replicated and verified (Lewis, Ritchie, Ormston & Morrell, 2014). For semi-structured interviews and observations, triangulation of sources allows for comparison of data between different research methods (Lewis, Ritchie, Ormston & Morrell, 2014), providing the verification if participation is being implemented at various levels.

## 5.10 Concluding thoughts

This chapter has identified the methods used to conduct qualitative research involving observations and semi-structured interviews. Utilising these research methods, provides the ability to achieve the research aim and answer the three research questions while producing knowledge that can help increase levels of participation in the Hawke's Bay community to achieve Sustainable Development Goal (SDG) 3, target 3.8. There are many ethical considerations to deliberate when conducting research on Indigenous communities as cultural values and beliefs are an important component of their identity. With a conscious effort on creating a strong relationship and partnership with HHB and the research participants, it will ensure that the research remains relevant and can facilitate empowerment in the community. The use of a thematic analysis will enable five themes to be identified from data collected during the field research. Through the engagement of the triangulation method, this enables the information collected to be credible and trustworthy. Chapter Six will provide background

information on the programme that is the focus of this research while also explaining the connections to the Aotearoa health care system.

# Chapter Six:

## Health Hawke's Bay

*Of all forms of inequality, injustice in health care is the most shocking and inhumane.*

Dr Martin Luther King

(The Medical Committee for Human Rights, 1966 cited in World Health Organisation, 2014)

### 6.1 Introduction

The health and wellbeing of the Hawke's Bay community is a focus for many organisations within the Hawkes Bay region, as statistics demonstrate that the health of the community needs improvement. This thesis focuses on a health programme delivered via Health Hawke's Bay- Te Oranga Hawke's Bay, also known as Health Hawke's Bay (HHB). HHB works with the Hawke's Bay community to improve the health and wellbeing of the locally enrolled population. This chapter will explore the demographics of Hawke's Bay, HHB and the Whānau Wellness Resource Programme (WWRP), a targeted health programme providing one year of free primary health care and prescription medication to those with the most need, to ensure the health and wellbeing improves for the population of Hawke's Bay.

## 6.2 Aotearoa health structure

There are different levels of health care in Aotearoa with different organisations, both nationally and locally, holding responsibility to ensure health care needs are delivered. This section seeks to explain the health structure and the role of various organisations involved in the delivery of health care.

Within the Health and Disability system the Ministry of Health (MoH) has stewardship to administer legislation and regulations according to the Health Act 1956 (Ministry of Health, 2017e). In relation to Aotearoa, the MoH has the mandate to advise the government regarding policy for the health of the Aotearoa population. The MoH is responsible for funding, management and development of former, current and potential health care solutions (Ministry of Health, 2017e).

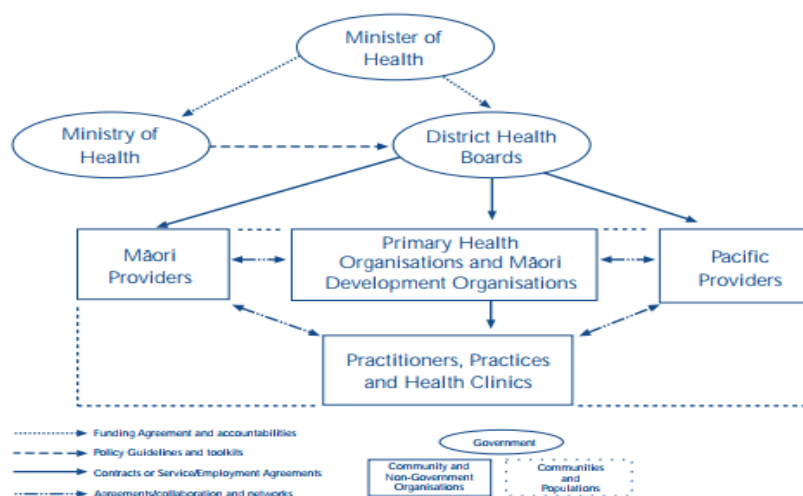
There are 20 District Health Boards (DHBs) across Aotearoa who hold the responsibility of distributing funding and delivering services for the majority of health care within their designated area (Ministry of Health, 2017e). The agreed objectives by the DHBs include the promotion and protection of the health of communities and individuals; providing effective and efficient health care service delivery and focusing on health disparities and inequities (Ministry of Health, 2017e). There is an expectation by the MoH that DHBs will ensure social responsibility whilst also providing community participation in the improvement of the population's health (Ministry of Health, 2017e).

In accordance with the 2001 New Zealand Primary Health Care Strategy, Primary Health Organisations (PHOs), not-for-profit organisations, were mandated to lead primary health care services for communities. DHBs provide funding to PHOs to ensure that communities receive essential primary health care services, for example funding for essential general practice services referred to as Capitation Funding (Ministry of Health, 2011). Individuals are encouraged to enrol with a general practitioner to receive subsidised care based on funding

models that are developed to reflect the need of the enrolled population based on age, ethnicity deprivation level and gender. According to the Ministry of Health (1991) “a strong primary health care system is central to improving the health of New Zealanders and, in particular, tackling inequalities in health” (Ministry of Health, 2001, p. 7) and whilst this is well supported, it has been difficult to achieve as there are many perceived barriers (Health Hawke’s Bay, 2014). In 2016 this strategy was replaced with the New Zealand Health Strategy Future Direction (Ministry of Health, 2016c), where the focus remains on delivering primary health care services that recognises people’s health needs and provides an integrated service across health sectors.

A funding stream provided by the MoH to help reduce inequities in vulnerable populations is known as Services to Improve Access (SIA). This funding model is targeted at Māori, Pacific and those residing in Quintile 5 areas (Ministry of Health, 2014b). SIA funding is allocated to the PHO depending on their enrolled population and is utilised for new services or programmes and to increase the access of the vulnerable populations engaging in primary health care (Ministry of Health, 2014b).

Figure 5 (image retrieved from Ministry of Health, 2001, p. 5) demonstrates a visual representation of the relationship between the different bodies that delivers health care within Aotearoa (Ministry of Health, 2001).



*Figure 5 Relationship between health providers and organisations*

### 6.3 Hawke's Bay demographic

The Hawke's Bay population is considered older than the rest of Aotearoa and has a higher percentage of Māori while having a lower percentage of people from Pacific Island descent. According to Statistics New Zealand (2013) the 2013 Census identified that the population size of Hawke's Bay is 151, 179. Of the Hawke's Bay population, 34, 662 people or 25.9 percent identify as Māori, compared to the national percentage of 15.8 percent (Ministry of Health, 2016b). This equates to approximately six percent of the total Aotearoa Māori population residing in Hawke's Bay and this is continuing to grow (Statistics New Zealand, 2013; Jackson, 2012).

Deprivation levels in health are reported in quintiles and is developed from data collected through Statistics New Zealand Census this is used for a basis for additional funding formulas for DHBs and PHOs. The Deprivation Index is determined through area-based measures of socioeconomic deprivation of each small area (SHORE Whariki, 2016). Quintile 1 is considered the least deprived in the population and quintile 5 is considered the most deprived (Ministry of Health, 2016b). Nationally, each quintile represents 20 percent of the population, however in the Hawke's Bay region 28 percent of the population are residing in quintile 5 (Ministry of Health, 2016b), 37 percent of the population is considered high needs, with Māori equating to 25 percent of this figure. The MoH state that a high needs population is Māori, Pacific or New Zealand Deprivation Index quintile 5 (Ministry of Health, 2016b).

### 6.4 Health Hawke's Bay- Te Oranga Hawke's Bay

HHB believes in the promotion of high quality health care that is available to all and this is reflected in their vision (Health Hawke's Bay, 2017). The vision for HHB is "excellent health services working in partnership to improve the health and wellbeing of our people and to reduce health inequities within our community" (Health Hawke's Bay, 2017). HHB is the only PHO for

the Hawke's Bay region, with 97 percent of the Hawke's Bay population enrolled as of October 2017 (Ministry of Health, 2017b). HHB is a funding PHO that supports 28 general practices, as a funding PHO, HHB is involved in the design and implementation of services and contracts to general practice and Māori Health Providers for the delivery of primary health care services (Health Hawke's Bay, 2017). HHB focuses on improving the health and wellbeing of the Hawke's Bay population and as an organisation they continue to develop, design and implement services into general practice and contracting with general practice for the delivery of health services (Health Hawke's Bay, 2017). By developing these services HHB is able to target improved health outcomes (Health Hawke's Bay, 2017).

HHB has a focus on improving the health and wellbeing of the Hawke's Bay and as an organisation they continue to develop strategies and programmes that target improved health outcomes (Health Hawke's Bay, 2017). Taking into consideration the demographic makeup of Hawke's Bay, HHB holds responsibility for the total enrolled population of Hawkes Bay, which encompasses Māori and the vulnerable population. Due to the number of the Hawke's Bay population living with high levels of deprivation, the Hawkes Bay District Health Board (HBDHB) is allocated additional funding through the MoH to ensure the health needs of this population are met (Ministry of Health, 2016b).

HHB has four values that they hold as important to their organisation which are: Tauwhiro, Rāranga te tira, He Kauanuanu and Ākina. Tauwhiro represents the delivery of high quality health care to patients and consumers. Rāranga te tira holds the belief that there is a need to work in partnership within the community. He Kauanuanu identifies the need to show respect to each other, staff, patients and the consumer. The final value is Ākina and this identifies the need to continuously improve everything they do (Health Hawke's Bay, 2017).

The 2016-2017 Annual Report for HHB highlights the goals of the organisation. Whilst there is a focus on health and reducing inequities, they do this by trying to establish partnerships by

looking to work in a participatory manner and are committed to the process of community empowerment. These goals highlight the ideas of empowering the community through the support of individuals, whānau and the community and embrace the concept of partnership with the community and the HBDHB (Health Hawke's Bay, 2016).

## 6.5 Whānau Wellness Resource Programme

The concept of Whānau Ora is one used widely in health and places emphasis on supporting Māori whānau to achieve maximum levels of health and wellbeing (Ministry of Health, 2017g). This perspective on Māori health focuses on self-management and healthy living which is reflected by WWRP. Health systems and programmes can contribute in the changes of the health and wellbeing of whānau, however, it is important to understand that whānau and individuals can have separate aspirations and levels of health and wellbeing (Ministry of Health, 2017g). Whānau Ora has resulted in a growing number of whānau being able to increase their strengths and capabilities to achieve improved outcomes in health (Ministry of Health, 2017g). Under HHB, WWRP was initiated in 2015 to fulfil the purpose of providing free health care for one year to Māori, Pacific and the quintile 5 population in Hawke's Bay. Since the establishment of this programme criteria has been revised to quintile 5 and Māori and Pacific residing in quintile 4 who have a Community Service Card are now included<sup>11</sup>. The vision of WWRP as described in the business case is:

*To improve the reach and quality of Health Hawke's Bay - Te Oranga Hawke's Bay, support health care to those most in need, and to create a system that allows our underserved population to access the healthcare they need even though they may not be able to afford it.*

Health Hawke's Bay (2014, p. 9)

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<sup>11</sup> As mentioned in the Introduction Chapter the focus of this study is on Māori.

In Hawke's Bay, it was identified that the vulnerable population within the community required additional support to access to primary health care services. Lack of access to primary health care services had a negative impact on the oranga of their whānau and HHB established WWRP to address this concern (SHORE Whariki, 2017). WWRP provides whānau with access to free general practice services, medication, screening and healthy homes<sup>12</sup> for a 12-month period (SHORE Whariki, 2016). This programme is limited to 200 Whānau, a total of 1500 people per year, residing within the same household (SHORE Whariki, 2016). WWRP is not specifically designed for Māori as other ethnic groups are able to access the programme if they reside within a quintile five area. Māori participants are a significant percentage on the programme with approximately 84 percent of the participants on the 2016 WWRP cohort identifying as Māori.

WWRP provides participants with four quarterly education sessions where one champion from each whānau is required to attend. These sessions offer key health messages and access to local health care services with the purpose of increasing health literacy levels in participants (SHORE Whariki, 2016). Health literacy is described as “the capacity to obtain, process and understand basic health information and services in order to make informed and appropriate health decisions” (Ministry of Health, 2010, p. iii). Research conducted by the Ministry of Health (2010) conclude that Māori have poor health literacy skills, in comparison to non-Māori, and this impacts negatively on health outcomes. SHORE Whariki (2017) associates that there is evidence to support that WWRP can address health inequities within the enrolled population of Hawke's Bay. While there have been some issues in implementing the programme, staff have been able to create solutions to ensure that the programme runs smoothly (SHORE Whariki, 2017).

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<sup>12</sup> A programme that funds the provision of heating and insulation for homes (SHORE Whariki, 2016).

## 6.6 Hawke's Bay and Sustainable Development Goal 3, target 3.8

The New Zealand Ministry of Health strategy (2016c) states that the current system of funding does not provide support a sustainable health care system and changes are required to ensure the government is able to provide the resources required to achieve equitable health and wellbeing for all. Sustainable Development Goal (SDG) 3, target 3.8 focusses on universal health coverage, and while this is important, a Ministry of Health strategy (2016c) states that some funding structures in health has caused an increase in health inequity and unmet needs. Creating health equity in Aotearoa is important as it can improve people's sense of wellbeing and can reduce health care and social welfare costs (Ministry of Health, 2017f).

In Hawke's Bay, SDG 3, target 3.8 is important because it highlights the significance of universal health coverage as it will enable the development and achievement of creating affordable and accessible health care to those in need. McElnay (2016) states that there are many health inequities faced by the Hawke's Bay population, these vary significantly between different areas of the community. HHB recognises these issues and through the establishment of WWRP it is endeavouring to increase equity while also focusing on delivering affordable and achievable health care (SHORE Whariki, 2016).

## 6.7 Concluding thoughts

To conclude, Hawke's Bay has a diverse population in comparison to Aotearoa requiring different services to ensure equity occurs. HHB holds the responsibility of ensuring the enrolled population has access to affordable and quality health care service. WWRP provides a service for 12-months to those who are unable to afford health services to aid in the improvement of whānau throughout the region. The next section of this study reports on the research findings that occurred during the field research having completed the data collection and analysis.

# Chapter Seven:

## Research Findings

*I think people need to be innovative with Māori and think of the family rather than the individual. A whānau approach for Māori that is empowering and doesn't make Māori reliant.*

Senior Māori Advisor

### 7.1 Introduction

The purpose of this chapter is to discuss the research findings and themes identified from my fieldwork with the Health Hawke's Bay – Te Oranga Hawke's Bay (HHB), Whānau Wellness Resource Programme (WWRP). The interviews identified five clearly defined themes that contributed to achieve my research aim and answer the research questions. The themes that are the focus of this chapter are: inequity, valuing relationships, partnership and participation, tokenism, and empowerment. The establishment of these themes occurred throughout the semi-structured interviews, observations and analysis of the field research.

### 7.2 Research themes

When examining the six semi-structured interviews and the four observations, five themes were identified as being relevant for this research. The narratives, stories and language shared by the interviewees aided in the formation of these themes. Some interviewees incorporated Te Reo

Māori in their interviews, so the use of an interpreter was required to ensure the context was correct.

### 7.3 Inequity

The main barriers to achieving equity were seen to be cost, cultural appropriateness in general practice, access to services and relationships with health professionals. One of the questions posed when conversing with the interviewees was regarding barriers faced by Māori when accessing primary health care, which they agreed are an issue for Māori. In terms of cost and access a Māori Community Leader stated:

*“There are barriers to Māori accessing health care, and that is no secret. Cost is a big one and the issue with our health care system is that you have private business with our GPs [General Practitioners], but they are also there to provide a service. You have a clash of ideologies really.”*

Māori and Community Leader

Many interviewees expressed their concern with the ethical aspect of private businesses providing primary health care and had issue over the concept of paying to access services in primary health care. While the Aotearoa Government partly subsidises the cost of primary health care, the time restraints of consultation and associated costs, were viewed as being detrimental to access.

#### 7.3.1 Funding

When undertaking the interviews many participants raised the issue with regard to funding. This section of inequity seeks to explore the concept of funding for WWRP. During the observations, many participants expressed that access to free health care through WWRP has improved how they access primary health care and the overall health of themselves and their whānau. While initially some whānau stated there was difficulty changing their mind-set of

consulting with health professionals, once they started engaging and accessing primary health care services, without cost as a barrier, the ora of the whānau improved.

*“From a whānau point of view and their engagement- loving it. I’m loving it, they’re loving that they can get access to their medical professionals and don’t have to worry about cost when they walk out. That’s great, but it is also about preparing them for the next stage when they leave the programme. How are they going to keep engaging? They won’t be able to engage at the higher levels that they are now. So that’s the challenge and it’s big huge juggling act.”*

Senior Māori Advisor

The Senior Māori Advisor expressed a positive reflection on the WWRP participants accessing free primary health care services for 12 months. Whilst this time allows participants to engage and access primary health care services, there is concern how they will continue to participate once they exit the programme. The Programme Staff Member interviewed expressed that she did not believe 12 months was a sufficient allocation of time to be beneficial to participants. By extending the programme a further six months, she believed the participants would gain a greater understanding of the health care system and would feel more comfortable and confident in continuing to engage and access services. However, while there is a desire to extend the length of the programme and the number of participants involved, limitations of funding constraints are the reality of this occurring.

*“It frustrates me that funding follows the practices rather than the patients. I think it should follow patients and that would make a big difference, so programmes including WWRP and ‘Life Clinics’ would give us the opportunity to tailor our practice towards encouraging excellent services for high need populations. The reality is the funding is not enough from the government. I think it is really important for Māori to develop relationships and engagement.”*

Registered Nurse

The way funding is distributed for primary health care was discussed by many of the interviewees. It was expressed that within Aotearoa, the subsidised funding for patients enrolled with a Primary Health Organisation (PHO), is directed to the patients nominated General Practitioner (GP) within a general practice. This funding does not necessarily follow the patient if they relocate to a different general practice and many of the interviewees did not agree with this model.

A further question posed during the interviews was regarding the current Aotearoa health system and if it is providing accessible and affordable health care for Māori. It was stated by some interviewees, that on the surface it appears that affordable health care has been achieved due to the government subsidising primary health care visits as well as some medications, however, all interviewees identified that affordable and accessible primary health care continues to be an issue for Māori. This is demonstrated in the quote below from the Senior Māori Health Advisor.

*“Currently there would be an argument that we are achieving universal health coverage. Would be great to have, it all looks great, but we are nowhere near that. I think it is applicable and for all government services to be talking together and planning with good consumer input. How are they actually implementing this?”*

Senior Māori Advisor

The below quote demonstrates the frustration felt by individuals working within the health sector and the challenges faced when working in the current Aotearoa funding model. It was expressed that if Aotearoa wanted to achieve Sustainable Development Goal (SDG) 3, target 3.8, changes needed to occur in the health system especially in relation to primary health care funding. Conversations and debates regarding the cost of accessing primary health care could influence a change in how funding is delivered which may correlate in the reduction of inequity within the community.

*“No, not unless you have stroppy people in positions like me. If I look at the funding of Māori, Pacific and other low quintile people to health services, it is the practice that determines what and how they receive the money.”*

Senior Māori Advisor

When discussing inequities in health with the interviewees it became apparent there was concern felt by all regarding affordability and accessibility for Māori. It was felt that a stronger targeted focused policy by the government on the implementation of SDG 3, target 3.8 would be of value to achieve the improvement of health and wellbeing of Hawke’s Bay population.

## 7.4 Valuing relationships

This section focuses on the value of relationships and many interviewees identified the need to improve the relationship between WWRP participants and health professionals, this section also examines how the interviewees believe their own culture and ethnicity impacts on the relationships they enter. During the interviews, it became apparent the value of relationships was highly regarded as significant and influenced how people participated in the health care system. However, this was often reflected in a negative context when discussing relationships where an imbalance of power was apparent. This theme can be divided into three sub themes and these are culture and relationships, developing and valuing relationships and the final sub theme is relationships and empowerment.

### 7.4.1 Culture and relationships

The first sub-theme is culture and relationships, and this explores how culture can influence a relationship. It was expressed by the interviewees that culture influences how they interact with others. By not showing cultural consideration towards an individual, power imbalance can occur within a relationship.

*“There is a definite need to build a relationship with health professionals to build trust and to enable families and individuals to be honest. What Māori do say is that we are sick and tired of telling our same story to different health professionals because we don’t have just one doctor. To have successful outcomes you need to have a relationship with the person that you are engaging with.”*

Senior Māori Advisor

The Senior Māori Advisor discussed in great detail the value and importance of Māori having a good relationship with health professionals. However, while it was expressed that a relationship was required, it is also important that health professionals are culturally competent when engaging with Māori. During the quarterly education sessions, the engagement style between the WWRP Facilitator and participants demonstrated the respect they held for each other and how they felt their cultural values were upheld. Participants felt comfortable to convey to the Facilitator their thoughts and the progress they believed they were making in the journey regarding their health outcomes.

During the observations, one participant expressed the frustration they faced when unable to access the same GP at each consultation which diminished their ability to form a relationship, and this was not beneficial for the improvement of the health and wellbeing of themselves and whānau. In contrast, those who could build a relationship with their GP were able to see improvements in their health and wellbeing. One of the aims of providing free medical visits during their time on the WWRP is to ensure that deeper relationships are developed, and this was actively encouraged by programme staff.

*“My culture is about bringing people along and walking alongside them. It’s about empowering individuals. There is a saying ‘Kaua e whakaiti tangata’ and to whakaiti means to put people down and by no means do I do that..... It’s giving whānau information in a way that they understand. My culture is about empowering or ‘tu kaka koutou (stand up whānau and be confident/strong), whakamana nga tangata (empower the people) e hara ki te whakaiti’ (so don’t put people down).”*

Senior Māori Advisor

The statement above, from the Senior Māori Advisor, expresses the way that interacting with the participants during the quarterly education sessions should transpire. Those running the sessions are aware that while there is a need to reiterate messages regarding screening and the requirements for being on this programme, there is a way in which to deliver these messages without being demeaning. Utilising humour and personal stories provides an environment where participants feel comfortable and can relate to the programme staff. Through creating this environment, it became apparent that participants sought to share their stories and journeys with each other as they feel safe in this environment.

It was observed during the third quarterly education sessions that presenters varied in their interaction with participants. A number of presenters actively engaging with participants and appeared to be striving to develop relationships with those present. These presenters, for example, remained at the venue following their presentation allowing time for participants to engage in private discussions. However other presenters appeared to make little effort to form relationships that could be beneficial to the participants. It was apparent that presentations that were engaging and interesting maintained the participants attention, while those less engaging did not retain the participants attention. While the presenters were there to provide information regarding health, the way in which their messages were provided impacted on participants engagement with the health services.

#### 7.4.2 *Developing and valuing relationships*

This section on valuing relationships places emphasis on the development of relationships between different stakeholders in the primary health care sector in Hawke's Bay. The Registered Nurse interviewed for this research described the value of relationships at various levels, not just between participants and general practice. She expressed the view that there needs to be a strong relationship between those designing health programmes and those delivering the service within general practice.

*"I think that is the key to good relationships. I think primary care will pull back if they don't have that relationship. It's all about relationships, trust and good faith."*

Registered Nurse

A Registered Nurse of Māori and Cook Island descent also expressed similar concern over the lack of communication and involvement during the initial stages of the programme development. Whether the lack of communication was due to time restraints or due to the relationships remains unclear.

The motto for WWRP is 'this programme is a hand-up not a hand-out', which was reiterated throughout the interviews. However, one interviewee expressed the difficulty of implementing this motto.

*"For a lot of hard to reach families you need to take them by the hand. They need a lot of effort."*

Programme Staff Member

It was expressed that most health professionals see participants as receiving a form of aid, when enrolled in this programme, which does not reflect the vision that the WWRP Facilitator envisioned. The relationship between health professionals and participants involved in the programme needs to evolve to create greater understanding. In some general practices, having

extra support staff, including social workers, to walk alongside participants ensures there is a relationship that support participants needs. The forming of relationships with different members within a general practice requires health professionals to empathetic to the participants circumstances and situation regarding their journey.

#### *7.4.3 Relationships and empowerment*

During the observations, health professionals and presenters engaging with participants were asked that this was delivered in a respectful manner to contribute to relationships being formed. Positive relationships with health professionals assist participants to gain confidence and increase their engagement with primary health care services. While the quarterly education sessions are providing education on health and wellbeing, they also aid participants in form relationships with one another. During the sessions it was observed that the participants valued the idea of supporting each other and sharing experiences. For some participants this appeared to be beneficial as it lessened the isolation they were experiencing.

In the context of WWRP, the programme facilitator places great emphasis on the value and importance of forming strong relationships. While the interviewees reiterated the value of relationships, some identified that their ethnicity influenced how they perceive relationships. One interviewee identified that her upbringing has enabled her to form the kind of relationships that empowers others. It was also identified by another interviewee that by having a similar cultural and ethnic background as those they are engaging with in WWRP is beneficial with the initial development of a relationship as it can make participants feel more comfortable and at ease in the situation.

### **7.5 Partnership and participation**

The Health and Disability Sector believe that Māori participation in the decision-making process ensures services are developed that are appropriate for the population (Ministry of Health,

2014a). In terms of participation in health, Māori involvement is related to employment within the health sector, rather than participating in the development of health services. To improve the involvement and participation of Māori, it is important to upskill and encourage Māori to work within the health field while also providing equitable access to opportunities and education (Ministry of Health, 2014a).

*“We work on the 3ps [participation, protection and partnership] with the Treaty [Te Tiriti o Waitangi] and so partnership is one of those things we really emphasise and giving them ownership and responsibility. Having Māori be brought on board for the implementation and structure [of WWRP] allows for them to become a part of the journey that allows for change. They become privy to seeing the highs and the lows and that is the full responsibility.”*

Registered Nurse of Māori and Cook Island descent

This quote recognises the need to improve engagement through partnership and participation with health programmes to ensure that health providers increase consumer involvement. Throughout the interviews it was expressed that to improve Māori health outcomes, health professionals need to work alongside Māori as equals. It was reiterated through many interviews that there is an unequal power distribution that occurs between health professionals and Māori patients. It was stated by the Māori Community Leader as well as the Senior Māori Advisor that Māori need to cease being subservient in the partnership with health professionals, and that they should be regarded as equal partners in their own health and wellbeing. While most interviewees highlighted the value of partnership and participation for those on WWRP, some believed that having programme participants attending the quarterly education sessions was considered enough participation.

*“I think with any successful health delivery you need to get the whānau involved and part of the creation stage. They need to buy into it.”*

Māori Community Leader

A Māori Community Leader states the importance of the involvement and participation of Māori in the design of health programmes aimed to benefit the community. He also expressed that when designing a health programme, it would be beneficial for project managers to meet with community stakeholders as a prerequisite to project initiation. In doing this, there is open communication with those who would be affected by the programme and participants are able to participate by expressing their own needs and requirements.

When conducting the interviews, I asked the interviewees to reflect on how their own culture affects the way they encourage and view participation. While the majority identified their culture as having a positive impact on the engagement and encouragement of participation in WWRP, one of the interviewees was concerned that her ethnicity and culture affected how participants engaged with her. While the Senior Māori Advisor expressed that culture, ethnicity and religion are not an issue in her iwi, for the Programme Staff Member this was of concern to her.

*“You don’t know if it would be different if I was someone else. I don’t know if that would change their actual participation because I am just a person on the end of the phone to them.”*

Programme Staff Member

Whilst the Programme Staff Member expressed concern that some people may not approach or engage with her due to her not being from the same cultural background, she stated that there are some participants who are welcoming and accepting of her role within the programme. This was a contrast to the opinion of a Registered Nurse who is expressed that her cultural background and upbringing had an impact and influence on her involvement in the health system.

*“My dad is Māori and so I am Māori and I think that it definitely helps as I have been brought up in a very whānau orientated way so that is my personality. And it does have huge benefits. Not sure if that is because of my culture or my personality. Working with something like this makes me very happy. Seeing the imbalances in the health system and they need people like me to advocate for them.”*

Registered Nurse

The cultural background of this Registered Nurse has encouraged her to participate within the community as well as advocate for those who are unable to voice their concerns.

*“Most definitely. There is the saying that knowledge is power and when health workers take the time to provide health messages that are useful and let whānau know the pros and cons, it is so simple that it seems to be hard. Sometimes with our culture we appreciate truthfulness. Let us know what we need to get better outcomes and that comes down to relationships. It is also working in a partnership model, whereas the medical model is not a partnership model as the doctor has all the power and there are time limitations.”*

Senior Māori Advisor

The Senior Māori Advisor expressed that her cultural upbringing values equal treatment for all and through this value, participation and partnerships can occur. She also expressed that both health professionals and Māori participants on the programme require knowledge to ensure there is an understanding of what each party requires from the partnership they are forming.

While all interviewees expressed that participation and partnership is a valuable component to improving health outcomes, the above quotes expressed their differing views of participation in relation to their own beliefs. In relation to SDG 3, target 3.8 all interviewees were appreciative of the intent of the target and believed that it would impact the health of the community, especially if participation was utilised to its fullest extent. When discussing the Sustainable Development Goals (SDGs) in more depth with interviewees, they lacked knowledge regarding

the existence of these goals. While there was unanimous agreement regarding the value of SDG 3, target 3.8, most perceived the need for a change in the way primary health care is funded and the engagement health care providers have with their patients.

## 7.6 Tokenism

Throughout the interviews, five of the six interviewees identified tokenism as being an issue. Reflecting on Chapter Four Participatory Development, while many organisations allow people to have a voice and share their opinions, this does not mean that the voices and opinions will be listened to and taken into consideration.

*“My current role is within a Māori service and all I see is a token type called for a karakia, called for a blessing or some opening of the building”.*

Social Worker

The Social Worker interviewed presented the situation that Māori were often not included in the design, implementation or consultation of health programmes. Māori deem their involvement in some situations as being tokenistic if their only involvement is to present a karakia, blessing of food or the opening of a building. Other interviewees supported the Social Worker’s statement by identifying that Māori are asked for their approval in the final stages of designing health programmes and not from the initial planning of programme development. The Māori Community Leader identified that to achieve full Māori involvement, those creating health programmes need to encourage community participation through engaging with those that the programme would impact upon.

*“It does worry me that there is shoulder tapping. I look at some of the committees I am on and I think it is some of the same faces you see all the time and I think we can look to a lot more of our consumers and that we could be encouraging people and we have to be proactive with our encouragement.”*

Registered Nurse

This quote by one of the interviewees is reflective of the process of recruitment and selection process for consumer participants on health steering groups and committees. Often the roles are filled by an individual being approached, rather than volunteering or through application.

In relation to the observations, it was clear that participants were willing to share their experiences and concerns in the third quarterly education sessions. Whilst their voices are heard by the facilitator and staff member, it is difficult to determine the eventual outcome for the intention of this information. Participants were asked what their requirements prior to engaging with the education programmes. It was identified that this did not necessarily equate to the topics that were provided which could be perceived as a tokenistic form of education. For many participants, this is the first time they had engaged with primary health care service providers and many actively expressed their gratitude for how the programme had impacted positively on their lives and that they felt like they were actively engaged and listened to.

During the semi-structured interviews, it was identified that there needed to be increased consultation and involvement with the Māori community when establishing primary health care programmes aimed at the community. Comments obtained stated that it can be difficult to engage with the community when they feel their voice is not heard, however it was perceived as an important step to increase participation.

*“I think that there is a desire to engage with Māori communities. In the past, it has been very tokenistic. I think it can be improved a lot.”*

Māori Community Leader

*“Not doing tokenistic things is beneficial for our whole society. You have to know why you are doing it, you have to believe in why you are doing it and go forth in the right manner and that is really important.”*

Registered Nurse

Both quotes demonstrate a need to create change towards how Māori are included and involved in the design and implementation of primary health care service delivery. One

interviewee identified the need to engage with the Māori community at the initial stages of the design process to ensure that the community is actively supporting and engaging with the health programme that is designed for their needs and that it does not cause harm. It was identified during the interviews that there was a steering group, consumer groups and individuals from the local iwi involved in the set up and design process for WWRP, however, the time given to commence this programme was limited due to support and funding constraints. During the process, one interviewee expressed concern that general practice was not consulted regarding the commencement and the implementation of WWRP and this did not allow for the expectations of general practice to be clearly defined. The Registered Nurse of Māori and Cook Island descent believed that if there was greater general practice consultation during the development of the programme there would have been enhanced investment from general practice.

For those working in general practices and have a number of patients eligible for WWRP, the process required has increased the volume of work required to engage and recruit participants. Whilst the development of WWRP endeavoured to encompass many different thoughts, opinions and perspectives from stakeholders, consumer groups and iwi, this was difficult to obtain due to time and funding constraints encountered in the initial stages of the programme. With the continuation of the programme, there is an ongoing determination to ensure all stakeholders are consulted in a non-tokenistic manner allowing the programme to best fit the community and their needs.

## 7.7 Empowerment

Empowerment of participants is an aim of WWRP and interviewees expressed this during the semi-structured interviews by acknowledging how it was evident and had developed in some participants since engaging with the programme. Empowerment has previously been discussed in Chapter Four, Participatory Development, with reflection on literature by Elliot (2013), Parpat

(2014) and Cornwall (2008). This discussion regarding empowerment can be divided into two components. The first component is in relation to how WWRP aims to empower participants and the second demonstrates that our current health care system can be very disempowering for Māori.

### *7.7.1 Empowerment of participants*

All interviewees identified that WWRP enabled participants to gain empowerment and have a sense of autonomy as they were encouraged to attend their general practice appointments and engage with health professionals through asking questions and partnering in decisions with regard to their health. This idea was reiterated throughout the interviews and observations.

*“Yes, the feedback I have heard from all the quarterly sessions is that the information has just been awesome, so it certainly gives them education in a way that will improve the choices that they make.”*

Social Worker

The above quote demonstrates how the quarterly education sessions are a beneficial aspect of WWRP by providing participants with information to make informed decisions for themselves and their whānau. In the observations, it was noted that participants were eager to gain more knowledge and understanding as they actively engaged with presenters. During the introductions of the quarterly education sessions, many participants expressed how they felt empowered and able to make significant changes in their lives. These testimonials from the participants at the observations were a humbling experience as participants were open and vulnerable regarding their journeys and their gains since commencing WWRP.

*"If I look at the health system and how it is not working for Māori, the health system continually rescues, it does not empower individuals to take charge and have control of their own destinies. That is where I always clash with general practice staff 'I am not a rescuer I am an empowerer and you guys shouldn't be rescuing either because post these 12 months they are going to expect that type of commitment and input from you. So, stop rescuing and actually just tell people this is the consequence if you choose not to do it'."*

Senior Māori Health Advisor

This quote represents the challenges the programme faces to ensure that participants are committed and willing to make changes. It was discussed in a few of the interviews that many Māori are perceived as needing to be rescued and require a handout to improve their lives. As WWRP 'is a hand up, not a hand out' it demonstrates a change in how some primary health care programmes are wanting to be perceived and delivered in the community by HHB. The majority of people enrolled on this programme are hoping to improve their lives and to feel empowered when discussing health concerns with health professionals. The Senior Māori Advisor is advocating for individuals to take personal responsibility for their own health and wellbeing and for the health of their whānau.

*"Absolutely [It has created empowerment]. It definitely does concern me it is only a year. Some people haven't taken on the full opportunity but for some it has definitely helped, and they have made the most of it."*

Registered Nurse

One of the Registered Nurses interviewed expressed that while WWRP looks to facilitate the process of empowerment for participants on the programme, not everyone embraces the opportunity. This can be supported by documentation provided by HHB which expresses that approximately 23 percent of participants do not attend any practice nurse, nurse practitioner or GP consultations during their time on WWRP (SHORE Whariki, 2017). Whilst this statistic is significant, no further research was conducted to clarify why participants did not access primary

health care services during the time on the programme. It is perceived that through not accessing these services, participants are unable to form relationships with health professionals, which can result in the lack of empowerment of participants as they are unable to develop the confidence and self-esteem required to engage with their health care providers.

It was apparent in the observations that those who attended the quarterly education sessions and regularly presented to general practice came across as more confident and empowered by the experience. Many participants expressed gratitude at how this programme has had a positive impact on their lives and increased their utilisation and engagement with health professionals. They conveyed they felt more confident to express concerns to health professionals and were willing to request better care for themselves and their whānau.

#### *7.7.2 Empowerment in the health care system*

When discussing the health care system of Aotearoa with the interviewees, they expressed concern that the current health care system is not empowering for Māori. It was also expressed by many that the current delivery model of primary health care is constraining due to many practices following a biomedical model rather than a wellbeing model. The current health models do not empower Māori when the system has a time limit on consultations resulting in participants often feeling rushed and coerced into accepting the health care offered. This makes them feel disconnected from health professionals.

*“No because we seem to be a system that ‘does to’. This isn’t empowering.*

*Māori are always looked at as the deficit i.e. bad health statistics.”*

Senior Māori Advisor

The Senior Māori Advisor demonstrates that the health care system perceives Māori with negativity due to current Aotearoa health statistics provided by the Ministry of Health. It was discussed that Māori tend to have a different view of health, and the current health care system does not encourage the holistic approach that Māori encompass.

*“Māori need to be involved in the plan and be a part of the plan. If the government is going to do something like this, Māori need to be a part of the solution. There needs to be a whole lot of money invested into Māori models. Māori are empowered to not only receive the service but deliver it.”*

Māori Community Leader

The Māori Community Leader stated that there needs to be greater inclusion and consultation with Māori regarding the primary health care system. It was expressed throughout many of the interviews that if Māori were included and held ownership over their own health care system, it would enable empowerment and thus increase the oranga of the community.

## 7.8 Concluding thoughts

The research findings have demonstrated five main themes that were reiterated throughout the semi-structured interviews and observations. Inequity, valuing relationships, partnership and participation, empowerment, and tokenism were the identified themes and have been discussed with examples provided from the field research. Whilst these themes have been identified separately within the chapter, there is overlap when they were being examined. Throughout this research, it was clear to see the passion of the interviewees who wanted to create an environment where participants of WWRP could gain accessibility to affordable health care. While the SDGs are not recognised within this programme, there was urgency by those interviewed to embrace SDG 3, target 3.8 and reach the target. The stories and messages shared throughout the interviews and observations provided a humbling experience and it was amazing to see how willing people were to share their journeys and express their concerns. While the participants of WWRP were not interviewed during this research, many felt empowered to share their journeys during the third quarterly education session which I observed and found a privilege to witness. The next chapter of this thesis will provide an in-

depth discussion of the research findings, linking this to concepts and literature discussed in previous chapters.

# Chapter Eight:

## Discussion

*The Whānau Wellness Resource Programme aims to empower families with information, access and improved relationships to achieve and maintain tino rangatiratanga, self-determination, in all aspects of life.*

Whānau Wellness Resource Programme Facilitator

### 8.1 Introduction

The above statement from the Whānau Wellness Resource Programme (WWRP) Facilitator expresses her vision regarding the participants achievement through the programme. Participation will be key to the accomplishment of this laudable goal described by the WWRP Facilitator and as this thesis demonstrates, to the achievement of SDG 3, target 3.8. This chapter analyses and connects theory to the research findings and literature discussed in earlier chapters to answer the research questions posed in this thesis. Firstly, general discussions will occur regarding the use of participatory development (PD) in achieving Sustainable Development Goal (SDG) 3, target 3.8 of universal health coverage. Secondly, White's Typology of Interest (1996) will be applied to the research findings to analyse the different levels of participation both from the perspective of the programme and through analysis of the third quarterly education sessions. Finally, conclusions will be drawn on the relevance of SDG 3, target 3.8 within the Aotearoa context.

## 8.2 Research aim and questions

The aim of this research was to explore:

Is Sustainable Development Goal 3, target 3.8 relevant to Māori health and wellbeing in the Hawke's Bay region and does a participatory development approach can facilitate the achievement of this important global goal within the Aotearoa context.

Three research questions that were posed:

1. Is a participatory development approach an effective mechanism in contributing to the achievement of Sustainable Development Goal 3, target 3.8 of universal health coverage?
2. Is the Health Hawke's Bay – Te Oranga Hawke's Bay, Whānau Wellness Resource Programme, using participation to contribute towards the achievement of Sustainable Development Goal 3, target 3.8 of universal health coverage?
3. Does Sustainable Development Goal 3, target 3.8 have value in the Aotearoa context?

## 8.3 The effectiveness of participatory development

The focus of the first research question is to understand if PD can be an effective mechanism in contributing to the achievement of SDG 3, target 3.8. This will be examined through discussion of PD in relation to the findings. In Chapter Two of this thesis, the history of global goals as well as a discussion on the Sustainable Development Goals (SDGs) with reference to SDG 3, target 3.8 occurred. Research question one asks, "Is a participatory development approach an effective mechanism in contributing to the achievement of Sustainable Development Goal 3, target 3.8 of universal health coverage?". To answer, participation will be discussed in terms of the positive and negative attributes.

### *8.3.1 Positive attribute*

There are positive aspects of utilising participation to contribute to the achievement of SDG 3, target 3.8. Participation allows for increased involvement, encourages the creation of new ideas and concepts and opens communication channels (Cornwall, 2008). By working in a participatory manner, a space is created where conversations regarding SDG 3, target 3.8 could provide an effective mechanism to discuss opportunities for the achievement of this target. This was demonstrated in the interviews conducted during the field research, where many interviewees wished to discuss this goal and the implications this could have on the Hawke's Bay community. There was collective agreement that this target would benefit the community as they all raised the issue of inequity and concern over barriers including the rising cost and lack of accessibility to primary health care services. WWRP and Health Hawke's Bay- Te Oranga Hawke's Bay (HHB) staff in collaboration with health professional can share learned knowledge and ideas towards increase of participation in primary health care and this could contribute towards the achievement of SDG 3, target 3.8.

To contribute to the achievement of SDG 3, target 3.8, collective consultation and participation is required to ensure that all perspectives and opinions are heard and to determine what steps are important. The Ministry of Health (2014), in looking to reflect on Te Tiriti o Waitangi principles, defines participation as enabling everyone to be included in the decision making, planning and delivery process within the Aotearoa health and disability sector. Due to concern over District Health Boards (DHBs) being unable to fully assess and understand the needs of Māori health, introducing Māori health board members and increasing the number of Māori health professionals and consumers having input into policy guidelines for the improvement of health and wellbeing has been a significant participatory step (Durie, 1998). One interviewee expressed concern, however, that shoulder tapping occurred to recruit rather than advertising positions of interest in the community. It is important to ensure that those who are being

consulted are able and willing to commit and not overburdened. They also expressed how she was often approached to be on health committees and boards and felt that other Māori health professionals should be given this opportunity, and this may require capacity building or succession planning to occur.

In the health sector, Te Tiriti o Waitangi is enacted to ensure participation, protection and partnership occurs (Ministry of Health, 2014). The World Bank (2002) states that creating openness and encouraging participation allows people to become empowered and have a voice when required. In the past, however, Durie (1998) expressed that there was little encouragement for Māori to participate, especially in health. Pulver et al., (2010) explains that while there has been improvement in health globally, inequities are still occurring with poor Indigenous health outcomes. Due to poor Indigenous health, as demonstrated in statistics provided by the Ministry of Health, HHB developed WWRP to help combat these issues.

As the Ministry of Foreign Affairs and Trade (2017b) stated, there is the need for Non-Government Organisations (NGOs) to be working with communities to achieve the SDGs. To guarantee that SDG 3, target 3.8 is achieved, Māori should be included at all levels. With HHB and WWRP building relationships and encouraging participation in the Hawke's Bay community, they are contributing towards Aotearoa's SDG commitments. As participants on the programme are receiving free primary health care, an increase in the utilisation of services has occurred making primary health care easily accessible and affordable while on the programme. However, in the long-term levels of participation in primary health care used by WWRP participants contributing to the achievement of SDG 3, target 3.8, is difficult to predict as the future of the programme is uncertain.

### *8.3.2 Critical attributes*

While the positive use of participation to achieve SDG 3, target 3.8 has been discussed above, when relating participation to the field research and SDG 3, target 3.8, there appears to be one

major critique. An issue identified surrounding participation is that it is often perceived as tokenistic or occurring in a tokenistic manner.

In the research findings, many participants identified tokenism occurring when engaging Māori in health. Reflecting on Chapter Three: Participatory Development, tokenism was discussed as the middle level of Arnstein's Ladder (1969) and includes informing, consultation and placation. Under this level, tokenism is understood as people having a voice and sharing their opinions, however there is no guarantee their voices and opinions will be taken into consideration. In terms of development Cornwall (2008) expresses that what Arnstein's Ladder (1969) deems as tokenism, some development agencies consider participation. The confusion over what is considered a tokenistic approach of participation can affect how agencies choose to engage with people.

### *8.3.3 Summary*

This question has identified the relevance of using PD to contribute towards the achievement of SDG 3, target 3.8. While there are positive and negative aspects of this model, from the perspective of WWRP, PD can be utilised in a positive manner and have positive outcomes for participants. Whilst WWRP has unknowingly been engaging in participation at some level, consideration could be given to develop and expand their understanding of participation to achieve full PD. Now there is awareness of SDG 3, target 3.8, by interviewees due to participating in this research, discussions are occurring and there is an interest in investigating this model further.

## **8.4 WWRP and the utilisation of participatory development**

To ensure that research question two is examined, the third quarterly education sessions provided by WWRP will be discussed, alongside the interviews. Research question two states "Is the Health Hawke's Bay – Te Oranga Hawke's Bay, Whānau Wellness Resource Programme,

using participation to contribute towards the achievement of Sustainable Development Goal 3, target 3.8 of universal health coverage?”. To answer this question the interviews and observations from the WWRO third education sessions for participants will be analysed through a participatory model utilising White’s Typology of Interest (1996). Reflection on Rowland’s (1997) power dynamics in relation to this participation model will occur to gain an understanding of how WWRP is using participation.

In the field research completed for this thesis, four quarterly education sessions were observed in various locations to determine how WWRP is influential in their contribution towards the achievement of SDG 3, target 3.8. Due to the complexities and different levels of involvement and participation on the WWRP project, an abstract model of participation was required to ensure that the various levels were understood. White’s Typology of Interest (1996) considers participation from two perspectives and assesses how participation can occur between the implementing agency and those on the receiving end. White’s Typology best fits WWRP as it examines the relationship between two parties and how they engage with participation and interact with one another. The abstract concepts within this typology can lead to a broad range of interpretations over what level best fits the implementing agency and the recipients of participation.

#### *8.4.1 Accessing primary health care*

When analysing SDG 3, target 3.8 a component of this target reflects on the access to quality essential primary health care services. The Primary Health Care Strategy (2001) identified the need to encourage greater community participation to ensure engagement (Smith, 2009). While it was identified in 2001 that there was a need for greater engagement in primary health care, the WWRP Facilitator recognised this need was still required in 2015. Due to this lack of engagement, HHB identified that the vulnerable population were not necessarily accessing primary health care services and that inequity was increasing within the Hawke’s Bay

population, and in particular Māori. Hence the development of WWRP which began with the first cohort in 2015. As demonstrated in White's Typology of Interest (1996), there are two different typologies that can relate to WWRP. The two typologies that will be discussed are representative and transformative.

#### 8.4.2 *Representative participation*

This research has highlighted that while WWRP was unfamiliar with participation as a development practice, the use of participation through quarterly education sessions has provided a positive result for participants as reflected in their feedback during these sessions, however, due to ethical limitations I was unable to interview participants. Conversations in the quarterly education sessions suggest that these sessions have impacted on participants lives and their engagement with primary health care services. It can be concluded that through engaging participants and actively encouraging participation, WWRP can contribute towards the achievement of SDG 3, target 3.8.

Under White's Typology of Interest (1996), WWRP is considered the implementing agency as they are responsible for the funding of the programme and the delivery of the quarterly education sessions for participants. When reflecting upon the field research, it can be observed that as an implementing agency, WWRP corresponds to the representative level of participation, which can be perceived as being at a higher level of White's Typology of Interest (1996). The WWRP programme, through the provision of the quarterly education sessions enables participants, enrolled on the programme, the opportunity to increase their health literacy levels, to build empowerment and become informed decision makers regarding their health and wellbeing. While WWRP sits at the representative level of White's model (1996), the current funding models does not enable this programme to achieve the transformative level. This is due to participants being dependent on WWRP for the provision of funding for access to primary health care services and medication whilst they remain on the programme. This can be

considered a limitation of White's model (1996) as certain funding is not directly accessible to the public as it filters through health funders, such as the Primary Health Organisation (PHO). While this may be the case it does not mean the services delivered inhibit the use of participation.

WWRP is considered an implementing agency for both general practice and health professionals, while general practice and health professionals are considered the implementing agency for participants of the programme. The relationship between the two is important to ensure that WWRP is delivered effectively and achieving its intended outcomes. The relationship between these two parties, WWRP and health care professionals, can be observed in the representative level of Whites Typology of Interest (1996). As discussed in the research findings under 7.4 Valuing relationships, one interviewee expressed that the relationship between health professionals and WWRP staff was nominal and could also be considered tokenistic. Interviewees expressed the need for continued communication between health professionals and WWRP staff to ensure that the needs of the target population are continuing to be met and the programme is implemented successfully. It is important that the relationship between stakeholders and WWRP staff continues to grow, as through this growth true participation can develop.

SDG 3, target 3.8 has a focus on providing affordable and accessible health care without financial risk to those accessing services. WWRP provides free health care, for one year, for those enrolled on the programme to access primary health care services. To ensure that this form of health care continues to be affordable, participants are advised to commence an automatic payment with their general practice allowing accumulated debt to be paid while also accumulating credit. While this is of benefit to the practice, it is unknown how this may impact on participants and contradicts the targets stance of universal health coverage without financial burden.

WWRP is funded from Service to Improve Access Funding (SIA) funding which is allocated to HHB for the vulnerable population. According to the Ministry of Health (2014) SIA funding is allocated specifically to a PHO to establish new programmes and support successful and current programmes. Interviewees expressed that the establishment of new funding models by the MoH, could consider releasing funds to follow the patient which would enable participants to voice where and how those funds are utilised for their health and wellbeing. While WWRP can be perceived as achieving transformative participation, the current funding structure in the health care system in Aotearoa does not allow participants to have direct access to government funding as HHB is the direct recipient of these funds and is accountable for how they are disbursed. It is therefore unlikely that WWRP will achieve true transformative participation and will continue to be at the representative level whilst current funding models remain.

#### *8.4.3 Transformative participation*

Transformative participation is perceived as the highest Typology of Interest in White's (1996) model. For the participants accessing WWRP, this can be perceived as the level in which they are engaging, as they are on the receiving end of participation. Transformative participation encourages those on the receiving end of participation to feel empowered in decision making and act for themselves (White, 1996). At each of the quarterly education sessions, participants have the opportunity to gain knowledge, understanding of health services and preventative measures to remain healthy. Participants are actively encouraged to have continued engagement with primary health care services as the relationships between health professionals and participants is important. Best Practice Journal (2008) expresses that there is a requirement that health professionals establish a relationship with patients. This statement is supported by the actions of WWRP by encouraging participants to engage with health professionals and primary health care services which was observed during the third quarterly education sessions.

White's model (1996) also examines how participation can affect and influence those on the receiving end of the education sessions. When examining it from this perspective it can be perceived that WWRP is ensuring that those on the receiving end are gaining a transformative typology. Using this form of participation, WWRP are encouraging the power dynamic of 'power within', ensuring participants have power within themselves to make changes to improve health and wellbeing thus leading to empowerment (Rowlands, 1997). It can be argued that empowerment involves more than participating in decision making as it is designed to allow people to believe they are capable and entitled to make their own decisions (Parpat, 2014). To ensure empowerment occurs, it is important to realise that while it is viewed as being achievable, it is relative to the context and situation in which it is being applied (Parpat, 2014).

#### *8.4.4 Summary*

When WWRP was established, utilising a participatory development approach was not considered, as there was lack of knowledge of development models. Through applying White's Typology of Interest (1996) to WWRP, it has been demonstrated that they have unknowingly created an environment which reflects this model. Through the WWRP model and educating participants regarding the importance of accessing primary health care services, there is the potential for increased utilisation of these services once participants exit WWRP, which could contribute towards the achievement of SDG 3, target 3.8. While WWRP provides free primary health care for one year for those on the programme (Health Hawke's Bay, 2014), there is no evidence to support that this programme achieves long term universal health coverage.

### **8.5 Aotearoa and SDG 3, target 3.8**

While this thesis placed emphasis on SDG 3, target 3.8, finding literature or information regarding this goal within the Aotearoa context was difficult. The wider literature has highlighted a general response to how the Aotearoa Government has agreed to assume

responsibility on the SDGs and that a long-term plan is required (Ministry of Foreign Affairs and Trade, 2017b). This statement from the Ministry of Foreign Affairs and Trade (MFAT) demonstrates that SDG 3, target 3.8 is a focus to the Aotearoa Government, as they are signatories of these global goals, and have a responsibility in achieving this target. It is identified that to achieve the SDGs, all sectors of the government in conjunction with community organisations and NGOs, including Primary Health Organisations (PHOs), are required to collaborate to implement health programmes that ensure universal health coverage (Ministry of Foreign Affairs and Trade, 2017b).

Research question three seeks to examine “Does Sustainable Development Goal 3, target 3.8 have value in the Aotearoa context?” While this research has focused on a specific case study, WWRP, based in Hawke’s Bay, Aotearoa, one could argue that if this goal has value in Hawke’s Bay it will have value nationwide. During the interviews, I discussed the concept of the SDGs with interviewees and all were unaware these goals were developed and agreed to by the Aotearoa Government. When discussing the relevance of SDG 3, target 3.8 with the interviewees they believed that it is of value in Aotearoa as they expressed that there are barriers and unmet needs in the community and more resources are required to achieve this goal.

SDG 3 states to “ensure healthy lives and promote wellbeing for all at all ages” (United Nations General Assembly, 2015, p. 20). In terms of wellbeing, Cram (2014) states that there can be confusion regarding what is considered to be government and individual responsibility. With many varying cultures having differing perspectives on wellbeing, the line between government and personal responsibility can be problematic. A report by the World Health Organisation (2002) comments that careful and responsible management of citizen’s wellbeing creates a good government. They also state that governments are required to have a long-term view on how issues and health concerns should be governed, however, there needs to be a balance to

ensure governments do not overstep their boundaries and authority (World Health Organisation, 2002).

Due to the universality of the SDG targets and indicators, Aotearoa is expected to implement these goals into domestic frameworks and policies to achieve the set targets, without increasing inequities (Ministry of Foreign Affairs and Trade 2017b). This global approach recognises that social inequalities occur on a global scale and require the government to address the issues at hand to ensure inequity does not increase (Ministry of Foreign Affairs and Trade, 2017b). In theory, it can be perceived that Aotearoa is achieving SDG 3, target 3.8 as the government provides free healthcare within publicly funded hospitals, co-payments and subsidies within primary health care and some prescription medications are funded.

While research question three has a focus on the Aotearoa context and the research was conducted in the Hawke's Bay region, as highlighted in Chapter Six, health statistics demonstrate that health inequities and barriers are occurring for some populations across the entire country with regard to primary health care. While this may be the case, health statistics between Māori and non-Māori consumers demonstrate continuing inequity (Ministry of Health, 2016c).

#### *8.5.1 Cost as a barrier*

World Health Organisation (2002) states that higher income earners can afford health care through self-funding services thus improving their health and wellbeing compared to those who are unable to afford it, as explained in Chapter Four. Cost prevents one in five adults who live in socio-economic deprived areas from accessing a General Practitioner (GP) (Ministry of Health, 2017a). While all New Zealanders can access subsidised primary health care, the cost of accessing services for some remains a barrier (Ministry of Health, 2017a). Most medication prescriptions in Aotearoa are subsidised under a co-payment scheme funded by the government, whereby patients pay a NZD\$5 (New Zealand Dollar) prescriptions fee for

subsidised medication (Ministry of Health, 2017a). However, approximately seven percent of adults in the general population do not collect their medication due to the cost being a barrier, and for Māori this increases to 14 percent of the adult population (Ministry of Health, 2017a). These statistics demonstrate the value of SDG 3, target 3.8 within the Aotearoa context as those currently not collecting their medication would have the barrier of cost removed. With people expressing concern that cost is a barrier to accessing primary health care, health care in Aotearoa is unaffordable for some and requires new health care models that encompass a focus on achieving SDG 3, target 3.8.

#### *8.5.2 Reducing inequities*

While the government and health professionals are striving to reduce inequity within the current health care system, there remains a gap between Māori and non-Māori health outcomes (Ministry of Health, 2017f). The Ministry of Health (2017f) expressed the requirement to ensure that the health system remains sustainable. To achieve this, services need to remain affordable and there is the requirement to ensure improved health outcomes for those who are accessing primary health care services. While there was no specific reference to SDG 3, target 3.8, the goals of the Ministry of Health (MoH) mirror that of the SDG target. When reflecting upon research question three, there is value in Aotearoa achieving SDG 3, target 3.8 as statistics represent that people are not accessing essential health care services due to barriers which can be real or perceived. By working on this goal, the Aotearoa Government has agreed to, there is hope that new health models will encompass solutions to the barriers and this will reduce the levels of inequity that is faced in the community.

#### *8.5.3 Summary*

In the Hawke's Bay context, WWRP was established to combat the issue of vulnerable populations being unable to afford access to primary health care and medication (SHORE and Whariki, 2016). The provisions of free GP, nurse practitioner and practice nurse visits as well as

funding the cost of some prescription medications for a period of one year is providing a contributing step towards the achievement of SDG 3, target 3.8. As this research was conducted on a primary health care programme established in the Hawke's Bay, correlations can be made to the rest of Aotearoa. While the government subsidises primary health care, statistics provided from the MoH demonstrate that the vulnerable population in Aotearoa continue to face barriers when accessing primary health care services which can be affected by cost and accessibility. This demonstrates the requirement to achieve SDG 3, target 3.8 and create true universal health coverage without placing people in a financial burden would impact those not currently accessing services and reduce inequity.

## 8.6 Concluding thoughts

This chapter has provided answers to the three research questions posed at the beginning of this thesis. These questions were answered from the observations conducted on the third quarterly education session and interviews with various people involved in the design and delivery of WWRP. The first question explores if PD is an effective mechanism in contributing to the achievement of SDG 3, target 3.8. Whilst considered effective, it is depended upon who the model is intended for and who is involved in the delivery. For WWRP, while unknowingly were implementing a form of participation, it can be considered that is programme is contributing towards the achievement of SDG 3, target 3.8. However, to achieve true PD a greater understanding of this would need to occur by those implementing this service. The second question highlighted that WWRP is using PD and was observed as unknowingly implementing a version of White's Typology of Interest (1996). It was identified that there were two different typologies of participation occurring, for the implementing agency, WWRP, they can be perceived to be conducting a representative typology, whereas those on the receiving end, the participants, can be viewed at a transformative typology. However, while these two typologies' have been discussed, people can reflect on the levels of typology differently depending on their

individual perspective. The final question examined if SDG 3, target 3.8 is relevant to the Aotearoa context, and it was concluded as being beneficial, as universal health coverage would enable all to have access to primary health care services without financial burden.

# Chapter Nine:

## Conclusion

*Ma tou rourou ma toku rourou, ka ora ai te iwi- With my contribution and with your contribution the people will prosper*

Māori Proverb

### 9.1 Introduction

As reflected in the quote, with everyone contributing towards a common goal, the desired outcome can be achieved for the people. This proverb, provided to me by the Whānau Wellness Resource Programme (WWRP) Facilitator, is an insight into how she envisions the WWRP community working together to achieve better health outcomes. WWRP is unknowingly contributing towards the achievement of universal health coverage in primary health care for Māori, and those of Pacific Island descent and people residing in quintile 4, who also have a Community Services Card, and people residing in quintile 5 in the Hawke's Bay region. The journey of this research provides insight into how WWRP has unknowingly utilised differing levels of participation to engage Māori and health professional to contribute towards the achievement of Sustainable Development Goal (SDG) 3, target 3.8 of universal health coverage. The purpose of this chapter is to summarise the research, reflect on how the research answers the aim, indicate how this research has contributed to development and provide recommendations for future research and policy.

## 9.2 Research journey

To start this journey, I initially researched current literature on Sustainable Development Goals (SDGs), Māori health and participatory development (PD). Through the collation and understanding of these resources I was able to develop interview questions and criteria for my observations at the WWRP third quarterly education session. Chapter Eight, discussed the findings of the research questions in relation to the literature review, PD and with field research discussed in Chapter Seven provided the opportunity to answer the research questions.

As a nation, Aotearoa has agreed to work towards the achievement of the SDGs. When conducting the interviews, there was limited knowledge regarding the SDGs and specifically SDG 3, target 3.8. Through accomplishing this research, conversations occurred surrounding the relevance and importance of this target for primary health care in Hawke's Bay and the necessity to ensure that this is achieved. Throughout the research journey it was demonstrated how participation can be utilised to achieve SDG 3, target 3.8. The relevance of this target was demonstrated in Chapter Four where Māori health and inequities were addressed, alongside Chapter Six, where the demographics of Hawke's Bay were further discussed identifying growing concerns in the community and thus recognizing the need to accomplish SDG 3, target 3.8. This research has demonstrated the utilisation of participation and how it can contribute to the achievement of SDG 3, target 3.8 within the WWRP.

The aim of the research is to explore "Is Sustainable Development Goal 3, target 3.8 relevant to Māori health and wellbeing in the Hawke's Bay region and does a participatory development approach can facilitate the achievement of this important global goal within the Aotearoa context." The journey of this research has enabled the aim to be investigated and the conclusion to be drawn that participation is of value in contributing towards the achievement of SDG 3, target 3.8 for the Māori population as demonstrated through WWRP and therefore relevant within the wider Aotearoa context.

Question one reflects on the effectiveness of PD contributing towards the achievement of SDG 3, target 3.8. The question was answered by reflecting on literature from Chapter Three generating a discussion on the positive and negative aspects of PD. This question established that there is benefit of utilising PD and while WWRP was unaware that they were using the mechanism, by gaining a greater understanding and knowledge of this model they could implement PD into their model.

The second question of this research examined the use of White's Typology of Interest (1996) to understand how WWRP embraces participation. Through using WWRP, as an example, it was demonstrated how participation can be applied to contribute towards the achievement of SDG 3, target 3.8. It was concluded that WWRP encompasses different levels of participation due to the various stakeholder's involvement within with the programme. I selected a participation model most relevant to the configuration of WWRP, and the observed interaction between the stakeholders. While conclusions were drawn to determine the model, it is important to understand that participation is a concept that is ambiguous and can have different values and meanings depending on the person or situation.

The final question queried the value of SDG 3, target 3.8 within an Aotearoa context. While the conclusion drawn was that it has value, obtaining information to support the implementation of the goal was difficult. Reflections were made through the literature that was analysed and links were created with the Māori health literature allowing the question to be answered. As research has highlighted the inequities faced by Māori within the health system, focusing on this target could be a step towards an equitable society.

### 9.3 Contribution to development

This research has investigated the relevance of participation in contributing towards the achievement of SDG 3, target 3.8. Results from this research have provided the conclusions that SDG 3, target 3.8 has value in the Hawke's Bay and Aotearoa context and by striving to achieve

this goal utilising participation in relation to White's Typology of Interest (1996). Through conducting this research, the work that has been undertaken in Health Hawke's Bay- Te Oranga Hawke's Bay (HHB) has been documented and the use of development theory as a lens through which to examine this programme has been highlighted.

With a focus on participation in primary health care there is emphasis placed on increasing equity to help achieve SDG 3, target 3.8. While this research has been conducted on a Global North health care system, there is hope that this research can contribute to development as it has provided insight into the development theory of participation. As the SDGs are global goals, they are applicable to all 193 countries that have agreed and signed to these goals. Through conducting research on the Global North, it provides insight into inequity experienced in the primary health care sector and the requirement to the achievement of this goal on a global scale, as it can be assumed that if it is relevant in a Global North country, it will be relevant elsewhere.

McElnay (2016) emphasises that everyone has a role in reducing inequity in health and the solutions for this issue can lie within the community. By utilising a development framework when researching a primary health care model, the opportunity to examine the reduction of inequity in health through participation occurred. The use of the development perspective has allowed conversations to occur between myself and the interviewees and has created an awareness to SDG 3, target 3.8 and how a holistic approach to health could help increase participation within the primary health care system.

## 9.4 Recommendations

Recommendations for this research will be discussed below and are divided into three components. These relate to the quarterly education sessions, stakeholder involvement and participation. It is important to emphasise that these are only recommendations provided by the researcher and therefore no obligation is required for them to be implemented.

### 1. Quarterly education session

- a. To ensure participants gain value from the sessions, it is important WWRP facilitators continue to provide the opportunity for participants to attend. These sessions need to be accessible, interactive and directed at an appropriate literacy level for participants. Examples of this would be working with former and current participants for their feedback and suggestions for continuous quality improvement that is reflective of participants requirements.
- b. For former participants of the programme, a voluntary yearly meeting with the WWRP Facilitator could be provided. This would enable those who wish to attend the opportunity to continue to increase their health literacy by providing updates on primary health care services. This would also provide the opportunity to observe if there is continuing engagement and participation with primary health care services.

### 2. Stakeholder Involvement

- a. The continuation and building of relationships with the health care professionals involved in the delivery of the programme is essential for sustained success. A communication network between health care professionals and WWRP could provide feedback and input enabling for quality improvement, increased engagement and participation.

### 3. Participation

- a. For further development of the programme, participation in future design is required from current and former participants and health care professionals. A co-design model ensures the needs of the population WWRP engages with is heard.
- b. To consider utilising participatory development models for further new development of primary health care programmes at Health Hawke's Bay.

- c. To grow WWRP and expand it into other regions in Aotearoa will enable the use of participation to expand in primary health care.

## 9.5 Further research

While the research conducted provided insight into how WWRP has utilised participation to achieve affordable and accessible health care, the scale in which the research was conducted has limited the outcomes of the findings. As a low-ethics approval was accepted for this research, being able to have in depth conversations with participants of WWRP was unable to occur. If further direct research on this topic was to transpire, I believe that it would be important to include discussions with WWRP participants to gain a greater understanding on how participation affects their health and wellbeing.

To study how participation is utilised and the effect it has on contributing to the achievement of SDG 3, target 3.8 a longitudinal study would be beneficial. This would create insight into the participants journeys and if levels of participation changed whilst on the programme while also determining if WWRP is empowering them to achieve universal health coverage for their whānau.

Further research could potentially be undertaken in how other Indigenous health care models in Global North countries utilise participation. By analysing and assessing different health models of care, conclusions can be drawn on how they implement programmes within their community. The examination of other primary health care programmes in Global North countries and the way they engage local populations would provide insight into how participation can influence the delivery of health care and reduce inequity.

The final suggestion for further research is the critical examination of traditional western health models in different contexts where health programmes are targeted at Indigenous people. This would determine if developing a new primary health care programme is required or a different perspective on health is necessary, such as those drawing on indigenous models of health and

wellbeing. With health inequity remaining a concern, there would be benefits to investigating new models of care, and how these could be implemented into the Aotearoa health care system ensuring that inequity is resolved.

## 9.6 Concluding thoughts

As inequity continues to be of concern within the Aotearoa context, new models for primary health care need to be considered. Using a PD model and engaging with consumers of primary health care services to participate in the development of services could be the future. WWRP is providing a new direction for primary health care programmes, as they unknowingly embraced the development framework of PD. This research has demonstrated the relevance of SDG 3, target 3.8 in the Aotearoa context and how other health organisations can learn from WWRP and the new model of delivery they have established that is able to contribute to the achievement of SDG 3, target 3.8.

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# Appendices

## Appendix One: The Tohunga







I

(Grace, 2017).

## Appendix Two: Informed Consent

### Informed consent:

Can a participatory development approach contribute to the achievement of Sustainable Development Goal target 3.8 (universal health coverage)?

Lessons from the Whānau Wellness Resource Programme in Hawkes Bay

### PARTICIPANT CONSENT FORM - INDIVIDUAL

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

I agree / do not agree to the interview being sound recorded. [circle as appropriate]

I agree to participate in this study under the conditions set out in the Information Sheet.

I would / would not like a summary report of the findings sent to me on completion of this research [circle as appropriate].

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Full Name (printed): \_\_\_\_\_

Email address: \_\_\_\_\_

## Appendix Three: Information Sheet

### Information Sheet

#### *Contact details:*

*Researcher:*

Brooke Carter

*Supervisor:*

Helen Leslie

#### *About the researcher:*

Kia Ora, my name is Brooke Carter and I live in Havelock North with my family. I'm studying towards a Masters degree in International Development at Massey University. Prior to starting my Masters, I completed a Bachelor of Arts with a Major in Psychology and a Minor in Development Studies. While my Masters is in International Development, I believe that the development issues that I study have relevance to Aotearoa and that it is important to give back and help the community that has shaped me and helped me become the person I am today. I acknowledge that I am a young Pākehā women researching a programme that is predominantly focused on Māori and I am therefore very grateful for the privilege that has been afforded me to be able to conduct this important research.

#### *About this research:*

After conducting a placement in 2016 at Health Hawke's Bay for one of the papers towards my Masters, I became interested in knowing how this organisation utilises the development studies concepts that I had been learning about (such as participation and empowerment) within the implementation of their programmes and projects. I have always had an interest in the health and wellbeing of a community, however not from a clinical perspective. Researching health and wellbeing from a development perspective provides a broader view on how other factors influence the delivery of programmes. Since starting my studies in development, I have had an increased interest in how participation can be used to influence the empowerment of communities.

In 2015 the international community (including Aotearoa) signed up to implement 17 Sustainable Development Goals aimed at reducing poverty and inequality and improving people's lives. One of these targets was 3.8 'Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all'. This goal highlighted the need for increased participation in communities at a local level to improve health and wellbeing. This research aims to examine the impact of participation to achieve Sustainable Development Goal 3, target 3.8 and to determine its relevance in attaining affordable health care in the enrolled Māori population of Health Hawke's Bay.

*Your role in the research:*

If you choose to take part in this research, there will be two main aspects to the process:

1. Discussion on role within the Whānau Wellness Resource Programme:

This involves a final conversation, if necessary, to ensure that your role within the Whānau Wellness Resource Programme is appropriate for my research.

2. Interviews:

To gain the information necessary to answer my research questions, I will conduct one-on-one interviews with Health Hawkes Bay staff, Board Member and Medical Professionals. Interview times and locations will be arranged with each interviewee.

*Your rights as a participant:*

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- Decline to answer any question;
- Withdraw from the study prior to the interview phase;
- Ask any questions about the study at any time during participation;
- Provide information on the understanding that your name will not be used unless you give permission to me;
- Be given access to a summary of the project findings when it is concluded;
- Ask for the recorder to be turned off at any time during the interview.

*Ethics:*

This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher named

above is responsible for the ethical conduct of this research. If you have any concerns about the conduct of this research that you wish to raise with someone other than the researcher, please contact Dr Brian Finch, Director, Research Ethics, telephone 06 356 9099 x 86015, email [humanethics@massey.ac.nz](mailto:humanethics@massey.ac.nz)".

*After the interview phase:*

Once I've collected the information, I will analyse the findings, along with those from other participants and the observations that have been conducted. The information I collect from interviews and observations will then, and only, be used in the production of my thesis and associated research outputs (e.g. conference presentations) I hope to submit my thesis for marking by February 2018. At that stage, the results will be made available to you as an individual and to Health Hawke's Bay – via the report.

*Confidentiality:*

I will strive to maintain confidentiality and anonymity to the best of my abilities. If you wish to remain anonymous, then the name will not be included in my thesis. My thesis itself will only be seen by a proof-reader, supervisor and secondary marker. If any opportunities to publish an article on my findings arise, yourself and Health Hawke's Bay will be notified. You have the right to remain anonymous in any publication.

If you have any further questions that have not been addressed in this information, please don't hesitate to ask myself or Helen Leslie (supervisor).