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Sustaining organisational partnerships through authentic connections and engagement. A systemic-governance approach to obesity prevention in a complex health system

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Abstract

This research explores the ‘systemic-process’ that drew together three organisations trying to sustain an obesity intervention and prevention programme aimed at Māori and Pasifika in a dynamic and complex health system. The purpose was to identify what brought these three organisational partners together, the roles and needs of each of the three partners and how they could work to achieve their collective aims, centred around improving long-term health conditions for Pasifika. This research was part of an evaluation led by my supervisors Professor James Liu and Associate Professor Siautu Alefaio-Tugia. As a Pasifika inside-researcher I have drawn upon Pacific Indigenous Psychology to provide a lens for understanding and contributing new knowledge about what matters most for communities in need. Through talanoa (Pasifika cultural dialogue) with ButtaBean Motivation (BBM), focus group interviews with Total Healthcare (THC) and The Ministry of Health (MoH), and my own cultural-immersion participation, a new governance approach grounded in ‘collective-good’ was uncovered. Key themes that emerged were: shifting in focus towards connections and engagement, applying a perspective in humility and acknowledging what is not working, being open to learning new things and innovative ways of engagement, and resilience-thinking system that is transformative and sustainable based on Pacific-diasporic values and beliefs. Altogether these themes demonstrate the processes that each organisation as a system undertook to collaborate together. Results reveal three key processes that were instrumental in bringing them together: 1) a willingness to collaborate, 2) open to being flexible and adaptive, and 3) a shared goal. Additionally, what has helped them succeed in maintaining the partnership as well as sustaining the weight loss programme ‘From the Couch’ is: fostering good relationships, open communication, good infrastructure, and privileging and supporting Pasifika ways of knowing, doing and being. Through the lens of Pacific-Indigenous psychology this research has found solutions for improving health outcomes for Pasifika in Aotearoa lie within their own people as evidenced through BBM, and through systemic processes as new governance approaches that are based on the ‘collective-good’. Together this provides transformative and sustainable change.

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Fa'afetai tele lava.

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 in this document is responsible for the ethical conduct of this research. If you have any concerns about the conduct of this research that you want to raise with someone other than the researcher, please contact Professor Craig Johnson, Director (Research Ethics), email humanethics@massey.ac.nz.

Table of Contents

Sustaining Organisational partnerships through authentic connections and engagement. A systemic-governance approach to obesity prevention in a complex health system

Abstract.....	2
Table of Contents.....	6
Chapter One Introduction.....	9
Positionality.....	9
Research Objectives.....	13
The Pacific diaspora draws from ‘The Pacific Way’	14
Chapter Two Literature Review.....	16
Health disparities for Pasifika, and the historical context for disparities.....	16
The current institutional and cultural environment that is responsible for these disparities...	21
The Current National Primary Health Initiative - The Green Prescription (GRx).....	26
Culturally adapted obesity intervention and Prevention programmes.....	27
Indigenous psychology.....	29
Pacific Indigenous (PI) Psychology as a new platform for re-informing psychology.....	32
Implementing primary care intervention programmes into indigenous communities.....	39
Systems Thinking.....	41
Collaborating in Primary Healthcare.....	45
Chapter Three Method.....	48
Research Aims.....	49
The Coming Together of Three Systems.....	50
ButtaBean Motivation.....	50
Total Health Care.....	50
Ministry of Health, Health New Zealand.....	51
Pacific Methodology.....	52
Talanoa.....	57

Cultural - Participatory immersion a Pacific-Indigenous approach similar but differnt to Participant Observation.....	58
Methods of Data Collection.....	59
Talanoa.....	60
Semi-structured Focus Group Interviews.....	61
Procedure.....	62
Methods of Analysis.....	63
Thematic Analysis.....	63
Braun and Clarke 6 Phase Guideline (2006).....	63
Phase One: Familiarising yourself with your data.....	63
Phase Two: Generating initial codes.....	64
Phase Three: Searching for themes.....	64
Phase Four: Reviewing themes.....	65
Phase Five: Defining and naming themes.....	65
Phase Six: Producing the report.....	66
Chapter Four Results.....	66
Theme One: ‘Shift in focus towards connections and engagement’.....	66
Facilitating conditions in the macro-environment.....	68
Equity lens.....	68
People are the systems.....	69
Theme two: Shift in Focus towards a perspective in humility - acknowledging what wasn’t working.....	71
Holistic view of health.....	72
Benefits of and Willingness to Collaborate.....	73
Theme three: Resilience-thinking system that is transformative and sustainable based on Pacific-diasporic values and beliefs.....	75
Lived Experience.....	75
Pasifika values.....	76

Findings from Cultural-Participatory Immersion.....	81
Governance Group.....	81
Recruitment process for Cohort One.....	81
Outcome of Cohort One.....	82
Recruitment process for Cohort Two.....	82
Outcome of Cohort Two.....	83
Chapter Five Discussion.....	86
Primary Care for reducing health disparities.....	86
Improving access to healthcare through culturally safe interventions.....	87
Using cultural knowledge to inform interventions.....	89
Community Ownership.....	91
Joining cultural knowledge to inform interventions.....	93
Conclusion.....	95
References.....	97
Appendices.....	106
Appendix A: Outline of open ended questions used in talanoa and focus group interviews.....	106
Appendix B: A copy of the governance report.....	109

List of Figures

Figure 1.....	52
Figure 2.....	54
Figure 3.....	64

Chapter One: Introduction

This chapter explores how my Samoan and NZ European background has informed my worldview into the different experiences and realities for Pacific People and Palagi (a Pacific term that is commonly used to refer to people of European descent) in Aotearoa, New Zealand.

Positionality

I am a second-generation NZ-born Samoan, Palagi woman with a Samoan Dad and a Palagi Mum who was born and raised in Auckland, New Zealand in an English-speaking household. These circumstances are the foundation to my worldview today. Much of my worldview has been shaped by my access into Palagi and Samoan spaces. Family and school were two influential domains in my life where I experienced shifting in between two cultural worlds.

Like many Pasifika, growing up I was always surrounded by family - grandparents, aunties, uncles, cousins, and friends who are family. I learned early on that aiga (family) is an important part of the foundation to our sense of belonging, wellbeing and culture. That is because it is interwoven into all aspects of our lives including how we behave and why we do what we do. I also identified that the concept of family is perceived and understood differently across groups of people. For Samoans the notion of 'extended family' does not exist, it is just family/aiga and collectivism. Whilst in Palagi culture it is not uncommon to distinguish relationships within the family unit. A common example is distinguishing between 'first' and 'second' cousins. The western concept of cousin is largely based on the biological relationship. In Samoa and many other Pacific cultures cousin not only includes the biological relationship but a sociocultural interpretation as well. It is a representation of the type of relationship between people that includes anyone who they perceive to fit their social interpretation of 'cousin'.

Being Samoan and Palagi I have observed how people come to understand what family looks like to them. For example my mother is adopted and therefore there is no biological

relationship to my cousins. As their definition of the ‘cousin’ is informed by a western understanding our relationship does not ‘fit’ with their understanding of cousins, which prompts the need to further explain our relationship. This is followed by “they are my cousins, although not technically because we're not related”. I have recognised that much of my worldview is based on Samoan and Pasifika values, such as how I have conceptualised family aligns with the Samoan understanding. It is examples in my life like these that have allowed me to acknowledge that one concept can be perceived so differently by different groups of people which in turn influences their attitudes, values and their overall worldview.

Between two worlds

Growing up in Aotearoa it felt as though I was constantly moving in between two worlds – In one world I was proud to have a Samoan name, in another I found myself wishing for a more Palagi name. Throughout my schooling I attended various schools, my primary and secondary school had a predominantly Māori and Pacific population, whilst the intermediate I attended had a predominantly Palagi population. Similar to my personal life, shifting between schools with different demographics exposed me to the different realities being lived in Aotearoa. It was also through attending different demographics of schools where I was constantly negotiating my identity, and how I felt in the different spaces.

I recognised early on that for many Māori and Pasifika their experiences in Aotearoa were very different for Palagi living in Aotearoa. I went to a decile 1 primary school with a high Pacific and Māori population. It was not uncommon for some children to come to school without having breakfast or lunch. As this was a regular occurrence, the school always had lunch available for any students that did not have food that day. The intermediate I attended was a decile 10 school which often correlated with families of higher economic status. I noticed that there was no need for that type of service because children turning up without lunch was not an issue they had to worry about.

Intermediate was also the time where I became much more aware of my identity. I remember not liking my name and wishing I had an easier ‘whiter’ name. I remember going

from primary to intermediate felt like a culture shock, but by year 8 I had figured out how to act to fit in. I then moved to a high school with a predominantly Māori and Pasifika population and found it took me a while to settle in. I had just spent the last 2 years forming myself into what I thought I needed to be and now I was in a space where I was surrounded by other people who expressed their cultural identity unapologetically. Once I had settled in, I remember feeling like I belonged. In my final year of high school I joined the Samoan group where we competed at Polyfest (a polynesian festival where schools showcase their culture through performing traditional songs and dances in competition against other schools). For the 10 weeks that we practised, Samoan ways of knowing, doing and being were at the forefront of everything we did. There was an alignment between how I identified and the environment that I was in. As I settled into my new high school the desire for an easier whiter name soon began to disappear. I had shifted from wanting an easier name to now proud and fortunate to have a Samoan name. Like my understanding of family, much of sense of belonging, wellbeing and cultural values are grounded in a Samoan understanding, which I believe is why when I am in Pacific spaces I have a greater sense of belonging and alignment with my values.

One of the biggest reflections throughout my schooling years was how I felt in the different spaces. Being in a space where I was comfortable, I was able to look back at my time in intermediate and I remember a distinct difference in the way I felt. I realised that when you are surrounded by people and a place that aligns with your cultural values and attitudes it has a positive and lasting impact. It is these experiences where I have been able to reflect that my wellbeing stems from being able to operate in a culturally relevant and safe system. I saw that being in an environment where your ways of knowing, doing and being were celebrated and encouraged have a significant impact on your wellbeing and your experiences in institutions.

Health for All?

Like many Samoan families, my grandparents migrated to Aotearoa in the 60s and resided in Ponsonby. The promise of milk and honey apparently did not extend to the Pacific community, instead they were met with low paying jobs, long hours and a change in diet, exacerbated by discrimination and an intolerance to their Samoan worldview. This is an all too

familiar story for many Pasifika families in Aotearoa. As a consequence, disparities in health status between Palagi and Pasifika emerged.

In my own family, I witnessed these health disparities. Throughout my childhood my Samoan grandparents struggled with the long term condition obesity and its sequels, such as stroke and diabetes, and complications from diabetes. In contrast to my Palagi side, I never observed my grandparents experience any long term conditions impacting on their health. I understand now why this was the case - the differences in access to resources and experiences accessing healthcare played a significant role.

The importance of Pacific knowledge in research

What sparked my interest in this research was how BBM, a community led organisation, has combined Pasifika ways of knowing, doing and being in a modern western world that speaks to their community in South Auckland. We have seen no improvement in the overall health of Pacific people in Aotearoa, in fact the inequities continue to grow. It is vital that Pacific people lead their own health initiatives for their community. That is why we need Pacific indigenous research to inform our health initiatives because it privileges Pacific ways of knowing, doing and being. When a western worldview is the dominant worldview and normalised in society it can be blinding and to recognise that a western system does not work for everyone can take time as people need to unlearn and relearn to look at the systems differently. This project has shown that and that is why I continue to maintain interest in psychology, in particular Pacific indigenous psychology

The privilege of my tertiary education has afforded me the knowledge and reflexivity to know that there are systemic issues in place that ensure groups of people do not have the same opportunity as other groups of people. And even when they do, the lack of reflexivity from people within those systems exacerbates the burden of those systems. My education has given me this knowledge that not everyone has access to. It is knowing this that continues to spark my interest in psychology and how psychology can give our Pacific people the knowledge and

confidence to recognise that their culture and values, their resilience and ability to adapt can improve their health.

Research Objectives

1. Identify what brought three organisations (community, government and health provider) together in a voluntary collaboration. Further, what roles, strengths and needs each of the three organisations bring together to achieve their collective goal of improving long-term health conditions for Pasifika.
2. Explore a new governance approach as a ‘systemic-thinking’ process of collective-good, a system that is trying to sustain an obesity intervention and prevention programme aimed at the most hard to reach in a dynamic and complex health system.
3. Understand how different cultural knowledge systems work together to develop and sustain an obesity intervention with the goal of improving the health of Pacific peoples. In particular, reducing the prevalence of obesity and long-term conditions.

The Pacific diaspora draws from ‘The Pacific Way’

The following section defines and describes the term diaspora, the Pacific diaspora, and the Pacific diasporic community in Aotearoa, NZ.

The Pacific diaspora in Aotearoa NZ consists of - Pacific Peoples. It is a collective term used to refer to the many ethnic groups that make up Polynesia, Micronesia and Melanesia. There are 8 main groups comprising Pacific People in New Zealand - Samoa, Cook Island Māori, Tonga, Niue, Fiji, Tokelau, Tuvalu and Kiribati, but the term is inclusive of all ethnic groups across the Pacific. Previously the term used to describe the people of the Oceanic region was ‘Pacific Islanders’. The term reflected a more migrant population, but today the NZ-born population represent the majority of the community, therefore the NZ government now refers to the term ‘Pacific peoples’, as it is a more appropriate representation of today's population.

Defining diaspora and the Pacific diaspora

“The term diaspora carries a sense of displacement; that is, the population described finds itself separated from its national territory; and usually it has a hope, or at least a desire, to return to their homeland at some point, if the “homeland” still exists in any meaningful sense” (Alefaio, 2009, p. 171). Historically the term was used to describe the historical movements of the dispersed population of Israel (Alefaio, 2009). The term ‘Pacific diaspora’ is used to describe the movement of Pacific people through the Pacific region, Alefaio (2009) states it is “a way of understanding the movements or scattering of people through the Pacific region” (p. 171).

Spickard (2002) stated Pacific islander migration has always been a diasporic movement. Pacific people are original voyagers of the sea and have been migrating across Oceania for thousands of years. Evidence suggests movement has always been multidirectional and continued long after settlement (Spickard, 2002; Hau’ofa, 1993). More recently the diasporic movement of Pacific people changed, Alefaio (2009) explains, this change was a result of “the encounter with European and American and colonialism, which had the effect of channeling migration along the sinews of trade and empire.” (p. 171).

The Pacific diaspora in NZ

The Pacific diaspora in NZ has become a community of its own, drawing from the similarities of the many cultures that make up the region. As the population has transformed from a largely migrant population to a NZ born population, a ‘Pacific’ or ‘Pasifika’ identity has emerged. In Crocombe’s book (1976) ‘The Pacific way: An emerging identity’, the author speaks about a shared identity. He explains “the origins of ‘The Pacific Way’ was partly due to the need to unify and did this through drawing from every symbol of similarity and oneness, as well as symbols that draw on a common interest or distinguish us from foreign” (p. 30). The conceptualisation of ‘The Pacific way’ may be seen as a foundation to the ways of knowing, doing and being in the diasporic community.

The culture of the diasporic community has largely been cultivated in the urban areas of Auckland, firstly Central Auckland and now more prominently in South Auckland. Generations of Pacific children have been adapting their Pacific cultures and merging it with aspects from their more western modern, urban environment. Mila-Schaaf (2009) explains “Pasifika is a diasporic concept within the context of Aotearoa and that Pasifika is inclusive of the way in which Pacific peoples operate within diasporic communities”. This current study refers to the Pacific diasporic community of South Auckland where community organisation BBM is located.

The research will demonstrate that the Pasifika community in Aotearoa already have the knowledge and tools to lead their own health initiatives and improve their own health outcomes. It will also explore what mainstream providers and the public health system can do to support them. Pasifika or Pacific Peoples will be used interchangeably throughout this thesis in reference to the Pacific diaspora of Aotearoa NZ. Anae (2001) states that “there is no generic ‘Pacific community’ but rather Pacific peoples who align themselves variously, and at different times, along ethnic, geographic, church, family, school, age/gender-based, youth/elders, island-born/NZborn, occupational lines, or a mix of these” (p. 7).

Chapter Two Literature Review

Introduction

This review of literature explores the research and scholarship documenting the health disparities in Aotearoa NZ as well as other countries with Pacific communities. It examines the historical context that allowed for these disparities to manifest, and how it has impacted the health status of Pasifika today. It examines local and international literature on the current institutional and cultural environment that is responsible for unequal health outcomes. I then conducted a review on the literature and scholarship on Indigenous psychology, specifically reinforcing psychology through applying Pacific knowledge systems, methods, and methodologies to improve the outcomes of Pacific communities. A review of the research and scholarship on Systems thinking was conducted because of its versatility and ability to see the big picture of such complex health problems such as Long term conditions where the cause of the issue is non-linear. Subsequently Systems thinking is increasingly being used as a lens, as a way of viewing things more holistically and focusing on the interactions/ relationships in the systems. Māori and Aboriginal scholars identified many similarities between Systems thinking and their Indigenous worldviews. I reviewed the current research that looks at how Systems thinking allows indigenous ways of knowing, doing and being to be appropriately articulated for non-indigenous researchers to understand. Lastly the literature on collaborating in primary healthcare is predominantly from international literature as this a new partnership.

Health disparities for Pasifika, and the historical context for disparities

In Aotearoa, New Zealand disparities in health experiences and status between Pacific People and NZ/Europeans (NZE) are well documented and long standing particularly relating to ethnicity and socioeconomic deprivation (Ministry of Health, 2008, Ministry for Pacific Peoples, 2021, Statistics New Zealand., Ministry of Pacific Island Affairs, 2011., Harris et al., 2019). These disparities have been observed for many decades (Blakely et al., 2003, Tobias & Cheung,

2003, Marriott and Sim, 2003). Disparities in health can be characterised as “a particular type of difference in health or in the most important influences on health that could potentially be shaped by policies; it is a difference in which disadvantaged social groups (such as the poor, racial/ethnic minorities, women, or other groups that have persistently experienced social disadvantage or discrimination) systematically experience worse health or greater health risks than more advantaged groups” (Braveman, 2006, p. 180). This section will explore current research and scholarship on the relationship between ethnicity and socioeconomic deprivation and health outcomes. I will then look at the current health status of Pasifika and their interactions with New Zealand’s public health system to understand the impact of these factors. Lastly I will undertake an examination of obesity in the Pacific community, as it is commonly a product of the intersection between ethnicity and high socioeconomic deprivation.

Socioeconomic factors along with ethnicity are arguably the most important determinants of health status and overall well being (Salmond et al., 2005). Whilst both of these factors have independent effects on health status (Hefford et al., 2005), for many Pasifika they are often intertwined. This review of research and scholarship begins by examining the effects of each separately before investigating the intersection of both factors. When looking at the relationship between socioeconomic disparities and various health outcomes in NZ, numerous studies have found that high levels of socioeconomic deprivation were associated with a number of negative health outcomes including reduced life expectancy (Tobias and Cheung, 2003), increased prevalence of cardiovascular disease (CVD) (Chan et al., 2008), higher rates of stroke (Heeley et al., 2011) and an increase in obesity rates (Ministry of Health, 2020) among Pacific people in New Zealand. These findings are consistent with International research from other developed countries (Major et al., 2010) which may suggest that there are systemic issues in society that perpetuate poorer health outcomes for people living in areas with higher socioeconomic deprivation.

Given that New Zealand has high levels of health inequality there have been a number of studies conducted over the last 20 years capturing the disparities particularly between NZE and Māori and Pacific People. Studies conducted by Tobias and Cheung (2003) and Chan and colleagues (2008) found that deprivation did not account for the overall disparity stating that ethnicity placed a heavier burden on Māori and Pacific adults. They stated that Māori and Pacific

People had lower life expectancy compared to non-Māori, non-Pacific adults at each level of deprivation and found an increased prevalence of CVD particularly for Māori and middle aged Pacific adults. This is particularly concerning. In a report from the Ministry of health cited by Hefford and colleagues (2005) they illustrated the impact of socioeconomic deprivation:

“Had all New Zealanders enjoyed the avoidable hospitalisation rates of those living in deciles 1–4, 28% fewer avoidable hospitalizations would have occurred in 1997 or 1998—an annual ‘saving’ of approximately 26,000 hospital admissions. Further, eliminating the socioeconomic gradient in avoidable mortality would postpone over 2000 deaths per year. Had the avoidable mortality rates for Māori and Pacific been the same as the other rates, Māori would have experienced 970 fewer deaths and Pacific people 210 fewer deaths each year than actually occurred; this represents 45 and 35% of all Māori and Pacific deaths in the 0–74 age group, respectively (p. 11).

This means for Pasifika and Māori of Aotearoa NZ just by being Pasifika and Māori in Aotearoa equates to having poorer access to healthcare and higher mortality rates.

Current Health Status of Pasifika in NZ

Ethnic disparities in health status have been observed for many years (Ajwani et al., 2003;Marriott & Sim, 2015; Gurney et al., 2020). Quantitative data illustrates the detrimental impact these disparities have had on Pasifika health outcomes. Pacific People have a lower life expectancy of approximately 6 years compared to NZ Europeans (75 years for Pasifika men & 78 years for Pasifika women compared to 80.9 and 84.3 years) (Ministry of Health, 2020, Health and independence report, 2019). They have higher rates of avoidable mortality (47.3% compared to 23.2%), and a much earlier onset of disease. The prevalence of Long term conditions is much higher in the Pacific community (Ryan et al., 2019; Ministry of health, 2008; Ministry for Pacific Peoples, 2021). They are the biggest contributors to Pacific Peoples overall mortality in particular diabetes and cardiovascular disease. In NZ 20% of Pacific adults (aged 20 - 79) have diabetes, which is significantly higher than any other ethnic group (Māori 10%, NZ/European 6% and Asian 8%) and much greater than the OECD average (7%) (Ryan et al., 2019). The overall incidence for cancer is lower in the Pacific community but they have higher rates of

cancer related deaths compared to NZ/Europeans, this may suggest that there are issues regarding access to healthcare that are contributing to this statistic. One of the most important modifiable risk factors for diabetes, CVD and common cancers is obesity. Pacific People experience disproportionate rates of obesity (Ministry of Health, 2022). In a recent National health survey (2020/21) it was reported that 70% of the Pacific adult population were classed as obese (compared to 34% of NZ/European adults). These outcomes are also found internationally in other western societies where there is a significant Pacific population such as Australia and the United States (Keawe‘aimoku Kaholokula et al., 2018) demonstrating this is a global phenomenon for the Pacific diaspora.

Historical context for disparities

The burden of disease falls heavily on Māori and Pasifika. This is due to the unequal distribution of resources (Marriott & Sim, 2015), colonisation and its ongoing effects as well as racial discrimination (Harris et al., 2019; Talamaivao et al., 2020). All of these factors have contributed to a significant and growing health gap.

Racism has been associated with negative health outcomes and is an underlying cause of ethnic health inequities (Talamaivao et al., 2020). In their study Talamaivao and colleagues (2020) have characterised Racism as “an organised system of oppression involving the social construction and valuing of racial/ethnic groups based on ideologies of superiority (and inferiority), which serves to privilege some groups over others” (p. 1). Racism can manifest in different ways at different structural levels - interpersonal, intrapersonal and institutional level. “Internalised racism involves attitudes, beliefs or ideologies often founded on understandings of supposedly innate superiority and inferiority that may be held by members of dominant social groups and/or oppressed ones. Interpersonal racism refers to racism between people, with varying degrees of frequency and intensity, including manifestations from racially motivated assault to verbal abuse, ostracism and exclusion. Systemic, structural or institutional racism involves the production, control and access to material, informational and symbolic resources within societal institutions, laws, policies and practices” (Talamaivao et al., 2020. p. 1).

Talamaivao and colleagues (2020) recently conducted a systematic review analysing a total of 24 quantitative studies that looked at the relationship between self-reported discrimination across a number of health measures. They found that racism was consistently associated with poorer health outcomes. Similarly Harris and Colleagues (2019) found an association between reported experience of racism and higher rates of unmet needs as well as lower overall satisfaction in Pasifika, Māori and Asian ethnic groups compared to NZE and others.

It is widely agreed that the health of an individual is not based solely on their own individual actions and behaviours but that a person's health outcomes are affected by social and environmental factors, these are commonly known as the social determinants of health (WHO commission on Social Determinants of Health, 2008). They consist of income stability, employment security, access to quality education, healthcare access and quality, neighbourhood and built environment and the social and community context, they can have a direct or indirect effect on health. (World Health Organisation, 2022). In western colonial countries such as New Zealand, Australia, Canada and the USA these determinants of health are not evenly distributed across groups resulting in a health gap between ethnic minorities, indigenous groups and the dominant group.

In a comparative study by Marriot and Sim (2015) they “investigated a number of inequality indicators in New Zealand” (p.1) between Māori, Pasifika and NZE. In the area of education they found an increasing gap in gaining a bachelor's level degree or higher. The authors stated “it is generally accepted that educational achievement is linked with multiple positive outcomes: higher incomes, greater employment opportunities and positive health associations” (p.33). Similarly Pasifika have a higher rate of unemployment than NZE (7.1% vs 3.2%) . They also found an increasing gap in median weekly income between PP and NZE, they reported an income difference of \$239pw between PP and NZE in 2012. Marriott and Sim also reported on areas such as household crowding and internet access at home as indicators for neighbourhood and built environment and social and community context. They found that 23% of Pacific peoples were living in crowded households in 2013, this has decreased slightly since 2001(25.8%) and the overall gap between Pacific People and NZE was said to be ‘closing’, however large gaps remain (23% vs. 2.7%). Lastly the authors reported 65% of Pacific People had access to the internet while 86% of the NZE population had access in 2012. Whilst the data

from the study is from almost 10 years ago the findings are still relevant today. In a more recent study, Gurney and colleagues (2020) findings were consistent with Marriott and Sim's (2015) study. They found in their study that Māori and Pacific People are more likely to live in areas with higher levels of socioeconomic deprivation; this means they have poorer access to resources required to maintain good health, such as the high cost of healthy foods. They went on to explain that Māori and Pasifika are more likely to live in areas where there are less health-positive resources and a larger presence of health-negative factors such as fast food outlets and liquor stores. One of the consequences of the way in which the determinants of health have been distributed can be seen in day to day realities of many Pacific People.

In a recent review of Pacific health, Ryan and colleagues (2019) found 24% of Pacific People have reported not having enough money to put food on the table and they are more likely to live in damp, mouldy and cold homes, additionally they are more likely to experience overcrowding compared to NZE (Ministry for Pacific Peoples, 2021). The Ministry for Pacific Peoples (2021) stated that insecure tenure, poor dwelling conditions and household crowding has an impact on access to local services, education and health. The literature has consistently reported Pasifika being worse off across all social determinants of health. Given that it is widely accepted that they (social determinants) impact an individual's overall health, the current health status of Pacific People in Aotearoa NZ comes as no surprise. The unequal distribution of resources and an increasing gap (between NZE and Pacific People) across a number of indicators (Marriott & Sim, 2015) further suggests that there are underlying systems and structures enforcing inequality.

The current institutional and cultural environment that is responsible for these disparities

In the previous section I examined the health disparities experienced by Pasifika particularly in NZ and the various determinants and structures that perpetuate such health disparities. In the following section I identify the current institutional and cultural environment that is responsible for these disparities.

In 1978 The World Health Organisation (WHO) proposed the Declaration of Alma-Ata where they identified primary health care as the key attainment for the goal of “Health for All” (World Health Organisation, 1978, p.1). Primary healthcare is a model of care that supports first-contact, accessible, continuous, comprehensive and coordinated person-focused care. It aims to optimise population health and reduce disparities across the population by ensuring that subgroups have equal access to services (*WHO*, n.d). As opposed to secondary care which can be characterised as treatment that is delivered after the first point of contact has been made, may also be known as community and hospital care. The declaration called on governments to “formulate national policies, strategies and plans of action to launch and sustain primary care as part of a comprehensive national health system and in coordination with other sectors” (p.3). Following the declaration, In 2001 New Zealand implemented a new Primary health care strategy based on the principles of the Alma-Ata declaration (Hefford et al., 2005). A significant feature was the grouping of primary care providers (general practitioners (GPs), primary care nurses and health professionals such as Māori and Pacific health providers and health promotion workers) into networks called Primary Health Organisations (PHOs) (Hefford et al., 2005). One of the main goals of this new structure was to reduce barriers impacting access to primary care. Since the restructure, reports from the Ministry of Health found that GP enrollment rates for Pasifika are high and utilisation of the GP is similar to the wider population (Ryan et al., 2019).

Despite a more focused effort on primary healthcare, quantitative data report ethnic disparities in access to quality care and utilisation of the health system still exist. Subsequently qualitative studies that have explored the experiences of Pacific People in healthcare have consistently reported issues of cultural competence (Ryan et al., 2019; Ludeke et al., 2012). This suggests that while there is an increased rate in GP utilisation, given the high levels of deprivation for Pasifika, they are more likely to use free services such as the public hospital rather than pay for the GP hence the high-rates of emergency admissions at Middlemore in comparison to others nationally (Ryan et al., 2019). Wright and Hornblow (2008) have stated that access and utilisation of public healthcare in New Zealand (along with other factors) have contributed to Pacific Peoples poor health outcomes, this is further supported by Ludeke and colleagues (2012) who stated that “poor access to primary care is known to compound existing inequalities in health” (p.1)

An individual's ability to access quality care can be explored through different dimensions. In a paper by Gulliford and colleagues (2002) they identified four potential dimensions where quality of access to healthcare could be evaluated. These were service availability which refers to having an adequate supply of health services available. Utilisation of services and barriers to access referring to the personal, financial and organisational barriers that can influence an individual's utilisation. Relevance effectiveness and access refers to access to the right healthcare at the right time. Lastly, equity and access is concerned with equal access to health services across all groups with equal needs. Similarly in another paper by Richardson and Norris (2010) they state that access to good quality healthcare is based on being able to gain access to the health system, having access to a general practice or other sites of primary care services, and meeting the individual and cultural needs of the patient. I recognise that the dimensions are intertwined and access issues in one area are going to impact other areas however, depending on what area of the health system they are accessing care, some dimensions may be more or less salient.

There have been a number of quantitative studies reporting on Pacific Peoples interactions with the health system where they have found discrepancies across several dimensions relating to 'access'. A New Zealand study conducted by Rahiri and colleagues (2017) investigated ethnic disparities in rates of publicly funded bariatric surgery for people who are morbidly obese across a 5-year period. They found that the procedures do not appear to be accessed equitably. When looking at the numbers of procedures performed per thousand there was a clear unequal distribution of the service (3.0 for NZE, 1.4 for Māori and 0.7 for Pasifika) with the number of publicly funded procedures 5 times lower for Pasifika than NZE. These findings suggest a number of implications. First, given that Pasifika have the highest rates of obesity in NZ followed by Māori we would expect to see a more equitable access rate of the service across all equivalent groups. This suggests that there are structural inequalities in the mainstream system that needs to be adapted to improve access for Māori and Pacific People. Second, bariatric surgery is a secondary care intervention for people who are morbidly obese, this may suggest that there are access issues in primary care services that are a) impacting their ability to receive bariatric surgery and b) there is not adequate access to effective intervention

and prevention programmes that prevent people from needing that level of intervention. Lastly, given that primary care influences the utilisation of secondary and tertiary care - developing and adapting interventions in primary care to meet the socio-cultural needs of Pacific People can work towards reducing ethnic disparities over the long term.

One way to look at the effects of the institutional environment is to explore how Pasifika are utilising the health system. In a recent report reviewing evidence of health equity for Pacific Peoples in Aotearoa by Ryan and colleagues (2019) the authors stated that Pasifika have the highest rates of ambulatory sensitive hospitalisations for both children and adults compared to any other ethnic group. The rate of Ambulatory sensitive hospitalisations (ASH) in the Pasifika community (8787 per 100,000) were almost more than double that of the total New Zealand population (3789 per 100,000) (Ministry of Health, 2018a cited by Ryan et al., 2019). High rates of ASH may suggest a number of things, that Pacific People are not accessing the right healthcare at the right time, or when they do seek care they are not receiving adequate quality health care. Additionally hospitalisations can be seen as a means as a last resort because of both deprivation and negative experiences in primary care. Ryan and colleagues (2019) explained that The Ministry of Health (2018) often uses Ambulatory sensitive hospitalisations as a “measure of the effectiveness of the interface between primary and secondary health care and can be seen as a marker of unmet need” (p. 28). The authors stated that to reduce rates of ambulatory sensitive hospitalisations, primary care providers need to ensure access is equitable, affordable and Pasifika are receiving culturally safe quality care.

Another indicator that further illustrates health inequalities is unmet needs. Unmet needs are “the difference between services judged necessary to deal appropriately with health problems and services actually received”. Pacific Peoples tend to have high rates of unmet needs compared to NZE, in the recent New Zealand health survey (2020), 33% of Pasifika reported not being able to see their primary care practitioner when they needed to. 20% of Pacific people were not able to see their GP due to cost (compared to 15.2% NZE), similarly 17% of Pacific People reported not being able to fill prescriptions due to cost. The cost of healthcare is a major barrier for many Pasifika and impacts their access and utilisation. We know from the previous section that Pacific People have a lower median income than NZE, and live in areas with high levels of deprivation,

this may mean that for some Pasifika they have to choose between seeing their GP or paying for a prescription and putting food on the table. These findings are a reflection of the socio-economic realities of many Pasifika and how they intertwine with gaining access to and utilisation of primary healthcare services.

In the same review Ryan and colleagues (2019) synthesised qualitative studies on Pacific Peoples experiences of care and presented a range of barriers and enablers to healthcare. They are communication, cultural competence, stigma and discrimination, and competing priorities. In relation to access and utilisation of health care services they found issues with cultural competency, cultural safety and a clash in cultural worldviews heavily impacted their quality of healthcare and health seeking behaviours. Cultural competency refers to the provider or organisations ability to meet the socio, cultural need of the patient, and cultural safety refers “to the need for health professionals to consider their own cultural background and the impact of power, privilege and their personal biases on healthcare systems and organisations and the relationships within them” (Health Navigator, 2022, p.1). Ryan et al., (2019) stated that many Pacific People “judged the quality of their health care by their sense of whether or not the vā was being respected... when the relationship between patient and health professional respects the va, then, to the Pacific person, there is a completely different quality to the relationship” (p. 8).

Similarly Ludeke and colleagues explored Pacific Peoples access to General Practices. They identified five areas that may be influencing access; language and communication, rushed consultations, appointment availability, reception and Pacific presence. Excluding appointment availability, the rest of the findings can be attributed to cultural competency. For example, with regard to ‘reception’ a key factor was the mispronunciation of names by receptionists, the participants of the study perceived this as lacking cultural sensitivity, and is seen as an indicator of racial discrimination. Consistent with Ryan and Colleagues review, Ludeke and colleagues (2012) also found that when care and attention is put into building a relationship, Pacific People perceive the quality of healthcare more positively (Ryan et al., 2019; Ludeke et al., 2012).

As outlined in the previous section, there is a strong relationship between ethnicity and socioeconomic factors with health outcomes. These disparities have emerged due to the unequal distribution of resources compounded by interpersonal and institutional racism. Disparities in

access to quality health care and utilisation persist, exacerbating health inequities. Many of these issues arise due to the “values, beliefs, and behaviour embedded in the New Zealand health care system reflecting the wider Palagi cultural context” (Wright & Hornblow, 2008, p. 26). One of the ways that the NZ health system has reacted to the disparities has been through the development of Pacific led health organisations, ethnic specific health initiatives and adapting services to meet the needs of the target population. This is underpinned by the assumption that services should reflect the values, beliefs, attitudes and knowledge systems of the specific ethnic group.

The Current National Primary Health Initiative - The Green Prescription (GRx)

Given the alarming rates of obesity in NZ and the associated comorbidities, there has been a number of prevention and intervention initiatives implemented into primary healthcare locally, regionally and nationally. At the national level, prevention initiatives have focused on a whole population approach where the focus is primarily on increasing physical activity and improving nutrition (Ministry of Health, 2020). The GRx was implemented in 1998 nationally as a prevention tool in primary healthcare where health professionals can ‘prescribe’ the GRx to advise increasing an individual's activity levels as part of their health management (Ministry of Health, 2021). It was primarily prescribed to individuals with preexisting medical conditions such as long term conditions (e.g. cardiovascular disease, type 2 diabetes) and weight problems. The GRx has been found to be a cost effective approach (Garrett et al., 2011) and quantitative studies found that individuals who adhered to the GRx requirements saw increases in activity levels (Hamlin et al., 2016; Elley et al., 2003). In Hamlin and colleagues (2016) study only 7% of the participants were of Māori or Pacific descent and there was no mention of ethnicity in Elley and colleagues (2003) study. A qualitative study looked at the experiences of Pacific women who had completed the GRx and found that they all had positive experiences (Tava'e & Nosa, 2012). All of these studies were conducted on participants who adhered to and completed the GRx requirements. Research exploring the participants who did not complete the programme may provide further insight. Additionally outside of the annual patient survey reporting on peoples experiences (Wood & Johnson, 2018) there is a lack of reporting and research on the number of people who have been referred to and how many have completed the GRx by

ethnicity and DHB. Given Pacific People experience inequitable rates of obesity the number of referrals and number of people who have completed the programme should reflect this. Whilst physical activity is an effective approach to preventing obesity and reducing an individual's BMI, targeting physical activity alone for Pacific individuals who are obese may not produce long term sustainable outcomes because it does not take into account the many other factors that contribute to the disproportionate rates of obesity in the Pacific community.

Culturally adapted obesity intervention and Prevention programmes

Obesity has been identified as a significant public health issue due to its comorbidities of other Long term conditions such as CVD, diabetes and common cancers. In a recent report from the NZ institute of economic research (2021) they found that obesity is costing NZ approximately \$2 billion dollars per annum or 8% of healthcare budget. As with other health outcomes the prevalence of obesity in the Pacific community is a product of high rates of urbanisation and deprivation relating to poor access to healthy foods, unequal distribution of resources, poorer access to quality healthcare, unmet needs, utilisation of healthcare along with issues of cultural competency, cultural safety and a clash in worldviews and values. Since the recognition of the impact of values, beliefs and behaviours in healthcare, primary care interventions have increasingly been culturally adapted to meet the cultural needs and values of the given community. This is particularly salient for obesity intervention and prevention programmes. There have been a number of studies that have developed and examined culturally adapted intervention and prevention programmes. Many of these programmes are focused on exercise and nutrition with various adaptations, this is because there is a wealth of evidence supporting lifestyle interventions that focus on increasing physical activity and improving nutrition for prevention and intervention of obesity (Galani & Schneider, 2007). However, to fit the target community, evidence based interventions need to be adapted to meet the socio-economic and cultural needs of the group (Oetzel et al., 2020).

Recently a systematic review was conducted by Mack and colleagues (2022) analysing and reviewing a range of interventions that have been developed and adapted for Māori and/or

Pacific people to prevent or manage obesity through sustained weight loss. Some of the culturally adapted features included the programme being set within the church setting, for many Pacific people this is a significant place for them where they regularly congregate. Another adaptation seen in one of the studies was culturally adapted nutritional information whilst another programme adopted a Kaupapa Māori design. Their review included studies from NZ, the USA, Australia and the Pacific Islands. They explored a total of 21 qualitative and quantitative studies. All of the studies' main focus was on increasing physical activity and improving nutrition to prevent or manage obesity. In the quantitative studies they found moderate to significant weight loss in participants, but many studies did not have any long term follow up, therefore there were no reports on sustained and long term weight loss. The qualitative studies explored enablers and barriers to engaging in the intervention and found that enablers of the programmes were related to connections & relationships. Furthermore achieved sustainable changes were culturally centred and had engagement strategies such as incentives. Barriers consisted mainly of adherence. Mack and colleagues (2022) review highlighted the importance of good quality evidence - particularly for receiving government funding, and long term sustainability for effective weight loss interventions. Additionally it was found that many of the interventions (15 out of 21) were developed and conducted by the researchers as opposed to community led and initiated, therefore once the research was complete the intervention ended as well as any behavioural changes observed. Issues of long term effectiveness and sustainability of the interventions were raised by the authors. Given that there is a wealth of evidence supporting exercise and nutrition, this systematic review may suggest that obesity intervention and prevention programmes need to shift their focus towards engagement and community ownership for sustainability.

In a study by Mahrshahi and colleagues (2017) they conducted an evaluation on the effectiveness of an obesity prevention programme for school aged children from the Pacific diaspora (including Māori) in Australia. The intervention focused on increasing physical activity and improving nutrition through culturally centred approaches. They utilised what they called Multicultural health workers to deliver the programme as well as designing the evaluation and providing cultural insight to the results. The Multicultural health workers were of Pacific heritage, this reflects the assumption that there are nuances that may only be identified and

acknowledged through insider knowledge. For example the Multicultural health workers advised researchers that fruit intake generally wasn't a concern for Pacific children, rather a more focused effort on increasing vegetable intake would be more suited. This suggestion came from their own knowledge as a Pacific person. Interestingly this advice was supported in their study where they found Pacific childrens fruit intake was similar to their Australian European counterparts. They also found that by using multicultural health workers to deliver the programme they were able to effectively engage with Pacific students and as a result they observed an increase in knowledge around food literacy and the importance of physical activity. The Good start programme recognises the social and cultural environment that Pacific children are growing up in and appears to have effectively implemented a culturally adapted programme that targets the socioeconomic and ethnic related health disparities. In doing so it demonstrates their recognition of institutional structures that have caused the disparities and continue to implicitly or explicitly reinforce them. In addition, implementing Multicultural health workers suggests that there is a need for programmes and initiatives to reflect the cultural values, beliefs and behaviours of the targeted group. From an indigenous psychology point of view it moves away from cultural-deficit theorising and towards a structural determinants approach (Curtis, 2006).

Indigenous psychology

Indigenous psychology (IP) emerged as a reaction against western hegemony in psychology. The goal of IP is to “develop psychologies that are not imposed or imported; which are influenced by the cultural contexts in which people live; are developed from within the culture using a variety of methods; and result in locally relevant psychological knowledge” (Nikora et al., 2004, p. 2). For too long WEIRD psychology (Henrich et al. 2010) has dominated the field, constructing and disseminating knowledge, models and practices through a Western Eurocentric cultural context onto non-western cultures. Consequently the framework represents only 12% of the world but comprises 80% of research participants. The implications have been devastating for indigenous communities around the globe, Groot and colleagues (2018) wrote “when dominated by one way of knowing, the consequences may well be imperialism, racism, cultural violence, and the further denigration of Indigenous peoples (p. 198). The goals of indigenous psychologists around the world vary dependent on their needs and context, “some indigenous

psychologists are in search of psychological universals, some interested in cross national studies, and some in teasing out minute similarities and differences between cultures, others have bent to the task of solving local challenges within their own contexts with compatible approaches” (Nikora et al., 2004, p. 2). For indigenous communities throughout Oceania much of indigenous psychology is about developing frameworks, paradigms and methodologies that reflect the knowledge systems, values, practices, attitudes and beliefs of Pacific people to enhance their lives. As awareness increases within the health sector that the ethnic specific values, beliefs and worldviews need to be reflected in the health system, the role of Indigenous psychology becomes more important.

The term ‘indigenous’ is highly contested, Nikora and colleagues (2004) state that indigenous has two meanings: “one refers to these 4th world peoples; another to all peoples residing in a society; in both, the focus is on peoples who are self-reflecting” (p.1). In the case of the Pacific, Nikora (2016) writes, the term indigenous “might be understood in two ways, firstly, as referring to the people of the land, whose life ways, histories, values and cultures are intimately related to the place... While many rightfully claim to be indigenous, there is significant diversity within this category often reflective of specific locations and histories giving rise to tribal groups, clan and village communities, or island groups. Relationality and the method by which this is determined, for example, by genealogy or residential status, reflects the complexity and richness of who and how we are as indigenous peoples” (p.4). Whilst Māori and Pasifika are connected as “indigenous cousins of Te Moana-nui-a-Kiwa (The Pacific Ocean), in Aotearoa, Māori are the indigenous peoples, they are mana whenua - authority over the land and tangata whenua - people of the land (Curtis, 2016), whereas Pacific peoples are indigenous to Oceania. Finally, it is important to acknowledge indigenous psychology aimed at Pacific peoples living in Aotearoa refers to the knowledge systems, values, and practices that are indigenous to the Oceanic region.

Indigenous psychologists around the world emphasise the need to be aware of the histories of indigenous groups with colonial powers and how they continue to have an impact on their present day to day lives. For the Pacific region “while the sea was a giver of life, it was also the bringer of strangers, of explorers, traders, missionaries, colonisers, new technologies and knowledge, and different systems of commerce and education. While colonial powers were competing over the Pacific and its resources, Pacific people were increasingly experiencing the

impacts of colonisation.” (Nikora, 2016, p. 3). The presence of the west also brought outside researchers to the shores of the Pacific who have come from different cultural contexts. All of these events have had a significant impact on how Pacific people perceive themselves today.

In Aotearoa, Māori scholars, and academics have paved the way to decolonise and reclaim their cultural knowledge, practices and beliefs to enhance the lives of Māori through research. Notable Māori scholar Smith’s (2021) book on *Decolonizing Methodologies* discusses an indigenous research agenda. “The agenda is focused strategically on the goal of self-determination of Indigenous peoples” (p. 133) through four directions - decolonisation, healing, transformation, and mobilisation. It is conceptualised using the metaphor of ocean tides. Smith explains, these directions are not end goals rather they represent processes “which connect, inform and clarify the tensions between the local, the regional and the global. They are processes which can be incorporated into practices and methodologies” (p.133). The tides represent the conditions and states that indigenous communities move through - survival, recovery, development and self determination.

Indigenous peoples of the South Pacific have been researched ‘on’ from outside researchers who through their western worldviews have conducted research interpreting or ‘misinterpreting’ their experiences and perceptions of Pacific peoples. In Alefaio’s (2018) chapter on Samoan indigenous psychology the author discussed two studies - “Coming of Age in Samoa: A study of adolescence and sex in primitive societies (Mead, 1928) and The fateful hoaxing of Margaret Mead: A historical analysis of her Samoan research (Freeman, 1999)” (cited by Alefaio, 2018), stating that these studies exemplified the notion of ‘outsider’ researchers and illustrate how “globalisation has imposed a dominant homogenising Western ideology on non-Western cultures” (Jackson, 2005 p. 53, cited by Alefaio, 2018). Tongan scholar Vaioleti (2006) reiterated the dangers of outsider researchers and the power that research holds in shaping the perceptions of groups of people. Similarly Groot and colleagues (2018) discussed the consequences of outsider research on Māori stating that Māori have understandably become suspicious of researchers and their agenda as they have historically been labelled as exotic subjects to be researched ‘on’. Lastly, Smith explained: “They (outside researchers) may interpret it within an overt theoretical framework, but also in terms of a covert ideological

framework. They have the power to distort, make invisible, to overlook, to exaggerate and to draw conclusions based, not on factual data, but on assumptions, hidden value judgements and often-downright misunderstandings. They have the potential to extend knowledge or perpetuate ignorance” (1992; cited by Vaioleti, 2006, p. 23).

Pacific Indigenous (PI) Psychology as a new platform for re-informing psychology

Pacific Indigenous (PI) psychology encapsulates the worldview of Pacific nations, which reflects the values, beliefs and practices of the people of Oceania. How Pacific people think, act, perceive themselves and others, originates from a Pacific worldview (Alefaio, 2015). The premise of PI psychology is to bring to surface our ways of knowing, doing and being as they have largely been left out in the field of psychology. It refers to the ancestral legacy of Pacific wayfinders and navigators with their own unique cultural principles of psychology, that is now carried by the diasporic communities in migrant lands of New Zealand, Australia and the USA (Alefaio, 2015). I have used the terms ‘South Pacific’ ‘people of the south pacific’, ‘Oceania’ and ‘Oceanic people’ interchangeably to capture all indigenous people of the region inclusive of Polynesia, Melanesia, and Micronesia as described by Hau’ofa (1993) in his essay “*Our Sea of Islands*”. In his essay Hau’ofa explained in order to resist dominance of the west, the need for a collective ‘Oceanic’ identity is necessary for the collective wellbeing of Oceania. The importance of Pacific-Indigenous psychology are the Pacific principles that are brought to the fore. For example in *Saili Matagi* - a forensic rehabilitation programme for Pacific male violent offenders, Pacific-Indigenous principles from Samoa: *Vā Fealoaloa'i*, *Vā Tapuia*, *Fa'aleleiga*, *Fa'aaloalo*, *Ava Fatafata*, highlight cultural knowledge edicts that engage, challenge and transform participants' ways of knowing, being and doing (Alefaio, 2022). These foundational tools that are core to connections and engagement of Pacific peoples are new practices in psychological contexts that re-inform evidence for Pacific diasporic communities. This draws parallels to the BBM-way, as such PI psychology is drawn upon in this thesis as a platform for new knowledge production from within Pacific-diasporic communities such as the BBM programme.

The growing communities of the Pacific Diaspora

Hau'ofa wrote: “the world of Oceania no longer includes the heavens and the underworld; but it certainly encompasses the great cities of Australia, New Zealand and the USA and Canada” (p.12).

Over the last 60 years the Pacific community has transformed from a largely migrant population to now a predominantly NZ-born population. NZ is home to the largest number of Pacific people among the industrialised nations (Spickard, 2002). There are some island countries such as Niue, the Cook Islands and Tokelau where more of their people live in NZ (Ministry for Pacific Peoples, 2020). Today, over 60% of the Pacific population are NZ born and for those who were born in their island countries 46% have lived in NZ for longer than 20 years (Statistics New Zealand, 2018; Ministry for Pacific Peoples, 2021). Pacific People make up 8.1% of New Zealand's total population (Statistics New Zealand, 2018), they are the fastest growing group and are predicted to make up 12% of the total population by 2025. Today more than 25% of Pacific People identify with more than one ethnicity. A large proportion of the Pacific population live in the Auckland region (66%) and the majority of Pacific People in Auckland reside in the Counties Manukau region (53%). Compared to the general population the Pacific population can be characterised by their high levels of urbanisation, rapid growth and youthfulness (Southwick et al., 2012). Macpherson (2001), states that “NZ-born generations' world-views, lifestyles and identities have been constructed in very different social and economic circumstances. They have had to define themselves in different social and economic circumstances and in relation to different others” (p. 67).

This change in demographic has contributed to the formation of Pacific diasporic communities. Often grouped together as Pacific people, and Pasifika. Whilst there are distinct differences in culture, language, values, practices and knowledge across the Pacific nations, the Pacific diaspora have connected through similarities in enduring cultural values such as the importance of family, spirituality, collectivism, communitarianism, reciprocity and respect, (Ryan et al., 2019; Anae, 2001), and shared socio-economic experiences. They are also spatially

close to one another in South Auckland where the highest concentration of Pacific peoples are located.

South Auckland is situated within the Counties Manukau region and is home to the largest Pacific community in Aotearoa New Zealand with 35.4% of the Pacific population residing in the region. To understand the significance of Counties Manukau it should be noted that the region with the second highest Pacific population is Auckland with 17% of the Pacific population residing in the Auckland region (Ryan et al., 2019). The shared values, beliefs and behaviours along with shared experiences as well as being spatially close has created space for a thriving Pacific diasporic community.

Spickard (2002) states as groups move away from their homeland they reconstitute their cultural and communication practices considerably to reflect upon their migration experiences. Also, upon moving to new places, cultural groups adapt, incorporate, and modernise (Westernise). The Pacific community have done exactly that and this is visible across various avenues including the domain of arts - NZ's most successful hip hop group 'The Royal Family' attribute their success to what they have coined 'polyswag' an adaptation of Pasifika attitudes and behaviours incorporated into Hip Hop culture. Festivals such as the annual Pasifika festival and Polyfest is a place to showcase and celebrate Pacific cultures mainly through traditional food and dance. Another area where it can be seen is in sports. For example the recent formation of Moana Pasifika a Pasifika super rugby team based in Auckland further reinforces the Pasifika identity and further cementing Pacific diasporic communities in NZ. It can also be seen in the health sector and other areas of the public sector where organisations have been constructed for the purpose of serving the needs of Pacific communities. Organisations such as ButtaBean Motivation (BBM) are just one example of a Pacific diasporic organisation who reflect the Pacific community particularly in South Auckland.

A Pacific Worldview

The Pacific worldview is holistic whereby the connections and relationships between all things are integral to the wellbeing of Pasifika. Whilst there is no generic 'Pasifika worldview'

There are similar values, frameworks and philosophy that many Pacific cultures recognise that allow us to distinguish a Pasifika worldview in Aotearoa. Mila-Schaaf explains (2009), within the Pacific worldview relationships are imagined spatially - the space between is what connects one another rather than separates. This is known as the Va, “The va is the spatial ordering concept that exists between things. It administers a code of good (ideal) behaviour, an invisible language that enables space and things to be configured in a positive manner” (Refiti 2002, p.209; cited by Mila-Schaaf, 2009, p. 1). The Pacific worldview can be captured in the exert below.

Tamasese Ta’isi Efi (2007) cited by Mila-Schaaf (2009) wrote “Imagine, if you will, a worldview that understands the environment, humans, the animate and the inanimate all natural life as having its sources in the same divine origin, imbued with the life force, interrelated and genealogically connected (Tamasese Ta’isi Efi 2007). In this worldview the interrelationship between all things (between people, the land, sea, sky, rocks, plants, surroundings) is sacred and cosmologically determined. Equation and alignment with other people and parts of life is integral to an ordered system of interconnection (p. 1).

Pasifika Values

Within the Pasifika worldview are Pasifika values. There are a number of common values shared across the Pacific such as the centrality of kin-based relationships, spirituality, respect and reciprocity, communalism, collective responsibility, gerontracy, humility, love and service (Sualii-Sauni et al., 2009; Anae, 2001). Values in Pacific cultures underpin the worldview and inform cultural practices, attitudes and beliefs. In addition many of these values have informed a number of ethnic specific and pan pacific models of health, which will be explored later on. Sualii-Sauni and colleagues (2009) stated these commonalities make it possible to speak generally of Pacific philosophy, and practices.

The Pasifika notion of the ‘self’

Of particular importance in psychology is the notion of the ‘self’. Bush and colleagues (2005) conducted a study with psychiatrists in NZ and compared Samoan perspectives of the self with psychiatrists perspective of the self. “The Samoan self is a relational self, having meaning

only in relationships to others. It is ‘a total being comprising spiritual, mental and physical elements which cannot be separated’, deriving its ‘sense of wholeness, sacredness and uniqueness from its place of belonging in family and village, genealogy, language, land environment and culture’ (Bush et al., 2005, p. 622). Their study reiterated the disparities between Samoan and Western notions of the self, further highlighting the need for culturally specific models that reflect the values, philosophies and worldviews of Oceania. Whilst there are inter ethnic differences to the self across the South Pacific - the Samoan concept of the ‘self’ reflects commonalities of holism, interconnectedness, relationships and spirituality. It is this difference in western and Pacific cosmologies that is the foundation for the need for a Pacific indigenous psychology to centre the views of the South Pacific.

Pacific Methodologies

In research, methodologies represent the theory of how knowledge is gained and outlines an appropriate approach to systematic inquiry. For the right knowledge to be produced, the process of inquiry needs to reflect the knowledge systems, values and practices of the group. Given the disparities in worldviews, values, and cosmological ideology that have been outlined, the need for Pacific methodologies is integral to the production and dissemination of Pacific knowledge. “The collective efforts of Pacific and Pasifika academics engaging with indigenous methodologies such as Talanoa, Fa’afaletui, Kakala and more aligns with global interests in indigenous studies to espouse indigenous knowledge and practice (Smith, 2012; Suaalii-Sauni & Fulu-Aiolupotea, 2014)” (cited by Matapo, 2016, p. 3-4) Matapo (2016) states “Pacific indigenous research methodologies foreground Pacific values, knowledge and ethics in an effort to decolonize indigenous Pacific studies” (p. 3).

Renowned Tongan scholar Vaiioleti (2006) highlights why methodologies need to be embedded in the cultures of the those that are part of the research in the following extract:

“there is a danger in assuming that all Western, Eastern and Pacific knowledge have the same origins and construction so that, by implication, the same instruments may be used for collecting and analysing data and constructing new knowledge. Researchers whose knowledge is derived from Western origins are unlikely to have values and lived realities that allow

understanding of issues pertaining to knowledge and ways of being that originated from the nga waima (spirits) and whenua of Samoa, Tonga, Fiji, Tuvalu or the other Pacific nations. Research methodologies that were designed to identify issues in a dominant culture and provide solutions are not necessarily suitable in searching for solutions for Pacific peoples, whose knowledge and ways of being have unique epistemologies, as well as lived realities here in Aotearoa.” (p. 22).

“Pasifika research needs to be reflective of Pasifika cultural values in order to systematically reveal cultural knowledge and the social construction of social identity within the discipline of applied research” (Sauni, 2011, p 61 cited by Matapo, 2016, p. 3). Across the Oceania “oratory and verbal negotiation have deep traditional roots” (Vaioleti, 2013, p. 193), The 'Pacific way' is spoken rather than written. Pacific methodologies are not just culturally safe but imbued with the values, attitudes, and nuances indigenous to Oceania. The application of Pacific methodologies in research has grown in popularity for Pacific scholars and researchers, in using Pacific methodologies it is consistent with the principles of decolonising. Alefaio (2018) stated:

“The voices of Indigenous researchers and academics are in tune with a new song, one that has been sung for generations past and present. The song plays to the tune of re-ject, re-claim, re-form, and re-store. The ‘re-search’ is the melody that holds the tune together” (p. 221)

Research with Pacific communities

Since the proliferation of Pacific research in Aotearoa, Pacific research guidelines were developed to ensure the safety of Pacific communities. These have been the *Pasifika education research guidelines* (Anae, 2001) and the recently updated *Pacific health research guidelines* (Health Research Council, 2014). “Pasifika research similar to that of Kaupapa Māori, situates in an anti-positivist debate and argues for critique, resistance and emancipation (Smith, 2012)” In the Pasifika education research guidelines, Anae outlines the role of Pacific research stating:

“The role of Pacific research is primarily not only to identify and promote a Pacific world view, which should begin by identifying Pacific values, and the way in which Pacific societies

create meaning, structure and construct reality, but complementary to these is the need to also interrogate the assumptions that underpin western structures and institutions that we as Pacific peoples have adopted without much questioning.” (p. 7).

This relates to how Pasifika and Pacific peoples perceive themselves - through the lens of western understandings. Anae states Pacific research must benefit the Pacific community therefore research needs to reclaim Pacific knowledge and values whilst “trying to validate indigenous epistemology that was undermined in the very histories of colonisation and imperialism” (Matapo, 2016, p. 3).

Pasifika concept of Health

I have outlined in previous sections the ethnic disparities in health outcomes disproportionately affecting Pasifika. I also outlined that these disparities were exacerbated by a clash in cultural worldviews. Given the differences in worldviews, values, knowledge systems and philosophical framework - how Pasifika conceptualise health and their wellbeing is also going to differ to a western understanding of ‘health’.

In healthcare these assumptions prompted the development of a range of Pacific health models; *Fa'afaletui model* – Samoan model, *Fonofale model* – Pan-Pacific & Samoan model, *Fonua model*, *Tivaevae model* – A Cook Island model. All of these models reflect the worldview, values and philosophy of the South Pacific. For instance the Fonofale model is holistic in which the physical, mental, spiritual and ‘other’ aspects of health are interconnected. Inclusive of Pasifika health is culture and family - these are intertwined with the physical, mental and spiritual health. We can see even in Pasifika’s understanding of health that their worldviews, values and knowledge systems are embedded in all aspects of their lives - they cannot be separated.

Pan-Pacific models, frameworks and methodologies have rightfully been criticised for the homogenisation of the South Pacific region, making distinct inter and intra ethnic differences invisible. However, specifically speaking on health, these disparities in health have largely

emerged from poor economic and social policies, systems and cross cultural differences that have affected the ‘Pasifika’ community at large. One of the strengths of Pacific people is their strong connections to their homeland and to their culture, this has allowed Pacific people to connect with a Pasifika identity whilst maintaining connection to their own ethnic identity. This was also observed by Spickard (2002) where he wrote about Pacific people's ability to hold tension to multiple identities comfortably. Lastly many Pacific people particularly the second, third and fourth generations consist of multiple Island-nation cultural heritages meaning Pasifika models and frameworks are a starting point for Pacific ethnic-specific developments.

To conclude, I argue that for truly equitable health outcomes to be achieved, Pacific ways of knowing, doing and being must be at the forefront of all issues pertaining to the Pacific community in Aotearoa. Additionally Pacific people need to see the value in using their knowledge and practices to address issues. When developing or implementing health initiatives for Pacific People, working within the Pacific-Indigenous psychology framework can ensure that the needs of the Pacific community are privileged.

Implementing primary care intervention programmes into indigenous communities

Just as interventions need to be culturally adapted to meet the socio-cultural needs of the group, there needs to be a framework that can effectively assess implementation of those programmes into Māori and other indigenous communities. Primary care initiatives can be designed using evidence-based practices, but if they are not implemented effectively then that programme is going to struggle to achieve their outcomes. Oetzel and colleagues (2017) have designed and constructed the He Pikinga Waiora Implementation framework to enhance the implementation of interventions aimed at reducing chronic disease in Māori and other indigenous communities. The authors state that the framework is underpinned by Kaupapa Māori and has indigenous self-determination at its core. The framework assessed interventions based on four elements; “*cultural-centeredness* (““voice” for problems and solutions, reflexivity, and structural transformation and resources” (p. 3)), *community engagement* (“collaborating with groups directly affected by a particular health issue or with groups who are working with those affected... And partnership among community members and researchers/health professionals in

developing interventions” (p. 4)), *systems thinking* (a conceptual lens to see health inequities within the wider picture), and *integrated knowledge translation* (“the potential to build bridges between researchers/academics and communities to increase the potential for research to lead to improved health outcomes and health equity” (p. 5)). The authors found the He Pikinga Waiora model provides a robust framework for enhancing the implementation of primary care interventions into Māori and other indigenous communities. This research has highlighted that not only do interventions need to be culturally adapted, the ways in which they are implemented also need to be adapted

Following from this study, Harding and Oetzel, (2019) conducted a systematic review investigating the effectiveness of implementing interventions targeting chronic disease in Māori and other indigenous communities across New Zealand, Australia, Canada and USA using the He Pikinga Waiora framework. The authors reviewed a total of 21 interventions relating to non-communicable disease. They found that most of the studies had variations of the 4 core elements, but were unable to distinguish whether all four core elements are needed to effectively implement an intervention. The saliency of each element may be dependent on the target community. Similarly the ways in which these elements were applied varied from study to study. About two thirds of the studies had high levels of community engagement, this was applied through community based participatory research as well as other participatory frameworks. The authors suggest community engagement ranges from very little community involvement to community ownership. They found that many interventions used community health workers to engage with the community. The authors stated that high levels of community engagement has been linked to neighbourhood unity and social capital (Harding & Oetzel, 2019). They also stated that there has been evidence to suggest that community organisations were more successful at engaging hard to reach groups than any government initiatives. This supports the Pacific indigenous framework that calls on indigenous knowledge to inform initiatives and Pacific ways of knowing, doing and being to engage with the community.

Systems Thinking

The dynamic nature of public health systems has prompted researchers to turn to Systems thinking as it provides a “greater understanding of the complex adaptive systems involved in both causing and solving public health problems” (Leischow et al., 2008, p. 1). It has also recently been gaining popularity within primary care to understand complex health issues such as obesity, and other long term conditions (Carey et al., 2015) as well as a framework for implementing culturally appropriate initiatives in indigenous and marginalised communities. More recently Systems thinking has been recognised as a suitable framework that aligns with Indigenous knowledge and frameworks (Heke et al., 2019).

There is no one definition of Systems thinking, partly because as Leischow and Milstein (2006) state, “there is no single discipline for systems thinking, because it is oriented to the linkage of disciplines” (p.1). Since its popularity in public and primary healthcare it has been conceptualised in a number of ways, and this is dependent on what the researchers are investigating. For example, systems thinking can be applied as a perspective or a way of seeing the world, because systems thinking views the ‘issue’ as a whole i.e. looking at the elements and their interconnections (Shiell and Riley, 2017). In another study a systems approach is described as “a paradigm or perspective that considers connections among different components, plans for the implications of their interaction, and requires transdisciplinary thinking as well as active engagement of those who have a stake in the outcome” (Leischow and Milstein, 2006, p. 403). Ultimately, the authors stated “at the heart of systems thinking is an emphasis on relationships” (p. 403).

The popularity in Systems thinking has emerged out of recognition that complex issues such as obesity are not caused by one factor rather a myriad of dynamic and interacting factors. Approaches such as a reductionist approach will not address the entirety of the issue because reductionism reduces the complex issues down to the sum of the parts. Whilst it is able to identify causes, it does not account for the interactions and interconnections. Furthermore issues such as obesity, long term conditions and trying to improve a health system do not operate in

isolation of each other, therefore it does not represent the entirety of the issue at large. Subsequently systems thinking views the problem as a whole and within society therefore providing a fuller picture of the issue.

Joining up cultural knowledge/practice with institutional resources and power to reduce disparities

Due to the holistic nature of systems thinking there has been an interest from indigenous researchers. This section will examine the current research and literature that has brought together cultural knowledge and practices with institutional resources to develop health prevention and intervention initiatives. I focused on Systems thinking and Community based participatory research (CBPR) as these approaches have commonly been used to design and implement primary health initiatives. I will investigate how these approaches negotiate bringing together different systems, and whether they are effective in reducing health disparities in the given community.

Due to the complex nature of obesity, Systems thinking and Systems thinking methods have been gaining popularity for designing, implementing and evaluating public health interventions for obesity and other long term conditions in indigenous and marginalised communities (Allender et al., 2019; Browne et al., 2019; McKelvie-Sebileau et al., 2022; Allender et al., 2015; Oetzel et al., 2017; Heke et al., 2019). That is because it is a holistic approach to looking at the problem, which is able to identify and then address the elements that perpetuate inequities. Systems thinking is applied as a conceptual lens to look at problems from the 'big picture'. It shifts away from a reductionist approach and focuses on the relationships and interconnectedness of the many factors and the impact of those interactions. Systems thinking removes the person from the centre of the problem, by recognising that the issues are within the systems themselves rather than just the individual. It does not assume that the individual's actions caused obesity merely that the interactions and the interconnectedness between the person, their age, occupation, educational level, access to quality healthcare, delivery of healthcare services, policies and socioeconomic status are all interacting, and obesity is an emergent property of the system (Heke et al., 2019, Rutter et al., 2017).

One way Systems thinking has been applied is through use of methods and tools. Its tools and methods have been used to engage community members and conceptualise the problem collaboratively (Allender et al., 2015). A New Zealand based study by McKelvie-Sebileau and colleagues (2022) applied Systems thinking to explore initiatives and interventions that were already implemented in a regional community with a high indigenous population to further improve them. Their application of Systems thinking encouraged collaboration between multiple stakeholders such as community members, health professionals, practitioners and policy makers. Collaborating with various professionals provides a bigger picture of the problem as it allows different perspectives and positions on the one problem. The authors stated that the involvement of multiple stakeholders enabled them to identify areas in the system where intervention would be the most effective for their communities (McKelvie-Sebileau et al., 2022; Allender et al., 2015). The efficacy of this is because stakeholders are involved at various levels and engaged to varying degrees as well, and therefore they have ‘insider’ knowledge as to how the interventions are already operating and where the greatest need is.

The implementation of interventions is a crucial element that can enhance or hinder the effectiveness of a programme. Recently a New Zealand based systematic review was conducted by Harding and Oetzel (2019) examining the implementation of interventions indigenous communities across NZ, Australia, USA and Canada using the He Pikinga Waiora (HPW; Enhancing Wellbeing) implementation model. The authors explained there is a paucity of evidence based models for non-communicable disease that get implemented into practice despite evidence of their effectiveness. Furthermore when they do get implemented this can take many years. As previously mentioned The He Pikinga Waiora (HPW) framework includes 4 elements: one of them being systems thinking. The authors explained Systems thinking is included in the framework because it helps to address the “complexity of the local context and the variety of levels and determinants of health problems... it facilitates new framing strategies” (p. 2), secondly it encourages “new ways of thinking from researchers, practitioners to community members through considering different perspectives, relationships among people/facets of the health system and multiple level analysis” (p. 2). Lastly elements of systems thinking such as “multiple perspectives, relationships and levels of analysis along with feedback loops” (p. 3) were identified as specific key elements for implementation into indigenous communities.

In a review of interventions targeting long term conditions in Māori and other Indigenous groups, systems thinking was a key feature for successful interventions (Oetzel et al., 2017). The authors stated that “Systems Thinking reflects a complex understanding of the chronic disease workforce and clinical care pathways and enables a coordinated approach to the intervention” (Oetzel et al., 2017, p. 9). Studies that have applied ST to evaluate current interventions have found that a ST lens and tools allowed them to evaluate their own initiatives and identify how it was impacting their community (Allender et al., 2019; Heke et al., 2019). Due to the collaborative nature of ST, those who have been evaluating the initiative are also connected to the ones implementing it. ST appears to provide an appropriate approach for evaluating the interventions whilst increasing capacity and capability in the communities.

Given the holistic nature of ST, it has become an increasingly popular lens and tool to privilege and legitimise indigenous knowledge in primary health and prevention initiatives (Heke et al., 2019; Browne et al., 2019; Oetzel et al., 2017; McKelvie-Sebileau et al., 2022). Studies have found that a ST lens aligns with indigenous thinking and knowledge (Browne et al., 2021; Heke et al., 2019; McKelvie-Sebileau et al., 2022). Many indigenous and non-western cultures have a holistic worldview where everything is connected and intertwined that allows them to make connections and see issues within the wider context. In doing so, health challenges like obesity are viewed within the context from which it has emerged and allows indigenous communities to use their knowledge and resources to develop effective interventions. For too long much of the research regarding indigenous people and other marginalised groups has been from a deficit lens. ST forces researchers to restructure the problem and look within the systems that have contributed to the inequities, removing the individual from the centre and exploring the interactions with systems that have led to obesity. These studies indicate that ST provides an appropriate framework for indigenous knowledge to be prioritised, and finds natural affinity and alignment with PI psychology due to Pasifika being 'others-centered' (Alefaio, 2022). From a PI psychology lens the interactions of BBM highlight a total affinity with being 'others-centered' as their whole focus is centered on the wellbeing of others, specifically the hard-to-reach communities of obesity which the Green prescription failed. From the BBM core of being 'others-centered' everything operates from this foundation. On the other hand, Total Healthcare

and Ministry of Health come from differing foundations yet spurred along by the impact achieved by BBMs initiatives.

From the studies it appears that ST effectively brings together cultural knowledge and institutional resources. Heke et al., (2019) expressed their views stating that “Causal loop diagrams provided a powerful language for telling the systems stories of indigenous groups in ways that retained the integrity of their particular worldview” (p. 28). Similarly Browne and colleagues (2019) conducted research with Aboriginal health professionals and found that many of the Aboriginal health professionals felt that Group Model Building (a ST tool) aligned well with Aboriginal ways of knowing doing and being due to the “holistic, visual and collaborative nature of the method and its emphasis on sharing stories and collective decision-making” (p. 5). Meadows (2008) who is a leading practitioner in systems science described the fundamental concepts of systems approach as “connectedness, relationships and community — concepts which are the essence of a deep spiritual awareness” (p.7). Heke et al., (2019) also stated that “we hope that our initial efforts to describe these innovations using Systems Thinking tools will enable people without a deep cultural knowledge to appreciate the value of what is being done in both communities and more generally to appreciate the value of approaches that are grounded in the cultural knowledge of the people involved” (p. 29).

Collaborating in Primary Healthcare

Collaboration and partnership with different organisations in public health has become increasingly popular in healthcare. In public health, collaborative partnerships attempt to improve conditions and outcomes related to the health and well being of entire communities (Roussos & Fawcett, 2000). One of the challenges in collaborating with different organisations is the long term sustainability of the partnership as they have to contend with a myriad of internal and external factors. There is a small body of literature that has explored the coming together of various health organisations to identify the attributes and characteristics required to sustain a partnership (Alexander et al., 2003) along with the barriers and/or challenges to multi sector collaboration. Alexander and colleagues who have done some extensive research in this area

explain the difficulties in assessing and evaluating the sustainability of a partnership because it “indicates a future state” (p. 133). This makes it difficult to assess directly therefore researchers/investigators are forced to rely on the assessment of factors that serve as the precursors or foundations for potential sustainability.

In Alexander and colleagues (2003) study they examined 4 community health networks to identify key features/characteristics of a long-term partnership. The authors identified 5 attributes for increasing the viability of sustaining the partnership; 1) *outcomes-based advocacy* (the ability of the partnership to effectively identify and communicate specific short-term, sometimes symbolic, achievements of the partnership to internal and external stakeholders, while articulating the partnership’s unique contribution to those achievements over and above those of individual partnering organisations), 2) *vision focus balance* (the ability of the partnership to come to agreement on a broad, long-term vision of community health), 3) *systems orientation* (ability of the partnership and its leadership to conceptualise community health problems as the result of multiple interacting forces and to envision the solutions to such problems in terms of a coordinated effort of different sectors and actors within and outside the community), 4) *infrastructure development* (the ability of the partnership to develop internal support systems that foster effective member participation, develop leadership, and avoid overburdening key members) and 5) *community linkages* (refers to the ability of the partnership to establish strong, working relationships to institutions and individuals in the community and to be inclusive with regard to direct community input and participation in the partnership) (p.135). From their examination of four community health networks they found that these attributes were able to differentiate between partnerships they deemed to have high potential for long term sustainability and those that had low potentiality.

The authors pointed out a number of considerations when investigating the sustainability of a partnership. First, *the context (historical/cultural/political/ environment) in which these partnerships operate will determine how important each of the factors are*. Second, *the factors are not separated in fact they are highly connected and interdependent of one another* meaning issues relating to one factor will consequently impact the other. With regards to sustaining an intervention that is aimed at a high needs population such as Pasifika who are obese, it is *extremely important to understand the context in order to identify what factors are going to be*

more or less important. In line with the literature on Pasifika and the primary care system, we might expect to see an increase in saliency of community linkage as the literature has illustrated.

Another study in Australia by Sibthorne and colleagues (2005) reviewed five studies of sustaining innovative primary healthcare initiatives across six domains - political, institutional, financial, economic, client and workforce sustainability. The authors explained, to sustain an innovative health initiative each of these domains needs to be taken into consideration. Each of these domains have the ability to both facilitate and hinder the sustainability of an initiative. For example the authors found that facilitators for institutional sustainability was about good relationships, ability to be flexible and good transfer of information across the various levels, both formal and informal. Conversely they found that lack of partnership structures and processes were significant inhibitors to sustainability. This study differs from Alexander and colleagues (2003) research as it was focused on innovative health initiatives rather than a collaborative partnership. This paper illustrated the *6 domains that need to be considered when trying to sustain an initiative in a public health system that is complex, adaptive and dynamic.* They highlighted the importance of recognising the political climate the initiative sits within and stated the importance of aligning the initiatives with current policies as well as the goals of the public health system. For example, equitable outcomes for all ethnic groups has been at the forefront of primary care in NZ, therefore we would expect initiatives targeting high needs populations to have an increased chance of being funded.

Conclusion

The current research and scholarship has provided insight into the complexities of Pasifika health - the historical context that created an unequal environment as well as the current institutional and cultural factors that continue to reinforce the disparities. It has outlined the strength of Indigenous psychology, specifically Pacific-Indigenous psychology that draws on Indigenous cultural-knowledge principles as foundational to re-informing psychology today. Whilst many interventions that have been adapted for Pasifika appear to have at least a small significant effect, many of them were not sustained post evaluation and were developed by researchers using evidence-based practices. This is important to note, given the dire need for interventions to be sustained. Current research and scholarship around obesity intervention and

prevention programmes has stopped at the bringing together of cultural knowledge and western institutions and resources. Currently there does not appear to be any research that has explored how these systems work together in delivering the programme.

As far as I am aware there is not currently any research exploring the coming together of 3 different organisations to implement an obesity intervention programme that has been developed from the ground up based on an individual's own experiences of being obese and has proven to be effective in the community. In NZ's current climate the need for new and innovative ways to reduce disparities is urgent. This thesis is based on a larger study of BBMs *From the couch* programme. This thesis will add to the current body of literature by exploring what it takes to implement a primary health intervention for Māori and Pasifika from a Pacific-Indigenous psychological lens which is akin to Systems-Thinking.

Chapter Three Method

The Present Study: Context

Māori and Pacific led community organisation Brown ButtaBean Motivation (BBM) have developed a 12 week lifestyle programme called From the Couch (FTC). It is an obesity intervention programme that has been specifically designed for people who cannot stand for long and have no ground exercise. The programme has proven to achieve sustainable and long term weight loss in obese adults through increasing physical activity and improving nutrition through education. The programme is completely free and consists of two group fitness classes and one nutrition session. Through BBMs success and their ability to showcase it through social media, BBM have attracted members from the Long term conditions team at the Ministry of Health (MoH) and Primary health organisation Total Healthcare (THC) who have voluntarily formed a triangular partnership.

This present study investigates a new collaborative partnership between three partners (BBM, MoH and THC) that has not been seen in NZs public health system before. The partnership is bringing together three health organisations who operate at different levels in the health system. To date the primary health sector has struggled to implement culturally effective and sustainable interventions that target the inequities exacerbating obesity rates in the Pasifika population. As mentioned earlier THC and the long-term conditions team from The Ministry of Health have collaborated with BBM in a tripartite partnership with the goal to further enhance the effectiveness of the FTC programme and increase its sustainability.

Research Aims

The aim of my research is to explore a new governance approach as a ‘systemic-process’ of collective-good, that is trying to sustain an obesity intervention and prevention programme aimed at Māori and Pasifika in a dynamic and complex health system.

My objectives are to identify what brought these three partners together through to a voluntary collaboration, what are the roles and needs of each of the 3 partners and how they can work to achieve their collective aims which centre around improving long term health conditions for Pasifika.

The Coming Together of Three Systems

Given this study explores how these organisations as systems came together as well as the roles and needs in the partnership, it is necessary to first understand how each organisation fits within the wider public health system.

ButtaBean Motivation

ButtaBean Motivation (BBM) is a Pacific and Māori-led non-governmental organisation (NGO) founded by Dave Letele that delivers a range of free workout classes to the community. NGOs are an integral part of New Zealand's health and disability system delivering a wide range of innovative and flexible services in primary care, personal health, mental health, and disability support services, including kaupapa services such as Māori and Pacific providers (Ministry of Health, 2022). Compared to Total Health Care and the Ministry of Health, BBM is significantly smaller in capacity and resources and receives much less funding. NGOs typically rely on funding from the Ministry and/or their District Health Board (DHB). In BBMs case, Letele is also well-known as a motivational speaker and has a large social media following: this has enabled BBM to survive even without ministry funding. The Ministry of Health have committed \$500,000 in funding to BBM over a two year period. Dave has designed and implemented a system based on what worked for him - these were from his own lived experiences as a Pacific person living in south Auckland. And as a Māori and Samoan man who was previously obese. BBMs ability to engage with a population of people that the mainstream health system have thus far struggled with has attracted the likes of bigger players like Total Healthcare and the Ministry of Health to form a tripartite partnership.

Total Health Care

Total Health Care (THC) is one of the largest primary health organisations in the country with over 230,000 patients enrolled across the Auckland, Waitemata and Counties Manukau region. Primary health organisations such as THC receive funding from the MoH to deliver primary health care services mostly through general practices to their enrolled population. In their 2022/23 business plan THC outlined their budget, where funding was being allocated and how much they were allocating. They have a budget of \$10,136,851. This funding comes from flexible funding, health promotion and care plus. THC have allocated 53% of their budget to Long Term Conditions, that is \$5,362,000.

THC currently have 54,700 Pasifika patients enrolled across the Counties Manukau region, making them the largest primary health provider to Pasifika in Counties Manukau. From their total population, over 60% are characterised as high needs by the Ministry of Health (Māori, Pasifika or those living in a quintile 5 neighbourhood). Relevant to THC are the capitation payments where "PHOs are funded on a capitation basis for providing a specified set of treatment and preventive services to their enrolled populations regardless of whether contact is made during the period" (Ministry of Health, 2022). In addition to capitation funding, there are a number of funding streams available to PHOs based on the demographic of their population and their needs called the Flexible funding pool. In Total Healthcare's 2022/23 business plan they outlined the additional funding streams they use; these are services to improve access, health promotion, management and care plus. THC are eligible for a number of funding streams because a significant proportion of their population is classified as high needs. THC strives to offer the broadest continuum of care from wellness support, exercise and nutrition to prescription subsidies and extended clinic hours.

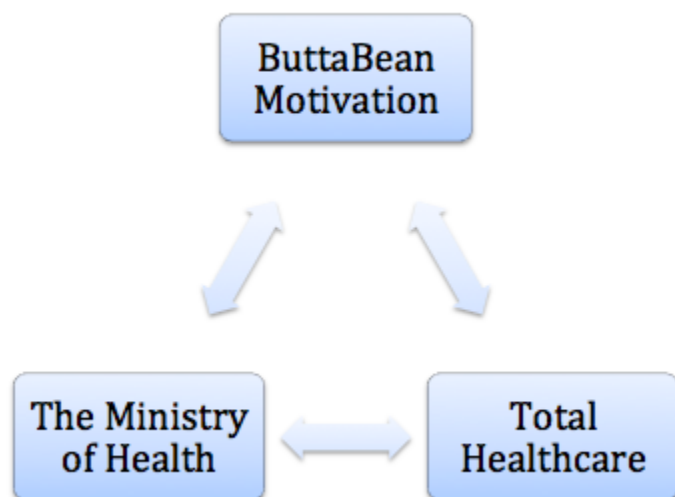
Ministry of Health, Health New Zealand

The third organisation in the partnership is the Ministry of Health, specifically the long term conditions team. The MoH is the government's principal advisor on funding and system settings for health and disability. They set the direction and policy for the health system, regulate the health system, and monitor health outcomes (MoH, 2022). Much of the public funding for

health comes from Vote Health and ACC - Accident Compensation Corporation. In the 2022 Budget, \$14.3 billion has been provided to Vote Health. (MoH, 2022). Preceding the recent health reforms implemented on July 1st, 2022 the long term conditions team were under The Ministry of Health. The Long term conditions team now sit within Te Whatu Ora. They are the government agency who oversee the day to day runnings of the health system today. They are also responsible for improving services and outcomes. Additionally they manage all health services including hospital and specialist services right through to primary and community care (Te Whatu Ora, 2022). The goal of the health reforms is to create a more equitable, accessible cohesive and person-centred system. On their website Te Whatu Ora explain “primary health, wellbeing and community-based services are planned and then purchased through the four regional divisions of Te Whatu Ora. Each region works with their district offices, located closer to local communities, to develop and implement plans based on local needs to improve the health and wellbeing of communities”. I will refer to the Ministry for the remainder of this study as it is the Ministry who have funded BBM.

This partnership is bringing together 3 different organisations, governed by different roles, processes, worldviews, knowledge and resources but with a shared goal of reducing obesity and improving the overall health of Pasifika. This research examines the role that Pacific indigenous knowledge played in informing this new system affecting the Pacific community, particularly hard to reach obese members of this community.

Figure 1. *An illustration of the tripartite partnership*

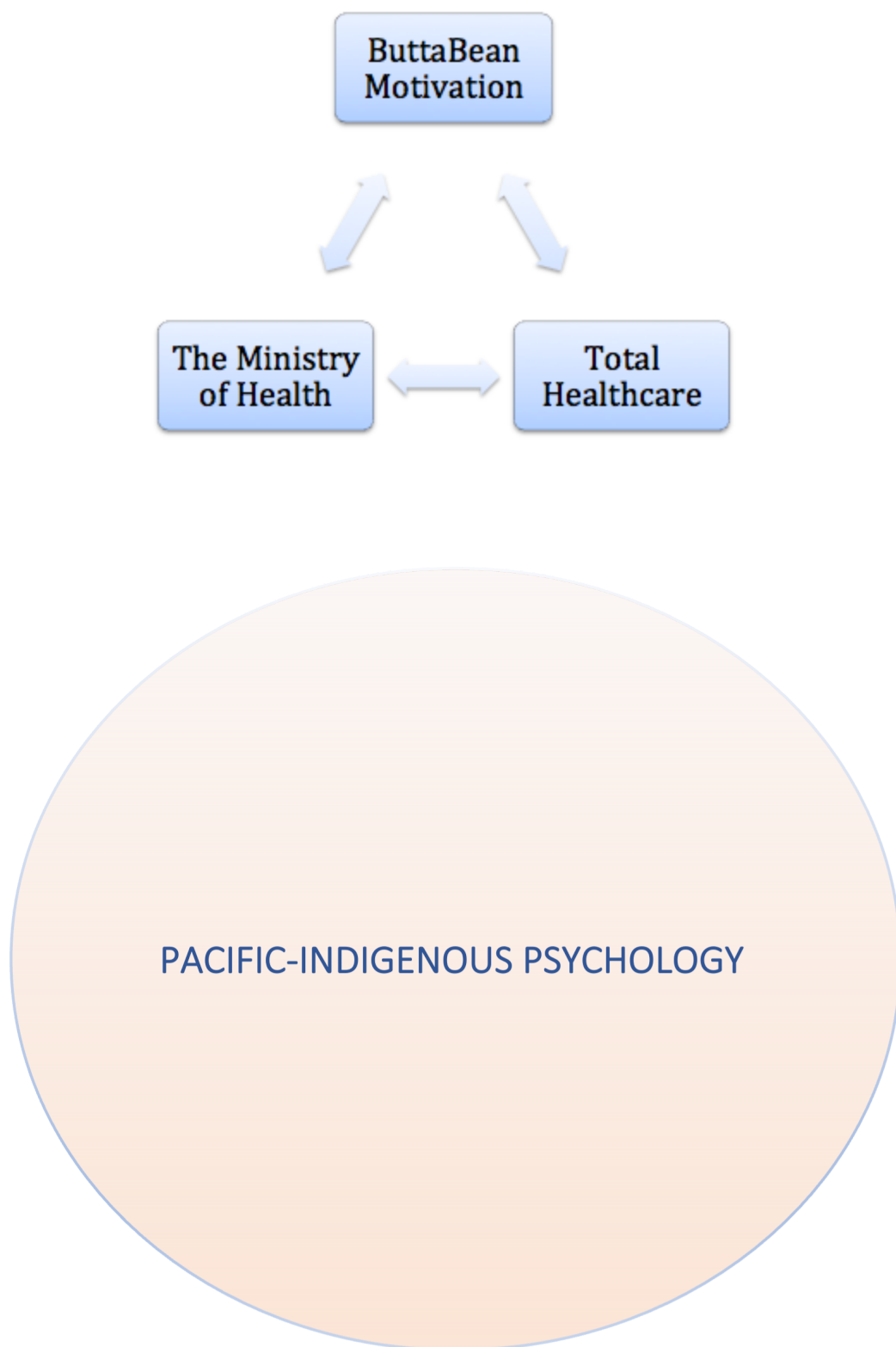


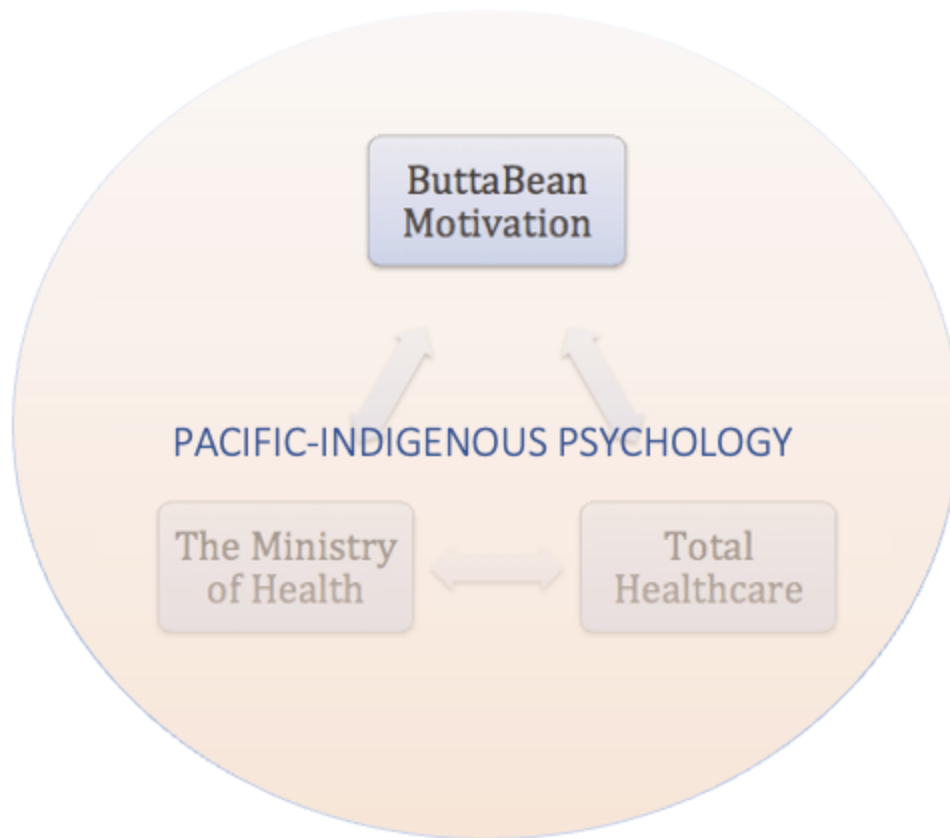
Pacific Methodology

In the previous chapter on ‘Pacific Indigenous psychology’, I discussed the importance of Pacific methodologies as they privilege and legitimise Pacific knowledge and practice. As a Pacific researcher applying a Pacific methodology better enables me as a researcher to “authentically experience and capture the phenomenon being researched” (Vaioloti, 2013, p. 192). Methodologies inform what is deemed real and the way in which knowledge has been produced. Methodologies are connected to the epistemology and ontological positioning of the researcher.

As an ‘insider’ researcher carrying an inherent Pacific-Indigenous view of the world where all living and nonliving things are connected and interdependent from people, to the land, the sea, the skies, ancestors, aiga, village - it is through my conceptualisation of the world that shapes what I see as real. It is also through my worldview that forms what I deem to be valid forms of knowledge production. In Samoa and other Pacific cultures storytelling through talk, song and dance have been mediums for producing and sharing knowledge. Across Oceania knowledge production is relational, meaning knowledge is not produced in isolation rather it is constructed with others and this knowledge is shared orally - “The mind does not create thoughts in and of itself, without having something or someone to interact with” (Alefaio, 2014, p. 91). It is through my worldview that Pacific methodologies such as Talanoa are seen as a culturally appropriate methodology. As such Figure 2 illustrates how this study draws on Pacific-Indigenous psychology (akin to Systems-Thinking) as a lens for exploring and understanding the relationships, principles and processes of the tripartite partnership

Figure 2. *An illustration of the tripartite partnership conceptualised through the lens of Pacific-Indigenous psychology*





Talanoa

According to Vaioleti talanoa is a phenomenological approach to research but “The long history of *talanoa* in the Pacific Islands is based on discussions that lead to a common understanding. This understanding is, in turn, the product of natural laws, beliefs, traditions, values and culture of those engaged in the *talanoa*” (Prescott, 2008, p. 130). Vaioleti stated:

“In a good Talanoa encounter, *noa* creates the space and conditions. *Tala* holistically intermingles researchers' and participants' emotions, knowing and experiences...it is the sum of *noa* and *tala* that adds to the total concept. It requires researchers to partake deeply in the research experience rather than stand back and analyse” (2006, p. 24). Talanoa has gained popularity in the Pacific research community in order to privilege the voices of the Pacific.

Pacific researcher Faleolo (2020) applied talanoa to her research stating “The difference between *talanoa* and any other kind of dialogue conducted during fieldwork is that it is a form of respectful communication, built upon important Pasifika protocols and cultural understandings of maintaining sociospatial relationships. Talanoa done correctly will nurture ‘beautiful social spaces’ between researcher and informants, a socio- spatial process better known as *tauhi vā* (to maintain relationships and nurture spaces between) by Tongans and *teu le vā* (to beautify the relationships and embellish the spaces between) by Samoans (Ka’ili, 2008; 2017)”

“Talanoa is an existing cultural practice of the Pacific. As an oratory tradition, talanoa is a concept recognized in Samoa, Fiji, Tonga, Cook Islands, Niue, Hawai‘i and the Solomon Islands (Prescott, 2008; cited by Fa’avae et al., 2016, p. 140). Talanoa prioritises the upholding of good relationships, respecting the *va* among participants and researchers where every participant’s voice is valued and respected (Havea et al., 2021). Participants have the power to define the problem with the researcher. Talanoa also validates the relational production of knowledge through storytelling. Talanoa is a mode of communication for Pacific peoples “that is integral to the way in which many Pacific peoples learn, relate to each other, narrate and tell stories” (Vaioleti, 2013, p. 193.).

There are some principles and protocols integral to talanoa methodology. Gremillion and colleagues (2020) outlined values associated with Pan-Pacific Talanoa - “Mo’oni - pure, authentic, Malie - energise and uplift spirits to create a positive state of connectedness and enlightenment. This leads to mafana - warmth. Faka’apa’apa - respectful, humble and considerate, Anga Lelei - kindness, tolerance, helpful, calm and dignified” (slide 4). Vaioleti (2013) stated that empathy is also integral to the effectiveness and authenticity of talanoa as it gives space for participants to “speak freely from the heart” (p. 194). As a researcher it is my responsibility to act in a way to “preserve the cultural, spiritual, physical dignity of all that is involved” (p. 208) Finally, in Talanoa the researchers' worldview, values, attitudes and beliefs are not ignored rather they provide a lens for inquiry. In the Pasifika education research guidelines, Anae (2001) points out the subjectiveness of research quoting Taufe’ulungaki who explained:

“One of the myths that we have internalised is the belief that scientific inquiry is neutral and objective....The competing assumptions, questions and procedures of research contain values

that represent different perceptions about authority, institutional transformation, and social order. Embedded in research are issues of epistemology, political and cognitive theory as well as peoples' responses to their material existence" (2000, p. 11 cited by Anae, 2001, p. 7).

It is because of the subjectiveness, and the validity of knowledge being passed on through oral traditions that I used Talanoa methodology to inform my research with Pasifika people. Lastly, given that my research is with the Pacific diaspora utilising common Pasifika values in the community was important.

Cultural - Participatory immersion a Pacific-Indigenous approach similar but different to Participant Observation

Cultural-Participatory immersion is an approach to research that is characterised by the inside-researcher phenomenon often described by Indigenous researchers and in this case myself as a Pacific researcher actively participating in the research. This is typically described as participant observation in an ethnography, but for Pasifika communities and the diaspora in particular, cultural-participatory immersion is beyond just observation and observing participants as a researcher. Cultural-participatory immersion involves the researcher's own cultural frame of reference being immersed and engaged in active participation with the study. Termed in 2016 through an evaluative study undertaken by Alefaio-Tugia et al., (2016), cultural-participatory immersion (C-PI) involved the Tongan researcher being invited as the daughter of an esteemed Minister of the community to share her life-story with kainga (family) in the programme. This culturally appropriate and safe engagement was due to the researcher's own leadership standing within her community (i.e. cultural frame of reference).

Talanoa is the main method of data collection but it is supplemented by cultural-participatory immersion that took place after talanoa and interviews, to see the ideas gathered from the talanoa and interviews realised in practice within the governance group. Havea and colleagues (2021) stated that an important dimension of cultural-participatory immersion is the participation of 'researchers' and being known to participants. It has similarities to Autoethnography (Ellis et al., 2011) whereby "the researcher is also an immersed participant in

the culture and programme under investigation” (Havea et al., 2021, p. 86). Throughout my research, I was actively engaged with the programme under investigation. I was immersed primarily through the governance and steering groups and participated regularly in the From the Couch workouts. What this entailed was sitting in on monthly governance and steering group meetings over the past 10 months, working out alongside the FTC participants on a weekly basis, and conducting talanoa with staff from each organisation as well as the FTC participants. Along with myself and 2 student researchers we became immersed in the partnership, offering recommendations to THC and BBM around improving recruitment and adherence to the programme. This form of immersive community engagement reflects the Pacific Health Research guidelines (2014) of best practice, as it enabled ‘meaningful and reciprocal engagement’, constant consultation and ‘cultural sensitivity and respect’.

Methods of Data Collection

To align with the epistemologies and worldviews of each partner - Talanoa was conducted with BBM and two separate semi structured Group interviews were conducted with THC and the Long Term conditions team from the Ministry of Health.

Talanoa

Given that BBM is a Māori and Pacific led organisation I used Talanoa as my method of data collection because it provides space for the participants and researcher to express themselves freely using Pasifika vernacular and nuances that may not be fully understood outside of a Pacific worldview and the diasporic community. As a method, Vaioleti (2013) explains that there are various dimensions and elements of talanoa - talanoa vave, talanoa faikava, talanoa usu, talanoa tevolo, talanoa faka’eke’eke, Po talanoa, talanoa’i, and Talanga. Each of these dimensions have variations. For example Vaioleti explains talanoa vave can be described as a surface level verbal exchange between 2 or more people where its purpose “may be to inform, report, inquire and clarify” (p. 200) whereas Vaioleti describes talanoa usu in contemporary Aotearoa as an “engagement to share, to create a sense of mafana and malie (Manu’atu, 2002 cited by Vaioleti, 2013) that can lift the participants to another level of spiritual fusion and

enlightenment...for researchers it is an ideal way to build trust for other more objectified talanoa” (p. 201). According to Vaioleti one of these dimensions may be more salient than others whilst moving in and out of the various dimensions interchangeably - this is dependent on the intention of the researcher and the direction of the talanoa. My use of talanoa encapsulates the fluidity of moving in and out of these various dimensions. Most salient were talanoa’i, talanoa faka’eke’eke, talanoa usu and talanoa talanoa vave. These dimensions are not explicitly stated beforehand but align with the purpose of the talanoa and those that were present.

In using Talanoa as my method of data collection it legitimises the ways in which knowledge is produced across the Pacific. Additionally it privileges the construction and dissemination of knowledge orally and it prioritises building and respecting relationships. The essence of talanoa is a conversation, an exchanging of ideas or thinking, this can take place in formal and informal settings and almost always carried out face to face (Vaioleti, 2006). “Participants engaged within talanoa are encouraged to share and express their narrative worldviews in a fluid and less restricted way than traditional, western interviews (Prescott, 2008)

Procedure

The Talanoa consisted of two BBM staff members (founder and operations manager), who were purposively selected within their organisation, along with myself and two senior researchers. Because the research is focused on the coming together of 3 ‘systems’ via a new governance system, it was important that the participants were part of the governance group. Although the preference is for talanoa to be conducted face to face, at the time, Auckland was still under lockdown restrictions preventing any face to face meetings. As a result the talanoa took place via zoom. Our talanoa was conducted particularly within the dimensions of talanoa vave, talanoa usu, and talanoa faka’eke’eke whereby we moved fluidly back and forth and interchangeably through the 3 dimensions. There is no set length of time for talanoa as it ‘flexible’ and ‘takes no rigid stance’, it is a back and forth reciprocation of storytelling, contesting and validating between the two participants. The talanoa came to a natural finish after 70 minutes - this was identified when no new information was being constructed. The talanoa was digitally recorded through the zoom application and then transcribed verbatim. The talanoa took place before the first cohort had commenced and therefore this was an account of BBM as

an organisation and how they came to collaborating with MoH and THC as a community organisation.

Semi-structured Focus Group Interviews

We conducted semi structured group interviews with THC and MoH staff because they reflect the knowledge systems, values and attitudes of western organisations. Focus groups were chosen as an appropriate method for data collection because the focus groups are seen as one entity. Given that this new system is between the organisations as opposed to individuals, focus group interviews were deemed appropriate (Di-Cicco & Crabtree, 2006). Group interviews fall within the qualitative paradigm which assumes that multiple views of reality exist, therefore the goal of qualitative research methods like group interviews are to describe the realities from within that specific context. Some key features of focus group interviews include the view that the respondents are a valuable source of information. In addition Vaughn and colleagues (1996) explain it is not about discovering findings that are generalisable to the population rather focus group interviews facilitate “an interactive discussion that can elicit a greater, more in-depth understanding of perceptions, beliefs, attitudes, and experiences from multiple points of view and to document the context from which those understandings were derived” (p.16). Another feature of focus group interviews is that the inquirer (researchers) is not objective or removed in focus group interviews, rather their interactions with the respondents have the potential to provide further insight, this also falls within the assumption of the qualitative paradigm. Lastly the group dynamic allows interactions between respondents which can in turn provide greater openness in responses.

I chose semi structured interviews as an appropriate method for inquiry as I am exploring a new partnership that has not been seen before, and I was seeking to gain insight into the thoughts, knowledge and experiences of the organisations. By using a semi structured outline in a group setting it provided the space for interactions between respondents and moderator to produce new questions and areas for probing will emerge. Again these interviews took place preceding the start of the first cohort.

Procedure

For the group interviews, participants were staff from each organisation particularly those who occupied management and leadership positions. Members from each organisation were invited via email and they were purposively selected in their organisations as key members of the partnership. The group interviews took place via zoom due to restrictions caused by the Covid-19 pandemic. The interviews were divided into their respective organisations, Total Health Care and the Ministry of Health – Long Term conditions team. It was decided to conduct the interviews separately for each organisation to allow each group the opportunity to share their side of the story, and for us as researchers to understand their journey leading up to the partnership and their view on the partnership thus far. The number of people attending the interviews differed from each organisation. MoH interview consisted of two participants and THC interview consisted of six participants. Vaugh and colleagues (1996) state that an ideal number of participants is between 6 and 12 for reasons being too few will not stimulate enough dialogue whilst too many may not provide the opportunity for everyone to voice their thoughts and opinions. The number of people in our interview with MoH reflected the people involved from their organisation in the partnership therefore it was suitable, subsequently given the respondents roles in MoH their knowledge and experiences will provide in depth insight into the health system. We had outlined a set of open ended questions that would allow for new questions to emerge through dialogue between respondents and respondents to the moderator. Refer to appendix a to view the outline of questions. The interviews ranged from 60 to 90 minutes. Group interviews were also conducted and recorded via zoom and then transcribed verbatim.

Methods of Analysis

Thematic Analysis

I used Thematic Analysis (TA) to analyse data for both the talanoa and focus group interviews (Braun & Clarke, 2006). “TA is a method for identifying, analysing and reporting patterns (themes) within data” (Braun & Clarke, 2006, p. 79). Thematic Analysis was applied to analyse the data due to its in depth analysis “that quantitative analysis lacks” (Castleberry & Nolen, 2018, p. 808), independence from theoretical underpinnings, and its accessibility, and

flexibility in the process of analysis. To analyse the data I followed Braun and Clarke's (2006) 6 phase guideline because it "offers a clear and usable framework" (Maguire & Delahunt, 2017, p. 3353) providing a more rigorous and deliberate process. It was important to have a framework when dealing with qualitative data to avoid only organising and summarising (Maguire & Delahunt, 2017). TA needs to be "undertaken with special care and attention to transparency of the method in order to ensure confidence in findings" (Castleberry & Nolen, 2018, p.808). The following section outlines the 6 phases I undertook to analyse the data.

Braun and Clarke 6 Phase Guideline (2006)

Phase One: Familiarising yourself with your data

In the first phase, I listened to each recording right through to familiarise myself with the content. Seeing as I was part of the talanoa and group interviews I had already begun to form ideas and identify areas of interest. Once I had listened to the recordings right through, they were transcribed verbatim ensuring that I retained the information from the verbal accounts. Due to the rigorous nature of transcribing data, I had begun to develop an in-depth understanding and familiarity with the data.

Phase Two: Generating initial codes

After familiarising myself with the data, I went through each transcript working systematically line by line and 'coded' any data extracts relating to roles, needs, and how they came together in partnership - through a systems thinking lens and a Pacific indigenous/Oceanic lens. Using google docs I highlighted interesting extracts yellow and then would write a brief description along with an initial code in the comments section. "Codes identify a feature of the data (semantic content or latent) that appears interesting to the analyst, and refer to 'the most basic segment, or element, of the raw data or information that can be assessed in a meaningful way regarding the phenomenon' (Boyatzis, 1998, p. 63 cited by Braun & Clarke, 2006, p. 88). It was important to keep some of the surrounding data to ensure the context was not lost. At the

initial stage of generating codes there were extracts that had multiple codes. Once I had coded all 3 transcripts - I collated all the data extracts together within each code

Phase Three: Searching for themes

“This phase, which re-focuses the analysis at the broader level of themes, rather than codes, involves sorting the different codes into potential themes, and collating all the relevant coded data extracts within the identified themes” (p. 89). Because I was completing 3 separate analyses in this phase, I collated codes that appeared to be clustering around similar themes. Using post it notes and a whiteboard I wrote out each code and organised them into ‘theme-piles’. For example it became apparent that social media is a key feature in BBMs ecology, therefore social media at this phase was tentatively a theme and I had clustered all codes that had some association to it.

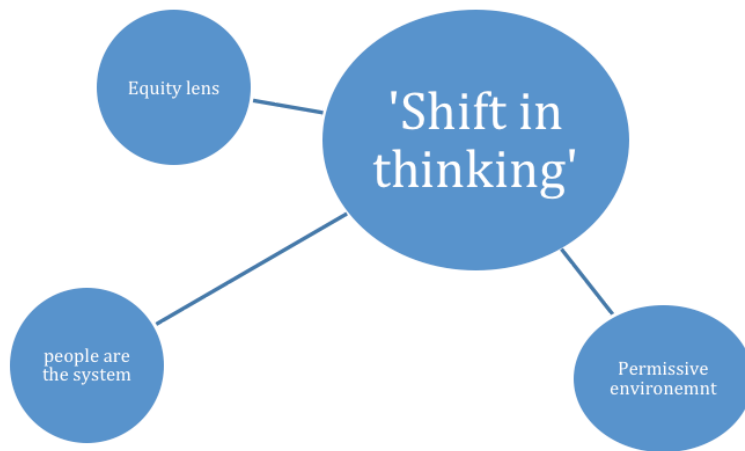
Phase Four: Reviewing themes

Braun and Clarke (2006) explained that this phase consists of two levels. The first level requires reviewing the collated extracts to a code and making sure they “appear to form a coherent pattern. The second level is to review the themes within the entire data set. Because I was seeking themes for each organisation, I had identified one overarching theme for each organisation. This reflected what brought each organisation to this partnership and they were influenced by pacific indigenous psychological principles and through a systems thinking conceptual lens.

Phase Five: Defining and naming themes

“By ‘define and refine’, we mean identifying the ‘essence’ of what each theme is about” (p.92). As mentioned earlier my analysis is directed at exploring the partners separately to understand what brought them to this novel partnership. The following example illustrates an overarching theme I identified with the Ministry of Health. This theme ‘shift in thinking’ will be further explained in the report, but as an overview the theme reflects the precursor that led Ministry of Health to reach out to BBM to collaborate.

Figure 3. *An illustration of collating codes under a theme*



Phase Six: Producing the report

The final phase is the writing up of the results. My ‘report’ is in the following section. Refer to appendix B to view the internal governance report of the partnerships first year.

Chapter Four Results

Chapter Introduction

It is important to note that the talanoa and group interviews were conducted before the first BBM x THC FTC cohort had commenced. From my analysis I identified one overarching theme for each organisation that captures what led them to this partnership. They are '*Shift in focus towards connections and engagement*', *Shift in Focus towards a perspective in humility - acknowledging what wasn't working. Open to learning new things - innovative ways of engagement*. And '*Resilience-thinking system that is transformative and sustainable based on Pacific-diasporic values and beliefs*'.

Theme One: 'Shift in focus towards connections and engagement'

The Ministry of Health are a government organisation that operate under the guise of western knowledge systems, values and beliefs. They are required to deliver equal and positive health outcomes to all of Aotearoa and showcase it through easy to measure outcomes. The Ministry of Health has come into this partnership having not reduced the prevalence of long term conditions in Pasifika communities through their current systems. They recognised that what they were doing was not working. The Ministry are positioned at the government level where they allocate funding to PHOs and NGOs. Organisations who receive funding must meet targets and specifications connected to the funding. The long term conditions team are in a position where they have come across BBM and the success that they have been having and have found that they were not currently receiving any funding from the government. Subsequently they found that their processes for applying for funding may not be reaching the organisations who are doing the work. This prompted the Long term conditions team to reflect on their current processes and seek a new approach to reducing the prevalence of obesity and other long term

conditions. This is what led them to this partnership and the overall theme of the partnership is a shift in focus towards connections and engagement.

This main theme encapsulates what brought the Ministry of Health (MoH) long term conditions team to this partnership - that is a 'shift in focus towards connection and engagement' across all spheres, but especially their own shift towards working better together for the collective-good as opposite to picking up the pieces from the bottom of the cliff. This was captured by 3 codes: *'equity lens'*, *'facilitating conditions in the macro-environment'* and *'people are the systems'*.

The Ministry of Health are a government organisation who give funding to PHOs, where they allocate funding is a significant indicator to how the public health system views health. For example in the following extract one of the respondents stated that long term conditions have been handled largely in secondary care. As we have seen from the literature Pasifika are disproportionately overrepresented in obesity and Long term conditions with no sign of these outcomes slowing down. In our interview with the Ministry of Health one of the respondents stated; *Our focus has been very secondary care focused ambulance at the bottom of the cliff. When you look at the data and the results, not a lot has changed, we haven't stemmed the prevalence of diabetes and other long term conditions, so you know you have to take a reflection and go we're not we're not getting the gains that we need.* This type of response requires a shift in thinking towards 'looking at the bigger picture'. Furthermore looking within their own systems to recognise its not the people but rather the systems that need to change can be difficult for an organisation to recognise and acknowledge. The following extracts capture the elements that have led to the long term conditions team reaching out to BBM.

Facilitating conditions in the macro-environment

Although this is a new type of partnership that has not been seen in New Zealand's public health system both the literature and the current climate have facilitated the conditions within this macro-environment for this partnership to have formed. In the following extract Manager of the Long Term Conditions team at discusses the shift within the Ministry of Health;

“So I think that the one thing about this that I see is a move into primary and community care and that's something that I see across all long term conditions beginning to occur at the moment”

Once again this shift towards community care illustrates that there has been a shift in thinking within the organisation as there are different principles and assumptions that inform community and primary care compared to secondary care. Furthermore a shift towards primary care recognises the impact that the social determinants of health have on long term conditions.

In the following extract they discussed the influence of the political climate and how it has had some indirect influence towards this partnership being able to go ahead;

“yeah and I think the other thing that you're seeing at the moment is with Covid you're seeing even politically. You know, major political parties aligning together and not not fighting each other, and I think you're likely, I mean I would hope that you'd see that same cooperation in the future around big issues like you know, like obesity.”

The current climate of the world requires a move towards collaboration, the interconnectedness of social systems inevitably requires collaboration. Recognition that collaboration is necessary further acknowledges the complexity of both the health system and long term conditions

Equity lens

This shift in towards connections and engagement has been further supported by the Ministry of Health's focus on equity - equitable outcomes for all ethnic groups in Aotearoa. Given that Māori and Pasifika have significantly worse health outcomes than their NZE counterparts an equity lens for mainstream organisations is primarily going to mean focusing on Māori and Pasifika. This is demonstrated in the following extract;

And I think the other things that have changed, I think there's a big focus on equity and help that certainly Ashley Bloomfield is and, the whole of ELT you know we have A big focus on equity that I haven't seen in health i've seen things that paid lip service to it in terms of you know You know, every health report you right you'd have to write a paragraph on you know closing the

gaps and things like this, but I haven't seen such a big focus on equity in a in a practical sense, as I as I have more recently.

How an equity lens is operationalised can have significant impact on outcomes, for example in the previous extract, they stated that previously an equity lens was merely mentioning it in a paragraph at the end of a report. Unsurprisingly there have been no significant improvements. Within this shift towards connection and engagement, is recognising how to truly apply an equity lens that is going to see tangible change. Long term conditions manager explains;

And if you think about where the need is then you have to have systems that allow those equitable outcomes to actually be realised.

This aligns with the notion of health disparities being a systemic issue that can be improved through systematic change. It further highlights the need for systems to be adapted to the communities as the current systems in place do not meet the needs of the community and that is engagement and connection.

People are the systems

This shift in thinking didn't just happen, I identified a sub theme 'people are the systems' this refers to the idea that people are the systems and it is the people within the systems who have the power to make change. However people within the systems need to reorient their thinking and how they perceive the issues in the health system. In the following extracts the MoH discussed the actions they took for this partnership to happen;

“so the traditional style is business case approval request for tender on decks, you know there's quite a bureaucratic process to go through. With this one we seized an opportunity to go, you know what this is actually quite unique and that is the term we use this is a “unique” proposal, so we were able to use whatever exemption rules we could that meant we could operate outside of those traditional tendering processes”

The complexity of the health system makes it inescapable of bureaucratic processes, whilst necessary organisations need to have the capacity and capability to develop a strong business proposal. As a consequence, community organisations delivering programmes that are embedded in the community may not be receiving the funding they deserve due to not having the resources, capacity or infrastructure to compete with larger organisations who have the ability to

develop a business proposal that is compliant to bureaucratic processes. What the long term conditions team have done is bypass the business processes and identified BBM as an organisation who already have a successful programme embedded in South Auckland. Similarly they also reduced the level of required reporting that goes hand in hand with funding from the government.

“with us is more flexibility and less demand for reporting from the Ministry, we've tried to be we've we've put in some reporting, because obviously we need that. But in the contract we've tried to be very minimalist about the reporting that we require”

“And I think the other thing about it as being two years is a lot of the funding that we put out as for a one year period because that's how our budgets tend to work. And you know, even though it's not a huge amount of money, committing for two years is unusual.”

Once again these actions that the long term conditions team have undertaken for this partnership to go ahead reiterates the *“need for systems to allow equitable outcomes to be realised”* and is consistent with a shift towards engagement and connection. Rather than placing the onus on the individual, this shift has oriented the Ministry of Health and the long term conditions team to look within, at the barriers their own bureaucratic processes might impose.

The role of the MoH is to ensure equitable health outcomes are achieved for the total NZ population. Currently they have been unsuccessful. They came into this partnership as they were shifting their focus towards primary and preventative care to address long term conditions. They recognised that they have not reduced the prevalence of long term conditions with their current model. Their partnering in this initiative came about due to a shift in thinking , this was made possible because there were Facilitating conditions in the macro-environment, equity lens and people within the systems willing to take action.

Theme two: Shift in Focus towards a perspective in humility - acknowledging what wasn't working.

Similar to MoH, I identified one overarching theme that captures what brought THC to want to collaborate with BBM. This was a shift in focus towards a perspective in humility - acknowledging that their current methods of engagement were not working for this community, and their openness to learning new and innovative ways of engagement. This was illustrated in the codes; 'holistic view of health', 'willingness to be innovative', and a 'willingness to collaborate'.

In the following exert, THC staff discuss being unable to engage with a group of people;

“So basically our journey with health coaching began with recognizing that there were a group of people who were poorly engaged who were registered with us

There has been acknowledgement that while they were people focused the people were poorly engaged, so their shift in thinking was towards acknowledging they didn't have the right strategies in place. This was the catalyst for seeking a partnership with BBM. Total Healthcare were able to see that BBM were engaging with a cohort of people that they have thus been unsuccessful in engaging with as discussed in the following exert; *“Engagement. It is their ability to engage with patients that we can't despite our best efforts. We know they have proven to be very effective in engaging with the community that we've not been great in engaging with them, in particular, that target population that we're going to be working with them”*. Because they have observed these people willing to engage with BBM it further reinforced that their current strategies were not meeting the socio-cultural needs of the target group as opposed to their (the target group) unwillingness to engage.

Holistic view of health

A holistic view of health recognises the importance of physical, mental, emotional and spiritual health. By having a holistic view of health it orients organisations to make sure they are addressing all aspects of health through their services. This can be seen by the use of the health coaching model;

“So basically our journey with health coaching began with recognizing that there were a group of people who were poorly engaged who were registered with us... and so we looked around for models of peer support and primary care and came across this whole health coach model developed in high needs communities”

“we're not coming in from a clinical perspective we're coming in, as a walk beside and it's really I see it as more of a relationship management role where we're actually helping the patient give a voice for themselves and direct their own kind of health outcomes”

Another aspect is their commitment to reducing as many barriers to access as possible. We know from the literature that health is impacted by a range of social determinants such as socioeconomic status, specifically the impact socioeconomic status can have on accessing health care. Furthermore much of the barriers of access for Pasifika are attributed to cost. THC actions towards reducing barriers is highlighted by THC staff in the following extract;

“we offer extended hours and low fees... we now charging \$15 if you're over over 18 but it's still free if your under 18 but that's for enrolled patients and you've got access from 8am to 11pm, at least one of our large practices, seven days a week, so you know you can see. There is no issue... we've lowered the barriers to access as far as we can, we've placed them near bus routes and so on”

Primary Health organisations have access to a number of funding streams, their access to what is called flexible funding can be used by PHOs to improve access and utilisation of primary care services especially for their high needs populations. From there, PHOs have the flexibility to use that funding in areas where they see are needed. Some PHOs directly fund their GPs, whereas THC have used their funding to develop and test innovative programmes and initiatives for their population, this is explained by the Clinical Director of Mental Health and Wellness Support;

“What we've been able to do is have the flexibility to actually test evidence based stuff and find what works with our communities and grow some quite innovative programs, so a lot of

what we do in terms of group programs and health coaching initiatives. And the broader integrated model that we deliver came out of the capacity to be innovative and testing things”

Evidence based models have found to be ineffective in high needs populations especially ethnic minority groups such as Pasifika. The flexibility and willingness to try new things captures the holistic and dynamic nature of healthcare. Whilst THC have implemented a holistic view of health their journey towards this partnership is because there was acknowledgement that while they are people focused, the people were poorly engaged, so their shift in thinking was because there was acknowledgement they did not have it right.

Benefits of and Willingness to Collaborate

Healthcare is a business and as a consequence there tends to be a resistance to collaboration. However THC identified BBM and saw the impact they were having in the community where they were ineffective and seized an opportunity to collaborate. Their vision to enhance the health of their people and recognition that they have been unable to engage with a cohort of people has led them to this partnership. The benefits of collaborating are discussed below by THC staff;

“But I mean this is just a beautiful compliment really in that they, that Dave’s team, and he himself through his social media presence, just are able to engage a group we thus far struggled with”

The following extracts are from THC staff discussing the benefit of collaborating;

“...that's where the intervention of the pre screening comes in, with the nurses and the health coaches and doing that initial pre screening. With those patients who are going into the program we will be able to guide and understand where the cardiac respiratory and health conditions are”

In addition to providing health checks for pre screening, they open up a new avenue for clinical indicators to be used as outcome measures. In the following extract THC staff member discusses the benefit of clinical indicators;

“...around the success of the actual program...In that also if you've got your clinical indicators that show the success of... so a patient may not necessarily lose weight, but within their own blood works, they will show improvement in their ldl's and decrease their hdl”

For the participant, if they see that there has been no significant weight change they can feel discouraged and may deter them from carrying on, whereas if there are other markers of change available, participants are able to see changes in areas that would not have been accessible without the partnership with THC. Lastly From a sustainability standpoint, being able to demonstrate improvement through a number of outcome measures is going to be beneficial for future funding.

Total Healthcare have presented themselves as a holistic organisation who aim to offer the broadest continuum of care from physical health right through to social needs. As a PHO they have access to multiple funding pools which has allowed them the freedom to explore and fund innovative primary initiatives. Their willingness to be innovative and embrace a holistic view of health and recognition of the wider social determinants have created a foundation for THC to seek collaboration with other organisations in the community. Total Healthcare came into this partnership because they identified that despite their best efforts there was a cohort of people who they could not engage with.

Theme three: Resilience-thinking system that is transformative and sustainable based on Pacific-diasporic values and beliefs

I have identified one overarching theme of BBM - *“Resilience-thinking system that is transformative and sustainable based on Pacific-diasporic values and beliefs”* This theme encapsulates the essence of BBM and what has enabled them to achieve the results that mainstream organisations have struggled to do. The elements that demonstrate this theme include lived experience, and Pacific diasporic values and beliefs and the use of social media

“Overcomer mentality” that sustains a new lifestyle and fuels a whole new community of collective-good. Overturning the tide of obesity requires a community-led movement for change

Lived Experience

NZ-Born Samoan, Māori man, Dave Letele was born and raised in South Auckland, and like many Pasifika he found himself morbidly obese, and depressed. In a bid to get his life back he embarked on a health journey through exercise and nutrition.

“The way the way this started was me and my my own health journey, and I think that's a big difference with us and other providers that it started, you know really purely out of someone getting their own life back And then, helping others to regain their lives and help their fitness not just physical but mental mental health, a big part of my journey was mental health”

Given that Dave has been on a similar journey to those who attend FTC, he knows what it takes for our people to lead healthy and sustainable lives.

Throughout his journey Dave took to social media sharing his workouts, his meals and opening up about his experiences along the way:

“So on when I started the group, it was a chance for me to be myself and you know just share what I was doing differently you know the eating and training, all that stuff stuff and just sharing my thoughts being very open and vulnerable”. He found that connecting via social media helped him along his journey and allowed him to connect with others who were also embarking or wanting to embark on a health journey of their own. From the Facebook group that Dave had created, he started to run free bootcamps around Auckland for everyone to join. It was the beginnings of a BBM community.

Pasifika values

For many children and grandchildren of the diaspora their worldviews, knowledge systems, values, attitudes and beliefs and practices are indigenous to Oceania. This sub theme outlines the Pasifika values and how they have been incorporated and adapted within more western institutions such as the ‘gym’ and modern technology such as facebook. BBM have grounded their organisation in Pasifika values and these values are underpinned by a philosophical framework that shapes that way Pacific people perceive the world and the way they behave.

Prioritising Relationships and Connections

Many Pasifika cultures are relational, meaning they do not exist alone or separately rather in relation to everything around them. Fostering relationships is one of the foundations of which most activities are built on. Because BBM is a Māori and Pacific led organisation they know the value of establishing relationships, and how to foster relationships in a safe and respectful way. In the following statement it is evident that relationships are a precursor to an individual successfully adhering to the programme as illustrated by Dave in this statement:

we have to train it's not just doing it in the gym, we have to be you know texting calling people checking in on how they are you know outside of the gym and, you know meeting them outside of training now while we're still working you know...I'd always check in, how's your evening going and what have you done today all these little things, but it makes them feel like oh man he really cares, which I do so our trainers, you know, I know, two, three trainers running a class, they have to be you know take on board that they're going to have to help these people it's not just just training them, you know.

Value of Family

At BBM participants are encouraged to bring a support person, their children and anyone else that would make them feel more comfortable but also allows them to still participate. One of the ways in which they present themselves as a family oriented organisation is by allowing participants to bring their children along with them to the workouts, this was emphasised by a BBM staff member:

so what attracted me to be BBM was it was a movement that was centred on family, family values was very inclusive, so I could bring my family and, at the time for me personally, I was struggling with my weight my mental health and BBM provided a safe environment for me to come not be judged, so the cultural aspect that kind of resonated really um deeply with me was that you know was safe I could bring my kids and I was not judged and I could lose weight and you know, be supported in and around people with the same goals.

At most mainstream gyms children are not allowed on the premises, this reflects a western worldview. Pacific cultures view children and elderly as valuable members of society, integrated into family life which is central to personal life. This is illustrated in the FonoFale model, a Pacific health model where family is the foundation. Being able to bring your children

to the gym while you workout may not be seen as a big deal but it may be the difference between participants being able to attend the sessions or not. When organisations prioritise Pacific values, their services are going to be better aligned with a Pasifika understanding of health.

Collectivist view

The essence of BBM is a collectivist view prioritising the needs of the community over individual needs. In the case of BBM the needs of their community are at the forefront of their organisation;

Our why is always our people, you know that's our purpose and as long as, as long as our why is our people we can never, it doesn't matter how big we get doesn't matter how much money we get it still we're still going to remain the same it's all about delivering you know for our people

BBMs commitment to their people, to their community is part of their kaupapa and when the needs of the people are at the core of the organisation, what we see is those organisations working towards what is going to bring the best outcomes for their people. This is illustrated in the following extract: *we should all be looking at each other and saying how can we work together to make the health of our people better*

Social Media (SM)

SM has been one of the most significant elements in BBMs ability to engage with the community. Their utilisation of SM is multifaceted, whilst it has been a prominent tool to connect with participants, they have also used the medium to showcase their work, to other people and organisations in the health sector. Dave highlights the importance of showcasing their work in this extract:

You know, with without the funding and that's I think that's an important piece, because you can't rely on on government funding to be sustainable you've got to have all these other avenues of different stuff...And then I mean you've got to be able to showcase it, you know, thats why social media so important for us, especially linkedin right it's we're not bragging about what we're doing we're highlighting the issues out there because bubbles existed long before Covid.

where people up here have no idea what's happening to people down at the bottom, so all we're doing is showcasing

Through social media, they are able to connect with both those in the community, health professionals and organisations in other areas of the health system.

The leveraging of social media came from Dave using it during his own journey: *So when I started the group, it was a chance for me to be myself and You know just share what I was doing different you know the eating and training, all that stuff stuff and just sharing my thoughts being very open and vulnerable.* He saw the impact SM was having on his own health journey and recognised the potential of using social media to connect and engage with other people who were also on their own journey or wanting to start.

It is now used as a way to connect with their participants and create a safe space for people to share their journey. Social Media creates another medium for BBM to extend their support when they are outside of BBM: *So it really comes alive, when people are struggling to get around and support each other and that's really what I started the group for So it can be a place where people can be surrounded by positivity because it, you know and in there normal day to day life they might not have that you know.*

BBM utilise modern technology such as facebook, and linkedin and western institutions such as the gym whilst retaining Pasifika values throughout.

The partnership came about under the premises of voluntary collaboration. It was the actions of key personnel from each organisation who came together because they could see the impact that BBM was having on improving people's health, especially for Māori and Pasifika. This is because BBM are active members on social media and have leveraged the power of social media to connect with people and other health professionals to promote the work that they have been doing with the community. Another key factor that attracted THC and MoH was their ability to engage with the community, especially in South Auckland. THC has been struggling to engage with the specific cohort of people that BBM are successfully engaging with. Finally Because MoH is a government agency, and we know from the various health reports that there has been a shift in focus towards primary health care for achieving health equity, as well as a push for collaboration and community led initiatives on top of the fact that the prevalence of

obesity and long term conditions continues to rise for Pacific People, provided the right conditions for a collaborative partnership.

As part of my research I was fortunate enough to have experienced the BBM environment and FTC classes. I was able to witness firsthand how these Pasifika values were implemented into their service. I found that like many Pacific and indigenous health models BBMs model is also holistic whereby all the elements are intertwined that cannot be separated from one another, for example, BBM's prioritisation of collectivist culture, family values, and relationships are incorporated in their use of social media. It is used as a means to create relationships and connect with Pacific People in the wider community as well as overseas. An institution where people go to work out is a modern concept and has been popularised by the health and fitness industry due to low daily activity levels in industrialised countries and urban settings. BBM have used the concept of the gym to create workout classes that are embedded in Pasifika values and attitudes. Their workouts are purposefully designed to create connections and relationships with not only other participants but with the BBM staff.

Conclusion

As outlined in the beginning this analysis was from talanoa and group interviews conducted in the developmental stages - through my role as a researcher I have observed the interactions between the organisations as they work together to overcome challenges and implement FTC. The following section will discuss my findings through cultural-participatory immersion.

Findings from Cultural-Participatory Immersion

The following section discusses the governance groups actions and processes leading up to the launch of Cohort 1 and Cohort 2. To reiterate, my participation in the governance group meetings and attending the FTC programme along with being a member of the Pacific diaspora has created the space for cultural - participatory immersion.

Governance Group

The governance group of the partnership consists of members from each organisation. They oversee the partnership and ensure the processes and structures around the intervention are in place according to policy and contractual requirements, they are also tasked with identifying and mitigating risk. The governance group meets on a monthly basis and is organised and operationalised by Total Healthcare. An agenda is sent out via email a few days before outlining what will be covered; this also provides an opportunity for people to include anything on to the agenda. The meetings then follow the agenda allowing every group the opportunity to discuss what they have been doing. The minutes are recorded and then sent out after the meetings for members to go through and ensure that the minutes match what was said in the meetings. There is a clear structure and process to the operations of the governance group.

It is in these governance meetings where discussions surrounding recruitment strategies were held. Leading up to Cohort 1 it had been agreed by all partners that they were going to utilise Total Healthcare's large database to identify people who fit the criteria, and then cold call them. The criteria for cohort 1 was; enrolled under THC, 30-50 year olds with a BMI of > 40 who are living with one or more Long term conditions – i.e. diabetes, gout or CVD, and live within 10kms of BBM gym. They were also wanting to engage with those who had not had a consultation in the last 18 months to two years.

Recruitment process for Cohort One

Following the recruitment process using Total Healthcare's access to a large database they were able to identify Māori and Pacific obese adults living in South Auckland (Counties Manukau region) enrolled with THC. Once they had purposively identified people who fit the

criteria a list was compiled and given to BBM coaches who were given a script to follow and made cold calls to potential participants offering them an opportunity to take part in From the Couch. Initially more than 50 clients agreed to the programme over the phone.

Outcome of Cohort One

In February 2022 the first BBM x THC 'From the Couch' cohort launched, from the 50 clients that agreed to participate over the phone less than 10 turned up on the first day. After attempts to contact and remind clients there were no further improvements in attendance numbers. In addition no participant who was recruited via cold call completed the 12 week programme. It became clear very quickly that standard mainstream methods were shown to be utterly ineffective in reaching obese and overly obese citizens in South Auckland. This was understood by the principals, but it was deemed important to give these methods a chance.

Recruitment process for Cohort Two

Given there were such low numbers in cohort 1, the governance group came together to discuss the recruitment process and identify areas of change. Since the mainstream method for recruiting did not achieve the desired results, the group did a rapid pivot and it was decided as a collective that cohort two would be recruited using BBMs ecology and expertise in engaging. This method of recruitment is how BBM have previously attracted people to their gym. One of the strengths of BBMs ecology is their strong social media presence. Rather than cold calling - posts and videos were put up across a number of social media platforms such as Facebook and instagram.

Because BBMs method of recruitment does not fit within the systems and processes of the health system, a number of issues were raised in the meetings. First enrollment - through this new method clients who are not enrolled under THC are able to sign up. The group then had to decide how they were going to approach it, and agreed to allow people outside of THC to participate. Second, the eligibility criteria changed- THC no longer had control over who was enrolling into the programme it was by self identification. And lastly, data privacy and sharing of information issues arose. These types of bureaucratic barriers are what can prevent community organisations from being able to receive funding. But the governance group handled these

changes with a minimum of fuss. The programme shifted in cohort 2 to social media based recruitment, not limited to THC clients, but still focused on the obese and overly obese.

Similarly if smaller community organisations experienced outcomes like what happened in cohort 1- they may not have the time, management and resources to adapt which is what is able to happen with this type of partnership. Once these issues had been raised in the governance group, they had the collective capacity, flexibility, and capability to address them. The lack of micro-control from the funder allowed these shifts to take place without triggering a number of bureaucratic processes that would have slowed things down. The humility demonstrated by THC showed a willingness to go beyond their usual methods of recruitment towards BBM's social media system that received a lot more engagement from the target population.

Outcome of Cohort Two

May saw the launch of cohort 2 using BBMs ecology. As a result the number of participants in cohort 2 significantly increased with 43 participants turning up in the first week compared to 10 in cohort 1. Between the completion of cohort 1 and the launch of cohort 2 there was less than 4 weeks for the governance group to implement BBMs methods - the groups willingness to adapt, and fast pivot out of standard methods into Māori and Pasifika community-led efforts was instrumental in increased numbers in cohort 2.

What the success of Cohort 2 has shown is that BBM have a systematic process that is dictated by values - the environment may change but the values remain. To mainstream organisations their recruitment method may seem disorganised, and unstructured, but upon further inspection from a Pasifika view their method of recruitment has been about connecting and making relationships. Pacific cultures are relational and the engagement and connecting are fundamental to Pasifika. Another interesting feature is that THC wants to improve the health of Māori and Pasifika that is evident, but the contrast between cohorts 1 and 2 emphasised how influential culture is and for Pasifika it cannot be and should not be separated.

I also identified that the differences between cohorts 1 and 2 are consistent with issues of access to quality healthcare for Pasifika, for instance some people may look at cohort 1 and blamed the participants in cohort 1, rather than looking at the artificial recruitment process that

was inconsistent with the local culture. As we have seen when using a process that has been adapted to the community people are more willing and able to engage.

To conclude, from the findings, three overarching themes were identified, - A '*Shift in focus towards connections and engagement*', *Shift in Focus towards a perspective in humility - acknowledging what wasn't working. Open to learning new things - innovative ways of engagement.* and *The BBM way/Resilience-thinking system that is transformative and sustainable based on Pacific-diasporic values and beliefs.* Each of these themes represent the conditions necessary that have allowed these organisations to come together to establish a systemic process of 'collective-good'. What the three overarching themes illustrated is that there are precursors required for these types of partnerships to be successful in implementing and sustaining an obesity prevention programme.

In addition, through participant observation, talanoa and the group interviews I identified a number of key characteristics that were demonstrated in the partnership that have been vital in keeping the systemic process of 'collective-good' together thus far. These were: 1) prioritising and fostering the connections and relationships between organisations, 2). Prioritising the knowledge and insights of BBM and the BBM community, 3). Lastly, the participation of organisations from different levels of the public health system has provided the capacity, capability and resources to pivot rapidly to conditions on the ground and cover the requirements of actually implementing a partnership initiative in primary healthcare. Again participant observation, talanoa and group interviews enabled me to identify features that are helping to sustain the partnership thus far: *fostering good relationships, open communication, good infrastructure, and privileging and supporting Pasifika ways of knowing, doing and being.* In addition, as sustainability is the most salient issue facing community organisations, I suggest that it is also these features that are needed to sustain the programme in the public health system.

The systemic process of 'collective-good'

The systemic process of collective good is what is keeping the organisations together. The fuel is collective-good, but the two non-Pasifika organisations MoH and Total Healthcare can finally SEE (their organisational eyes were open to seeing BBM). There (MoH & THC)

organisational systemic focus is now towards connections and engagement. The tripartite partnership represents a systemic process of 'collective-good', whereby organisations from various levels of the health system have come together with a shared goal to reduce the prevalence of long term conditions in the Pasifika community of South Auckland.

Chapter Five: Discussion

Chapter Introduction

The study set out to explore and unpack how a new governance structure as a ‘systemic-process’ of collective-good is working together to sustain an obesity intervention and prevention programme aimed at Māori and Pasifika in a dynamic and complex health system. My objectives were to identify what brought these three partners together through a voluntary collaboration, what characteristics are necessary to collaborate in a complex environment and how they have operated this far to achieve their collective aims which centre around improving long term health conditions for Pasifika. To the best of my knowledge there has been no research exploring the interactions of a governance group that is trying to develop and sustain an obesity intervention with the goal of improving the health of Pacific people in particular reducing the prevalence of obesity and long term conditions.

The novelty of this partnership means that there are currently no studies that have identified whether this type of partnership brings improved outcomes for high needs populations. However, this partnership is consistent with the literature that calls on primary care for reducing health disparities (World Health Organisation, 1978); improving access to healthcare through culturally safe interventions (Ryan et al., 2019); using cultural knowledge to inform interventions (Smith, 2021; Alefaio, 2018); community ownership (Harding & Oetzel, 2019) and joining cultural knowledge with western sources (Heke et al., 2019).

Primary Care for reducing health disparities

The Ministry of Health's role in public health is to ensure equal health for all NZ citizens. Before this partnership they explained that much of their focus for long term conditions was secondary focused. An organisational shift into primary and community care is consistent with the literature for reducing health disparities particularly in long term conditions (Hefford et al., 2005). Funding a partnership within the Primary care space to reduce health disparities is also consistent with the messaging from the World Health Organisation and the Alma-Ata declaration

as well as the current direction of NZs public health system. We know from the research that ethnicity and socioeconomic deprivation are the most significant indicators of health status (Salmond et al., 2005) and have a strong influence on how Pasifika access and utilise NZs health system (Ryan et al., 2019). The partnership directly addresses the ethnic disparities by funding an initiative that focuses on improving the health outcomes of Māori and Pasifika communities where LTCs are disproportionately prevalent. Similarly they have ensured that ‘From the Couch’ is completely free, this is an important factor as Pasifika have some of the highest rates of unmet needs impacting their ability to access services (New Zealand health survey, 2020). Secondly, another important factor is BBMs gym is centrally located in Manukau, South Auckland making it more accessible to the participants.

Improving access to healthcare through culturally safe interventions

For interventions to be culturally safe they need to be grounded in the target groups own cultural worldviews and values and reflect their socio-cultural needs. A key element that makes the structure of this partnership so innovative is that BBM, a Maori and Pacific led community organisation, has the space to implement the structures and processes that have been so successful for them. In doing so the intervention is culturally safe because BBM reflect the socio-cultural needs of their participants and wider community. The governance group have demonstrated that this partnership is culturally safe through ensuring BBMs strategies of engagement and connection are at the forefront. The increase in the number of participants in cohort 2 compared to cohorts demonstrate Pasifika are willing and able to engage in primary care services when access to these services reflect their cultural worldview and their concept of health. This is consistent with Mahrshahi and colleagues (2017) study who culturally adapted an obesity prevention intervention to meet the socio-cultural needs of a group. Their study found that they were able to engage more effectively when using Multicultural health workers.

THCs struggle to engage with a cohort of ‘hard to reach’ people along with the low numbers recruited in cohort 1 demonstrate that access is not just about lowering and removing barriers, but access is also about engagement and connecting. Qualitative studies have found that Pasifika judge their experiences in healthcare based on relationally (Ryan et al., 2019; Ludeke et

al., 2012). For example In Ryan and colleagues (2019) study they found that many Pasifika based their experience on whether they feel their Va is being respected. Similarly Ludeke and colleagues (2012) found in their study that prioritising establishing a relationship from the GP had a positive impact on whether they were likely to engage with their GP. In the same study participants highlighted gestures such as the receptionist correctly pronouncing their names or at least trying to pronounce their names increased their willingness to access the GP in the future. Other local studies have found Pasifika associated not being able to pronounce their names as a form of discrimination. These studies reiterate that access for Pasifika goes beyond meeting the social determinants of health but access is also about engagement and connection and is consistent with why BBM have been successful because they place a large focus on connecting with their community. The innovative structure of this partnership where BBM are in charge, reinforces the importance of engagement and connection when it comes to access and utilisation for Pasifika. Furthermore, the partnership demonstrated that access and utilisation for Pasifika is about relationality. This is consistent with a Pasifika worldview, a Pasifika concept of health and the Pacific concept of self.

The importance of establishing relationships, connections and engagement particularly when working with the Pasifika community has been highlighted several times throughout this partnership. Total Healthcare is driven by providing quality services to their total population but have struggled engaging with a group of Pasifika people living with long term conditions, despite a holistic approach to healthcare and despite efforts to reduce barriers to access. Total healthcare reflects the issues that are seen within other mainstream institutions. Those being issues with access to and utilisation of quality healthcare experienced by Pasifika.

Using cultural knowledge to inform interventions

Using cultural knowledge to inform interventions has been highlighted as a key element in any initiatives aimed at Pacific people. The findings have shown that BBMs model is transformative and sustainable because they have used their own lived experiences and cultural knowledge and developed a programme that directly reflects their needs, experiences and realities. BBM is an overcomer-led practice informed-evidence programme as opposed to a research-led evidence based programme. The partnership has demonstrated to THC and MoH that community organisations have the skills and knowledge to lead their own initiatives.

Furthermore BBM have demonstrated Pacific diasporic values throughout their organisation further reinforcing the notion that cultural values are intertwined with wellbeing and how we come to view and conceptualise our health.

The importance of engagement and connections when it comes to access to quality healthcare is consistent with a Pacific worldview that promotes collectivism and relationality. It also illustrates the need for Pacific indigenous psychology in the primary healthcare space. Indigenous psychology promotes the use of local knowledge, values and practices to inform initiatives. BBMs model is based on their own lived experiences. They have created a system that is grounded in a Pacific worldview but is specific to the Pacific diaspora community in South Auckland. The demographic of Pasifika people differs from what it looked like 50 years ago and BBM reflects the current demographic of Pacific people. BBMs ability to engage with the community is consistent with the literature emphasising the need to use cultural knowledge and practices (Harding & Oetzel, 2019), furthermore it demonstrates to the wider health system that Pasifika are willing and able to engage when their values and practices are made visible. This is consistent with the current research and literature stating that interventions should meet the cultural needs of the participants (Harding & Oetzel, 2019).

BBM have demonstrated the impact they have had on the community when they use their ecology - this was illustrated in the change of recruitment method that saw a significant improvement in the attendance rates from cohort 1 to 2. Another reason for applying a Pacific worldview is that it removes issues relating to interpersonal, or institutional racism, which as we know from the literature is an underlying cause for ethnic disparities. Additionally, when the participants can see that their own cultural knowledge is being used to inform a health initiative they are going to be more familiar with it and it is going to better reflect their concept of health. Equally they will have a better understanding of the overall goal of the intervention.

Community Ownership

A significant portion of their (BBM) success has been because they have prioritised their connections and engagement with their community, in turn their high levels of engagement has

contributed to the fostering of community ownership. Additionally, applying BBMs engagement strategies, along with BBM leading the partnership as well as being involved in the governance group have all contributed to high levels of community ownership. BBM and the FTC programme demonstrate high levels of community ownership because they have been observed to be involved in all areas of the partnership. The role of community led initiatives is that it is based on the assumption that members of the given community have insider knowledge of the needs of the community and how they operate. This knowledge is not accessible to members outside of the community like Total Healthcare and the Long term conditions team.

Lifestyle interventions for reducing weight loss have been widely researched as an effective intervention. In Mack and Colleagues (2022) recent systematic review long term sustainability was the most salient issue. This is because many of the interventions in the review were designed and implemented by researchers using evidence based ‘best practice’ in a top down approach. In this innovative structure FTC was already an established programme, they had proven their efficacy and their ability to engage. The FTC programme is based on Dave’s lived experience and what worked for him when he was on his health and weight loss journey. As a result, they are not having to start from the ground up and resources can be focused on improving the programme rather than evaluating its effectiveness. The fact that FTC was already up and running is a significant factor as it has been found that research -led interventions do not appear to be sustainable in indigenous and Pacific communities. On top of that the programme is observed to be successfully embedded in the community, this is what makes it transformative and sustainable because it has been developed based on the communities needs and the socio-cultural context which has enabled a sense of community ownership over the programme.

Systems thinking, Community based participatory research approach and a Pacific worldview all prioritise and promote the importance of relationships. Relationships are integral to the functioning of the partnership. From a systems thinking perspective each organisation is seen as their own system. The relationship between stakeholders should not be underestimated and are a key characteristic to the success of the initiative.

Their model aligns with core elements of Pacific indigenous psychology as well as key elements from implementation frameworks such as the He Pikinga Waiora framework (HPW)

(Harding & Oetzel, 2019). More importantly BBMs organisation reflects the Pacific diasporic community in South Auckland, from the values, attitudes and beliefs the organisation is grounded in right through to the staff who are members of the community. The change of recruitment method between cohorts 1 and 2 further demonstrated the need for interventions targeting Pasifika to be grounded in Pasifika ways of knowing, doing and being, and community led. This is consistent with the principles of Pacific indigenous psychology that promotes the use of cultural knowledge and practices when working with Pacific communities.

Joining cultural knowledge to inform interventions

In keeping with Heke and colleagues (2019) findings, collaborating via this new governance structure provides an avenue for mainstream and government organisations to appreciate the value of approaches that are grounded in cultural knowledge and community member insights. Before the partnership FTC consisted of BBM trainers/coaches, 2 x weekly fitness classes and a nutrition and cooking session, these were once a week and alternated between nutrition education and cooking. Their progress was tracked by their weight. Upon the newly formed partnership, the structure of FTC remained unchanged, but THC provided a nurse who was able to take bloods and blood pressure. This was a key factor to mitigate risk to ensure that the participants were not putting themselves at risk. It also provided another marker for participants who may not see their weight decrease each week but have another marker to show them that their efforts are working. THC also provided health coaches. Their (THC) health coach model has been adapted from an evidence-based model with the idea of improving engagement with their services and supporting patients with their health needs. This is an example of joining cultural knowledge with support and resources from mainstream organisations. And is consistent with community based participatory research principles and cultural safety. The Ministry of Health and Total Healthcare reaching out to BBM reflect principles of community based participatory research, whereby it is a collaborative approach that involves the equal involvement of all partners (Sheikhhattari & Kamangar, 2009). CBPR paradigm recognises the need for both community involvement and the health experts, this has been evident in the partnership where THC and MoH need BBM to engage with the community.

Throughout the literature relationships and connections have been cited as key to maintaining partnerships. Relationships are also integral to the Pasifika worldview and Pasifika

communities. One of the reasons for the governance groups ability to fast pivot and adapt to improve their recruitment method was made possible because of the positive relationships between stakeholders. Relationships are the core of the partnership it is through these relationships in which the systems connect and interact. Similarly it has been through the success of the organisational partnerships whereby they were able to join the knowledge and insights from BBM with THC's strong infrastructure.

The study demonstrated the need for cultural and institutional knowledge and resources to come together to improve the health of Pasifika. What is important is that BBM's ways of knowing, doing and being are at the forefront of the partnership whilst THC and MoH use their knowledge and resources to provide infrastructure, mitigate clinical risks and ensure they are in keeping with contractual requirements. As stated before, sustainability of community interventions is the most salient issue facing community organisations implementing a primary health service. Total Healthcare's experience in the health sector has afforded them a wealth of knowledge and experience regarding the foundations and structures required to maintain a cohesive partnership and implement primary health service.

The effectiveness of service delivery is dependent on the infrastructure particularly when there are multiple stakeholders involved. Studies that have explored the sustainability of collaborative partnership have found that strong structural foundations and internal support are key features for sustainability (Alexander et al., 2003; Sibthorne et al., 2005). THC provides infrastructure support to BBM which allows BBM to focus on delivering FTC and plays to the strengths of each organisation. The implications from these findings demonstrate how cultural knowledge and institutional resources can come together to reduce health disparities by allowing communities to lead whilst mainstream organisations support Māori and Pacific organisations by using their institutional knowledge and resources.

The formation of this partnership is consistent with systems thinking whereby the joining together of government agency, primary health organisation and community organisation has created a 'horizontal' government. We know from the literature that long term conditions and obesity are complexly impacted by systems and policies, institutional barriers and interpersonal and individual behaviours. By collaborating in a 'systems approach' this partnership is able to address the problem holistically providing a bigger picture for areas where intervention is going

to be effective and sustainable. This partnership also means that when a problem arises they are able to come together to identify where improvements can be made and set them in motion. This was evident in the quick turn around between cohorts 1 and 2.

The capacity and capability that the three organisations have brought to the governance group has allowed for the process of ‘real time’ feedback and recommendations from both the researchers and learning from previous cohorts and then implementing those recommendations into the following cohort. This type of real time feedback would not be possible without the collaborative process between THC, BBM, the Ministry and the research team and the willingness of “collective good”. Additionally the relationships that have developed between members from BBM and THC have allowed for productive discussions about what is working and what needs to be improved. The significance of this can be contrasted to Harding and Oetzel’s (2019) paper where they discussed it can take up to years for interventions to be implemented into the community. This further supports investing resources and capacity into initiatives that are already implemented rather than developing initiatives from the ground up.

Conclusion

The current national health strategy wants to see more community owned, community led initiatives whilst imposing processes that community organisations like BBM do not have the capacity to jump through bureaucratic hoops. The partnership suggest that the current systems that connect community organisations with funding may not be reaching Māori and Pacific community organisations who may not have the infrastructure and capacity to ‘compete’ for funding. An implication from this finding is that despite a big focus on equity and community led initiatives, the systems and structures surrounding do not appear to allow for equitable outcomes to be achieved. This may be because the same processes that have contributed to health inequities cannot be the same processes that generate improved outcomes for Pasifika. From the government’s perspective, providing NGOs and community organisations the opportunity to acquire funding at the surface appears to be an appropriate and fair approach. What was not taken into account is the capacity and capability to correctly apply for funding. This was discussed in the talanoa with BBM. Furthermore exploring the barriers that the long term conditions team removed may be areas where further inquiry is needed to ensure the funding systems are accessible to all community organisations. Given that this study was part of

a formative evaluation of a new partnership, further exploration into the governance system after two years may help to provide insight into how much the partnership has transformed and whether this new system of 'collective-good' has provided a transformative and sustainable processes of engagement that improves health outcomes for the Pacific community.

As we can see from the various bodies of literature I have drawn from, implementing and sustaining an innovative obesity prevention intervention comes with great complexity. To conclude this research has highlighted a number of key elements; 1) prioritising and fostering relationships is the most important element to sustaining organisational partnerships. 2) It is vital that Pacific communities lead their own health initiatives. 3) It further highlighted how important it is for mainstream organisations to understand the impact of cultural worldviews when it comes to providing a service. 4) The partnership demonstrated to other mainstream organisations how they should be using their knowledge and resources to support Pacific organisation. 5) The partnership illustrated the power of communities, collectivism and relationships and how they can create transformative and sustainable change to the health outcomes of the Pacific community.

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Appendices

Appendix A: Outline of open ended questions used in talanoa and focus group interviews

1. Describe your journey in the health sector and thoughts on mental health? (everyone)
2. What does being healthy look like to you?/ What does being healthy mean to you?/
What is your understanding of health? (Everyone)
 - a. What is your understanding of the role BBM can play in helping Pasifika to achieve this standard of health? e.g. What are your thoughts on obesity? (BBM)
3. What do you think should be the ideal relationship between BBM and the MoH; and between BBM and the PHOs?
4. What are your thoughts on the Pacific providers of health (including PhOs)? Have you considered them as partners? If not, why not

TH: What is your perspective on Pasifika health providers in South Auckland?

5. Why have you chosen to form a partnership with total healthcare? (BBM)

For example:

 - a) whether there are advantages in terms of data management and financial resourcing
 - b) interested in TH health coaches training up BBM staff better understand mental health issues
 - c) would you like any support from us in terms of training up your staff to do “citizen science”? (e.g. be able to interpret survey results, get quick feedback from us on survey results?)
 - d) business potentials?

6. Do you have any concerns about the new clients that are going to be referred to you from TH? (did people come to you voluntarily previously, as opposed to cold calling hard to reach clients?)
7. How do you plan on maintaining quality care and having a significant impact as you grow and franchise? (BBM)
8. How will you review your performance? (Everyone)
 - a. We may want to have some probes if responses are too vague for 7 and 8
9. What do you value as successful? How will you measure your success? (everyone)
 - a. What will be considered a success? (everyone)
10. How has the partnership been so far?
 - a. Have you encountered any misunderstandings with other members of the governance team? (even slight?)
 - b. If not, can you foresee any issues that might be a deal-breaker in the future? i.e. you would seriously consider leaving the partnership?
 - c. had to overcome any disagreements within your management team and across your partnerships with the other organisations? And if so how have you done this?
11. If there was a major rupture/fallout in the partnership, how will you ensure BBM FROM THE COUCH clients will not be affected by possible disruptions from governance and management groups? (Everyone)
12. What is your end goal with this new partnership? (Everyone)

Appendix B: A copy of the governance report



COLLEGE OF
HUMANITIES AND
SOCIAL SCIENCES

Sustaining organisational partnerships through authentic connections and engagement

a systemic-governance approach to obesity
prevention in a complex health system

By Alosina Nua

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Alefaio-Tugia

Background

Poor access to primary care, particularly with respect to preventative healthcare for obese clients, is known to compound existing inequalities in health. As the Primary Health Organization (PHO) with the largest Pacific enrolled population in Counties Manukau, Total Healthcare (THC) noted a significant number of people who are enrolled with them, but not engaging in their services. Simultaneously, the Long term conditions team at Ministry of Health now Te Whatu Ora (TWO) also identified BBM as a community-based organization with extraordinary outreach and engagement into hard-to-reach communities. There were severe health-based inequalities that the government's Green Prescription failed to reach. Talanoa and focus group interviews with members of the governance group before the launch of the first cohort documented how these factors, together with BBM's quest for the means to reach wider into its community triggered this tripartite alliance.

A new collaborative partnership between three partners (BBM, MoH and THC) is rarely observed in NZ's public health system: bringing together three health organisations who operate at different levels. To date the primary health sector has struggled to implement culturally effective and sustainable interventions that target the inequities exacerbating obesity rates in the Pasifika population. As mentioned earlier THC and the long-term conditions team from The Ministry of Health connected with BBM in a tripartite partnership (illustrated in Figure 1) with the goal to further enhance the effectiveness of the BBM FTC programme and increase its sustainability.

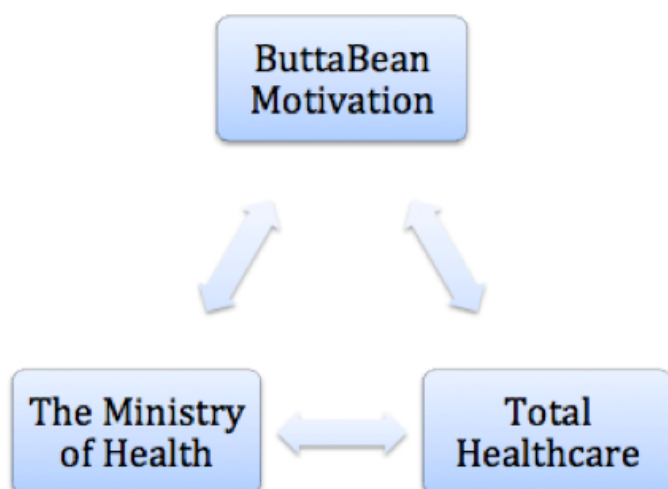


Figure 1

An illustration of the tripartite partnership

Shift in Thinking: If its Broke then Fix it

Ministry of Health now Te Whatu Ora (TWO) and Total Healthcare (THC) both recognized existing programmes were not working, and they needed to try something to reach clients as community citizens in need of prevention-focused healthcare.

Ministry of Health (Long Conditions Team)(TWO)

"our focus has been very secondary care focused ambulance at the bottom of the cliff. When you look at the data and the results, not a lot has changed, we haven't stemmed the prevalence of diabetes and other long term conditions, so you know you have to take a reflection and go we're not we're not getting the gains that we need"

"And if you think about where the need is then you have to have systems that allow those equitable outcomes to actually be realised. So projects like this should be informing what needs to change to achieve those equitable outcomes for"

"There is an increasing need for community led community driven new partnerships and new ways of working, we know that from a prevention lens"

"And that is the audience that David is able to reach and engage with who have probably been underserved by some of our traditional approaches"

"It was serendipity for the Ministry that THC was looking to work with BBM at exactly the same time, as they bring business acumen and healthcare professionals that reduce the risk for funding BBM".

Total HealthCare (THC)

“Engagement. It’s their ability to engage with patients that we can’t despite our best efforts. We know they have proven to be very effective in engaging with the community that we’ve not been great in engaging, in particular that target population that we’re going to be working with them.”

“I think the other key is he’s completely authentic. He really cares deeply about the people he interacts with him, he really wants to change people’s lives, he really wants to..just the passion emanating from him.”

Despite their best efforts, THC were struggling to engage certain clients and TWO had not stemmed the prevalence of long term conditions. This enabled both organizations to seek collaboration with BBM for a new and innovative way of engagement necessary for sustainable long-term change.

BBM’s From The Couch (FTC) Programme

A new and innovative way of engagement that starts with one’s own life journey of overcoming obesity and setting a new course trajectory for total wellbeing.

BBM Founder Dave Letele shared that *“The way this started was me and my own health journey, and I think that’s a big difference with us and other providers that it was started, you know really purely out of someone getting their own life back and then, helping others to regain their lives and help them ..not just physical but mental health.. the big part of my journey was mental health”*

And over the course of BBM’s development both as a person but more importantly as a community led organisation, this approach attracted other trainers with similar life journeys from the same, hard for the mainstream (providers such as THC) to reach communities:

“so what attracted me to be BBM was it was a movement that was centred on family.. family values was very inclusive, so I could bring my family and, at the time for me personally, I was struggling with my weight my mental health and BBM provided a safe environment for me to come not be judged, so the cultural aspect that kind of resonated really deeply with me was that you know was safe.. I could bring my kids and I was not judged and I could lose weight and you know, be supported in and around people with the same goals”

Organisational shifts towards embracing the new innovations of BBM's Digital Ecology

Despite good intentions the first recruitment cohort for this tripartite relationship did not succeed. Cold calling obese clients from the THC database resulted in 50 people agreeing to come to the gym for BBM's FTC programme, but only 10 actually turned up (and none completed the 12 week programme). By contrast, recruiting through BBM's community based social media ecology was very successful: 30 of 52 clients completed the programme, most lost weight, and almost all experienced significant improvements in mental health.

Equitable health access is not just about lowering and removing barriers, it is also about **engagement and connecting**. Qualitative studies have found that Pasifika judge their healthcare experiences based on relationality. For example many Pasifika based their experience on whether their Vā is being respected (Ryan and colleagues, 2019). Similarly Ludeke and colleagues (2012) found that prioritising and establishing a relationship from the GP had a positive impact on whether they were likely to engage in the future. In the same study, participants highlighted gestures such as the receptionist correctly pronouncing their names or being seen to make an effort to pronounce their names increased their willingness to access the GP in the future.

Key Findings

Sustaining transformational change through organisational coherence in the midst of a complex health system

Four innovative areas were identified by this study as being instrumental in demonstrating a new collaborative governance for 3 very different organisational groups. These were:

1) Prioritising and fostering the connections and relationships between organisations.

The complex, dynamic and adaptive nature of the public health system means that for a primary health initiative to be institutionally sustainable the relationships between organisations need to be prioritised and fostered. This was observed through the strong infrastructure, regular governance meetings, formal and informal means of communication, especially between THC and BBM.

- 2) Prioritising the knowledge and insights of BBM and the BBM community.** The governance group have prioritised the knowledge and insights of BBM and the BBM community. BBM's recruitment and engagement strategies cannot be replicated by a less community-oriented organization. BBM's commitment to Pasifika cultural values ensures that the governance group remains culturally centred as they provide voice for their community, and they have access to insider knowledge that allows them to understand the needs of their community. It also reinforces the importance of larger organizations having the means and the determination to be flexible enough to align with the socio-cultural needs and practices of the target community.
- 3) Participation of organisations from different levels of the public health system.** The participation of organisations from different levels of the public health system has provided the capacity, capability and resources to pivot rapidly to conditions on the ground and cover the requirements of actually implementing a partnership initiative in primary healthcare. A small organization like BBM can pivot more rapidly than a larger organization like THC, but a larger commercial organization like THC has greater resources and access to health professionals that can increase the comprehensiveness of health access and coverage. Both can pivot more rapidly than a national organization like Ministry of Health, which has the funding that can support these initiatives.
- 4) Community led as opposed to research-led.** From the Couch was already successfully up and running and the community were already engaging with their services. This is an important factor as a recent systematic review by Mack and Colleagues (2022) looked at culturally adapted weight loss prevention and intervention programmes, and found a key barrier was that the programmes would come to an end when the researchers had completed their research, preventing long term sustainability. Funding can be used to evaluate and improve capacity and

capability on a programme that has already proven to be successful, as opposed to developing a programme from the ground up.

Conclusion

implementing and sustaining an innovative obesity reduction intervention comes with great complexity. The current national health strategy wants to see more community owned, community led initiatives whilst at the same time imposing bureaucratic processes that community organisations like BBM struggle with.

The formation of this tripartite partnership is consistent with systems thinking whereby the joining together of a government agency, primary health organisation and community organisation has created a 'horizontal' government. We know from the literature that long term conditions and obesity are complexly impacted by systems and policies, institutional barriers and interpersonal and individual behaviours. By collaborating in a 'systems approach' this tripartite partnership is able to address the problem holistically providing a bigger picture for areas where intervention is going to be effective and sustainable. It also means that when a problem arises they are able to come together, identify where improvements can be made and set them in motion. This was evident in the quick turnaround between cohorts 1 and 2. The capacity and capability that the three organisations have brought to the governance group has allowed for the process of 'real time' feedback and recommendations from both the researchers and learning from previous cohorts and then implementing those recommendations into the following cohort. This type of real time feedback would not be possible without an effective and collaborative governance process between THC, BBM, MoH and the research team. Additionally, the relationships that have developed between members from BBM and THC have allowed for productive discussions about what is working and what needs to be improved. The significance of this can be contrasted to Harding and Oetzel's (2019) review where they found it can take years for interventions to be implemented into indigenous communities. This further supports investing resources and capacity into initiatives that are already implemented rather than developing initiatives from the ground up.

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