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**WHAKAWHIRINAKITANGA AHUA:
EXPLORING A MĀORI MODEL OF
HEALTH SERVICE DELIVERY**

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Abstract

Māori health service delivery is underpinned by Māori tikanga, philosophies, values and processes; and Māori providers have consistently developed and delivered tikanga-based services to meet the needs of Māori and whānau. This thesis explored a Māori model of health service delivery, Whakawhirinakitanga Ahua, developed by an iwi health provider, Best Care (Whakapai Hauora) Charitable Trust. It aimed to uncover if health service delivery was reflective of the model, and if it addressed the health needs of Māori accessing services at Whakapai Hauora. This research was undertaken within the interpretivist paradigm using qualitative methods aligned to Māori-centred research. It drew upon the experiences, attitudes and beliefs of 50 key informants; health professionals (Māori and non-Māori) who delivered services and Māori who accessed services at Whakapai Hauora. The primary focus is on collaborative processes involved in the delivery of integrated health care. Findings in this research indicated how Māori and non-Māori work together in a Māori health environment, how they work with clients and whānau, and also at the interface with mainstream services. It demonstrated how Māori utilise tikanga-based service delivery in the provision of care to individuals and whānau; and how non-Māori working at Whakapai Hauora utilise significant aspects of tikanga-based and Treaty principles in service delivery, in response to Māori health interests within the context of Government health priorities and social policy. This thesis draws a distinction between client-centred care and whānau focused care. While client-centred practice has been a widely accepted philosophy in holistic approaches to care, whānau focused care places whānau central to all service delivery processes. It challenges health professionals to reconsider the way in which they engage with Māori and whānau, shifting mindsets from working with individuals to whānau as a collective. It challenges health professionals to acknowledge the wider environment and the determinants that impact on health and wellbeing. This thesis also acknowledges the expertise and strengths from both Te Ao Māori and Te Ao Pākehā, and highlights the significance of health professionals having to walk in both worlds in order to facilitate better outcomes for Māori.

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Glossary of Māori words

ahua:	to form, make
aroha:	love
aromatawai:	assessment
awa:	river
awhi:	embrace
hapu:	sub-tribe, clan
hauora:	health, wellbeing; health centre
hinengaro:	mind, mental
hōhā:	bored, annoyed
iwi:	tribe, nation
ihi:	the power
kai:	food
kaimahi:	worker, employee
kanohi ki te kanohi:	face to face
kapa haka:	Māori cultural performance
karakia:	prayer
kaumātua:	elder
kaupapa:	strategy, theme
kawa:	protocol, etiquette
korero:	speak, narrative
koro:	grandfather

kotahitanga:	unity, collective oneness
kuia:	elderly woman, grandmother
kupu:	talk, statement, discussion
Kura Kaupapa:	Māori language immersion school
mana:	prestige
manaaki/manaakitia:	to care for, show respect
manaakitanga:	entertain, hospitality, generosity
manuhiri:	visitor
marae:	meeting area of a village or settlement including its buildings and courtyards
mātauranga:	knowledge, education, information
mihimihi:	a greeting to welcome visitors
mokopuna/moko:	grandchild
nga kete o te mātauranga:	the baskets of knowledge
noa:	free from tapu
ora:	to be alive, well, safe
Pākehā:	non-Māori, European, Caucasian
pakeke:	adult
powhiri:	welcome, opening ceremony
puku:	stomach
pupuri taonga:	the capacity for guardianship
rangatahi:	youth
raranga:	to weave, weaving
taha Māori :	a Māori perspective

tamariki:	child
tangata whenua:	people of the land
tangata whaiora:	mental health consumers
tapu:	sacred, forbidden
tauwiwi:	non-Māori, foreigner
tautoko:	to support, to advocate, to agree
Te Ao Māori:	the Māori world
Te Ao Pākehā:	the non-Māori world
te reo:	the language
Te Whare Tapa Wha:	Māori model of health developed by Dr. Mason Durie
tika:	to be true, correct
tikanga:	protocols, practices, customs
tinana:	body, physical
tino rangatiratanga:	self-determination, sovereignty
tohunga:	a skilled person in healing
tohatohatia:	the capacity to share
tūpuna:	ancestor
tūrangawaewae:	a place to stand and belong
waiata:	song
wairua:	spirit, attitude
wairuatanga:	spirituality
waka:	canoe
wana:	the authority

wehi:	to be awesome
whakamā:	shy, ashamed, embarrassed
whakamana:	the capacity to empower
whakatuaki:	proverb
whakapapa:	genealogy
whakapiki tangata:	empowerment
whakapono:	faith, trust
whakatakoto tikanga:	the capacity to plan ahead
whakatuia:	integration
whakawhanaungatanga:	coming together as a family/group
whānau:	family
whānau pohara:	restricted family
whānau tukino:	unsafe family
whānau tumokemoke:	overwhelmed family
whānau wewete:	laissez-faire family
whanaungatanga:	relationship, kinship
wharenui:	main building of a marae where guests are accommodated
whenua:	land

Glossary of Abbreviations

AOD	Alcohol and Other Drug
BSMC	Better Sooner More Convenient (Care)
CBG Research	(Carol Boustead & Barry Gribben) Research
CEO	Chief Executive Officer
COPC	Community Orientated Primary Care
CYFS	Child Youth and Family Services
DHB(s)	District Health Board(s)
DNA	Do (Did) Not Attend
GP(s)	General Practitioner(s)
IFHC(s)	Integrated Family Health Centre(s)
IT	Information Technology
MDHB	MidCentral District Health Board
MOU	Memorandum of Understanding
MPDS	Māori Provider Development Scheme
PHO(s)	Primary Health Care Organisation(s)
RHA(s)	Regional Health Authority(s)
TMI	Tānenuiārangi Manawatū Inc.

Chapter One

Introduction

An introduction to this research

Mainstream¹ health service delivery has not been effective for Māori.. One reason for this is that Māori views of health and wellbeing differ from mainstream; typically holistic, views encompass physical, spiritual, mental and whānau wellbeing. There is also increasing evidence that suggests differences between access to primary and secondary health care services among Māori and Non-Māori (Russell et al (2013); Ellison-Loschmann and Pearce, 2006; Reid and Robson, 2006). Health reforms in the 1990s focussed on promoting and encouraging cooperation with better collaboration among providers towards achieving integrated health care. These reforms also saw the emergence of Māori health providers, mainly within the primary health care sector where services were developed by Māori for Māori with the intent to reduce Māori health disparities. For Māori health providers, cultural concepts and practices have been key components in health service delivery. Over the past decade, whānau ora (the wellbeing of whānau) has emerged as a key concept of Māori health and wellbeing, rather than the health of individuals, as the wellbeing of whānau impacts on an individual and vice versa.

This thesis is an exploration of a Māori model of health service delivery, Whakawhirinakitanga Ahua, developed by an iwi health provider, Best Care Whakapai Hauora Charitable Trust. Health service delivery is underpinned by Whakawhirinakitanga Ahua, to facilitate whānau ora. This thesis aims to examine core values and key concepts underpinning this model. This is intended to provide insight into the practiced principles of health service delivery at Whakapai Hauora. It attempts to identify the collaborative processes involved in health service delivery and also to establish possible improvements to Whakawhirinakitanga Ahua.

¹ Mainstream refers to services or systems which are intended for the population as a whole.

Background to this study

In 2003, after four years as a practice nurse at Whakapai Hauora, I was ready for further challenges and transitioned into community health nursing within the organisation. At that time, I realised that most of my relationships established with Māori and whānau were within the confines of a clinic room where I would provide health education and nursing care for illnesses that were more likely preventable. Often there was a feeling of being ‘the ambulance at the bottom of the cliff’ or that I was ‘putting a sticking plaster’ on things, rather than being able to help with related underlying causes of ill-health. While health education is key to early intervention and disease prevention, there are also other significant factors that impact on the ability of people which either prevent or allow them to act; as social, cultural and economic determinants of health play a major role in the health and wellbeing of communities (National Health Committee, 1998). I was also challenged by the desire to develop stronger relationships with Māori communities and networks, and to be more adaptable towards meeting the health needs of those that I had nursed in the community.

Whakawhirinakitanga Ahua was developed in 2004, the following year by management. This model is based on intersectoral² collaboration towards a multidisciplinary³ approach in addressing the health needs of individuals and their whānau towards achieving whanau ora. My contribution and participation towards its development during this time was at a grassroots⁴ level; with other co-workers, we provided feedback to management in terms of how we utilised Māori models of health in practice. It was also at this time that I took over managing quality systems at Whakapai Hauora and in 2005, moved into the role of health manager, which is still currently my position within the organisation.

² means working with more than one sector of society to take action on an area of shared interest. In this instance it refers to services across the sector, including wider related supports (e.g. education, social welfare, justice, housing, etc.).

³ This approach requires a team of health and other professionals to work together to deliver services to a patient. It includes representatives from of various disciplines who coordinate the contributions of each profession to prevent overlaps, and streamline the provision of care.

⁴ Workers as distinct from the active leadership of an organization.

The rationale for this study

Collaborative health service delivery among providers is integral towards achieving healthcare integration. Despite integrated care being an important aspect of 1990s health reforms (Kiro, 1998), the extent of integrative healthcare in New Zealand is still relatively unknown (Cumming, 2011; Reid, 2007; Rea et al, 2007).

Furthermore, there is limited published data on the beneficial impacts relating to health outcomes of integrated care models (Smith and Ovenden, 2007). In terms of healthcare for Māori, the application of Māori health models towards the development and delivery of health services is imperative; Māori desire tino rangatiratanga over the direction and shape of their health services as Māori concepts of health differ to mainstream ideas (Durie, 1998a; Dansy, 1995; Murchie, 1984). There are also fundamental differences in approaches towards health service delivery between Māori and mainstream providers (Cram, Smith and Johnstone, 2003). Māori views of integrated care go beyond the scope of providing coordinated health services for people to include social, housing, justice and education in order to address the wider determinants of health. Factors that have significantly affected Māori health status include the socioeconomic environment, health behaviours and access to appropriate health care (Lomax, 1999).

While the current health system continues towards healthcare integration with greater emphasis on collaboration among service providers, integrated care has been described as being fragmented with a lack of coordination which Cumming (2011) stated, has been attributed to a wide range of professionals and providers involved in the delivery of care, the lack of effective communication and liaison between professionals and providers. As Whakawhirinakitanga Ahua is a collaborative model of health service delivery, exploring it will provide a deeper insight into Māori health concepts and whānau ora from the perspectives of health professionals⁵ who work at Whakapai Hauora and Māori clients who access services at Whakapai Hauora. It will also give a deeper insight into collaborative processes involved in the delivery of integrated care for Māori.

⁵ Health professionals at Whakapai Hauora include doctors, nurses, counsellors, social workers and community health workers.

These are important areas for research to address, particularly in the provision and delivery of health services for Māori. Findings may signal clearer pathways towards achieving better integration between Māori and mainstream services. Results will assist Whakapai Hauora to improve and enhance service delivery towards achieving better outcomes for Māori and whanau accessing services.

The aims and objectives of this study

The research questions:

The broad research questions this study sets out to answer are:

- is Whakawhirinakitanga Ahua reflective of health service delivery at Whakapai Hauora, and
- as a collaborative model, does it address the health needs of Māori accessing services at Whakapai Hauora?

The overall aims are to:

- explore the core values, fundamental principles and key concepts of the model by investigating the processes of health service delivery at Whakapai Hauora,
- draw upon the experiences, attitudes and beliefs of key informants in order to determine if the key concepts of the model assist to facilitate collaborative health service delivery, and establish possible improvements to the model.

In order to attempt to answer these broad questions, some further questions needed to be considered. These are:

- what are the core values underpinning Whakawhirinakitanga Ahua in health service delivery?
- what are the practiced principles relating to health service delivery at Whakapai Hauora?
- what are the collaborative processes involved in health service delivery at Whakapai Hauora?
- does collaborative health service delivery assist in achieving health outcomes for Māori?

Parameters of this thesis

This thesis describes health service delivery based on a Māori conceptual framework that characterises the way in which services are delivered at Whakapai Hauora; as service delivery is an expression of Māori values and belief systems. This thesis explores the collaborative processes involved in service delivery towards integrating care at a micro⁶ and meso⁷ level; it concerns the extent of engagement between Whakapai Hauora health professionals, Māori health consumers and their whānau, other health service providers (mostly mainstream) and wider related support services⁸. This thesis describes service delivery processes that are unique to Māori, from the perspective of 19 health professionals at Whakapai Hauora and 31 Māori clients who access services at Whakapai Hauora. Findings in this study are derived from primary and secondary sources of data, including my own observations during interviews. This research, while concerned with collaboration towards integrated healthcare, does not include an examination of collaborative processes at an organisation to organisation level, funding or contractual arrangement (macro) levels. This research explores Whakawhirinakitanga Ahua which is model of health service delivery aimed at achieving the aspirational goal of whānau ora for Māori accessing integrated healthcare at Whakapai Hauora as well as external service providers.

Organisation of this thesis

This thesis is organised into nine chapters:

Chapter Two, *Literature Review* canvases Māori health and wellbeing perspectives and the current state of Māori health. Movement and changes in the New Zealand health sector are described covering critical aspects of Māori development and the health reforms of the 90s. Concepts of integrated care, the current state of integrated care in New Zealand and Māori views of integrated care are discussed. The final section in this chapter covers Māori health providers and Whānau Ora integrated services. It also discusses moving towards outcomes-based service delivery and highlights the significance of Māori and mainstream alliances.

⁶ Collaborative activities within a single organisation

⁷ Working activities that promote collaboration between practitioners in different organisations

⁸ Wider related support services generally refer to social welfare, housing, justice, counselling and education –based community support services.

Chapter Three, *The Research Methodology* discusses the theoretical perspectives that frame the research design providing the basis for the use of qualitative enquiry aligned to Māori-centred research which is the methodology used in this study. It also covers the ethics of Māori research, and my position in this study as an indigenous, non-Māori undertaking health research within a Māori health context.

Chapter Four, *The Research Methods* outlines the methods used to collect and analyse the data for this study, the rigour of this research, ethics, and the dissemination of information. It also discusses key concepts of culturally safe practice involved in conducting this research.

Chapter Five, *Best Care Whakapai Hauora Charitable Trust* incorporates the synthesis of secondary sources of data collected for purposes of this research to provide an overview of the organisation, its structure, vision, and philosophy as an iwi provider of health, social and disability support services. It also discusses whānau ora from the perspective of Whakapai Hauora and describes Whakawhirinakitanga Ahua, its model of health service delivery developed in 2004, which is explored in this research.

Chapter Six, *It's all about Collective Care* presents the data collected from health professionals (respondents) delivering health, social and disability support services. Findings are based on their experiences, views and beliefs of health service delivery at Whakapai Hauora. It concludes with a framework from which both Māori and non-Māori operate at Whakapai Hauora when delivering services to clients and whānau.

Chapter Seven, *They should walk a mile in my shoes* presents the data collected from Māori clients who accessed a range of health, social and disability support services at Whakapai Hauora including other primary, secondary and wider related support services. It presents the findings from individual and group interviews (consisting of couples who were whānau) based on their experiences, views and beliefs along their journey through a continuum of health care.

Chapter Eight, *Weaving the research findings together* draws upon the data presented in Chapters Six and Seven. It weaves together the themes to present insights into findings. This chapter covers the main themes which provide a deeper insight into Whakawhirinakitanga Ahua, outlining the initial drivers of service delivery at Whakapai Hauora.

Chapter Nine, *Discussion* considers the influences that impact on health service delivery for Māori and explores the model in relation to whānau ora principles, values and aims. It answers the broad research questions highlighting pathways towards collaborative care in order to achieve the aspirational goal of whānau ora. It discusses the possibility of improvements to the model; it also considers what this research challenges, its strengths and limitations, and concludes by reviewing the overall aims of this study.

Chapter Two

Literature Review

Introduction to the literature

This chapter presents an overview of Māori health service delivery in New Zealand. It provides a backdrop to this study and the context for this research, which explores Whakawhirinakitanga Ahua, a Māori model of health service delivery and the collaborative processes involved towards achieving integrated care. The literature presented here is divided into four sections:

Section 1: Māori health and wellbeing. This section begins with an overview of Māori as Tangata Whenua, and how Māori conceptualise health and wellbeing. It looks at the current state of Māori health in New Zealand and socio-economic disparities in contemporary Māori society. It highlights the relationship between Māori and the Crown under the Treaty of Waitangi, the Treaty principles and its application in health service delivery for Māori.

Section 2: Movements and changes in the health sector. This section continues from the previous section to look at influential factors that had significant impacts for Māori health and wellbeing; the decades of Māori development and New Zealand health reforms of the 1990s which occurred simultaneously. At the time, Māori desire for greater control over their own health and wellbeing concurred with the government agenda of devolution of health services to Māori providers, community groups and NGOs. This created the avenue for Māori to develop and deliver services by Māori for Māori. Three key documents in the early 2000s that paved the way for further primary health care reforms are discussed leading the current government health initiatives, Better Sooner More Convenient Care and the Whānau Ora environment which focus on greater collaboration among health service providers, the integration of primary and secondary care, and Māori health advancement.

Section 3: Collaboration. This section discusses differences between ‘collaborative care’ and ‘integrated care’, and reviews international literature on various models of integrated care. It also looks at the current state of integrated care in New Zealand, Māori views of integrated care and the whānau ora environment.

Section 4: Māori health providers. This section continues from the previous section of literature in relation to Māori views of integrated care. It looks at whānau ora integrated services and the move from outputs to outcomes-based service delivery. It also highlights the significance of Māori and mainstream alliances in relation to the delivery of integrated care.

1. Māori health and wellbeing

“Tangata Whenua”

Māori refer to themselves as “tangata whenua” (people of the land). The notion of tangata whenua refers to a direct genealogy link to the land that requires people to live in harmony with nature (Ngata as cited in Sorrensen, 1986) and places an emphasis on reciprocal relationships between all living things (Mikaere, 1994). This worldview, or understanding of the natural world prioritises ethics such as preservation and conservation (Durie, 1998a), respect and balance (Patterson, 1992) and collectiveness and kinship (Pere, 1994). Therefore a Māori worldview is concerned with the interconnectedness and interdependence of all things. Making and affirming connections are a significant theme in many Māori creation narratives; through whakapapa (genealogy), tangata whenua are connected to the land, stars, animals, plants and the universe. For Māori, whakapapa has been described as being a fundamental way of knowing as to how we are all connected; it informs relationships (Walker, 1993).

Te Ao Māori (the Māori world) is based on the interaction between the spiritual and physical realms; myths and legends are also central to fundamental knowledge as these provide a framework for a basis of realities perceived (Marsden and Henare, 1992). Māori beliefs concerning knowledge are contained within the legend of the

three kete (baskets) of knowledge (Tua-uri, Aro-nui and Tua-Atea) obtained by Tane (a higher being) in his quest for knowledge (Marsden and Henare (1992). According to Marsden and Henare (p: 8): Tua-uri contains knowledge that comes from “*beyond, in the world of darkness*”, which is considered as the “*real world*”; Te Aro-Nui, the kete of secular knowledge corresponds to the “*natural world*” that surrounds us and perceived by our senses; and Tua-Atea, “*the world beyond space and time*” is infinite and eternal, it is the spiritual realm of Io (the supreme god). Marsden and Henare (1992, p: 11) stated that “*the eternal world of spirit is ultimate reality*”. Te Ao Māori is holistic and Māori see the spiritual and physical worlds as being interlinked. Te Ao Māori conceptualises health and wellbeing in a holistic way. In a contemporary context, Māori models of health such as Whare Tapa Wha⁹ (Durie, 1998a) and Te Wheke¹⁰ (Pere, 1984) emphasise a holistic approach. Also, tikanga (protocols, practices and customs) and customary values are key elements of health and wellbeing for Māori as a person’s understanding of health and illness is intricately associated with cultural values and beliefs (Holdaway, 2002). These holistic views to health and wellbeing have implications towards approaches to health service delivery for Māori.

A common experience among indigenous peoples such as Māori is the effects of colonisation that brought about disease and oppression, loss of land and culture, and assimilation into western culture which have had long lasting effects on indigenous people till this day, and the next section reviews the current state of Māori health and wellbeing.

⁹ Also referred to as the Four Cornerstones of Health, depicting four main pillars that support the basic structure of a whare. Each pillar is significant to the dimensions of physical, mental, spiritual and whānau wellbeing. All four cornerstones must be in balance in order to attain wellbeing.

¹⁰ Developed by Rose Pere, this model represents an octopus with eight tentacles and is used to define the health of whanau. The head is symbolic of whanau, the eyes of the octopus represent waiora (total wellbeing for the individual and whanau) and each of the eight tentacles depicts a specific dimension of health: wairuatanga (spirituality), taha tinana (physical wellbeing), hinengaro (the mind), whanaungatanga (extended whanau), mana ake (the consequences of each individual and whanau), mauri (life force), ha a koro ma a kui ma (the breath of life from our tipuna) and whatumanawa (the open and healthy expression of emotion). Each dimension is interwoven representing the close relationship of the tentacles.

The current state of Māori health and wellbeing

Contemporary Māori society is diverse as Māori live in a wide range of cultural, social and economic realities (Durie, 1995). The determinants having the greatest influence on health are income and poverty, employment and occupation, education, housing, and culture and ethnicity (Public Health Advisory Committee, 1998). Those in the lowest socio-economic group consistently have the poorest health status and Māori mostly fall into this group (Public Health Advisory Committee, 2004). Government policies and legislation continue to affect all people living in New Zealand and disparities exist between Māori and non-Māori, most conspicuously in areas of health, income, education, employment, housing (Ministry of Health, 2010a), and criminal justice status (Durie et al, 2010). Despite Māori health gains in life expectancy over the last four decades, Māori health continues to lag behind non-Māori. In 2012, Māori made up 15.4 percent of New Zealand's population with noticeable changes in the over 80s age group (Statistics New Zealand, 2012); there are twice as many Māori in this age bracket compared to 2002. It is projected that the Māori population as a whole will increase by 28 percent in 2021. These demographic changes have major implications for the provision of health, education, housing and employment.

In terms of Māori health trends, the Ministry of Health (2013) published a paper which presented key findings from the New Zealand Health Survey 2011/12. In summary, it stated that: Māori have higher obesity rates; two in five Māori adults smoke; Māori have higher rates in ischaemic heart disease, stroke, diabetes, asthma, high blood pressure, chronic pain and arthritis; Māori adults have a higher rate of mental distress. Māori are more likely to have teeth removed due to poor oral health. The paper also noted that Māori have a higher level of unmet needs in healthcare related to cost; a significant percentage of Māori (including children) did not have their prescriptions filled in the previous year due to cost. The current disparities and health statistics continue to reinforce the need for government to address Māori health needs and the next section in this literature review looks at the Treaty of Waitangi in relation to Māori health and wellbeing.

The Treaty of Waitangi

The Treaty of Waitangi signed in February 1840 by representatives of the Crown and Māori chiefs has been described as the founding document of New Zealand. The Treaty establishes the relationship between the Crown and Māori. Three main articles in the Treaty form the basis for this relationship: under Article 1 of the Treaty, the Crown was given ‘kawanatanga’ (the right to govern) and to establish rules and laws as a society. Under Article 2 of the Treaty, Māori retained the right to tino rangatiratanga i.e. their sovereignty, status and authority over their land and all that that was considered as taonga (treasures). The English version of the Treaty refers to their land, fisheries or forests. However to Māori, their culture, knowledge, language, health and wellbeing are also considered as taonga. Under Article 3 of the Treaty, Māori were given equal rights and privileges as British subjects. In terms of health and wellbeing, this assures that Māori have the same level of health status as non-Māori with equal access to health and wider related support services. Durie (2001) stated that socio-economic disparities such as poverty derived from low income, poor standards of housing or poor health status are inequalities which indicate a breach of Article 3 provisions.

The Treaty principles, endorsed by the Royal Commission on Social Policy (1988) are partnership, participation and protection which emerged from both Māori and English versions of the text. These principles are particularly relevant to Māori health and underpin the relationship between the Crown and Māori (Ministry of Health, 2002, p: 2). Partnership is basis for Crown and Māori working in partnership to develop strategies towards Māori health gains and appropriate health and disability services. Participation recognises Māori rights to practice health within Māori culture and is basis for Māori to be involved at all levels of the health sector (Māori are active in decision-making, planning, development and delivery of services). Protection is the basis for the Crown to work towards ensuring that Māori have equitable levels of health to non-Māori. Protection also concerns the safeguard of Māori cultural concepts, values and practices. This special relationship between the Crown and Māori is acknowledged in key health policy documents, the New Zealand Health Strategy (Ministry of Health, 2000), the Primary Health Care Strategy (Ministry of

Health, 2001) and The New Zealand Disability Strategy (Ministry of Health 2001). The Treaty principles are embedded in He Korowai Oranga, the Māori Health Strategy (Ministry of Health, 2002). In this way, the Treaty has been fundamental in responding to Māori health needs and enabling positive health change.

The next section looks at events that occurred simultaneously in the 90s and 2000s that resulted in significant change in the health care system and paved the way for the development of health services by Māori for Māori, the provision of integrated care and Whānau Ora services.

2. Movement and Changes in the Health Sector

This section of literature looks at changes that occurred in the health sector over the past two decades. A process of “*radical societal change*” (Durie, 1998b, p: 11) occurred in New Zealand from the mid-80s onwards. Reforms led by government redesigned structures and processes of public services such as health, welfare and education. Reforms were meant to improve efficiency, reduce expenditure, to improve managerial accountability and public health sector responsiveness to New Zealanders. While government moved towards the privatisation of health service delivery in the 90s, changes also occurred simultaneously for Māori with the demand for mainstream health services to be more responsive to Māori needs. There was also a greater desire by Māori for tino rangatiratanga; to have control over their own health and wellbeing. As these agendas were aligning simultaneously, they created the opportunity for Māori to enter into health service delivery; to develop and deliver services by Māori for Māori based on Māori concepts and a Māori worldview. In the early 2000s government introduced key policy documents that acknowledged the Treaty of Waitangi placing a greater emphasis on Treaty principles in health service delivery for Māori.

Decades of Māori development

Tino rangatiratanga, assured in the Treaty, underpins Māori hopes and aspirations; the right to self-determination has been critical in guiding Māori initiatives towards control over their lives and their health and wellbeing. The first 1984 Hui Taumata¹¹ launched a decade of Māori development which signalled a stronger focus on approaches to Māori social, cultural and economic advancement. Hui Taumata took Māori in new directions placing greater emphasis on commercial awareness, better use of resources and active participation in education and the economy on a national level (Durie, 1998b). Iwi development was the preferred mechanism for Māori development due to the devolution of many government functions to various iwi authorities (Durie, 1998b). For example, Matua Whangai¹², Maccess Training Programs¹³ and Mana Enterprises¹⁴ were delivered and managed by Māori utilising Māori resources and skills. At the conclusion of Hui Taumata, six themes centring on positive Māori development arose: the Treaty of Waitangi, tino rangatiratanga, iwi development, economic self-reliance, social equity and cultural advancement (Durie, 1998b). The first Hui Taumata in 1984 also set the basis for the following two decades which led to Māori economic and cultural renaissance (Durie, 2005).

According to Durie (2001), it was evident that the connection between health and the position of Māori in society (social, economic and political) had a direct bearing on Māori health status. Therefore, Māori health needed to be viewed within the context of broader aims of Māori development. The second Māori Economic Summit Conference (Hui Taumata 2005) aimed at celebrating Māori achievement over the past 20 years and also, to empower Māori thoughts towards developing strategies that would expand Māori economic pathways over the next 20 years. The 2005 Hui Taumata *“focussed on economic development through the lens of people, assets and enterprise”* (Durie, 2005, p: 2) which centred on the future: concern for whānau as well as iwi; engagement in collaborative networks; governance and leadership; and a

¹¹ In October 1984 a Hui Taumata (Māori Economic Summit Conference) was held at parliament. Convened jointly by the Ministers of Māori Affairs and Finance, chaired by Professor Ngātata Love. It was specifically to give impetus to a Māori-focused economy due to the growing socio-economic gap between Māori and Pākehā (European New Zealanders). It set a path for Māori economic development over the next twenty years and focused on advancing Māori economic, social and cultural development.

¹² The Maatua Whāngai (‘foster parenting’) programme launched in 1983 substituted interventions made by the Department of Social Welfare in the lives of Māori children and young people with caring networks within whānau, hapū, iwi.

¹³ Developed to provide Māori Trust Boards with the means to establish and deliver skills-training programs to the unemployed.

¹⁴ An enterprise scheme designed to fund entrepreneurial development.

greater emphasis on Māori outcomes. Unlike the 1984 Hui, reference to the Treaty of Waitangi was minimal, in relation to the state, either as a partner in development or as a funder of choice. Durie (2005) also noted that while developments had occurred at iwi and hapū levels over the past decades, many whānau had little benefit from iwi economic gains. Causes were due to tribal priorities being different to whānau needs.

Mechanisms required for iwi development differed to what was necessary for developing whānau capacity; to care for whānau members, transmission of culture, to plan and create wealth, and to successfully manage whānau estates (Durie, 2005). Durie also reiterated the significance of whānau potential in terms of being the gateway to Te Ao Māori as they are an integral aspect of a system based on cultural values and a distinctive heritage. He urged developing whānau specific strategies for cultural and economic goals to be achieved at whānau levels. Durie (2005) noted that although some Māori may not have links to their hapū or iwi, they are very much part of a whānau and therefore whānau development must be a priority for building Māori capacity. During these decades of Māori development, major health reforms were also occurring, and the next section covers literature on these reforms and impacts on Māori health providers.

Health reforms of the 90s and the emergence of Māori health providers

There is extensive literature on the New Zealand health reforms of the 90s that document major changes to the health and disability support service sector¹⁵. The privatisation of health service delivery in 1993, were turbulent times due to major structural changes that occurred within a short span of time such as the introduction of market-type incentives whereby public and private providers could compete for service contracts from public purchasers (Ashton, 2005). Durie (1998a) suggested that efficiency and value for money were fundamental factors effecting purchase decisions made by four Regional Health Authorities (RHAs) at the time creating a competitive environment with opportunities for other community-based health providers to enter into direct contracts with RHAs. This in turn, generated a significant increase in contracts for services and public providers were no longer

¹⁵ See for example: Ashton and Tenbense (2010), Ashton (2005) and Durie (1998b).

privileged to access public funds over similar private providers (Easton, 2002). It also paved the way for the emergence and growth of health services developed, owned and provided by Māori for Māori.

The devolution of health services to Māori providers, community groups and NGOs (Non-Government Organisations) had the potential to make services more responsive and accessible to the needs of Māori and local communities. Devolution also concurred with Māori ambitions of tino rangatiratanga which was a focus of the 1984 Hui Taumata; autonomy to develop and deliver their own services underpinned by Māori concepts and a Māori worldview. In 1996 further changes occurred with the establishment of one purchaser, the Health Funding Authority, assuring national levels of consistency in access to services focussing on promoting and encouraging cooperation (Cumming and Mays, 2002).

Subsequent changes in November 1999 promoted an emphasis on greater collaboration among health providers and the integration of primary and secondary health care¹⁶ services. In 2001, health reforms continued with the implementation of the New Zealand Public Health and Disability Act 2000 which was instrumental in creating 21 District Health Boards (DHBs) with a population based health approach. This signalled for greater public participation towards identification and decision-making processes involved in local community health needs. The Act states that DHBs must establish and maintain processes for Māori participation and contribution towards strategies that will improve Māori health; this also represents the inclusion of the Treaty in social policy legislation that incorporates Māori decision-making in health and disability services (Boulton, 2005). This brought forth Māori representation on DHB boards of governance and at all levels of service delivery. Durie (2005) stated that within a decade, Māori had become major participants, effectively entering into health service delivery which was previously the monopoly of the state and professional communities.

¹⁶ Secondary care refers to a service delivered by medical specialists who usually are not a first point of contact for patients. Secondary care is usually delivered in hospitals or clinics and patients are referred to secondary care by their primary care provider (usually their GPs and in some instances primary care or practice nurses).

Kiro (2001) claimed that there were many challenges faced by Māori providers; they needed to rapidly learn about new roles in governance, management, negotiation and liaison. There were contracting issues and a high turnover in management staff due to the huge demands placed on these positions particularly between 1993 and 1996 of provider establishment. There were also shortages in clinical and management expertise that required long-term strategic workforce development to resolve. Despite these challenges, Māori providers had a significant contribution to make the health sector in terms of their well-established knowledge of local communities, social commitments to joint programmes with iwi and other community groups, their own experience in the field of health promotion, the use of Te Reo and tikanga and their commitment to positive Māori health outcomes (Kiro, 2001).

Māori health service delivery advanced mainly in the areas of primary health care, public health promotion, mental health, and disability (Ringold, 2005). A key feature of Māori primary health care services is that they are developed from within the communities they serve, with good background knowledge of the needs of their own communities (Crengle, 2000). Services have been delivered by a diverse range of Māori organisations including iwi, hapū and urban Māori groups including organisations within Māori communities not associated with iwi, hapū or urban Māori groups. Crengle (2000) suggested that despite these diversities, they are all governed by Māori and have structures and systems that enable community participation in the development and function of services, accountability to their communities and a forum for community health concerns to be raised. These mechanisms are particularly important for Māori, as Māori health concerns are far ranging, encompassing the wider social determinants of health. In order to address these wider issues, collaboration with other providers, mainstream and wider related support services has also been crucial in terms of Māori primary care service delivery and reducing inequities. Key government policies have also influenced health services for Māori. The next section looks at literature pertaining to four key documents in the early 2000s that paved the way for further reforms.

Strategic developments in the early 2000s

The New Zealand Health Care Strategy (2000) identified priority health areas and the direction of health services for the population, targeting health inequalities. It set goals and priorities which included Māori development and advancement in health. Main objectives were to build Māori capacity in the health sector; for Māori communities to identify and provide for their own needs; and to foster and support Māori health workforce development. This key document also identified that tackling inequalities would require government departments and agencies working collaboratively across sectors with community engagement. The New Zealand Disability Strategy (2001) set out a long term plan to augment the full participation of disabled people in society. It gave a framework guiding government agencies creating policy and services impacting on the disabled. It acknowledged the Treaty of Waitangi in relation to the special relationship between Māori and the Crown and the implementation of Treaty principles emphasising Māori participation at all levels, partnerships in service delivery and protection and improvement in Māori health and wellbeing.

The Primary Health Care Strategy (2001) focussed significantly on the development of primary health care with six key directions (Smith, 2009): working with communities and enrolled populations; the identification and reduction of health inequalities; the development of comprehensive health services; coordinating care across services (including primary, secondary care and allied health care); the development of the primary health care workforce; and the use of crucial information from enrolled populations to improve public and primary health care interventions. The Strategy also established a network of Primary Health Organisations (PHOs), to design and coordinate the delivery of primary health care.

Alongside these changes, a separate Māori health strategy was developed. He Korowai Oranga (The Māori Health Strategy, 2002). It required Crown agencies and Treaty partners to work together and placed whānau at the center of public policy; the aim being whānau ora. This key policy document set a new direction for Māori health with a purpose to affirm Māori models of health and disability and improve Māori health outcomes. A common theme throughout this strategy was to reduce

inequalities in health and disability outcomes, with improved access to services. Recognizing both Māori and Government aspirations and contributions, it provided pathways for action: the development of whānau, hapu, iwi and Māori communities; active Māori participation at all levels of the health and disability sector; to ensure that whānau receive effective health and disability services; and to effectively work across sectors in order to address the determinants of health (Ministry of Health, 2002).

‘Better Sooner More Convenient’ primary health care

Further changes towards the end of the 2000s shifted to new models of care which were patient centred-care and aimed at delivering seamless care across primary, secondary and community based services. This entailed the greater use of primary and community-based care being ‘closer to home’. Cumming (2011) stated that these reforms led to further major changes such as the amalgamation of smaller PHOs with bigger PHOs from approximately 80 to 36 in 2010. Alliances were to be formed consisting of a single governing body with an integrated management structure using alliance contracting mechanisms for proposals. Alliances are to collaborate innovatively to plan and deliver new services. Through funding and services being devolved from DHBs (District Health Boards) into the community, each alliance plans to deliver particular initiatives that will improve care coordination between primary care providers and hospitals, the development of integrated family health centres, multidisciplinary teams and an increase in nurse led services.

The ‘Better, Sooner, More Convenient Health Care’ initiative introduced in 2009 facilitated the creation of Integrated Family Health Centres (IFHCs). The development of IFHCs aim to tackle an aging population, doctor shortages, and to reduce the demands placed on hospital emergency services by making secondary care easily accessible. It also seeks to improve integration across different types of primary health care services as well as improve the interface between primary and secondary health care services. With the focus on preventative care, particularly for those with chronic illnesses, it adopts a multi-team approach such as health workers,

doctors and nurses working collaboratively to deliver comprehensive care in the community.

The whānau ora environment

Whānau ora (healthy families as outlined in government policy) can be described as Māori families supported to attain maximum health and wellbeing (Ministry of Health, 2002). The concept of whānau is also often applied by many organisations and groups as a basis for managing relationships (Walker, 1988). Defining whānau ora is complicated as concepts are often constructed from individual experiences, perspectives, and knowledge with no clear explanation (Kingi, 2007). Whānau continues to be an integral element of contemporary Māori social structure and has been identified as a potential mechanism through which health gains can be achieved (Ratima et al, 1996). The ideal whānau provides a supportive and learning environment which acculturates its members into a sense of collective affiliation, obligatory roles and responsibilities, and the importance of uniting its members (Moeke-Pickering, 1996).

The intricate way in which Māori form relationships within whānau and the wider community are affirmed by common principles and values that assist whānau social wellbeing. According to Metge (1995), whānau values are described as (but not limited to) the concepts of aroha (love), whanaungatanga (relationships), manaakitanga (generosity), awhi (embracement/support), tika (being correct, just or fair) , pono (truth and honesty), mana (prestige), mahi-a-ngakau (duty and obligations), and kotahitanga (unity). These values underpin tikanga (Mead, 2003) and whanaungatanga is significant within whānau as it unites whānau.

In the pursuit of achieving whānau ora, the application of whānau ora models to health service delivery is critical. Towards the late 2000s, the Honourable Taraina Turia (Minister for Whānau Ora) introduced the concept of the Whānau Ora initiative and how it should be applied by Māori, primary care and all New Zealanders. The Whānau Ora initiative has been described as an approach in the provision of services to families throughout New Zealand requiring multiple government agencies working collaboratively intersectorally with families, rather than individuals. The ultimate

concept is collaborative health service delivery responsive to the health, social and educational needs of whānau (Best Practice Journal, 2011).

The Whānau Ora taskforce

In 2009, Cabinet approved the establishment of a Whānau Ora taskforce to develop a whānau centred approach towards whānau wellbeing, and to engage with Māori service providers in order to meet whānau health and social service needs. The taskforce was required to provide evidence-based frameworks for whānau-centred service delivery and the implementation and measurement / evaluation of Whānau Ora service delivery. A total of 22 regional hui were held with urban and rural whānau, iwi and service providers which finally culminated in a discussion document from the taskforce entitled “Whānau Ora: a whānau-centred approach to Māori wellbeing”.

The Taskforce report (Durie et al, 2010 p: 7) identified 6 major goals:

- Whānau self-management
- Healthy whānau lifestyles
- Full whānau participation in society
- Confident whānau participation in Te Ao Māori
- Economic security and successful involvement in wealth creation
- Whānau cohesion.

There were 6 key recommendations in this report: the establishment of an dependent Trust to govern, coordinate and implement Whānau Ora, and report to a dedicated Minister of Whānau Ora; that the Trust manages a specific Whānau Ora appropriation(s); that Whānau Ora services are integrated and comprehensive, and shaped by Te Ao Māori with measurable outcomes contributing to whānau empowerment; that all government agencies with responsibilities for any aspect of whānau wellbeing commit to the Whānau Ora principles and support the Whānau Ora approach; and that the Trust establishes regional panels to ensure Whānau Ora contributes in positive and realistic ways in local communities. Interest in forming Whānau Ora provider collectives was high with a response of approximately 130

proposals from 350 providers. This was from national and regional provider collectives, Māori, Pacific, disability providers and migrant and refugee organisations. In terms of Māori provider proposals, 22 were received from iwi collectives out of whom 15 were successful. Further expressions of interest towards forming Whānau Ora collectives occurred in 2012/13. Central to the development of collectives is also the concept of integrated contracting. An integrated contract is a single contract over a three year period, which is outcomes-focused and developed for individual community, iwi and Māori service providers who currently have multiple contracts with Government agencies (Te Puni Kokiri, 2011).

In 2010/11, the Whānau, Innovation, Integration and Engagement Fund also became available to build whānau capacity and cohesion, support whānau leadership, and create optimal environments for best outcomes. Te Puni Kokiri (Ministry of Māori Development) administered these funds; however in July 2013 the government announced that control over funding would be moved to 3 non-government commissioning agencies based in the North and South Islands, and one for Pacific communities. This move comes in line with a taskforce recommendation, to have an independent trust that governs, coordinates and implements Whānau Ora. This structure is expected to be in place by June 2014.

The Whānau Ora initiative is an integrated way in which services and opportunities are provided to families in need throughout New Zealand. Collectively rolled out by three government departments (Te Puni Kokiri, the Ministry of Health and the Ministry of Social Development), this initiative targets disadvantaged whānau rather than individuals and aims to empower and transform whānau to self-determine their own direction towards health and wellbeing. While whānau have a choice to work with any provider they wish, specialist Whānau Ora providers have practitioners or ‘navigators’ to assist whānau in identifying their needs, developing a whānau plan and delivering wrap-around services specific to whānau needs. Practitioners / Whānau Ora navigators act as brokers on behalf of whānau to gain greater access to a wide range of health and social services. This initiative will continue to evolve and vary to meet whānau needs in different communities in order to build whānau capacity towards self-sustainability. As government policy continues to focus on greater collaboration among health and social services and integrating health care, the

next section reviews literature on collaborative care, integrated care, and an overview of the development of integrated care in New Zealand.

3. Collaboration

Collaborative care

The provision of health care, particularly for those with chronic or complex needs is reliant on the skills of various health and social service professionals. To ensure continuity of care, cooperation and teamwork is needed among all service providers involved in the delivery of patient care (McKinlay et al, 2013). Cooperation and effective teamwork is underpinned by collaboration (Craven and Bland, 2006). A collaborative team approach requires commitment to cooperation towards achieving shared goals. ‘Collaborative care’, often referred to as shared care, is described broadly as a method of working together and cooperating with other health providers and professionals to deliver comprehensive services that meet individual and whānau needs. Various ways of achieving this include effective communication, sharing clinical care, joint education, joint program and system planning. Collaborative care models have evolved to being defined as arrangements which include the use of quasi-specialist staff¹⁷ working closely with patients, who liaise with clinicians and specialists to improve the quality of care (Doughty, 2006). Typical features of collaborative care models include multidisciplinary teamwork and care.

Another issue raised in literature concerns the roles and skills of staff which are an integral part to teamwork. Understanding one’s role as well as the role of others within a team is usually defined by the set of skills one has. When skills overlap, negotiation is required to prevent any conflict (MacDonald et al, 2010). Recognition and value is given to the expertise and perspectives of those from different disciplines, characterised by greater interdependence, joint goals and holistic care plans (Solheim et al, 2007). When role clarification is achieved, there is respect and trust in each other’s respective roles and an understanding of each other’s skills, knowledge and scopes of practice (Orchard et al, 2005). Effective collaboration among providers

¹⁷ A term which can be used to describe case managers or health workers.

allows for a range of comprehensive health care to be integrated in a seamless manner.

Integrated care

There are various definitions for integrated care. However, it is broadly recognised as ‘an organising principle’ aimed to improve patient care and experience through improved coordination (Shaw et al, 2011; p: 3). Rea et al (2007, p: 1) described it as being the provision of ‘seamless’ care for those with acute and chronic health conditions at any point within a health care system. It encompasses preventative and social care, as well as care and support in the home based on the premise that social conditions impact on health and conversely.

However, integrated care in New Zealand is not clearly defined. Cumming (2013) proposed two perspectives of integrated care: collaboration and cooperation across services from provider perspectives; and coordinated care with a seamless journey where transition between services is continuous from service user perspectives.

Cumming (2013) also described broader perspectives of integrated care:

- Horizontal: the integration of care across a particular sector of health (for example primary health care);
- Vertical: the integration of care between primary and secondary (hospital) care; and
- Intersectoral: the integration of care across health and social development services.

International models of integrated care

Smith and Ovenden (2007) in New Zealand conducted an extensive review on the development of integrated primary and community health services. They reviewed research done on several international models such as the Community Orientated Primary Care (COPC) model used in the United States and Great Britain (which is also an NGO model in New Zealand); the Integrated Community model and Professional Coordination model in Canada; and innovative models of primary care in

Australia. They described primary health care as being a complex adaptive system with no absolute comprehensive model of integrated primary care. Community models are designed towards meeting the health needs of specific populations by providing necessary medical, health, social and community services. Crampton et al (2004, p: 17) stated that models based on community governance aim to ensure that an organisation is in the control of its users, constituents or clients. This is particularly significant in countries such as New Zealand, the United States and the United Kingdom where not-for-profit organisations have been important service providers for low income and uninsured people since the late 60s as they cater to the needs of their users and communities they serve. Various types of collaborative models used in a certain context are dependent on desired outcomes of a local primary health care system.

Smith and Ovenden (2007) stated that increasing numbers of qualitative reports relating to improved outcomes highlighted models of process improvement based on strong clinical engagement; with insights into strategies on multidisciplinary teamwork; and community orientated primary care and chronic care models. They summed up a number of key points in their literature review associated with effective integration:

- That change could be more effective in primary and community health service delivery when organisational structures are able to control funds through contracting and planning;
- The duration of time for implementation and stability are crucial factors when new organisational arrangements are made for integrating primary, community care and secondary care in terms of community adapting to change, systems development, sustainable capacity and trust;
- Working with multidisciplinary teams is crucial in terms of service development towards addressing chronic disease. Changes in professional behaviour and education are both critical factors towards achieving this; and
- Infrastructure investment, including IT (information technology) is important, particularly for improved access, equity, quality and efficiency in primary health care.

Integrated care in New Zealand

The extent of New Zealand's integrated healthcare is generally unknown (Reid, 2007; Rea et al, 2007). The accelerated momentum of change in the health system environment has made it difficult to measure outcomes attributed to specific integrated care models (McDonald et al, 2006). Cumming (2013) suggested that integrated care is linked to good access to primary health care providers who are often seen as lead coordinators of care. Cumming (2011) however, described the health system as having delivered '*highly fragmented, poorly coordinated*' (p: 1) health care over a consistent period of time. Cumming (2011) noted that this is due to healthcare being provided by a wide range of professionals from various organisations, ineffective communication in terms of sharing information, and the lack of liaison between health professionals and provider organisations. Crucial aspects in the provision of integrated care include factors such as maintaining an active collaborative interface between primary and secondary care which is crucial in managing chronic illness in a primary care setting. Another key to effective primary health care delivery is having greater access to secondary care such as hospital services, specialist referrals, diagnostic tests and appropriate secondary care support.

Cumming's (2011) review of integrated care in New Zealand highlighted a number of key developments as a result of the 90s and 2000s health reforms and noted three levels at which reforms had occurred:

- The micro level: collaboration and integration activates among individual practitioners working within a single organisation;
- The meso level: collaboration and integration activities between practitioners from various organisations; and
- The macro level: integration activities that promote organisation collaboration in terms of policy agreements, contractual arrangements, financial arrangements (pooled or joint budget holdings), the employment of staff in a single organisation; or creating new organisations to oversee these tasks. An example of integration at this level would be Whānau Ora collectives.

Cumming (2011) noted that despite primary care being a key aspect of integrated care, separate and private funding of primary care services make macro level reforms ineffective towards sufficiently delivering more integrated care single-handedly. At a meso level, recent reforms have shown some improvement in primary care; the development of primary care networks and the creation of PHOs have facilitated meso-level organisations towards strengthening primary care services and promoting more integrated care. However, concerns also lie at the micro and macro levels. Cumming (2011) stated that there are huge challenges in encouraging various service providers who currently work separately at a primary care level to increasingly collaborate effectively towards delivering integrated care. There is also a need for better links between primary and secondary care, and wider related support services including independent not-for-profit organisations. Cumming (2011) stated that it is yet to be seen as to how well all providers collaborate due to concerns over leadership and budgets.

Māori views of integrated care

Māori views of integrated care go beyond the scope of providing coordinated health services for people. A holistic Māori model of health proposes that other services be integrated such as social services, housing, justice and education in order to address the wider determinants of health. Despite various perspectives and challenges, integrated care has potential towards achieving whānau ora goals. According to Andrews (1988), integrated Māori provider organisations¹⁸ with an established range of health and disability support services are more likely to achieve Māori health gains based on locally developed solutions that provide wrap-around services to meet community needs.

Māori health providers deliver a diverse range of health services such as counseling for alcohol and substance abuse, clinical services (midwifery, General Practitioners, community health nursing), disability support services; mental health community support services, traditional healing services as well as community health programmes that focus on health promotion, health education and health screening (Crengle,

¹⁸ Refers to larger Māori health provider organisations who offer and provide a wide range of health and social services, including social work, family support and education programmes, including a variety of comprehensive health services.

2000). They are committed towards meeting the needs of their communities and have provided greater access to health services such as cheaper co-payments for GP (General Practice) services; transport for consumers, the facilitation of mobile clinics in outreach areas; flexibility with appointments; and the provision of walk-in services¹⁹. Crengle (2000) also noted that services are delivered in various locations targeting sports venues, marae, hui, cultural festivals and provide information in a manner that is easily understood by Māori. For Māori providers, integrating health services is frequently practiced in service delivery; they engage in tikanga, utilising resources and methods appropriate and acceptable within Māori communities. They work with individuals and mainly with whānau towards meeting health, social and educational needs.

4. Māori Health Providers

Māori providers and whānau ora integrated services

When health reforms began in the 1990s, there were a small number of approximately 20 Māori health providers. As reforms continued, this number grew and is currently estimated at 264 providers situated in various locations throughout New Zealand. They are also described as having a distinctly not-for-profit type philosophy (Mauriora Ki Te Ao, 2010) and are mainly categorised into 3 groups which are:

Specialised: these providers are relatively small in size and focus on one speciality type service for example sexual health services, smoking cessation, rongoā.

Comprehensive: these providers offer a mix of public health and personal services; for example, public health promotion programmes, primary health care nursing services, mental health services, general practice, and

Integrated providers: these providers offer and deliver a wide range of health and social services including social work, family support and education type programmes including a range of comprehensive health services.

¹⁹ Walk-in clinics are usually primary health care clinics, a first point of contact for a patient where no appointment is necessary. Any person is able to walk in to the clinic and access health services that are available.

A report by Mauriora Ki Te Ao (2010) examined case studies from 6 Māori health providers which focused on defining and describing the term whānau ora integrated service delivery. All providers were led, governed or owned by iwi-based organisations that were committed to improving Māori and whānau health and wellbeing. This report highlighted certain approaches of Māori provider service delivery where several key themes emerged. The delivery of whānau ora integrated services involved having a good understanding of whānau realities in order to meet whānau needs rather than sole individuals. It also concerned building relationships with Māori and their whānau, and providing clinically sound and culturally appropriate services capable of responding to multiple whānau conditions. Tikanga and Māori health models underpinned practice, service delivery and were also utilised within the scope of which organisations operated and engaged with each other. Māori providers worked in a holistic way to encompass the wider determinants of health such as housing, income and employment in service delivery (Mauriora Ki Te Ao, 2010). Tailoring specific packages of services to meet whānau needs requires having a good level of coordination skills and also support from other services involved. The establishment of multidisciplinary teams and strong alliances with other health and social service providers has been crucial particularly if Māori provider organisations did not have the capacity to provide one or more specialist services for Māori and whānau. Having collaborative working relationships with key people or other organisations in the pursuit of achieving common goals, sharing knowledge and limited resources were important. Collaborative relationships are pivotal in terms of effective integration of services as there is a considerable amount of reciprocity among organisations (Mauriora Ki Te Ao, 2010); the exchange of resources between organisations for mutual benefit facilitates partnership whereby organisations can work together to achieve common goals.

The Mauriora Ki Te Ao (2010) report also noted other strong features among Māori providers; one such feature was that they often assumed non-specific health responsibilities. Many took on advocacy roles, including ensuring Māori and whānau were receiving care from secondary, tertiary or other providers, keeping fully informed about their care. Many providers spent a considerable amount of time referring or arranging and organising contact for direct support for whānau to deal

with other health or social conditions (Mauriora Ki Te Ao, 2010). Working beyond contractual requirements was another common feature among many providers in order to meet whānau needs; this places pressure on Māori provider organisations, stretching them to their limits. Despite demands placed upon them, Māori providers continue to work this way and deem it necessary in the delivery of care; they also accept this added responsibility in a positive light in order to achieve desired outcomes for Māori and their whānau (Mauriora Ki Te Ao, 2010; Boulton, 2005).

From outputs to outcomes-based performance in service delivery

At present, the current contracting environment for health is geared towards achieving outputs in service delivery. When measuring performance in service delivery, two issues are considered; the measurement of outputs occurring and the more difficult measure of determining the contribution the service has made towards reducing health disparities. Performance measurement is tracked by key performance indicators which account for information to service providers. It is also used as a basis for reports to funders on what has been achieved within certain timeframes of service delivery. It targets levels of impact of a service; for example, the measurement of specific outputs (levels of access, number of early / brief interventions,) provided by the service. Performance management programmes facilitated by PHOs also include levels of health measurement in terms of patient screening and health risk assessments undertaken by general practices.

Reid (2004) however, argued that measuring health did not simply equate to indicator levels of immunisation, cervical screening, or blood pressure readings, but rather a broader evaluative approach was needed in terms of gauging service quality.

Crampton et al (2004) acknowledged the increasing complexities of primary health care and suggested that performance measurement should accommodate different perspectives. Although common features of performance measures include improved access to care and service utilisation rates, measures do not consider what is unique to Māori dimensions of health care that are important to Māori communities from Māori health provider perspectives. Durie (2003) highlighted a parallel need for indicators to encompass Māori perspectives of health. Māori perspectives

depicted in contemporary health models such as Te Whare Tapa Wha consider whānau as one of the “*four basic tenets of life*” (Durie, 1985; p. 483). Therefore the health and wellbeing of whānau is crucial towards achieving outcomes in service delivery for Māori.

Aspiring to achieve whānau ora requires a move to empower whānau towards self-determination, self-reliance and self-responsibility rather than being reliant on health service providers to manage their health and wellbeing. The Whānau Ora initiative focuses on outcomes based on the six major whānau goals identified in the Whānau Ora taskforce report. When gauging the effectiveness of health services for Māori, Abel et al (2005) raised key issues concerning what should be measured and who decides what these measures are; their suggestions also included outcomes based on levels of whānau and spiritual wellbeing and culturally appropriate service delivery. According to the Mauriora Ki Te Ao (2010) report, the exclusion of output measures and specifications is not practical and a mix of both is more likely to occur; their study highlighted the important of achieving results or outcome-based agreements with funders that meet whānau needs as being critical in terms of implementing agreements. As funding for the provision of Māori health services is through mainstream government organisations (for example, the Ministry of Health, DHBs, Te Puni Kokiri etc.), the importance of collaboration, Māori leadership in governance and Treaty partnerships play a crucial role in establishing outcome-based agreements.

Māori and mainstream provider alliances

Alliances with mainstream providers are crucial towards collaborating care. Abel et al (2005) claimed that the establishment of PHOs engaged many Māori providers with mainstream primary health care providers due to PHOs having to meet the criteria of forming strategic relationships. Smaller Māori providers who did not have the capacity to provide certain essential clinical services delivered within mainstream primary care ran the risk of being marginalized as forming strategic alliances may well have jeopardized their autonomy. However, Abel et al (2005) noted that larger Māori providers could transition into PHOs relatively easier due to their stronger position, particularly if they were the major or sole partner within a PHO. Further developments in terms of mainstream alliances included initiatives presented at the

Iwi Leaders Hui on Onuku Marae in May 2009 by the Iwi Chairs Forum which highlighted iwi Māori opportunities to co-invest with a DHB for the design, construction and ownership of an infrastructure asset, and also to co-invest with general practice or a group of providers for the ownership of an IFHC or Whānau Ora Centre. Partnerships and alliances with mainstream are opportunities for both Māori and mainstream providers to work collaboratively and embed whānau ora philosophies and values into developing models of integrated service delivery.

While there is potential to achieve whānau ora service delivery, the Mauriora Ki Te Ao report (2010; p: 8) summarised a number of challenges for Māori providers such as: the policy direction, design and delivery of government services need to be strongly aligned with whānau needs and providers working at the coalface.

Another challenge concerns making a shift from ‘whānau related’ service delivery to whānau centred approaches that empower whānau to ‘do it for themselves’, having tino rangatiratanga and taking charge of their own care. The next critical challenge is to integrate services and contracting arrangements; these models would involve having streamlined reporting and a common set of outcome measures for contracts based on cross-agency collaboration; contracts supporting provider growth and development; and a framework for outcomes monitoring and reporting. Other important challenges include: how whānau views and perspectives would be embedded in service delivery and design; how decisions are executed at a local level between funders and providers; how collaboration occurs between different service providers and what additional support might be necessary in terms of provider capacity and capability to implement integrated service delivery for whānau.

Although single case studies in New Zealand suggest that certain Māori health services accessed by Māori can improve engagement, evidence concerning the effectiveness of integrated care for Māori remains limited (Ball, 2010). Cumming (2013) also stated that there is little data and research on integrated care in New Zealand, particularly from service user perspectives; and emphasised a need for more research in these areas. This thesis explores Whakawhirinakitanga Ahua, a whānau ora model of health service delivery. It is concerned with investigating the collaborative processes involved in the delivery of integrated care from the perspectives of service providers (health professionals) at Whakapai Hauora and

Māori who are service users at Whakapai Hauora. It also intends to examine if health service delivery addresses the needs of Māori accessing services at Whakapai Hauora. Results of this thesis will contribute towards the ongoing body of research and knowledge significant to integrated care for Māori in relation to tikanga-based concepts and practices; its application when working with mainstream service providers, Māori service users and whānau; and potential outcomes in care. The next chapter outlines the methodology used in this study.

Summary

Māori have a particular way in which health and wellbeing is conceptualised and this is reflected in contemporary Māori models of health stemming from Te Ao Māori. Health reforms in the 90s focussing on devolution of services concurred with a Māori desire for greater tino rangatiratanga over their own affairs. Tino rangatiratanga, assured under the Treaty has been critical in guiding Māori initiatives towards greater control over their own health and wellbeing. The Treaty principles of partnership, protection and participation underpin the relationship between Māori and the Crown and have been fundamental in response to Māori health needs. The inclusion of the Treaty in social policy legislation allowed for Māori representation on DHB boards of governance and at all levels of service delivery. All these factors have been instrumental in the emergence of Māori health providers with greater autonomy over the development and delivery of their own health services.

Further reforms in the late 2000s shifted to new models of care, where two government initiatives were introduced, 'Better Sooner More Convenient Care' and 'Whanau Ora'. Central to both initiatives is the concept of collaborative health service delivery and the integration of care to meet the needs of Māori and all New Zealanders. There is little research on integrated care in New Zealand particularly from service user perspectives, and research concerning the potential benefits of integrated care for Māori is also limited. This thesis is an exploration of a whānau ora model of service delivery. It aims to uncover the collaborative processes involved in the delivery of integrated care; tikanga-based concepts and practices; its application when working with mainstream service providers, Māori service users and whānau; and potential outcomes in care. Research results will contribute towards the ongoing body of research and knowledge significant to integrated care for Māori.

Chapter Three

The Research Methodology

Introduction

This chapter outlines the use of qualitative research methodology used in this study. This research was undertaken within the interpretivist paradigm using qualitative methods aligned to Māori-centred research. This chapter outlines ontological, epistemological, methodological and axiological assumptions in this study, and the ethical guidelines for this research. It concludes by highlighting the researcher's position within this study.

The Acquisition of Knowledge and 'Truth'

Researchers are concerned with seeking knowledge and 'truth'. However, what constitutes 'truth' and the way in which research is conducted is preceded by the researcher's own belief and value systems. A personal worldview is influenced by one's own ethnicity, culture, gender, class, history, values and beliefs (Denzin and Lincoln, 2000) providing the structure that shapes one's ideas and actions. In qualitative research inquiry, a set of beliefs comprising of epistemological, ontological, axiological and methodological assumptions by which researchers approach their research is widely acknowledged (Creswell and Plano Clark, 2007; Savage, 2006; Patton, 2002). These four basic beliefs guide the research process; the unique way in which they interplay with each other distinguishes the type of research questions asked, the approach to the topic and the methodology employed to ascertain answers.

- **Ontology:** concerns the nature of reality; ways of being. The ontological position of the interpretivist paradigm suggests that reality is socially constructed and therefore multiple; this varies through social and experiential meanings and understandings (Hennink et al, 2011).

- Epistemology: concerns the nature of knowledge; ways of knowing. The epistemological position of the interpretivist paradigm suggests that multiple knowledge generated, is subjective, whereby it is rooted in contexts and people (Lincoln and Guba, 2000).
- Methodology: concerns the approach to a systematic enquiry; ways of gaining knowledge. The methodology in relation to the interpretivist paradigm concerns the use of qualitative methods to understand phenomena in context specific settings (Patton, 1990). Multiple methods are employed such as interviews, document review and field notes so as to obtain multiple perspectives giving better interpretations of data.
- Axiology: concerns the nature of ethical behaviour in research; it involves the role and values of ethics in research. Based on the relationship between researcher and research subjects, an early framework was developed by Guba and Lincoln (1991) in terms of the criteria for rigour being trustworthiness, authenticity and fairness. This was later expanded upon by Lincoln (2009) who added reflexivity, rapport and reciprocity.

Western and Indigenous Research Paradigms

Cryer (2006 p.76) described a research paradigm as “*a school of thought or a framework for thinking*” as to how research should be undertaken in order to obtain ‘truth’. Cryer (2006) also noted that it is not possible to list all research paradigms, as various scholars apply different terminologies while debating this, even when paradigms are broadly similar. From western research perspectives, within the field of social science research, two main paradigms have emerged; the positivist (quantitative) and the interpretivist (qualitative) research paradigms (Bryman, 2001). Both have a plethora of information²⁰ highlighting their distinct differences, their research methods and the type of knowledge each paradigm generates. There is also mixed methodology research, employing various research methods from both paradigms (i.e. quantitative and qualitative methods) capable of answering questions

²⁰Refer to Denzin, N.K., Lincoln, Y.S. Handbook of Qualitative Research, 2nd edn, London: Sage Publications.

which cannot be answered from a single paradigm alone. However, western research paradigms that were initially grounded in a positivist approach have begun to diverge towards more interpretive enquiry. Indigenous worldviews have different philosophical foundations to non-indigenous worldviews (Walker, 2004; Little Bear, 2000; Pichette et al, 1999) and indigenous research paradigms place indigenous interest, knowledge and experiences central within research methodologies and practice (Rigney, 1999).

Indigenous paradigms emerged from indigenous people's close relationship with their environment (McKenzie and Morrissette, 2003). Furthermore, research paradigms based on indigenous expectations of research are relational (Graham, 2002), where knowledge itself lies in the relationships and not in separate parts (Pawu-Kurlpurlurnu et al, 2008). Chilisa (2011) and De Crespigny et al (2004) also subscribed to the notion of relational, highlighting not only the significance of relationships between the researcher and those being researched, but also being able to understand and acknowledge the relational ontology and axiology of indigenous people. Henry et al (2002) commented that indigenous research processes are underpinned by indigenous knowledge to develop ontological, epistemological, axiological and methodological levels that are holistic, establishing the interconnectedness of things. Māori knowledge stems from a holistic Māori worldview which is fundamental to Māori ways of being and knowing. Traditional knowledge is premised on the interconnectedness and interdependence of individuals and the collective, and the relationship between man and his environment (the physical and spiritual realms); while contemporary knowledge acknowledges the historical, social, economic and political impacts on Māori (Ratima, 2001). Māori knowledge is also the basis for Māori values and tikanga which shape the way in which Māori relate to and interact with others (Mead, 2003).

Indigenous research agendas such as kaupapa Māori focus on the indigenous right of self-determination; to make decisions about research concerning their people and methodologies for their own purpose and benefit without the influence of others (Tuhivai-Smith, 1999). Porsanger (2004), an indigenous Skolt Sámi scholar defined

indigenous research approaches as being ethically and culturally appropriate as they are based on indigenous knowledge and ethics in terms of determining access to knowledge, the choice and use of theoretical approaches, and selection of research tools (methods) when conducting research.

Research and Indigenous Peoples

Weber-Pillwax (2004), a Métis scholar stated that indigenous researchers select and work with their research methods intricately, taking forms that are deep-seated within the values and beliefs about human interaction which is distinctive to their own indigenous cultures. Despite on-going debate concerning the nature of significant differences between western and indigenous research methodologies, Tuhiwai-Smith (1999) a Māori scholar, asserted that ‘decolonising’ methodologies does not imply having a total rejection of all western research theory or knowledge, but rather: *“centring our concepts and worldviews and then coming to know and understand theory and research from our own perspectives and for our own purposes”* (p.39.)

Tuhiwai-Smith (1999) and Battiste (1998) a Mi'kmaw educator, noted that decolonising Western research theory or knowledge is crucial, as the term ‘research’ is inextricably linked to European imperialism and colonialism which is concerned with agendas based on power and control. When conducting indigenous research, Rigney (1999) an Aboriginal Australian scholar, stated that indigenous interests, knowledge and experiences must be central within research methodologies. Central to indigenous methodologies are also ethical principles involving safety; that the purpose of research is to benefit indigenous peoples and their communities, and that the researcher is accountable for the effects of the research on the lives of indigenous peoples (Weber-Pillwax, 2004).

According to Tuhiwai-Smith (1999), the indigenous research agenda takes into account survival, recovery and development of indigenous peoples. It should incorporate healing, mobilisation, transformation and decolonisation on multidimensional levels through which indigenous communities traverse with the

main goal of achieving self-determination. Lakota scholar Cheryl Crazy Bull (1997) suggested that in order to ascertain such a plan in research practice, some scholars develop research agendas to preserve and revitalise indigenous traditions, language and cultural practices which allows them to regain physical, emotional and spiritual wellbeing; to develop social, economic and governing systems; and to preserve sovereignty and nationhood.

Lavallée (2009), an indigenous scholar of Algonquin and Cree ancestry stated that indigenous researchers are progressively undertaking research within their own communities who present paradigms that frame their approach in terms of theory, epistemology, methodology and axiology. Lavallée noted that frequently, there is a bridging of western practices and indigenous knowledge. Durie (1996) stated that although western paradigms cannot interpret indigenous realities such as Te Ao Māori, western paradigms can be adapted and used in a manner that is consistent with a Māori enquiry paradigm. This research proposes that there is some common ground between the interpretivist paradigm and Te Ao Maori. This common ground is seen as the interface between the two, on the next page.

Table 1: Basic Beliefs of Research Tradition at the Interface of the Interpretivist Paradigm and Te Ao Māori

Research Paradigms (the four basic beliefs)	Interpretivist Paradigm	Interface	Te Ao Māori
Ontology: the nature of reality. (Ways of being)	Reality is socially constructed and knowledge is subjective. It may change through social and experiential meanings and understandings (Hennink et al, 2011).	Reality is a process of relationships and experiences; it may be defined by our relationships with people or things.	Traditional knowledge is premised on the interconnectedness and interdependence of individuals and the collective, and the relationship between man and the environment (the spiritual and physical realms); while contemporary knowledge is holistic recognising historical, cultural, social, economic and political impacts (Ratima, 2001).
Epistemology: The nature of knowledge. (Ways of knowing)	Multiple knowledge generated is subjective; the focus is on details of situations and the underpinning realities. Research participants and the researcher are interlocked in a process that is interactive where both influence each other (Lincoln and Guba, 2000).	Knowledge that is constructed extends meeting new situations and environments.	Mātauranga (Māori knowledge) emerges from within a Māori worldview (Mead, 2003). On one level the world is ever changing with contemporary realities and on another level there are consistent universal principles that inform research, knowledge generation and creative processes (Mead, 2003; Durie 1998c).
Methodology: the approach to systematic enquiry. (Ways of gaining knowledge)	Qualitative research methods that employ a naturalistic approach that seeks to understand phenomena in context specific settings (Patton, 1990).	Multiple perspectives produce in-depth interpretations of meanings that are compared through dialectics.	Research practices centre on Māori culture, values, knowledge and complexities of diverse contemporary Māori realities (Durie, 1996).
Axiology: the nature of ethical behaviour (Values)	Trustworthiness, authenticity and fairness (Guba and Lincoln, 1989), reflexivity, rapport and reciprocity (Lincoln, 2009)	The research is value-bond; the researcher is also part of what is being researched.	The ethics of Māori research: Māori kawa and tikanga are central with respect and appropriate cultural behaviour (Stokes, 1985). The principle of building respectful and reciprocal relationships (King, 2004; Tuhiwai-Smith, 2006).

The Theoretical Framework for this Study

The use of qualitative research for this study

For this study, I have chosen the interpretivist paradigm using qualitative methods as I am studying the lived experiences of respondents. I believe that the interpretivist paradigm is a way for us to make sense and gain knowledge of the world through our own experiences in life, and by reflecting upon these experiences. As each and every one of us experiences events in a way that is uniquely our own, our interpretations, understandings and learning become our very own reality. This shapes our world, our knowledge of it, and the uniqueness of each and everyone's different realities. Qualitative research deals with how people understand their experiences, having special value for investigating complex and sensitive issues (Trochim, 2006). Qualitative methods generate rich and detailed data employing a naturalistic approach that seeks to understand phenomena in context specific settings (Patton, 1990). Green and Britten (1998) also noted that qualitative research is key in addressing difficult questions of how evidence informs practice. This research can contribute towards informing practice by addressing questions in relation to the collaborative processes involved in working towards integrated healthcare for Māori; and inform evidence-based practice. This qualitative study is also aligned to Māori-centred research.

Māori-centred research

There has been steady advancement in relation to appropriate research processes for Māori out of which two main positions have developed; Kaupapa Māori research (Bishop, 1994; Tuhiwai-Smith, 1999, Smith, 1993) which emerged from within the field of education, and Māori-centred research (Durie, 1997a) which developed from within the field of health. Kaupapa Māori research involves Māori as being both significant participants and primary researchers. However, I am an indigenous non-Māori, undertaking research within a Māori health environment; therefore I chose to engage in this study using Māori-centred research. The term 'Māori-centred' was phrased by Durie (1996) to characterise a certain approach to health research which prioritises Māori health gains. Durie identified that Māori health research was

essentially concerned with the health of Māori people, fully acknowledging Māori knowledge, culture and contemporary Māori realities. Māori-centred research has similar goals to Kaupapa Māori research; Forster (2003) stated that they both address “*critical failings*” and the “*impacts and limits*” of positivist methodology on Māori people; research design and methodology are underpinned by “*traditional Māori values*” (p: 49). Māori centred-research methods and practices place Māori at the centre of the research activity; according to Durie, (1996) and Bishop (1996), it involves the following three principles:

- Whakapiki tangata (empowerment), as knowledge generated empowers Māori, who are better positioned to control their own health with the aim to improve their health status;
- Whakatuia (integration), which is the recognition of a holistic Māori view of health, and the links between health, culture, economics, social standing, and historical events; and
- Mana Māori (control), whereby research involving Māori as participants or that investigates aspects of Māori society, culture or knowledge must have high levels of Māori participation throughout all research processes. Thus, a Māori-centred approach facilitates Māori aspirations and initiatives and rejects the notion of Māori being ‘passive’ subjects.

A Māori analysis is undertaken; however Māori-centred research may not necessarily be undertaken by Māori (Cunningham, 2000) and may employ western methodologies situated within western paradigms. Ratima (2003) and Durie (1996) argued that Māori-centred research can be adapted and used in a consistent manner with a Māori inquiry paradigm. Ratima (2001) acknowledged that Māori-centred research generates and transmits Māori knowledge. Ratima (2001) also noted that where Māori health research is concerned, it is expected that this knowledge will affect positive health outcomes for Māori and contribute towards Māori development. In this study, Māori-centred approaches include recognising Maori expectations towards research. It focuses on generating answers to questions that are important and relevant to Māori in terms of health service delivery. The nature and extent of Māori involvement in this study, the undertaking of a Māori analysis, Māori practices of

engagement and culturally safe research are further detailed in Chapter 4, The Research Methods.

Insider research

There has been much discourse concerning two different positions taken in qualitative research interpretation, the outsider and insider position. Thompson (1998) discussed issues concerning perspectives in interpretation of qualitative data. The researcher's perspective influences interpretation and the knowledge that comes from research. Thompson (p: 3) stated that the outsider position assumes a judgemental authoritative type role, where the culture being researched is observed against the ideology of the researcher's own culture, but more importantly according to methods and practices of the scientific community. Whereas, the insider position forgoes authority and attempts to undertake research according to methods and practices of the participants or community being studied.

Insider research can also be described as research undertaken by people in their work settings (Robson, 2002), or who are part of the community being researched (Dwyer and Buckle, 2009). Mehra (2002) noted that a researcher's values and beliefs are reflected in the choice of methodology and interpretation of findings. Mehra (2002) also noted that it is not possible to completely separate oneself from the study or the people being studied due to the knowledge that is created which comes from the interaction between the researcher and participants. I am aware of my own position as the health manager of Whakapai Hauora, undertaking this research. I have also worked in this organisation since 1998 as a nurse which has been detailed in the background to this study (in Chapter 1). Having knowledge based on my own experience working at Whakapai Hauora, also with access to greater information concerning the organisation, its employees and clients, poses a conflict of interest in terms of undertaking this study. A number of issues that I acknowledged and was constantly aware of were:

- As the researcher, what impact would my relationship have on participants (who were employees and clients of the organisation) in relation to the data obtained from interviews;
- Would my own knowledge or cultural views lead me to misinterpret or make false assumptions about the data, or miss significant aspects of data; and
- Would my responsibilities to the organisation lead to misinterpretation of the data.

There were a number of measures employed to address these issues; one was to journal field notes on an ongoing basis in order to reflectively examine my own assumptions about the data. Other measures were also taken throughout the research process: I received ongoing supervision from my academic supervisors at the university to assist me to examine my data analysis in order to consider other possible interpretations. I met with key people on a regular basis such as kaumātua within the community, the cultural advisor at Whakapai Hauora, and participants on a regular basis to inform them of initial findings; I also sought their feedback and made the process of the study more public. All these measures are further detailed in Chapter 4, The Research Methods.

Ethics of Māori health research

The ethical guidelines used in this study were initially developed by Tuhiwai-Smith (1999) and Cram (2001), and later adapted by Tuhiwai-Smith (2005) as a 'Community-Up' approach to defining researcher conduct. These guidelines recognise key accountabilities of a researcher when researching indigenous communities. I found these guidelines to be extremely useful and appropriate when conducting research with Māori. The defining values to these guidelines were explained by Kennedy and Cram (2010):

- Aroha ki te tangata: which translates as having respect for people and allowing them to define their own terms with regards to meeting, and their own space.

- He kanohi kitea: the significance of a face-to-face approach, and being a familiar face (being seen and known within the community).
- Titiro, whakarongo...korero: to look, listen and then perhaps speak. This refers to having the ability to understand in order to determine a place from which to speak.
- Manaakitanga ki te tangata: as in sharing, hosting and being generous. Smith and Cram (2001) noted that this also facilitates 'giving back' in relation to the sharing of knowledge and results of a research project.
- Kia tupato: staying careful, astute, culturally safe and reflective throughout the entire research process.
- Kāua e takahia te mana o te tangata: being able to maintain the mana and dignity of those that are being researched.
- Kia mahaki: being humble in the way the researcher shares knowledge.

These guidelines are intended to respect and safe-guard the rights and interests of those being researched which are crucial towards establishing relationships based on trust between the researcher and those being researched. King, (2004) and Tuhiwai-Smith (2006) noted that research is concerned with relationships; King (2004) discussed consideration in terms of the researcher and sponsor / institution relationship; the researcher and community relationship from where potential participants derive; and the relationship between participants and their communities. According to King (2004), each relationship varies in duration, responsibility, power and ethical considerations and the researcher must consider how to nurture and maintain these relationships without affecting the research. Tuhiwai-Smith (2006) noted that this could get complicated when factoring in whanaungatanga, in relation to nurturing reciprocal relationships in a sense of having to share stories and knowledge, rather than taking them away from participants. Therefore, the researcher must consider how 'giving back' to communities and participants are done, and 'what is given back'.

In this study, these guidelines were demonstrated throughout my engagement with participants and the community engaged in the researched. Key aspects of engagement included consultation, face-to-face-contacts, sharing of kai (hosting participants), recognising whakapapa (making connections through the whakapapa of my children), the dissemination of research findings and maintaining ongoing contact throughout the research process. These key aspects of ethics are elaborated upon in the next chapter.

My Position in this Research

Gifford (2003) noted the significance of connecting with all those involved in the research and the research context, particularly when conducting research with Māori. As the researcher, I identify as indigenous, non-Māori undertaking health research within a Māori health context. Currently as the health manager at Whakapai Hauora, I work with staff and the running of the organisation on a day to day basis, manage quality systems and actively participate in stakeholder and leadership health groups providing input into local and regional health plans. Due to several factors: the nature of my own personal growth and professional development within the organisation; having a genuine interest towards contributing positively to Māori and whānau who access services at Whakapai Hauora; and the vision of the organisation and staff who deliver services, it was only a natural processes for me to choose to explore Whakawhirinakitanga Ahua as my PhD topic.

Indigenous roots

My journey at Whakapai Hauora began in 1998, when I took up practice nursing, after having worked in a variety of mainstream health settings for many years. Working at Whakapai Hauora gave me more than just a sense of familiarity and being comfortable; the experience of working within an iwi organisation gave me a sense of purpose, and a feeling of belonging. I am of mixed ethnicity which is Irish, Portuguese and Javanese. However, I identify as being indigenous and affiliate with my Javanese heritage. The Javanese people are indigenous to Java (modern day

Indonesia) and traditional Javanese principles are based on “Kejawen”²¹. The traditional concept of Kejawen is animistic²² where both spiritual and physical worlds are not separated. All living and non-living things including the natural environment have a life force or spirit; humans are considered part of the environment (Iannone, 2001). Kejawen cosmology embodies the interconnectedness, interdependence and interrelatedness of the personal, social, physical and spiritual realms (Van Peursen and Doerer, 1985). The ideological basis of Kejawen belief is that social interaction is “*collective, consensual and cooperative*” (Bowen, 1986; p: 545). Megawangi et al (1995) suggested that being Javanese means being one who is “*civilized, who knows his manners and his place*” (p: 101). Individuals are part of a family or collective. Life in society is ideally described as “rukun” (harmonious unity), “akrab” (intimate and close relationships) and “kangen” (a strong sense of belonging). Koentjaraningrat (1995) stated that the concept of individualism and being part of a family or collective are interrelated which also has purpose; the term “gotong royong” relating to the equal sharing of assistance and responsibility for family and community also reflects the idea of rukun. Javanese families have a bilateral kinship system, whereby the heritage of both men and women in families are of equal importance (Robinson, 1999; Wolf, 1990).

The Javanese social hierarchical system is also embedded in unity and harmony as everyone has an understanding of their place and duty within family and society; there is respect for those in higher positions, and benevolence towards, and responsibility for those in lower positions. This deep respect is also offset by reciprocity in the way of protection and patronage among members within extended family and kinship relationships (Mulder 1992). Javanese values that underpin social integration are obedience to superiors, generosity, avoidance of conflict, understanding of others and empathy (Koentjaraningrat, 1985).

Javanese people have their own traditional practices and medicines for healing. The ‘dukun’ is archetypal of the Kejawen belief system indigenous to Java underpinned by animism, shamanism and ancestor worship. Dukun are known traditional healers,

²¹ Kejawen is the pre-Islamic Javanese belief system

²² Animism is widely found in the religions of indigenous peoples (see Iannone, 2001).

spirit mediums as well as experts in custom and tradition; their knowledge is transmitted orally, either inter-generationally or to those who are chosen (Watson and Ellen, 1993). Most Javanese elders actively participate in society as cultural advisors and child-care providers, and are considered to be important authority figures; some are teachers, concerned with the transmission of knowledge and values to younger generations while others are concerned with maintaining ancient Javanese heritage into contemporary society (Albert et al, 2007).

Similarities between Māori and Kejawen beliefs

There are similarities between Javanese and Māori culture; both cosmologies are concerned with the interconnected and interrelated universe where both spiritual and physical realms impinge upon each other. The Kejawen belief of a life force (or spirit) within the natural environment, animals, plants, rocks, and landscapes resonates with the concept of mauri, which Māori consider to be the life force or essence of all things living and non-living. The Kejawen concept of rukun emphasizes harmonious existence among all individuals within society underpinned by values such as respect, obedience, generosity, avoidance of conflict and empathy (Koenjaraningrat, 1995; Geertz, 1961). Such values are also similar to Māori concepts and values of maintaining the mana of individuals; manaakitanga in relation to generosity (Mead, 2003); tapu and noa which is a code of social conduct based essentially on keeping safe and avoiding conflict or risk (Durie, 1998a); and aroha which is related to having empathy for others (Metge, 1967).

The Kejawen idea of harmonious unity is similar to the Māori concept of collectiveness (Bishop, 1996) in relation to notions of unity and bonding. The Javanese social system based on the cultural tenet of “gotong royong” is very much alike Māori ideals of a shared life (Patterson, 1992) where whanaungatanga and collective responsibility are central. Family and kinship relationships in both cultures are reciprocal; like Kejawen tradition, it is whānau who take care of individuals. Within whānau and kinship systems, individual members have their own

roles and responsibilities, and nurture and support each other (Moeke-Pickering, 1996).

“Dukun” and tohunga are considered as healers with expert knowledge within their respective cultures having similar practices of employing traditional healing methods. Traditional knowledge has also been transmitted orally through generations in both Javanese and Māori cultures. Kaumātua, similar to Javanese elders are active members within their communities, taking care of younger whānau members, imparting traditional knowledge and maintaining tikanga (Waldon, 2004). Being of Javanese heritage myself, it was no effort at all for me to grasp the concepts of whānau, whanaungatanga, tikanga and holistic health and wellbeing from a Māori perspective. I was able to easily connect with Te Ao Māori, and also to the community that Whakapai Hauora serves. Simply immersing myself in all things that are Māori strengthened my own wairua, having a deeper appreciation of myself as an indigenous person. Working with whānau alongside my fellow colleagues gave me a greater insight into existing health disparities and inequalities for Māori and whānau.

My approach to this study

Apart from indigenous beliefs, my approach to this study also derives from my own personal orientation, at least in part, from both my training and experience of working as a registered nurse at a grassroots level and as middle management within an iwi health provider organisation. As the present health environment focuses on collaborative care, the use of Māori health models in the development and provision of health service delivery is integral towards addressing and meeting Māori health needs. Exploring Whakawhirinakitanga Ahua from the perspectives of those who implement service delivery and for those who receive services is an empowering process. It gives voice to those who are directly affected by the implementation of this model; also for the intended purpose of the model, which aims to address and meet the needs of Māori and whānau accessing services.

From the initial concept of this research project, it has been my intention to make a positive contribution towards Māori health development. This intention has underpinned my conduct and approach towards undertaking this study; from the initial stages in preparing my research proposal, gaining ethical approval, the recruitment phases, my fieldwork, data analysis and presentation of preliminary findings. All these processes took a considerable amount of time, however a highlight for me was the significant number of relationships that I developed throughout this entire period; the connectedness and engagement that took place while building these relationships is whanaungatanga described by Bishop (1996) as being one of the most fundamental concepts within Māori culture, both as a value and as a social process.

Summary

This study employed qualitative research methodology based on the interpretivist paradigm which allowed me to investigate respondents views, understandings, beliefs and experiences. Māori centred research has also significantly influenced the approach to this study. A Māori-centred approach allowed for research processes to focus primarily on Māori culture, knowledge, values, attitudes and beliefs as it is intended that findings will contribute to Māori knowledge. The interface between Te Ao Māori and the interpretivist paradigm has also been highlighted in this chapter. Identifying as indigenous non-Māori, the concept of whānau, whanaungatanga, tikanga and holistic health and wellbeing was a process easily understood. Central to this research is also the Māori ethical approach applied in this study based on the 'Community-Up' approach. The next chapter presents the research methods for the study covering areas such as participant recruitment, data collection and analysis, ethical considerations and the rigour of this research.

Chapter Four

The Research Methods

Introduction

This chapter outlines the phases of the study which consisted of respondent²³ (participant) interviews. Crucial aspects covered are data collection and analysis, the research rigour, dissemination of information and ethical aspects such as informed consent, confidentiality and managing potential risk or harm. This chapter highlights the significant number of relationships formed during the course of this research through Māori methods of engagement.

Consultation

Establishing a rapport with both Te Mauri O Rangitaane²⁴ and the CEO began long before the conception of this study. I had already been working at Whakapai Hauora for nine years prior to undertaking this study; therefore it was not a process of having to build relationships from scratch where trust would have taken some time to establish. As a practice nurse during my early years at Whakapai Hauora, I came to know some kaumātua and their whānau as I had worked with them in the clinic. Later as a community nurse, they welcomed me into their homes to deliver health education and nursing care for them and their whānau. I was also quite often a familiar face at pōwhiri²⁵ and cultural events held on Tūturu Pumau marae, as I took the opportunity to make myself known and seen among the Māori community. In the first instance it was vital to seek approval from the community in which this research would take place. Consultation began with Te Mauri O Rangitaane who are the Board of Trustees for Whakapai Hauora and the CEO who is the head of operations at Whakapai Hauora (see Appendix 1). This process involved initial discussions with the CEO who agreed in principle (see Appendix 2). I then did a presentation

²³ The terms respondent(s) and participant(s) are used interchangeably in this research (both meaning those who participated in this study).

²⁴ Refers to the Council of Elders at Tanenuiarangi Manawatu Inc. (Rangitaane iwi authority).

²⁵ Pōwhiri is central to Māori protocol, and is a ceremony to welcome visitors or guests. It involves speeches, waiata and hongi. While traditionally used to welcome visitors on to marae - Pōwhiri can take place anywhere that tangata whenua (hosts) wish to formally greet manuhiri (visitors).

outlining the study; its purpose, intentions, methods and justification for conducting this research at a monthly Te Mauri O Rangitaane Board hui. During the presentation, Council members were given the opportunity to ask me any questions regarding the undertaking of this study *kanohi ki te kanohi*. This also provided the forum for any discussions to take place concerning the study. The Council had to consider if this research met Māori needs and aspirations and if they would support this study. After their consideration of these matters, the Council gave their consent for this study to be undertaken (see Appendix 3). Therefore primarily, this study was community led and approved.

Methods

Participant recruitment

In all, a total of 50 participants took part in this study which consisted primarily of focus group interviews with Whakapai Hauora health professionals and interviews with clients who accessed care at Whakapai Hauora. For focus group interviews, I employed purposeful sampling in order for me to target specific groups of service providers with a common characteristic. The common feature among these groups was that they worked directly with Māori and *whānau* who accessed a wide range of services which involved collaborative care processes with other service providers. This was open to both Māori and non-Māori working at Whakapai Hauora (see Appendix 4). Patton (1990) proposed that this method of recruitment generates information-rich data capable of intensely manifesting the studied phenomena. Also, my reason for conducting provider interviews first was, should further areas of investigation arise from health professional interviews (see Appendix 5), these may be probed during Whakapai Hauora client interviews.

I held three separate hui²⁶ over several weeks with Whakapai Hauora health professionals, *kanohi ki te kanohi*, to announce the undertaking of this research and to provide them with information about the study. The recruitment process was easier than I had anticipated as I thought it would take some time for them to consider

²⁶ The term hui in this sense is used in a more general and contemporary sense such as in reference to team meetings and informal gatherings as well.

participating in this study. However, there was a very good response from most who attended these hui.

During the course of conducting health professional interviews, I began recruitment for Whakapai Hauora service clients. Flyers and information sheets (see Appendix 6) were placed at Whakapai Hauora reception advertising the study to clients accessing services. Some Whakapai Hauora health professionals also volunteered to inform clients about the research and handed out information sheets to those who were interested in the study. For this recruitment process, I also employed purposeful sampling:

- Clients who identify as Māori, are 18 years or older and are currently accessing a Whakapai Hauora service (or services); as well as
- any other primary, secondary service or services; and / or any wider community support services.

While other ethnic groups and non-Māori access Whakapai Hauora services, the purpose was to recruit Māori as Whakawhirinakitanga Ahua is a Māori model of health service delivery developed by Māori for Māori. This study is intended to focus on contributions to Māori knowledge, Māori health and hauora development. The majority of Māori participants accessing Whakapai Hauora services came by means of word of mouth (i.e. snowballing), whereby Whakapai Hauora health professionals assisted me in identifying potential participants. Once contact was established with potential participants, I offered to further explain the study and discuss any issues or concerns they may have with this research. This process was significant in gaining informed consent from participants. This took place in two ways; some were able to confirm their participation via a phone call but for the majority, it entailed meeting *kanohi ki te kanohi*, at their homes to explain the study.

Data Collection

Semi structured interviews

Data was collected through the use of semi structured interviews. Whakapai Hauora health professional interviews consisted of focus groups as well as individual interviews (for those who preferred to be interviewed individually). Consent forms were signed before all interviews took place (see Appendix 7). There was a total number of 19 health professionals with almost two-thirds being Māori. While conducting health professional interviews, I also made contact with clients who showed an interest in participating in this study. I visited them face to face, in their homes to explain the research to them. After these visits there was a waiting period of approximately one to two weeks before they contacted me to confirm their participation. All consent forms (see Appendix 8) were also signed on the day of the interview, prior to it taking place. There were a total of 31 participants; consisting of individuals as well as groups (whānau who were couples) wanting to participate in this study.

According to Loftland and Loftland (1984), the use of semi-structured interviews permits the researcher to explore within predetermined inquiry areas. It allows more latitude to move from one context area to another, to follow up on participant cues, and to spend a considerable amount of discussion on one subject or another (DiCicco-Bloom and Crabtree, 2006). As there were certain areas I wished to explore in more detail, prompt questions were also used for client interviews (see Appendix 9). I was assisted by kaumātua from Te Mauri O Rangitaane when developing prompts as part of culturally safe research practice. Prompts for participant interviews were open-ended which allowed participants to choose how they wished to respond, what was important to them and to explore different thoughts, feelings and views. I also found prompts to be very useful in teasing out various strands of information in order for more in-depth participant stories in relation to experiences. These prompts were piloted with Whakapai Hauora's cultural advisor as well as some kaumātua from Te Mauri O Rangitaane, who were then satisfied that prompts were suitable and culturally appropriate for participants.

Interviews with Whakapai Hauora Health professionals

In total, there were 4 focus groups; three health professionals were unable to attend group interviews due to other commitments, and therefore requested to have individual interviews with me. These took place after focus group interviews were completed. Focus groups were more specific to scopes of service delivery (for example, social workers, counsellors, general practitioners, nurses, etc.) which allowed group members to speak and discuss issues in an open forum relating to their scopes of practice. In total, these interviews took a period of up to 3 months to complete. Focus group interviews foster whanaungatanga (kinship) and collectiveness where participants can interact in ways that aspire to the quality of whānau values (Metge, 1995), to capitalise on each other's shared experiences, and explore and clarify their views in ways that would have been less easily accessible in a larger group setting where discussion could be generalised. This type of environment also promotes active on-going participation from all members and provides the avenue for a collective approach to shared experiences and views on the subject being researched. It was imperative for me to be true to the intent of the research and the inherent values of the study therefore, focus group interviews were appropriate for interviewing, although offering individual interviews if requested.

Group members knew one another quite well as they often worked collaboratively to deliver care for Whakapai Hauora clients and their whānau. While prompts are useful, they were not often used during focus groups, as discussions were interactive and lively. The direction in which conversations were steered by focus group members seemed to automatically align to areas of inquiry that I had hoped to explore. Participants felt comfortable in their group settings and seemed eager to share their experiences, views and beliefs among themselves as well as engaging with me in this research. On the other hand, prompts were initiated from time to time during individual health professional interviews in order to gather data and further explore specific issues raised in focus group interviews.

All health professional interviews were conducted on site, either at Tūturu Pumau marae (which is attached to Whakapai Hauora) or within certain areas of Whakapai

Hauora complex (such as meeting rooms) where they felt the most comfortable. Light refreshments were served before each focus group commenced as the importance and significance of kai (food) for Māori is seen not only in terms of the requirements of hosting (manaaki) but also in the spiritual processes of lifting 'tapu' (restrictions) and making things 'noa', i.e. free from tapu / unrestricted (Durie, 1998a).

Interviews with Whakapai Hauora clients

This involved individual face-to-face interviews with clients and groups (whānau who were couples) accessing services at Whakapai Hauora. In total, all interviews took 7 months to complete. Individual interviews are a key in maintaining confidentiality when relating individual experiences and journeys along the care continuum. It serves to collect information on individual views, beliefs and practices which are subjective revealing unique individual experiences. This also allows participants to reflect on their own realities, revealing content in relationship with the context (often a cultural context) which gives their experiences meaning (Bishop, 1996). Only a small portion of participants preferred to come to Whakapai Hauora complex to be interviewed as the majority preferred me to conduct interviews in their own homes. Transport was offered to those who chose to be interviewed at the complex and light refreshments were also served. Interviews were conducted at their request, at times which suited them. When I conducted interviews at participant homes, I was made to feel welcomed, and interviews took much longer than anticipated.

Some participants offered me kai before interviews. The concept of manaakitanga is an important aspect of Māori society having several meanings associated with it. Mead (2003) stated that the principle of manaakitanga underpins tikanga and is significant in terms of nurturing of relationships and being careful in the way we treat people. Being able to share kai with them was an important part in building a rapport and trust with my participants; to also share my time and company with them. Although formal introductions were made during initial visits, our korero also focussed on our whānau. It was a crucial time where whakapapa links were made. There were a number of participants who knew my children's surname as soon as I mentioned it; whakapapa connections were recognised and established through the

Awa (the Whanganui River) where my children's great grandparents had lived, as my children are named after them. Some kaumātua that I spent time with also knew my children's grand-uncles. While sharing kai with me prior to interviews, they shared stories about younger days and the mischief they got up to. There was plenty of laughter, smiles and memories relived of days gone by. Just by listening, having kai, and being privileged to share these moments with them was a celebration whereby all these crucial processes had cemented our ties and relationships; this is an important aspect of whakawhanaungatanga, which is the process of getting to know each other (Bishop, 1996). Walker (1990) stated that connections made through whanaungatanga help identify and clarify participant relationships to each other, thus assisting them to join in the research process; the significance of such an event is reflected in the regard that Māori have for whanaungatanga. As the interviews commenced and progressed, participants were open and very spontaneous in sharing their experiences, beliefs and journeys along their care continuum.

From time to time, prompts were initiated and during the course of telling some of their stories, participants included their views about the health and wellbeing of their whānau and how they also perceived the experiences of their own whānau accessing health and other support services. Sometimes, an individual client or group (whānau) interview took up to 2 hours to complete. Being flexible and patient was key for me, in terms of fitting in with individual timeframes of participants, to conduct the interview at the location of their choice and also to accept their manaakitanga that was so warmly and generously offered to me.

Secondary data

Secondary data collection included the collection, examination and analysis of Whakapai Hauora documents. This included Whakapai Hauora 2004 Whānau Ora Award application documents and supporting evidence, Quality Health New Zealand Baxter Award application documents (for Whakawhirinakitanga Ahua), and health provider service specifications.

Data Analysis

Thematic analysis was used to analyse data obtained from participant interviews: sensing themes, developing codes and interpreting the information and themes (Boyatzis, 1998). Thematic analysis is a process of “encoding qualitative information” (Boyatzis, 1998; p: 7) where the researcher looks for patterns in the data and develops codes to label sections of data, such as themes. I was aware that participants’ experiences and stories would be wide ranging, in terms of focus group interviews (with various health professionals delivering services) and individual interviews (with clients/whānau accessing a variety of services at Whakapai Hauora including external services). Therefore, thematic analysis was best suited for data analysis. The process of thematic analysis began by reading the raw data several times in order to become familiar with the content and to gain a better understanding of participants’ experiences and stories. Passages from the data obtained from semi structured interviews were examined for meaning and to identify patterns, which were then coded according to phenomena of interest, the essence of each theme, and closeness to the data (Boyatzis, 1998). This then allowed for data to be organised and initial themes to be established. Initial themes were further analysed and brought together to form broader themes which encompassed a comprehensive picture of the collective experience from health professionals delivering services and clients / whānau who accessed services.

An analysis of secondary data was mainly for the purpose of providing a context to Whakawhirinakitanga Ahua, health service delivery at Whakapai Hauora, and also for the type of information contained in participants’ stories and experiences. The process of data analysis was not linear, and I often found myself moving fluidly through the data while analysing it as a whole.

Fieldwork

I also examined my fieldwork journal which I had entered notes in during phases of my field work. All interviews were audio-recorded which allowed me to replay and closely listen to particular statements or responses recorded if I needed to revisit any parts of the data. Notes in my fieldwork journal also assisted me to make important links to particular statements and also my recordings of what I may have seen and thought. I transcribed the data as soon as possible, after each interview. Transcripts and notes made in my journal were stored in a locked cabinet at Whakapai Hauora. Clients and whānau were offered their transcripts for review. Whakapai Hauora health professionals that participated in individual interviews were also given the opportunity to receive their transcripts for review.

Being the insider

Being aware of my own personal orientation in terms of my approach to this study (outlined in the previous chapter), I was conscious that all factors noted as being an insider to this research would have some bearing on this study and its findings. Therefore, I applied some measures to counterbalance subjectivity and keep myself in check throughout the course of this research. I consistently recorded what I saw and heard in my journal during the entire research process, and then wrote my personal reactions to this. At times, I found myself critically analysing my own reactions as this helped me to reflect on multiple perspectives and various possible interpretations. I could also return to my journal at any time to re-examine my field notes. This process kept me open to research respondents' views and beliefs; as an insider to the research process, it was about trying to see as much as possible, what was happening within the context of a setting. Another means to counterbalance subjectivity, was having access to the cultural advisor at Whakapai Hauora and some kaumātua from Te Mauri O Rangitaane (The Council of Elders) to discuss certain findings during the course of this study. Undertaking regular supervision with my primary and second supervisors at Te Pūmanawa Hauora, Massey University also assisted in counterbalancing subjectivity.

A Māori analysis

Boulton (2005) noted that basically, a Māori analysis employs the application of Māori frameworks and models. Critical to this research is that Whakawhirinakitanga Ahua is a Māori model of health service delivery underpinned by Māori models and frameworks of health and wellbeing. Therefore, an analysis grounded in a Māori perspective was employed with Māori culture, values and beliefs being central to the process. An important aspect of a Māori analysis also involves the ability to understand and interpret the data in relation to tikanga, Māori epistemology, and Te Ao Māori. Being able to see the bigger picture is crucial in terms of Māori cultural and societal contexts that frame the research. These aspects of a Māori analysis were undertaken by receiving continuous expert supervision in the area of tikanga and te reo, which involved engaging with kaumātua and the cultural advisor from iwi. Supervision was also extensive with both my academic supervisors at the university, particularly with my primary supervisor during the data and analysis write-up phase of this study. When initial findings were completed, the process of establishing the trustworthiness of data commenced. This is discussed in the following section.

Establishing the Research Rigour

A major issue with all research is the credibility of data. Reliability and validity are commonly used tools in establishing the rigour of data. According to Winter (2000), they are both rooted in a positivist epistemology. Joppe (2000) stated that in quantitative studies, reliability is concerned with the consistency of results over a period of time and if results can be replicated by means of a similar methodology, then the research instrument is considered reliable. Shenton (2003) noted that the rigour of qualitative research is quite often debated among positivists possibly because it does not address their concepts of validity and reliability in a similar way. Morse et al (2002, p.5.) noted that the nature of knowledge within a quantitative paradigm is different to a qualitative paradigm, therefore there are distinct *“paradigm-specific criteria for addressing rigour”* in each type of research. The seminal work of Lincoln and Guba (1985) replaced the terms ‘reliability’ and ‘credibility’ with the corresponding term ‘trustworthiness’ which has four aspects comprising of credibility (as an alternative to internal validity), transferability (as an

alternative to external validity / generalisability), dependability (as an alternative to reliability) and conformability (as an alternative to objectivity). In this research, two methods are used to establish the research rigour: triangulation and respondent validation.

Triangulation

In the field of qualitative research, triangulation has been widely advocated as a credible method used to test trustworthiness of qualitative data. Denzin (1970) identified four forms of triangulation: methodological triangulation; data triangulation; investigator triangulation; and theoretical triangulation. Methodological triangulation was employed in this research. Methodological triangulation simply means employing multiple methods to gather data. This was an ideal tool to test trustworthiness, due to having gathered my data from a variety of sources including my field notes and Whakapai Hauora work documents. Supporting data from background documents strengthen any information from participants, while observational notes during interviews give greater depth in relation to participant behaviour (Shenton, 2003). Employing different methods of data collection counterbalances for individual limitations within each method and highlights their corresponding benefits (Brewer and Hunter, 1989; Guba, 1981). Trustworthiness is usually established when findings from different sets of data are able to converge.

Respondent validation

Respondent validation is another means by which trustworthiness may be achieved as participants are able to agree if the findings are a reasonable account of their experience (Richards, 2005; Mays and Pope, 1995; McKeganey and Bloor, 1981). This is another popular method used to establish rigour in qualitative research (Barbour, 2001) and this study had a feedback loop whereby respondents were presented with initial findings for oral feedback. I originally organised 4 separate hui; one for Whakapai Hauora health professionals, another for Whakapai Hauora clients / whānau and the third hui for key community stakeholder groups who worked collaboratively with Whakapai Hauora services (this was to gauge their response to

preliminary findings). Participants were informed of the stakeholder hui and also invited to attend, as it was my intention to engage in the research process with participants as much as possible. A fourth hui was held for the CEO and the Council of Elders (Te Mauri O Rangitaane who endorsed this study). This took place at one of their monthly council meetings.

The first hui was held for health professionals (who were respondents), to provide early findings and gain their feedback. Those who also had individual interviews were agreeable to attend these hui. Feedback indicated that early findings had captured the many experiences of respondents. When this was completed, I proceeded with respondent validation from Whakapai Hauora clients and whānau. I intended having a hui for them to obtain feedback as some participants initially suggested that holding a hui after interviews would be a good idea when they agreed to participate in this study. However an overwhelming majority were not in favour of being identified in a group setting. There were no other reasons given by them, therefore preliminary findings were sent to some who wished to read and comment, while the majority preferred attending the stakeholder hui at a later date. In this way they were unidentifiable and could easily blend in with the crowd. Obtaining feedback from Whakapai Hauora clients / whānau was generally slower. I anticipated that it would take some time before they were ready to provide their responses. Those who read the preliminary findings contacted me by phone later to tell me that they were pleased with the early results indicating that it reflected their experiences.

The stakeholder hui took place at Tūturu Pumau marae (see Appendix 10). This was extremely helpful in terms of verifying some of the research data with regards to processes involved in collaboration and the delivery of care. It was attended by 61 people (including respondents) and stakeholders who were from MidCentral DHB, Central PHO, Public Health Services, CYFS, including a variety of General Practice groups and a wide range of other health, social and disability support provider organisations within the Manawatu. There was also a strong kaumātua presence from Ngati Hineaute, Ngati Apa, and Ngati Porou; affiliations were not limited to a particular hapū in terms of established links within diverse Māori communities. After the pōwhiri and presentation of preliminary findings, questions were raised and

general feedback was given from some members of the audience. Some provided feedback via email (See Appendix 11).

After the presentation during shared kai at Tūturu Pumau, I was approached by some respondents who were clients in this study. They introduced me to their whānau and thanked me for voicing their concerns about their health care. Their verbal feedback indicated that their views were reflected in the early findings as well. One whānau member also commented that the link made in preliminary findings to health and wellbeing in association with marae-based cultural activities was spiritually uplifting as they believed that their tūpuna are always there with them. Te Mauri O Rangitane also provided me with feedback after they were presented with preliminary findings (see Appendix 12) at their monthly board meeting. Early feedback obtained from respondents, stakeholder groups, and Te Mauri O Rangitane suggested that this research has been positive in view of its contribution towards health service delivery for Māori and whānau. However, it is yet to be seen as to how the final research findings may inform the model, Māori health service delivery and mainstream service provision. Later, after the write up of the analysis, another hui was held with kaumātua, the cultural advisor, and one health professional (who was initially involved with the development of the model). This was crucial in terms of obtaining further feedback on the written analysis.

Ethics

Approval

This research was approved by the Lower South Regional Ethics Committee (Ministry of Health), Project Key: LRS/08/07/036 (see Appendix 13). In 2010, there was a change with my primary supervisor. As a result I transferred from Pūtahi-a-Toi (School of Māori Studies) to Te Pūmanawa Hauora (Research Centre for Māori Health and Development, School of Public Health). There was also a change concerning storage and disposal of data. Instead of being stored at Te Pūtahi-a-Toi for a period of ten years (as noted in participant information sheets) consent forms, data, interview transcripts and field notes were to be in the safe-keeping of the researcher or supervisor (where the project is conducted) and disposed of at the completion of the project. This was in accordance with the Massey University

Human Ethics Committee (2010) code of conduct for ethical research. Safe-keeping was discussed with my primary supervisor, and it was agreed that all data would be stored in a locked cabinet at the researcher's workplace. Disposal of data was the researcher's responsibility and this would be carried out by Document Destruction Services. Storage was accessible only to the researcher and supervisor. The Lower South Regional Ethics Committee and all participants were informed of these changes in 2010. All changes were approved by the Lower South Regional Ethics Committee.

Throughout this research, I attempted to uphold all ethical standards set out by the Health and Disability Ethics Committee and the Health Research Council "Guidelines for Researchers on Health Research Involving Māori" (2010). Being fully aware that this research is concerned with relationships with the desire to 'give back' to the community being researched, I followed the ethical guidelines set within the 'Community Up' approach (Tuhiwai-Smith, 1999; Cram, 2001; Kennedy and Cram, 2010) which has been discussed in the previous chapter.

Informed consent

Participant consent is paramount to ethical health research (Boga et al, 2011) and there were a number of ethical implications that needed to be addressed due to my status as being the Health Manager at Whakapai Hauora. An important issue was the freedom to consent or withhold consent. In this study, health professionals were fully informed that participation in this research was completely voluntary; participation or non-participation would not in any way, affect their employment at Whakapai Hauora or their professional relationship with me as their manager. Clients were assured that participation was entirely voluntary and that participation or non-participation would not in any way effect treatment or care for them or their whānau at Whakapai Hauora. All participants were informed that they could withdraw from this research if they chose to. Both oral and written consent was obtained and protective mechanisms such as kanohi ki te kanohi hui with participants were undertaken to explain the study and to answer any questions about this research prior to signing consent.

Anonymity and confidentiality

Participants were informed that their identity would not be disclosed and that any identifiable private information would be held in confidence. While the majority of clients were recruited by means of snowballing, they were also assured that their identity would not be disclosed to Whakapai Hauora health professionals. All raw data transcribed had identifying features removed (participant names, organisation and place names). In the case of focus group interviews, after transcription of recorded interviews, I allocated a pseudonym for each participant. While participants signed consent forms agreeing not to disclose any information discussed at interviews, they also agreed verbally not to disclose the identity of individual members in their group to Whakapai Hauora staff or anyone else. For individual client or whānau interviews, a pseudonym was used to replace each participant's name after they returned their transcripts to me. For those who did not request their transcripts, pseudonyms were allocated after the transcription of raw data. All research data and consent forms will be disposed of in accordance with Massey University Human Ethics Committee (2010) code of conduct for ethical research.

Managing potential risk or harm

Each study carries different risks and a complete guarantee of safety to participants is not possible (Shaw and Barrett, 2006). Therefore reasonable protection is undertaken with appropriate mechanisms to mitigate potential risks or harm that may arise within a study. These may be discomfort (physical, psychological or social), incapacity, or any adverse experience as a result of participation. In this study, there was no potential harm envisaged as the data obtained from participants centred on views, beliefs and opinions on health service delivery. However, individual views can be somewhat disconcerting emotionally for some if voicing negative experiences. Health professionals may criticise their employer, and clients may criticise health service delivery at Whakapai Hauora. Some may raise issues concerning unsafe clinical practice at interviews. Considering all these factors, participants were reminded that they did not have to answer any questions that they felt uncomfortable with. They were assured that this would not affect their participation or contribution to the study in any way. If issues concerning unsafe clinical practice came up during

interviews, participants would have been advised as to whom to approach in order to appropriately address these issues with. Participants who were clients were informed that they could have a person of their choice or a whānau member to support them at their interview. Also, participants who were not comfortable with the interview venue were given the option to choose a venue which they were comfortable with.

Other issues to consider in group environments are that some participants may be domineering, causing discomfort to other members. During focus group interviews, a round table approach was used giving each participant in a group time to answer questions, if domineering situations arose. Focus group members were offered individual interviews if they wished, in order for them to provide their views and opinions on a one-to-one basis with me. During the course of all respondent interviews, none of these risks occurred. Another aspect of safe research involves cultural safety which is discussed in the next section.

Culturally safe research

Cultural safety is closely associated with ensuring ethical research practices. Wilson and Neville (2009) discussed the significance of culturally safe research methodologies and processes when working with indigenous peoples who are marginalised due to historical and contemporary experiences. They suggested that researchers understand and consider their own cultural realities and its impact on those of a different culture when conducting research. Wilson and Neville (2009) also cited four elements involved in culturally safe research: partnership, participation, protection and power; the first three are aligned to the Treaty principles in terms of cultural safety in nursing practice. Power is concerned with engagement, where researchers share 'power with' as opposed to having 'power over' those being researched. Despite identifying as indigenous, I am aware that Māori culture also has its own uniqueness, stemming from traditional beliefs and practices embedded within Te Ao Māori. It was critical to demonstrate these elements of culturally safe practice while conducting this study:

- Partnership: involves developing relationships with the community being researched and establishing their needs, which in this chapter, has been described in various ways, applying Māori methods of engagement. These relationships have also been on-going throughout the progress of this study.
- Participation: involves the inclusion of key members of vulnerable populations in the planning phases of the study. This has been demonstrated by consultation with the community being researched, as this study is community driven. Advice and guidance from key members such as kaumātua and the iwi cultural advisor has also been sought throughout this research process.
- Protection: involves observing key protocols and beliefs of vulnerable populations and recognises the knowledge and epistemologies of vulnerable populations. This has been demonstrated through a Māori centred approach. Methods used for this study, particularly in terms of developing the research tools (i.e. research prompts) for interviews, data collection and data analysis; incorporating a Māori analysis, in order to establish a Māori meaning from the data that will significantly contribute towards Māori knowledge and development.

Power: ‘power with’ requires researchers to be willing and confident to engage in power sharing when conducting research. Wilson and Neville (2009) also proposed that this approach requires having an understanding of epistemologies and discourses that could prevent power sharing. This aspect of conducting culturally safe research has been demonstrated through developing and sustaining relationships and on-going participation by key members from the researched community. It has also been demonstrated in the nature and extent of Māori involvement in this research.

Dissemination of information

Researcher accountability (Cram et al, 2003) and reciprocity (Wolfgramm 2008) are crucial when conducting research with Māori. Therefore, having on-going engagement was key in this research process. Apart from presenting preliminary findings, I met regularly with our cultural advisor and kaumātua from iwi to inform them of the progress of the study and also to seek guidance and advice on any cultural

matters relating to this study. Participants of this study were contacted regularly on a six monthly basis and given updates on the progress of the study after presentation of preliminary findings at Tūturu Pumau marae. In terms of accountability towards the community being researched, the CEO of Whakapai Hauora and Tanenuiarangi Manawatu, Te Mauri O Rangitaane (Council of Elders) were updated on a regular basis through monthly reports to the Council. While engaging with these major groups has been crucial towards maintaining a good relationship ethic in research, results will be disseminated further to iwi, hapū, whānau and Māori. Māori organisations such as Manawhenua Hauora²⁷, Te Puni Kokiri and other Maori provider organisations will be offered the research results. Research results will also be disseminated to mainstream health and social service organisations who work with Māori and whānau, including Māori academics and researchers involved in Māori research, journal publications and kanohi ki te kanohi presentations / conferences. Research results will also be made available to the Central Primary Health Care Organisation, Ministry of Health, Child, Youth and Family Services, Ministry of Social Development, and MidCentral DHB as it is also intended for this study to inform public health policy. The next chapter gives an overview of Whakapai Hauora and its health service delivery model which is explored in this research.

Summary

This chapter outlines the research approach and methods to this study. It also raised crucial factors for non-Māori undertaking research with Māori. Consultation and buy-in from the community being researched was critical in terms of gaining approval and support. Utilising Māori practices of engagement such as consultation hui, kanohi ki te kanohi interviews, sharing kai and whakapapa to connect were some of the most significant aspects of the research process as this allowed me to establish rapport and trust with participants. The amount of relationships established and strengthened through this process, also in terms of on-going engagement with the wider community has been personally rewarding for me in terms of appreciation and support for this research. Being the insider to this study has also challenged me to

²⁷ A consortium of all four Iwi who have mana whenua (territorial rights) status in Manawatu, Horowhenua, Tararua and Otaki districts. Representatives are from Ngati Raukawa, Muaupoko, Rangitaane and Ngati Kahungunu. This consortium was established to advance iwi Maori health and to work together to achieve best possible health outcomes for iwi Maori people residing in these districts.

critically analyse my own thoughts and assumptions in relation to health service delivery for Māori while undertaking analysis of the data. This chapter concluded by outlining how research findings and participant voices may be heard through the dissemination of information.

Chapter Five

Best Care (Whakapai Hauora) Charitable Trust

Introduction

Chapter Five presents an overview of Best Care (Whakapai Hauora) Charitable Trust; Rangitaane o Manawatū health, social and disability service provider that is part of Tānenuiārangi Manawatū Incorporated which is located in Palmerston North. This chapter gives an insight into whānau ora service delivery from a Whakapai Hauora perspective which is concerned with the health and wellbeing of individuals and whānau. Whakapai Hauora has developed pathways towards achieving whānau ora through its own model of health service delivery, Whakawhirinakitanga Ahua. This chapter describes the model and highlights the significance of its exploration in this study.

Tānenuiārangi Manawatū Incorporated

Tānenuiārangi Manawatū Incorporated (TMI) is the iwi authority for Rangitaane O Manawatu since 1989. TMI was the vision of its founder, the late Whaea Ruth Harris, a descendant of Rangitane Chief Tamati Te Panau. As an iwi authority, TMI deals with Treaty claims and consults with local and national organisations on matters affecting the tribe. Apart from Whakapai Hauora, TMI also has a bi-lingual radio station, an environmental centre and a marae. Te Ao Turoa, TMI's environmental centre provides assistance and advice with resource consent applications, submissions, as well as policy and plan interpretation. The centre gives information and consultation on Māori values and perceptions in relation to the environment. Te Hotu Manawa o Rangitaane o Manawatu Marae (Tūturu Pumau) also provides an environment for cultural activities, training and community events.

Best Care (Whakapai Hauora): an iwi health, social and disability support service provider

Whakapai Hauora is a non-profit service provider owned and operated by TMI in Palmerston North. Established in 1995, Whakapai Hauora is committed towards total wellbeing of its community. It provides holistic health and social services along a continuum of care to improve the health and social status of its community. Enabled by the health reforms of the early 1990s, Whakapai Hauora has grown into one of the largest iwi health, social service, educational and disability support service providers in Palmerston North. Initially, health service delivery commenced with the provision of a part-time General Practice service and a community health nursing service.

In order to meet both growing needs and health demands of its community, Whakapai Hauora was successful in building health and social services through a wide range of funding organisations, with the larger proportion of service contracts funded by the Ministry of Health and MidCentral District Health Board (MDHB). The devolution of services enabled by the health reforms during the 90s as well as Māori desire to have tino rangatiratanga over their own health services created the avenue for this to occur. Although its target population is Māori, Whakapai Hauora also provides a range of services to a diverse community (see Appendix 14). Whakapai Hauora management structure works with key stakeholders in order to ensure community needs are incorporated into planning service provision and delivery. Whakapai Hauora is part of a much larger entity that operates from within Te Ao Māori.

Whakapai Hauora Vision

“The most proactive, culturally appropriate client-centred provider of holistic health, disability support and social services for people regardless of age, disability or cultural background in the Manawatu.”

Whakapai Hauora Mission Statement

“Kia haere waimarie ana ki runga i te Whaea Papatuanuku”

(To empower people to significantly improve their well-being to walk in balance on Mother Earth through exercising choice in healthcare)

Whakapai Hauora’s vision as a ‘client-centred’ provider is reflective of the health environment at the time health reforms took place in the 1990s; the devolution of services to NGOs and Māori providers offering people individual choice in accessing services that were more responsive to their own needs.

Striving for excellence in Te Ao Māori and Te Ao Pākehā

The organisational culture is underpinned by tikanga and kawa of Rangitane. There is a strong kaupapa Māori focus which filters through the organisational structure of Whakapai Hauora headed by Te Mauri o Rangitane Manawatu (Council of Māori Elders) who meet on a monthly basis with management to discuss governance issues. Employees are encouraged to attend kapa haka and waiata sessions regularly and the annual Matariki Noho²⁸ event which is also part of team building. They are offered Māori language classes and cultural supervision by kaumātua. Apart from a Māori focus, there is a strong emphasis on a culture of continuous quality improvement, based on mainstream accreditation standards as well as Māori health frameworks.

The organisation has dual accountability towards delivering services that are underpinned by Māori models of practice as well as mainstream best practice models. Whakapai Hauora has been accredited by Quality Health New Zealand²⁹ since 2003 and the Royal New Zealand College of General Practitioners since 2006. Employees actively participate in quality improvement processes covering aspects of policy and procedure development, infection control, occupational health and safety, risk management and quality control. Formalising service planning, strategic

²⁸ Matariki is the Māori name for the group of stars also known as the Pleiades cluster of the seven Sisters; and what is referred to as the Traditional Māori New Year. This is marked by the rise of Matariki and the sighting of the next new moon. Whakapai Hauora holds a noho marae (overnight stay at Tuturu Pumau marae) every year for hapū, whānau and staff to celebrate this event.

²⁹ currently known as the DAA Group, leading providers of quality and risk management auditing services to the health and disability sector in New Zealand.

development and establishing audit measures are developed through processes involving both management and employees.

The organisation strives for high performance, and over the years has won several major awards for health service delivery, management and quality improvement at The Ministry of Health, MDHB and Quality Health New Zealand Awards. Central to these achievements are the provision and delivery of best care which is reflected in the name of the organisation (Whakapai Hauora) towards attaining best outcomes for individuals, whānau and the community it serves. This thesis which is an exploration of Whakawhirinakitanga Ahua is another critical step towards Whakapai Hauora seeking best outcomes in service delivery and care.

Strategic direction of the Government and funding implications

Government strategies direct the way in which funding is allocated for health services in New Zealand, thus having a bearing on the types of health contracts Whakapai Hauora obtains through its funders. At present, Whakapai Hauora services are funded by MDHB, Ministry of Health, Central Primary Health Care Organisation, Child Youth and Family Services (CYFS) and Te Puni Kokiri. There are also a number of external forces that impact directly or indirectly on the operations and strategic direction of Whakapai Hauora such as local community and consumer health needs; MDHB strategies/policies; decreasing government funding (e.g. capitation, budget holding); funder expectations that are disproportionate to funding levels, a competitive contracting environment; information technology capacity, priority outcomes for Māori, service consumer wellbeing status and health consumer access and choices to services. However, a critical driver of health service delivery is the relationship between Whakapai Hauora and its funders underpinned by Treaty principles (i.e. government/crown organisations to have partnerships with iwi/Māori providers and both parties to have active participation in service design, development and delivery).

At a local level, Whakapai Hauora set in place a Memorandum of Understanding (MOU) with MDHB since June 1999 in which both parties give effect to their Treaty relationship. This works at a governance level between both parties who have agreed in principle to work in partnership to:

- Add value to the delivery of health services to Māori in the Manawatu;
- Examine opportunities for joint venture, sub-contract and other arrangements for the delivery of specific services to Māori;
- Improve the performance of each organisation through the sharing of knowledge and information as appropriate; and
- Both parties will consult with each other on issues of significance, which are likely to impact on Māori health development in the Manawatu and in particular on the health of Rangitaane O Manawatu. (Best Care Whakapai Hauora Charitable Trust, 2013).

Through this relationship, Whakapai Hauora and MDHB have collaborated and participated in several of joint initiatives sharing information, knowledge, expertise and resources with each other. Examples include having the Mobile Dental Health Unit at Whakapai Hauora, MDHB staff supporting Whakapai Hauora in its journey towards accreditation and Whakapai Hauora staff being able to access MDHB training programmes for workforce development. In terms of Māori leadership, Whakapai Hauora health professionals contribute towards the development of MDHB health priority plans by participating in district management and reference groups, and committees established to monitor and implement MDHB strategies and plans. Whakapai Hauora is also part of Manawhenua Hauora³⁰ who also has an MOU with MDHB which are:

- to have a common interest and commitment to advancing Maori health;
- to build on the gains and understandings already made in improving Maori health;

³⁰ is a consortium of our Iwi who have manawhenua status in Manawatu, Horowhenua, Tararua and Otaki districts. The roopu comprises representatives from Ngati Raukawa, Muaupoko, Rangitaane and Ngati Kahungunu. For further information refer to the MDHB website: <http://www.midcentraldhb.govt.nz/AboutMDHB/manawhenuahauora/Pages/default.aspx#>

- to apply the Treaty principles towards achieving the best outcomes for Maori health; and
- to work in partnership and mutual regard.

Health inequalities in the MidCentral Region³¹

The last health needs assessment conducted by MDHB was in 2008. The health status disadvantage of Māori was evident for the five most common causes of mortality which are circulatory diseases, cancers, respiratory diseases, endocrine diseases and external causes (accidental and non-accidental injuries). Socioeconomic disadvantage was slightly worse for the MidCentral region compared overall within New Zealand, being higher in Horowhenua and Otaki. This assessment also suggested that socioeconomic disadvantage had possibly increased due to those experiencing hardship. Blakely and Simmers (2011; p: 3) stated that fundamental drivers of health inequalities are an unequal distribution of social determinants (income, housing and employment). Behavioural risk factors such as smoking and unhealthy eating also contribute to health inequalities.

Apart from Māori health provider development and key policy documents in the early 2000s that include equity goals, Blakely and Simmers (2011; p: 4) also cited a number of activities undertaken by Government to address health inequalities such as the implementation of social welfare policies for example, Working with Families; and the implementation of intersectoral activities such as the Healthy Homes Programme (insulation of homes), Before School Checks and the National Immunisation Register. However, Blakely and Simmers (2011, p: 5) noted a number of critical actions required to further address inequalities; to maintain and enhance social cohesion by ensuring accessible services for all. They stated that this requires a whole government approach with greater and better coordination from ministerial to service delivery levels.

³¹ Taken from the 2008 MidCentral Health Needs Assessment.

It also involves a greater understanding of health equity where everyone working in service delivery can change their practice to reduce inequalities ensuring that all health services are equity focused; for example, the prioritisation of health resource allocation, quality improvement policies, programmes and information systems. This includes monitoring and on-going provider education and support. MDHB health priority areas seek to address health inequities for Māori; these are outlined in the MidCentral District Health Board Māori Health Plan 2013/14. As MDHB are major funders for Whakapai Hauora and partners in health service delivery, the organisation's strategic health goals are aligned with MDHB local Māori health priorities.

Strategic direction of Whakapai Hauora

In MDHB's Māori health plan (2013/14), Manawhenua Hauora identified four local Māori health priorities. These are smoking cessation, oral health, women's health and whānau ora. Three significant priorities relate directly to the strategic direction of Whakapai Hauora services in terms of achieving best outcomes for Māori, whānau and all its clients:

- Smoking cessation: smoking identified as a behavioural risk, contributes towards health inequalities. Whakapai Hauora is part of a Māori provider smoking cessation collective (Te Ohu Auahi Mutunga service) targeting Māori and pregnant women. This service employs a whānau ora approach and also uses general practices' databases to capture potential clients and whānau for the service. MDHB have invested in smoking cessation resources for this service.
- Women's health: A new model of service for regional women's health services will be implemented by MDHB and Whanganui District Health Board. The consultation process involved was extensive involving iwi partnership governance boards from both DHBs (Manawhenua Hauora and Hauora a Iwi) who provided feedback and challenges in improving cultural responsiveness to services. This is to address Māori health outcomes and reduce health inequalities for Māori and high needs groups. Whakapai

Hauora already has an existing contract with MDHB to provide free contraceptive services to women who are Māori, Pacific Island and under 25 years of age. This service has been in place since 1997 and continues to roll over on a 3 yearly basis.

- Whānau ora: there are two local Whānau Ora collectives that were accepted into the Te Puni Kokiri Whānau Ora programme: Te Hono ki Tararua me Ruahine; and Te Tihi o Ruahine Whānau Ora Alliance (which Whakapai Hauora is part of). Both collectives have consulted extensively with whānau, hapū, iwi and a wide range of agencies concerning organisational arrangements and future priorities in terms of Whānau Ora service delivery. Such a process is challenging in terms of getting a diverse range of stakeholders to define Whānau Ora, how it could meet the needs of their communities and agreeing upon how whānau ora service delivery would be implemented in their communities. Implementation plans were to be completed by both collectives in 2013. MDHB will support Whānau Ora through the planning and implementation phase; and has committed to review contracts with providers to meet the aspirations of these two collectives with the aim to move towards outcomes orientated contracting.

Whānau ora from the perspective of Whakapai Hauora

For whānau ora to occur, the health, social, economic, political and cultural needs of whānau must be met collectively in an intersectoral, collaborative manner. Whānau, one of the four cornerstones in Te Whare Tapa Wha provides strength, tautoko, security and identity to Māori. It is also the concept of manaaki that underpins quality of life, and to live as Māori:

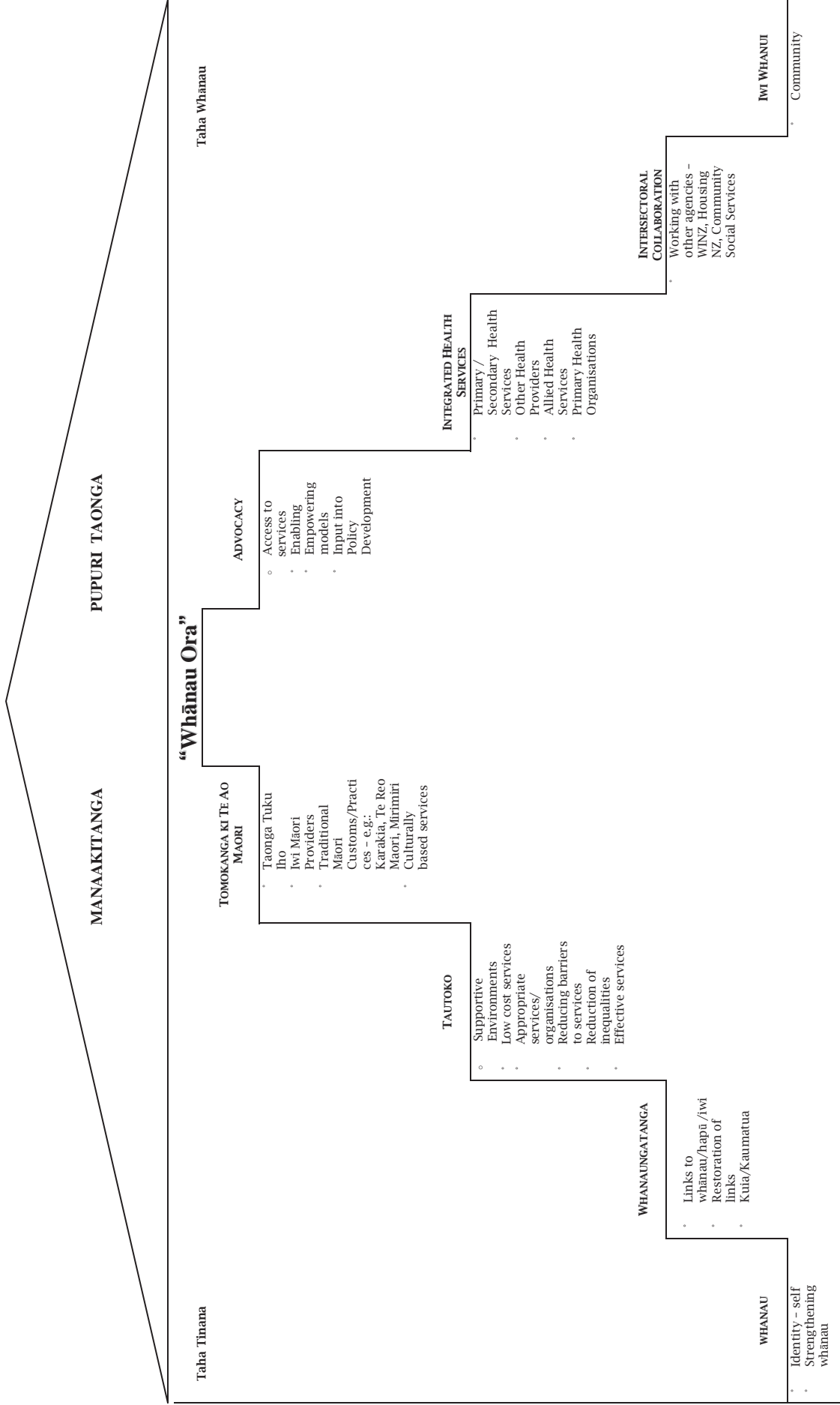
“Manaakitanga is one of our most important values as Iwi. It is protecting, people - centred and extends beyond routine caring. Manaaki is concerned with life and involves sensitivity, caring, empathy, tolerance, compassion and accountability.”

(Best Care Whakapai Hauora Charitable Trust, 2013).

As Whakapai Hauora services grew through contracts from a range of funders, service delivery was underpinned by a number of different models for example, the biomedical western model (in diagnosing disease), nursing models of practice (client-centred) and Māori models of health (Te Whare Tapa Wha). This evolved over a number of years with the diversity of people working within the organisation. Eventually, there was a need for a cohesive way to articulate a model of service delivery that reflected practices at Whakapai Hauora. With the introduction of He Korowai Oranga in 2002 emphasising whānau health and wellbeing as being central to Māori, Whakapai Hauora developed its own model of health service delivery towards advancing Māori health and reducing inequalities. Whakawhirinakitanga Ahua was developed in 2004. Whakapai Hauora also outlined pathways which progressed towards achieving whānau ora; housed within Te Whare Tapa Wha, these steps are overarched by the value of manaakitanga and the ideal of pupuri taonga³². Underpinning these steps are values stemming from Te Ao Māori and also the Treaty principles of partnership, protection and participation in relation to health. The diagram on the next page sets out Whakapai Hauora pathways towards achieving the goal of whānau ora (as illustrated in the 2004 Ministry of Health Whānau Ora Awards).

³² Pupuri taonga refers to whānau having the capacity for guardianship, therefore whānau are considered as a treasure for further generations.

Diagram 1: Whakapai Hauora Pathways towards achieving Whānau Ora (Ministry of Health Whānau Ora Awards 2004)



Taha Hinengaro

Taha Wairua

TE TIRITI O WAITANGI* Kotahitanga Tino Rangitiratanga

He Whakatauaaki: “Ko te whānau te hunga tuturu, ko te kaupapa hoki o te iwi”
The family is the natural and fundamental unit of society

Note: a diagram illustration of Whakapai Hauora pathways to achieving Whānau Ora (adapted from Best Care Whakapai Hauora Charitable Trust, 2004).

It was established that Whakawhirinakitanga Ahua would address the needs of whānau and contribute significantly towards achieving whānau ora. A small project team consisting of two Whakapai Hauora staff members at the time initiated this project. Wide and extensive literature searches were undertaken covering areas of Māori health models, whānau ora and Ministry of Health documents (policies, strategies, plans). A draft was created and consultation took place at management level. Amendments were made and consultation again took place between Te Mauri O Rangitaane Council of Elders, Iwi, hapū, whānau, managers, staff, and also among service consumers via focus groups. The final draft of Whakawhirinakitanga Ahua was then ratified and implemented at Best Care Whakapai Hauora. The approach taken in terms of initiating this model was top-down³² as it was developed by management, endorsed by Te Mauri O Rangitaane O Manawatu (Council of Elders) and then transferred through Whakapai Hauora services.

Whakawhirinakitanga Ahua as a Māori model of health service delivery

Whakawhirinakitanga Ahua is a system of interdependence derived from nga kete o te mātauranga and delivered within the framework of Te Whare Tapa Wha. It is a model based on a collaborative and multidisciplinary approach in addressing the health needs of individuals and their whānau. Whakawhirinakitanga Ahua is depicted as a series of relationships fanning out to form a collective web with the individual at the centre, surrounded by whānau. Strands within the web also stretch out to whānau, hapū and iwi, Whakapai Hauora services, other primary and secondary care health providers, community organisations, groups and wider related supports (including key stakeholders, national health, social and disability support service).

³² An approach that begins at the highest conceptual level and then works down to the details.

The word “Whakawhirinaki” means “to bring together” and tanga (the suffix) indicates a rapid sequence of events:

“Strand by strand Whakapai Hauora staff begin to weave a seamless wrap around service for the service consumer / whānau; Whakapai Hauora team members use all their skills, expertise and resources to enable the service consumer to achieve maximum health and well-being”

(Best Care Whakapai Hauora Charitable Trust, 2013).

Each relationship within the web relies on the other for support, strength and sustainability. A weakening of the relationship has a ripple effect on those surrounding it thus affecting its overall efficacy. This model is also underpinned by nga kete o te mātauranga which provides the base from where knowledge in terms of service provision is derived. According to those who developed the model, these baskets contain information towards delivering collaborative services that are effective towards meeting Māori and whānau needs. The picture on the following page depicts the three baskets within a contemporary context of health service delivery at Whakapai Hauora.

Picture 1: Nga kete o te mātauranga:

The following picture illustrates Whakapai Hauora interpretation of the concept of the three kete within Whakawhirinakitanga Ahua in 2004 at the time of the model's development. It is a contemporary interpretation of nga kete o te mātauranga within the context of health service delivery at Whakapai Hauora.



Te kete Tua-uri: Knowledge from this kete is specialised and held by the key worker³³ who works closely with individuals, whānau, other community agencies and intersectoral organisations in order to sustain a balance while weaving seamless wrap around services for individuals and whānau.



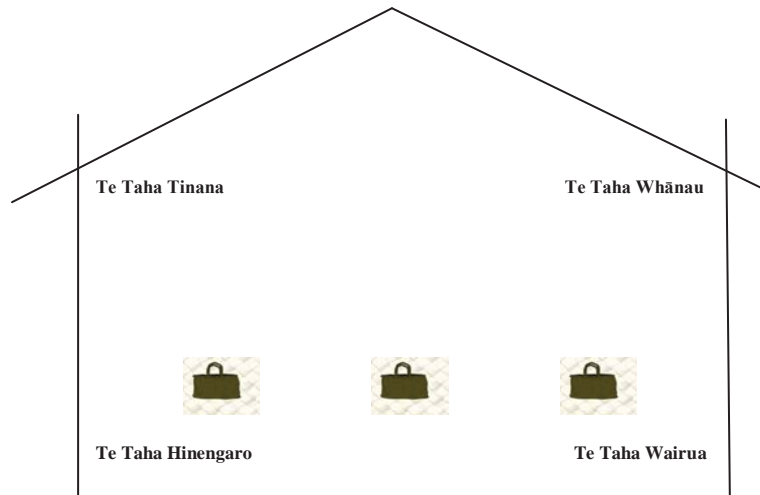
Te kete Aro-nui: Knowledge from this kete is obtained from health professionals and community workers within agencies, organisations, including key stakeholders that contribute towards the care continuum of individuals and their whānau.



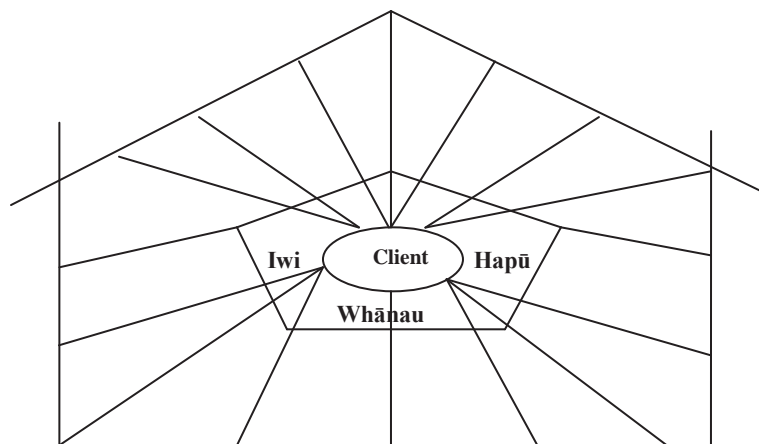
Te kete Tua-atea: Knowledge from this kete is concerned with the spiritual realm. Man is a spiritual being within himself (Marsden and Henare, 1992). Therefore derived from this kete is knowledge obtained from individuals and whānau in terms of acknowledging their wairua and meeting their needs in the provision of care. The diagram on the next page illustrates this model.

³³ At the time this model was developed, community nurses, social workers or community health workers working at a grassroots level with Māori and whānau were often referred to as key workers.

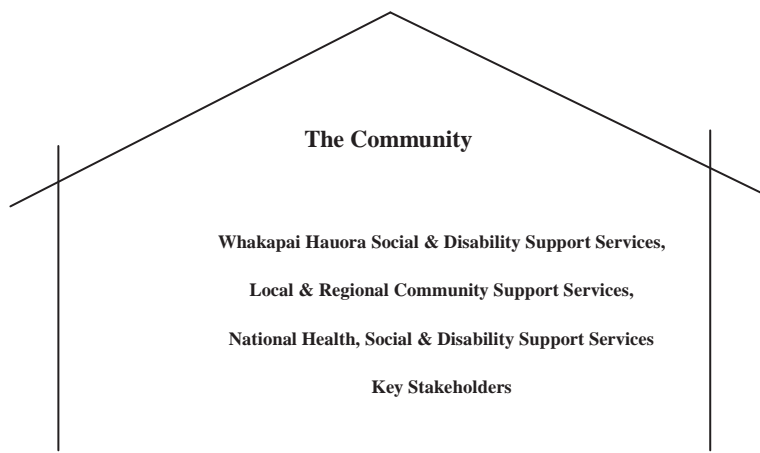
Diagram 2: A depiction of Whakawhirinakitanga Ahua (when developed in 2004):



Whakawhirinakitanga Ahua is depicted as a web within a whare; the four pillars of the whare are firmly supported by Te Whare Tapa Wha. Within the whare are nga kete o te mātauranga; these kete contain knowledge from key workers, individuals, whānau and other health professionals/service providers that underpin the delivery of wrap-around services for individuals/whānau.



Encased within the whare is a web; at the centre of the web is the client, surrounded by whānau, hapū and iwi. Strands within the web connect and strengthen the client within four pillars of the whare.



Whakapai Hauora service providers begin to weave a seamless wrap around service for the client; strands woven within the web connect the client to whānau, hapū and iwi, Whakapai Hauora services, other primary and secondary care health providers, community organisations, groups and wider related supports including key stakeholders, national health, social and disability support services.

The recognition of Whakawhirinakitanga Ahua as a Māori model of health service delivery

After the implementation of the model in 2004, Whakapai Hauora entered the Inaugural National Māori Health Provider Awards (2004) held by the Ministry of Health and won the Quality Award, Excellence in Management Award.

Whakawhirinakitanga Ahua won the highly commended award in the Whānau Ora Award section. The following year, in 2005, Whakawhirinakitanga Ahua was presented at the Quality Health New Zealand / Baxters Awards and took away the Māori Health Provider Award. Since then, Whakapai Hauora went on to win a series of other awards with Whakawhirinakitanga Ahua as its model of service delivery.

The model was developed as a conceptual framework that describes the way in which services are delivered at Whakapai Hauora and is underpinned by Māori values and belief systems. This model was designed to improve the health and wellbeing of

Māori from a holistic paradigm within Te Ao Māori. Health service delivery is a dynamic concept that changes to suit the needs of its consumers.

Summary

This chapter gave an insight into Whakapai Hauora and its model of health service delivery, Whakawhirinakitanga Ahua. Enabled by health reforms in the 90s and self determination to develop and deliver services to Māori, Whakapai Hauora grew into a large provider of health, social and disability support services in the Manawatu.

Through Treaty principles of partnership and participation, Whakapai Hauora has established a strong working alliance with MDHB, its main funder towards achieving Māori health gains and addressing health inequalities. With a growing number of services, a range of diverse staff and various models of practice, there was a need to develop a cohesive model of service delivery that reflected practices at Whakapai Hauora. With He Korowai Oranga in 2002 placing an emphasis on whānau health and wellbeing, the organisation worked towards developing its model of service delivery, Whakawhirinakitanga Ahua with steps towards achieving the goal of whānau ora. This thesis which is an exploration of Whakawhirinakitanga Ahua, is a critical step towards Whakapai Hauora seeking best outcomes in service delivery. The next chapter contains initial findings of data gathered from primary sources, Whakapai Hauora health professional interviews.

Chapter Six

“It’s all about Collective Care”:

“It’s all about collective care, wrap-around care built on strong relationships,

Whakawhanaungatanga³³”

Introduction

Chapter Six presents findings from health professional interviews. Findings begin with their understanding of Whakawhirinakitanga Ahua (the model of service delivery) and the way in which it captures the complex nature of their work. How they work with clients and whānau, with each other, and how they work collaboratively across sectors are presented, including the many challenges they face. Their views are wide ranging and varied as the participants themselves who provide services to individuals and whānau. Findings also include what respondents envisage as best outcomes for their clients and whānau. The data is presented under four headings, with several sub-headings. This chapter concludes with a table containing a framework of service delivery from which both Māori and non-Māori health professionals operate when delivering services at Whakapai Hauora.

1. Understanding models of health service delivery

Initial findings captured data that centred on the ways in which respondents deliver services, collaborative care including their understanding of the model Whakawhirinakitanga Ahua. Their responses were diverse as the population they serviced however, reoccurring themes that were identified included a holistic and collaborative model of health service delivery.

³³ Health professional focus group interview, 24th April 2009.

Māori views of a holistic model of service delivery

A reoccurring feature among respondents was acknowledging the significance of Whakawhirinakitanga Ahua as being a holistic model of health service delivery. Some voiced this reflecting a range of Maori values and concepts or through client-centred approaches in care. Māori respondent views were closely linked their own cultural values, beliefs and Māori models of health. This is demonstrated by some of the following statements:

“Whakawhirinakitanga [Ahua] is the holistic embracement of all... Whakawhirinakitanga [Ahua] demonstrates how it works, pulling in whatever care is needed for clients and whānau, wrapping them securely in a safe and secure weave of care; starting firstly with the sound pillars of Tūturu Pumau [Rangitaane o Manawatu marae] that represents importantly the whenua, our tūpuna, aroha and our culture, significantly spinning tightly together are our Kaumatua, kuia, o te iwi, nei thus adding enduring strength to our web of service that being Best Care Whakapai Hauora.” D: 1, 2.

Another respondent also spoke of how Māori health models interlink holistically, and are not separate from each other:

“Well to me, it’s [Whakawhirinakitanga Ahua] just kind of like an encasement of Te Whare Tapa Wha and then you’ve got the ketes which we have too, but they’re not something that becomes problematic and that you have to go “oh what’s this?”... and they seem to complement each other, and working with them and they haven’t been a problem in which you go “oh, what’s that one?” It’s holistic it’s not something separate; they all join in...” C: 3, 4.

Māori models of health and wellbeing are ways of expressing traditional values and beliefs. One respondent from community health nursing services believed that Whakawhirinakitanga Ahua was based on working as a collective to provide services and to support clients. This respondent’s statement highlights the weaving of kotahitanga (unity, which is a traditional value) into contemporary service delivery:

“Our land, all that is on it, our tūpuna, kaumātua, whānau, and our people are what I see as being important to holistic wellbeing, and Whakawhirinakitanga [Ahua] ... it’s about gathering everybody together to manaaki them[clients] in one role and then it sort of connects with Te Whare Tapa Wha which is delivered here. So it’s sort of yea...whirinaki, is sort of bringing them in all into one, like a bigger holistic-type model.” J: 1.

Another respondent highlighted the importance of wairua and a collective approach to health care delivery:

“Well, we have a model of health delivery for the clients we serve and I think it is applicable, Whakawhirinakitanga Ahua has a wairua to it; it’s followed through with everybody doing a similar thing and it’s far more holistic to care to any mainstream models of care.” A: 1.

The same respondent also said:

“...it’s all encompassing and that we’re working with our client, their whānau, hapū, iwi and also with the community to make things better and to get that optimal outcome for them.” A: 2.

Non-Māori views of a holistic model of service delivery

Non-Māori respondent views about Whakawhirinakitanga Ahua being a holistic model were associated with valuing what was important to the client when delivering services. One respondent stated:

“I think it’s a very great model to use in my service... the focus is very much client-centred and so I think with that model, it incorporates all the beliefs and what is really important for the client; and it incorporates like a holistic overview for that person you know, with their spiritual needs and their mental wellbeing and it’s a very empowering model I feel because even though you are working alongside the client, it’s pretty much an empowering model for them to be able to empower them to look after their needs as well as incorporating other sources, you know; the support networks that you need to make it work.” P: 1.

The same respondent also commented on the importance of including spirituality in holistic care:

“And when you work holistically, you have to consider their spirituality as well, if it’s important to them to practice their faith and their religious beliefs, so you sort of support them with that as well.” P: 3.

Another respondent made a similar statement:

“I do encourage religious practice that’s important to any of my clients, cos it can help them accept illness and come to grips with their situation...it also gives them hope, it helps to heal...it’s an important part of holistic care, considering their wairua.” L: 2.

Nursing models of holistic practice in New Zealand are aligned to the Treaty principles of partnership, protection and participation. One respondent articulated the application of such a model and how it related to client-centred practice:

“It’s the total package of how we deliver that care; our care’s based on this model; it’s holistic and it looks at a person as a whole; and their extended family, and how we can care for them covering all the aspects like wairua, and all the things that we need that take into account the Treaty, and their principles of protection, participation and partnership, and all of the things that are specific to each individual that they may want included in their care” Q: 1.

Another respondent linked holistic approaches to collaboration with other providers including clients in order to provide greater access to other services to meet individual needs:

“Our model is a collaborative and holistic one; we talk to each other [service providers] about patients and we talk to our patients, allowing patients ... clients, the opportunity to go through different services or giving them the opportunity to, if they need to, to meet their individual needs.” M: 1.

It should be noted that despite these differences in holistic beliefs, both Māori and non-Māori health professionals practiced alongside each other and believed that they were all working in a similar way, with a unified approach to deliver care. They acknowledged a holistic perspective as being critical to service delivery.

A collaborative model of health service delivery

Respondent views concerning collaborative care were linked to the model. Various ways in which respondents understood and related to Whakawhirinakitanga Ahua was evident in their approach to delivering care within their own organisation as well as using other external provider services. In some services such as mental health and addiction collaboration is essential in order to meet the needs of individuals and whānau. One respondent believed that the combination of internal and external services was a strength in service delivery; providers would support each other when gaps in service delivery occurred:

“Whakawhirinakitanga [Ahua] is the embracement of all. This model to me is a service plus outside services, all being spun into a strong web of care; if a link is weakened or broken, it will be supported by the rest that when tangata whaiora approach our service they are embraced and trust that the services provided are the best care possible.” D: 1.

Another respondent believed that the model guided processes involved in service delivery which was based on collaborative relationships between their service, other services, the client and their whānau. This respondent’s statement relates to the weaving of another traditional value ‘whanaungatanga’ into contemporary service delivery:

“Whakawhirinakitanga Ahua is a model that guides us, in that tangata whaiora are at the centre of the web which is attached to the wharenuī³⁴, Tūturu Pumau, and what happens is that when we see tangata whaiora through assessments, through their treatment plans, aromatawai³⁵, we start to weave strands, relationships... with their whānau, other services as we need to; and also reaching out into the community so weaving then those strands, whanaungatanga around our tangata whaiora as we need to...” E: 1, 2.

Another respondent indicated that service delivery was about collaborating and integrating resources and services in an efficient cost-effective manner:

“Using all the resources available whether they be Māori health providers, secondary or primary health providers ... bringing them all the care that is necessary for our clients in a collaborative and integrated way...not doubling up on services which happens a lot. But utilising all that there is to give our clients in our community.” A: 3.

The model encourages collaboration in order to facilitate greater access to services that individuals and whānau require. This also involves the ability to navigate clients and whānau through the health system. One respondent’s statement highlighted the importance of having knowledge as to what services are available to clients and how services can be more appropriately accessed:

“... from my point of view, when I think of the model, is specifically being aware of all the other services that a client could tap in to and pointing them in the right direction. Sometimes, only to do the actual referral and sometimes only you need to direct, or give advice ...this is the way that you go, so it’s like being the citizen’s advice bureau

³⁴ The meeting house; main building of a marae used to accommodate guests

³⁵ meaning assessment

for this patient that's how they can access all kinds of services that would be important for their health." M: 1.

Another respondent also noted that the primary and secondary care interface can be difficult for some clients and their whānau. This respondent believed that collaborative care also involved active client and whānau participation:

"Yes, it's about making their access easier in some cases...particularly between the interface of primary care and secondary care which is quite a hurdle for some people but also integrating the family and the patient... sometimes ... I mean sometimes, the deal between this patient and the family is to see a therapist, and the patient is out there somewhere, so you have to draw them all in ... family needs are also important to consider when they have to help support the patient". N: 1.

There are certain benefits for service providers who work collaboratively such as the provision of support among each other when gaps in service delivery occur and the cost effectiveness of services. Having sufficient knowledge about the availability of other services in order to navigate clients through the health system and engaging with clients and whānau in order to encourage active participation in care were also noted as being key aspects to collaborative care.

2. Barriers to access and collaboration

Respondents discussed a number of significant concerns related to service delivery in terms of barriers to accessing care and collaborating care. These were limited funding and resourcing, overlapping of health services in some areas of service delivery, lack of awareness among mainstream providers concerning Māori provider diversity and services, mainstream provider attitudes towards collaboration and mainstream provider attitudes towards their clients. Respondent issues are raised in the following section of the data.

Limited funding and resources

A major concern for respondents who worked in health services was limited funding and resources. They spoke of the limitations of existing health systems and difficulties in seeking alternative avenues when delivering care. One respondent related this issue to other provider attitudes of ‘passing the buck’ in terms of entry criteria to a service which causes delays to accessing assessment and treatment:

“The barriers in mental health! ... They [mainstream mental health services] can’t treat the ones you want because they [clients] don’t meet the criteria! They [mainstream mental health services] say ‘it’s an alcohol and drug issue’ and you think that well, if they did a comprehensive assessment, maybe they’ll see that this person actually has, whatever, some disorders prior to drug and alcohol use; but that [a comprehensive assessment] was not done. They’ll [mainstream mental health services] just say ‘it’s a drug and alcohol issue, it’s not a mental health issue’. So what? They [clients] still need to be seen by a professional so any door’s the right door and to get them into [name of an acute mental health service provider] too, is sometimes a barrier; to get tangata whaiora help. I mean that takes a long time, you know, to go and get someone to help someone at [name of an acute mental health service provider]. So I see this as lack of funding and resourcing and I mean that we’re not a crisis service here. We don’t know anywhere to put tangata whaiora and look after them 24 - 7³⁶.” C: 12.

Another respondent working in an outreach clinic also stated:

“I’ve found in the outreach [clinics], a lack of resources³⁷; now for some reason I cannot practice as I do back here [at Whakapai Hauora] effectively... the funding and resources are not there and I cannot stabilise my tangata whaiora as quickly and effectively as they can be stabilised, and there’s a lack [of services to cater] for transient people who keep in that perpetual cycle of drug use because they are drifting from house to house and only friends they know; because you find that with the drug and alcohol [issues], more tangata whaiora tend to only know one circle of friends who also have the same addiction, so you try to stabilise them cos they have no place to live. They will drift from house to house, where all that stuff goes on; those behaviours go on; It’s not just the [lack of] resources... there’s a high need and you get these transient tangata whaiora who keep perpetuating the same behaviours; and I come in and I counsel them but it’s not as effective and sometimes I haven’t been able to get tangata whaiora into other services because their books are closed due to a lack of funding.” F: 11.

³⁶ “24 – 7” is referenced as being a 24 hour per day job.

³⁷ Resources in this respondent’s statement refer to a rehabilitation centre or a safe house for those with addictions.

Another respondent spoke of the inadequacies in mental health services, highlighting the limited resources available to some clients who need acute care. Respondent R's story also demonstrated the consequence of inappropriate access to a service when proper services were unavailable:

"I think one of the things is limitations for mental health services. They haven't got safe services. Say, somebody has rung; this client is suicidal or whatever; they will only keep them for a few hours. A social worker might come back and talk to them and all that ... but there are very limited appropriate services for follow-up for these things... And the worse incident happened with one of my clients who was suicidal. Her husband got very frightened that she could harm herself. So he rang [name of Crisis service]; there was no answer for several minutes, no answer at all. And then he rang 111 and got the police. The police came when he said what she was doing; 2 or 3 cars blaring, you know ... with the lights going on and all that. By that time, the client had finally settled in bed. It was alright. But they said "you have to come to the police station." She said "No I don't want to go". But they said "otherwise we will arrest you". So the whole thing went bad. She spent 2 or 3 hours there, and then she was just dropped off outside her house, and they were gone ... this is not good care; mental health services should be available and the police should know how to deal with that ... cos you wouldn't upset the client. But you can see that's not service ... very inadequate." R: 6.

The following conversation was from a focus group interview where three respondents discussed the barriers they faced in delivering services. The issue of closed books compounded by health professional shortages were difficult; however one respondent believed that it was also not having enough knowledge to access key people in certain service areas:

"Money, funding. Cost...the most frustrating thing is closed books! Like up at the [name of secondary care service] ... they're not taking any more patients so they close the books and can't deal with the demand because of funding." N: 3.

"Yea, but I also think what compounds it is the shortage of health specialists out there; those specialists. It makes it so hard ... you don't know where to send people who need that kind of treatment." O: 3.

But I believe also, it's who you know, or actually who you don't know. So it's a lack of awareness or knowledge of what's really out there. M: 3.

Lack of funding and resourcing are barriers to clients accessing appropriate care in an appropriate and timely manner. Also, having adequate and appropriate knowledge of services and key contacts are vital for both service providers and clients in order to avoid negative consequences associated with the use of inappropriate services to deal with acute care situations, such as mental health care.

An overlap of health services

On the other hand, respondents also identified a lack of awareness among service providers in general which resulted in an overlap of health services. The issue of overlapping health services may also be attributed to working in silos where individual organisations focus on their own goals and objectives:

“I recently went to a forum for services out there; they were all set up to basically do similar things; you’ve got your mobile nursing care, district nursing care, then you’ve got you’re cancer support nurses at the [name of organisation] cancer coordination services, oncology nurse. Why do we need all those services? I mean you’ve got all these people involved in much the same thing. What are they doing that each other aren’t? And that happens a lot. I think that mainstream [providers] would say the same thing. I was absolutely amazed at the services out there, those that are being duplicated.” A: 12.

At one focus group interview, some respondents spoke about the same issue. According to them, overlapping was a reflection of ineffective communication and poor service coordination which at times tended to confuse clients. They also indicated a preference for one nurse to take the lead for care among multiple providers:

“There’s too many services going into one place at one time; but if we all could develop some sort of calendar where everybody that was in there put their name on the calendar and we know when they are coming; and then everybody that’s in that house writes a little bit down; who’s been there and who’s done what.. yea...cos I went in there and she had already had social services in there so they were evaluating the care she’s been having in the home and then after her, there was [name of government agency] that was in there to assess the home and her needs, and then there was me; I was in there for community mental health nursing. Cos I’m doing social isolation, well she was well socialised that day! I had a look at that and said, “oohh, she’s done very well”. J: 6.

*“That’s like the five Toyotas up the driveway and one Nissan from Whakapai!”
K: 7*

Respondent J and K considered a sensible approach to this situation:

“And if we [multiple providers delivering care to an individual] could develop something where we could leave in the home and everybody could use to say I was in here, the family could write in and say “well mum didn’t sleep last night”. Well, one of us will see that and be able to work with it. Why isn’t she sleeping, you know? Or if she says “I have a sore puku³⁸”, well, you know, maybe it’s just ...in other roles that I’ve done if you’ve got abdominal pain, we’ll do your analysis, you know, basic nursing.” J: 7

“They [clients] become confused because they’re told different things [by multiple providers delivering care], like one of my clients out in [name of town]. He had a diabetes nurse from the [name of primary care organisation], he also had a district nurse and a cardiac nurse from the [name of secondary care provider] coming in ...on top of me to see him. Four nurses visiting him; he got confused for a time, but now it’s just me going in there. And I’m doing the whole lot.” K: 7.

“Well that makes more sense doesn’t it?” L: 7.

“Well it does!” K: 7.

“And they don’t get conflicting information” L: 7.

“And he’s great now; he is like so compliant and so on to it now.” K: 7.

Respondent J also considered the significance of developing positive working partnerships with other health professionals and clients based on trust and respect:

“Cos we can do the blood sugar levels, we can do the blood pressures, we can do wound dressing; and if we’re not sure of the dressing, we can always ring one of our colleagues and say “Well, what would you put on this, there’s a lot of exudates, you know...what can you use to soak it up?... Cos we’ve got that skill here, see? ... You’re also breaking down the confusion and giving your clients actually quality time where they can actually do something for themselves and not have visitors. They mightn’t like us all being in their house, you know?” J: 7.

The issue of overlapping services highlighted a number of key issues. While respondents believed that the causes were due to a lack of awareness and ineffective communication among providers, there also seemed to be a silo approach to service delivery among other providers, rather than a collaborative one. Respondents believed that working collaboratively eliminated confusion among clients and also streamlined service delivery among providers. This reinforces the need for building collegial relationships towards working in partnership.

³⁸ Māori word for stomach

Mainstream provider awareness of Māori health providers

Focus group respondents raised the issue of a general lack of awareness among mainstream providers concerning urban and iwi Māori health providers and their diversity in terms of the services they offer and how they operate:

“They think that all iwi and Māori providers are the same. They think that all our services are like that Cos they think we’re all the same. That’s like [person’s name] out in [name of a place], “Oh are you the iwi nurse?” ... which iwi? Which Māori provider? They don’t even know the difference. They also think we’re only for Māori, but they can also refer others [non-Māori] to us.” K: 16.

“But that’s how they connect us ... all as the same organisation ... or like the same type of provider. They think we all deliver the same kind of service and yea ... that we’re only for Māori or that only Māori can use our service. It cuts the rest out.” L: 16.

Another respondent indicated that mainstream providers were often confused about Māori providers and uncertain as to how they deliver services:

“I find that people [mainstream providers] do ask me because there is confusion, especially about other Māori providers and knowing how we’re different ... how we do things.” M: 15.

In relation to mainstream and Māori providers working collaboratively, respondent A’s views highlighted the complexities and challenges of working at the Māori/mainstream interface:

“Their [mainstream service providers] understanding of Māori and iwi health providers, our strategies and the way we work, is not good. I’d say it’s almost non-existent because they are aware of us out there and around the place, they’re aware that we have Māori models of health that we work to; they’re aware that there are Māori health strategies but they don’t know how it works... They do know that you’re out there; they say “Oh you’re that Māori place”... they have no idea. There’s still a big gap and I don’t think that’s our fault ... Although they are aware of our services, they’re not quite sure where or how we fit in with them [mainstream services]; not quite sure exactly how to approach us.” A: 2, 3.

Another issue was the inability of some providers to understand Māori practices and how it makes a difference in service delivery for Māori:

“Some mainstream providers are not even aware of all our services...which isn’t uncommon...not knowing what all our services are. They don’t understand kaupapa Māori³⁹, why we use it and why it makes a difference for Māori.” B: 2.

The inability of mainstream providers to distinguish differences between Māori and iwi providers, a lack of understanding of things done in a Māori way, Māori health strategies and models of practice were difficulties raised by respondents towards working collaboratively in the delivery of care. The establishment of collegial relationships towards having positive working partnerships assist in overcoming such challenges giving mainstream providers a better understanding of the diversity among urban Māori and iwi providers, Māori cultural practices and the application of Māori health models to practice.

Attitudes towards Māori providers

Attitudes of mainstream providers in relation to securing their own domain of service provision were also identified by respondents as a challenge to collaborative care.

Respondents labelled such attitudes as ‘patch protection’:

“A lot of mainstream people seem to be very protective in their own territory ... I don’t know if they see the bigger picture that we’re all on the same playing field working towards what’s best for our clients and for their family and yet they seem to keep themselves very tight; in tight knit groups and don’t want to let outsiders in ... they see me as an outsider or some think, “Well our ways have worked so well before with our own nurses that we don’t need extra in.” I think they judge it before they even give it a chance to work. So, I think in some ways that people pre-judge, make up their own mind before they even give us a chance.” P: 3.

A competitive contracting environment may also contribute to a protective mentality among some providers which is not conducive to collaborative care:

“They’re very protective; some service providers think you’re taking money out of their pockets because they think you’re taking their clients away from them.” K: 12.

³⁹ ‘kaupapa Māori’ is referred to by respondents as meaning ‘things done in a Māori way’ (incorporating tikanga and Māori culture)

One respondent stated that despite a reduction in barriers to care, the issue of patch protection still exists and believed that mainstream see this as ‘working within professional boundaries of responsibility’:

“You know what a patch is? It’s very, very common and it’s among themselves [mainstream providers]. They are patch-conscious; they do this and you do that and why are ‘you’ involved while ‘we’ are involved? ‘We’ have our responsibilities and ‘you’ have yours. Barriers are starting to be recognised, barriers are starting to be broken, but they’re still there; just a matter of keeping within your patch.” A: 5.

Another respondent noted a lack of mainstream provider understanding of Māori concepts of relationships and believed that whanaungatanga could go some way in addressing the issue of patch protection:

“But we also have whanaungatanga and we work better when there’s whanaungatanga. Mainstream don’t understand whanaungatanga, how we work and how we can all work together to better the outcomes rather than keeping to your own patch.” J: 16.

Māori providers have a fundamentally different philosophical basis to practice. For Māori, the facilitation of Māori values such as kotahitanga and whanaungatanga are key to success. Provider relationships based on a clear understanding of each other’s roles and parameters may facilitate better collaboration in service delivery where the focus is on positive client and whānau outcomes.

Attitudes towards clients

Health service provider attitudes towards clients are equally important in determining standards of care delivery and outcomes. From respondent views, racist or negative attitudes of other service providers and stereotyping clients were other barriers at the primary and secondary care interface which caused inequities in care. The following discussion among respondents at a focus group interview highlighted the issue:

“I have to say that on a few occasions I’ve been shocked by their [other providers] responses. I’ve had complaints from various people and I know a couple of them would not have happened if they had been a European person of the same age. Just one of a few things that have really, really ... there’ve been 2 recently that are shocking ... It’s more how the patients are treated, and sort of ‘throw away’ type of

remarks or attitudes and assumptions they have... 'Uneducated dole bluggers' ...that sort of thing have been barriers to patient care because they've upset the patient enough to make them not want to come back. Or because the patient doesn't....for example they assume that certain people can't afford medical insurance and so don't offer it; an appointment in 4 to 5 years' time and never even think to say "could you be seeing a private ...?" that kind of thing you know?" N: 5.

"I once had a bad experience with [name of patient]; you referred to me, remember? for her diabetes?" O: 5.

"Oh, that was a disaster!" N: 5.

"Yes, I took her up to see the [type of specialist] for support up at the [name of service] and he told her she was too fat, and if she didn't lose weight she'd be dead soon. Can you imagine how she felt? I felt so bad for her, after that she said she was never going back there again. And she can't afford to go private." O: 5.

"And not being able to afford is part of the health disparity in New Zealand. There are some people who just can't afford." M: 5.

"They need people skills and yea....just thinking! And not coming from their own narrow little perspective and just having a look around really. And thinking well maybe this isn't how it is for this person." O: 5.

Navigating through complex systems of care

Although some respondents spoke of negative experiences, others noted that not all other providers have negative attitudes towards clients. Having knowledge as to how other organisations operate and access to key people are crucial. Respondent N's statement highlights this, and also captures a way of navigating through a complex system of social care in order to achieve a desired outcome:

"Some of them [other providers] I find are really brilliant and I've always said, "If you've got to go in there, ask for this person". And I find I tell them to ask for certain people when they go to places; cos with other people, you don't get any results. If they're looking for a house with [name of government agency], as mine are all mums with babies, I tell them to go to [name of mainstream community NGO]. Whereas if they go into [name of government housing agency] saying "oh mum's told me that I have to get my own place cos I've got a baby now", they'll say "you already got a place to stay; you're not high needs". But if they're at a community house, they often have short term housing. So I tell them to go there and get that short term accommodation first, then go to [name of government housing agency] cos then they'll be considered high needs. They follow criteria very strictly; they've taken away....there's been no emergency housing list for so long." L: 8.

Another respondent in the group also emphasised the importance of teaching clients to navigate their own way through complex systems of care:

“Yes, it’s the right person I think ... there are some real good people out there in mainstream who sometimes bend over backwards for our clients. Yes, definitely it’s who you know and how to work the system. Then, teaching them [clients] how to use it.” J: 8.

Racist and negative attitudes of providers are barriers to accessing health care which disadvantage the most vulnerable; mainly those who cannot afford private health care and are dependent on the public health system. Being able to source and collaborate with key contacts within the system is vital towards assisting clients meet their needs. The issue of service navigation resurfaced again among respondents, where knowing how mainstream systems operate and teaching clients to self-navigate through systems were considered critical in terms of greater access to services.

3. Working from a “Kaupapa Māori worldview”

There are fundamental differences in service delivery between mainstream and Māori health services. Respondents believed that their way of delivering services better suited the needs of Māori and whānau which is captured in the following segments of data in this section.

Differences between mainstream and Maori health service delivery

One respondent compared visiting clients at home as opposed to clients attending clinic appointments. This highlighted certain advantages with access to whānau, being able to see the bigger picture in terms of client care, and maintaining the care continuum:

“Mainstream community services are often set up for clients to come and see them and sometimes, the place is very clinical. But we visit our clients where it suits them. Sometimes they prefer to come here [at Whakapai Hauora] cos services are marae-based but mostly we visit them in their homes, and I think it’s a better way of doing things cos we get to see them in their own environment, with their own whānau and we have a better understanding of their situation ... we get to see a bigger picture. When they get referred to mainstream they tend to DNA [Do Not Attend]. Then that continuity of care decreases.” L: 2.

Another respondent commented on the flexibility of appointments:

“The comment that tangata whaiora make, they say ‘time stands still in a Māori place’. They don’t feel rushed or ‘you got an hour now; you know I got to see someone else!’ Instead they feel safe and warm. You don’t get this in mainstream. There’s set times for appointments. When time’s up you got to go. Our tangata whaiora tend to not like that. It makes them feel like its just business as usual; and bet you, they won’t come back.” C: 14.

One respondent mentioned crucial aspects of whānau-based service delivery which is underpinned by tikanga and Māori values:

“There is a difference between Māori assessors and others; they have a better understanding of the whānau influence and the Māori world view. Mainstream acknowledges it, that Māori culture is different. But they find it hard to understand because they are not involved with it on a day to day basis, on a face to face basis. They don’t actually have a true understanding of it. Although many of them try, they can’t... I wouldn’t say they don’t quite get it, but they don’t quite comprehend and they don’t quite make that difference.” A: 7.

The same respondent also noted the significance of extra support delivered by Māori providers:

“You do it without even thinking. You identify the need, the support, and it’s not a 9 to 5 job. They ring you up at 10 to 5 and say ‘I’m in crisis’. You don’t leave them. So you stay with them as long as you need to support them to make the right decisions that they need and for where they’re going. Mainstream, there are clear boundaries.

It stops at a certain point and you don’t go over that point ... that’s why I feel that our model works well within Whakapai [Hauora] itself and with the support from my peers here; but when I broaden it out into mainstream integrated care, they [mainstream service providers] don’t have the same view; they don’t know the principle behind it or they don’t know how to make it work. They don’t know how to apply it to practice. They’re not use to applying it to their practice. And they would argue with you and say “oh but we do it all the time”; but they don’t do it all the time. And I’ve worked in mainstream and I’ve worked here, and I know.” A: 8.

One respondent commented on the working environment at Whakapai Hauora that facilitates better access to services. This respondent’s statement relates to the weaving of another traditional value in contemporary service delivery, ‘manaakitanga’:

“Mainstream have a different philosophy and Māori needs are different to others. Their needs...and we all know what it’s like to do extra for them; we help each other when we have clients like that.” M: 3

Another respondent spoke of their working relationships with each other:

“There’s a difference in the philosophy of outside people⁴⁰. I can’t put my finger on it but it is different here because we’re all on the same page. We communicate better, we know each other’s services better, and we already know each other at work. Access is also better because we’re all in the same place.” N: 3

Another respondent mentioned the benefits of a tikanga-based approach to service delivery:

“See, its different here; we work together as a whānau ... not in our own little silos. Yes, there’s lots of services here but we’re all on the same page...Māori and non-Māori here; we work together to awhi and manaaki them [clients] and their whānau. We model trust, respect and aroha so that whānau we work with can see that. Many of them don’t have that in their lives. If they see that in us, they may want the same with their own whānau.” A: 4

One other respondent commented on the uniqueness of Māori health models of practice:

“When we stop working with Whakawhirinakitanga Ahua, or those other Māori models, Whare Tapa Wha, Te Wheke or Oranga Poutama⁴¹ or whatever those Māori models are, once we stop working that way, then what makes us different to any other health provider? It’s unique and special for Māori in the way that we work, as long as we remember that it’s different.” H: 17.

Respondents raised some key points in relation to whānau based service delivery which differ to mainstream approaches to care. Whānau based service delivery is underpinned by Māori health models which stem from Te Ao Māori, a fundamentally different paradigm to mainstream paradigms⁴² of care.

Working at the primary and secondary care interface

While integral aspects of primary health care focus on prevention and early intervention of illness, it also entails the management of chronic disease in a primary care setting; this is where access to specialist clinical services in secondary care becomes a critical issue in chronic care management.

⁴⁰ A reference made to external service providers, mainly mainstream.

⁴¹ He Oranga Poutama is SPARC sports- led initiative supporting Māori wellbeing through Māori community leadership, increased opportunities for whānau to learn and participate in Māori sport and physical recreation and also to revitalise and further develop sport and traditional physical recreation.

⁴² Refers to mainstream mind-sets based on western ideology, ethical values and approaches to health care.

Respondents acknowledged the clinical skills, expertise and knowledge of mainstream providers who brought different strengths to the mix of care. One comment made by a respondent was:

“Yes, they are mainstream [service providers] and we link with them because they often have things available that we don’t. They can offer our clients a lot more because they have the clinical expertise in that area of health, so we use them.” A: 4.

Another respondent stated that:

“Because our complex clients with high health needs need specialist services. They need to be assessed and treated up at the hospital by a specialist with clinical skills and expertise for their health conditions. We can’t do it here at a primary care level. So they’re also a quite big part of that care.” M: 2.

Another respondent noted that:

“There’s other people out there with more knowledge or needed expertise which in a particular area like for example medication; mental health and etc...etc... . So we will use that to integrate with our tangata whaiora accessing other services that the community have and they [other services] become part of your resource which is part of that web, so that’s where we start practicing in practical terms.” F: 4.

One respondent spoke of strength-based approaches to care where clients, their whānau and a range of services are involved in care. This has the potential to move beyond a deficit care model which focuses mainly on dysfunction and treatment:

“We look at the strengths tangata whaiora have and the strengths their whānau have, the strengths that we have and then look at what other strengths other agencies have for the best outcomes for tangata whaiora ... it’s not just about tangata whaiora’s illness, its more than that. It’s giving our best to get the best outcomes for them.” C: 3.

Another respondent spoke of the benefits of collaborative care in relation to sharing workloads and utilising of the strengths of others to provide support:

“When you have very difficult tangata whaiora with lots of high needs that you have to take care of, you know you’re not doing this on your own. There’s other agencies involved and sometimes it’s just too hard to be in there doing it all on your own. And when you’re involved with other agencies, they’re taking some of that responsibility and ownership of care too...and taking some of that workload. We can’t be everything to everyone and yea...” G: 9.

Mainstream providers in secondary care play a substantial role in chronic disease management due to their levels of clinical and specialist expertise. Therefore fostering relationships with them were crucial for respondents in terms of delivering the best possible care. Added benefits include the sharing of responsibility towards care which helps lighten individual workloads, potentiates a strength-based approach to the delivery of care and improves timely access to specialised care.

Building and sustaining relationships

Respondents believed that building and sustaining relationships was integral towards collaborative care pathways when working at the primary and secondary care interface. The significance of having a good rapport with key people in other services was also crucial in relation to timely access of services:

“Out at [name of town], I’ve got a really good rapport with the district nurses and I can self-refer to them, rather than go through the [name of secondary care service] for my patients. Building those networks...is really important.” K: 7.

One respondent in a focus group interview acknowledged that mainstream and Māori providers share a common goal:

“When you think of it really, what we all want, Māori and mainstream is better outcomes for our clients, especially Māori clients and their families who have poor health. No matter how different we are, we’re all working for the same goal. We all have our responsibilities when we share care. We’re also accountable for what we do. There has to be understanding and willingness to make a go of it... it’s a give and take kind of thing. There has to be a relationship between us and them.” K: 9.

A fundamental principle of whanaungatanga (relationships) is reciprocity (Mead, 2003).

An important aspect of relationships among service providers involves reciprocity, particularly when working towards attaining a common goal for health outcomes in service delivery. Another respondent in the group said:

“Because of our belief in our model... the way we work here and how we support one another, it becomes natural ... building those effective relationships with other organisations as well is that ‘giving and receiving’... all of us have an important part in delivering care no matter how different our services are. And when a mainstream provider needs help, especially with one of their Māori clients, we always help if they ask us. We know that if we ask them to help one of our clients, they’ll do the same too. It’s our responsibility to help each other when we can.” P: 4.

Another comment made by a respondent was:

“It’s all about collective care, wrap-around care built on strong relationships, Whakawhanaungatanga ... connecting is the key.” J: 1.

Two significant statements concerning working relationships were also made at another focus group interview:

“To me, Whakawhirinakitanga [Ahua] is something that in my mind, just kind of brings that all in and gives you a metaphorical look on the web and how we weave, and the strands are relationships; and I mean the key really, to Whakawhirinakitanga [Ahua] is relationships. And it’s having relationships, good relationships, with everyone we deal with throughout.” C: 4.

“Well, you know the common thing that’s coming right through the questions we’re answering is whakawhanaungatanga; it’s about building relationships; not only with our work colleagues but also with outside organisations, is really a reoccurring theme. Its relationships, relationships, relationships! Once you’ve got those, and it comes with not only the work and understanding of what that means, but the organisations that you’re working with have an understanding of what that means. They can understand ‘this person is here to provide this care around this tangata whaiora’; it’s about a relationship with outside workers, so that when they see you, they understand what you do, and consequently, you understand what they do. If you can have that relationship, then that becomes good for tangata whaiora. If you end it, then it’s gone. But it’s on-going though.” H: 7.

During discussions about relationships, respondents identified ways in which they developed and fostered relationships with other providers. One respondent spoke of a face-to-face approach, and sharing kai:

“We often invite other providers and organisations regularly to come and meet with us. We all share information about each other’s services and then provide kai. That’s a good way to meet face to face and network. Networking is a good way to meet key people from other services or community groups. They get to know us and we get to know them in a friendly way. It’s about manaakitanga, hosting and caring and kanohi ki te kanohi.” E: 5.

Another respondent told a story of developing a culturally safe environment and supporting a mainstream colleague:

“There was one time when a cancer nurse came to me and said “I have a Māori family that I’m supporting and I’m not sure I’m doing what I’m supposed to do”. She needed my help and support so I went in to visit the family with her and listened to what they had to say and to what she was saying back to them ... and it just opened up

that forum for them to have that frank talk. I also advised her to ask; not to be afraid to ask the whānau if she was not sure of what was appropriate for them. And everything's fine now, that family has a trust with her, she has a trust with them; but she also knows that if she gets into hot water she can come back to someone here [at Whakapai Hauora] and say "help!" and I will support her in her role again. We have a relationship; it's one that has trust, understanding and support". A: 5.

Professionalism has a distinctive set of values that shape best practice. Honesty, integrity, respect, responsibility and accountability are some of the main attributes of professionalism. Some respondents spoke of the significance of having a set of values when working with others:

"When you work with them [mainstream and other providers] you have to build that relationship with them. It's based on trust, respect for each other and supporting each other ... knowing what to do and always being consistent in what you do. If you say you'll do something, then you do it, you keep your word ... it's being professional." I: 5.

"And so I can expect for myself that the key elements to being professional would be honesty, my integrity, trust and speaking my truth and not being afraid to speak it; and having passion for your work. Nothing that's unseen, as the others see you and they come to recognise that and that's your representation of what you are ... your role, and how you deliver your service." F: 7.

A consistent thread throughout respondent data signalled the significance of building and sustaining relationships (whanaungatanga). Respondents described certain values that underpinned working relationships such as reciprocity, support for each other, trust manaakitanga and professionalism. Positive working relationships enhance group cohesion and collective decision making processes towards shared goals in service delivery.

Collective decision making

Three respondents spoke of their working relationships with each other at Whakapai Hauora in relation to collective decision making. These relationships were again underpinned by a set of values:

"When we all talk together and say what's going on and that sort of thing, say what we don't like, hash out a way to do it that we all agree with and just carry on going for it ...it's been very robust and that we agree to disagree sometimes, but we can still work together. It's not a personal thing, but a professional thing...making decisions together. We trust and respect one another, so we all listen to each other and good

things come out of it... we've developed so much more I think, in a team environment. We have good working relationships with each other here." Q: 9.

Another respondent said:

"Here, we really have good working relationships with each other here. We trust each other and we know we are accountable for what we do. We always support each other and find ways to help each other when we have high needs clients when there's a whole lot more that needs to be done." L: 9.

One other respondent stated:

"I think we all have it here, good relationships. I think it's strong and solid. We can rely on each other. The communication is good and we're not afraid to talk to each other when we have problems. We don't agree on everything, but that's ok ... we still compromise. There's respect for each other, and that's a good working environment." R: 4.

At a group interview, three respondents spoke of the nature of their work, where the collective assumes responsibility over individuals within a team; a fundamental principle of kotahitanga involving collective cohesion and collaboration (Barlow, 1991):

"Although I'm a team leader, I'm part of the team. I don't make all the decisions; as a team we make the decisions together. It's a collective voice, and there are very rare times...that someone would make a decision without the team's input and that's how I like it to be because I think everyone here, like if I wasn't here, the team could run itself. And that's important." C: 12.

The same respondents also stated that working as a collective within a kaupapa Māori environment kept them safe:

The next thing I want to be teaching everyone is to be able to do policies as well, so I think that's something that I'd like the team to learn how to write policies so they know what's involved with policies. And I guess our policies with having kaumātua here to awahi and to keep us safe, the kawa is tika and all of that, that's what we follow ... tikanga Māori. And all the kupu⁴³ that changes all the time, everyone in the team has to be ok with that. So they're joint decisions. Its kaupapa Māori ... the policies are all about Māori, Te Ao Māori."
C: 12.

"But it's not hierarchal work ..." F: 13.

⁴³ kupu is referred to by this respondent as meaning 'talk concerning work'

“It comes to respect given there ... trust and respect for each other. That works. You know, that helps us”. G: 13.

At separate group interviews, three respondents spoke of their relationships with management. One respondent highlighted the significance of effective communication and the provision of support from management. Respondent A spoke about being supported to find solutions that best meet client needs:

“We are well supported by management, our kaumātua and colleagues here. Other organisations out there are not supported, that’s why it doesn’t work well for them, because they don’t feel supported, and they can’t go out there and do it [work] to the extent that we do it. If you recognise something that’s interfering with your mahi, you can go to management and say ‘This is happening’ they will listen and help, and that’s that effective communication. Not getting shut down and like, “Tough, you sort it out!” There’s that collaboration between you and management which allows you to be secure knowing that it will be sorted.” A: 14.

Two other respondents stated:

“I think lines of communication between management and us are really good; like if I have a problem, I can go talk it out with management and don’t feel uncomfortable about it. I know I’ll be heard and then we’ll work things through together. When there’s trust and respect you feel supported and you can do your job a lot better.” I: 8.

“The support [from management] is there. We feel that we own the decisions we make when changes happen; it’s a quality process and we feel good about it, about being able to be part of those changes.” G: 9.

Respondents recognised that positive relationships are based on a set of values consisting mainly of trust, honesty, integrity, support and mutual respect for each other. While some respondents spoke of such values in the light of professionalism, others associated it with Māori values. Respondents gave value to a collective voice which was a strength in service delivery, as they felt a sense of ownership in decision making. Respondents also believed that they were well supported by management and kaumātua within their organisation.

Whānau focussed care

Respondent experiences and views also focused on building relationships with clients and their whānau which is also crucial in the delivery of care. Again, the data highlights certain values that are practiced when working with clients and whānau. This are demonstrated in some of their experiences which also include important aspects of whānau involvement in care. One respondent told a story of how she delivered care for an elderly couple. The importance to Māori in terms of making connections with others cannot be underestimated when building relationships:

“I remember one time when I had to visit a kuia whose elderly husband was not very mobile. I had to put some home support in place for her because she couldn’t do his personal cares; she couldn’t lift him or shower him ...he used to do this himself before he got unwell. When I got to her home she was whakamā⁴⁴ because I could see that she needed some help with the housework as well. Their place wasn’t tidy and it looked as though it had been that way for quite some time... it took a few visits before I could convince her to let me help her. At each visit it was just building her trust by listening to her stories, her priorities, their needs and also sharing whakapapa, stories about our different whānau ties. Although we were not related in any way, her husband knew my koro’s whānau; this helped us make a connection which was really good. It took a while for them to warm up to me, but I was prepared to do this. It was about paying respect to her and her husband, gaining their trust. She finally decided to have [help with] personal cares for her husband, some help for her housework ... and also some respite care for herself so she could have a rest from caring for him. You see, I’m the one going into the homes, seeing their environment; not going there to scan what sort of environment they’re in. That’s one of the worst things you could do; for them to see where you’re looking at. It’s just being respectful and easing your way into their trust”. B: 5.

From respondent perspectives, the inclusion of whānau in an individual’s care was paramount. Another story from a respondent working in community health nursing demonstrated the significance of having relationships in order to navigate whānau through a range of services for better client and whānau outcomes. This also demonstrates the amount of work involved to achieve a desired outcome. A whānau centred approach allows a health professional to see beyond an individual’s illness and takes a holistic view to care:

⁴⁴ to be ashamed, shy or embarrassed

“I visited a whānau once, to do an assessment on a child who had very bad asthma. My role was to teach the mother about his inhalers, what they were used for, how to use them and any side-effects. But when I got there, I saw that some whānau were smoking in the house. The house was cold, with no heating and it felt damp. I knew that I needed to get more services involved in his care. It took time to gain the whānau’s trust, but when it did happen, we went to [name of government agency] to try and get a better place to live and then to social welfare to help with heating. I also arranged for a smoking cessation coach to help whānau understand the effects of passive smoking. Although they continued to smoke, they decided to make their home smoke-free.” O: 6.

Another respondent explained the significance of whānau involvement in an individual’s care:

“... getting their whānau involved and teaching them about their [the client’s] illness, better ways to cope and support that tangata whaiora ... it’s about empowering which leads to tino rangatiratanga.” G: 3.

One respondent from a community health support service explained why it was important to have a relationship with whānau:

“When whānau get in the picture, clients recover faster cos everyone plays an important part in helping that client heal. When the care is shared around, whānau learn new ways to deal with sickness and manage things better on their own.” A: 5.

Another respondent also noted that listening to clients and whānau is also crucial in order to effectively communicate and support them with choices in care:

“I think that the korero has to be simple too when you’re dealing with clients and whānau ... it’s important to that relationship. There’s a lot of information out there and sometimes if you give them too much, they can’t understand it; so you got to sit down with them and make sure it’s simple. Listening to them is important to help them make the best choice and it’s whānau that need to know as well, cos most of the times, that’s where the support is.” B: 5.

A fundamental principle of manaakitanga is to take care of people and sustain relationships (Mead, 2003). This story demonstrated respondent K’s need to go the extra mile, to manaaki, in order to achieve a desired outcome. It also signals the complexities of maintaining a relationship with a client, and the time and commitment to sustain a relationship:

“There was a solo mum, Māori, that I visited ...she had no whānau support as they lived up the coast. She was new in town, had no close friends. I remember there was one time when she didn’t have any food in her house. Because, I guess, she trusted me enough to tell me, I felt I needed to help her myself. I didn’t want to tell her, “Well, I can give you the details of a food bank to go to and someone there will help you with a food parcel” or “Have you tried social welfare? They can give you an emergency food grant.” I rang the food bank myself, arranged for the parcel and picked it up and delivered it to her the same day. You end up doing things that you probably wouldn’t have intended to do; but because you’ve developed that rapport with them, they don’t have anybody else they’ve got. No whānau around that you end up doing that social role. Not letting them down and just making it more accessible for them ... It’s about that aroha; having aroha for them and showing manaakitanga. You know they don’t have any whānau to help them with what they need, so you just help them rather than send them off to someone else to get the help they need. A lot of clients are too shy to go to places like the food bank to ask for hand-outs.” K: 4.

Providing additional support

Another respondent noted the importance of providing additional support to clients towards relationship building and achieving desired outcomes for clients:

“Because they’ve got no transport to go in and see them [other services] or they may not have a phone to get to those services. They’ve got a cell phone but it’s only for txting... they don’t have any credit on it to ring services up. So I either tell them about it or I either come back in here and I will ring those services and then I will txt them to say “Is this time good for you?” or I’ll talk to [name of a mainstream service provider] to make 3 different appointment times and then I’ll go back to the mother and say “Look, we’ve got 3 different appointment times here, which one of these ones are going to be better for you?”. And then they can get there for those ... or to come in here for the contraceptive contract. If you show them that you’re genuinely concerned about them you build that trust with them. It’s also showing them that you’re prepared to do more than what other services would normally do to help them. It’s like, they feel too embarrassed to ask for extra help? It’s the extra support that’s important if you want a good outcome for them.” L: 3, 4.

Respondent N’s experience indicated the need to empower clients by making them aware of their entitlement to services:

“Māori patients are often too shy to ask for help. I try to make them aware of their entitlements, that they are entitled to all those other services or money from [name of government agency] to help with the cost of care; that they shouldn’t feel grateful for it and I try not to make them feel like its charity. I’m really keen on people knowing that it’s there’s to have...and when they trust what you say, they don’t feel embarrassed to get that help or support they need”. N: 7.

Two respondents noted the significance of providing advocacy and support to clients in order to effectively navigate them through care. This was discussed at their group interview:

“Let’s say someone’s got an appointment at renal clinic or something, they don’t understand that it takes an awful lot of trust to enable us to get our client to go to that meeting. And after a couple of meetings, they send you out a letter to say that well, if you want us to referetc...etc.... They have no idea of the fear or other reasons that are keeping the client from actually going? we yea.... earn the trust from the client; they know that we’re there for them. Whereas they just...you know...I mean if there’s someone a bit hōhā⁴⁵ about it or something like that, generally the doctors will tell me or another nurse, you know, to go and hold their hand for support or offer help or something ... but... and that’s quite easy to do if you can get the client, but, some of them just straight DNA [do not attend], because of fear and nothing else. Mainstream don’t know it.” O: 3.

“No they don’t; they just put the service there on the table and say “here it is, come and get it”. Whereas we tell them to go and we go with them. It makes it easier for the person to access it and accept it. But the services there, secondary care want the people to access it but they don’t make any movement towards that. It’s just, the service is there. But because we’re working for better outcomes for them, we have to earn their trust by helping them.” N: 3.

Being able to manaaki clients and whānau was noted as being important towards attaining desired outcomes:

“ And also I think, Māori health providers and Māori health workers are our own worst enemies because we understand the culture...give and give....and give...a little bit further... we manaaki; whereas, others would think, we’ve done this and that’s all we need to do, it’s up to them now. We do a lot more than what we should. But it gets the outcomes you want for Māori.” A: 7

“Yea, because we’re iwi, and we all know what a Māori heart is, we do it because we need to get the outcomes for our clients and we do the best. And you know, that’s what I think is the beauty about the difference between Māori and mainstream?... is that we’re prepared to. And yea, it’s huge and it’s not part of our requirement.” B: 7.

Respondents believed that establishing and maintaining relationships (whanaungatanga) with clients and whānau are also an integral aspect in the delivery of care. Respondents believed that manaakitanga in terms of additional support,

⁴⁵ A Māori term meaning bored or annoyed.

advocacy, having aroha for those receiving services and empowering them are critical towards achieving best outcomes for clients and whānau.

Balancing dependence and independence

Issues concerning over-reliance on community health service providers were raised during interviews. Service providers often tread a fine line when balancing with the provision support, advocacy and system navigation towards empowering clients and whānau. When the right balance is not maintained, there is the potential to create over-reliance on providers:

“Well, if anything, I’ve probably been way outside where I should be. Always. I have the tendency though once they get in, I hold on to them a little bit longer and possibly make them a little dependant. That’s what I’m working on. Because if you do all the social services, and you go to the appointments with them, I think you take away their ability to manage themselves. And I have a tendency to do that. I know I shouldn’t but I do it.” J: 4.

“So, how are you working this one out?” K: 4.

“Well, I’m sort of working in with their GPs to try and be as specific as I can with regards to ‘mild to moderate’ [mental health criteria] for my service and I keep looking back at the service plan that I have and that’s what made me realise that I’m way beyond where I should be and perhaps I am creating that dependence by being there. And by being there, they rely on me instead of their whānau which are also there. So I use Koro [name of kaumātua] as well to try and connect them to their whānau, cos they don’t know some of them...especially with the Māori ones; and he can find a connection for me somewhere; and then I go and try and encourage them. Some of those families, say, they have a huge breakdown and that’s why I sort of get more involved, but I can overdo it. And I take away their mana, if you like.....by letting them rely on me. Then I try and stop them and say, “well you know it’s not my role” but then it’s too late; I’ve done it! Because they’re only in our service for a short time, because of ‘mild to moderate’ and then they need to be out with that in mind ...I should be working with them and when they’re well, get them back into the community and keep going back to see the doctor when they’re not well, the doctor will refer them back; but they’re not doing that. See, also with these clients, when you see them often, they come to expect you’ll be there in 5 minutes. But I can’t make it to them; it’s as simple as that. So if I do it once, then I’ve got to be consistent, not take it away because I feel like I’m not doing my job.” J: 5.

In response to respondent J's statement, respondent K also raised the issue of over-reliance from other providers:

"I suppose that's one thing in my job out there too, is cos I'm running these clinics, they're a free service, people are ... word of mouth's going and they're going "oh well, the nurse is down there". So I'm getting all sorts of things turn up. And that can be quite difficult cos you do some things that can be done by their own GP service. I'm not a practice nurse. But there was a doctor in [name of a town] who didn't have a nurse so he relied on my nursing service for a while which is community health! A lot of his patients are still coming to me for dressings and things. I can do it, but my main job is to educate clients and help them to make lifestyle changes, to work with families in the community. Like it's kind of You can't turn them away... and they keep coming back to you. They sort of expect that? And they rely on you instead of going back to their own GP service?" K: 5

In response to respondent K, respondent J made a crucial statement concerning opportunistic screening in relation to Māori in particular as some have limited access to a range of necessary services; the emphasis was also on teaching clients to access appropriate services:

"And it's probably what we've done to the doctor too; I don't know what, or how we've explained ourselves, our services; this is what we can do? I mean I was saying to you before, I would have loved to have done that smear the other day because I can. And you know, having that skill, I would have liked to have done it if I could...I should have just done it. But in my [current] nursing role ... but I think maybe ... maybe we should look at that as opportunistic, anyway. If you've got a nurse role and you're wearing that hat and you've got that skill, you should do it, especially for Māori clients because they don't usually access the services that they should be. But really I think you do it if there's an immediate need, and then you educate them to access the right service. You teach them ... empower them." J: 5.

While some respondents spoke of client dependence, others acknowledged the initial need for over-reliance in some situations and addressed the importance of moving a client along the dependent- independent care continuum:

"At first they need dependence. I was just thinking of one of our tangata whaiora who was a diabetic since 18; has not been taking good care of herself, who is going blind, kidney failure, and now she's only in her late 30s. So basically, what we did was we got her to all her appointments. Now, some people would say ...and we had comments, "oh, you're making her dependent on you." But she needed to go to those.

What should we have done? Just not encouraged her to go to those appointments? Tell her to go when you knew she couldn't get there? So we got her to all her

appointments. She's been absent from all alcohol use since then and what has happened now is that she's catching busses. She's getting to her appointments; she's watching her diabetes getting better. It's much improved now. Sometimes they're not in a place to take self-responsibility, well, why would you if you're not well? It all goes out the window, you know? When you're depressed and life isn't so great, how can you take on self-responsibility? So that's why we need to whakawhirinakitanga⁴⁶; we ahua⁴⁷, we put in those strands of care, we awahi that person wherever they need to go until such time when we can stand back and they can get themselves to those appointments.” C: 13.

Respondents believed that it was critical, when dealing with clients and whānau, to be able to manaaki them. Going beyond what was contractually required in order to manaaki clients and whānau was significant feature in terms of portraying themselves as health professional within a Māori health environment. The provision of additional support is not accounted for within service contracts, and therefore is not included in service delivery performance measures. This issue was raised by respondents and is presented in the next segment of data.

Performance measurement in service delivery

While discussing working beyond contractual requirements there was also talk about performance measures. Respondents had mixed views; some looked at performance measures in a positive light, seeing it as a reflective tool for service delivery:

“You're actually evaluating not just your performance, but you're evaluating your service performance and about what you can do to change this or improve the outcomes...what can I do to manage my workload better so that I can actually see the people I need to see without getting bogged down with paperwork or whatever? You can actually prioritise things, I think.” Q: 7.

Another respondent also had a positive view:

“In some ways its good cos you can see where maybe you did too much work in one area or where you did too little in another so you know where to focus on for service delivery and balance your workload better...” L: 8.

Despite agreeing that it was a reflective tool, there was also comment as to performance measurement being ineffective in capturing client outcomes:

⁴⁶ bring together quickly

⁴⁷ form (or make)

“I think yea, it is a measuring tool, it’s reflective but not effective ... maybe not a true picture of the real outcomes, yea.....yea.....That doesn’t.....it doesn’t truly show the whole outcomes ... the positive, or the not. And it’s more numbers. No, not the true measurement of a positive outcome...most definitely not.” P: 4.

Several respondents felt that performance measures focussed strongly on outputs and did not reflect what they did in the community:

“I think it’s a great guideline, for you to know that you’re maintaining your service delivery. That you’re keeping your outputs up; I think organisational wide and quality wise, and possibly funding wise, yes, a great indicator. But in the community, it’s not that obvious. I think they’re great for inside the service delivery because you know you’re on track but they don’t quite capture everything. Client outputs, yes; you know you’re on track and you’re heading in the right direction with compliance but you don’t really see the true extent of client outcomes in the end. It’s strictly for the service delivery.” A: 6.

“They’re just a number, a statistic for funding purposes, or whatever...and you got to have that. But our true work and the outcomes for tangata whaiora are never really measured. That’s the reality of it ...and sometimes it’s really hard to have to get a certain number all the time when there’s more work that we need to be doing with tangata whaiora.” F: 15.

“It just shows numbers going in and out of services. But who can tell what the outcome of that was? Did it make things better for anyone? Did it improve their health, or their wellbeing? Who knows..? Are they [funders] even interested in that [outcomes]? R: 9.

Despite some advantages to performance measurement in relation to more efficient service delivery, respondents believed that as a tool, it was not capable of capturing the true nature and extent of their work, and the extent of client outcomes as opposed to outputs.

Culturally appropriate services

Following on from discussions on performance measures, respondents spoke of the significance of culturally appropriate service delivery. The way in which knowledge is gained relating to cultural appropriate practice has two distinct paths for Māori and non-Māori respondents. For Māori, it is implicit stemming from the intergenerational transfer of cultural knowledge, values and beliefs which come instinctively when

working with Māori and whānau. For non-Māori, this knowledge is often explicit, gained through formal education incorporating Treaty principles, cultural safety and competence-based practice as requirements for working with Māori. Māori respondents believed that certain cultural aspects of service delivery made them different to other service providers. For some, being able to deliver services that were marae-based was integral towards their work for Māori and whānau as it allows them to connect with tikanga and whakapapa which are all important as part of a kaupapa Māori service:

“Tūturu Pumau [marae at Whakapai Hauora] brings a spiritual presence for us here; we feel our tūpuna with us...we karakia at work; it lifts us in our mahi.” D: 2.

“Here [at Whakapai Hauora] we have Tūturu Pumau. It brings us back to our ways as being Māori again; there’s wairuatanga here...our tūpuna are guiding us in what we do, our work here as kaimahi for our people.” B: 6.

Two respondents spoke of the cultural appropriateness of their practice which signals diverse Māori realities and the intergenerational transfer of Māori culture and values. According to respondents A and B, working in a Māori way came naturally to them. This is demonstrated by their following statements made during a group interview:

“I know my Māori culture; my nanny instilled it in us. I didn’t grow up on a marae but I do have my own understanding of it. It also makes it easier I think, to understand other minority cultures, Asian, Thai, Pacific Island cultures.” A: 8.

“It’s natural; and it’s something that we do; it’s just natural. You’re brought up with whānau values; whānau, marae ...yea...hapū, iwi. But not everyone [all Māori] is brought up like that.” B: 8.

Respondents A and B also stated that working in a Māori way came instinctively:

“When I was little I grew up on a marae. My nanny and koro were always with us, teaching us things Māori and handing down knowledge to us. We grew up in a place that was ‘whānau, hapū, iwi’ ...as for applying the Treaty to service delivery, it’s nothing that I feel about it; it comes naturally.” B: 9.

“To be honest, 9 times out of 10 you don’t say “I want to do this under the Treaty”. It’s something you do naturally. You’re naturally creating partnership in your relationship with them; and so you’re naturally bringing them in to participate in their care otherwise you’re not doing what you’re supposed to. And therefore you’re naturally protecting them because you’re allowing them to make choices, assuring them that they have choices; you’re ensuring that they have the power to make informed choices to look after themselves. I think we do it naturally; I don’t think we go in there thinking, right, this is what we’ve got to do”. A: 10.

Two other respondents also made similar comments in relation to working a Māori way which may perhaps be difficult for others to understand:

“So to me it’s something that we do naturally with tangata whaiora; we work in a kaupapa Māori way as we go through their assessment and include what they need in their aromatawai to strengthen that person; I mean, you know, we know that tangata whaiora lack a secure identity; What does that mean? ‘A secure identity?’ what does that mean? It’s about Te Ao Māori.” C: 3.

If you live it like we do; we live it, you know? I think that if people can get past the fact that it’s something we do, and embrace it... G: 9.

Another respondent also spoke of working implicitly in a Māori way that fits within a Māori paradigm:

“Well I have to be honest and say, sometimes I wing it when I’m out there, and then I come back and it fits; that Whare Tapa Wha ... and I’ve done it; like you know, that whakawhirinakitanga ...bringing everybody in and that nurturing process and wairua and everything else that goes with it; I’m not actually thinking about the model when I’m out there. I’m just doing it and then you come back and you... you just do it without thinking? And then you’ve just got that backup when you get there cos I think if you have a passion for the community and a passion for working with people from anywhere, for Māori with anything, you know I think you just naturally do it. It just comes naturally. But then when you say “What’s Whakawhirinakitanga Ahua?” If you’re not from Te Ao Māori, well, what the hell’s that?” J: 1.

Non-Māori perspectives of culturally appropriate services

On the other hand, when non-Māori respondents spoke of cultural appropriateness in service delivery, they raised the subject of cultural safety and cultural competence.

The statements made by two respondents highlight the application of explicit knowledge derived from competence-based practice which is requirement for non-Māori when delivering services to Māori working from a Treaty base:

“The Treaty principles also guide us to practice in a culturally safe way; protection, participation and partnership. We apply this not only to Māori but to all whom we care for. It’s also about respecting the differences in each culture. These are all important when it comes to cultural safety.” R: 8.

“Cultural safety is part of our practicing competencies. It’s required of us to have an understanding of our own culture and also Māori and different cultures... it about practicing in a culturally appropriate way that helps us to meet their needs” I: 6.

Another respondent from general medical services spoke of the Treaty in relation to culturally safe practice:

“Those [Treaty] principles are the foundation for how we base our care; they’re the things that we use to make sure that we cover all the areas we need to cover for people; including family in a client’s care is important if they [clients] want to include them. It’s part of implementing the Treaty principles; you encourage them [clients] to participate in their care with family and work in partnership with them and their family for the best possible outcome.” Q: 1.

Despite different knowledge pathways through which cultural appropriate practices are gained, respondents believed that the delivery of culturally appropriate services to Māori were crucial in order to create partnerships and work collaboratively with them, to get them to actively participate in their delivery of care, and to protect them by giving them opportunities for them to make their own choices in care.

4. The journey towards health and wellbeing

The final segments of data in this chapter relate to sustaining health and wellbeing. Discussions on meeting client needs led to what respondents considered as positive client outcomes. There was also further discussion on what needed to occur for this to be achieved. Respondent views related mainly to the particular context of their service and what needed to occur.. Their statements also reflect the nature of their work at a grassroots level.

A change in behaviour

Respondents believed that a change in client behaviour was a positive outcome. They noted that behavioural changes took place over time which required patience and gaining client trust on their part. They highlighted the importance of understanding and meeting client needs, effective communication and educating clients in health care:

“For me, has been a changed behaviour which results in people accessing health care more appropriately which very often is earlier in the disease process than later ... and that’s a process, a journey; and that’s one that you watch and you’re absolutely delighted by when you realise that somebody has responded earlier to a boil and gone to a strange doctor even! Had the courage to go to somewhere else because they were somewhere else in the country. Then that’s a good outcome as far as I’m concerned.” M: 8.

“That’s what I see; people taking responsibility for themselves; not just once you know, but over a continuous... especially with chronic disease, they’re suddenly beginning ...” N: 8.

“The light goes on; they take their inhalers⁴⁸, they do their finger pricks⁴⁹, they, you know, they alter their behaviour just like everyone else; they alter their behaviour; they do all that without me behind their back; and which I think that’s where they ought to be. They’re doing it because they’re doing it for themselves. Not because they know that ... you know, I’ll be cross at them!” N: 8.

“That’s it! That’s it! Their behaviour’s altered; you go along for a visit and eventually, finally, all of a sudden, the light goes on! You go for a visit and they show you “look, I’ve done all my finger pricks” and they’re proudly showing you all the weeks’ worth in the book or something...” O: 8.

And they’re good ... and if it’s gone up to 9[mmol]⁵⁰, they’ve done something about it. N: 8.

“So you actually do see; and they’re proud of themselves. It is aye? They do...they get, you know ... and it’s big ‘hug’ time and ...you know?” O: 9.

*“And ultimately, one hopes that this gets passed on to the next generation as well. Whoever we’re dealing with, that it goes through to the kids as well.” M: 9
“But it’s not overnight. It doesn’t happen overnight, but it will happen!” O: 9.*

⁴⁸ Asthma medication.

⁴⁹ A blood sugar monitoring test for diabetes.

⁵⁰ A measure for blood sugar levels

When prompted to answer how behavioural change can be achieved, respondents emphasised the importance of building trust, and educating clients:

“Frustrating...You’ve got to have a lot, and lot, and lot of patience. But the thing is ... you’d build up a relationship and that’s something I don’t think that mainstream realise. It doesn’t happen, you don’t walk in a bubble and you know, push your way through and everything’s going to be good; it doesn’t happen like that. It can take six months for them to smile at you, sometimes. And that’s the main thing, you just got to build the trust up so that they believe what you’re saying; and they do, eventually.” O: 9.

“There’s lots of education, it’s trying to get that message across ...” M: 9.

“Repeatedly, educate them ...” N: 9.

Understanding client health literacy levels also play a crucial part in educating clients:

“This is the interpreter bit; I believe one of my roles is to interpret what I understand and know from the scientific evidence about health and health care and medication and all that kind of stuff and interpret it into lay man’s language so that person can grab hold of it for their specific need; for their specific health thing, and I do think we spend a lot of time talking to people, trying to explain; they will understand.” M: 9.

Not dictating to clients what needs to be done, but working together with them to achieve positive outcomes was also critical towards establishing trust with clients:

“I find, getting myself and the patient’s agendas lined up and realising that my agenda might not be the appropriate one on that day or indeed in that month, sometimes...and that’s helpful if you’re trying to understand them... Compliance I think, your agenda is “please take your blood pressure stuff”; theirs is different. And they’re not going to tell you what it is either; not for a long time. Not until they feel they can trust you.” N: 9.

A change in behaviour to take on self-responsibility signals empowerment which leads to independence in self-care. According to respondents, building and sustaining relationships with clients and whānau, health education, and health literacy levels are crucial factors that influence changed behaviour in clients. The relationship between poor literacy levels and a range of health related outcomes have been well established (Ministry of Health, 2010b). Therefore, the ability to translate health knowledge into simple language for the purpose of educating clients and whānau is critical towards achieving empowerment. Respondents also envisaged that health

knowledge gains would be transmitted in an intergenerational manner to create healthy whānau futures.

Seeing the big picture

Respondent perspectives were similar as they associated positive outcomes with clients having tino rangatiratanga over their own care; being able to self-determine their own choices in care. Respondents believed that empowerment leads to tino rangatiratanga which is autonomy and self-determination (Durie, 2003) in care. They believed that it took time for this behaviour to occur and it was important to see the bigger picture; to have a good understanding of health determinants that impacted on clients in order to support them towards achieving better health outcomes:

Well, it's when they start making the right choices for themselves, and being able to do self-cares effectively. They start attending their specialist appointments, things like that ... it's when it starts to happen and it continues! When they rely on themselves. Those are the kind of outcomes ...” K: 19.

“But it takes a lot for that to happen ... who the hell is interested if they have bigger stuff to deal with. A lot of them survive from one benefit to another ... there's things like poor housing, no jobs ... plenty of that around. If you go in there just thinking you can teach them to use their asthma pump and how to do peak flows, well good luck! They won't care if their benefit's run out 2 days before they get their next one.” J: 19.

“Yea, if you want those positive outcomes, you got to peel through those layers and really see what's going on for them. You get the bigger picture. If you can get them some help, like maybe an emergency benefit or something ... a food parcel maybe ... then you're really helping them with their needs. They'll listen to you; they'll realise, eventually; when everything else isn't a priority before their health.” L: 19.

“It's when you can help them get through those other issues, they get their confidence back. Then they'll listen to you... they'll learn from you and make those healthy choices for themselves.” J: 19.

While respondents identified health education as being key towards positive client outcomes, having patience and non-judgemental attitudes was considered to be just as important. Understanding client and whānau realities, priorities and their immediate needs in order to see the impacts of health determinants on clients and their whānau were considered critical towards supporting them to attain better health outcomes.

Cultural identity and wellbeing

A strong cultural identity contributes towards health and wellbeing (Durie, 2004). Māori realities are diverse and for some Māori, access to Te Ao Māori may be limited. According to respondents, being a whānau to disadvantaged clients and role modelling this in a professional way had reciprocal gains for their clients and whānau that contributed towards wellbeing:

“Māori that are sometimes tangata whaiora ... don't know much of their culture and their whakapapa, and how they can be, and how they are more than just one ... that special strand ... that we are whānau here for them ... and it's about modelling that in a professional way that they can model back into their own lives; and that they can go back to their own whānau and marae.” F: 6.

“And that's part of looking at perspectives from a healing way, and for this person to find out where they've come from ... then their health grows. Just carrying on from there, it's awesome ... just being able to ahua.” G: 6.

Another respondent in the group spoke of kaupapa Māori and its link to a secure identity:

“We work in a kaupapa Māori way as we go through their assessment and include what they need in their aromatawai to strengthen that person; I mean, you know, we know that tangata whaiora lack a secure identity; What does that mean? 'A secure identity?' what does that mean? It's about Te Ao Māori.” C: 3.

One other respondent in the group who worked in social services suggested that a Māori environment creates a sense of safety and security for Māori especially when they choose to return for their appointments:

“And I would say even in the shorter term, you know, when you see someone coming from probation who's not turned up for an appointment...if they choose to continue to come back is the real positive thing. They don't have to, but if they're coming back... especially Māori, then they feel safe here. This place ... they identify with it as kaupapa Māori ...” I: 9

Working in a Māori way actualises a Māori environment which benefits the disadvantaged and most vulnerable Māori. It is an environment where Māori cultural values and practices are role modelled and reciprocated, creating a sense of cultural identity which is a significant contributing factor to Māori health and wellbeing. In view of findings from the data in this chapter, the table on the next page summarises a framework from which respondents operate when delivering services.

Table 2: Tikanga-based Framework from which both Māori and non-Māori operate at Whakapai Hauora when delivering services

Worldviews	The principle of whanaungatanga	The principle of manaakitanga	The principle of kotahitanga	The principle of tino rangatiratanga
Te Ao Māori	<p>Reciprocal, supportive, interdependent relationships: in sharing the burden of care with clients/whānau and other providers involved in the delivery of care.</p> <p>Making the best use of resources; identifying and addressing immediate health determinants/needs to health service issues and streamlining service delivery.</p>	<p>Generosity; hosting; empathy, respect and the ability to care in the provision of extra support and advocacy (addressing Māori needs by working beyond contractual compliance).</p> <p>Māori holistic concepts of care: the interconnectedness of all things (the impacts of health determinants on an individual and their whānau).</p> <p>Hui with other service providers: engaging with other providers kanohi ki te kanohi, sharing kai and exchanging information about each other's services and respective roles.</p>	<p>Collectivism: collective control and ownership in service delivery and care to achieve common goals and best outcomes.</p> <p>Utilising the collective strength and effort of all involved in an individual's care (whānau and other providers) to deliver wrap-around services.</p>	<p>The capacity to whakamana (empower) clients/whānau through imparting knowledge and health education. Maintaining a balance in the provision of support, advocacy and system navigation.</p> <p>Teaching clients/whānau how mainstream health /social support systems operate towards self-navigation.</p> <p>Cultural empowerment by means of marae-based service delivery with access to cultural resources (i.e. tikanga, Te Reo, whakapapa, kaumātua).</p>
Te Ao Pākehā	<p>The Treaty principle of Partnership</p> <p>Collaborative and supportive partnerships with other providers: when sharing the burden of care. Making the best use of resources; addressing the health needs of clients and whānau, and streamlining service delivery.</p> <p>Collaborative partnerships with individuals and whānau in the delivery of care. Sharing the burden of an individual's care with whānau.</p>	<p>The Treaty principle of Protection</p> <p>Non-Māori providers have an understanding that Māori needs are different to non-Māori in terms of extra support and advocacy; they collaborate effectively with all other providers in the delivery of care.</p> <p>Individualised care: client-centred approaches in meeting all the needs of clients, protecting client rights (understanding client priorities including whānau and the impacts of health determinants).</p>	<p>The Treaty principle of Participation</p> <p>Team work with active participation among all providers involved in the delivery of care: negotiation, cooperation, shared responsibilities in problem solving and decision-making in service delivery.</p> <p>Recognising whānau as a collective; capitalising on whānau strengths and capabilities to support an individual along the care continuum. Actively encouraging individual and whānau participation in the delivery of care.</p>	<p>The principle of Self Determination</p> <p>Empowering clients/whānau by teaching them how to do and manage self-cares.</p> <p>Making clients/whānau aware of their full entitlements when accessing health and related support services.</p> <p>Teaching clients/whānau how mainstream health / social support systems operate towards self-navigation.</p>

Summary

This chapter has presented the initial findings supported by evidence from interviews with Whakapai Hauora health professionals. Findings indicated that respondents believed Whakawhirinakitanga Ahua to be a holistic model which draws on traditional values to facilitate health service delivery. Māori respondent perspectives of the model were strongly linked to their own cultural beliefs while non-Māori views were based on client-centred practice, collaboration and the Treaty principles. Despite these differences in beliefs, they worked collaboratively to achieve best outcomes. Respondents' views concerning service delivery were based on collaborative approaches to care, and facilitating greater access for clients and their whānau to essential health, social and wider related support services. The nature of their work also captured the way in which they navigated through complex health and wider sector systems in order to achieve better client and whānau outcomes. Their challenges included funding and resourcing issues, differences in mainstream service delivery and attitudes of mainstream providers.

The significance of fostering relationships with providers, clients and whānau was central in the data. Relationships were underpinned by honesty, trust, respect for others, maintaining their own integrity and the integrity of others, being supportive, consistent and professional in their dealings with clients, whānau and other providers. Respondents believed that their services were culturally appropriate in meeting the needs of clients and whānau. Going the extra mile in order to manaaki clients and whānau, and working towards achieving common goals with other providers in a collaborative and unified approach were acknowledged as being crucial towards achieving desired outcomes in health service delivery. Respondents also associated positive outcomes with clients having tino rangatiratanga over their own care. Building and sustaining whanaungatanga based on trust, respect and an understanding of client/whānau priorities plays a pivotal role in behavioural changes for clients in terms of being receptive to care, participating in their care and making self-determined choices in care.

Chapter Seven

“They should walk a mile in my shoes”:

“Then they’ll know how it feels ...they have no idea where I’m coming from⁵¹”

Introduction

This chapter presents findings from clients and groups (couples who were whānau) who accessed a range of Whakapai Hauora health, social and disability support services. A total of thirty-one pakeke and kaumātua participated in this study which consisted of thirteen individual interviews, and nine whānau interviews. This chapter begins with respondents’ understanding of health and wellbeing which placed whānau at the centre of their own health and wellness. During interviews, respondent discussions quite often included whānau when sharing views, experiences and stories of their journey along a continuum of care. The data is presented under three headings with several sub-headings. At the end, a table is presented illustrating Whakawhirinakitanga Ahua (the model of service delivery) pathways towards achieving whānau ora.

1. Holistic health and wellbeing

Respondent interviews began with discussing their understanding of health and wellbeing. Most referred to health as being physically well, while the state of wellbeing was more subjective; often referring to as a general overview of their quality of life, including their whānau. They were also asked to describe what was important to them in terms of their own health and wellbeing. This opened up a forum for a range of responses in relation to an interconnectedness of intrinsic and extrinsic factors associated with their cultural beliefs.

⁵¹ Individual clients/whānau interview, 4th November 2009.

It's about whānau

One respondent spoke of health and wellbeing from a Māori holistic perspective with whānau being the most significant factor:

“Health and wellbeing is about everything really; the whole ... and I mean the whole, that’s all interconnected. Not just the physical state It’s about the emotional, the mental state; it’s about our spiritual safety, it’s about our cultural safety, our environment. It’s about our whānau safety; it’s about the bigger whole picture... and the wellbeing of my whānau is the most important because they mean everything to me. They are here for me when I need them; their help, their awahi when I get sick and when they need me, I am there for them.” Y25: 1.

Another respondent related health and wellbeing to a bigger picture encapsulated within Te Ao Māori. Whānau again, was considered to be an important aspect of holistic wellbeing. This respondent also spoke of what he considered as being pivotal to service delivery for Māori; that Māori understand the services being provided to them, that providers working with Māori have a better understanding of their roles in order to work collaboratively with each other and that a face-to-face approach is used when working with Māori:

“We [Māori] as a people see health in a holistic way; our physical, spiritual and mental being is important; whānau are precious to our wellness. Then there is being Māori, it’s who we are ... our identity as Māori; our whenua, hapu, iwi ... our tikanga, language, values, beliefs ... Te Ao Māori ... This is all very much of what health and being well means to me. And that’s how I see your people working with us; not just treating the physical but also working with us to help us ... in a kaupapa Māori⁵² way. Everything is connected to our wellbeing. I also think with health and wellbeing, especially for our people, is that that they understand more about the services provided to them. For our people is that there is an understanding between providers who work closely together for the patient, so that they understand more about each other, and their service. We find that a lot of our Māori people, they’re more visual people, than if you give them a piece of paper that says this is what a service is all about. Kanohi ki te kanohi is what works best for us.” V22: 1.

Another respondent spoke of health and wellbeing from her perspective as a mother, considering important aspects of preventative care for her children. There was a strong focus on her children, rather than herself with an emphasis on the transmission of tikanga and te reo Māori within her whānau:

⁵² kaupapa Māori also referred to by these respondents (clients) also means things done in a Māori way.

“I think about physical health as well as mental health and health of the whānau unit and as well as spiritual health I guess; and also the environment. They’re all related to each other. I think obviously also physical health, things around the body being healthy and you look at it ... looking at it from a preventative point of view so you try to keep yourself healthy so you don’t get sick and ...like I think about my own kids ...I think about, you know, when winter comes we always know there’s colds and things like that so it’s trying to keep their health up so that they don’t....we don’t sort of...we go into that routine every year. And so in terms of that I sort of think about diet, making sure they’ve got healthy food, they’re not eating too much junk.....those sorts of things, so I think a lot of it is diet and exercise, you know being fit and healthy and its quite hard to think that I have to think about it in terms of myself because I’ve always focussed on my children so from a perspective of a mother I suppose you can sometimes forget about your own health. But I’ve always focussed on keeping them healthy and maybe not so much myself sometimes. So on the physical side and there’s also like dental health. Also an important part of their health and wellbeing is their Taha Māori and their tikanga. So in terms of my kids, they’ve been through their Kura Kaupapa and now they’re at college. But Te Reo is big, well from my perspective as a mother; for my children being Māori children, their Reo is a huge part of their health and wellbeing, their tikanga Māori.” B2: 1.

Another respondent explained the notion of holistic health and wellbeing in relation to having an awareness of healthy choices:

“Health and wellbeing, it’s mental, physical, spiritual, whānau, Te Ao Māori, you know? our tikanga; it’s everything; everything’s related to each otherto me I suppose it’s also being aware of choices that I can make; being in a comfortable environment, yea, you know, with the person that I’m actually speaking with?and I suppose who’s giving me those choices? Yea, that’s what it means to me, it’s a healthy environment also and being able to make those healthy choices.” Q17: 1.

During interviews, respondents also spoke of the important role of whānau within their own lives. For them, the support provided by whānau was crucial. Their statements also highlight the many roles that whānau play as a collective to support individuals at times of critical illness, including on-going support to achieve better health outcomes for them. One respondent spoke of how her illness impacted on her whānau. Her experience captures the collective role of whānau in taking care of her and helping her cope with illness:

“Health and wellbeing for me also means how well my whānau is. My whānau are important to me; it’s like me in the centre and my whānau that sit around me, so whatever is wrong with me affects them because they help me to take care of myself. I’m a diabetic, it was bad before; but when whānau stepped in, it made things easier for me. They took special care with my kai; my daughters cooked for me and made sure I didn’t get takeaways...my son always got my pills from the chemist and made me take it! My husband always follows me to the doctors for my check-ups ... you know? It was hard making that big change, like not being able to eat how you did before, having to take pills every day and going back to the doctor to get more pills!... but because of their help, my diabetes is under control. It’s also about them being well too...when my whānau are well, so am I.” R18: 1.

Another respondent also spoke of the on-going support received from whānau to help him maintain a level of independence:

“I’m 79 years of age and my health is very sound. However, in the past years my body has aged and I’ve had to have four hip replacements. I have had many illnesses ... I hope that my health just keeps so I can carry on much further and be there for my mokopuna. My whānau have always been here to help me with things that I can’t do for myself, but I want to be independent on my own for as long as I can. I can’t move around as much as I use to before so whānau take me to where I want to go. It will be hard if they weren’t here, or weren’t well themselves. I try to spend as much time as I can with my mokopuna⁵³ who are just as important to me.” M13: 1.

One respondent spoke of extended whānau who supported her at a critical time of illness, when immediate whānau were unable to travel to her location to provide vital support. Whānau support has been a crucial part of this respondent’s reality over a long period of time:

“I mean I look back on it and I think, yes that’s what helped me get better too; all that support. And then that might be different because I was born down here. You know this [area], I have my whānau. Where I was in [name of a major city], my aunty and uncle travelled to be with me. It cost them to travel but they still came for me. Then when I had my breasts taken off, there was my cousin who helped me ... I mean it’s easier to access [services] down here, don’t you? My whānau don’t have to go out of their way to help me.” N14: 7.

⁵³ grandchildren

Another respondent spoke of her daughter as a main source of support. She was also concerned for her daughter's health and how her health needs impacted upon her daughter:

“If it wasn't for my daughter, see I don't drive and [daughter's name], well she'sshe knows that we're just not well. She'll make it that she can come in and be here. But I know that that's not going to last forever because she's going to be moving away. And she said “Oh I'll come... I'll be here for you” ... but I don't want her to have to ... because she isn't a well person herself and she'll put others ahead of herself and at the moment she's in dire straits. And so to me, that ... she's got to get herself right and she's just been through an ordeal ... we have other children, but they're not close by ... living out of town, so you know, she's the main one that's there for us. So her health is just as important to us.” D4: 5.

For respondents, health and wellbeing is closely linked to whānau and is inclusive of nuclear and extended whānau. The wellbeing of their children was also significant. During conversations about health and wellbeing, respondents also spoke of their own perspectives of a hauora (a health centre) and access to services for them and their whānau.

A one-stop shop service provider

According to respondents' views, a hauora was inclusive of a range of services for whānau situated in one location. They also considered the significance of having a marae on-site by a hauora, such as Tūturu Pumau (the marae) Whakapai Hauora which is situated next to Whakapai Hauora. This is demonstrated in following statements made by respondents:

“To me I think ... if we're looking at health holistically, then all those services should be in one place. Maybe it's not realistic, but I've seen some places where this has happened and it works well. But marae-based services is best, I think. Like this place, you got the social and cultural here... not just clinical like Pākehā services ... it all just connects.” G7:3.

“You have so many services all in one place. Also ... just thinking of the marae itself and what, you know...what happens at the marae... I mean that's part of the wellness as well? And everything else that happens here ... the organisation, from the kapa haka to the waiata, to the kuia, kaumātua and the way that everybody is sort of you know...is nurtured in our culture; you feel you belong and this is the wairua here. And you can feel it here... This is what a hauora [health centre] really is; taking care of your health but you can also go to workshops or activities and do

things with your whānau on the marae... Everything else that happens on the marae; I don't know anywhere else where you have all this. And it's such a privilege to be a part of it...you know? To be a patient here at a hauora [health centre] like this. To be part of it! This is what hauora [health and wellness] really is" Q17: 5.

"yea... that's why we come here, because we can get to use not just one, but many services. All in one place. It's also easier to get into health services here. It's for the whole whānau like Tamariki Ora, Whānau Ora, the service with [name of Whakapai Hauora health professional]... and we use her a lot! Not only that, having our hauora by the marae here, there's such a lot of things; like waiata⁵⁴, kapa haka⁵⁵, raranga⁵⁶; ... and there's line dancing, Tai Chi and you know, to keep us fit...we just love it, what they put on at the marae for kaumātua and whānau. We can all join in and celebrate who we are and be well...you feel it all, all that wairua. It's just uplifting." A27: 3.

Māori and iwi providers are often one-stop-shop health providers, with a range of health and social support services in a central location providing seamless access to services for the whole whānau. This respondent's statement describes a collaborative service delivery model including the presence of culture within Whakapai Hauora:

"Yea, my whole whānau's health is important, not just mine. And that's what I like about Māori providers; cos they have other services under one roof, but better still cos they know each other well and that makes it easier for us and whānau to use. But this place, there's a marae and whānau workshops sometimes, you guys run? Yea ...there's obesity and diabetes in our whānau ... huge issues. The doctor put us on to the nurses and other kaimahi⁵⁷ here? And we went to a diabetes cooking workshop run by one of your ladies? Yea...so now we know about cooking healthy kai? I see the marae also used for things like waiata, kapa haka and classes for grannies to do raranga? I think it's a really good idea of a hauora; not just the physical but also others things ... whānau and social ..." Y25: 1.

These views were common among respondents and the statement made below by another respondent is an exemplar of this:

"Mainstream is sort of separate like separated and they've got like the GP service here and then another organisation's got the mental health, and another organisation's got social wellbeing, that sort of thing. Whereas iwi providers, they have everything within and yep..." F6: 3.

⁵⁴ Māori songs

⁵⁵ Māori cultural performance

⁵⁶ Weaving

⁵⁷ The term kaimahi means worker(s) or employee(s)

However, one respondent identified that not all iwi providers have services in one location:

“But I think a proper health centre should be like a one stop shop in the same building and looking at [other iwi provider’s name], I think [other iwi provider’s name], they have 5 or 6 different buildings, but they’re all one organisation. So some iwi or Māori providers can be sort of separated too. Yea, whereas here it’s all in the one place; so it is a one stop shop. It makes a big difference” G7: 3.

One respondent also believed that there would be better communication between different services if they were located in one place making it easier for clients without having to explain their health issues repeatedly to different service providers:

“Yea ... yea, it does; it makes a difference ... if you had to go to another building it’s almost like going into a whole new world cos they all work differently. And then you also have to explain what the problem is from the start again, again and again whereas throughout Whakapai[Hauora] it just moves on and the next person, or if you’ve been referred on say, social...they already know what’s going on. You don’t have to explain all again because they don’t have all your health information” F6: 3.

Respondent understandings of health and wellbeing are holistic encompassing physical, spiritual, mental, whānau and cultural wellbeing. Whānau were integral to this, as whānau support and care facilitated better health outcomes for respondents. They believed that having a marae on-site by a hauora gave them access to cultural resources; this was a visible part of the service at Whakapai Hauora with all activities that take place on the marae. Respondents also had a preference for a range of health services situated in one location; they noted that it made a difference due to access and communication among service providers, which are some of the barriers to service delivery. The next section of data covers the most notable barriers experienced by respondents.

2. Barriers to accessing services

When sharing their experiences about service delivery, respondents had a number of different experiences. Most respondent experiences and views highlighted many barriers encountered while accessing other primary, secondary, and wider related support services. Some also spoke of the barriers encountered by their own whānau when accessing services. There were a few respondent stories that captured positive experiences with secondary care providers. The most notable respondent experiences are captured in the following sections of data.

Cost and waiting times

Some of the most common tangible barriers were cost, transport and lengthy waiting lists to services. With regards to cost, a common view among respondents related to the expense of after-hour GP services. One respondent commented on the cost of after-hour care leading to use of inappropriate hospital services:

“You end up having to go to the hospital [emergency service] at night because the after-hours doctor costs too much. Then you just sit and wait for hours and hours before you get seen because it’s not a GP service. But people do it, because it costs nothing.” A1: 3.

Another respondent’s experience concerning the cost of her husband’s care made her question the purpose of accessing after-hour care in relation to the overall cost which included medication:

“Another bad experience also was when my husband got sick. He’s on a lot of medicine because of his lungs and other things, so we went to [name of after-hour GP service] on a Friday night. I just about had a shock of my life when the lady there said to me, “you have to pay \$75!” I said “What? My GP only costs \$15 and we are pensioners!” She pointed to the sign and said “Oh but those are our charges”. I didn’t know that; and I had to pay it for him. Then I had no money left after paying that bill. But he needed the medicine because of his chest infection; and he was in pain. I didn’t know what to do except ring my daughter and she came down and she paid for the medicine. I don’t know how we would have managed ... What’s the use of seeing the doctor if you’ve got no money left for your medicine?” L12:5.

Cost factors associated with transport are also causes for individuals not to attend important and necessary appointments. These issues were raised by some respondents while discussing preference for a one-stop-shop service provider:

“Transport is sort of one before we had a car it was hard just getting there [to appointments]. We had to walk everywhere, or catch the bus. But now that we have a car, it’s still hard [laughter] cos of our income; we can only spend so much on petrol each week. So yea...it’s real tight.” W23:3.

“Yea...yea... transport is a big problem. And when you have to go to different places, it’s really hard. It gets expensive after a while with petrol [costs] now. When you’re sick and you need to go to different services...well, if I had to go from one place to another, I’d probably hold off.” F6: 3.

Coordination between the primary and secondary care interface, particular for clients with chronic disease has important implications towards maintaining continuity of care. Another concern raised by some respondents was lengthy waiting lists to secondary care services. One respondent’s condition had worsened due to the wait:

“I had horrific breathing problems and it took two years before I could get [the test] I needed [my GP] had been trying to get me in for ... [this test] for two whole years! I got sicker before I got seen. I’m very disappointed and frustrated with the system. Going to a private specialist is just too expensive.” J10:3.

Another respondent believed that there were no guarantees of getting an appointment in an overbooked system where referrals were consistently reviewed:

“You get a referral from the GP and it goes up to the hospital and they send you back a letter two weeks later saying you’ve got an appointment in four or five months or you’ve been put on a waiting list and that it will be relooked at in the next six months ... from their [secondary care provider’s] point of view, there’s just a huge waiting list that’s overbooked for everything, so you’re just a number down the line, not a person with real needs. Insurance will only cover so much for private [appointments].” G7: 4.

Although cost, transport and lengthy waiting lists were identified as barriers for respondents, their experiences also centred on the attitudes of other providers towards them which were negative experiences for them. These were also significant barriers to accessing care.

Negative experiences with mainstream services

During a whānau interview, one respondent spoke of his experience accessing kaupapa Māori health services after moving away from a major city. Following on from this, he spoke of his wife's experience with a secondary care service. His wife (also a respondent) had recently taken a turn and went into secondary care. The conversation continued as they told their story which highlighted some concerns about the service they received; such as the lack of effective care, poor communication and a lack of being treated with respect:

“Well, I ... as far as I'm concerned when we left [name of a city] to come up here, I found it different because here at Whakapai Hauora, is run by Māori and iwi practices and all that sort of thing. Kaupapa Māori⁵⁸, that's right and it's different from where we came from, you know? Amongst non-Māoris, you know? We got to go by their rules and that sort of thing...and now we're here its sort of different; you just fall straight into it! And you feel as if you're welcomed...like you belong to the people...? It's a real whānau environment; everyone cares about you and that's the difference that you feel. Well, my wife recently went into hospital and it wasn't a good experience at all. ” P16:3.

“Yes, just two weeks ago on Saturday night I went in. I took a turn and they took the blood from here, but they took it from there [right hand], and my whole hand blew up. I got an infection so I went back to [Whakapai Hauora health professional's name], straight away, and told her; by that time I could only use this hand.” O15: 3.

“But the thing is, before, when she, before she got discharged, I approached them about her wrist cos it was swollen and I didn't like it. The dressing wasn't done properly and it was showing up and blood was leaking through it.... I said to the nurse, “Look at this” and she looked at it and said “oh, it's alright” and she laughed about it. She could have attended to it, but she didn't and it got infected later.” P16: 3

“Yes, it was this one aye?”[showing her right arm to respondent P16] O15: 3.

“So I said to the nurse, I said “Look at this! This needs to be attended to!”P16: 3.

“It was all over my clothes...” O15: 3.

⁵⁸ kaupapa Māori in this statement is referred to things being done in a Māori way.

“And at that time, when I approached her, she should have gone and ...well, attended to that ... that could have gone...infected, you know?” P16: 3.

“Yes, you don’t expect that...? You think they would give us some respect? We are kaumātua, and I was sick ...” O15:3.

“Umm ... no respect at all. I mean there’s no need for it; she could have just gone and even changed the dressing on it and put another one on, and stop the bleeding and that. But she didn’t seem to care. And from then on, 3, 4 days on, it started swelling. So she went to see [Whakapai Hauora health professional’s name] and she gave her some stuff to ...” P16: 3

“Antibiotics...she gave me antibiotics. She was really good about it.” O15: 4

Respondent P16 also recognised the extent of service delivery at Whakapai Hauora:

“She provides a good service cos she’s got, you know, as you say, the aroha behind it. And she’s got all the love in her, you know, for people. Aroha; people; you know, she’s got a very humble approach to people, I mean, especially patience and respect. You know, cos after all, it’s not only a job, it’s everyone’s job as well, your job, as you say, she’s doing a lot of other work besides what she’s supposed to be doing. You know, can you see other non-Māoris in other places doing that? ... Doing work that they’re not supposed to be doing?” P16: 4

Another respondent had a heart condition and spoke briefly of her experience when accessing a secondary care service. From her perspective, the service was inappropriate to her needs. Ineffective communication on the part of the provider and lack of respect were key issues:

“I had problems with the [name of secondary care provider]. Well I just think they need to be more on to it really and yea, not work on that ‘in and out’ process. That’s how I feel... I think they need to listen, they actually need to listen to you and understand what you’re feeling, like the pain you’re going through. I had really bad chest pains when I went there. I waited hours to be seen; my doctor sent me there. But they didn’t really listen to me, they were just like trying to guess you know saying “no, no, that’s not what you’re feeling, this is what you’re feeling”. So they need to listen I think, and show some respect. They did some tests and it wasn’t my heart problem, but it was just the pain I had, they didn’t seem to care. Just in and out ... painkillers and then you’re out. They were telling me that it couldn’t be all that bad ... but my pain... I was still in a lot of pain. They didn’t seem to believe me.” H8: 3

Another respondent spoke of a ‘quick fix’ attitude of mainstream providers; his emphasis was also on a lack of support and the way in which clients were treated.

He was also concerned with the presentation of information to clients:

“Well, I’m not too sure how they integrate care for their patients, but I do know that the [secondary care provider] has an appalling way of dealing with patients up there... the lack of respect! And all they want to do is medicate ... the quick fix ...try this pill; if it doesn’t work, try another. Then you’re out of there ... if it still doesn’t work then go back to your doctor... You don’t really get fixed properly. And

sometimes you end up being worse off than what you were. There’s no support and no proper korero. It’s just like other mainstream services out there. All their information is on paper. They give it to you on paper and that’s it. You have to read about their service and a lot of us are too shy to ring and ask questions or what we’re entitled to. But with Māori providers, yes there is support and the support I would say, is the support we are looking for. It’s the aroha and the manaaki they have for you... it’s the face to face service that they give. It’s not the service where you get information on the phone; you get that full service with Māori providers. If they’re not ... if the patients are not too sure of what they need, then the nurses, whoever it is, they visit you and say this is what you need and this is what you need to do. And that’s the sort of service that I’ve never seen in any other places. I know that Māori services and the [name of secondary care service] are two different things, different things altogether, but it’s the way we’re treated ... the way they treat us up there ... and they think they’re providing a service? A health service?” V22: 2.

One respondent was pleased with the secondary care service she received and understood the reasons for secondary care professionals being unable to provide a one-on-one approach to care:

“When I was in [name of secondary care service], I think because they have so much people you know, that come...oh no, the mainstream, the oncologist, doctors and nurses were wonderful. But I mean because they have a lot of people coming in and out all the time, I don’t think they have that time you know, no time for one on one? You know, like a bit of real good support? I mean the service I got when I was there; they’re very good, especially the nurses...but no time for one-on-one.” N14: 3.

However, after this respondent was discharged from secondary care she experienced difficulty in accessing community health support services. Being Māori, she thought that community health support providers would visit her. Although she received a pamphlet with information to access services she was too afraid to ask for assistance. Eventually, she was helped by whānau members to access Māori provider services:

“When I got out, the support system wasn’t good. Cos you had to ask for it and I never asked for it. And I never had the support there, I was too whakamā. But you know, being Māori you would have thought that they would have come around to see you? You know what I mean? Come around to see you but not. I could ... I saw all the services there but I didn’t ... I was too chicken too, you know what I mean? You know, when you get diagnosed with cancer, then you get your breasts taken off... and they had the services there written for me to access but I didn’t. Well cos all my whānau are down here you see and my cousin went and got aunty to help me. I didn’t know where else to get help so they took me to see [Whakapai Hauora health professional] who got the support for me. She spent a lot of time with me, she listens, you know? listens to us? And she cares about my whānau ... she understands what they’re going through because of me. We trusted her with things...” N14:5.

Respondents had expectations of being cared for in a certain way; being listened to, being treated with respect and receiving more support than what was given. Their views indicated that the mainstream services they accessed focused on clinical aspects of care such as test results, medication and treatment with a lack of effective communication. This in turn, resulted in negative experiences with mainstream service providers. However, one respondent noted a high client turnover in secondary care services and attributed this factor to not being able to receive additional support while in secondary care; another noted that non-Māori working in a kaupapa Māori environment have a better understanding of Māori needs in comparison to those who work in mainstream services.

Positive experiences with mainstream services

Some respondents had a more positive experience of mainstream service. One respondent stated that this was mainly due to effective communication and the attention she was given during her brief stay:

“I had a [type of treatment] just at the beginning of [month] and I must say, having this [treatment] made a huge difference to my health. I admit, I was petrified; I was scared stiff of what was gonna happen because I myself suffer from claustrophobia. I can’t go up lifts so I walked up the stairs very cautiously to the [place of treatment] and I was very, very frightened; and the service I got at that [name of treatment unit] was absolutely fantastic because they explained to me what was going to happen. They said they wouldn’t leave me alone for too long; procedure was procedure and I think I had when I went into [place of treatment], I had 3 or 4 people in there including the [name of specialist]. And it was really good because I was going under local [anaesthetic] that made it more nerve wrecking for me. But the service up there in that particular unit was tops. They treat you with respect. I mean they put through

so many patients in a day, quite amazing. And they never left me alone for any more than about 3 minutes. And after the [type of treatment] was performed they got my clothes, they told me to get changed, I did. When I went back to sit down, there was a tray there with sandwiches, couple of biscuits, yoghurt and a cup of tea on it. Now you don't get that service anywhere else ... And I mean, what public have got to realise is that up there, those poor staff are flat tack all the time. They don't get a break, they don't get a day that they can say "oh...I've got nothing on today" because the work's there the whole time." A1:3, 4.

Another respondent also recalled being treated in a professional manner when accessing a mainstream service provider. According to this respondent, there was effective communication, and he was treated respectfully which made him feel comfortable throughout the entire process:

"and there was something else I was going to...oh yea, I went in there with an internal problem that she sent me to the hospital and I went into...where I went for a ...[sigmoidoscopy] to have a look at all the rest of it and I was there with about 5 girls, stripped down and everything you know; but I was treated with respect and I actually wrote a letter to the [secondary care service] and thanked them for the service I got because they made me feel comfortable, good and not embarrassed or anything, you know? ... they were good and friendly; ... explained everything to me and I wasn't afraid. They were professional about what they did. Kept me informed about everything. And I actually filled out one of those forms and sent it back to the hospital and said thanks very much. I felt good about it" D30: 6.

Respondent R18 was referred to a mainstream primary health care service for ongoing education with diabetes. She stated that it was a learning experience in terms of understanding mainstream perspectives on diabetes management. Although the environment was different, she enjoyed the experience due to a reciprocal relationship where health knowledge was shared and gained with each other at group sessions:

And it was really interesting; it was interesting for me to see that how their [Pākehā] perspective was on diabetes? Because had I been in a room full of Māoris, it would have been totally different! So it was good for me to see you know, where they came from and all...some of the issues that they had, with control and things like that. But yea, I enjoyed it; I'm still with that group because of the knowledge, what I've learnt about diabetes, but also, what I shared with them; my experience as a diabetic... it's really, really good." R18:4.

This respondent also noted the difference in a Pākehā perspective of care and believed that if whānau were not involved, it would have been a potential risk to her health and wellbeing:

“It’s really different though, the Pākehā way; because they’re there, discussing themselves; but I can’t discuss myself without including my whānau because sometimes, you know, it was about me teaching ... now that I’m on injections, teaching everyone in my whānau to ... if I go on a low, this is what you need to do. You need to get this injection. And so I’ve trained all my...yea, so and you know, cos this other thing like when I’ve been really sick and if someone needs to be off work looking after me, they need to know what’s going on with me; so in my house it’s about everyone needs to know about my illness, so if anything happens they can call ... [someone]. So when I was in that forum, they didn’t do that! ... the people running the service and the Pākehā using the service, no, no! No thought of whānau. And it’s like who takes care of you if anything’s going to happen? And they said, well you know my wife or my husband knows these things and it was like but...yea what about your whānau? What exactly do they know and where will they get enough information to do your total cares? Well I feel for me, it might have been a dangerous situation.” R18:4, 5.

It was a learning experience in terms of understanding mainstream perspectives on diabetes management for respondent R18 and she valued the knowledge and expertise of the group; she had also formed a reciprocal relationship where knowledge was exchanged and she could share her experiences of being a diabetic with non-Māori in a group setting facilitated by a mainstream primary health provider. She highlighted some crucial factors concerning the collective role of whānau in her care, as opposed to a Pākehā perspective where the burden of care lies mainly with an individual’s partner. She also raised the significance of intergenerational transfer of health knowledge in terms of teaching whānau members how to take care of her and help manage her diabetes.

Barriers to accessing wider support services

Some respondents spoke of their experiences accessing wider related support services towards seeking financial assistance with health-related costs. Ineffective communication and attitudes of those involved in a client’s care has an effect on client outcomes. One respondent highlighted this experience and noted the significance of having advocacy and support when accessing wider related support services.

Her story also signals the reluctance to access this service, due to the expectations of being declined for assistance, being treated with a lack of respect and feeling whakamā:

“I just don’t want to go there, you know, I just try not to. I always avoid trying to go there, but there was one time when I had to go for my glasses, to depend on the money. But it was through [Whakapai Hauora health professional] is how I got it. Cos she was the one; and had a bit of a ...argument with them, you know, they don’t really like it, cos we’re entitled to so much? Cos we don’t know that! They don’t tell you these things! And that’s how I got my glasses, straight away through [health professional’s name]. Cos I was told we couldn’t get them; but she said “we’re going back there now”. And I said, no I don’t want to go back cos I abused them. I said some nasty things and I don’t want to go back. [Health professional’s name] said “we’re going back, you’ll be having your glasses; we’ll get them done today”. We went down; well, she just went to them and told them that we’re entitled to a thousand dollars or something...for the glasses. But mine cost me \$500, so they took it out from my pension; I was paying \$20 a fortnight, ...Well I didn’t mind doing it that way, but I couldn’t afford \$580 straight out? So that’s why; so, it was with her help, that’s how I got my glasses like that. Cos I was so nasty, and they said to me I couldn’t have it cos I have a spouse? I feel as though before you go in and ask for help, you already feel whakamā, because it’s like you’re asking for hand-outs. And sometimes you feel like they have no respect; they’re talking down to you when they tell you that you’re not entitled to certain things, although you really need it; or they cannot always give you an answer straight away because they’re not sure. They have to speak to their supervisor first and you have to wait for a letter to come in a week. And it’s not always, you get it...the money you need, you get declined.”
L12: 4, 5.

Another respondent who shared her story was an independent working woman before suffering from a stroke. She believed that her journey of illness and recovery was a learning experience for her. Accepting her limitations and having to rely on whānau and other services for necessary care, support and financial assistance were all very difficult, but necessary in order to have better control over her health and wellbeing. She also described deficiencies in the workforce as barriers to adequate support services. She expressed her concerns with younger people who delivered some essential support services; although qualified in their roles, she believed that they lacked the necessary experience and life skills to provide services that met her needs:

“Maybe I’m not an old woman, but I find that most of the places I go to I’m finding children that I go to that have no life skills. Today it’s like they just come straight out of school and because they’ve got a certificate, they think they’re good at something ...makes them good at something, they don’t know what a kick in the head is, or you know, hard life, losing children, grief, you’re getting counselling for someone or somebody that’s never experienced death and they’re a grief counsellor? You’re getting counselled by someone for relationship marriage problems that’s never been married; you have people dealing with you in hospitals when you’ve had children but they have never had children, those sort of things! Yea, they give you negative advice. They should walk a mile in my shoes; then they’ll know how it feels ... they have no idea where I’m coming from.” J10:4.

She recognised that a certain level of dependence on whānau and service providers was necessary at the initial stages of her physical rehabilitation as she was struggling to cope with daily tasks, compounded by feeling whakamā to seek assistance. Her story captured the significance of health education as a tool for empowerment in the recovery process:

“After my stroke while I was recovering, I still tried to do everything on my own; I was getting dragged down doing it. I was too whakamā to ask for help; and it was through you guys at Whakapai [Hauora] that actually said to me “Stop, take a step back and we can get these services for you”. But I know madam here [respondent referring to herself] she knew best and she could do it all on her own, cos she’d been doing it for years. So yea ... my whānau was also involved and Whakapai [Hauora staff] got them to speak to me. Through the support of my whānau and children and my mokos⁵⁹ who says to me “Nan, you can’t do it anymore! You’ve got to stop trying to be super-nan! Go to these places.” I thought I shouldn’t have to, because I’ve never had hand-outs before but your staff gave me all the information about what I was really entitled to, and home help as well. So it came to the point where I had to get some help. It was the staff at Whakapai [Hauora] together with my whānau who helped me come to terms with actually accepting what happened to me. Also the nurses teaching me about my medications and how important rehabilitation was for me and how to cope; because now I can walk and talk properly. I’ve had my [driving] licence taken off me, but I’ve learnt to take control of my situation and decide how things need to be for myself.” J10:6

This respondent identified that effective communication, a face-to-face approach and not focussing mainly on prescriptive aspects of care, were contributing factors to successful service delivery:

“For me personally better communication and more knowledge available, the face-to-face thing; not just by pamphlets, but those that you’re dealing with, need to know these things. It would be wonderful if every doctor’s rooms as I say, even health

⁵⁹ A shortened word for mokopuna (meaning grandchildren)

clinics knew that there was those services available... If you know what I mean, that there are places, but it's sort of like "here, take these pills and go home". But they didn't say to me "did you know you can get this one...showered [assistance with personal cares] while you're blah blah blah...." They make you feel like that, it's sort of like "see ya!, you've got your pills, off you go." J10:7

A number of critical issues were raised in respondent stories that captured significant barriers to accessing essential and wider related support services. While cost, transport and lengthy waiting times to access specialist services were issues for respondents, the attitudes of service providers play a crucial role in relation to access and also in maintaining the client care continuum. Their negative experiences highlighted some critical issues in the delivery of care such as a lack of respect, a lack of effective care, ineffective communication and deficiencies in the workforce such as people who lack the necessary experience and life skills to provide support services that meet client needs. Cultural appropriateness of mainstream services in terms of the way in which Māori prefer to engage, such as *kanohi ki te kanohi* and maintaining the dignity of clients who access services were also notable barriers for respondents. *Whakamā* is another barrier to accessing services as some respondents noted that they were too shy to seek assistance. Respondents believed that the provision of advocacy and support from Māori providers helped to alleviate some barriers to access.

3. Gaining control over health and wellbeing

Towards the end of client / whānau interviews, respondents were asked if collaborative care had made a difference in achieving better outcomes. The data indicated that clients who had knowledge of how health systems operate were capable of navigating their way through essential services. Also, key indicators of successful outcomes that became evident in the data related to respondents having control over their own health and wellbeing. Strengths and benefits from drawing on knowledge from *Te Ao Māori* and *Te Ao Pākehā* when working at the interface of service delivery are highlighted, including the significance of health education in management of chronic illness.

Self-navigation through services

Being informed of all available services, knowing how to access services appropriately and having knowledge of how mainstream systems operate can allow a person to self-navigate through services. One respondent who accessed various services stated that accessing mainstream services improved his health, however being Māori, there were no expectations of mainstream providers taking into account certain cultural considerations:

“I’ve used quite a few services before ... it’s a whole different environment being in the [name of mainstream service] of course, but you kind of expect that so, ... yea, I know how they’re run, and I don’t have an expectation of a particular type...you know, them treating me ...to expect to be treated this way [as in a kaupapa Māori service environment] and I know, like, I know they don’t take into account you know, any specific cultural ... I might have, or things like that ... I don’t have any expectation of them. But there were times when I needed to go there, because I needed treatment, and it made me better.” B2: 2.

Another respondent who had knowledge of how mainstream health systems operate had similar views with the realisation of having to fit within criteria to access services. This respondent’s statement also signalled a reluctance to engage with mainstream providers, unless really necessary:

“I only use them when I really have to. I know how they work, you know? You got to fit in a tick box ... no cultural ... no respect for you ... your culture. Well, a very clinical environment. I suppose being mainstream, aye? I don’t expect them too. But I used some of them before and it made a difference, things got better for me.” T20: 3.

Another respondent’s experience with a mainstream community service provider also made a positive difference to her care. She indicated that this was due to the flow of effective communication between the provider and her GP. She understood the terms of access and eventually had to go off their books as there was a cut-off period due to funding limitations of the service:

“When I was sent over to [a mainstream community service provider] they were always sending stuff back to my GP and when I used to see my GP, said “oh yes, I can pull it up” and she had all this information and it was like, oh this is really good! You know, to know that my GP had the information I was getting. And so even when I look at the past.... it was excellent. That communication was really excellent and that made a huge difference to my care. But I had to go off their list because it had

something to do with funding, their list; and I'd been on their list for 2 years. And so... I must say, using [name of mainstream service] made a big difference for me... But probably looking at...because like with my particular condition, like being diabetic, it's an on-going thing you know? But when funding is handed down, there's a cut off period ... and they could no longer keep me on as a client. I had to go off their list; they said it had something to do with the funding for their service. I don't think they realise the importance of being able to maintain the on-going care, yea. Because of funding they could no longer keep me? Cos they have to keep moving? Yea, there was a cut off period. Cos I still got diabetes, you know, but they had to discharge me from their books." R18: 5.

Acknowledging the difference of a mainstream environment with no expectations of being cared for in a kaupapa Māori way; understanding the criteria to access; and cut off periods for care due to funding limitations were critical factors in understanding how mainstream systems operate. Despite having this knowledge, some were still reluctant to engage with mainstream providers unless necessary, with the realisation that utilising services would make a difference to their health.

Kaupapa Māori services

Respondents had an overwhelming preference for Māori providers and noted that Māori provider involvement in care made a significant difference in positive outcomes. The following respondent indicated that Māori providers had a better understanding of being Māori in relation to meeting his needs. This respondent also noted that Māori who work in mainstream services have limited capacity to work in a kaupapa Māori way:

"You don't feel nice especially talking to someone else who's sort of ... ain't Māori with not a lot of understanding of stuff, yea; like growing up Māori and stuff like that ... the cultural thing. It's easier to talk to a Māori about things cos they've been through it already you know, stuff like that; and it's not just read out of a book ... with no experience. I like it here, cos it's also done in a kaupapa Māori way...that makes the difference. There are Māori in mainstream, but it's not kaupapa Māori and you don't feel it ... it's not right. Being in a Māori or iwi service is what's been better for me." W23:3.

For many respondents, whanaungatanga was important in creating an environment in which they felt comfortable; this is demonstrated in the following respondents' statements:

“What I really enjoy is the friendly environment that Māori services have, like here at Whakapai [Hauora]... it’s feels like a whānau here, coming in, having reception there, having [receptionist’s name] there, they’re really excellent. They are ... the korero that goes on between them and patients are really good. And they always, as receptionists are concerned about your wellbeing too. So it more or less puts you in a really good frame of mind by the time you get to the doctors or the person you see and then there’s this overall, this overarching feeling that everyone is involved in your care, not just one person and you feel valued... There’s the whanaungatanga here ... here at Whakapai [Hauora] and the nurse, she even gets into that mode as well. So it’s just all around the reception; the nurses, the doctors, and all the doctors, you know, because you get to go... have the whole lot of them eventually?

And they’re very ... the personal side “hello?” they will greet you? And it’s like oh? They don’t have to? You don’t get that anywhere else? It’s just normally your own doctor will know who you are. But here, if you’ve been to see the other doctors, they greet you too you know, it’s really quite good.” R18:3.

“And there’s the kaumātua here, he knows all about my background and can whakapapa⁶⁰ back to my whānau; there’s a connection there, to my family and stuff like that; yea, same with most of the workers down here, they know most of my whānau. The whanaungatanga is really important; yea it is. And that makes it even more comfortable.” W23: 5.

“Well, I was ... I tell you something... I always preferred a Māori person because when I first got diagnosed, well it was too late anyway because aunty had called [a Māori health service] and they had one [health professional]. But because she was English; you know, because she was Pākehā I shyed away from her? I sort of connect better with Māori. Some workers know my whānau well, and some are related to me, through whakapapa.” N14:4.

Another aspect of difference is the approach to service delivery such as a focus on whānau, face-to-face methods of engagement and additional support:

“I mean the reason we went to you guys is because I’ve had dealings with [other organisation’s name] before and I didn’t appreciate the ‘one size fits all’; you know, sort of attitude that they have and that “well, this works for them so try that” sort of thing, so a... and I’ve worked for a Māori organisation before too, so I probably knew what to expect from another provider, another Māori provider, so yea..... because it’s more a ‘sit back and look at the family and see how’ not see how you can help but, wait you know? You wait as well until the family realises and then you can help the whole lot. Whereas with mainstreamfor me it’s not like for me mainstream is like ‘we’re there, we got to get to it’ and then you get A, B or C. It’s

⁶⁰ Whakapapa refers to genealogy. In this instance, it is meant that this kaumātua was able to relate his genealogy back to this client’s family.

just not I don't mean to...I mean I work for mainstream now but it doesn't mean I like it [laughter]. I don't know, I just think it's ... They got more money, but ... I don't know what it is about mainstream; it's not for my family, not for my new baby and my kids, especially my new baby who was born premature with complications. The stress ... I don't want it for my family. Being able to get into other services has also easier with you guys. There's lots of support there and information sharing face-to-face ... that's important for us to know these things like what other services can offer and how to use them." I9: 2.

One respondent indicated that accessing Māori provider services made a difference due to actively engaging with whānau in care, addressing whānau priorities, providing greater levels of support, and having a better understanding of the barriers that impact on Māori:

"Having a whole lot of different services involved in my care has been good for me and helped my whānau to cope with stress. It's helped the healing process for me in more areas and not just the ... you know... physical side of things. It's good being cared for by a Māori service; we are always too whakamā to ask for help. But they know how many things effect you and whānau; like having no transport to go to a hospital appointment, or coming with you and explaining to you what the doctor said because you didn't understand; or teaching you about your health ... Definitely, obesity is increasing in our whānau and we have things like ... different ones in the whānau who have diabetes. So they [Māori service providers] teach you about how you can eat better food and budgeting; they help you with these things. It's also things like having no money to go to the doctor and get your medicine, or having no food in your home till you get your next benefit. Or maybe having no heating in your home in winter. All these things count big time! ... it's the aroha; the support that makes a difference for your health and your whānau." Y25: 4.

A common theme evident in the data was respondent feelings of whakamā. One also commented on the practice of manaaki and the support from Māori providers, and how this helps clients to overcome whakamā and fear of the unknown:

Yes, I have to say yes. It's made a difference, and it's helped our health improve. But if we had to go to these places, and sort them out on our own, you know... some, we didn't even know were there. That's why it's good working with our people you know? Māori services ... they make the real difference. They know the ins and outs of this kind of thing. They tell you how to use this one, how to get into that one, what you can get from this one?... It's the support ... the manaaki and understanding you get from them. If we had to do this on our own, we won't know where to begin. Also I think, too afraid ... too afraid to approach different ones to ask for help. A27: 5.

Another respondent commented on collaborative care; a collective approach to care, including whānau involvement had a positive outcome for this respondent:

“I would say yes it would have to be, very positive. On the whole, I must say that having integrated services has made a difference for me, a positive one. My tinana has been taken care of; I’ve come to understand that that’s just as important as my wairua, hinengaro and whānau wellbeing. Having your doctor, your nurse and kaimahi work closely with the [secondary care service], those specialists up there including my whānau, has made my healing a lot faster.” V22: 3.

Another respondent also indicated a preference for Māori approaches to service delivery due to their face-to-face approach, effective information sharing, and better communication. This respondent also emphasised the important role of kaimahi working in the community in relation to greater levels of support.

“Information is the key to everything; if they don’t tell us everything, we’re never gonna know. And thank goodness for your kaimahi coming to see me cos that’s how I knew what I was entitled to. The korero was kano ki te kano. I like that cos you ask questions and you get straight answers. Not having to ring a service, and then no one answers, then you leave a message. Then they get back to you. Some never do. You don’t hear from them. By that time, na... you’re not interested anymore. The support from Māori kaimahi is awesome ... is what makes that difference ... easier to get into other services and yea ... using those other services made my health better.” C29: 5.

The following comments by one respondent highlighted the benefits and strengths from drawing on knowledge from both Te Ao Māori and Te Ao Pākehā when working at the interface of service delivery:

“I suppose what I love seeing about Whakapai Hauora is that it can walk in the two worlds. And what I mean by that is there’s a good, good representation of Māori in there ... however in regards to tauwiwi⁶¹ terms, it’s still got a really good structure, really good; and you can see it and you can feel it. It’s organised and it’s got good infrastructure around it and you can feel it when you go in there, there’s ora. That’s really important too; it works really well in two worlds. And there are very few places [Māori service providers] that I know that can actually do that; it’s either too Māori or too tauwiwi. We get the best outcomes for our people. Our culture, our knowledge and also Pākehā knowledge.” Y25:3.

⁶¹ “Tauwiwi” is a term used to describe non-Māori. In this instance it is used to describe an organisation system that also incorporates western standards.

While respondents acknowledged that collaborative care made a difference in terms of better health outcomes, there was an overwhelming preference for accessing Māori providers. The majority believed that due to Māori provider involvement, outcomes were positive. According to respondents, Māori providers worked in a Māori way, in a Māori environment where values such as manaakitanga, kotahitanga and whanaungatanga were the norm. Respondents noted that having an understanding of whānau needs and barriers to access is also crucial towards helping overcome whakamā and fear of the unknown.

Care and management of chronic illness

This section of data captures what respondents considered to be critical in relation to achieving better health outcomes. Respondents believed that the knowledge they gained through their journey of care allowed them to have better control over their health and wellbeing. One respondent recalled how his journey began, with limited knowledge of his illness and having to come to terms with it:

“It means a lot to me you know, when I first, 15 years ago when I first became diabetic, you know...I was shattered and I didn’t think that there was anything wrong with me but as the years went by, you know, it gets to you and it’s a hard thing to battle. If I’d had known what it was, how it started...too many sweet things, you know, the food we ate and it’s just no good for you; you know, Māori people, when we were young you know, we had to eat different things which was not healthy, that’s what started it all, but as you get older, you say, “well, why, why did it happen to me?” We didn’t understand; you know, what the reason was. But that was what we lived on, all that food. We didn’t know that it was not healthy for you. Even today I can’t eatI use to love sea food; I can’t eat it now. It just makes me sick; I still want to throw up. A lot of things, so yea... But now a better understanding of what it’s like to live a healthy life. I know in some days I struggle, or Imy wife, she’s done a wonderful job of looking after me. You know, she [respondent’s wife] gets stressed out too; things that I used to do, I was a fitness fanatic back in my younger days and I can’t do them anymore. People got to realise that as you get older, slow down...you think that....no....when you look back and you say “ahh no, that won’t happen to me!” but it happens to you. It’s just life. See? Gotta accept it. But you can also agree to the....what the doctors say and tell you, you know...what not to do and Different things and take your medication and that! Well, for 15 years I’ve been diabetic and some people don’t even last that long. It’s all about being in control of it and knowing to do it.” E31: 1

This respondent also spoke of having to learn about his condition in order to make the right choices enabling him to have better control over his diabetes. His story highlights whakamā as being a barrier, as well as sensing a racist attitude among previous providers involved in his care. Again the significance of a face-to-face approach is accentuated, including knowledge translation which are both vital towards effective health education:

“Yea, aye...things have changed. I never used to think about my kai or my weight ... or about my smoking habit. I used to get really sick sometimes. I had pills for diabetes and told I had too much sugar in my blood; that was all I knew. I never asked more about ... too whakamā ... They treated me like I was a dumb Māori and never bothered ... like, to do anything more. I didn't know it was important, and sometimes I didn't get them [medication]. When I moved here, I joined up with your crowd [Whakapai Hauora services] and they gave me a better service. Kanohi ki te kanohi ... you know ... the doctor took the time to explain things to me ... about diabetes, and why I had to take my pills. She made me feel it was okay to ask questions ... she also sent a nurse to see me at home. I learnt to eat the right kai, how bad it was for me to smoke and why. I got to understand all these things and it wasn't easy; it was hard making changes in my life ... just so use to living it one way? and now I got to change it all, but I chose to because I understood what was happening to me and why I got really sick sometimes. I didn't want to be sick anymore and I knew what I had to do to.” E31: 3.

Respondents also noted that there were reciprocal gains for whānau with the capability for intergenerational transfer of knowledge concerning healthier choices and lifestyles through role modelling:

“It's being able to move more freely, it's being able to let me sleep better; and it's also given me a chance to do a lot of the things that I wasn't able to do 3 years ago... but most importantly is that now I know how to take care of myself. I had to learn to choose the right things ... how to ...When you know what to do, you're steering your own course; you got that waka going where you want it to go ... you're in control of it, your own health. And by that, I also mean that your whānau get to see it, especially your mokopuna; the next generation. You pass it on to them, that knowledge, that healthy way of living. They learn from you and that's how it should be. That's what it's all about.” V22: 4.

“I think...the most important thing is education ... I put a real focus on education because I firmly believe that if my children are educated, then they will always search for information regarding health and in that I say it works in terms of what they do; their diets and their exercises and things like that but they wouldn't have had that without education? So... education for me is where I see where health is. It's also important that they never be shy to ask for knowledge when they don't know or are unsure of anything. Whakamā is big with Māori people. When they are aware ... different whānau members will gain different knowledge in different areas; but when they all talk together, they all try out these things?... so it's all about educating; ...and sharing that knowledge; definitely ... when there's knowledge, there's control over things, better control over your health.” R18: 1.

“Another thing that's important for me to, and from where I've come, you know ... my journey in this illness is ... I ... it's being able to take better care of myself. I'm in that place now, and it's a good place. A lot of hard knocks on the way, changing your life around isn't easy, and your whānau get involved with it too. But it's mostly education. You know how to make important choices for you and whānau ... to take a better hold of things and you can get to that good place.” Q17: 5.

Respondents equated the measure of successful outcomes as them and their whānau having control over their own health and wellbeing. Although health education was emphasised by respondents, it was partly responsible for behaviour change as they also identified other key factors that facilitated this: accepting one's limitations in chronic illness, having knowledge of one's illness, applying preventative measures in care by choosing healthier lifestyles, and the inclusion of whānau in health education in order for intergenerational knowledge transfer to occur. These factors also have implications for providers who deliver care to Māori in terms of their ability to connect and appropriately interact with Māori and whānau, how well information is transmitted in relation to service access, how well knowledge is transmitted when delivering health education, and their level of understanding of Māori health needs.

In conclusion to both data chapters Six and Seven, a table is presented on the next 2 pages summarising pathways within the framework of Whakawhirinakitanga Ahua (Whakapai Hauora's model of service delivery) towards achieving whānau ora. Table 3 demonstrates key characteristics of relationships that underpin the model. Relationships are values-based, which build and sustain tikanga-based service delivery: whanaungatanga, manaakitanga, kotahitanga; and promote tino rangatiratanga. Whakawhirinakitanga Ahua pathways are discussed in Chapter Eight, the research themes.

Table 3: Whakawhirinakitanga Ahua pathways towards achieving whānau ora

Key characteristics of relationships that underpin Whakawhirinakitanga Ahua	Making Connections	Effective Communication	Maintaining Dignity	Reciprocity	Interdependence	Collective Decision Making
<p>Values that build and sustain whanaungatanga, manaakitanga, kotahitanga and promote tino rangatiratanga (tikanga-based service delivery):</p>	<ul style="list-style-type: none"> • Manaaki; • Trust among each other; • Respect for each other; • Honesty; • Whakamana. 	<ul style="list-style-type: none"> • Respect for each other; • Trust among each other; • Support (awhi) for each other; • Consistency with information (doing things tika). 	<ul style="list-style-type: none"> • Aroha; • Manaaki; • Respect; • Valuing others; • Patience; • Support (awhi). 	<ul style="list-style-type: none"> • Aroha; • Manaaki; • Respect; • Trust; • Maintaining everyone's dignity; • Mutual support (awhi) for each other. 	<ul style="list-style-type: none"> • Consistency; • Professionalism; • Integrity in one's work; • Aroha; • Trust; • Manaaki; • Respect; • Support (awhi) 	<ul style="list-style-type: none"> • Honesty; • Integrity; • Professionalism; • Consistency; • Trust among each other; • Support (awhi) for each other. • Maintaining everyone's dignity.
<p>The actions of Whakapai Hauora Health professionals towards building and sustaining relationships among themselves, with clients, whānau and mainstream / other service providers</p>	<ul style="list-style-type: none"> • Face-to-face approach; • Sharing kai; • Sharing information about each other; • Sharing stories; • Sharing whakapapa; • On-going contact with each other. 	<ul style="list-style-type: none"> • Conversations are robust by hashing out issues; • Listening and acknowledging each other's views; • Having open lines of communication without being afraid to speak one's views; • Giving clear and concise information that is easily understood. 	<ul style="list-style-type: none"> • Acknowledging individual/whānau strengths/limitations and responding to their needs accordingly; • Having a non-judgemental attitude; • Understanding the impacts of health determinants on clients/whānau; • Acknowledging the expertise of mainstream/ other service providers and their contribution towards collaborative care. 	<ul style="list-style-type: none"> • Role modelling whānau values to clients/whānau for reciprocal gains; • Mutual exchange of information and knowledge for each other's benefit. • Teamwork with service providers; • Sharing of client / whānau care with other providers; • Negotiating and compromising towards shared care (i.e. 'give and take') 	<ul style="list-style-type: none"> • Reliance on whānau members to contribute towards an individual's care; • Reliance on other service providers involved in the delivery of care to be consistent in their contribution to care. • Understanding the limitations of others and responding accordingly to maintain the client/whānau care continuum. 	<ul style="list-style-type: none"> • Acknowledging whānau as a collective; • The inclusion of whānau in care; • Willingness to work collectively; • Having shared goals; • Acknowledging the different perspectives of others; • Contributing to joint decision-making; • Negotiating and compromising to reach joint decisions.

<p>Potential outcomes for clients and whānau.</p> <p>The capacity to empower towards tino rangatiratanga:</p>	<ul style="list-style-type: none"> • Better knowledge and understanding of options, access and service delivery process; • Overcoming whakamā • Overcoming fear of the unknown. 	<ul style="list-style-type: none"> • Better understanding of treatment and care; • Informed choices in care; • Health education and health literacy gains; • Better understanding of how mainstream systems operate; • Self-navigation of clients / whānau across multiple services (with greater access); • Overcoming whakamā; • Overcoming fear of the unknown. 	<ul style="list-style-type: none"> • Addresses issues of pre-judged assumptions about mainstream / other service providers; • Feeling 'cared for'. 	<ul style="list-style-type: none"> • Holistic service delivery; • Reconnecting with Te Ao Māori • Maintenance of Māori knowledge, Tikanga, Te Reo and intergenerational transfer; • The building of whānau capacity and resilience; • Positive whānau development. 	<ul style="list-style-type: none"> • Shared responsibility in an individual's care; • Intergenerational transmission of health knowledge; • Reciprocal health gains for whānau and the individual • Better compliance to treatment and care; 	<ul style="list-style-type: none"> • A sense of collective identity; • Active participation in care; • Active partnerships with providers; • A sense of ownership in decision-making processes; • Healthier lifestyle choices; • Client whānau empowerment/self-management of cares and self-determined choices
<p>Potential outcomes for collaborative pathways among Whakapai Hauora health professionals, mainstream providers and other wider related service providers.</p> <p>The capacity for intersectoral collaboration towards integrating care:</p>	<ul style="list-style-type: none"> • Promotion of respective provider services and roles; • Better knowledge about each other's services and key community contacts; • Strengthening of networks among providers. 	<ul style="list-style-type: none"> • The potential to eliminate patch protection; • The potential to eliminate an overlap in service delivery. • All providers are 'on the same page' with client/whānau health information. • Client / whānau needs are better understood. 	<ul style="list-style-type: none"> • Addresses issues with pre-judged assumptions about Māori service providers (mainstream); • Addresses issues with negative stereotyping of clients / whānau ; • A better understanding of whānau priorities and tikanga -based service delivery. 	<ul style="list-style-type: none"> • Mainstream and wider related support providers have a better understanding of working at the interface with Māori providers; • Multidisciplinary approach to care (sharing of knowledge); • Better understanding of Māori health models of practice; and Māori diversity (cultural competence). 	<ul style="list-style-type: none"> • Shared workloads; • Support (awhi) from other providers in the provision of collaborative care; • Strength-based approaches to collaborative care. • The ability to move clients/ whānau along the dependent – independent care continuum. 	<ul style="list-style-type: none"> • Active partnerships among providers; • The application of knowledge from Te Ao Māori and Te Ao Pakehā to service delivery (i.e. service innovation); • Streamlined collaborative work processes; • Clearer intersectoral pathways with client /whānau navigation across integrated services.

Summary

This chapter captured Māori client experiences, views and beliefs along their journey through a continuum of health care. Their journeys also highlighted the many complexities in navigating services and challenges along the way towards achieving better health outcomes. Their views of holistic health and wellbeing reflected Māori cultural beliefs and holistic models of health. Whānau were significant in relation to respondents' own health and wellbeing due to their collective role providing support and assistance in critical times of illness. They also believed that there could be reciprocal gains for whānau with the capability for intergenerational transfer of knowledge concerning healthier choices and lifestyles through role modelling. There was preference for a one-stop-shop approach in terms of greater access to a range of services.

Apart from barriers to services such as cost, transport and lengthy waiting times, mainstream provider attitudes towards respondents mostly resulted in negative experiences for them, with a reluctance to engage in services. There was a strong preference for Māori providers due to Māori ways of engagement such as *kanohi ki te kanohi* (a face-to-face approach), *whakawhanaungatanga* (establishing relationships) and the significance of additional support (*manaakitanga*), as some discussed feelings of *whakamā* towards seeking assistance. According to respondents, Māori providers had a better understanding of their needs.

Client and whānau awareness of all available services, modes of access, and how mainstream systems operate can facilitate self-navigation through a range of services to achieve better outcomes. Respondents recognised that accepting their own limitations was necessary in order to cope with their illness. They believed that having control of their own health and wellbeing was a positive health outcome, and the acquisition of health knowledge and education were crucial factors towards achieving this.

Chapter Eight

Weaving the research findings together

Introduction

Drawing on the data presented in Chapters 6 and 7, this chapter weaves together the themes to present insights into findings. The data in this study is derived from 2 groups of respondents; Whakapai Hauora health professionals and Whakapai Hauora clients. There were sub-groups among health professionals as respondents scopes of practice were in mental health / AOD, social work and chronic disease management. Whakapai Hauora clients also consisted of two sub-groups, individuals and whānau. The data presented a range of diverse and complex views which captured respondent journeys through a care continuum. Three main themes emerged; Theme 1: Health and Wellbeing; Theme 2: Values Based Service Delivery; and Theme 3: Whānau focused Care. The many complexities surrounding respondents' perspectives and beliefs are analysed highlighting key issues that evolved from discussions concerning access to services and the intricate nature of relationships in relation to collaborative pathways in service delivery.

Theme 1: Health and Wellbeing

In relation to health and wellbeing, the data showed that Māori perspectives were holistic and closely affiliated with their own cultural beliefs while non-Māori clinician perspectives were client-centred. Service delivery models are underpinned by health models, reinforced by values and principles with fundamental philosophies stemming from worldviews which guide and influence service delivery. However, service delivery models do not have any specific processes that direct the use of values and principles. Such processes are often determined and applied by individuals who deliver services themselves; heavily influenced by their own values, concepts and beliefs, their lived experiences and their worldviews. Findings indicated two worldviews operating alongside each other within Whakawhirinakitanga Ahua; Te Ao

Māori, and Te Ao Pākehā. This was demonstrated in respondents understanding of health and wellbeing and holistic care.

Holistic concepts of health and wellbeing

Concepts of health and wellbeing were expressed in a range of understandings by Māori respondents (health professionals, clients and whānau) reflecting a Māori worldview. These centred on the interconnectedness of the land, environment, ancestors, elders, iwi, hapu and whānau. Respondents also emphasised that spiritual, mental, whānau and physical wellbeing were important. These aspects of a Māori worldview are well documented in indigenous health literature and in the health model Te Whare Tapa Wha which is widely promoted and accepted within New Zealand health policy and across health systems (Davis, Lin and Gauld, 2009). Holistic concepts also included sustaining “*tikanga, language, values and beliefs*” (V22: 1) and acknowledged by Māori clients as being important towards wellbeing. Cultural revitalisation and preservation are key components within the wider Māori pursuit for self-determination and wellbeing (Durie, 1998b). Customs, language, values and beliefs are significant facets that are essential to one’s culture providing a unique cultural identity. Cultural identity is an important factor towards wellbeing providing a sense of belonging and security; it also allows one to affiliate with social networks that provide support and have shared values and aspirations. This was very clearly expressed by respondents who were clients/whānau in this research.

Māori health professionals also described Whakawhirinakitanga Ahua as being “*the holistic embracement of all*” (D: 1, 2) underpinned by Māori values and beliefs capable of demonstrating the provision of holistic care from a Te Ao Māori perspective. Working in a Māori way came instinctively to them: “*it’s something that we do naturally with tangata whaiora; we work in a kaupapa Māori way*” (C: 3). They also understood that this service delivery model was based on providers working collectively to support and meet the needs of clients and whānau. They believed that working with clients, whānau, hapu, iwi and community had the potential towards achieving best outcomes.

A whānau focus in health and wellbeing

Māori respondents (health professionals, clients and whānau) identified whānau as being significant to health and wellbeing. While the environment and wider community have an impact on health and wellbeing, the role of whānau is integral; with the care and support of whānau, recovery can take place more effectively. Whānau also have an important role to play in terms of cultural identity as tikanga, language, values and beliefs are learnt from whānau and sustained by whānau: “*My nanny and koro were always with us, teaching us things Māori and handing down knowledge to us.*” (B: 9). Whānau were also acknowledged as a mechanism whereby health knowledge can be “*passed on to the next generation*” (O: 9).

Client-centred practice

Non-Māori health professionals (respondents) related holistic care as having a focus which was “*very much client-centred*” (P: 1); an individualistic approach to care. ‘Meeting all client needs’ and what was ‘important to clients’ as expressed by non-Māori health professionals is consistent with client-centred practice. This was also articulated by a client (respondent) who attended health education sessions facilitated by a mainstream service provider: “*It’s really different though, the Pākehā way; because they’re there, discussing themselves; but I can’t discuss myself without including my whānau ...*” (R18: 4, 5). However, non-Māori health professionals in this research recognised whānau as being an important aspect of an individual’s health and wellbeing in relation to care.

Client-centred practice emerged in the late 1960s within mainstream healthcare in response to a need for patient-sensitive care. It is concerned with understanding each client as being a unique individual (Lipkin, Quill and Napodano, 1984) and evaluating care from client perspectives (Beach, Saha and Cooper, 2006). Fulford, Ersser and Hope (1996) indicated that perhaps the nursing process was first to favour an individualised, client centred-approach to care which looks at the ‘whole’ person, including the client’s cultural traditions, family situation, social circumstances, personal values and lifestyle. Client-centred practice differs to Māori concepts of

holistic practice where whānau are central and everything is interrelated having an impact on a person's health, wellbeing and care.

Non-Māori health professionals also considered collaboration and working in partnership as being important towards developing a more collaborative approach to holistic health care. They indicated that Whakawhirinakitanga Ahua was a collaborative model in a number of ways: in terms of working with other providers, working together with clients and whānau, protecting their rights and getting them to participate in their own health care. Holistic practice was also aligned to the Treaty principles and non-Māori health professionals believed that these principles guided their practice not only when working with Māori, but with all their clients. The Treaty principles of partnership, participation and protection are demonstrated in cultural competence-based practice as part of the requirements when working with Māori.

Cultural competence

Non Māori health professionals spoke of providing care in a culturally safe manner. Cultural competence is continually developing in the area of health as well as other disciplines such as social work (Social Workers Registration Board, 2010) and education (Ministry of Education, 2011). For this to occur in practice, one must be aware of cultural differences and work with clients in a culturally safe manner (Papadopoulos, 2006). Wilson (2005) stated that there are overlaps between cultural competence and cultural safety. Cultural safety requires one to recognise and respect the cultural identity of others; it is also concerned with knowing and recognising one's own culture and the influence this has on one's own interactions with others (Papps and Ramsden, 1996). Cultural competence has the potential to prevent any misunderstanding that may happen in a clinical situation; it acknowledges diversity among, as well as within cultures. It can also provide clinicians and health workers with a better understanding that one way of providing care is not applicable for all clients.

The complex nature of wairua in holistic care

Despite the differences in holistic concepts of care, wairua was considered to be important to health and wellbeing. Wairua refers to spirit (Durie, 1998a); while some consider it to be part of a whole person, wairua may also dwell in one's psyche as an unseen force residing in the hearts and minds of Māori (Komene, 2010). The nature of wairua may be expressed in a number of different ways. For example, Māori health professionals noted having a marae on site at Whakapai Hauora held a spiritual significance for them linking them to tūpuna, with karakia, reaffirming and grounding them in Te Ao Māori. Whereas clients and whānau related wairua to a feeling that was present on the marae: "*you feel you belong and this is the wairua here*" (Q17: 5) as it was a place where cultural activities such as "*waiata, kapa haka, raranga*" (A27: 3) took place. Māori health professionals also believed that their model of service delivery guided their practice and that "*Whakawhirinakitanga Ahua has a wairua to it*" (A: 1).

Pere (1982) stated that Māori see the physical realm as being "*immersed and integrated with the spiritual realm*". (p: 13). This aspect of Māori culture is an important part of a kaupapa Māori service. The word wairua is sometimes used to refer to a presence or sense of connection underpinned by the qualities of ihi (the power), wehi (the awesomeness) wana (the authority) of the created work (Kruger, 1980) such as cultural activities on a marae and the work undertaken by Whakapai Hauora health professionals to deliver services that meet the needs of clients and whānau.

Durie (1998a) argued that Māori spirituality (wairuatanga) is not confined to the land, ancestors and the natural world. Māori have also associated wairua with both religious beliefs as well as a relationship with the environment. According to Durie, religious beliefs and practices are not necessarily associated with regular attendance at church or affiliation with a particular religious denomination. Instead, both formal and informal karakia affirm a belief in God, and spiritual wellbeing also implies spiritual communication with the land; acknowledging one's limitations over the environment as the land holds a spiritual significance (Durie, 1985).

Non-Māori respondents understood the concept of wairua more narrowly, linking it with religious beliefs: *“and when you work holistically, you have to consider their spirituality as well, if it’s important to them to practice their faith and their religious beliefs”* (P: 3). They encouraged religious practice as they believed that it was integral to the healing process. While views of spirituality in mainstream society have been mixed, it has often been associated with religious beliefs and practices (Emblen and Halstead, 1993; Burkhardt, 1989). However, due to a rise of secularism in western society, contemporary ideas of spirituality have become broad (Hogan, 2010). It has been described as being an immaterial reality (O’Brien, 1982) to an enlightened inner path of one’s true essence (Sheldrake, 2007). Prentice (2003) indicated that spirituality may also be seen as intrinsic to human nature while Weil (2006) drew a clearer distinction between spirituality and religion describing spirituality as being concerned with the non-physical aspects of one’s being, rather than a belief in God. Regardless of what one’s interpretation may be, both spirituality and religion have been seen as an important coping mechanism in ill-health, particularly for those with chronic disabilities and illnesses, and those who are terminally ill (Puchalski, 2001). It instils a sense of hope as well as healing which can be perceived as an acceptance of illness and being at peace.

Despite differences in understanding wairua, respondents who were clients believed that non-Māori working at Whakapai Hauora had a better understanding of Māori health needs compared to mainstream providers: *“We [Māori] as a people see health in a holistic way... and that’s how I see your people [Whakapai Hauora health professionals] working with us; not just treating the physical but also working with us to help us ... in a kaupapa Māori way”* (V22: 1). All respondents delivering services (both Māori and non-Māori) believed that they were working holistically to meet client and whānau needs and that wairua was important to health and wellbeing. They also believed that they had good working relationships with each other and worked closely together towards achieving desired outcomes in service delivery.

Working in partnership

Both Māori and non-Māori health professionals believed that positive working relationships significantly contributed towards better service delivery. A set of values were identified when they spoke of building and sustaining ongoing collaborative relationships: honesty, trust and respect. They also characterised collaborative relationships as maintaining consistency in one's work, providing support to others and maintaining one's integrity and professionalism. They believed that these values were reflected in their relationships with each other as well as intersectoral relationships when working with other providers towards access to care.

Establishing good relationships with clients and their whānau was also vital towards ensuring seamless care which is well demonstrated in this research. Both Māori and non-Māori delivering services believed that building and maintaining trust (whakapono) with clients/whānau; having respect and maintaining the dignity of clients/whānau (maintaining mana); having empathy and the ability to care (aroha and manaaki); and to support (awhi) clients/whānau in order to meet their needs were critical. These values have also been identified in the literature (Metge, 1995) as key whānau values. Being non-judgemental, having consistency and professionalism (tika), patience, humility and integrity were also considered important factors when working with clients and whānau by respondents in this research.

Working together as a whānau

Māori respondents who were health professionals believed that they were a 'whānau' and relied on each other to uphold individual responsibilities when delivering care for clients and whānau. While some also referred to themselves as being part of a team, a main team attribute was interdependence. They believed that if they were unable to uphold their responsibilities, they could rely on other team members: "*... like if I wasn't here, the team could run itself. And that's important*" (C: 12). Interdependence is a common behaviour practiced by whānau (Durie, 1998a) and this particular arrangement of Māori whānau (as

mentioned by these respondents) is often referred to as ‘kaupapa-based whānau’ (Metge, 1995; Walker, 2006) where members are not related by descent but have a common bond or a shared purpose. Durie (1998a) noted that from a Māori perspective, to stand alone may not be beneficial when interdependence is the norm. Working collaboratively with others to deliver care involves sharing responsibilities and being reliant on each other to uphold responsibilities towards achieving desired outcomes in service delivery: *“they’re taking some of that responsibility and ownership of care too...and taking some of that workload”* (G: 9). Metge (1995, p: 102) stated that whānau members acknowledge a collective responsibility to their own group. The value of whānau relationships is reflected in kotahitanga, the collective unity of the group.

Working together as a team

Non-Māori respondents understood that they worked well as a team and were able to negotiate effectively towards sharing client care. They also believed that they maintained good working relationships based on professionalism, support, trust and mutual respect for each other. Support was paramount in terms of sharing care when dealing with high needs or high risk clients/whānau where a considerable amount of work was necessary. Good working relationships are indicative of productive teams (Wheelan, 2005) and have several distinguishing characteristics such as effective communication (Reina and Reina, 2006) that is reciprocal (Sillars et al, 2004), based on mutual trust, respect, partnership and support (Mullin et al, 2007). A team approach requires a collective orientation where unity is paramount in terms of individuals acknowledging the team’s success as taking priority (Kalisch et al, 2009) in the delivery of shared care to clients and whānau.

Māori provider experiences with mainstream services

Respondents delivering services raised a number of critical issues based on their experiences with mainstream providers. For example, mainstream providers having limited knowledge of Māori health providers and tended to think that Māori services

are “*all are the same*” or that “*only Māori can use our service*” (L: 16). There are implications to this in terms of appropriate access to Māori health providers and the diverse range of services they offer. Also, all Māori providers do not operate in the same manner due to a number of factors such as capacity, capability, diversity and need (marae-based/urban providers). Their range of services is also dependent on contracts from funders, and the needs of their communities.

Another critical issue was mainstream provider attitudes of being “*patch-conscious*” (A: 5) towards Māori providers. Patch protection among service providers potentially undermines collaborative efforts (Abramson and Mizrahi, 1996). A good understanding of respective roles, differences in service provision and professional boundaries play a crucial part in collaborative care as some degree of conflict may arise among members from different professions (Cooke, 1997). Berteotti and Seibold (1994) argued that it may be necessary for some members within a team to forgo a certain degree of autonomy due to role confusion, overlapping responsibilities or achieving different goals which affect collaboration. Seigel (1994) however noted that goal and role conflicts are often perceived as personality conflicts or interpersonal communication problems. Abramson and Mizrahi (1996) cited three critical factors to working collaboratively; these were mutual respect, having similar perceptions and the ability to effectively communicate with each other. Pike (1991) concluded that providers should also appreciate each other’s contributions, develop a sense of caring for each other and their relationship with each other, as effective collaboration potentiates a synergy capable of improving service delivery and client care. All these critical factors have been well demonstrated in this research.

Mainstream provider attitudes towards clients relating to racist attitudes or negative stereo-typing with assumptions such as “*uneducated dole-bluggers*” (N: 5) was another critical issue. Respondents noted that these were barriers to care as “*they’ve upset the patient enough to make them not want to come back*” (N: 5). There is growing evidence that suggests racism is a significant contributor towards health inequalities for Māori (Harris et al, 2012).

Māori often feel marginalised within mainstream health services and therefore tend not to seek appropriate assistance or support towards meeting their own health needs (Wilson, 2008). Jones (1999) described racism in three ways: institutionalised, where there are differences concerning access to power and information which often manifests in “*inaction in the face of need*” (p: 16)”; personally mediated, where different assumptions are made about others of a particular race which manifests in prejudice and discrimination; and interrelated, where members of an ethnic group accept negative assumptions about their own self-worth which manifests in feeling helpless, hopeless, and giving up. Discrimination, attitudes and behaviours of mainstream providers may cause fear and distrust among Māori. Discrimination has detrimental effects towards health and wellbeing and is a barrier to accessing care. It deprives a person of their right to have care.

Client and whānau experiences with mainstream providers

In this research, client perspectives concerning mainstream services focused more on a number of key issues relating to constraints set by mainstream providers. While some had positive experiences, the majority had difficulties. They discussed difficulties such as the cost involved in accessing after-hour GP care; having to meet specific criteria for access; lengthy waiting lists in secondary care and differences in mainstream service set-ups such as strict hours of operation including non-flexible appointments; clinically focused services with a “*quick fix*” (V22: 2) and “*in and out*” (H8: 3) processes. There was no time for “*one-on-one*” care (N14:3) due to the large volume of clients accessing services mainly in secondary care. Their experiences also highlighted a lack of being treated with dignity and respect, ineffective communication, and inappropriate methods of engagement which have all been well documented in this research.

Understanding barriers and whānau priorities such as “*no money to go to the doctor and get your medicine, or having no food in your home till you get your next benefit. Or maybe having no heating in your home in winter.*” (Y25:4) are also crucial factors towards health and wellbeing. Halpern (2003) stated that there are physicians who detach themselves emotionally in order to provide reliable care for their clients.

Hughes (2008) however, argued that patient expectations are to be cared for by competent health professionals who meet their physical as well as emotional needs. There are also other factors to consider in the provision of client care; workloads and time constraints are critical factors that impinge on care delivery. Some of these issues were raised by one respondent who accessed mainstream secondary care: *“those poor staff are flat tack all the time. They don’t get a break, they don’t get a day that they can say “oh...I’ve got nothing on today” because the work’s there the whole time.”* (A1: 3,4) Hughes (2008) noted that the environment in which health services are delivered is often complex, with a series of interactions between many factors such as the process of illness, clinicians involved in care, technology, policies, procedures and available resources. The complexity of all these issues compounded with some of the restraints they may pose, also have an impact on the delivery of care.

Another issue that surfaced a number of times in the data was respondents’ feelings of whakamā which was a deterrent to accessing services. Cram, Smith and Johnstone (2003) identified whakamā as being a potential barrier to healthcare for Māori and noted the value of providing personal support to facilitate access and engagement with health services. Funnell, Koutoukidis and Lawrence (2009) also pointed out that indigenous people are more likely to endure twice as much a culture shock in mainstream systems; first from how the system operates within itself and second from an imbalance of power, where dominant groups have discriminated against them over many years. These points have been demonstrated in this research.

Jansen and Smith (2006, p: 229) stated that the values reflected in mainstream health systems promote individualism and self-advocacy which delivers care in a way that benefits certain groups including higher socio-economic groups; non-Māori, non-Pacific groups; and those without disabilities. The most vulnerable in terms of health are those with the least influence on the health care system who need greater support from service providers to access the care they require. Mainstream health systems also strongly favour a biomedical view; *“all they want to do is medicate”* (V22: 2) in their approaches to care, as demonstrated in this research. Failure to recognise the

difference in worldviews and the health needs of Māori has the potential to compromise positive outcomes for Māori (Wilson, 2008).

Preference for Māori providers

Respondents expressed an overwhelming preference for Māori health provider services. From their perspectives, the most significant characteristics of Māori provider relationships were: the provision of extra support, advocacy and manaakitanga, having aroha for them, gaining their trust, having respect for them and maintaining their dignity. Respondents believed that these values were inherent in Māori health service providers: “*With Māori providers, yes there is support and the support I would say, is the support we [Māori] are looking for. It’s the aroha and the manaaki they have for you...*” (V22: 2). Manaakitanga is the expression of aroha, hospitality, generosity and mutual respect through acts of caring for or taking care of others. It is through these acts that wellbeing is fostered and maintained. The principle of manaakitanga concerns acknowledging the mana of others therefore, raising and enhancing the status of all.

Whanaungatanga focuses on relationships (Mead, 2003) which were another important factor in terms of preference for Māori providers. Bishop and Glynn (1999) related whanaungatanga to kinship ties, obligations and loyalty. Some respondents noted that Whakapai Hauora health professionals, and kaumātua at Whakapai Hauora were able to “*whakapapa back*” (W23: 5) to their own whānau. Others commented on the whānau environment at Whakapai Hauora: “*What I really enjoy is the friendly environment that Māori services have, like here at Whakapai [Hauora]... it’s feels like a whānau here ... there’s this overall, this overarching feeling that everyone is involved in your care, not just one person and you feel valued.*” (R18: 3). A fundamental principle of whanaungatanga is that the individuals expect to be supported by the collective, and the group also depends on the support and participation of the individual (Mead, 2003). Whanaungatanga also provides social and cultural support creating a safe and comfortable environment for individuals and the collective.

Going the extra mile

Going beyond what is contractually required is consistent with Māori health providers: *“We do a lot more than what we should. But it gets the outcomes you want for Māori.”* (A: 7). When speaking of having to go the extra mile, both Māori and non-Māori health professionals raised the issue of performance measurement and indicated that it did not reflect the true nature and extent of their work or outcomes achieved for clients and whānau. Non-Māori respondents found performance measurement as having some value in terms of gauging their own level of performance as it alerted them to areas of over or underperformance. This allowed them to balance their workloads effectively and in turn, influence better service delivery. They agreed however, that performance measurement was a reflective, rather than an effective measurement tool: *“I think yea, it is a measuring tool, it’s reflective but not effective.”* (P: 4). Performance measurement is characterised by regular and more direct measurement of certain aspects of performance (Mayne and Zapico-Goni, 1997).

However, performance measurement appears to be partly reflective, rather than fully reflective as Māori health professionals were not so favourable towards measures; they stated that it was more output focused rather than outcome orientated showing numbers *“going in and out of services”* (R: 9). According to their view, performance measurement was of little value, and was merely a tool for gathering statistical information. Some also noted that it was difficult to maintain contractually required client numbers to meet these measures, particularly when existing workloads consisted of high needs clients where a greater number of services were involved in the provision of care. Boulton et al (2013) indicated that performance measures for Māori providers should be flexible towards local priorities, rather than having being established at the beginning of a contract; and measures needed to be reviewed regularly with providers and funders in order to create a performance framework that is sensitive towards adapting to on-going review and change.

Findings in this study also indicated that the most significant outcomes occurred when clients and whānau could exercise tino rangatiratanga over their own health and wellbeing. Respondents noted that achieving this outcome was time consuming as *“you’ve got to have a lot, and lot, and lot of patience”* (O: 9) and intensive at times as it involved *“lots of education, it’s trying to get that message across”* (M: 9). Additional support is often required: *“You identify the need, the support, and it’s not a 9 to 5 job”*. (A: 8). However respondents also noted that *“it’s about empowering which leads to tino rangatiratanga”* (G: 3) which comes from providing education, support and establishing positive relationships with clients and whānau. Tino rangatiratanga is the principle of self-determination; it pertains to the ability to make decisions and control one’s own direction (Kamira, 2003). Tino rangatiratanga is concerned with empowerment and has significant implications for positive outcomes in terms of Māori being able to self-determine and control their own health and wellbeing. Self-determination is also a process that assists whānau to regain and maintain tino rangatiratanga over their own health and wellbeing.

Respondents delivering services stated that initial indicators towards positive outcomes were changes in client/whānau behaviour: when clients and whānau could make their own choices and manage their own care appropriately. Some examples were noted as compliance to medication, treatment and also, when clients continually returned to access health services on their own accord without being prompted. However, it must be noted that these are the views of respondents who work at a grassroots level dealing with clients and whānau who often have multiple needs.

A number of key factors that assist to facilitate tino rangatiratanga were identified by respondents who were clients: Māori ways of engagement in terms of approach such as *kanohi ki te kanohi*; appropriate knowledge translation; having knowledge of one’s illness and accepting one’s limitations in chronic illness; applying preventative measures in care by choosing healthier lifestyles; and the inclusion of whānau support in the delivery of care were all critical factors which have implications for providers who deliver care in terms of meeting Māori health needs. Whānau participation in the provision of care is important in terms of empowerment with health knowledge which can be transmitted intergenerationally. Certain factors that enable and enhance

the strengths and capability of individuals and whānau such as motivation, self-esteem and self-efficacy must be considered when working with them. Findings in this study also indicate that the ways in which service providers engage with clients and whānau can either contribute towards them achieving tino rangatiratanga or disempower them.

Reciprocal relationships towards intersectoral pathways in service delivery

Establishing positive working relationships with all concerned in the delivery of care involves reciprocity described as ‘*a give and take kind of thing*’ (K: 9) by Māori respondents delivering services. When mainstream providers required assistance particularly with Māori clients, respondents delivering services at Whakapai Hauora would provide help. Respondents also believed that if they approached mainstream providers for their clients, they would receive assistance. Reciprocal relationships are about giving and receiving based on mutual cooperation. Significant to indigenous views are the social ties created or reinforced between those who give and those who receive (Haviland et al, 2008). According to respondents (both Māori and non-Māori), Whakawhirinakitanga Ahua is premised on reciprocal relationships and they believed they shared a mutual goal with mainstream service providers which was to increase levels of Māori health and wellbeing.

Respondents spoke mainly of their work at the primary and secondary care interface and noted that mainstream providers had a different set of skills to perform different functions. They acknowledged the strengths of other providers by stating that “*there’s other people out there with more knowledge or needed expertise which in a particular area like for example medication...*” (F: 4). Primary and secondary care interface is particularly important in terms of chronic care management which is vast and complex. Knowledge and skills between generalists at a primary care level and specialists at a secondary care level are different (Al-Saweer, 2007). While primary care is a vital source for early assessment, intervention and prevention of illness, secondary care provides specialist services and treatment. Therefore, provider relationships become crucial in terms of working more effectively together to achieve common goals

towards best outcomes. A collaborative approach enables Whakapai Hauora health professionals to deliver comprehensive packages of care and also create situations for clients and whānau to move easier through levels of care.

Summary

This theme captured significant aspects of respondent data relating to health and wellbeing. Despite differences in philosophical concepts relating to holistic care, both Māori and non-Māori respondents delivering services believed that Whakawhirinakitanga Ahua was a holistic model. A set of values that underpin service delivery plays a pivotal role in relationship building and facilitating access to services. Values identified and practiced in service delivery such as aroha, awhi, manaaki, whakaponu, tika, maintaining mana, valuing and respecting each other, interdependence and reciprocity are values that stem from a Māori worldview. While non-Māori respondents believed they worked as a team, Māori respondents portrayed themselves as a whānau within their organisation where collective responsibility, ownership of shared care, and reciprocal relationships were consistent in their dealings with each other. These very same values permeated through their lived experiences of working with clients and whānau as well as collaborative work carried out with mainstream service providers.

Fundamental differences in mainstream service delivery as highlighted in this research can significantly decrease the likelihood of achieving desired outcomes for Māori. Clients and whānau who were respondents frequently spoke of the inability of mainstream providers to respond to their wider health needs such as, to be ‘cared’ for, respected and listened to. They believed that services delivered by Māori providers met their needs with holistic approaches to care. Clients and whānau (respondents) who accessed services at Whakapai Hauora believed that services they received had a strong emphasis on ‘caring’. The culture of services in terms of Māori ways of engagement, the application of Māori values and principles in service delivery (whanaungatanga, manaakitanga and kotahitanga) and access to cultural resources such as marae/kaumātua have been demonstrated as being significant factors that appeal most to Māori clients and whānau in this research.

Theme 2: Values Based Service Delivery

Making connections and communicating effectively in terms of engaging with other providers, clients and whānau were also emerging themes within the data. Māori respondents delivering services expressed a variety of ways in which connections were made by practicing values embedded in Māori culture such as face-to-face contact, sharing whakapapa and stories and hosting others with kai. Respondents also believed that effective communication was crucial when working with clients, whānau and other health providers. This research demonstrated that effective communication is underpinned by certain practiced values such as trust, respect, support among group members and consistency with information.

Understanding health information

Effective communication is critical when working with clients and whānau. Respondents who were clients stated that they were not always able to access important and necessary information about health and related support services. They noted that the ability to understand health information is crucial when making choices in treatment and accessing care. Subsequently, respondents delivering services were concerned about “*getting the message across*” (M: 9) to clients. Effective communication is not only about making all necessary information available but it is also concerned with making sure ‘*it’s simple*’ (B: 5). Health information must be framed to a client’s level of understanding and also in a way that is actionable for the client (Ratzan, 2001)

Kōrero Mārama published by the Ministry of Health (2010b) stated that overall, New Zealanders have limited ability to obtain, process and understand basic health information with Māori having poorer health literacy skills compared to non-Māori (Ministry of Health, 2010b). Health literacy can be defined as one’s capacity to access, process and understand basic health information and services in order to make appropriate health choices (Ratzan and Parker, 2000). Coulter and Ellins (2007) and Kickbusch et al (2005) cited a range of adverse consequences from having low health literacy levels leading to poorer health status; such as the inability to make appropriate

health decisions, to engage with health professionals and to participate in decision-making. Low health literacy levels may also be concealed by individuals to maintain dignity (Basu et al, 2010). Nielsen-Bohlman et al (2004) stated that health literacy is dependent on a number of critical individual and systemic factors that converge such as education, health services, social and cultural factors.

Health literacy levels of individuals have implications for the way in which health professionals engage with their clients. This involves being able to assess a client's ability to read, to comprehend written information and the capacity to apply health information in decision making (Speros, 2005). For Māori, communicating not only involves transmitting information and knowledge that is easily understood and actionable, but it also concerns communicating in ways that accept and respect cultural differences. This has the potential to mitigate situations where clients/whānau feel whakamā to seek assistance. It also allows them to gain a better insight and understanding of health conditions, treatment and care; they are better equipped to make informed choices, to take action and to increase control over their own health.

Being informed

Consistency in providing all necessary information about the processes involved when utilising services is a right to those who access healthcare. Clients and whānau who were respondents also indicated that effective communication was crucial in terms of being told what to expect from mainstream services, particularly secondary care as it was important for providers to have "*explained everything*" (D30: 6) and being "*professional about what they did*" (D30: 6). This alleviated fear of the unknown and made respondents comfortable with service delivery processes. When a person is not completely informed about processes that occur in service delivery, it has negative consequences: "*it's not good ... not good at all there; I was left on my own and never told anything*" (O15: 4). Ineffective communication can result in people not wanting to have any further engagement with a service. Not being fully informed of one's entitlements when accessing wider related support services is also a barrier to access: "*if they don't tell us everything, we're never gonna know. And thank goodness for*

your kaimahi coming to see me cos that's how I knew what I was entitled to." (C29: 5). Practices by Māori health professionals and kaimahi are values-based; by employing methods of engagement such as *kanohi ki te kanohi*, communication is more effective as better discussions can occur.

Connecting face-to-face (*kanohi ki te kanohi*)

This research demonstrated that Māori respondents (health professionals, clients and whānau) considered a face-to-face approach as being the ideal way of connecting with each other, as well as engaging with mainstream providers in service delivery. This is consistent with other research where *kanohi kitea* (the seen face) is considered as a preferred and effective cultural engagement practice when dealing with Māori people (Cram, 1992). Māori culture has a strong oral tradition (Haviland et al, 2008); through face-to-face contact better discussions can take place, respect is established and the building of trust occurs: "*Kanohi ki te kanohi ... you know ... the doctor took the time to explain things to me ... about diabetes, and why I had to take my pills. She made me feel it was okay to ask questions*" (E31: 3). *Kanohi kitea* gives all parties the opportunity to fully engage, evaluate information, and identify any advantages or disadvantages for them (Pipi et al, 2004).

Sharing whakapapa and stories to connect

Making and affirming connections are significant to indigenous peoples as many of their creation stories connect them through genealogy to the land, stars, animals, plants and the universe (Marsden, 1992). Māori respondents also spoke of sharing whakapapa and stories to make connections. For Māori, whakapapa is described as being the most fundamental form of knowing (Marsden, 1992), a way of knowing as to how we are all connected to the natural world and each other (Roberts et al, 1995; Walker, 1990). Non-Māori respondents also acknowledged that making some sort of connection through common links assisted them a great deal when striking up relationships with Māori. According to Colquhoun (2002) establishing associations with all people are important as this forms the basis of relationships, especially for Māori; this may also be by sharing information about each other, such as people that

both parties know or places that both parties may be connected to. Māori respondents also placed great value in sharing their own stories with others, as they considered this another way to connect when building relationships. Bishop (1996) suggested that sharing stories is an empowering process, as it allows one to recollect lived experiences and reflect on their realities; the exchange of knowledge also occurs when experiences are shared by means of storytelling (Sole and Wilson, 2002). For Māori, connecting is significant in terms of engaging and fostering whanaungatanga.

Two frameworks for culturally appropriate processes of engagement have been developed: the Meihana model (Pitama et al, 2007) and the Hui Process (Lacey et al, 2011). Lacey et al (2011) noted that the Meihana model, a clinical assessment framework (developed within the context of mental health service delivery) includes the consideration of historical and contemporary influences on patients and whānau health experiences. Health professionals are able to have a broader view when understanding patients' presentation of illness; patients are encouraged to talk more broadly about their circumstances and this also facilitates whakawhanaungatanga (p: 74). The Hui Process developed for doctor and Māori patient engagement provides four key components in its approach to working with Māori. These are based on traditional principles of engagement: mihi (greeting), whakawhanaungatanga (making a connection/establishing a relationship), kaupapa (attending to the main purpose of the encounter) and poroporoaki (farewell). Lacey et al (2011) state that this is a basic framework for enhancing therapeutic relationships between clinicians and Māori (p: 76). Fostering culturally appropriate methods of engagement are crucial as this may potentially improve health outcomes for Māori facilitating better access to services and active participation in their own care.

Sharing kai to connect

When working with other providers, both Māori and non-Māori health professionals believed that sustaining professional relationships with their networks, particularly with key people, required a conscious effort. One of the best ways to connect with other service providers was to engage with them in person on a regular basis and share

kai with them. The sharing of food is an integral aspect of Māori societal and whānau custom which brings people together for various reasons. For respondents, it was an important way of connecting by showing respect and hospitality to their guests: “*It’s about manaakitanga, hosting and caring and kano ki te kano.*”(E: 5). Māori consider this to be an important part of the process where connections can be made and trust is developed (Edwards et al (2005)). Connecting in this manner also allows for information to be exchanged in a relaxed and friendly environment. For example, the promotion of respective provider roles can occur; providers can develop a better knowledge about each other’s services and key community contacts can be established which strengthen networks. There is also opportunity to discuss sharing resources, collaboration towards cost effective services and streamlining service delivery.

Effective communication and collaboration in service delivery

Understanding and acknowledging different views are important aspects of effective communication as rich information may emerge, where diverse practitioner backgrounds provide a robust basis for discussion. According to respondents delivering services, this is concerned with giving and receiving clear and concise information that is easily understood. When working with other providers, respondents considered listening and respecting each other’s views as being significant factors that contribute to effective communication. Having open discussions where issues could be ‘*hashed out*’ (Q: 9) created robust conversations. According to O’Daniel and Rosenstein (2008), robust dialogue contains crucial content where meaning can influence service delivery styles, creating a way to work cooperatively. This gives greater effect to collaboration and teamwork, where there is shared responsibility for problem-solving and decision-making in service delivery within an organisation, as well as when working with other organisations sectorally and intersectorally.

Communicating effectively contributes to collective decision-making which facilitates collaboration among service providers. Collaboration allows service providers to work together cooperatively to achieve common goals in service delivery.

Kotahitanga, a Māori principle, is a collective unity of purpose and direction based cooperation. Māori have an ideal of shared life and central to this is collective responsibility (Walker, 1987). Through the unity of shared responsibilities outcomes are better managed:

“When you think of it really, what we all want, Māori and mainstream is better outcomes for our clients, especially Māori clients and their families who have poor health. No matter how different we are, we’re all working for the same goal. We all have our responsibilities when we share care.” (K: 9).

Through kotahitanga, Māori have strength which can also be seen as a collective response to commonly held visions or goals. This principle underpins collaboration and partnerships towards reducing Māori health disparities and elevating levels of hauora.

Effective communication within the organisation

Concerning working together in their own organisation, respondents (Māori and non-Māori health professionals) delivering services stated that there was an open line of communication where a person could effectively communicate matters without feeling uncomfortable: *“like if I have a problem, I can go talk it out with management and don’t feel uncomfortable about it. I know I’ll be heard and then we’ll work things through together”* (I: 1). Respondents believed that their concerns were heard and that collaboration took place when sorting issues out with management. They also stated that they felt a sense of ownership in terms of decision-making as their concerns were heard. According to Longest et al (2000), an open line of communication is a vital source whereby essential information can filter through any barriers between management and staff such as environmental (organisation philosophy or settings) or personal (the nature of individuals and their interactions with others). It also allows staff to be involved in decisions that affect their work with implications for organisation performance and employee well-being.

Participation in collective decision making also provides staff with internal rewards such as a feeling of being valued, a sense of self-worth and a sense of ownership (Cummings and Worley, 2009). When the culture of an organisation encourages

active participation and collective decision making among its employees, it also facilitates innovative approaches to problem solving; these practices among employees within Whakapai Hauora have also been transferred to other work settings such as collaboration with clients, whānau and other providers, which has been demonstrated in this research.

Streamlining service delivery

Effective communication is capable of streamlining services that prevents situations such as having “*five Toyotas up the driveway and one Nissan from Whakapai!*” (K: 5). Respondents delivering services were concerned with overlaps in service delivery where multiple service providers conducted similar assessments on clients.

Respondents noted that “*they [clients] become confused because they’re told different things [by multiple providers delivering care]*” (K: 7). Lliadi (2010) stated that many health professionals have learnt to analyse situations emerging in collaborative teamwork. Communicating effectively allows for a good understanding of respective roles, differences in service provision and professional boundaries which play a crucial role in mitigating overlaps, and providing opportunities for better outcomes for clients and whānau.

Communicating effectively also assists in overcoming patch protection, another issue that emerged in the data which can undermine collaborative efforts among providers. Cumming (2011) identified patch protection as a barrier to integrating services. When differences in service provision, provider roles and gaps in services are communicated effectively among providers, it can influence attitudes, ideas and behaviours towards greater collaborative efforts; which can mitigate patch protection in the delivery of care. It also assists to reduce fragmentation of services and provides opportunities for providers to develop and coordinate services in a more holistic and comprehensive way. This can lead to more efficient use of resources and cost effectiveness in service delivery.

Summary

Connecting and communicating effectively with others are both critical when establishing relationships and gaining greater access to services. Particularly for Māori, relationships are a key dimension of a Māori worldview and culturally appropriate engagement is crucial when establishing effective relationships with Māori. On-going networking and hosting other providers facilitates this process. Connecting in this manner helps maintain professional relationships, provides a better understanding of individual provider roles and consolidates links with key people in other services allowing greater access for clients and whānau. Effective communication also plays a significant role in service delivery at an organisational level. A good understanding of each other's roles, responsibilities and scopes of service provision allows for better working partnerships and the sharing of resources for cost effective service delivery.

Effective communication is also vital when working with clients/whānau. Communication is linked to health outcomes; client/whānau health literacy levels must be considered to ensure that health information is understood, and contributes to decision-making. Respondents in this study indicated that relaying simple messages that are easy to understand and not overloading clients with unnecessary information are the best ways to communicate effectively with them. Communicating in a culturally appropriate manner is also crucial as effective communication has the potential to mitigate feelings of whakamā giving clients and whānau better insights into health conditions allowing them to make informed choices in treatment and care. A key aspect of Māori health provider services is the focus on whānau centred care which is discussed in the in the following section.

Theme 3: Whānau Focussed Care

Respondents (health professionals, clients and whānau) identified whānau as being central to health and wellbeing. Two whānau concepts were identified in this research; clients and whānau who were respondents recognised whānau as immediate, extended as well as intergenerational, what Walker (2006) referred to as whānau tūturu or intrinsic whānau. Māori respondents delivering services also portrayed themselves as a whānau, what Metge (1995) and Walker (2006) referred to as a kaupapa-based whānau; working as a collective to provide support and fulfil common goals. The significance of whānau in relation to health and wellbeing emerged from the data as respondents reflected on the transmission of whānau values, diverse whānau realities, and whānau influences and strengths within a collaborative care context.

The intergenerational transmission of Māori culture, values and knowledge

Durie (1999b) stated that while health and wellbeing depends on many factors, Maori consider cultural identity to be an important dimension. Durie noted that *“having access to supportive and reliable whānau is a fundamental gateway to Te Ao Māori”* (p: 149) in terms of intergenerational transition of culture, knowledge, and values. Despite diverse Māori realities as expressed by respondents delivering services, for example: *“I grew up on a marae ... in a place that was whānau, hapū, iwi”* (B: 9) and *“I know my Māori culture; my nanny instilled it in us. I didn’t grow up on a marae but I do have my own understanding of it”* (A: 8), they noted that working in a kaupapa Māori way came *“naturally”* (B: 9) to them. Despite growing up under different circumstances, Māori respondents in this research identified kaumātua (their grandparents) as having transmitted Māori culture to them.

Māori health professionals also noted that having the support of kaumātua at their workplace *“keeps us safe”* (C: 12) when maintaining tikanga and Māori protocols in service delivery. Māori elders play a significant role in the lives of whānau and Māori communities; they are regarded as repositories of knowledge (Barlow,

1991) in terms of language and culture and often contribute at both whānau and community levels (Waldon, 2004). Durie (2003) stated that the role of kaumātua is reciprocal whereby the skills of older Māori are utilised by the young and reciprocated in terms of care, support and respect. Durie (2011) also noted the significance that kaumātua have within communities and stated that they are sought by Māori providers who employ them; there is engagement between DHBs, community organisations, government agencies and kaumātua as they have greater links with better access to Māori communities. Durie (2011) also stated that their knowledge and advice is also sought in relation to policy development and implementation. This has been demonstrated in this research by Māori respondents delivering services: “*And I guess our policies with having kaumātua here to awahi and to keep us safe, the kawa is tika and all of that, that’s what we follow ... tikanga Māori.*” (C: 12).

Whānau capacity and influences

A key function of whānau is to act as a major support system for its members (Durie, 1998a) thereby influencing members’ health and wellbeing. When a whānau is operating effectively, the collective effort of whānau as a whole to support an individual in achieving health and wellbeing is important, particularly in times of illness. Respondents who were clients acknowledged contributions made by their whānau when they were unwell and if whānau were not part of the care equation it could be a potentially “*dangerous situation*” (R18: 4,5). Respondents indicated that responsibilities were shared among individual whānau members who depended on each other to achieve desired outcomes for them; in this way, recovery was quicker. There are also reciprocal gains for whānau in terms of health knowledge and education which lead to healthier lifestyle choices.

Being cared for in a whānau environment was important to respondents who accessed services. They believed that health professionals at Whakapai Hauora (both Māori and non-Māori involved in their care) were genuinely concerned for their wellbeing: “*It’s a real whānau environment; everyone cares about you and that’s the difference that you feel.*” (P16: 3). Durie (1997) identified five major

whānau capacities: manaakitanga (the capacity to care); tohatohatia (the capacity to share); pupuri taonga (the capacity for guardianship); whakamana (the capacity to empower); and whakatakoto tikanga (the capacity to plan ahead). It is through relationships that these values are expressed among individuals within a whānau, be they whānau tūturu or a kaupapa based whānau. Some main whānau capacities have been identified in this research by respondents delivering services (the kaupapa based whānau) in their ability to manaaki clients and whānau; to share health knowledge and education in a culturally appropriate manner which empowers towards self-determined choices; and planning in terms of better access and navigation through complex systems of care. Māori respondents delivering services also believed that when clients did not have support from their own whānau, they would assume the role of whānau by role modelling whānau values and sharing responsibility for the individual's care. Māori health professionals worked in a way that was both natural and whānau-centred as Te Ao Māori reinforces the significance of whānau rather than an individual.

Although non-Māori respondents delivering services identified their practice as being client-centred, they recognised that whānau was also an integral aspect of care:

“...sometimes, the deal between this patient and the family is to see a therapist, and the patient is out there somewhere, so you have to draw them all in ... family needs are also important to consider when they have to help support the patient” (N: 1).

Once whānau are included, whānau needs are identified in order to support the individual. The provision of care for whānau then also becomes significant: *“Māori and non-Māori here, we work together to awhi and manaaki them [clients] and their whānau”* (A: 4).

The inclusion of whānau in an individual's care recognises whānau as a collective which is a key concept in Māori society (Mead, 2003). Whānau involvement in decision making processes recognises the authority of whānau creating a sense of collective control and ownership over their health and wellbeing. For Māori, what binds and gives strength to a collective is whanaungatanga (relationships). In whānau or whānau-type relationships, Fitzgerald, Galyer and Ryan (2007) describe the principle of whanaungatanga as being the *“interconnectedness or*

interdependence of whānau members” (p: 31). Whanaungatanga augments the commitment people have to each other within relationships (Hirini, 1997) and this is often expressed by whānau values. Both Māori and non-Māori respondents delivering services believed they worked in a similar manner, providing care and support to clients and whānau, being advocates for them, navigating them through health systems, and sharing knowledge to empower them towards self-determined choices in care. However, not all whānau may wish to be involved in care, or some may be in dysfunctional situations that impact on the health and wellbeing of members.

Working with high risk clients / whānau

Respondents (Māori and non-Māori delivering services) who worked with high risk clients and whānau believed that establishing positive relationships was critical in order to work more effectively with them. However, being in a predicament of getting too involved in an entire situation affecting an individual or whānau was a substantial concern:

“Some of those families, say, they have a huge breakdown and that’s why I sort of get more involved, but I can overdo it. And I take away their mana, if you like ... by letting them rely on me. Then I try and stop them and say, “Well you know it’s not my role” but then it’s too late; I’ve done it!” (J: 5).

Allowing clients and whānau to rely too much on a service provider may be detrimental in a sense that it takes away their control over a situation affecting their health and wellbeing. The issue of dependency may also elicit feelings of guilt, insufficiency and worry on the part of health professionals as it creates a constant concern of having to weigh up providing insufficient or too much care. Strandberg and Jansson (2003) indicated that dependency on care is a burden to health professionals and is attributed to loss of self-determination and self-worth. The provision of too much care, even out of aroha may be damaging to whānau as it can attenuate their confidence and ability to undertake tasks that they are capable of doing. Some Māori respondents delivering services stated that in such a circumstance, it is necessary to step back, reflect on their role as service providers and try to determine the reason for the situation occurring. They

believed that instead of clients or whānau being overly reliant on them, it was their role to support them to actively participate in their own care and engage with all other services involved in their care.

On the other hand, some Māori respondents working in a particular scope of practice (for example mental health) noted that dependency on providers may be necessary initially due to the circumstances of their illness. Holland et al (2008) argued that illness can make us partially or totally dependent on care and that each relationship between health consumers and providers is unique; in some cases, independence is encouraged while in other circumstances, assistance to accept dependence is facilitated. Therefore it is crucial to continually assess dependence levels in order to move clients /whānau along the dependence – independence care continuum.

Role modelling whānau values in a professional way also plays a pivotal role when working with high risk clients and whānau as it gives them the incentive to “*model back [whānau values] into their own lives; and that they can go back to their own whānau and marae*” (F: 6). Reconnecting disadvantaged Māori to their extended whānau, hapu and iwi is also “*part of looking at perspectives from a healing way, and for this person to find out where they’ve come from ... then their health grows*” (G: 6). Apart from whānau focussed care, there are also other features of Māori health service delivery characterised by respondents (clients, whānau and health professionals) in this study. This is discussed in the following section.

Māori health service delivery

Clients and whānau in this study characterised Māori health providers as “*one-stop-shop*” (G7: 3) providers offering a range of health and social services often located in one place which made “*a big difference*” (G7: 3) for them. This alleviated some barriers to access, such as transport and cost. Most services delivered by Māori providers are often free of charge (Crengle, 2000).

Respondents who were health professionals noted positive spin-offs from services being located in a central place, and gave the example of their own work environment: “*We communicate better, we know each other’s services better, and*

we already know each other at work. Access is also better because we're all in the same place." (N: 3). There was better access to each other's services in terms of referral processes being easier. Communication was more effective as they knew each other, they could meet face-to-face making access to client information easier. These factors are also underpinned by relationships that are formed among providers when working in a central location.

Another critical factor noted by clients and whānau who were respondents, was the significance of marae-based service delivery: *"marae-based services is best, I think. Like this place, you got the social and cultural here... not just clinical like Pākehā services ... it all just connects."* (G7: 3). The marae also allows them to connect with whānau: *"you can also go to workshops or activities and do things with your whānau on the marae..."* (Q17: 5). They also believed that having a marae enabled a sense of belonging and to reconnect with Te Ao Māori: *"...we just love it, what they put on at the marae for kaumātua and whānau. We can all join in and celebrate who we are and be well."* (A27: 3). Russell (2006) stated that cultural identity is an important contributing factor to the recovery process, particularly in mental illness. Durie (1998a) however argued that identity in itself is not so significant if it is solely reliant on a sense of belonging without sharing a group's cultural, social and economic resources. Access to these resources such as tikanga, te reo, whānau, hapu, iwi, kaumātua whenua and marae are all significant contributors in having a secure Māori identity which is central to good health. This was highlighted by clients and whānau in this study as they expressed the significance of having a marae by Whakapai Hauora, where they and their whānau could participate in cultural, educational and social activities; they felt a sense of belonging and a connection with their people and culture.

Knowledge and empowerment

Empowering clients and whānau is an integral aspect of Māori health service delivery as the sharing of health information and knowledge facilitates client / whānau empowerment which leads to *"being able to make those healthy*

choices.” (Q17: 1). Crucial aspects of service delivery involved the provision of health information and education such as the importance of medication and treatment, self-management of illness and making healthy lifestyle changes (particularly for those with chronic illness). Respondents delivering services believed that health education was crucial in order for clients and whānau to make informed choices and manage their care. This was also evident in the data from client interviews, where they expressed the importance of receiving health information for themselves and whānau.

Despite the many challenges faced along their journey through a care continuum, clients/whānau stated that accessing a range of services was beneficial for them. Giving clients/whānau information as to how mainstream systems operate, how to access a wide range of services and navigate through complex health and social support systems is critical. Having such knowledge is empowering as it can facilitate better access to services. In this research, few respondents stated they had knowledge of how mainstream services operated, while the majority indicated that having a Māori service provider involved in their care made a positive difference. Clients believed that Māori health providers had good knowledge of mainstream health and social support systems making access to a wider range of services easier for them and whānau.

Navigation through the care continuum

Navigation through services was highlighted as an important role by all respondents delivering services. Their experiences highlighted the significance of having to navigate clients and whānau through a number of complex health and social support systems in order to utilise all necessary services for desired outcomes:

“My role was to teach the mother about his inhalers, what they were used for, how to use them and any side-effects. But when I got there, I saw that some whānau were smoking in the house. The house was cold, with no heating and it felt damp. I knew that I needed to get more services involved in his care ... we went to [name of government agency] to try and get a better place to live and then to social welfare to help with heating. I also arranged for a smoking cessation coach to help whānau understand the effects of passive smoking” (O: 6).

The concept of 'patient navigation' was developed by Doctor Harold Freeman in the United States during the late 1980s. His intent was to assist African American women with breast cancer gain better access to potentially life-saving treatment and care (Freeman, 2006). Patient navigation involved removing barriers for breast cancer patients to the diagnosis and treatment of early-stage disease; it also entailed patient advocacy and health education. Initially, the role was undertaken by non-professionals who were sensitive to cultural and language barriers to care in their community. Since then, patient navigation has been widely used for other diseases and medical conditions. Patient navigation models of care have been used in the United States since the 1990s (Doolan-Noble et al, 2012). Since then, the role has also been undertaken by social workers, nurses and community health workers who are familiar with health care systems. Freeman and Rodriquez (2011) stated that it improves engagement in medical care potentially resulting in better patient outcomes. Patient navigation was a relatively new concept when it first started in New Zealand. Farrisi and Dietz (2013) stated that patient navigation is client-centred towards eliminating barriers to accessing medical care. However, Māori providers also navigate clients and whānau through wider related support systems such as social welfare, housing, justice and education with assistance and advocacy towards achieving desired outcomes. Successful navigation also hinges on a critical factor, the ability to work collaboratively at the interface with mainstream services.

Working at the interface

Findings in this research indicated that Whakapai Hauora health professionals working at the interface with mainstream health and wider related support services had positive outcomes for clients and whānau. Although some respondents (clients and whānau) indicated that they had knowledge of how mainstream systems operate, they were reluctant to engage with mainstream services. They indicated that Māori health service providers made a significant difference; not only due to the provision of extra advocacy and support, but more importantly, that they worked in a Māori way, in a Māori environment where values such as manaakitanga, kotahitanga and whanaungatanga were the norm. It has been suggested that utilising a mixture of

western and Māori models of practice will provide more robust and professional services (Moeke-Maxwell, 2007). Working at the interface requires the ability to work effectively with everyone involved in the delivery of care. Apart from a significant amount of collaboration with all those involved in the delivery of care, working at the interface also entails having good knowledge about mainstream systems and structures. It requires having knowledge, skills and the ability to operate in both Māori and Pākehā systems in order to “*get the best outcomes for our people. Our culture, our knowledge and also Pākehā knowledge.*” (Y25:3). Māori providers work at a grassroots level with clients and whānau; their understanding of mainstream systems allows them to tap into resources necessary for Māori and whānau. While many are professionals qualified in various scopes of practice they are knowledgeable in Māori tikanga. There are also those with no formal qualifications such as kaimahi but they have the necessary skills and experience to work in their communities and are often well known by their people. They have greater links to disadvantaged and vulnerable whānau giving them a strategic advantage in targeting ‘hard to reach’⁶² Māori within their own communities.

Summary

This theme “Whānau Focussed Care” highlighted the integral role of whānau who are a major support system for individuals, particularly in times of illness. With whānau involvement, recovery is quicker. Whānau are also a means by which culture, values, beliefs and health knowledge are sustained through intergenerational transfer. Involving whānau in decision making processes instils a sense of collective control and ownership over their health and wellbeing. Findings in this research also indicated that services delivered within a whānau-like environment, in a Māori way incorporating Māori concepts of health and wellbeing were significant towards client and whānau wellbeing; health services in a marae setting also enabled a sense of belonging; it allowed clients to reconnect with whānau, with access to cultural resources, kaumātua and social activities. Navigating clients and whānau through a range of health and related support services was also an important aspect of work for Māori health providers. Access to these services is critical in terms of utilising all

⁶² A term used to describe those who are less likely to engage in services.

available resources to achieve desired outcomes. Successful navigation requires an extensive amount of collaboration and knowledge of how various health and wider related support systems operate. Another significant aspect of Māori health service delivery is empowering clients and whānau through health education which leads to self-determined choices in care. When healthcare is delivered in a manner that is perceived by Māori as being appropriate to their cultural values and beliefs, the chances of compliance to care and health outcomes are more likely to occur.

Chapter Nine

Discussion

Introduction

Chapter Nine focusses on discussing findings from the previous chapter and explores Whakawhirinakitanga Ahua in view of the research questions established at the beginning of this study. The two broad research questions were: is the model “Whakawhirinakitanga Ahua” reflective of health service delivery at Whakapai Hauora? As a collaborative model of service delivery, does it address the health needs of Māori accessing services at Whakapai Hauora? This chapter is set out to address these questions accordingly.

Findings from Chapters Six and Seven highlighted the experiences, views and beliefs of (Whakapai Hauora) health professionals, clients and whānau. The research explored the tikanga-based framework from which both Māori and non-Māori underpin their practice. In relation to this, Chapter Nine begins by exploring Whakawhirinakitanga Ahua as a framework that underpins practice in terms of aspiring to achieve whānau ora. This chapter also discusses influences and wider factors affecting Māori health service delivery in terms of Māori provider capacities and capabilities, and the current health climate. Despite Whakawhirinakitanga Ahua being developed as a Māori model of health service delivery, Te Ao Pākehā was also present. Research implications are discussed and research strengths and limitations are acknowledged. The chapter concludes by summarising key points of the study, highlighting the need and reason for ongoing research.

Exploring Whakawhirinakitanga Ahua

Aspiring to achieve whānau ora

Whānau ora draws on Māori understandings of wellness from a Te Ao Māori perspective. Whānau ora is based on the cultural foundation of collectivism in terms of its approach to wellness, the collective capacity for self-determination, intergenerational transfer of knowledge, values and full participation in society (Durie as cited in Ministry of Health, 2011b). Intersectoral collaboration is key towards capacity building for service providers and with Māori providers working as collectives, whānau potential and aspirations are more likely to be maximised. Whānau Ora is a vision, and a journey that whānau and health professionals embark on to work together towards assisting whānau to achieve optimal wellness. It is also concerned with whānau being self-sustaining in terms of ‘doing it for themselves’; taking care and responsibility of their own wellbeing. The Whānau Ora journey consists of goals set by whānau. The capacity and capability of each whānau to achieve their goals vary, dependent on resources, capacities and capabilities. Each goal is unique to a whānau circumstance. Therefore whānau themselves set their goals and determine how they will achieve outcomes. As goals are achieved, more are set towards whānau ultimately being able to self-manage their own health and wellbeing, and achieve tino rangatiratanga over all their affairs. This is a continuously evolving process and Whānau Ora navigators⁶³ play a major role in supporting whānau to achieve realistic and measurable outcomes.

Whakawhirinakitanga Ahua pathways towards whānau ora

This research demonstrated that tikanga-based service delivery creates an avenue for whānau ora and whanaungatanga plays a significant role in collaborative care settings. This research indicated that making connections and communicating effectively is the start towards establishing whanaungatanga. When a better understanding among providers, individuals and their whānau occurs, the dignity of all can be maintained in the delivery of care. Having a better understanding can also address issues such as negative stereotyping in terms of Māori needs being better understood. Reciprocal

⁶³ See Whānau Ora initiative on page 23 in Chapter Two of the Literature Review

relationships occur, as health professionals, clients and whānau have better knowledge of each other's position in the provision of care. This potentiates a strength-based approach as the burden of care is shared and there is interdependence as each relies on the strengths and capabilities of others. Working as a collective facilitates active participation and contributes towards shared outcomes that are realistic, achievable and measurable. It also instils a sense of collective ownership among health professionals where decisions and responsibilities are shared as demonstrated in this research.

Tikanga-based service delivery also allows for Māori to reconnect with Te Ao Māori. Māori values identified in this research such as manaaki (going beyond to meet a need), aroha (love), whakapono (trust), mana (having respect and maintaining dignity), awahi (support), tika (being true and correct) underpin whanaungatanga and remain consistent in practice among Whakapai Hauora health professionals. This research also demonstrated how applying and role modelling these values to practice in service delivery can potentiate a shift for clients and whānau along the dependence – independence continuum; which is a critical aspect of empowering whānau towards self-determination. Self-determination and self-management of care has been identified in this study as being integral to Māori health and wellbeing; early indicators of health outcomes were seen as changes in client behaviour towards self-management of illness and self-determining their own choices in care. The inclusion of whānau in an individual's care was also seen as paramount in whānau ora pathways.

This research also highlights the importance of being able to provide health information in a manner that is appropriate to the needs of clients and whānau. With a good understanding of their health needs, individuals and whānau are capable of making better choices in care. They also have greater knowledge of service options, access, provision and delivery processes, particularly with mainstream services. This helps overcome barriers such as fear of the unknown and whakamā; it also addresses any concerns they may have about mainstream services. As a result, they may navigate themselves through a range of comprehensive services.

This research also indicated that marae-based health service delivery creates opportunities for mātauranga Māori, tikanga and te reo to be sustained. These factors also contribute to positive whānau development in relation to intergenerational transmission of Māori culture and values. As levels of whānau capacity and capability increase, they move from dependence to independence towards self-determined choices in their own care. When whānau are healthy and confident in Te Ao Māori; they are more likely to have greater participation in society (Durie et al, 2010). Whānau themselves become role models for future generations, as the intergenerational transfer of health knowledge, mātauranga Māori and tikanga occur.

Whakawhirinakitanga Ahua as a model to facilitate intersectoral collaboration

This research highlights connecting and effectively communicating with sectoral⁶⁴ and intersectoral providers develops trust and respect. Mainstream providers have a better understanding of tikanga-based service delivery, Māori health models of practice and Māori diversity. It also gives the opportunity for promotion of respective services and roles with the establishment of key contacts which strengthen networks. With greater knowledge and understanding of different provider capacity and capability, the pooling of resources may occur avoiding overlaps in service delivery when engaging in collaborative care. The focus is centred on working together as a collective, or team involving active partnerships, support for each other and capitalising on each other's strengths and capabilities towards whānau focused care. A multidisciplinary approach also occurs, and the use of both western and Māori knowledge. With active on-going partnerships and teamwork, service processes become streamlined and intersectoral pathways are clearer for individual and whānau navigation across a comprehensive range of integrated services.

⁶⁴ means services pertaining to a sector; in this instance it refers to all health (primary and secondary) services including allied health services, such as pharmacy, diagnostics.

Service navigators

In this research, the majority of respondents delivering services identified navigation as key to achieving desired outcomes. Apart from delivering the care that they are contractually required to, their work was underpinned by principles of whanaungatanga, manaakitanga, kotahitanga and whakamana (empowerment) as outlined in Whakawhirinakitanga Ahua (the model of service delivery). Their work with clients and whānau entailed coordinating care, advocating and mediating, brokering for vital resources and other services, and assisting clients and whānau in goal setting; some worked in this manner to a greater extent than others, particularly those working in chronic and complex care management. Findings in this research identified that manaakitanga and aroha directs such behaviour. Findings also indicated that respondents working at Whakapai Hauora are often supported within their own organisation to work this way.

In this research the majority of respondents who were clients and whānau preferred dealing with one provider when accessing services for a number of reasons: it helps eliminate a variety of factors identified as barriers in accessing services such as inappropriate ways of engagement and having to share personal health information repetitively to different providers. They preferred to establish reciprocal relationships with one provider with which whānau have easy access to. The role of a specialist whānau practitioner (a Whānau Ora navigator) is to work with whānau intersectorally. Whānau Ora Navigators are also charged with having to build whānau capacity by reconnecting whānau with Te Ao Māori and building whānau capacities/capabilities in terms of education, communication technology and financial expertise.

In this research, findings have also highlighted the significance of being able to draw upon aspects of both western and Māori frameworks to deliver services that meet whānau needs; findings indicated the importance of educating individuals and whānau on how mainstream systems operate to facilitate better access to services. Also for whānau to flourish, the intergenerational transmission of tikanga, values and knowledge need to occur which centres whānau in Te Ao Māori, sustaining Māori culture throughout generations. This research also signalled the significance of

positive role modelling of whānau values; when working closely with Māori and whānau, it allows the most vulnerable and high risk whānau to experience being in a fully functional and supportive whānau environment. Working this way offers hope and encouragement; it raises Māori aspirations with the expectation that whānau values will be practiced by such individuals and whānau with support and through reconnecting with Te Ao Māori.

Gauging whānau ora success

As a model of service delivery, Whakawhirinakitanga Ahua has the potential to deliver services in ways that contribute to achieving whānau ora success by facilitating intersectoral pathways and solutions. However, if outcome measures are not aligned with Māori service delivery models, then determining whānau ora success will remain fraught with inconsistencies; as measures set by funders in the current contracting environment have continually focused on service processes and outputs. Findings from this research suggested that performance measurement did not truly reflect the extent of work carried out to enable individuals or whānau, nor did it reflect true client/whānau outcomes; it tended to be more of a reflective mechanism for providers allowing them to gauge their level of performance in meeting targets aligned with their service contracts.

Findings in this research highlighted the significance of being able to address client/whānau realities, their priorities; and their immediate needs. Being able to understand the impacts of health determinants on clients and their whānau were considered critical towards supporting them to attain better health outcomes. Durie (2013) argued that aligning whānau targets intersectorally would also be more realistic in terms of gauging successful outcomes for Māori. He suggested a number of possibilities to gauge whānau outcomes by quantifying measures with a percentage reduction in a number of targets set over the next few years. During a keynote presentation to general practitioners at a symposium, Durie (2013) suggested that these targets should be a mix of health, social, education and justice markers for Māori. These targets also have the potential to capture a better picture of the nature and extent of work done by providers working with Māori and whānau in their communities in terms of workloads and service processes.

Influences Affecting Health Service Delivery

Many factors influence the way in which health services are delivered within an organisation. There are national and local influences including government policies that drive funding. There are also more direct influences such as the culture of an organisation, provider capacity and capability. These direct influences are discussed first followed by the wider influences that affect Māori health service delivery.

Organisational culture and tikanga Māori

Organisational culture plays a pivotal role in determining levels of success or failure within an organisation (Deal and Kennedy, 1982). It is an invisible powerful element that shapes work processes within an organisation. Sun (2008) defined it as a “set theory” (p: 137) of important values, beliefs and understandings that members within an organisation have in common. While organisational culture has a significant influence, the overarching influence of Whakapai Hauora is tikanga Māori. Findings in this research indicated that values and principles such as whanaungatanga (relationships), manaakitanga (hospitality and generosity), kotahitanga (working collectively) and tino rangatiratanga (self-determination) in relation to empowerment are inextricably linked for respondents, in the way that they work with clients and whānau, with each other, as well as with other providers in all aspects of their work. Good relationships in terms of whanaungatanga were described as being reciprocal, interdependent and supportive utilising the collective strength and effort of all, fostering unity. These principles feature strongly as part of the culture within Whakapai Hauora and have been identified as tikanga-based principles that build Māori organisational culture (Harmsworth, 2005).

Durie (1998b) noted that Māori health development is holistic with strategies aligned to Māori advancement and self-determination creating the avenue for cultural rejuvenation, resilience and also according to White (2000), the building of social capital. Harmsworth (2002) noted that cultural values and principles remain highly relevant in contemporary Māori society. Wolfgramm and Waetford (2009) suggested that Māori management systems demonstrate a range of orientations between the

spiritual and secular influencing institutional innovation and culture. This was demonstrated by Māori health professionals in this research who specifically spoke of their work as ‘weavers of relationships within their community’, and the significance of having a marae at their worksite which connected them to tūpuna. The marae provides an environment for both spiritual and physical aspects of wellness which was noted by respondents who were clients; Māori and whānau also have greater access to cultural resources, including kaumātua and kuia, facilitating cultural empowerment which is an important aspect of whānau sustainable development.

Māori provider capacity and capability

Māori health providers vary in size, ranging from small to bigger sized organisations that usually function on a non-profit basis. While some services are similar to those of mainstream, their kaupapa and structure in terms of governance and management systems are different. On-going investment in developing their capacity and capability is critical towards Māori provider sustainability. Since the establishment of the Māori Provider Development Scheme (MPDS) by government in 1997, Māori health providers have been able to further develop service provision and expand their health and disability workforce. In 2009 Boustead and Gribben (CBG Research) evaluated the scheme by enabling participating Māori organisations to self-assess changes within their capacity across eight categories⁶⁵. The report highlighted some key implications for provider capability in terms of development. For example, in areas such as IT, there was lack of support in training and on-going servicing limited provider capacity to use IT systems effectively. In terms of scholarships, there was no assurance of funding beyond a year while providers incur added costs for training travel and accommodation. It was also noted that on-going costs for accreditation is problematic for smaller Māori organisations with few being recognised for their efforts; as organisations without accreditation status continue to receive contracts with similar terms and funding. However, despite these issues, this scheme remains a vital source of funding for Māori provider infrastructure and workforce development.

⁶⁵ These categories are identified in the evaluation report; refer to: *Evaluation of the Māori Provider Development Scheme (MPDS) by CBG Research*.

The evaluation report also focused on Māori provider capacity for service integration as a result of the scheme. Building relationships and maintaining links with Māori and non-Māori networks were noted as being critical to Māori providers with high levels of satisfaction from collaborative outcomes. Findings in this research highlighted whanaungatanga as being significant to successful collaboration in service delivery. This research also identified that collaborative relationships are underpinned by values such as honesty, trust and respect. It involves interdependence (being reliant on each other) and sharing responsibilities towards achieving desired outcomes in service delivery. Collaborative relationships are also reciprocal whereby giving and receiving is based on mutual cooperation. Collaborative working relationships potentiate pathways towards effectively integrating care. Health professionals in this study noted that when resources are shared, cost effectiveness of services also increase. Innovative ways in delivering services also occur with better information sharing and there is the ability to utilise a wider skilled workforce.

Wider Influences on Health Service Delivery

The current health climate

Wider influences that impact on Māori health service delivery are government strategies which are the main drivers of health policies. The Primary Health Care Strategy and He Korowai Oranga have been instrumental in the development of Whānau Ora pathways in terms of a population health approach to healthcare delivery. While He Korowai Oranga focused on building whānau resilience and capacity in terms of Whānau Ora development, primary health care reforms under the Primary Health Care Strategy moved from a fee-for-service to capitation funding, the promotion of population health management and the development of non-profit organisational infrastructure (PHOs) responsible for delivering primary health care services to their enrolled populations. The more recent initiative, Better Sooner More Convenient Care (BSMC) is concerned with greater integration of primary and secondary care in communities with goals and a vision that aspires to keep people healthier in their community longer. In doing so, it aims for better collaboration

among health professionals, better sharing of patient information, creating ‘seamless’ care, and reducing patient waiting time to access services, particularly secondary (hospital) services. It focuses on a more individualised system of care which is client-centred. There are differences in holistic concepts related to client-centred care and whānau focused care which have been highlighted in this study, . hence the reason for Māori health service delivery being different to mainstream service delivery. ‘BSMC’ is a Government approach to healthcare implemented alongside Whānau Ora which continues to evolve and suit the health needs of individual communities.

The Ministry of Health (2011a) cited a number of service innovations that continue to develop from the BSMC policy, such as first care contact providers (mainly GP services) having virtual appointments by email or phone; the use of high-definition video links in rural areas where patients have greater access to health care without a lengthy wait; electronically shared patient records; secondary care specialists working in GP services; longer consultation times with face-to-face contact; and Integrated Family Health Centre (IFHC) setups.

Some innovative features of BSMC developed to suit individual community needs (for example, rural communities) are virtual appointments and video links making access to health professionals easier. Innovations such as this privilege those who have the capacity to afford and maintain this technology. While schemes such as the MPDS allow for IT funding to Māori providers, the cost for training and ongoing maintenance of IT falls on providers who have to pick up extra costs with no further support. However, in terms of sharing information, there are potential benefits from electronically shared patient records as it could eliminate some of the barriers identified by respondents in this research which are noted accordingly: providers involved in collaborative care can access vital information easily; it may also prevent excessive patient re-assessments and providers can make the most cost-effective use of resources avoiding overlaps in service delivery. Still, much would also depend on the capacity of Māori and mainstream provider IT capability.

Some BSMC providers in IFHCs have offered longer consultation appointments. The challenge however, for many mainstream clinicians working with Māori would be to adopt a whānau approach rather than an individualised approach in their delivery of care. None the less, longer consultation times have the potential to build and strengthen relationships between Māori and health care professionals. Having greater access to secondary care specialists in community based settings could also eliminate a crucial barrier identified by respondents in this study particularly for those with long-term chronic conditions, as it alleviates lengthy hospital outpatient waiting lists. Shorter waiting times to see specialists are critical in terms of early preventative care.

There may be positive spin-offs from IFHCs as they have a range of services located in one place. Having a wide range of services under one roof was also identified in this study as being a significant factor in greater access to health care for Māori. The extent to which some IFHCs may comprise of are: GP services offering minor surgery, X-ray units, diagnostics (laboratory services), physiotherapists, pharmacists and a number of other health activities in a central location. This concept initiated by government focuses on sectoral integration⁶⁶ with secondary care providers shifting some services into community settings with primary care providers taking a more active role in treatment and care.

Letford and Ashton (2010) claimed that key stakeholder⁶⁷ positions concerning IFHCs are mixed; while PHOs support government policy, they receive minimal extra funding towards the implementation of large scale changes and Johnston (2010) stated that government funding was not intended to finance new facilities. Success is reliant on PHOs gaining the support of both secondary and primary care providers. In their review of government policy, Letford and Ashton (2010) also noted that although DHBs have worked together with PHOs to develop IFHC proposals, it has not been easily achieved. While some view IFHCs as new opportunities for improvement, others have doubts due to uneasy professional relationships. Furthermore, the implications of profit driven demands and a focus on population

⁶⁶ The integration of primary and secondary care services in the community.

⁶⁷ Refers mainly to primary and secondary care providers involved in the development of IFHCs

health continue; which have a different focus to the inequalities which are linked to Whānau Ora (National Māori PHO Coalition, 2010). Nevertheless, Māori providers can benefit from building relationships and alliances with these centres in order to strategically place some of their own services within IFHCs where Māori and whānau accessing mainstream primary and secondary care services can also access whānau ora services. There is also better sharing of knowledge, skills and expertise among mainstream and Māori health professionals. Mainstream providers will have a better understanding of whānau needs.

It is anticipated that IFHCs will facilitate greater access to health care; however their development is still at an early stage and a major factor for Māori and whānau in terms of access will be location and cost. With no extra funding from government, the question remains as to whether the cost of maintaining IFHCs will eventually fall on health consumer co-payments. While this research established that larger Māori health providers offer various services under one roof, the services they offer differ to the concept of IFHCs. Unlike IFHCs which are initiated by a top-down approach from government and health professionals, Māori providers are governed by Māori/iwi and are mainly community driven. They often include other services that address wider issues impacting on health and wellbeing such as social services, justice and education. The focus is on intersectoral service delivery which is typical of a holistic Māori approach to health and wellbeing including access to cultural resources such as kaumātua, kuia, marae, hapū, iwi and mātauranga.

This research identified that services within Whakapai Hauora worked well for clients and whānau due to the extent of collaboration, the relationships between health professionals within the organisation and a tikanga-based model of service delivery. However, when attempting to “*broaden it into mainstream care*” (A: 8), there was a lack of understanding on the part of mainstream providers due to different views, philosophies and approaches to service delivery. This research also identified the importance of marae-based service delivery and its significance to cultural empowerment. The concept of cultural empowerment is preeminent, particularly for indigenous peoples such as Māori due to historical and environmental factors that

continue to impact on their health and wellbeing. Although some Māori providers do not operate from a marae-based setting, they have vital links to these resources that facilitate cultural empowerment.

Māori responses towards BSMC have focused on implementing Whānau Ora as the preferred model of health care delivery for Māori and whānau. Led by larger Māori coalitions that operate under tikanga-based principles, Māori providers engage regularly with sectoral and wider intersectoral services and supports and have developed extensive networks throughout New Zealand. For Māori providers with GP services (who are part of larger coalitions) there is support in terms of appropriate cost effective after hour cover, innovative clinical programmes, links to secondary care services and community health promotion programmes. Smaller Māori provider organisations also benefit from greater support in achieving integrated health service delivery. Groups of smaller Māori coalitions also exist; at the time this research began, Whakapai Hauora was not part of a provider collective. At present, Whakapai Hauora is part of the Te Tihi o Ruahine Alliance Collective⁶⁸ comprising of 6 Māori providers and 2 national organisations which was granted approval by the Ministry of Health in 2012, allowing them to develop a programme of action towards achieving Whānau Ora.

Te Tihi o Ruahine Alliance are currently trialling the role of Whānau Ora navigators. Boulton et al (2013) however, noted challenges associated with this role in relation to recruitment and retention of culturally competent staff, the development of a validated training programme for Whānau Ora navigators, a framework and tool which can assess whānau at level of entry into the service and monitor whānau gains over time, and significantly, whānau ora outcome measures. These are all crucial factors to consider which raise challenges for Whānau Ora collectives in terms of implementing the concept and the role of Whānau Ora navigators within their communities, including Whakapai Hauora who is now part of Te Tihi o Ruahine Whānau Ora Alliance. Boulton et al (2013) also stated that a major challenge from a public policy standpoint would be contracting and accountability as Whānau Ora concepts may vary

⁶⁸ Te Tihi o Ruahine Whānau Ora Alliance Collective: see Te Puni Kokiri website: <http://www.tpk.govt.nz/en/in-focus/whanau-ora/providers/>

regionally, between organisation, providers and funders, and also among providers and whānau themselves. Boulton et al (2013) indicated that flexibility in design, operation, contracting and evaluation need to be specific to localities. Chomik (2007) suggested that service contracts should align with intersectoral work and be flexible in terms of financial arrangements where there is shared funding; Durie (2013) suggested that this could occur with integrated government policies. All these critical factors that impact on the delivery of Whānau Ora need to be addressed at macro-levels of service integration. Boulton et al (2013) also noted that a significant factor for Whānau Ora success is local community and Māori buy-in. In a nutshell, this would entail re-orientating and steering both government priorities and communities towards the best interests of Whānau Ora; where the best outcomes for Māori and whānau are widely promoted sectorally and intersectorally.

Addressing the broad research questions

Whakawhirinakitanga Ahua is a model of service delivery derived from Te Ao Māori based on cultural values and principles. In addressing the broad research questions, this study identified that the model is reflective of health service delivery at Whakapai Hauora as whanaungatanga is key in service provision and delivery. It also highlighted the values and principles that underpin health service delivery. Respondents in this study who were Māori service users believed that health service delivery was holistic, and tikanga-based service delivery as identified in this research was capable of addressing their health needs including whānau needs.

Implications of this Research

Māori and mainstream providers

While BSMC initiatives are focused on sectoral integration as a means of shifting some of the burden of secondary care into the community with greater access to comprehensive health services, Whānau Ora initiatives are centred on intersectoral integration to include wider related support services such as justice, education and social services. This approach to health and wellbeing is based on indigenous holistic

concepts that prioritise interrelatedness and interconnectedness. Te Ao Māori underpins Māori models of service delivery which are distinct from community-based models of mainstream primary healthcare. As a Māori model of service delivery, Whakawhirinakitanga Ahua assumes the importance of culture in relation to health and wellbeing. This research reaffirms how closely culture and health are entwined. As a consequence, Māori providers prioritise tikanga-based models and intersectoral pathways to meet the diverse needs of Māori and whānau in their communities to health, social and cultural development, so as to maximise potential benefits and outcomes for Māori.

From this approach, there are also implications for mainstream service providers working with Māori and whānau who have much to gain from having an awareness of tikanga-based service delivery in terms of collaboration. This may strengthen outcomes in the provision and delivery of care for Māori and whānau accessing mainstream services. Despite differences between Better Sooner More Convenient Care and Whānau Ora service delivery, both are capable of complementing each other where knowledge, skills and expertise are shared and best utilised for Māori health gains.

What this research challenges

This research challenges health professionals to consider how they perceive holistic health care for Māori within their communities. A Whānau Ora approach requires health professionals to re-examine fundamental key values in practice which determine the way they advocate, empower and provide care for Māori (Wilson, 2009). Client-centred practice has been a long-standing accepted philosophy in terms of holistic approaches to care. Whānau Ora on the other hand, is an indigenous approach to models of care requiring service providers to place whānau central to all service delivery activities. It challenges health professionals and workers to reconsider the way in which they engage with Māori and whānau; shifting mind-sets from working with individuals to working with whānau as a collective. It also challenges health professionals and workers to acknowledge the wider environment and the determinants that impact on health and wellbeing. Consequently, these

challenges affect the way in which service delivery models are developed and the reorientation of goals.

This research confirms that Whakapai Hauora is a whānau-centred, rather than a “*client-centred provider*” as mentioned in its vision statement; findings have demonstrated that both Māori and non-Māori respondents delivered whānau focused care. Although non-Māori respondents considered their care to be client-centred they included whānau needs and priorities in the provision of care and recognised whānau as a collective with strengths and capabilities. The term “*whānau-centred provider*” would be more appropriate and realistic in terms of achieving Whakapai Hauora’s vision towards whānau ora. Whānau ora models of service delivery such as Whakawhirinakitanga Ahua also challenge primary health care models of service delivery that focus mainly on sectoral integration. While greater access to secondary care will be of benefit, access to wider related supports are also important. Māori health service delivery considers the wider determinants of health such as social impacts, justice and education as being significant in terms of addressing whānau health and wellbeing. Mainstream providers involved in the delivery of care for Māori and whānau would benefit by establishing strong working partnerships with Māori providers who work intersectorally (such as Whānau Ora navigators) and have links to hapū, iwi and marae.

This research also highlights Māori and mainstream engagement in practice. It provides opportunity for policy and decision makers involved in health service delivery to rethink the use or adaptation of international trends, systems or models of collaborative care towards health service integration. While policy, practice and research are vital components of public health, the link between researchers, practitioners and policy makers tend to be weak (Jansen et al, 2010). It is critical to re-examine local evidence-based research driven by the very communities that public health policy affects. While this is already driven by Government and DHBs, the way in which results are applied and evaluated is crucial as this creates the ‘evidence-base’. Tikanga-based models of collaborative service delivery, particularly for Māori are noteworthy in terms of more accessible and relevant services for Māori. Tikanga-based models of service delivery serve in ways that can illustrate dual

purposes; for Māori in terms of cultural-based service delivery and also for mainstream stakeholders and funders in relation to Treaty principles and obligations in the provision of services. Whakawhirinakitanga Ahua is one example of how this may be achieved in the community with pathways that accommodate Māori values and tikanga, as well as mainstream Treaty principles.

Possible improvements to Whakawhirinakitanga Ahua

This study indicated that there is another worldview operating parallel to Te Ao Māori in service delivery which stems from a Te Ao Pākehā perspective. From this study there are two dimensions to the model which unfold as holistic concepts and approaches to health, wellbeing and relationships. At this stage, more research is required to investigate the model's further potential towards whānau ora. Under Te Tihi o Ruahine Alliance, Whakapai Hauora now has a Whānau Ora navigator working with individuals and whānau to achieve Whānau Ora objectives. There is a need for further evidence-based research of the model's potential towards achieving fully integrated care in terms of the Whānau Ora initiative. There is also a need for the development of outcome measures aligned with the Whānau Ora initiative. At present, as a model of service delivery, it continues to develop and evolve and further research will allow for improvements and changes to be made. Drawing from the data, the next sections in this chapter provide a closer look into the two dimensions of the model.

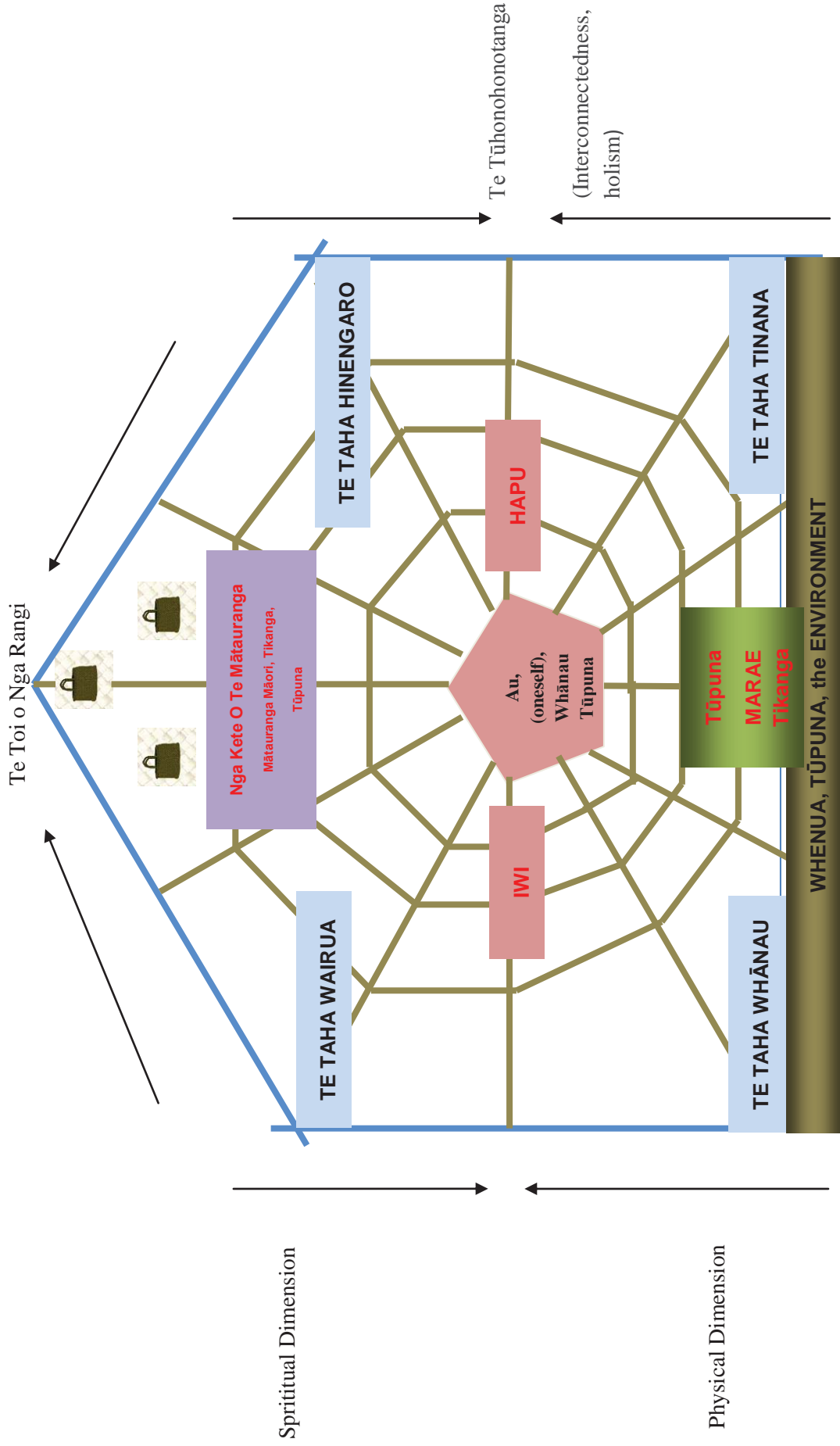
Whakawhirinakitanga Ahua holistic framework from a Te Ao Māori perspective

From Māori respondents' views, Whakawhirinakitanga Ahua is depicted as "*our web of service*" (D: 1, 2) within a whare supported by four pillars which is "*an encasement of Te Whare Tapa Wha*" (C: 3 4). Taha Wairua and Taha Hinengaro are at the top corners of the whare, while Taha Whānau and Taha Tinana are aspects of health and wellbeing on the physical plane, and therefore situated at the bottom corners of the whare, close to the land and the environment. Tūpuna (ancestors) are placed in both spiritual and physical dimensions. Although they are in the spiritual realm, the presence of tūpuna are seen as being everywhere; in the heavens, the marae, whenua,

the environment as “*our tūpuna are guiding us in what we do*” (B: 6). A sense of wairua was also clearly articulated by respondents in this study. The peak of the whare represents the highest of heavens (Te Toi o Nga Rangi) from where the three baskets of knowledge (nga kete o te mātauranga) came. The three baskets contain mātauranga Māori from which tikanga emerges. Mead (2003, p: 12) described tikanga as being “*tools of thought and understanding*” but also stated that tikanga can be considered as Māori “*ethic*” involving “*moral judgements*” (p: 6) that guide behaviour and everyday living. Tikanga guides the way that services are delivered at Whakapai Hauora to Māori and whānau, and also the way in which relationships are built and sustained. The original concept of these kete (developed within the model in 2004) was expanded upon, to include interaction between mātauranga and western science; to work at the interface incorporating knowledge from specialists, health professionals, key workers and mainstream community workers involved in client and whānau care.

At the centre of the web, are whānau and individuals seen within the context of their whānau. Whānau are central to all activities in health service delivery. Next to whānau are “*hapū, iwi*” (A: 2), representative of people who are at the interface of the spiritual and physical planes; as for Māori, both spiritual and physical worlds are inherently linked. The marae, also located within the web, links Māori to their land and ancestors: “*Tūturu Pumau [Rangitaane o Manawatu marae] that represents importantly the whenua, our tūpuna*” (D: 1, 2). Whānau activities and cultural practices such as “*waiata, kapa haka, raranga*” (A27: 3) take place on a marae, maintaining Māori traditions and customs. Maori consider marae as tūrangawaewae (a place to stand and belong). Whenua and the environment are located at the very base of the web representing the physical plane and are significant in terms of natural resources that nurture and sustain all life. The diagram on the following page illustrates these concepts in this research:

Diagram 3: Whakawhirinakitanga Ahua holistic framework from a Te Ao Māori perspective

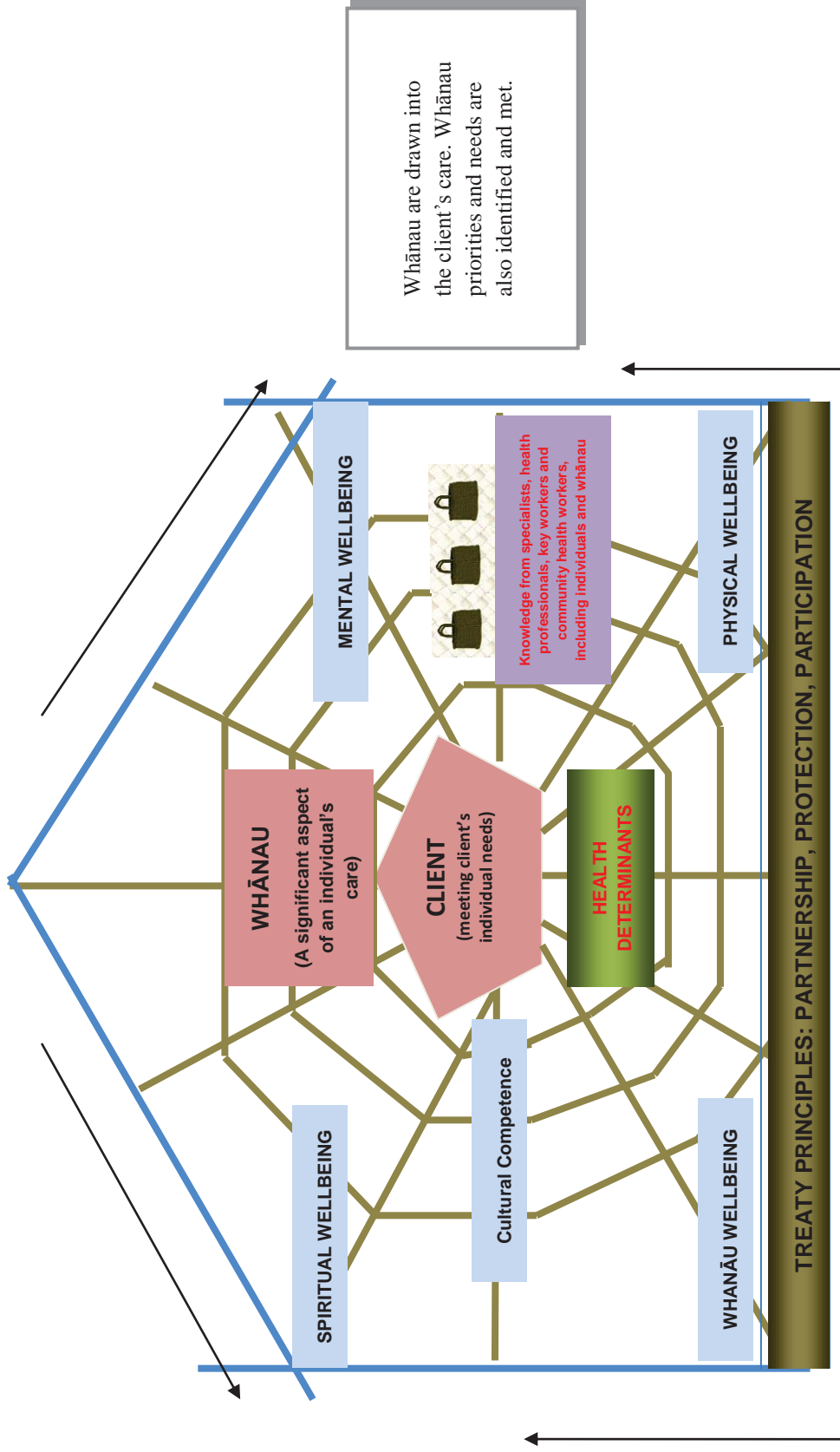


Whakawhirinakitanga Ahua holistic framework from a Te Ao Pākehā perspective

Non-Māori respondents gave insights into another dimension of the model stemming from a western worldview. The client is central to all activity and meeting all of clients' individual needs are key concepts of care. Whānau are acknowledged as being a collective with the capacity to share the care of an individual; whānau strengths are utilised and active whānau participation is encouraged in care. Rather than tikanga, the Treaty principles, cultural competence, specialist knowledge (western science) and knowledge obtained from individuals and whānau guide health service delivery in order to weave wrap-around services. The three kete are seen as one of the key drivers of health service delivery at Whakapai Hauora situated within the web.

Non-Māori respondents had an understanding of Te Whare Tapa Wha and its application in the provision of client-centred care. Addressing health determinants are also part of holistic approaches. Non-Māori respondents indicated that "*cultural safety is part of our practicing competencies*" (I: 6). Respondents indicated that cultural competence is a crucial factor in relation to meeting all of client needs and is considered as an integral aspect of holistic care. It provides knowledge of and sensitivity to cultural factors that influence health behaviours and processes that occur along an illness and wellness continuum; such as grief, death and healing (Mariano, 2007). Addressing health determinants were also considered by respondents as being a significant part of holistic approaches in meeting client/whānau priorities and needs. The diagram on the next page illustrates these concepts in this research:

Diagram 4: Whakawhirinakitanga Ahua Holistic Framework from a Te Ao Pākehā perspective



Client-centred care with whānau inclusion

The web of relationships within Te Ao Māori

Whanaungatanga and manaakitanga underpin the concept of the web of working collectives. All relationships are integral to achieving best possible outcomes for Māori and whānau who are at the centre of care. An individual's health and wellbeing is seen within the context of whānau dynamics due to the impacts one has upon the other. Respondents who accessed services indicated that there are gains for whānau as a whole, who benefit from healthier lifestyle choices. Immediate relationships within the web are among Whakapai Hauora health professionals who deliver collaborative care from a variety of health, social and disability support services available within the organisation itself. Important links are also with hapu, iwi and marae. Respondents delivering services indicated that networks such as secondary and other primary care providers are a critical aspect of relationships as they work at the interface to maintain a seamless continuum of care. Establishing and strengthening relationships with wider related support providers (e.g. social, justice, and education sectors) are an important aspect in achieving holistic approaches towards health and wellbeing for Māori and whānau. These relationships are also significant in terms of bridging the wider gaps and addressing determinants that impact on health and wellbeing. Regional community services and national health, social and disability support services are broader links within the web, yet also important in terms of access to screening services, provider training and workforce up-skilling.

The web of relationships within Te Ao Pākehā

Reciprocal relationships underpin the concept of the web where working as a team with shared responsibilities are a critical factors. Relationships among themselves (within their own organisation), with secondary, primary and wider related service providers are also similar to a Te Ao Māori perspective within the web. Whānau are 'drawn in' to share the care of an individual member. It is through recognising whānau as being an integral aspect of care, whānau needs are also identified, and addressed. The focus then shifts to centre on both individual and whānau needs.

Building and maintaining whānau relationships are equally important; benefits for whānau are similar as through sharing care, they have a better understanding of illness, preventative measures and are capable of making healthier lifestyle choices. Relationships with networks are significant in terms of establishing key contacts towards gaining better access to services for clients and whānau. The benefits for sustaining relationships with regional and national networks are also consistent with Te Ao Māori perspectives within the web.

Research Reflections

This study began with a set of broad questions relating to service delivery at Whakapai Hauora in order to explore the model Whakawhirinakitanga Ahua in relation to underlying values and principles, and if service delivery addressed the needs of Maori who accessed services at Whakapai Hauora. Initially, a key driver for this research on my part was the knowledge that by ‘Māori for Māori’ approaches have been proven successful (Kiro, 2001) and my own perception was that Whakawhirinakitanga Ahua was a model that reflected this. At the onset of the research, questions posed to each group and individual investigated concepts of health and wellbeing; respondent perceptions of how services were delivered; issues associated with service delivery; and client experiences along a care continuum.

There were two different paradigms involved in service delivery, Te Ao Māori and Te Ao Pākehā; and this was an important factor to acknowledge as part of exploring the model. While Māori health service delivery was well articulated in the data and analysis, a mainstream paradigm was also present, derived from data that captured the views and experiences of non-Māori working in a Māori environment. Being immersed in a Māori environment, they were supported by their colleagues and management to work in ways that met Māori and whānau health needs. This research demonstrated that respondents delivering services were consistently walking in both worlds, Te Ao Māori and Te Ao Pākehā. At all times, health professionals handle pressures from both worlds in order to address client and whānau needs effectively, to work collaboratively with others providers to achieve

desired outcomes in service delivery, and meet funder expectations in terms of contractual obligations.

This research identified Whakawhirinakitanga Ahua as a holistic and values based model; whanaungatanga is the glue that binds both Māori and non-Māori to work towards achieving desired outcomes in service delivery. It is through positive relationships with Māori that non-Māori have a better understanding of Māori and whānau priorities, needs, and the impacts of health determinants for Māori. It was also apparent, how important the nature of their work was, in order to meet Māori health needs. The extent to which services were delivered often meant going beyond contractual obligations; also a fact that this is not truly reflected in performance measures to service funders.

This research also identified that Whakawhirinakitanga Ahua can work at the interface between Te Ao Māori and Te Ao Pākehā. The way in which tikanga-based principles are understood and adapted by non-Māori working at Whakapai Hauora places Māori and whānau needs central to service delivery processes. It also illustrates a parallel between tikanga-based principles and Treaty principles in order to achieve desired outcomes for Māori and whānau.

The research did not however investigate views of mainstream, wider related support service and other Māori provider relationships in terms of collaborative service delivery with Whakapai Hauora health professionals. Identifying how these groups perceive relationships with Whakapai Hauora health professionals and Whānau Ora navigator, and the effectiveness of collaborative relationships towards fully integrating services requires further research. This will build on existing findings in this thesis and provide greater insights into the model; it will give a clearer picture of tikanga-based service delivery and whānau ora as perceived by a wider group of significant stakeholders. This thesis demonstrated two dimensions to Whakawhirinakitanga Ahua, Te Ao Māori and Te Ao Pākehā. While findings have drawn a distinction between client-centered practice and whānau focused practice, there is an integrated approach to care and service delivery. The model positions the

intrinsic place of culture and how services are delivered to facilitate the integration of both. Another aspect of future research would also be to explore the relevance and applicability of findings to other Māori communities within their own health specific context and environment.

Strengths and Limitations to this Research

Strengths

Strengths in qualitative research methodology allowed for describing complex phenomena with an understanding of respondents' personal experiences. It was also possible to examine how respondents interpreted certain constructs from Te Ao Māori and Te Ao Pākehā perspectives such as holistic health and wellbeing, relationships, values, and principles in health service delivery. The data also captured phenomena occurring from two different paradigms, as a Māori-centred analysis captured phenomena occurring with Māori and non-Māori in relation to services designated by mainstream funders. Findings in this study have also indicated the way in which non-Māori working at Whakapai Hauora utilise significant aspects of tikanga-based service delivery; working in a Māori environment and supported by their peers, they were able to deliver services that met Māori and whānau health needs.

Certain findings have been similar to Boulton's (2005) research which indicated that cultural values compelled Māori mental health providers to go beyond contractual obligations and that providers delivered services from their own understanding of Māori health and wellbeing based on philosophical views of Māori cultural traditions. Boulton's (2005) research also indicated that these are the differences evident between Māori and mainstream service provision. Boulton (2005) noted that performance measurement was inadequate in reflecting the extent of work done by Māori mental health providers. This study also demonstrated that barriers to healthcare for Māori as identified in previous research (Jansen, 2009; Cram et al, (2003); Bryant and Campbell, 1996) such as cost, transport, mainstream provider attitudes towards clients and whakamā continue to exist. Jansen (2009) and Cram et

al (2003) also noted that Māori experiences of healthcare are influenced by their past experiences including the experiences of their whānau, which was also evident from the data in this study.

Findings in this research build upon these studies highlighting the differences between mainstream and Māori health service delivery from the experiences of both Māori and non-Māori health professionals delivering services as well as Māori accessing healthcare at Whakapai Hauora. It demonstrated the extent of work involved in collaborative processes with other professionals, service providers and also with clients and whānau in the delivery of integrated care (within the context of primary and secondary care, including wider health related support services). It demonstrated how a tikanga-based service delivery model is utilised by both Māori and non-Māori within a Māori health organisation with whānau focussed approaches to care that addressed Māori needs. It demonstrated potential towards achieving desired outcomes for Māori and whānau ora.

This study's original contribution to knowledge

This thesis explored health service delivery processes at Whakapai Hauora, an iwi health provider from the perspectives of 19 health professionals (Māori and non-Māori) and 31 Māori who accessed services. It provided an insight into health concepts and whānau ora service delivery from the perspectives of both service users and Health professionals. It demonstrated how both health professionals and Māori clients/whānau at Whakapai Hauora perceive iwi based integrated health service delivery within the context of primary and secondary health care as well as wider health related support services. This knowledge is important and relevant to health providers as it gives an understanding of tikanga-based principles and values; and its application in service delivery with potential pathways towards achieving whānau ora.

This research demonstrated features of integrated care identified within literature: horizontal integration (primary care providers working collaboratively within Whakapai Hauora to integrate care); and vertical integration (the integration of

primary and secondary care). It also demonstrated the way in which Whakapai Hauora health professionals work intersectorally across health, social and wider related support services to deliver care for individuals and whānau. However, this study also demonstrated an additional feature to integrated care that is not identified in current literature; the integration of two worldviews in the delivery of care. At both horizontal and vertical levels of integration, health professionals at Whakapai Hauora are able to draw on the strengths of both worldviews in order to facilitate better outcomes for Māori.

Limitations

This research focused on exploring a Māori model of health service delivery with several sets of respondents; those who delivered health, social and disability support services at Whakapai Hauora, and Māori health consumers who were clients and whānau accessing these services. It is important to take into account the context and settings of this study as findings cannot be generalized to other Māori or iwi providers due to significant variables such as provider capacity, capability, diversity, and their own unique understanding of whānau ora service delivery derived from Te Ao Māori. However, those who have similar experiences in collaborative care may be able to utilise findings from this research to assist them in developing pathways towards achieving better integration with mainstream services.

Whānau that participated in this study consisted of couples (who were part of a larger whānau). Other whānau and extended members were not part of this study. The main focus of this research was service provision and the use of the model in service delivery. Due to time constraints and work commitments, it was decided to interview individual clients and couples, rather than several sets of larger whānau. However, the views of clients and whānau concerning their experiences are of value, as findings in the data have highlighted that whānau experiences impact on individuals and vice versa. External stakeholders such as mainstream / other Māori primary, secondary care and wider related support service providers that work with Whakapai Hauora staff were also not interviewed due to time and work constraints again. Therefore findings in relation to intersectoral collaboration and pathways relate directly to the

views of respondents delivering services who participated in this study. However, their insights into collaborative processes with other providers also have value due to their experiences of working directly at the interface between sectoral and intersectoral service provision.

Conclusion

The broad research questions posed initially in this thesis have been addressed. This research employed qualitative research methods with a Māori-centered approach to analyse data. This study demonstrated that tikanga-based service delivery creates an avenue for whānau ora and whanaungatanga is significant in collaborative care settings. Whakawhirinakitanga Ahua is a system of interdependence derived from nga kete o te mātauranga and delivered within the framework of Te Whare Tapa Wha. It is a model based on intersectoral collaboration towards a multidisciplinary approach in addressing the health needs of clients and whānau. The original model developed in 2004 was depicted as a series of relationships fanning out to form a collective web with the client at the centre. Each relationship within the web relies on the other for support, strength and sustainability; therefore it is important to note that all values identified in this research are significant towards maintaining relationships.

The overall aims of this study have been achieved. These were to investigate the processes of health service delivery at Whakapai Hauora and determine if health service delivery addressed the needs of Māori accessing services by drawing upon the experiences, attitudes and beliefs of key respondents in this study. Another aim was to establish possible improvements to the model. This thesis recognises the knowledge and expertise from both Te Ao Māori and Te Ao Pākehā in terms of health service delivery. It demonstrated the significance of health professionals having to walk in both worlds in order to facilitate better outcomes for Māori. Findings have also drawn a distinction between client-centered care and whānau focused care and further research is needed to explore external and internal factors that may limit or promote Māori wellbeing.

Results have placed an emphasis on strong links between culture, health and wellbeing. The intergenerational transfer of knowledge, culture, language and positive lifestyle choices are integral in achieving whānau ora. Role modelling of whānau values by health professionals creates a whānau environment, particularly when working with high risk whānau. There is the likelihood that these values will be reciprocated by individuals and whānau, and also maintained by whānau themselves. Relationships are key to service delivery processes. Positive relationships with whānau have the capacity to empower whānau towards achieving their goals of whānau ora. Building and maintaining positive relationships are also integral towards establishing collaborative service delivery that is streamlined, with clearer intersectoral pathways for client and whānau navigation through comprehensive healthcare. Findings in this research have also highlighted that non-Māori working at Whakapai Hauora were utilising significant aspects of tikanga-based service delivery. They worked in a Māori environment, with support from their peers which enabled them to deliver services that met Māori health needs.

Like all models of health service delivery, Whakawhirinakitanga Ahua continues to develop in a changing health environment; as models continuously adapt to an evolving health care system in New Zealand. Whakawhirinakitanga Ahua has shown the potential to work at the interface of Te Ao Māori and Te Ao Pākehā, with whānau focussed approaches in the delivery of care. This is also a reflection of the culture within the organisation, Whakapai Hauora itself, which draws on both western and Māori models and standards of practice within its structure and organisational processes.

By far, it is significant that tikanga-based values and principles underpin whānau ora service delivery as highlighted in this research. It is also critical for Māori and whānau to have knowledge and understanding of how mainstream services operate as this will assist them to self-navigate their own care. Māori and whānau will be better positioned to make self-determined choices in their care and more confident to self-navigate themselves through a range of comprehensive services that meet their needs.

Māori participants in this study have preference in dealing with one provider in terms of addressing their needs and the role of Whānau Ora navigators is crucial in assisting individuals and their whānau achieve their goals. Finally, new areas of research will provide a clearer picture of the relationships and service delivery processes from wider/extended whānau and external provider perspectives; this will also assist in establishing improvements to Whakawhirinakitanga Ahua and provide a greater insight into the model's further potential towards achieving whānau ora. It is intended that this will be the focus of future research.

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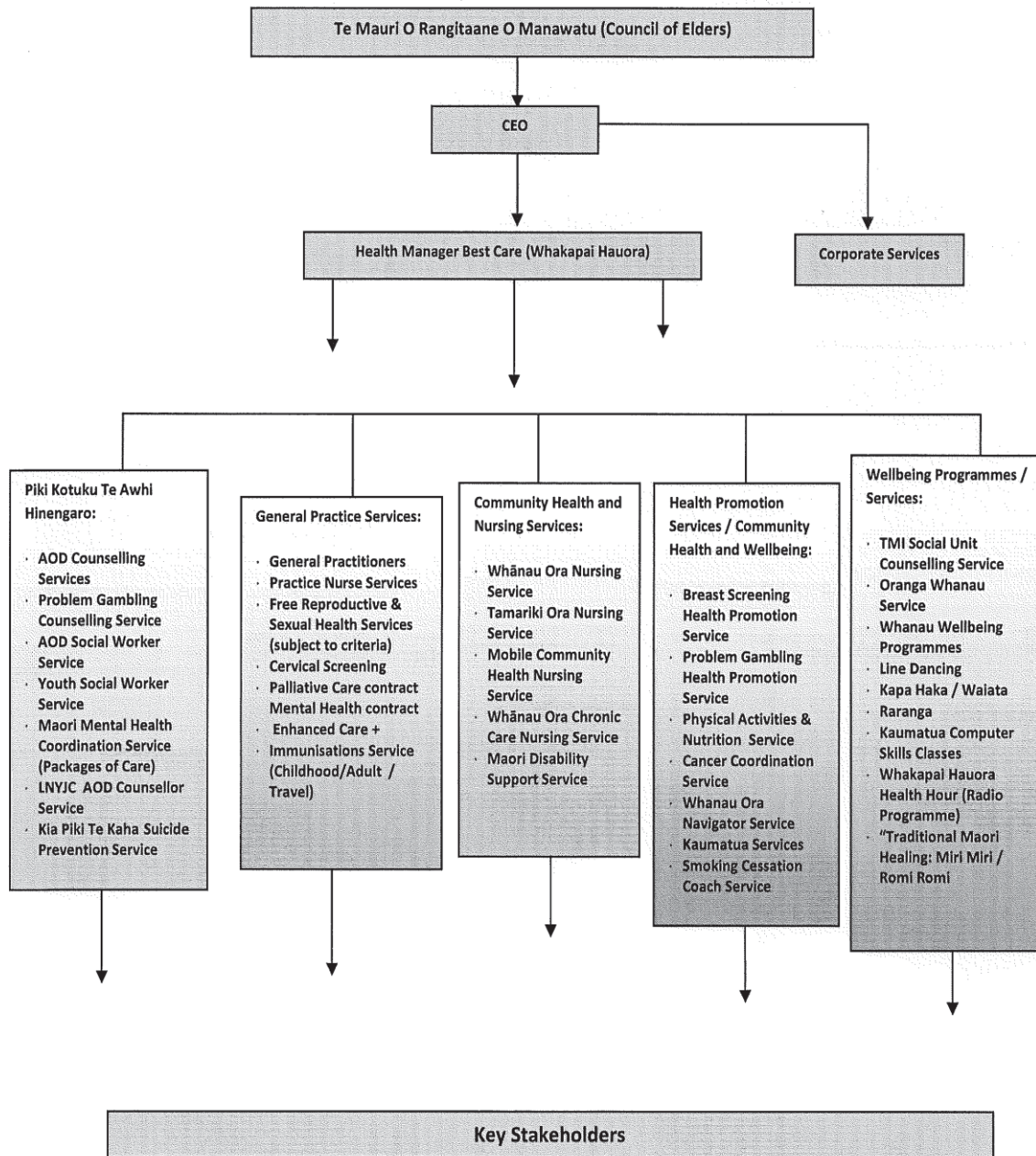
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Appendix 1: Whakapai Hauora organisation structure

Organisational Structure of Whakapai Hauora





Te Mauri O Rangitaane O Manawatu (*Council of Elders*)
Tanenuiarangi Manawatu Incorporated (*Mandated Iwi Authority*)
Phone: (06) 353 1881 Fax: (06) 353 1880 Email: TMI@rangitaane.iwi.nz Website: www.tmi.maori.nz

Best Care (Whakapai Hauora)
Charitable Trust
(Health/Social/Education Services)
Ph: (06) 353 6385
Fax: (06) 353 1883
Email: BCWH@rangitaane.iwi.nz
Website: www.whakapaihauora.maori.nz

Piki Kotuku
Te Awhi Hinengaro
Ph: (06) 353 1884
Fax: (06) 353 1885
Email: Piki.Kotuku@rangitaane.iwi.nz

Kia Ora 89.8 FM
(Radio Station)
Ph: (06) 353 1881
Fax: (06) 353 1880
Studio: Ph (06) 353 1882
Email: KFM@rangitaane.iwi.nz
Website: www.kfm89-8.org.nz

Tūturu Pūmau
Te Hotu Manawa O Rangitaane O Manawatu Marae
140-148 Maxwells Line, PO Box 1341, Palmerston North

15th October 2007

Appendix 2: Letter from CEO Whakapai Hauora

Professor Tairahia Black
School of Maori Studies
Massey University
Palmerston North

Tena koe, nga mihi nui ki a koe i roto i nga tini ahuatanga o te wa nei

LETTER OF SUPPORT AND PERMISSION TO UNDERTAKE PhD RESEARCH AT BEST CARE (WHAKAPAI HAUORA) CHARITABLE TRUST

1. Tanenuiarangi Manawatu Incorporated (the Mandated Iwi Authority) gives Carole Fernandez permission to undertake her PhD study to research "Whakawhirinakitangi Ahua", our model of health service delivery.
2. Tanenuiarangi Manawatu Incorporated also gives Carole permission to access and use the following documents for purposes of undertaking this study:
 - i. Best Care (Whakapai Hauora) Charitable Trust Strategic and Iwi Health Plan 2006-2016;
 - ii. Whakawhirinakitangi Ahua QHNZ Baxter Award Application 2005;
 - iii. Whanau Ora Award Application 2004;
 - iv. Health Service Specifications;
 - v. Health Service Plans;
 - vi. CBG Research Results for Best Care (Whakapai Hauora) Charitable Trust; and
 - vii. MPHO Performance Management Results for Best Care (Whakapai Hauora) Charitable Trust.
3. We wish her well in her study and are confident in her ability to provide a positive outcome for Best Care (Whakapai Hauora) Charitable Trust with this research.
4. If you have any queries or concerns regarding the above, please do not hesitate to contact me.

Heoi ano ra

D.P. Harris (Miss)
CEO

*Ka kabutia i te korowai, Te Rangimarie, Te Aroha, Te Whakaiti, Ka Whakapuawai he iwi humaarie
Spread the cloak of Peace and Love, so shall blossom the people of humility*



Te Mauri O Rangitaane O Manawatu (*Council of Elders*)
Tanenuiarangi Manawatu Incorporated (*Mandated Iwi Authority*)
Phone: (06) 353 1881 Fax: (06) 353 1880 Email: TMI@rangitaane.iwi.nz Website: www.tmi.maori.nz

Best Care (Whakapai Hauora) Charitable Trust (Health/Social/Education Services) Ph: (06) 353 6385 Fax: (06) 353 1883 Email: BCWH@rangitaane.iwi.nz Website: www.whakapaihauora.maori.nz	Piki Komku Te Awhi Hinengaro Ph: (06) 353 1884 Fax: (06) 353 1885 Email: BCWH@rangitaane.iwi.nz	Kia Ora FM 89.8 (Radio Station) Ph: (06) 353 1881 Fax: (06) 353 1880 Studio: Ph (06) 353 1882 Email: kfmstudio@rangitaane.iwi.nz Website: www.kiaorafm898.maori.nz
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Tuturu Pūmau
Te Hotu Manawa O Rangitaane O Manawatu Marae
140-148 Maxwells Line, PO Box 1341, Palmerston North

13th February 2009

Appendix 3: Letter from Te Mauri O Rangitaane

Carole Ann Fernandez
17 Rosalie Terrace
Palmerston North

Tena koe Carole,

Nga mihi nui ki a koe I roto I nga tini ahuatanga o te wa.

Presentation of your study "Whakawhirinakitanga Ahua: exploring an iwi model of health service delivery"

Te Mauri O Rangitaane O Manawatu (Tangata Whenua Council of Elders) (TMOROM) have instructed me to thank you for presenting your research project of the above at their meeting on the 8th of October 2008.

TMOROM appreciate being informed of such a significant study which they trust will assist to improve and enhance the provision of integrated care at Best Care Whakapai Hauora Charitable Trust.

In their opinion, the detail in your proposal captures their philosophy that each life is so very precious in this world, and your efforts are to be commended, as they know –

*Toia mai te waka wairua akoranga,
Maa te mana Mauri te mana motuhake*

*We learn by looking back,
We live by looking forward.*

They wish you every success with your study and are confident in your ability to provide a positive outcome with your research that will assist in health gains for Maori.

Noho ora mai

Maurice Takarangi
President
Tanenuiarangi Manawatu Incorporated
(Rangitaane Mandated Iwi Authority)

*Ka kabutia i te korowai, Te Rangimarie, Te Aroha, Te Whakaiti, Ka Whakapuawai he iwi humaarie
Spread the cloak of Peace and Love, so shall blossom the people of humility*



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Appendix 4: Whakapai Hauora Health Professional (participant) information sheet

Whakawhirinakitanga Ahua: Exploring a Māori model of health service delivery

INFORMATION SHEET

Tena koe,

I am Carole Fernandez, the Health Manager at Best Care (Whakapai Hauora) Charitable Trust in Palmerston North. I am currently undertaking a research project that explores “Whakawhirinakitanga Ahua”, a Māori model of health service delivery developed by Whakapai Hauora in 2004. The purpose of this project is to examine core values and key concepts underpinning this model which will provide some insight into the practiced principles of health service delivery at Whakapai Hauora. This will also identify the collaborative processes involved in integrated care delivered by BCWH. Integrated care can be described as the provision of ‘seamless’ care for those with acute and chronic health conditions at any point within a health care system. It encompasses preventative and social care, as well as care and support in the home based on the premise that social conditions impact on health and conversely. This research that I am undertaking is towards the degree of Doctor of Philosophy in Maori Health at Te Pumanawa Hauora (Research Centre for Maori Health and Development), Massey University. Contact details of my supervisors for this project are listed on page 3 of this information sheet.

This project has two stages. The first stage involves focus group interviews with Whakapai Hauora primary care providers (the G.P. service, Community Health nursing services, Counselling and Social Work services and Disability Support services). In particular, these interviews will provide information about the practiced principles in service provision and delivery in collaborative care at Whakapai Hauora. At the second stage, Whakapai Hauora clients accessing care will be interviewed individually in order to obtain their views and opinions about their own unique and individual patient journey through integrated care.

Participant Recruitment:

I want to hear from Whakapai Hauora service providers providing collaborative care to clients registered with their services. I would like to invite you to participate in this project if you are a provider of one of the following Whakapai Hauora Services:

- G.P. and Practice Nurses (to have one focus group interview);
- Community Health Nurses and Disability Support workers (to have one focus group interview);
- Piki Kotuku Alcohol and Other Drug (AOD) counsellors and Social Workers (to have one focus group interview).

Version 3, 4.2.09

P.T.O

**What you need to know before you consent:
If you decide to take part in this project,**

- Participation in this research is entirely voluntary. Participation or non-participation will not in any way effect your employment with Whakapai Hauora.
- There are no costs to participate in this research
- You will be asked to sign a consent form.
- The number of participants in your focus group will vary depending on which group you are in. This may be between 4 to 5, 7 to 8, or 8 to 10 participants per group.
- Your name and the names of all others in this group will be kept confidential and anonymous.
- The interview venue is Tuturu Pumau (Te Hotu Manawa O Rangitaane O Manawatu Marae) and focus groups will be conducted during working hours. Permission has been granted from BCWH CEO to conduct the interviews during working hours.
- A translator will be available should you wish to speak in Te Reo Maori.
- You agree to the interview being audio-recorded, and for me to take written notes.
- You agree to have the recording transcribed. The transcriber will sign a form agreeing to keep all information confidential.
- You agree to keep all information discussed in the focus group confidential.
- You agree to my supervisors having access to the recording and transcripts.
- You will be presented with a summary of initial findings to provide feedback which will be included in the final write-up of the project.
- All information gathered at the interview will be kept for ten (10) years in a locked cabinet, and then destroyed by the Head of Department, Te Putahi-a-Toi (School of Maori Studies) at Massey University.
- You agree to the information from this project being used for publications arising from this research project.
- No material which could personally identify you will be used in any reports on this study.

Throughout this project, you have the right to:

- Leave (withdraw from) the project before the final write-up of the project. This means withdrawing all the information you have given while participating in this project without fear of recrimination or discrimination regarding your employment at Whakapai Hauora.
- Not answer any questions;
- Ask to turn the audio-recorder off at any stage of the interview; and
- Ask any questions about the project at anytime.

Distribution of findings:

This research will be submitted for examination and lodged as a thesis at Massey University (Palmerston North). A summary report on the findings will be sent to all research participants, Te Mauri O Rangitaane (Council of Elders) and the CEO of Whakapai Hauora. In addition, a full report will be available on request. The research report will also be disseminated to Manawhenua Hauora, MidCentral District Health Board, Ministry of Health, Manawatu Primary Health Care Organisation and Child, Youth & Family Services.

Project contacts:

Please feel free to contact me or my supervisors at anytime, if you have any questions about this project:

The Researcher:

Carole Fernandez
Health Manager
Best Care (Whakapai Hauora)
Charitable Trust
140-148 Maxwells Line
Palmerston North 4414
Ph: (06) 3536385
Fax: (06) 3531883
Email:
carole@rangitaane.iwi.nz

Chief Supervisor:

Professor Tairahia Black
Te Putahi-a-Toi
Level 2, Room. 2.0
Turitea Campus
Massey University
Palmerston North 4414
Ph: (06) 3569099 ext 7458
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Email: T.Black@massey.ac.nz

Second Supervisor:

Dr. Maureen Holdaway
(Deputy Director)
Te Pumanawa Hauora
Research Centre for Maori
Health and Development
Te Kunenga ki Purehuroa
Private Bag 11222
Palmerston North 4414
Ph: (06) 3565799 ext 2986
Email:

M.A.Holdaway@massey.ac.nz

Contact details for Health & Disability Consumer Advocate:

If you have any questions or concerns about your rights as a participant in this research study you can contact an independent health and disability advocate. This is a free service provided under the Health and Disability Commissioner Act.

Phone: (NZ wide): 0800 555 050

Free fax (NZ wide): 0800 2787 7678 (0800 2 SUPPORT)

Email: (NZ wide): advocacy@hdc.org.nz

* This project has received ethical approval from the Lower South Regional Ethics Committee

* Tanenuiarangi Manawatu Incorporated and the CEO of Best Care Whakapai Hauora have given permission for this study to be carried out.

*In the unlikely event of a physical injury as a result of your participation in this study, you may be covered by ACC under the Injury Prevention, Rehabilitation and Compensation Act. ACC cover is not automatic and your case will need to be assessed by ACC according to the provisions of the 2002 Injury Prevention Rehabilitation and Compensation Act. If your claim is accepted by ACC, you still might not get any compensation. This depends on a number of factors such as whether you are an earner or non-earner. ACC usually provides only partial reimbursement of costs and expenses and there may be no lump sum compensation payable. There is no cover for mental injury unless it is a result of physical injury. If you have ACC cover, generally this will affect your right to sue the investigators.

If you have any questions about ACC, contact your nearest ACC office or the investigator.



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Appendix 5: Interview schedule for Whakapai Hauora health professionals

(Focus groups / Individual participants)

Interview Schedule for health professionals:

1. My study is an exploration of Whakawhirinakitanga Ahua, Whakapai Hauora model of service delivery. Can you tell me broadly, what is your understanding of this model as it applies to health service delivery at Whakapai Hauora?
2. Are you familiar with the cultural values and principles outlined in Whakapai Hauora Strategic & Iwi health plan? If so, how do these values and principles apply to the provision and delivery of your health service?
3. What types of services do you collaborate with on a regular basis in terms of providing integrated care for clients / whanau?
4. What are the collaborative approaches you undertake to provide integrated services for your clients? What do you see as being the key elements to effective collaboration with other organisations / service providers?
5. In your opinion, how effective is collaboration towards providing integrated care?
6. What do you see as being barriers to providing collaborative care?
7. What do you think are the necessary elements to make collaborative care more effective towards achieving better client/whanau outcomes?
8. What are your views on outputs in service delivery and how do you think it relates to improved health outcomes for clients / whanau?
9. How do you know when you have been successful in achieving positive outcomes in service delivery for clients/whanau?
10. Do you think that any improvements could be made to Whakawhirinakitanga Ahua in terms of better reflecting the practiced principles in service provision and delivery at Whakapai Hauora? If yes, what can be improved, and for what reasons?
11. Is there anything that you would like to talk about in terms of collaborative care that was not raised previously?

Finally, is there anything that you would like to ask me about this research?

Version 2, 4.2.09



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Appendix 6: Whakapai Hauora client participant information sheet

Whakawhirinakitanga Ahua: Exploring a Māori model of health service delivery

INFORMATION SHEET

Tena koe,

I am Carole Fernandez, the Health Manager at Best Care (Whakapai Hauora) Charitable Trust in Palmerston North. I am currently undertaking a research project that explores “Whakawhirinakitanga Ahua”, a Māori model of health service delivery developed by Whakapai Hauora in 2004. The purpose of this project is to examine core values and key concepts underpinning this model which will provide some insight into the practiced principles of health service delivery at Whakapai Hauora. This will also identify the collaborative processes involved in integrated care delivered by BCWH. Integrated care is the provision of on-going care delivered by more than one health professional for those with acute or chronic health conditions. Integrated care may also include the provision of *secondary services and *wider community support services (which are explained on page 2 of this information sheet). This research that I am undertaking is towards the degree of Doctor of Philosophy in Māori Health at Te Pumanawa Hauora (Research Centre for Māori Health and Development), Massey University. Contact details of my supervisors for this project are listed on page 3 of this information sheet.

This project has two stages. The first stage involves focus group interviews with Whakapai Hauora service providers (the G.P. service, Community Health nursing services, Counselling and Social Work services and Disability Support services). In particular, these interviews will provide information about the practiced principles in service provision and delivery towards collaborative care at Whakapai Hauora. At the second stage, Whakapai Hauora clients accessing care will be interviewed individually in order to obtain their views and opinions about their own unique and individual patient journey through integrated care.

Participant Recruitment:

I am wanting to hear from Māori clients accessing primary health services at Whakapai Hauora (this includes G.P. and nursing services, social work services, counselling services and disability support services). I would like to invite you to participate in this project if you Māori, 18 years or older and are currently accessing a Whakapai Hauora service (or services) as well as:

- any secondary service or services, and / or
- any wider community support service or services

P.T.O.

* **Any secondary service (or services)** refers to any hospital-based service or services (for example, outpatient clinics or nursing services).

* **Any wider community support service (or services)** refers to any government agency (or agencies) or non-government organisation (or organisations).

Some examples of government agencies are: Work and Income New Zealand, Community Probation Services, Child Youth & Family Services, Accident Compensation Corporation, Housing New Zealand, etc.

Some examples of non-government organisations are: Methodist Social Services, budgeting services, MASH Trust, etc. Non- government organisations also include any other community health service providers such as other Māori or non-Māori health providers.

**What you need to know before you consent:
If you decide to take part in this project,**

- Participation in this research is entirely voluntary. Participation or non-participation will not in any way effect the provision of care and services to you and your whanau at Whakapai Hauora.
- There will be no costs to participate in this research.
- You will be asked to sign a consent form and your name will be kept confidential and anonymous.
- You will be interviewed individually and asked to share your views and opinions about your own unique and individual patient journey through care as a client at Whakapai Hauora. If you wish, you may have a person of your choice, or whanau members to support you at your interview.
- Transport will be provided to and from the interview venue Tūturu Pumau, (Te Hotu Manawa O Rangitaane O Manawatu Marae) if required.
- If you do not wish to be interviewed at the venue, you can be interviewed in your home or at a place of your own choice.
- A translator will be available should you wish to speak in Te Reo Māori.
- You agree to the interview being audio-recorded, and for me to take written notes.
- You agree to my supervisors having access to the recording and transcripts.
- You agree to have the recording transcribed. The transcriber will sign a form agreeing to keep all information confidential.

- You agree to the information from this project being used for publications arising from this research project.
- No material which could personally identify you will be used in any reports on this study.
- You will be given a copy of your transcript to edit any information you have given during the interview. You will also receive a summary of findings and provide some feedback to me about the initial results. Your feedback will be included in the final write-up of the project.
- All information gathered at the interview will be kept for ten (10) years in a locked cabinet, and then destroyed by the Head of Department, Te Putahi-a-Toi (School of Māori Studies) at Massey University.

Throughout this project, you have the right to:

- Leave (withdraw from) the project before the final write-up of the project. This means withdrawing all the information you have given while participating in this project without fear of recrimination or discrimination regarding your health care at Whakapai Hauora.
- Not answer any questions;
- Ask to turn the audio-recorder off at any stage of the interview; and
- Ask any questions about the project at anytime.

Distribution of findings:

This research will be submitted for examination and lodged as a thesis at Massey University (Palmerston North). A summary report on the findings will be sent to all research participants, Te Mauri O Rangitaane (Council of Elders) and the CEO of Whakapai Hauora. In addition, a full report will be available on request. The research report will also be disseminated to Manawhenua Hauora, MidCentral District Health Board, Ministry of Health, Manawatu Primary Health Care Organisation and Child, Youth & Family Services.

Project contacts:

Please feel free to contact me or my supervisors at anytime, if you have any questions about this project:

The Researcher:

Carole Fernandez
Health Manager
Best Care (Whakapai Hauora)
Charitable Trust
140-148 Maxwells Line
Palmerston North 4414
Ph: (06) 3536385
Fax: (06) 3531883
Email:
carole@rangitaane.iwi.nz

Chief Supervisor:

Professor Taiarahia Black
Te Putahi-a-Toi
Level 2, Room. 2.0
Turitea Campus
Massey University
Palmerston North 4414
Ph: (06) 3569099 ext 7458
Fax: (06) 3505634
Email: T.Black@massey.ac.nz

Second Supervisor:

Dr. Maureen Holdaway
(Deputy Director)
Te Pumanawa Hauora
Research Centre for Māori
Health and Development
Te Kunenga ki Purehuroa
Private Bag 11222
Palmerston North 4414
Ph: (06) 3565799 ext 2986
Email:

M.A.Holdaway@massey.ac.nz

P.T.O.

Contact details for Health & Disability Consumer Advocate:

If you have any questions or concerns about your rights as a participant in this research study you can contact an independent health and disability advocate. This is a free service provided under the Health and Disability Commissioner Act.

Phone: (NZ wide): 0800 555 050

Free fax (NZ wide): 0800 2787 7678 (0800 2 SUPPORT)

Email: (NZ wide): advocacy@hdc.org.nz

* This project has received ethical approval from the Lower South Regional Ethics Committee.

* Tanenuiarangi Manawatu Incorporated and the CEO of Best Care Whakapai Hauora have given permission for this study to be carried out.

*In the unlikely event of a physical injury as a result of your participation in this study, you may be covered by ACC under the Injury Prevention, Rehabilitation and Compensation Act. ACC cover is not automatic and your case will need to be assessed by ACC according to the provisions of the 2002 Injury Prevention Rehabilitation and Compensation Act. If your claim is accepted by ACC, you still might not get any compensation. This depends on a number of factors such as whether you are an earner or non-earner. ACC usually provides only partial reimbursement of costs and expenses and there may be no lump sum compensation payable. There is no cover for mental injury unless it is a result of physical injury. If you have ACC cover, generally this will affect your right to sue the investigators.

If you have any questions about ACC, contact your nearest ACC office or the investigator.



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Appendix 7: Whakapai Hauora Health Professionals (Focus Group / Individual) consent form

Whakawhirinakitanga Ahua: Exploring a Māori model of health service delivery

PARTICIPANT CONSENT FORM: FOCUS GROUP

Please tick:

REQUEST FOR INTERPRETER

English	I wish to have an interpreter.	Yes	No
Māori	E hiahia ana ahau ki tetahi kaiwhakamāori/kaiwhaka pakeha korero.	Ae	Kao

Please tick an answer:

- | | |
|---|----------|
| 1. I have read and I understand the information sheet dated 18.8.08 for participants taking part in the study designed to explore Whakawhirinakitanga Ahua, a Māori model of service delivery. | Yes / No |
| 2. I have had the opportunity to discuss this study and am satisfied with the answers I have been given. | Yes / No |
| 3. I have had the opportunity to use whanau support or a friend to help me ask questions and understand the study. | Yes / No |
| 4. I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time and this will in no way affect my employment at Best Care Whakapai Hauora. | Yes / No |
| 5. I understand that my participation in this study is confidential and that no material which could identify me will be used in any reports on this study. | Yes / No |
| 6. I understand that there are no compensation provisions for this study. | Yes / No |
| 7. I agree not to disclose anything discussed in the focus group. | Yes / No |
| 8. I have had time to consider whether to take part. | Yes / No |
| 9. I know who to contact should I have any questions about this study. | Yes / No |
| 10. I consent to my interview being audio-taped/video-taped. | Yes / No |
| 11. I wish to receive a copy of the findings in this research | Yes / No |

Version 3, 4.2.09

Te Kunenga
ki Pūrehuroa

Te Pūtahi-a-Toi - School of Māori Art, Knowledge & Education
 Private Bag 11222, Palmerston North 4442, New Zealand T 06 356 9099 extn 80878 or 84358
 E TePutahi-a-Toi@massey.ac.nz <http://maori.massey.ac.nz>

I _____ (full name) hereby consent to take part in this study.

Date :

Signature :

Full name of Researcher: Carole Ann Fernandez

Contact Phone Number for researcher: (06) 3536385

Project explained by: Carole Ann Fernandez

Project role: Principle researcher

Date:

Signature:



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Appendix 8: Whakapai Hauora client consent form

Whakawhirinakitanga Ahua: Exploring a Māori model of health service delivery

PARTICIPANT CONSENT FORM

Please tick:

REQUEST FOR INTERPRETER

English	I wish to have an interpreter.	Yes	No
Maori	E hiahia ana ahau ki tetahi kaiwhakamaori/kaiwhaka pakeha korero.	Ae	Kao

Please tick an answer:

1. I have read and I understand the information sheet dated 18.8.08 for volunteers taking part in the study designed to explore Whakawhirinakitanga Ahua, a Māori model of service delivery. Yes / No
2. I have had the opportunity to discuss this study and am satisfied with the answers I have been given. Yes / No
3. I have had the opportunity to use whanau support or a friend to help me ask questions and understand the study. Yes / No
4. I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time and this will in no way affect my future health care/continuing health care at Best Care Whakapai Hauora. Yes / No
5. I understand that my participation in this study is confidential and that no material which could identify me will be used in any reports on this study. Yes / No
6. I understand that there are no compensation provisions for this study, except that transport will be provided to and from the interview venue should I need this to be provided for me. Yes / No
7. I have had time to consider whether to take part. Yes / No
8. I know who to contact should I have any questions about this study. Yes / No
9. I consent to my interview being audio-taped/video-taped. Yes / No
10. I wish to receive a copy of the findings in this research Yes / No

Version 3, 4.2.09

Te Kunenga
ki Pūrehuroa

Te Pūtahi-a-Toi - School of Māori Art, Knowledge & Education
Private Bag 11222, Palmerston North 4442, New Zealand T 06 356 9099 extn 80878 or 84358
E TePutahi-a-Toi@massey.ac.nz <http://maori.massey.ac.nz>

I _____ (full name) hereby consent to take part in this study.

Date :

Signature :

Full name of Researcher: Carole Ann Fernandez

Contact Phone Number for researcher: (06) 3536385

Project explained by: Carole Ann Fernandez

Project role: Principle researcher

Date:

Signature:



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AND SOCIAL SCIENCES
TE KURA PŪKENGĀ TANGATA

Appendix 9: Whakapai Hauora interview schedule for client interviews

Interview Schedule for Clients (participants)

1. My study is an exploration of Whakawhirinakitanga Ahua, Whakapai Hauora model of health service delivery. Can you tell me broadly, what are your views of health and wellbeing?
2. What is of value to you in terms of your health and wellbeing for you and your whanau?
3. Which service / services do you access at Whakapai Hauora, and in your opinion, does your service provider have an understanding of your needs concerning your own health and wellbeing? Would you expect this of Whakapai Hauora service providers?
4. What other services do you access, other than Whakapai Hauora Services? Do the other providers of these services have an understanding of your needs in relation to your own health and wellbeing?
5. Are your whanau involved in your care?
6. Can you tell me about your experiences with Whakapai Hauora service providers?
7. Can you tell me about your experiences with other service providers that you have accessed as part of your care?
8. Have you experienced any barriers to accessing services that you need towards maintaining your health and wellbeing?
9. What do think have been positive experiences for you in the provision of care?
10. What would you consider as being an increase in levels of health and wellbeing for you?
11. What difference (if any) has service delivery made towards achieving increased levels of health and wellbeing for you? If so, what are the factors that have contributed towards increasing health and wellbeing for you?
12. What needs to occur in order for service delivery to be more successful in terms of meeting your health needs (and assisting whanau who are involved in your care)?
13. Is there anything that you would like to talk about concerning your own unique journey through integrated care that you would like to share?

Finally, is there anything that you would like to ask me about this research?

Version 2, 4.2.09



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Appendix 10 – Stakeholder hui

Whakawhirinakitanga Ahua: Exploring an iwi model of health service delivery

(A PhD study at Te Pumanawa Hauora, Research Centre for Maori Health & Development, Massey University)

A presentation of preliminary findings from Stage 1 and 2 of this study will be presented

By: Carole Fernandez (Health Manager)

At: Tuturu Pumau, Te Hotu Manawa O Rangitaane O Manawatu Marae
140-148 Maxwells Line, Palmerston North

On: the 30th of July 2010 at 11 a.m.

In 2004, Best Care (Whakapai Hauora) Charitable Trust developed its own model of health service delivery “Whakawhirinakitanga Ahua” to address and meet the needs of clients and whanau accessing its health, social and disability support services. This model is based on intersectoral collaboration and a multidisciplinary approach towards achieving wellbeing, particularly aimed at Māori and their whanau.

Carole will describe her study, discuss the effectiveness of the model underpinned by whanau ora principles and its application in health service delivery at Whakapai Hauora. She will share preliminary findings from her collected data.

Light refreshments will be served.

RSVP by the 26th of July to:

Jenny Wikeepa - email: jenny@rangitaane.iwi.nz
Phone: (06) 3536385 (Best Care Whakapai Hauora)

Appendix 11: Feedback from attendees at Stakeholder Hui

Carole Fernandez

From:

Sent:

To:

Carole Fernandez

Subject:

RE: PhD

Kia ora Carole,

Firstly thank you for including me in the feedback, especially as I left early on.
Secondly I must say "WELL DONE", there is a lot of work done and you have accurately captured what most of us working in Maori Health know, that truly integrated care has many barriers and that those of us working at the coal face often go above and beyond our service delivery to ensure that our Tangata Whaiora and Whanau receive support and care in the appropriate "package" for them. Your research has identified and accurately captured this. This so much shows that Whanau Ora is the key to Maori Health Care. Maori Health Providers know this and most area already and have been for some time practicing this way.
Thirdly your presentation is simple and easy to understand and I think that it accurately reflects what those interviewed were saying,so well done and let me know how it all goes.

It is interesting in that as I have read through thi I hear my staff and our community in every page, they are saying the same things all the time.

Hope all is well at BCWH I often think of you all and wonder how it is all going. Am really enjoying it here and have hit the ground running. Now have a wee mokopuna 3 weeks old in PN, so you never know I may be back (Would you have me back????), but loving the people and the weather. 9 months has just flown by.
Love to everyone.

*Service Manager
Community Health Team*

Appendix 11: Feedback from attendees at Stakeholder Hui

Carole Fernandez

From: [REDACTED]
Sent: [REDACTED]
To: Carole Fernandez
Subject: RE: More information on Whakapai Hauora services
Attachments: image001.png
Kia ora Carole,

I greatly appreciated your kind invitation to attend the presentation. This was my first experience of a being invited onto a marae and I found this to be a warm and exceptionally friendly and kind encounter. The results of your research are very enlightening, providing good evidence of the need to make available greater support for Whanau and the implementation of Whanau Ora. As a service provider it is vitally important for me to understand how I can make our current services available to those organisations providing the 'navigator role' and how I need to adapt services to meet the needs of Whanau and individuals.

My physical address is shown below. Thank you once again for the opportunity to attend an excellent presentation.

Kind regards

Branch Manager

Office -
Mobile -

Palmerston North 4410

Appendix 11: Feedback from attendees at Stakeholder Hui

From: L..., ...
Sent: :
To:
Subject: RE: ka pai te hui + Cook Island Client

Kia ora

I/we enjoyed the presentation today from Carole. I will contact Carole directly to congratulate and talk over our responses and future potential collaborations. Thank you for organising the event and our only regret was that we had to return to Massey before joining you all for kai!. Please give my regards to too, it was lovely to see her again.

On another matter – as part of my contribution to the community I do some counselling with refugees in the Papaioea region. Today the PHO contacted me and asked if I would work with a Cook Island male, with moderate to severe PTSD symptoms, and regular marijuana use. My usual venue to work from is the building as this has a good status in the perception of the refugee clients, but I rather thought that this man might benefit much more from the services that Whakapai Hauora might offer- certainly in terms of whakawhirinaki. What is your response? Might you take him as a client? If so how does he register?

Kind regards
Na

<http://ε>



Te Mauri O Rangitaane O Manawatu (Council of Elders)
Tanenuiarangi Manawatu Incorporated (Mandated Iwi Authority)
Phone: (06) 353 1881 Fax: (06) 353 1880 Email: TMI@rangitaane.iwi.nz Website: www.tmi.maori.nz

Best Care (Whakapai Hauora)
Charitable Trust
(Health/Social/Education Services)
Ph: (06) 353 6385
Fax: (06) 353 1883
Email: BCWH@rangitaane.iwi.nz
Website: www.whakapaihauora.maori.nz

Piki Kotuku
Te Awahi Hinengaro
Ph: (06) 353 1884
Fax: (06) 353 1885
Email: Piki.Kotuku@rangitaane.iwi.nz

Kia Ora 89.8 FM
(Radio Station)
Ph: (06) 353 1881
Fax: (06) 353 1880
Studio Ph (06) 353 1882
Email: KFM@rangitaane.iwi.nz
Website: www.kfm89-8.org.nz

Tūturu Pūmau
Te Hotu Manawa O Rangitaane O Manawatu Marae
140-148 Maxwells Line, PO Box 1341, Palmerston North

4th August 2010

Carole Ann Fernandez
17 Rosalie Terrace
Palmerston North

Appendix 12: Feedback from Te Mauri O Rangitaane

Tēna koe Carole,

Nga mihi nui ki a koe I roto I nga tini ahuatanga o te wa.

***Presentation of preliminary findings for your study "Whakawhirinakitanga Ahua:
exploring an iwi model of health service delivery"***

Te Mauri O Rangitaane O Manawatu (Tangata Whenua Council of Elders) (TMOROM) have instructed me to thank you for presenting the preliminary findings from your research project of the above at their meeting on the 9th of June 2010.

TMOROM appreciate being informed of the early findings which will assist to improve and enhance Whakawhirinakitanga Ahua as a model of service delivery in the provision of integrated care to clients and whanau accessing services at Best Care (Whakapai Hauora) Charitable Trust.

The detail and depth in your study has highlighted very important aspects of whanau ora that are captured in the application of Whakawhirinakitanga Ahua to service delivery for clients and whanau at Whakapai Hauora.

TMOROM wish you every success with the completion of your study and are confident that the positive outcomes from your research will assist in health gains for Maori.

Noho ora mai

Maurice Takarangi
President
Tanenuiarangi Manawatu Incorporated
(Rangitaane Mandated Iwi Authority)

*Ka kahutia i te korowai, Te Rangimarie, Te Aroha, Te Whakaiti, Ka Whakapuawai he iwi humaarie
Spread the cloak of Peace and Love, so shall blossom the people of humility*

12 September 2008

Appendix 13: Ethics approval

Carol Ann Fernandez
17 Rosalie Terrace
Palmerston North 4414

Dear Carol,

Project Key: LRS/08/07/036

Full Title: Whakawhirinakitanga Ahua: exploring an iwi model of health service delivery

Investigators: Carole Ann Fernadaz, Tairahia Black and Dr. Maureen Holdaway (Co-Supervisors)

Localities: Tuturu Pumau Marae, Palmerston North.

The above study has been given ethical approval by the **Lower South Regional Ethics Committee**.

Approved Documents

Information sheet and consent form version 2 dated 18 Aug 2008.

Accreditation

The Committee involved in the approval of this study is accredited by the Health Research Council and is constituted and operates in accordance with the Operational Standard for Ethics Committees, April 2006.

Progress Reports

The study is approved until **30 April 2012**. The Committee will review the approved application annually and notify the Principal Investigator if it withdraws approval. It is the Principal Investigator's responsibility to forward a progress report covering all sites prior to ethical review of the project in **12 September 2009**. The report form is available at <http://www.ethicscommittees.health.govt.nz>. Please note that failure to provide a progress report may result in the withdrawal of ethical approval. A final report is also required at the conclusion of the study.

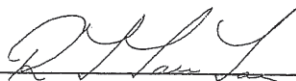
Amendments

It is also a condition of approval that the Committee is advised of any adverse events, if the study does not commence, or the study is altered in any way, including all documentation eg advertisements, letters to prospective participants.

Please quote the above ethics committee reference number in all correspondence.

It should be noted that Ethics Committee approval does not imply any resource commitment or administrative facilitation by any healthcare provider within whose facility the research is to be carried out. Where applicable, authority for this must be obtained separately from the appropriate manager within the organisation.

Yours Sincerely,



Riria Tautau-Grant
Administrator
Lower South Regional Ethics Committee
email: riria_tautau-grant@moh.govt.nz

Appendix 14: Whakapai Hauora range of services

Table 1: Whakapai Hauora Current Services 2013/14

Type of Service	Client Group	Numbers	Period of Time Whakapai Hauora Has Been Providing the Service
1 General Medical and Practice Services (joined Manawatu PHO on 1 st April 2005)	All categories	Over 3,000 as at June 2007	March 1995
2 Practice Nurse Services	All categories	Complimentary to GP services	March 1995
3 Whanau Ora Health Services covering a range of health education, promotion and training services targeted as follows: <ul style="list-style-type: none"> □ Tamariki (asthma, hearing nutrition, immunisation, injury prevention). □ Rangatahi (mental health, preventing self-harm, smoking, sexual health, alcohol and drugs). □ Pakeke (fitness and mobility, asthma and CORD, diabetes). □ Wahine (sexual health, maternity, breast and cervical screening). □ Korua and Kuia (fitness and mobility, asthma and CORD and diabetes). 	Includes Whakapai Hauora registered and non-registered clients of all age groups	Complimentary to GP services	May 1997
4 Breast Screening Health Promotion to Maori Women in Manawatu and Whanganui Regions	Women aged between 45-69 years	A total of 1,335 target population	July 1999
5 Tamariki Ora/Well Child Services (equivalent to Plunket)	0-5 years of age	Target 100 clients per annum	September 1999
6 Maori Disabilities Support Services to People with Physical, Intellectual, Sensory and Age-related (or a combination of these)	All age groups with the majority being korua and kuia	Target of 150 per annum	September 1996
7 Reproductive and Sexual Health Services	Maori and Pacific Island and women under 25 years	Over 200 clients were registered with the service in 200	May 1997
8 Provision of Nutrition and Physical Activity Health Promotion Services	Predominantly Rangatahi Maori in the Manawatu Region	Targets the whole community in a Public Health sense	July 2010
9 Best Care (Whakapai Hauora) Charitable Trust Social Counselling Services and Whanau Well Being	All ages - mainly Tamariki, Rangatahi and Wahine	Varies 50-60 per annum	January 1998

Type of Service	Client Group	Numbers	Period of Time Whakapai Hauora Has Been Providing the Service
<i>Programme (aimed at reducing family violence and child abuse within families)</i>			
10 <i>Kaupapa Maori Alcohol and Drug Service. Service area is as far south as Waikanae, as far north as Sanson and includes Fielding, Palmerston North and the wider Manawatu.</i>	<i>Tamariki, Rangatahi, Pakeke, Korua, Kuia</i>	<i>Varies</i>	<i>February 2001</i>
11 <i>Kia Piki Te Kaka Suicide Prevention Service</i>	<i>Rangatahi, Pakeke</i>	<i>Varies</i>	<i>September 2012</i>
12 <i>Social Service Programmes. Whakapai Hauora provides a range of programmes each year on demand or as needs are identified. Covers such topics as:</i> <ul style="list-style-type: none"> • <i>Parenting</i> • <i>Domestic Violence</i> • <i>Putting Culture Back Into Practice</i> • <i>Self-Esteem, etc.</i> 	<i>Course dictates client group which include Tamariki, Rangatahi, Pakeke, Korua, Kuia, Wahine and Tane, depending on focus of course</i>	<i>Varies</i>	<i>January 1998</i>
13 <i>Kaumatua Services and wellbeing programmes</i>	<i>Kaumatua, Kuia, Disabled</i>	<i>45-50 weekly</i>	<i>1999 (Line Dancing) 2010 (Wellbeing activities & programmes) 2012 (Kaumatua Services)</i>
14 <i>Provision of placements to nursing students from UCOL and Massey University, Massey University BSW students, Te Wananga O Aotearoa Social Work Students and AOD counselling students from WellTech. Also placements for nurse practitioners from PHO and trainee GP interns from RNZCGP.</i>	<i>Nursing/BSW Students</i> <i>Nurse practitioners / trainee GP interns</i>	<i>Varies per annum</i> <i>Varies per annum</i>	<i>UCOL - 1997 Massey - 2002 BSW - 1997 TWOA - 2003 WellTech - 2005 PHO - 2010 RNZCGP - 2006</i>
15 <i>Mobile Primary Healthcare Nursing Services in the Shannon, Foxton and Foxton Beach areas targeting all age groups and health areas (new service)</i>	<i>Predominantly Maori</i>	<i>Varies</i>	<i>2004</i>
16 <i>Problem Gambling Counselling & Health Promotion / Education Services</i>	<i>Predominantly Maori</i>	<i>Varies</i>	<i>2004</i>

Type of Service	Client Group	Numbers	Period of Time Whakapai Hauora Has Been Providing the Service
17. Social Worker (Violence Intervention)	Whanau/children	Varies	2005
18. Cancer Coordination Service	Predominantly Maori	Varies	2007
20. Whanau Ora Chronic Care Nurse	Predominantly Maori	Varies	2011
21. Mental Health Coordinator	Predominantly Maori	Varies	2009
22. Whanau Ora Navigator	Predominantly Maori	Varies	2010
23. LNYJC AOD Youth Counselling Service	Predominantly Maori	Varies	2010
24. Oranga Whanau Coordination Service	Predominantly Maori	Varies	2010
27. Smoking Cessation Coach Service	Predominantly Maori	Varies	2011