



Runanga Whakapiki Ake I Te Hauora O Aotearoa
Health Promotion Forum of New Zealand

Māori health promotion . a comprehensive definition and strategic considerations

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By Dr Mihi Ratima
Taumata Associates

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Executive summary

The purpose of this paper is to provide a definition of M ori health promotion and to discuss M ori health promotion strategic issues to inform practice.

M ori health promotion is the process of enabling M ori to increase control over the determinants of health and strengthen their identity as M ori, and thereby improve their health and position in society (Ratima 2001). While this brief definition gives an indication of what M ori health promotion is about, by itself it does not convey completely the meaning and uniqueness of M ori health promotion. To more fully understand M ori health promotion, it is useful to refer to two models for M ori health promotion - Te Pae Mahutonga (Durie 2000) and Kia Uruuru Mai a Hauora (Ratima 2001). Together, these models describe both the breadth of M ori health promotion and its defining characteristics. The characteristics include the underlying concept of health, purpose, values, principles, pre-requisites, processes, strategies, key tasks, and markers. A full definition of M ori health promotion is necessary to guide practice and enable common understandings as a basis for clear communication and advocacy for M ori health promotion.

Four M ori health promotion strategic issues are discussed in this paper; the changing political environment, community action, evidence-based M ori health promotion, and, workforce development.

The establishment of a National-led centre-right coalition government, alongside the international recession, provides a new political environment for M ori health promotion. The environment is characterised by a reduced role for the State in service provision, movement from shared and collective responsibility to individual and family responsibility (Blaiklock 2010), and lesser support for public health. While all of these features represent a risk to M ori health promotion, somewhat paradoxically there is political support for Wh nau Ora (Taskforce on Whanau-centred Initiatives 2010).

Wh nau Ora promotes a comprehensive collective rather than individual approach, which pushes for integrated multiple agency ways of working. Wh nau Ora, as a M ori framework concerned with prevention and addressing determinants of health, is entirely consistent with M ori health promotion. It is likely that with reduced government support for public health, increasingly M ori health promotion will be delivered through Wh nau Ora services. There are, however, risks associated with Wh nau Ora. For example, the integrated contracting and a de-emphasis of public health frameworks may reduce the capability and capacity of the M ori health promotion workforce. Further, the relocation of M ori health promotion efforts within Wh nau Ora initiatives may be a risk if the approach does not prove to be politically durable.

From a M ori health promotion perspective, community development has much potential to support positive intergenerational health outcomes that are driven and sustained by communities. Much work is still required to strengthen the community development and

community action aspects of M ori health promotion practice with regard to; understandings of the links between community development, community action and M ori health promotion; working strategically with local government; and, stepping back in order for communities to take control for the purposes of sustainability.

In the current environment the sector will only be moved by sound evidence. Therefore further effort to apply evidence-based approaches to M ori health promotion is required. However, for M ori health promotion there are a number of difficulties in applying an evidence-based approach that relate, for example, to the complexity of problems, measurement issues, the limited and variable quality of evidence, and the technical skills required to access and interpret information. It will be important to continue to build the evidence base, resource evidence-based approaches, build skills among the workforce that enable this approach, and expand the criteria for what is considered acceptable scientific evidence to include additional sources that are of particular relevance to M ori health promotion.

While there is a large M ori health promotion workforce in place with many strengths, M ori public health employees are much less likely than the total workforce to hold a tertiary qualification. Three major M ori health promotion workforce development strategic issues discussed in this report are; strengthening workforce competencies, access to training, and leadership.

Key M ori health promotion workforce competencies that require strengthening are the development of shared understandings of M ori health promotion, broader public health knowledge and skills, knowledge and application of health promotion theory, Wh nau Ora and associated integrated ways of working that take a social determinants approach, and evaluation capacity. Strengthening M ori health promotion workforce competencies through increasing formal tertiary qualification levels is reliant upon accessible training opportunities. Previous work has identified a range of barriers and facilitators of M ori participation in health field training, including in public health and health promotion, at the structural, systems, organisational and individual levels (Auckland Regional Public Health Service 2004; Phoenix Research 2004; Hapai te Hauora Tapui Ltd 2006; Ratima, Brown et al. 2007; Signal, Ratima et al. 2009). Where tertiary institutions have both the will and commitment, there is sufficient understanding and experience to enable strong action to put in place accessible training that meets the needs of the M ori health promotion workforce. It should also be kept in mind that while it is important to develop the competencies of the whole M ori health promotion workforce there is also a need for specific M ori health promotion leadership development initiatives.

Overall, in the new political environment much attention has been given to the risks faced by M ori health promotion in terms of maintaining the substantial progress made to date. While there is no doubt that the current climate will pose challenges it will also present opportunities, in the form of political support for Wh nau Ora and integrated ways of working that align with M ori frameworks, potential opportunities for workforce retraining, and a greater push for evidence-based approaches which are of high value to M ori health promotion. We should remain confident that whatever the challenges M ori

health promotion will be maintained and in time re-emerge with greater force for three reasons: M ori health promotion is an approach to improving M ori health outcomes that is entirely aligned to iwi and M ori preferences and aspirations and therefore communities may be relied on to maintain support for M ori health promotion; the high level of commitment of the M ori health promotion workforce and its capacity to work in other sectors and in varied roles while maintaining a M ori health promotion approach; and, the overwhelming evidence that prevention is the most cost-effective means to affect improved health for populations.

Introduction

The purpose of this paper is to provide a comprehensive definition of M ori health promotion and to discuss M ori health promotion strategic considerations as a basis for further planning and action to strengthen practice.

The meaning of M ori health promotion is discussed, with reference to underpinning concepts, values, principles, processes and strategies. The paper also identifies and discusses four M ori health promotion strategic considerations ó the changing political environment, community action, evidence-based M ori health promotion, and workforce development. Particular attention is given to M ori health promotion workforce development as a major ongoing strategic issue.

A comprehensive definition of Māori health promotion¹

M ori health promotion is the process of enabling M ori to increase control over the determinants of health and strengthen their identity as M ori, and thereby improve their health and position in society (Ratima 2001). While this brief definition provides an indication of the nature of M ori health promotion, by itself it fails to convey fully the meaning and distinctiveness of M ori health promotion. In order to more comprehensively understand the meaning of M ori health promotion, it is useful to consider two M ori health promotion models: Te Pae Mahutonga (Durie 2000) and Kia Uruuru Mai a Hauora (Ratima 2001).

Te Pae Mahutonga is well accepted and represents the first comprehensive effort to articulate M ori health promotion. It emphasises broad and contextual approaches to M ori health promotion and the role of M ori health promotion in contributing to M ori advancement. Kia Uruuru Mai a Hauora is a research derived framework to conceptualise M ori health promotion that makes explicit M ori health promotion's defining characteristics. Te Pae Mahutonga and Kia Uruuru Mai a Hauora are complementary. Together they provide a broad overview, as well as specific defining characteristics, of M ori health promotion.

According to Te Pae Mahutonga, M ori health promotion should create environments that facilitate the attainment of human potential. As shown in Figure 1, the model identifies two prerequisites and four key tasks of M ori health promotion.

The two prerequisites for M ori health promotion are *ing manukura* (leadership) and *mana whakahaere* (autonomy). The prerequisite of leadership recognises that although there is an important role for professionals, without community leadership interventions are unlikely to be successful. According to the model, health promotion leadership should include community leadership, health leadership (e.g. health professionals), tribal leadership, open communication, and co-operative relationships between leaders and key groups (i.e. community coalitions). The prerequisite of autonomy refers to the need for control of health promotion interventions to ultimately rest with communities. M ori health promotion should facilitate a greater degree of control for communities and, in this way, a measure of self-governance.

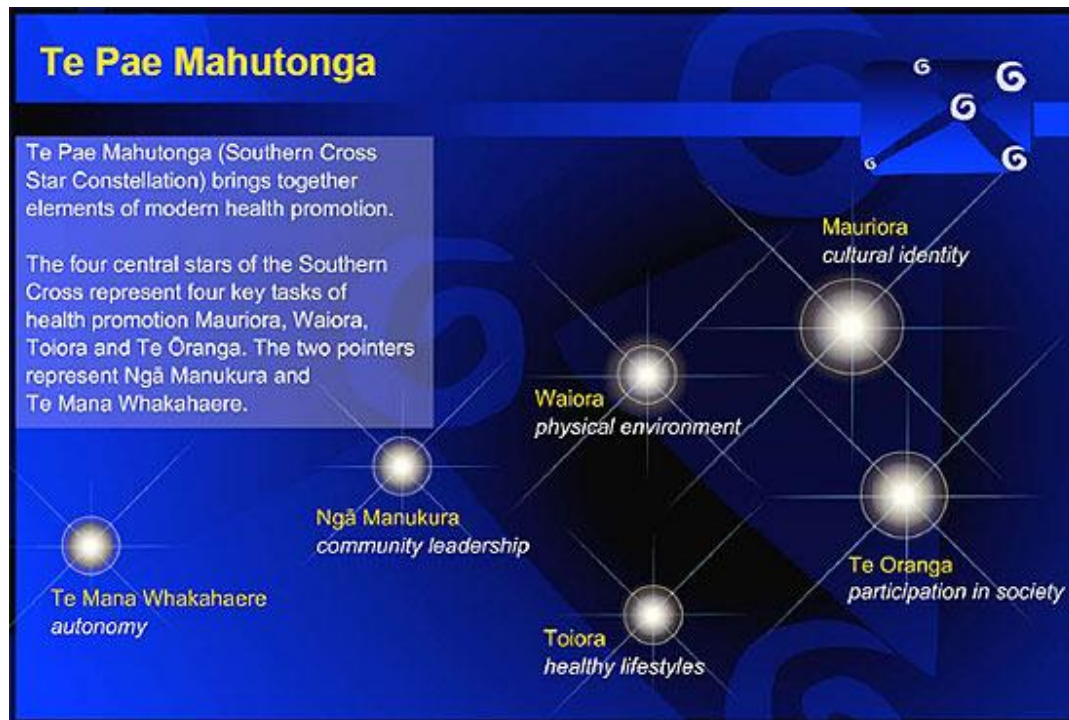
The four key tasks of M ori health promotion identified in the model are *mauriora* (access to the M ori world), *waiora* (environmental protection), *toiora* (healthy lifestyles), and *te oranga* (participation in society).

Access to the M ori world is important in order to achieve a secure M ori identity, which has in turn been associated with good health. In this context, the M ori world refers to M ori language and knowledge, culture and cultural institutions, economic resources (e.g. land and fisheries), and M ori social resources (e.g. M ori networks). Further,

¹ This section of the paper is largely drawn from the doctoral thesis *Kia Uruuru Mai a Hauora* (Ratima 2001)

according to the model, M ori should have access to social domains within New Zealand society where there are opportunities for the expression of M ori cultural norms.

Figure 1.



Source: http://www.M_orihealth.govt.nz/moh.nsf/pagesma/446

The task of environmental protection falls within the mandate of M ori health promotion primarily in recognition of the spiritual connection between M ori wellness and the environment. While protection of the physical environment is central to this task, another dimension is ensuring that there are opportunities for M ori to interact with the natural environment.

M ori health promotion has an important role in facilitating healthy lifestyles. This task mainly targets individual level behaviours, while acknowledging macro-level influences. The model identifies five areas of focus for promoting healthy lifestyles. They are harm minimisation, targeted interventions, risk management, cultural relevance, and positive development.

The final task, participation in society, relates to the macro-level factors that impact upon M ori health. It is about equitable M ori access to society's goods and services and, as a result, fair opportunities for M ori participation in New Zealand society. M ori health promotion has an obligation to increase M ori participation in the economy, education, employment, the knowledge society, and in decision-making.

Essentially, the model is ecological in perspective and so stresses the need to address determinants of health. Particular emphasis is placed on the importance of cultural factors, and that a secure cultural identity is integral to Māori wellness. Autonomy is also a strong theme.

The Māori health promotion framework *Kia Uruuru Mai a Hauora* identifies the defining characteristics of Māori health promotion (Table 1).

Table 1. *Kia Uruuru Mai a Hauora* – a framework for Māori health promotion

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

Source: (Ratima 2001)

Together these characteristics provide the detail in terms of defining Māori health promotion in order to facilitate shared understandings and as a basis for a more consistent and rigorous approach to practice. According to the framework, at a minimum, Māori health promotion practice will be consistent with Māori worldviews, embrace a holistic

concept of health, incorporate a focus on M ori identity, facilitate increased control by M ori over the determinants of health, and lead to M ori-centred health gains.

The concept of health on which M ori health promotion is based is positive and holistic in nature, in the sense that the well-being of individuals is linked to the well-being of wider M ori collectives, that the impact of determinants of health is acknowledged, and that connections between the material and spiritual worlds are recognised. A secure M ori identity is a fundamental element of M ori well-being. M ori models of health that capture these elements, such as Te Whare Tapa Whā, are well described in the literature (Pere 1984; Henare 1988; Durie 1998).

The purpose of M ori health promotion is the achievement of M ori-centred health gains, with the ultimate goal of M ori health promotion extending beyond the attainment of health for its own sake, to the realisation of M ori potential. Such an expansive purpose makes M ori health promotion vulnerable to the criticism that its boundaries cannot be distinguished from those of M ori development. However, while M ori health promotion shares many of the concerns of M ori development, it is only to the extent that those concerns can be considered as determinants of health.

M ori health promotion is founded on M ori worldviews. While those M ori worldviews are not yet well articulated, the following five themes have been identified in the literature as central to M ori paradigms and as relevant to M ori health promotion: interconnectedness, M ori potential, self-determination, collectivity and M ori identity (Ratima 2001). In terms of theory, for the most part specific theory underlying M ori health promotion practice is implicit. There are a range of M ori concepts that guide practice, such as manaakitanga and whanaungatanga, however these concepts are underdeveloped in theoretical terms. However, Te Whare Tapa Whā represents a distinctly M ori position that draws on M ori knowledge and insight and the model Te Pae Mahutonga may represent a first step towards the emergence of a macrotheory of M ori health promotion. There is also some suggestion that M ori health promotion draws theory from generic health promotion where it is consistent with M ori frameworks, but again this theory is not generally articulated in M ori health promotion. While currently it appears that the theoretical foundations of M ori health promotion are implicit and are drawn from both M ori and Western sources, the process of theoretical development will be important to bridge the gaps between theory and practice.

Four core values have been identified in the framework as underpinning M ori health promotion, they are: M ori identity, collective autonomy, social justice, and equity. The value of M ori identity implies the expectation that M ori health promotion will not only be appropriate to M ori, but will also reinforce M ori identity. As a M ori health promotion value, collective autonomy implies changes in power relationships in favour of increased M ori control over determinants of health. The emphasis on collectively as opposed to an individual focus indicates a prioritisation of the needs and aspirations of the group above individuality. Therefore, autonomy is positioned not solely as an individual issue, but primarily as a concern of M ori collectives. As a value, social justice implies that all people are of equal worth and have the right to equal consideration

in relation to development opportunities. Social justice therefore implies greater attention to increasing M ori access to relevant and effective health promotion interventions. Equity is about fairness as opposed to sameness. The endpoint of equity is not to achieve the same outcome for all people regardless of their individual preferences and capacities, but to ensure that there is fair access for M ori to opportunities that will allow them to fulfil their own self-defined potential.

While values provide moral guidance, principles give more practical direction for M ori health promotion activities. The principles identified in the framework are: holism, self-determination, cultural integrity, diversity, sustainability and quality.

The principle of holism has four main dimensions which relate to time, realms, sectors and focus. That is, M ori health promotion recognises intergenerational connections, acknowledges continuity between material and spiritual realms, seeks to address determinants of health, and the level of focus is that of the collective rather than just the individual. As a principle, self-determination has two main concerns. First, M ori health promotion should take a by M ori, for M ori approach, and it should contribute to the realisation of M ori self-determination and therefore increased control for M ori over the determinants of health. The principle of cultural integrity requires that M ori health promotion is not only culturally appropriate, but that it affirms and strengthens M ori identity. Therefore, M ori health promotion should reinforce M ori cultural values and practices. The main implication of the principle of diversity is that M ori health promotion should not be based on stereotypes, but should take account of the diverse and dynamic nature of M ori society. There are two concerns that are central to the principle of sustainability. The first is the durability of solutions and the second is the well-being of future generations. The second point refers to the requirement that the welfare of future generations is not compromised in the interests of the current generation. The principle of quality requires that M ori health promotion will meet high technical and cultural standards, be consistent, and take an evidence-based approach.

Overlapping M ori health promotion processes can be applied across a range of settings and a variety of issues. The central processes of M ori health promotion identified in the framework are; empowerment, mediation, connectedness, advocacy, capacity-building, relevance, resourcing, and cultural responsiveness. As a process, and from a M ori health promotion perspective, empowerment is primarily concerned with increasing M ori control over the determinants of health. It includes a focus on both individuals and M ori collectives, and functions through enhancing M ori community capacity and raising M ori critical awareness as a basis for social action. Mediation, for the purposes of M ori health promotion, is the process of facilitating intra- and inter-sectoralism. Intra-sectoralism refers to the co-ordination of approaches at all levels within the health sector and between the health sector and M ori communities. Intra-sectoralism, which is aligned with Wh nau Ora, recognises the role of M ori health promoters in mediating between stakeholders across sectors to facilitate integrated approaches to addressing determinants of health.

Connectedness, as a process, is about the use of mechanisms for intergenerational transfer of knowledge, inter-sectoral approaches, an explicit concern for locating health within the broader context of M ori development, wh nau-centred approaches, and the use of tribal and M ori community networks. Advocacy is a cross-cutting process in that it applies from the grassroots level through to regional, national and international levels. Advocacy is the process of lobbying for public, political and other stakeholders' commitment to the goals of M ori health promotion. Once commitment from stakeholders has been secured, it is essential that that commitment is formalised by such means as policy, regulation, and infrastructure support. The process of capacity-building recognises the marginalised position of M ori, and that increasing M ori community capacity will be necessary to enable communities to lead their own health development, enhance community readiness to take-on and benefit from interventions, and to ensure the sustainability of improvements in health outcomes. As a process, relevance is concerned with ensuring that M ori health promotion activities are appropriate to M ori realities. That is, they are accessible and address M ori priorities. The process of resourcing concerns both the level and type of resources that will be necessary to achieve improved health outcomes for M ori. M ori are not at the same starting point as the general population, and therefore additional developmental resources will be required if there is to be a realistic chance of attaining equitable health outcomes. As well there will be differences in the types of resources required, and these will include access to cultural resources. The process of cultural responsiveness has two dimensions. First, the implementation of measures to ensure that M ori health promotion interventions are culturally competent and second, the affirmation of M ori beliefs, values and practices.

Six M ori health promotion strategies identified in the framework are:

1. Reorienting health systems and services towards M ori cultural and health promotion criteria and therefore towards the goal of quality health systems and services in both a cultural and technical sense, and a shift in emphasis from tertiary care towards health promotion, primary health care and disease prevention;
2. Increasing M ori participation in New Zealand society so that M ori equitably enjoy the benefits of society and therefore have greater control over determinants of health;
3. Iwi and M ori community capacity-building through a developmental approach whereby iwi and M ori communities are better positioned to lead and benefit from health promotion interventions and to sustain those benefits;
4. Healthy and culturally affirming public policy that promotes health and is conducive to a secure M ori identity;
5. Intra- and inter-sectoral measures to address determinants of health to deal with social, economic, cultural and political determinants of health through co-ordination within and between sectors, and,
6. Adequate, efficient, and relevant resourcing of M ori health, informed by an appropriate evidence-based approach.

The markers identified in the Framework are intended to inform the population of M ori health promotion monitoring frameworks, as fields within which both universal and M ori-specific indicators may be developed that are best able to capture the effectiveness of M ori health promotion activities.

In combination, Te Pae Mahutonga and Kia Uruuru Mai a Hauora are most useful in that they provide a theoretically and empirically defensible comprehensive (in terms of both breadth and depth) definition of M ori health promotion.

Strategic issues in Māori health promotion

The changing political environment

The establishment of a National-led centre-right coalition government which includes the Māori Party, Act and United Future, alongside the international recession, provides a very different political environment for Māori health promotion. The new paradigm is one of a reduced role for the State in service provision (and therefore increased private sector delivery of health services) and movement from shared and collective responsibility to individual and family responsibility (Blaiklock 2010). The Horn Report (Ministerial Review Group 2009), the product of a ministerial review group to recommend how New Zealand can improve the quality and performance of the public health system, reflected a government shift away from supporting public health. The report largely lacked a focus on prevention, social determinants and reducing inequalities (Māori and Pacific were not mentioned in the report). To suggest a restructure of the health sector without consideration of these major issues is at odds with the central goals of the health system which relate to increasing life expectancy and reducing inequalities. An obvious example of a lowered prioritisation of public health and narrowing funding criteria is the reduced support for HEHA implementation.

In line with Horn Report recommendations a review of PHOs is intended to greatly reduce the numbers of PHOs, mainly through amalgamations, in order to decrease management and administration costs. The Horn Report suggests reducing management fees to small PHOs. The review represents particular risks for small PHOs that often serve Māori communities, are characterised by strong community governance, and carry out Māori health promotion functions. With an emphasis on size and efficiency, the important role of Māori PHOs in terms of their potential contribution to reducing inequalities through Māori health promotion and other activities and the quality of their relationships with communities are not explicitly taken into account. The proposed shift also supports moves towards funding health promotion by clinical staff and/or in clinical settings, rather than in community initiatives.

Changing government priorities that place greater emphasis on treatment services and reduce public health funding are a risk to Māori health promotion workforce capacity and capability. Restructuring, loss of contracts, fewer health promotion positions, and the retention of public health positions with statutory responsibilities ahead of others (Blaiklock 2010) are factors that are all most likely to impact the Māori workforce. However, while this is a major challenge for Māori health promotion it also represents an opportunity for prioritising retraining in health promotion as discussed in a later section of this paper.

Somewhat paradoxically, and largely reflective of inclusion of the Māori Party within the coalition, there is political support for Whānau Ora (Taskforce on Whānau-centred Initiatives 2010). Whānau Ora promotes a

comprehensive collective rather than individual approach, which pushes for integrated multiple agency ways of working and case workers who work with wh nau and have an advocacy role across sectors. Wh nau Ora, as a M ori framework which emphasis prevention and addressing determinants of health, is entirely consistent with M ori health promotion approaches. It is likely that with reduced government support for public health, increasingly M ori health promotion will be delivered through Wh nau Ora services. Wh nau Ora is an opportunity to strengthen intersectoral approaches to addressing determinants of health and thereby enhance whole of government responsiveness and to more consistently work within a wh nau-centred M ori framework. It supports integrated iwi programmes, prevention approaches, and M ori sector leadership. There are, however, also risks associated with Wh nau Ora. That is, that the integrated contracting and a de-emphasis of public health and health promotion frameworks will reduce the capability and capacity of the M ori health promotion workforce. Further, the relocation of M ori health promotion efforts within Wh nau Ora initiatives may be a risk if the approach does not prove to be politically durable.

In the changing political environment protecting health promotion funding that remains will be important, through for example arguing for ringfencing of health promotion resources and avoiding moves whereby health promotion funding is lumped together with that for chronic disease or with other components of capitation funding. While health promotion funding per patient is a small amount, where resources are grouped together for large numbers of patients (e.g. in large PHOs or a proposed regional flexifund) the resource may be substantial. The M ori Provider Development Scheme (Ministry of Health 2010) provides a potential avenue for protecting M ori health promotion funding. The 2010/2011 M ori Provider Development Scheme purchasing intentions now explicitly identify how Wh nau Ora will be supported and prioritised for funding by the scheme. There may be potential for a specific category within the M ori Provider Development Scheme for M ori health promotion.

Community action

From a M ori health promotion perspective, identity-based community development has much potential to initiate positive intergenerational health outcomes with self-priming communities (i.e. are driven and sustained by communities). There is widespread recognition amongst M ori health promoters of the central importance of working with M ori collectives and of strengthening community action towards the goal of self-determination (Durie 2000; Glover 2000; Moewaka-Barnes and Barrett-Ohia 2001). More generally community action has long been recognised as a core health promotion strategy (World Health Organization 1986; Labonte 1996; World Health Organization 1997; Laverack and Wallerstein 2001; Laverack 2007). The Ottawa Charter for Health Promotion (World Health Organization 1986) is a framework for generic health promotion that is used globally. One of the five health promotion strategies identified in the Charter is strengthening community actions. Further, the Jakarta Declaration on Leading Health Promotion into the 21st Century (a product of the WHO Fourth International Conference on Health Promotion) identified increasing community capacity as one of the five priorities for health promotion in the 21st Century, that is, òHealth

promotion...improves...the ability of...communities to influence the determinants of health (World Health Organization 1997 p4).

A community action approach to health promotion is primarily concerned with supporting community ownership and control of initiatives to address determinants of health. The social determinants of health are the circumstances in which people are born, grow, live, work and age (Commission on Social Determinants of Health 2008), and are mostly responsible for health inequities (which are therefore avoidable) including the wide health inequities between M ori and non-M ori (Reid and Robson 2007). In response to increasing concern about persistent and widening inequities, WHO established the Commission on Social Determinants in 2005 and the Commission's final report on how to reduce inequities was released in August 2008 (Commission on Social Determinants of Health 2008). The first of the three overarching recommendations from the report is to improve daily living conditions, and therefore to take action to support on-the-ground community development.

Much work is still required to strengthen the community development and community action aspects of M ori health promotion practice. This is an important area for further work, given that these approaches may facilitate the application of a health promotion agenda in a way that enables M ori communities to support the transmission of positive health practices and outcomes from generation to generation in sustainable ways. Areas to strengthen include: understandings of the links between community development, community action and M ori health promotion; working strategically with local government; and, stepping back in order for communities to take control for the purposes of sustainability.

Evidence-based Māori health promotion

Evidence-based M ori health promotion is concerned with achieving the greatest benefits within existing resources, accessing relevant information to inform effective practice, awareness of evidence supporting strategies including the strength of evidence, and most importantly using good judgement alongside the best available evidence (Ratima 2004). In an environment of constrained resources the sector will only be moved by sound evidence. Further, with low political priority accorded to public health and perhaps M ori health, this approach will be important to advocate for M ori health promotion. However, for M ori health promotion there are a number of difficulties in applying an evidence-based approach. In particular;

- problems are complex,
- there are limited M ori-specific health indicators that are able to capture the state of M ori health in M ori terms, universal indicators tend to focus on physical or mental health and neglect other dimensions of wellbeing, are disease rather than wellness centred, and often relate to service utilisation (Durie 1998),
- there are difficulties in measuring outputs versus outcomes,
- there is limited and variable quality evidence of the effectiveness of M ori health promotion interventions available,

- evidence tends to accumulate in areas that are easier to evaluate than necessarily around the most effective interventions leading to an evidence bias,
- accessing and interpreting information requires technical skills, including the capacity for sound M ori analysis,
- the cost of evaluation is often prohibitive and this is compounded by the low level of evaluation skills among the workforce, and,
- the extent to which evaluation findings for one intervention can be applied to other contexts may be questionable.

It will be important to continue to build the evidence base, resource evidence-based approaches, and build skills among the workforce that enable this approach. Given that this will take time, M ori health promoters should continue to recognise the value of an evidence-based approach while also acknowledging its limitations and the importance of ensuring the relevance of interventions to the M ori contexts. There is also a need to expand criteria for what is acceptable scientific evidence, for example, recommendations by respected M ori health promotion authorities based on health promotion experience, descriptive studies and reports of experts, and endorsement by M ori collectives. Organisational evidence, such as iwi and M ori community health plans and DHB M ori health plans should also be taken into account. Finally, M ori health promotion evidence will be important. This includes M ori aspirations as expressed at hui and M ori health promotion frameworks such as Te Pae Mahutonga.

Workforce development

This section describes the M ori health promotion workforce and the characteristics of an optimum workforce, and discusses three key M ori health promotion workforce development strategic issues ó strengthening workforce competencies, access to training aligned to workforce needs, and leadership.

A profile of the Māori health promotion workforce

There is no agreement in New Zealand on the distinction between the health promotion workforce and the public health workforce. While at one extreme arguments can be made that there is complete overlap between the two, it can equally be argued that the overall public health workforce is comprised of distinct sub-groups that include, for example, health promotion, health protection and public health medicine. As comprehensive work has not yet been done to specifically define and profile the M ori health promotion workforce, the workforce data here is drawn mainly from two reports profiling the M ori public health workforce and prepared by Phoenix Research (Phoenix Research 2004) and Te Rau Matatini (Roberts 2007). It should be noted, however, that there is a need to strengthen M ori health promotion workforce data collection, management and reporting in order to inform planning and action.

In 2004 Phoenix Research carried out surveys of the public health workforce employed in Ministry of Health funded public health organisations, and participants included 215 M ori employees. M ori comprised approximately 30% of the public health workforce

surveyed. While this level of participation seems high, consistent with recent research that has investigated the participation of M ori in the health and disability workforce overall (Ratima, Brown et al. 2007), the survey found that M ori tended to be clustered in areas that require lower levels of formal qualifications, are less well paid, and in less senior positions than the non-M ori public health workforce. That is, in the non-regulated public health workforce which includes the fields of health promotion, health education and community worker.

Of the M ori employees surveyed, around half (51%) worked for M ori organisations (21% were in public health units, and 14% worked for NGOs). M ori organisations make up 39% of public health organisations, and account for 30% of public health positions and FTEs. M ori organisations employ a much greater proportion of community workers and support workers compared to other public health organisations. Community workers constitute 55% of dedicated M ori roles in M ori organisations (compared to 21% of dedicated M ori roles in non-M ori organisations). Health promotion advisors/workers comprise 22% of the dedicated roles in M ori organisations, and 51% of those roles in non-M ori organisations.

According to the Phoenix Research public health workforce survey, of the 72 M ori organisations that participated in the research, most were working in narrow programme areas (i.e. nutrition, physical activity, immunisation, mental health promotion/well child, prevention of alcohol/drug harm/sexual health, injury prevention/tobacco control). M ori organisations were less likely to be working in broader determinants related programme areas (such as physical environments and public health infrastructure) and the only programme area in which these organisations had lower proportions of staff working compared with all public health organisations was in the area of social environments.

A 2006 survey of the M ori public health workforce by Te Rau Matatini recruited M ori who self-identified as working in public health units, providers of public health contracts or in other public health activities. Generally findings from the 2006 survey were consistent with those of the earlier surveys carried out by Phoenix Research. In total, 156 M ori respondents participated in the survey. Of the surveyed M ori public health workforce most (75%) were female, and were aged between 30 and 49 years (61.5%). Most respondents worked fulltime (81.4%) and were based in DHB public health units (29.5%) or with M ori NGO providers (21.8%). The most commonly reported public health job roles were community worker (16.7%), followed by manager (16%), mental health worker (13.5%), and health educator (10.3%). Of those surveyed, 6.4% specifically identified their role as health promoter. Over half of the respondents indicated that they held a dedicated M ori position (62.8%) and that they worked primarily with M ori (67.9%). The majority of respondents had been working within the public health sector for less than 10 years (72.4%), and almost a quarter (24.3%) indicated that they had two years or less experience in the sector. Around half (49.3%) of the respondents earned between \$30,001 and \$50,000 per year.

Close to half (46.4%) of the respondents were studying. Over half had completed a tertiary education certificate (65.1%) and a quarter to a third held an undergraduate diploma (24.3%), degree (27.5%) or postgraduate (27.5%) qualification. Most of those surveyed had been supported by their employer to undertake study. These findings are consistent with the earlier Phoenix Research surveys, which also noted that M ōri public health employees are substantially less likely than the total workforce to hold a tertiary qualification, including degrees.

An optimum M ōri health promotion workforce

The characteristics of an optimum M ōri health and disability workforce have been identified in the research report Rauringa Raupa (Ratima, Brown et al. 2007). Drawing on M ōri models of health promotion (Durie 2000; Ratima 2001), the Health Promotion Competencies for Aotearoa-New Zealand (Health Promotion Forum of New Zealand 2000) and the Generic Competencies for Public Health in Aotearoa-New Zealand (Public Health Association of New Zealand 2007), these characteristics are adapted below to the M ōri health promotion workforce.

- Diverse professional backgrounds, roles, and locations within health and other sectors.
- Equitable representation at all levels and proportional to the M ōri population spread and M ōri health needs.
- Public health and health promotion dual technical and cultural competencies.
- Tangible links to M ōri communities, including wh nau, hapū, iwi and other M ōri collectives.
- Well connected to M ōri health professional networks.
- Transferable skill sets to enable flexibility and movement between roles.
- Ongoing professional development consistent with the philosophy of life-long learning across the career lifespan.
- Evidence-based practice.
- Best health outcomes, M ōri health gain and prevention centred practice.
- Well developed intra and intersectoral relationships.
- Change responsiveness.
- Able to achieve work/life balance.

Strengthening workforce competencies

There is a large M ōri health promotion workforce in place with many strengths, but low levels of formal qualifications. The need to enhance workforce competencies and in particular the level of formal qualification is a strategic issue which needs to be addressed as a matter of urgency. Key competencies that require attention include development of shared understandings of M ōri health promotion, the broader public health knowledge and skills, knowledge and application of health promotion theory, Wh nau Ora and associated integrated ways of working that take a social determinants approach, and evaluation capacity.

A clear and comprehensive understanding of M ori health promotion is necessary to guide practice. It enables shared meaning and therefore enhanced communication between practitioners and facilitates both transparency and accountability. It is only by basing M ori health promotion practice on clear shared understandings of M ori health promotion that the effectiveness of interventions can be measured and proven, and that practitioners have a basis to justify actions. In order to advocate for and affirm the credibility of M ori health promotion, M ori health promoters must be able to, at the very least, clearly state its meaning, purpose and methodologies (Ratima 2001).

Wide recognition of the M ori health promotion model Te Pae Mahutonga has done much to facilitate common understandings of M ori health promotion among practitioners. However, the depth of understanding is often limited resulting in a narrow approach to M ori health promotion that is focussed on lifestyle issues and behaviour change, as opposed to a broader determinants approach and use of a range of processes including advocacy. As well, confusion remains as to the distinction between M ori health promotion often carried out by those based in M ori provider organisations and generic Ottawa Charter-based health promotion activities carried out by a M ori workforce in mainstream settings and using generic tools.

The capacity of the M ori health promotion workforce to contextualise their work within broader public health frameworks and to utilise health promotion theory to inform practice is limited by a lack of formal training in public health and health promotion. Despite the potential benefits of theory in guiding M ori health promotion practice, there is often confusion as to the link between theory and practice among the M ori health promotion workforce and the health promotion workforce more generally. While this is in part a training issue, it is also a function of an underdeveloped articulation of theory in this field.

The release of the Wh nau Ora report (Taskforce on Whanau-centred Initiatives 2010), the work of the Commission on Social Determinants of Health (Commission on Social Determinants of Health 2008), and policy shifts towards the inclusion of health promotion in primary care has reinforced the need to continue to focus on addressing determinants of health and integrated ways of working. While this approach is entirely consistent with M ori health promotion at the theoretical and conceptual level, in practice, many M ori health promoters are not operating at this level.

Figure 2 shows a continuum of activities to improve health which move from left to right from individual focussed activities delivered in primary healthcare settings to population focussed health promotion activities. Many of the activities that the M ori health promotion workforce routinely engage in tend to be concerned with behavioural and healthy lifestyle approaches and are more closely aligned to primary health care and an individual focus, such as the provision of health information, health education, and personal skill development. This is as opposed to broader health promotion activities as part of comprehensive healthcare, such as advocacy, supporting community action, influencing public policy and research for social change. As well, many M ori health promoters tend to focus on a limited number of health issues such as physical activity and

nutrition and are not always able to make the connection as to how behavioural interventions fit within the continuum of public health activities.

Figure 2. Activities used to improve individual and population health



Adapted from Victorian Government Department of Human Services 2000 in Ministry of Health (2003 p9)

That is not to say that many M ori health promoters do not understand the fundamentals of social determinants approaches and wh nau ora. In fact, in many respects the shift to this way of working will be easier for M ori health promoters given that the wh nau ora approach is an inherently M ori framework and that this is the type of approach long embraced by M ori provider organisations. What may be more difficult, however, is translating the approach into practice within the confines of their organisations and roles, and given that high skills levels are required to deal with the intersectoral complexity of the issue and to engage with high needs wh nau. Therefore, narrow approaches are not only due to a low level of understanding of determinants among the workforce, but are also reflective of infrastructure limitations that do not support broad approaches. For example, where M ori health promoters are located within small providers where health promotion is one content area alongside a much wider portfolio that includes clinical services or where M ori health promoters work in relative isolation from health promotion colleagues.

Limited evaluation competencies among the workforce, and therefore the limited evaluation capacity of providers, is also an area of concern. It is important to avoid romanticising what it is that M ori health promotion hopes to achieve, and instead be able to provide evidence of how M ori health promotion practice contributes to M ori-centred health gains and best health outcomes. In an environment of increasingly restricted resources, the government requires evidence-based practice and providers themselves are increasingly required to carry out their own evaluation. This highlights the importance of a workforce that has sound evaluation knowledge and skills and is able to measure the impact of M ori health promotion activities and understand the links between outputs and outcomes as part of their practice.

Access to training

Previous work has identified a range of barriers and facilitators to M ori participation in health field training, including in public health and health promotion, at the structural, systems, organisational and individual levels (Auckland Regional Public Health Service 2004; Phoenix Research 2004; Ratima, Brown et al. 2007; Signal, Ratima et al. 2009). Key barriers and facilitators relevant to the M ori health promotion workforce are summarised in Table 2 and Table 3. Selected factors of most relevance to increasing the formal qualification levels among the workforce are discussed in this section, while

acknowledging that there are also many valuable training opportunities that are located outside of tertiary education institutions, such as locally based workshops, short courses and hui/conferences.

Table 2. Barriers to Māori access to health promotion training

Categories	Barriers
Structural	social factors economic factors institutional racism poor alignment between health and tertiary education sectors
System	primary and secondary school education barriers poor access to quality health career information tertiary education system <ul style="list-style-type: none"> • high cost and low awareness of funding sources • location of courses • long course lengths/heavy study workloads • narrow entry criteria that does not take account of prior learning • inadequate Māori specific support programmes • poor promotion of training opportunities among Māori providers • low Māori representation • lack of formal links between Māori stakeholders and academic departments • system is not Māori friendly
Organisational	low educational institution commitment <ul style="list-style-type: none"> • lack of availability of courses • institutions/programmes not Māori friendly • lack of Māori specific study pathways or programmes delivered in a way that is appropriate to Māori and that facilitates accelerated study • poor integration of Māori health promotion course content • lack of value attributed to Māori health promotion models, frameworks and concepts • lack of or limited access to programmes delivered in a way that is appropriate to Māori • limited opportunities for practicum placements with Māori providers • personally mediated racism low health institution commitment <ul style="list-style-type: none"> • lack of support for study and other professional development
Individual	limited whānau experience in tertiary education work and whānau commitments Māori community expectations

Adapted from (Ratima, Brown et al. 2007) and incorporating work from (Auckland Regional Public Health Service 2004; Phoenix Research 2004; Signal, Ratima et al. 2009)

At the structural level, there is limited alignment between the health sector and the tertiary education sector generally. From a Māori health promotion workforce development perspective, there is a mismatch between the health sector's demand for qualified Māori health promoters with technical and cultural competencies and the range of training opportunities and Māori health promotion teaching capacity available through tertiary education institutions at all levels. This is a major impediment to accelerating Māori health promotion workforce development, and addressing this issue will rely on work to strengthen strategic alliances between tertiary education institutions and the health promotion sector, the public health sector and Māori stakeholders.

Māori health promotion training is a substantial area of opportunity for tertiary education institutions, in the context of: Whānau Ora and its associated workforce training needs;

the impact of the current political environment in terms of job losses and potential for increased retraining; demographic changes with M ori a growing proportion of the student market; ethnic inequalities in health and the linked high need for a skilled M ori health promotion workforce; and the size of the current M ori health promotion workforce and its accelerated capacity building requirements. In order to take advantage of the opportunities that M ori health promotion training activities may offer to tertiary institutions, work is required to overcome both systems level and organisational level barriers to M ori access to health promotion training. Resources that may be used to assist training organisations to strengthen their M ori health promotion activities include E Ara Tauwhaiti Whakarae (Te Rau Matatini 2007), the Report of the Taskforce on Wh nau-Centred Initiatives (Taskforce on Whanau-centred Initiatives 2010), the Health Promotion Competencies for Aotearoa New Zealand (Health Promotion Forum of New Zealand 2000), and the Generic Competencies for Public Health in Aotearoa-New Zealand (Public Health Association of New Zealand 2007).

Table 3. Facilitators of Māori access to health promotion training

Categories	Facilitators
Structural	social factors economic factors alignment between health and tertiary education sector
System	enhanced responsiveness of primary and secondary school education access to quality career information and advice enhancement of the tertiary education system <ul style="list-style-type: none"> • financial support available • course provision in workplaces and M ori contexts • part time and short length courses available • flexible entry criteria that take account of prior learning • promotion of training opportunities among M ori providers • a strong M ori presence within the sector • clear and accelerated study pathways • formal strategic alliances between M ori stakeholders and academic departments
Organisational	educational institution commitment <ul style="list-style-type: none"> • M ori health promotion content well integrated into papers that are relevant to the workforce • M ori health promotion papers delivered • bridging programmes, staircasing and M ori student support • formal partnerships with M ori health promotion providers • working with M ori health promotion stakeholders to determine M ori health promotion needs health institution commitment <ul style="list-style-type: none"> • employer study expectations and support • culturally safe and supportive, valuing M ori competencies • clear career pathways • placements and internships • provision of workplace training • cultural supervision and mentoring
Individual	wh nau encouragement and support practical experience and links to the health sector desire to work with M ori and make a difference to M ori health desire to improve health system responsiveness to M ori

Adapted from (Ratima, Brown et al. 2007) and incorporating work from (Auckland Regional Public Health Service 2004; Phoenix Research 2004; Signal, Ratima et al. 2009)

Table 3 identifies specific measures that may be undertaken to facilitate M ori access to health promotion training, particularly in terms of formal qualifications.

The current M ori public health workforce has a much lower level of qualification than the public health workforce generally, however, this workforce requires at least the same levels of qualification. Therefore, the journey for M ori health promoters to full qualification will start at a lower level entry point and will take longer. New and clear educational pathways to full qualification are required that take into account prior learning, have multiple entry points, provide bridging and staircasing opportunities, and are supported for the duration of the journey. These pathways should be able to accommodate an individual with no qualifications, but much experience, to accelerate their progress towards full qualification while maintaining quality. These new pathways will be important in equipping M ori health promoters for new roles and career pathways in the context of Wh nau Ora and an increased emphasis on integrated ways of working. As well, they should cater to those who as a result of the changing political environment are among many in the health promotion sector who will experience job losses.

Maximising opportunities for retraining will be reliant upon tertiary education institutions having in place strategic retraining pathways for M ori health promoters that are supported financially and in terms of study skills support. There are opportunities through existing programmes, such as the Ministry of Health's Hauora M ori Scholarships Programme, to financially support M ori health promoters to become fully qualified. However, at the same time new funding may need to be sought that enables those already in the workforce to take paid time out from work to complete qualifications for perhaps a period of a few months per year. Accessing additional funding will be difficult given the political environment and recent budget cuts to the tertiary education sector.

The research report Rauringa Raupa (Ratima, Brown et al. 2007) identifies support mechanisms and recruitment and retention programmes that are already in place for M ori health field students, as well as components of successful interventions. Proactive mechanisms should be in place to enable M ori health promotion students to access existing supports, and to develop support programmes tailored to their specific needs where required.

While there are a number of good quality health promotion courses available, overall there is much room for improvement in terms of alignment with the needs of the M ori health promotion workforce and the depth of M ori health promotion content. Further work is required to appropriately integrate M ori health promotion into public health and health promotion teaching, to align concepts of M ori health and M ori health promotion taught within institutions, and to strengthen M ori health promotion teaching capacity (in terms of both appointments to faculty and the inclusion of guest lecturers with practice experience). That some courses are provided in regions is a strength, but greater flexibility in terms of location and timing is required.

Strategic alliances between M ori health promotion providers and tertiary education institutions may have many advantages, including the provision of M ori stakeholder input into course design and content, location of training at workplaces or in other M ori contexts, access to guest lecturers with current practice experience, promotion of programmes among stakeholders (M ori health promotion providers have a low level of awareness of training opportunities), and the ability to arrange practicum opportunities for students. Hands on practical experience for students through placements with providers will be important for those who do not have exposure to M ori health promotion practice.

Leadership

The issue of leadership is particularly important in the current political environment, and may be considered at two levels in relation to M ori health promotion workforce development.

First, there is a need for strong leadership in M ori health promotion workforce development. E Ara Tauwhaiti Whakarae (Te Rau Matatini 2007) provides a good strategic framework that can be applied specifically to M ori health promotion workforce development. However, M ori health promotion workforce development leadership is currently dispersed between, for example, M ori organisations (such as Hapai te Hauora, Te Rau Matatini and Hauora.com), the Health Promotion Forum which includes a M ori Reference Group, and to a lesser extent academic institutions (no one institution is a clear leader in this field). While there is a role for a range of organisations, currently initiatives lack a sense of co-ordination and cohesion. There would be value in further efforts to determine how best key M ori health promotion workforce development leaders could come together in order to achieve a more comprehensive and co-ordinated approach to M ori health workforce development.

Second, while it is important to develop the competencies of the M ori health promotion workforce overall there is also a need for specific M ori health promotion leadership development initiatives. M ori health promotion leaders require particular expertise and cultural competencies that enables them to work at the interface between the M ori world and the Western world. That is, they must have the capabilities for effective communication at multiple levels (such as community/iwi, academic and government) and to move easily between M ori and non-M ori contexts (Ratima and Ratima 2004). M ori health promotion leadership will complement M ori leadership in other health professional groupings, communities, and iwi, all of which are important for effective M ori health promotion (Durie 2000).

The Leadership Programme for M ori in Public Health, has been facilitated by Tania Hodges (Digital Indigenous.Com Ltd) since 2002 mainly for the Northland/Auckland and Midland regions. The Ministry of Health have invested in six training programmes to be delivered nationally in four regions ó Auckland/Northland, Central, South Island, and Midland. The programme is co-facilitated by Grant Berghan and involves four two day noho marae over a four to six month period. It includes a variety of sessions relevant to leadership, public health, M ori health, and M ori development. During the training,

participants apply their learnings to a project that demonstrates leadership and contributes positively to M ori health. An evaluation of the earlier version of the programme indicated that the initiative was successful (Pipi 2005). Graduates of the training programme from 2002 ó 2010 will be coming together at their national hui in November 2010 at Turangawaewae Marae, Ngaruawahia.

Concluding comments

In the current political environment much attention has been given to the risks faced by public health and health promotion generally, and to M ori health promotion specifically, in terms of maintaining the substantial progress made to date. While there is no doubt that the current climate will pose challenges it will also present opportunities, in the form of political support for Wh nau Ora and integrated ways of working that align with M ori frameworks, potential opportunities for workforce retraining, and a greater push for evidence-based approaches which are of high value to M ori health promotion. We should remain confident that whatever the challenges M ori health promotion will be maintained and in time re-emerge with greater force for three reasons: M ori health promotion is an approach to improving M ori health outcomes that is entirely aligned to iwi and M ori preferences and aspirations and therefore communities may be relied on to maintain support for M ori health promotion; the high level of commitment of the M ori health promotion workforce and its capacity to work in other sectors and in varied roles while maintaining a M ori health promotion approach; and, the overwhelming evidence that prevention is the most cost-effective means to affect improved health for populations.

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