The Uniqueness of the Aotearoa 2012
Health Promotion Competency Framework:
Māori Inclusivity as an Essential
Prerequisite

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ABSTRACT

Background: In 2012 the Health Promotion Forum of New Zealand (HPF) published a reviewed and updated Aotearoa Health Promotion Competencies (HPC2012) framework. This framework was informed by consultation feedback obtained from the health promotion workforce. Competency frameworks, which define the essential knowledge, skills and attitudes needed for professional practice, ensures responsiveness of the needs of the population that health promoters work with. The HPC2012 were updated specifically to respond to critique that the earlier framework from 2000 had inadequately considered New Zealand’s cultural diversity, particularly in providing clear guidelines in working with indigenous Māori. Following a rigorous process to include Māori perspectives, the HPC2012 is widely acknowledged as being ‘unique’ among its comparator counties. Aim: The present dissertation explores this claim - its fundamental objective is to assess how successfully Māori interests have been integrated into the HPC2012, and the processes that have informed the cultural competency underpinning the framework. Methods: A qualitative research design consisting of a two-fold methodology was used where secondary data informed a cross-country comparative analysis of four international health promotion competency frameworks alongside analysis of primary data obtained from semi-structured interviews with health promotion and public health leaders based within New Zealand. Findings: The New Zealand competency development process was inclusive; the analysis showed that the cultural-sensitivity of the process was specifically enabled by (a) Māori tikanga values, (b) the inclusion of grassroots workers who are the backbone of the health promotion workforce, and (c) the provision of adequate consultation time to meaningfully hear the voice of Māori. Factors such as limited consultation resource and lack of recognition of Māori diversity were potential barriers to Māori participation within the consultation process. Conclusion: The
study findings confirm the ‘uniqueness’ of the HPC2012; the integration and centering of Māori values in the framework were the outcomes of systematic processes of inclusion. There are wider lessons associated with the study of the competency development processes as this approach can be presented as an example of best practice to ensure future competency frameworks meet the needs of indigenous, marginalised and increasingly diverse populations.
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# TABLE OF CONTENTS

Abstract .................................................................................................................. II
Acknowledgments ................................................................................................. IV
Table of Contents ................................................................................................. V
List of Tables .......................................................................................................... VII
List of Figures ........................................................................................................ VIII
List of Appendices ............................................................................................... IX
Glossary of Māori Words ..................................................................................... X
List of Acronyms .................................................................................................... XI

Chapter 1 Introduction .................................................................................... 1
  1.1 Research Rationale ..................................................................................... 3
  1.2 Research Question and Aims .................................................................... 5
  1.3 Methodology ............................................................................................... 6
  1.4 Background to the Researcher ................................................................... 6
  1.5 Structure of the dissertation ...................................................................... 7
  1.6 Conclusion .................................................................................................. 8

Chapter 2 Competencies in Health Promotion: An Overview ...................... 9
  2.1 The role of competencies in developing an effective workforce .............. 9
  2.2 Health Promotion Competencies ............................................................. 10
  2.3 Cultural Competence ................................................................................ 12
  2.4 Māori health promotion .......................................................................... 15
  2.5 Conclusion .................................................................................................. 19

Chapter 3 Research Methodology ................................................................. 20
  3.1 Primary data .............................................................................................. 20
  3.2 Secondary data .......................................................................................... 24
  3.3 Conclusion .................................................................................................. 25

Chapter 4 Competency Developments: A Cross-Country Analysis ........... 26
  4.1 CompHP Project Competency Developments ...................................... 26
  4.2 Australian Competency Developments .................................................. 29
  4.3 Canadian Competency Developments .................................................... 31
4.4 New Zealand Competency Developments.............................. Error! Bookmark not defined.
4.5 Discussion.................................................................................................................. 40
4.6 Conclusion..................................................................................................................... 47

Chapter 5 Māori Competency Developments in New Zealand: Barriers & Enablers ...... 49

5.1 Aspects of the process that enabled Māori to participate in the consultation ............ 50
  5.1.1 Use of Tikanga Māori protocols & practices......................................................... 50
  5.1.2 Provision of adequate consultation time............................................................... 52
  5.1.3 Equity and Empowerment within the process ..................................................... 53

5.2 Aspects of the process that were barriers to Māori participation .............................. 56
  5.2.1 Limited consultation resource ............................................................................. 57
  5.2.2 Limited recognition of Māori diversity ................................................................. 58

5.3 Conclusion..................................................................................................................... 59

Chapter 6 Conclusion.......................................................................................................... 61
  6.1 Conclusion..................................................................................................................... 64

References............................................................................................................................. 65
LIST OF TABLES

Table 3.1 Demographic characteristics of participants .................................................................21
Table 4.1 Analysis of cross-country review of health promotion competency frameworks ...45
Table 5.1 Themes related to the enablers and barriers to Maori participation .........................49
LIST OF FIGURES

Figure 2.1 Te Pae Mahutonga........................................................................................................18
Figure 4.1 The CompHP Core Competencies Framework for Health Promotion ..................28
Figure 4.2 Process to review the 2012 Aotearoa Health Promotion Competencies ..........38
Figure 4.3 Aotearoa Health Promotion Competencies 2012 ..................................................39
LIST OF APPENDICES

Appendix 1 Health Promotion Forum of New Zealand............................................................74
Appendix 2 Consent form ........................................................................................................75
Appendix 3 Consent form for Employee ..............................................................................76
Appendix 4 Participant Information Sheet .............................................................................77
Appendix 5 Iwi Tribes of New Zealand ..................................................................................80
## GLOSSARY OF MĀORI WORDS

<table>
<thead>
<tr>
<th>Term</th>
<th>Translation</th>
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<tbody>
<tr>
<td>Aotearoa</td>
<td>New Zealand</td>
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<tr>
<td>Hapū</td>
<td>Kinship</td>
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<tr>
<td>Hauora</td>
<td>Health</td>
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<tr>
<td>Hui</td>
<td>To gather or meet</td>
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<tr>
<td>Iwi</td>
<td>Tribe</td>
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<tr>
<td>Kai</td>
<td>Food</td>
</tr>
<tr>
<td>Karakia</td>
<td>To recite ritual chants or prayer</td>
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<tr>
<td>Kaupapa Māori</td>
<td>Māori customary practice</td>
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<tr>
<td>Manaakitanga</td>
<td>Kindness, generosity and care</td>
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<tr>
<td>Māori</td>
<td>Indigenous person of Aotearoa New Zealand</td>
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<tr>
<td>Pakeha</td>
<td>New Zealander of European descent</td>
</tr>
<tr>
<td>Tangata whenua</td>
<td>Local/indigenous people</td>
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<tr>
<td>Te Reo</td>
<td>Māori language</td>
</tr>
<tr>
<td>Tikanga</td>
<td>Correct procedure, custom, habit or lore</td>
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<tr>
<td>Wānanga</td>
<td>To meet and discuss or deliberate</td>
</tr>
<tr>
<td>Whānau</td>
<td>Extended family</td>
</tr>
<tr>
<td>Whakawhanaungatanga</td>
<td>Relationship or kinship</td>
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Te Aka Online Māori dictionary [http://maoridictionary.co.nz](http://maoridictionary.co.nz)
# LIST OF ACRONYMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AHPA</td>
<td>Australian Health Promotion Association</td>
</tr>
<tr>
<td>APHA</td>
<td>Australian Public Health Association</td>
</tr>
<tr>
<td>CompHP</td>
<td>Developing Competencies and Professional Standards for Health Promotion Capacity Building in Europe Project</td>
</tr>
<tr>
<td>GPHC</td>
<td>Generic Public Health Competencies</td>
</tr>
<tr>
<td>HPC2012</td>
<td>Aotearoa Health Promotion Competencies</td>
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<tr>
<td>HPF</td>
<td>Health Promotion Forum</td>
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<tr>
<td>HPO</td>
<td>Health Promotion Ontario</td>
</tr>
<tr>
<td>IUHPE</td>
<td>International Union for Health Promotion and Education</td>
</tr>
<tr>
<td>MoH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>PHAA</td>
<td>Public health Association of Australia</td>
</tr>
<tr>
<td>PHAC</td>
<td>Public Health Agency of Canada</td>
</tr>
<tr>
<td>SOPHE</td>
<td>Society for Public Health Education</td>
</tr>
<tr>
<td>WACHPR</td>
<td>Western Australian Centre for Health Promotion Research</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
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CHAPTER 1 INTRODUCTION

In 2012 the HPF published a reviewed and updated HPC2012 framework; for further detail on the HPF organisation see appendices. The updated framework was informed by consultation feedback gathered from the health promotion\(^1\) workforce, as presented in chapter four. The HPC2012 were updated in response to feedback that identified that the previous health promotion competencies framework in 2002 had inadequately considered New Zealand’s\(^2\) cultural diversity, particularly in providing clear guidelines in working with indigenous Maori.

Anecdotally the New Zealand consultation process and competencies framework is considered unique in its consideration of cultural competence and inclusion of Māori. Consequently this dissertation explores whether the HPC2012 framework and consultation approach is unique when compared to other international frameworks. This chapter provides the rationale and context for this research; introducing the research question, methodology, structure and aims of the study.

To answer the research question analysis of the processes to develop health promotion competencies will be undertaken, comparing the HPC2012 framework with three other international examples. This comparison is undertaken to identify the inclusivity of the consultation processes in relation to indigenous populations and consideration of cultural competencies within the frameworks. The necessity to analyse competency development processes is informed by the requisite that all competency frameworks should support the

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\(^1\) Within the dissertation health promotion refers to the Ottawa Charter definition where health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being (World Health Organisation, 1986).

\(^2\) The Māori name for New Zealand is Aotearoa, (Moorfield, 2011) within this dissertation both Aotearoa and New Zealand will be used interchangeably.
development of a culturally competent workforce that can work effectively with indigenous populations, increasingly diverse populations and disadvantaged communities. Analysing the processes will identify if cultural competence is presented in name only or whether the processes have really positioned cultural competence and indigenous populations centrally. Developing health promotion competency frameworks that do not have cultural competence at their core and are not informed by the communities and workforce they serve will result in largely ineffective frameworks that potentially increase health inequities and thereby reduce not only the validity of the framework but health promotion practice.

To supplement the comparative analysis of competency frameworks interview data obtained from interviews undertaken with health promotion and public health leaders will be analysed; identifying the barriers and enablers to Māori participation within the New Zealand consultation process. These interview participants have previously been involved in the development of the HPC2012; enabling them to provide detailed feedback on the processes undertaken. Identifying the barriers and enablers to Māori participation will assist in answering the research question by highlighting any unique aspects within the New Zealand approach. If findings indicate that there are unique aspects within the HPC2012 process and framework it can be presented as an example of best practice that can guide future health promotion competency developments nationally and internationally.

The research followed a two-fold methodology; using secondary data a cross-country analysis of the development processes of international competency frameworks was undertaken. Thematic analysis of primary data obtained from semi-structured interviews with health promotion and public health leaders was also undertaken. Conclusions were drawn to understand and guide further research that can contribute to future competency developments. The findings indicated that there were some unique aspects within the HPC2012 development process that considered cultural competence and enabled Māori participation. The findings
also identified aspects that may have hindered Māori participation; potentially impeding the development of an effective and appropriate competency framework for Māori.

1.1 Research Rationale

There are ongoing health inequities identified between the health of indigenous and non-indigenous populations such as those presented within the United Nations Human Development Index. This index compares health and social development across countries and has regularly placed Australia, Canada and New Zealand among the top ten countries in the world for life expectancy, access to education and gross national income per capita (United Nations Development Programme, 2014). Such elevated placing is not evident for indigenous populations who are placed lower on the ranking scale for such measures (Cooke, Mintrou, Lawrence, Guimond, & Beavon, 2007); clarifying the obvious disadvantages for indigenous populations that are not just historical but ongoing (Kunitz, 1994).

These inequities are witnessed within countries such as Canada, Australia and New Zealand, where Canadian data identifies that First Nations, Inuit, and Metis people experience much poorer health outcomes than non-indigenous populations (National Collaborating Centre for Aboriginal Health, 2013). Within New Zealand the Ministry of Health’s national health survey data identifies that Māori have poorer health, more unmet health care needs and higher rates of most health conditions than non-Māori (Ministry of Health, 2013); while Australian data identifies that the overall health gap between indigenous and non-indigenous populations continues to rise (Australian Institute of Health and Welfare, 2010) and has in fact been identified as the largest in the world (World Health Organization, 2008).

These inequities are a public health concern that requires an effective response; health promotion has been identified as such a response due to its proficiency in improving health equity and consequently indigenous health (McCalman et al., 2014). To deliver such effective
Health promotion requires a competent health promotion workforce that has the skills, knowledge and cultural competence for effective practice. To support effective practice, health promotion competencies have been developed, defining the knowledge, skills and behaviour health promoters require. Such competencies are increasingly informing health promotion capacity building internationally (Barry et al., 2012). Despite their increased use, inconsistencies continue both in the understanding and application of competencies (Dempsey, Barry, & Battel-Kirk, 2010) which elevates the necessity for competency frameworks to be appropriate and effective in meeting the needs of the workforce and the communities they wish to serve.

Within New Zealand, capacity development gaps have been identified by Helen Rance who led on the health promotion competencies development work at HPF identifying the lack of baseline qualifications for health promoters, lack of career pathway and lack of nationally accredited curriculum (H. Rance, personal communication, November 15th 2013). The necessity for improved capacity building is also emphasised by Ratima (2010) who suggests that both the Māori and non-Māori health promotion workforce requires training that clarifies the misunderstanding between theory and practice. These gaps and challenges elevate the necessity for appropriate capacity building tools such as health promotion competencies that support the development of an effective health promotion workforce.

Health promotion within New Zealand is also predisposed by political influence as illustrated by its journey to date. As an approach health promotion has been identified as becoming well established during the 1980s (Wise & Signal, 2000). The 1990s witnessing a market driven agenda that elevated competition for health promotion contracts and discouraged collaboration amongst organisations and across sectors while increasing the number of non-government organisations and allocating health promotion contracts to Māori health providers for the first time (Malcolm, Barnett, & Nuthall, 1996). Labour-led
governments during 1999-2008 re-elevated collaboration between agencies and restructured primary health care resulting in primary health organisations being funded to deliver health promotion which some describe as poorly implemented with funding spread too thinly to be effective (Lovell & Neuwelt, 2011). More recently, in 2008 the National government went into coalition with the Māori party resulting in the Whānau Ora programme; a cross-government approach that integrates health, education and social services to improve family outcomes (Ministry of Health, 2015b). The government is also currently rolling out a new initiative named Healthy Families New Zealand that aims to improve people’s health and prevent chronic disease across ten locations (Ministry of Health, 2015a). This journey highlights the fragility of health promotion within New Zealand due to its dependence on the political agenda and highlights the necessity for a sustainable and effective workforce that can deliver both these current and future initiatives.

In summary, the indigenous health inequities presented alongside the identified gaps in health promotion capacity building elevates the necessity for a culturally competent health promotion workforce and consequently effective capacity development tools such as health promotion competencies not only within New Zealand but globally.

### 1.2 Research Question and Aims

The overarching goal of the research is to investigate the anecdotal claims that the HPC2012 are unique in having successfully centred Māori within the developments and outcome of the framework.

To answer the research question the study aims to:

- Compare the competency development processes of the HPC2012 framework with other international frameworks
• Identify what aspects of the New Zealand consultation process enabled or hindered Māori participation in the development of the competency framework

The findings will identify if there were any distinctive features within the New Zealand consultation approach, particularly aspects that supported meaningful contributions by Māori. Consequently findings will clarify whether the HPC2012 is an effective capacity building tool that develops a culturally competent workforce to work effectively with Māori and can therefore inform future competency development frameworks that wish to improve the health of indigenous populations.

While the primary focus of the research analysis is based on competency development within New Zealand comparison is also undertaken with other countries, namely Australia, Canada and the Developing Competencies and Professional Standards for Health Promotion Capacity Building in Europe Project (CompHP) within Europe.

1.3 Methodology

The research question is answered through a two-stage analysis that consists of a cross-country analysis of the processes undertaken to develop four international health promotion competency frameworks while the second stage draws on primary data gathered from five semi-structured interviews undertaken with health promotion and public health leaders based within New Zealand.

1.4 Background to the Researcher

The concept for the dissertation arose through my role as the national lead for implementing the HPC2012 framework and as the New Zealand representative on the International Union for Health Promotion and Education (IUHPE) global Competencies and Workforce Development Working Group.
Involvement in this work elevated my knowledge of international health promotion competencies and concern that frameworks being developed had limited consideration for indigenous populations and indigenous health promotion and so were potentially constraining the effectiveness of health promoters aiming to improve the health of indigenous peoples.

Through my role I was aware that the HPC2012 reflected indigenous health promotion and so the research was undertaken to clarify the process undertaken to develop the HPC2012 and to identify if these competencies were unique in their consideration for indigenous health promotion, and if so what processes enabled this to happen.

Despite originating from the UK and therefore being non-Māori it was my years of health promotion experience within the UK and New Zealand which I supplemented with post graduate Māori health studies that positioned my suitability to undertake the research. Despite my competencies leadership role I was not involved in the development of the HPC2012 which enabled me to be objective throughout the research.

My validation for undertaking the research is informed by my knowledge that to date health promotion competency frameworks have not been studied to consider their alignment with indigenous health promotion and their role in improving indigenous health outcomes. Also, if the research findings indicate that the HPC2012 are unique in the way in which they have been developed and informed by Māori and indigenous health promotion, they have the potential to assist health promoters working with indigenous populations internationally.

I am also aware that the health promotion approach is well established in some countries while in others it is still being developed; accentuating the necessity for best practice competency frameworks that are appropriate and effective in meeting the needs of their populations and support the development of health promotion internationally.

1.5 Structure of the dissertation

This dissertation is organized into six chapters:
Chapter one provides the rationale, aims and context of the research.

Chapter two explores the role of competencies in developing an effective workforce, particularly the health promotion workforce.

Chapter three identifies the research based methodology, rationale and design undertaken.

Chapter four provides the first empirical data, a cross-country analysis of health promotion competency frameworks.

Chapter five draws on interviews that identify the enablers and barriers for Māori participation within the health promotion competencies consultation process.

Chapter six consists of a conclusion and recommendations for future research.

1.6 Conclusion

This chapter has provided the context of the research and has identified the rationale and justification for undertaking the study. To clarify the validity of competencies within the context of this study the following chapter explores their role in developing an effective and competent workforce.
CHAPTER 2 COMPETENCIES IN HEALTH PROMOTION: AN OVERVIEW

This chapter sets the framework for this study through providing an overview of the literature on the role of competencies, particularly health promotion competencies, in developing an effective workforce. The necessity for cultural competence is explored and illustrated through presenting Māori health promotion.

2.1 The role of competencies in developing an effective workforce

The necessity to research competencies relates to their increased use within and across sectors and disciplines and, consequently, the need to ensure they are effective, appropriate and therefore fit for purpose. However, examining competencies commences with a challenge as there is lack of consensus on their definition due to the many uses of the term (Delamare Le Deist & Winterton, 2005).

Despite lack of consensus, numerous definitions contain reference to their usefulness in defining skills and knowledge (Bowen-Clewley, Farley, & Clewley, 2005; Irgoin & Vargas Zuniga, 2002; Meresman et al., 2004), while others expand their purpose defining competencies as a “useful strategy to ascertain the scope of a profession”(Hazell, Maycock, & Howat, 2004 p.16) or simply clarify that competencies bridge the gap between what is required within education and the job (Boon & van der Klink, 2002). Despite this lack of definition, competencies are increasingly being used across and within different sectors. Their use commenced within the business field particularly for recruitment and selection (McClelland, 1973) followed by the education sector where an educational transformation took place resulting in a focus on graduate competence rather than focusing on what should be taught (Harris, Guthrie, Hobart, & Lundberg, 1995). This transformation clarified graduate
expectations, defined a graduate’s future professional needs and resulted in competencies informing curriculums (Kosa, Stock, Hall, & Davies, 2007).

Within health, competencies are increasingly used within professions such as dietetics, pharmacy and nursing, particularly for training and assessment purposes (Masters & McCurry, 1990). Mental health services increasingly use competencies not only for training but also for professional registration, performance appraisals and career pathways (National Mental Health Workforce Development Co-ordinating Committee, 1999). Within public health, competencies are used to describe the abilities to perform a specific role such as a Public Health Physician (New Zealand College of Public Health Medicine, 2012) while others define the essential knowledge, skills and attitudes necessary for the broader public health workforce and practice (Public Health Agency of Canada, 2008) resulting in a baseline set of competencies for all public health roles across all public health sectors and disciplines (Public Health Association of New Zealand, 2007). As illustrated, competencies can relate to the knowledge and skills for a particular role alongside required competence for a specific discipline. Health promotion competencies are described as both core and discipline specific, their role in developing an effective health promotion workforce is now explored.

2.2 Health Promotion Competencies

Health promotion has developed over time from a behavioural focused approach to one that has diverse and defined knowledge, skills and approaches for effective practice. To support on-going developments, particularly the development of a competent workforce, health promotion competencies are being developed. These capacity building tools identify the tasks, performance, skills and abilities required of health promoters (Meresman et al., 2004) enabling health promoters to work efficiently, effectively (Australian Health Promotion Association, 2009) and to an appropriate standard (Shilton, Howat, James, & Lower, 2001).
Within health promotion there are core competencies that identify the minimum set of competencies required, forming a baseline for roles (Dempsey, Battel-Kirk, & Barry, 2011) alongside discipline specific competencies that acknowledge that some practitioners will have specialism beyond core competence (Moloughney, 2006). Dempsey (2010) identifies the roles of core health promotion competencies as training and professional development, accreditation and professional standards alongside elevating health promotion as a specialised field of practice and raising accountability of practice. Hall (2014) expands on these roles suggesting that alongside defining knowledge and practice competencies ensure that health promotion principles, values and philosophy are reflected; ensuring quality of practice and enhanced recognition of the workforce.

Developing competencies also forms a shared vision on the specific knowledge and skills required for effective practice (Battel et al, 2009) which is increasingly necessary due to the lack of consistency within current international competency developments. Consistent capacity building tools are required to strengthen workforce capacity to improve global health (Allegrante, Barry, Auld, Lamarre, & Taub, 2009) and to continue developing global health promotion (World Health Organisation, 2009). Globalisation has elevated the need for a competent workforce (Hall, 2014) that can reduce the global burden of non-communicable diseases through core health promotion skills (Shilton, Champagne, Blanchard, Ibarra, & Kasesmup, 2013) and a workforce that can work across cultures and settings with an international perspective (De Rosa, 2008).

Despite this increased recognition of health promotion’s role in addressing global health issues health promotion capacity development continues to be challenged and impacted by social, political and economic diversity (Hall, 2014). Health promotion is also confronted by those who believe that anyone can undertake health promotion (Ontario Prevention Clearinghouse, 2006) which is a negative outcome of its strategy to make health
promotion everyone’s business (Shilton, Howat, James, & Lower, 2001). Hyndman (2007) suggests that competencies can challenge such beliefs through defining the knowledge and skills required which is critical if health promoters do not want to risk losing their knowledge, values, ethics and skills within the multi-disciplinary approach of health promotion (Berentson-Shaw & Price, 2007). Davies (2013) states that health promotion’s specific knowledge, skills and approaches are increasingly being recognized, consequently increasing the number of international competency frameworks being developed. This increased recognition is challenging and raising the bar of health promotion, requiring high quality training and education that develops a skilled and competent health promotion workforce (Hall, 2014). This contemporary health promotion practice and knowledge reflects a shift in our understanding of health, developing health promotion as a field of study and a distinctive academic discipline (Davies, 2013) that has elevated discussions towards the regulation of the workforce (Barry, 2009).

To explore the role of health promotion in addressing health inequities, particularly within indigenous and increasingly diverse populations, the necessity for cultural competence is presented.

2.3 Cultural Competence

Competence within health also relates to cultural competence and, increasingly, professions, organisations and individuals are expected to be culturally competent to work effectively. However, as with generic competencies there are many definitions of cultural competency. One expansive medical definition identifies that “cultural competence requires an awareness of cultural diversity and the ability to function effectively, and respectively, when working with and treating people of different cultural backgrounds. Cultural competence means a doctor has the attitudes, skills and knowledge needed to achieve this” (Medical Council of New Zealand, 2006 p.2). This quote amongst others acknowledges that
cultural competence goes beyond having knowledge and respect of cultures as it also requires having the necessary skills and knowledge on how to use them effectively (Orlandi, 1995).

Cultural competence is vital if we wish to improve health outcomes as cultural values, beliefs and worldviews shape a person’s behaviour towards health and illness and influence interactions such as health seeking behaviour (Jansen & Sorrensen, 2002). This demonstrates that to deliver culturally appropriate programmes the workforce must not only be competent in identifying and describing different cultures but must understand how cultures influence health behaviour and use this knowledge to develop health promotion programmes (Kreuter, Lukwago, Bucholtz, Clark, & Sanders-Thompson, 2002); as consideration of cultural beliefs and values within health promotion messages (Brach & Fraserirector, 2000) results in not only appropriate but more effective programmes (Resnicow, Baranowski, Ahluwalia, & Braithwaite, 1999).

This move from cultural awareness to obtaining cultural knowledge and skills and, most importantly, their application, are accentuated with theoretical frameworks of cultural competency (Kelly, 2011). These diverse frameworks consists of the essentialism theory which has a traditional view of culture, describing it as pre-determined, static and homogenous, enabling professionals to relate to people from differing cultures more competently; while the constructivism theory observes identities as socially constructed that evolve depending on circumstances, resulting in a mobile profile where cultural competence is dependent upon the skills of the professional (Nadan, 2014). Other theories such as Campinha-Bacote’s theory illustrates that health workers become culturally competent through integrating cultural awareness, knowledge and skills through engaging with people from culturally diverse backgrounds (Campinha-Bacote, 2003) whereas the expansive theory presented by Henry Giroux goes further by also considering the power of dominant groups and the reasons for health inequities (Giroux, 2000). Despite such diversity the theories
illustrate consistency through presenting the role of communication, knowledge, skills and their place in decreasing disparities (Kelly, 2011) which is pivotal for health promotion.

The importance of cultural competency within New Zealand is emphasised by the National Health Committee which describes culture as one of the most important determinants of health, stating that strategies to improve health must be aware of the influence of culture (National Health Committee, 1998). This competence subsequently enables providers to deliver services that are respectful of and responsive to the health beliefs, practices, cultural and linguistic needs of people enabling systems, agencies and professionals to function effectively (National Institutes of Health, 2015).

For health promoters cultural competence not only relates to the delivery of effective practices, but is also informed by health promotion principles that have respect for and are sensitive to cultural diversity (Allegrante et al., 2009) that is increasingly necessary to work effectively in a globalised world and across cultures and settings (Kumas-Tan, Beagan, Loppies, MacLeod, & Blye, 2007). Within New Zealand health promoters are increasingly required to work with ethnically diverse populations resulting in cultural competence becoming a requirement under the Health Practitioners Competence Assurance Act 2003 and professional regulatory bodies setting standards of cultural competence for their members (Health Navigator New Zealand, 2013). These standards guide work that integrates cultural competence into practice and support culturally competent professions to build competency into training and professional development (Australian Government, 2005).

The theories and evidence presented have highlighted that effective health promotion practice and a competent workforce are critical to achieving health promotion’s objectives (Smith, 2006); where practice is informed by competencies that reflect diversity and are therefore effective in improving the health of populations (Kreuter et al., 2002).
Health promotion competency frameworks that reflect cultural diversity are culturally competent standards that support effective practice. To illustrate the necessity for a culturally competent workforce further Māori health promotion is presented; highlighting the knowledge, skills and approaches that health promotion standards such as competencies need to reflect if they are to effectively improve the health of indigenous people.

2.4 Māori health promotion

Prior to illustrating the principles of Māori health promotion the necessity for effective and appropriate health promotion within New Zealand is illustrated through presenting current health inequities between Māori and non-Māori. The New Zealand Health Survey illustrates health inequities, identifying that 44% of Māori adults are obese and 41% of Māori adults’ smoke, these rates are twice as high for Māori as non-Māori. For Māori males the suicide rate in 2010 was identified as 23.9 per 100,000 whereas for non-Māori males the rate was 15.4 suicides per 100,000; while Māori males have a reduced life expectancy of 7.4 years and Māori females have 7.2 years less than non-Māori (Ministry of Health, 2013). Addressing these inequities is not only a moral and human rights issue (Williams, 2011) for those they directly affect, but addressing inequities benefits the whole of society (Nana, 2013) by providing equality of opportunity, social cohesion and reduced fiscal costs (Cabinet Social Development Committee, 2004).

Health promotion recognises the benefits of reducing inequities for all and is particularly effective in reducing inequities within indigenous communities that have experienced disempowerment and dispossession through colonisation as the approach is based on the principles of equity, social justice and empowerment (McCalman et al., 2014). For Māori effective health promotion reflects indigenous values, attitudes and aspirations through supporting cultural identity and indigenous leadership (Durie, 2004). This effective practice recognises the role of culture, identity and ethnicity in achieving positive health and
social outcomes (Forster, 2008) and understands the link between health and indigenous world views (Cunningham, 2009).

Health promotion practice within New Zealand is informed by both the international framework of the Ottawa Charter and the Treaty of Waitangi. The treaty is regarded as the founding document of New Zealand that was signed in 1840 by representatives of the British government and some Māori tribes; charting the terms and conditions of the English settlement and a new relationship between the Crown and Māori (Orange, 1987). Two versions of the treaty document were written, the English version known as the Treaty of Waitangi and a Māori version written in Te Reo Māori known as Te Tiriti o Waitangi. The two versions differ in both their translation and meaning, resulting in ongoing debate related to their intention, obligations and application.

Māori health promotion aligns itself closely with the Māori version of the treaty, basing the health promotion approach on the treaty articles that relate to governance, Māori control, self-determination and equity. Both versions of the treaty were informed by the promotion and protection of Māori health and health is referenced within the texts, indicating that both versions are current and useful frameworks for Māori health development (Kingi, 2007) and both versions of the treaty inform health promotion practice within New Zealand.

To clarify our understanding of Māori health promotion Ratima (2001) describes it as a process that enables Māori to increase control over determinants of health, strengthen their identity as Māori and improve their health and position in society. Māori health promotion is a positive, holistic approach that realises Māori potential, intergenerational connectedness and spirituality (Ratima, 2010) which draws on both old and new knowledge from Māori and Western experiences while remaining grounded in distinct Māori concepts, values and worldviews and focuses on the determination of Māori to be Māori (Ratima, 2001).
This Māori philosophy of health is illustrated via Te Pae Mahutonga, a Māori health promotion model that is named after the stars of the Southern Cross that was a navigational aid associated with the initial discovery of Aotearoa and later New Zealand (Durie, 2003). It is used symbolically to bring the components, goals and tasks of health promotion together. The four central stars shape the cross and consist of the Mauriora star which refers to the development of a secure cultural identity and the importance of language, custom and a supportive whānau. The Waiora star refers to the external world, spirituality and the connection of wellness to the cosmos, earth and water. The Toiora star refers to healthy lifestyles and behaviours acknowledging health’s dependence on the social determinants of health while the Te Oranga star links wellbeing to the terms of participation within society (Durie, 1999).

Lying in a straight line there are two accompanying stars that represent the prerequisites for effective health promotion, namely the Nga Manukura star which represents leadership and refers to the range of skills and influences within health promotion such as the vital role of community leadership within successful health promotion. The Mana Whakahaere star represents autonomy and refers to the participation, control and self-determination that communities require within health promotion and promoting their health (Durie, 2003). The model clarifies that the goal for Māori health promotion is to promote the security of identity and facilitation of entry into the Māori world (Durie, 1999a). Te Pae Mahutonga clarifies an understanding of Māori health promotion as well as elevating credibility of the approach and the delivery of effective practice (Ratima, 2001) that is aligned to iwi and Māori aspirations and has been identified as a cost-effective, sustainable approach to improving Māori health outcomes (Ratima, 2010). The Te Pae Mahutonga Māori health model is illustrated in Figure 2.1.
A Treaty Understanding of Hauora in Aotearoa New Zealand (TUHA-NZ) is also a specific Māori health promotion framework that identifies effective treaty based health promotion practice and assists health promoters understand and apply Te Tiriti o Waitangi in their work. Within the framework the goals for health promotion are to achieve Māori participation in all aspects of health promotion, achieve the advancement of Māori health aspirations and undertake health promotion action which improves Māori health outcomes (Health Promotion Forum of New Zealand, 2002). Te Pae Mahutonga alongside the frameworks of Te Tiriti o Waitangi and TUHA-NZ have informed the development of effective Māori health promotion practice within New Zealand and are reflected in the HPC2012. HPF was well positioned as the organisation contracted to lead on the development of both the 2002 and 2012 competency frameworks as the organisation’s work is underpinned by Te Tiriti o Waitangi and Māori health promotion. Valuing the role of Māori health promotion HPF has proactively undertaken consultation with Māori following
the publication of the 2002 health promotion competencies framework. Feedback on the 2002 framework identified that future frameworks needed to strengthen Māori values and practices and reflect the specific New Zealand context and Māori health promotion. The result is that HPF has led on the developments that have prioritised Māori health promotion within the HPC2012 which is presented in chapter four.

2.5 Conclusion

The chapter has presented the role of competencies in developing an effective workforce and has illustrated the necessity for a culturally competent workforce to deliver effective health promotion practice. Māori health promotion has illustrated the competencies required to address indigenous health inequities; highlighting that health promotion competency frameworks that do not reflect indigenous health promotion will be largely ineffective in improving indigenous health outcomes. Recognising this HPF has undertaken consultations with Māori and considered the vital role of Māori health promotion within the development of the HPC2012. Prior to undertaking a cross-country analysis of international health promotion competency processes to identify if this New Zealand process and approach is unique, the following chapter clarifies and presents the research methodology undertaken within the research.
CHAPTER 3 RESEARCH METHODOLOGY

Research methodology relates to the research strategy being undertaken, the methods being used within a study and is usually informed by the research question (Silverman, 2000). Within this study a qualitative approach was chosen that was effective in producing words for analysis (Patton & Cochran, 2002). The approach generated information rich data, revealed critical insights (Bradley, Curry, & Devers, 2007) and an understanding of people’s experiences through asking the what, how or why questions (Patton & Cochran, 2002). It provided an effective approach to explore people’s insights on the processes undertaken to develop the HPC2012.

This study is a small scale qualitative research study that consists of primary and secondary data, with primary analysis of interview data gathered from health promotion and public health leaders in New Zealand and secondary data analysis of reports, literature and consultation documentation reporting on health promotion competency framework development processes.

3.1 Primary data

Five health promotion and public health leaders were invited to participate in the research based on their previous involvement in the development of the HPC2012. Participants were identified from consultation reports stored at HPF.

The interview process consisted of potential participants being sent an email or receiving a telephone call to gauge their interest in participating in the research. When participants identified that they were interested in participating they were provided with a participant information sheet, consent form and interview questions.

All participants who were invited agreed to participate within the research; however, prior to one of the interviews taking place a participant identified that they had been involved
in the development of the 2002 health promotion competency framework but not the 2012 framework; as a result the interview was cancelled and a new participant was sought.

Four of the participants were public health or health promotion leaders, three participants working in non-Government organisations, one participant worked in a District Health Board while one participant was retired; despite being recently retired it was appropriate for them to participate in the research as they had been instrumental in the development of the HPC2012. Participants consisted of three women and two men; all were aged over forty years of age with ethnicities consisting of Māori, Pacific and NZ European; their demographics are presented in Table 3.1.

Table 3.1 Demographic characteristics of participants

<table>
<thead>
<tr>
<th>Gender</th>
<th>Ethnicity</th>
<th>Sector/Workplace</th>
<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>Tongan</td>
<td>Non-Government Organisation</td>
<td>Health promotion leadership and Pacific health promotion</td>
</tr>
<tr>
<td>Male</td>
<td>Māori</td>
<td>Non-Government Organisation</td>
<td>Health promotion leadership and Māori health promotion</td>
</tr>
<tr>
<td>Female</td>
<td>Pakeha</td>
<td>Previously Non-Government Organisation, now retired</td>
<td>Health promotion competencies development</td>
</tr>
<tr>
<td>Female</td>
<td>Māori</td>
<td>Non-Government Organisation</td>
<td>Public health workforce development</td>
</tr>
<tr>
<td>Female</td>
<td>Māori</td>
<td>District Health Board</td>
<td>Māori health promotion</td>
</tr>
</tbody>
</table>

These participants were selected as they were able to provide information rich data in relation to the topic of interest (Palinkas et al., 2013); namely the development of the HPC2012. The sample size was small which is characteristic of qualitative data (Patton & Cochran, 2002) and was informed in the knowledge that the interviews supplemented other approaches being undertaken to answer the research question namely; a literature review, cross-country analysis of competency development processes and analysis of grey literature.

As the research aimed to explore whether indigenous health promotion had informed the development of the competency framework and whether the consultation approach had enabled Māori to participate, it was essential that Māori participated in the research.
Consequently Māori were purposefully sampled, resulting in three of the five participants identifying as Māori. As a non-Māori researcher it was not appropriate for me to practice kaupapa Māori research as this is research undertaken with Māori by Māori. However I was able to apply some tikanga Māori practices within the interview process by offering food, face to face consultation opportunities and a safe and culturally appropriate environment. Further detail on tikanga Māori practices is presented in chapter five.

Prior to the interviews taking place I confirmed that the information sheets and consent forms had been read and the consent forms signed. Participants were also invited to ask any questions related to the research or interview process.

Semi-structured interviews with open-ended questions were used to obtain specific information whilst remaining flexible to explore participant feedback (DiCicco-Bloom & Crabtree, 2006) therefore providing richer and more complex data than structured tick box interviews (Baum, 2008). The interview questions were consistently asked while providing the ability to probe more in-depth when certain topics emerged (Hill et al., 2005).

As researcher, I recorded the data through note-taking alongside audio-taping the interviews which were transcribed verbatim within a couple of days of the interview taking place. Within a week of the interview, participants were asked to validate the data by carefully reading through a copy of their transcripts; providing an opportunity to validate or refute the data and make any amendments.

Despite initially planning to undertake the interviews face-to-face practicalities meant that only two of the interviews were undertaken face to face, with one interview undertaken via SKYPE and two of the interviews being telephone interviews due to the large geographical distances between myself and the participants. All interviews lasted between

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3 Kaipapa Māori research is an element of indigenous research and a philosophy that acknowledges Māori knowledge and practices that is undertaken by Māori researchers. The approach asserts Māori worldviews and consists of not only philosophy but also theory, methodology, and practice that benefit Māori. (Health Research Council of New Zealand, 2010).
fifty and sixty minutes in length. The face-to-face interviews were planned and undertaken in Auckland and all interviews took place between November 2014 and January 2015 at a time convenient for participants.

Throughout the research process I was concerned about any perceived conflict of interest as the research participants were colleagues who either worked within the same organisation or were connected to my work through advisory boards. To minimise any potential risk to the participants or research verbal and written assurance was provided to participants stating that their participation was unconnected to their work and was completely voluntary. Participants who were colleagues based within the same organisation had an additional statement within their consent form that was supported by the organisation’s Executive Director; clarifying that their participation was completely voluntary and not connected to their employment. Participants also had the ability to withdraw from the research at any time without affecting their employment. See appendices for copies of the consent forms and participant information sheet.

Ethics approval is essential for a research study and was gained from the University of Auckland’s Human Participants Ethics Committee on November 5th 2014.

Prior to the interview I reiterated to participants that the interview was being tape recorded to ensure that they were comfortable with the recording of their data. Following each interview participants were provided with a transcript of their interview. To ensure the security of data and anonymity of participants, the signed consent forms and interview data were stored in a locked secure environment throughout the study and will be stored securely for 5 years following the study. Electronic information was stored on the HPF’s password protected electronic files and no written reports or presentations refer to the identification of participants.
The data was analysed using thematic analysis to identify, analyse and report themes within the data. Widely used within qualitative data this analysis approach was chosen to identify the patterns of meaning within the data to answer the research question (Braun & Clarke, 2006). Each of the five interviews was transcribed consistently to quickly become familiar with the detail of the text. As researcher I was directed by a recognized six-phase process that guided actions and consisting of becoming familiar with the data, undertaking coding, searching for themes, reviewing the themes, defining and naming the themes and then finally writing up the information (Braun & Clarke, 2006). Although listed systematically the process involved moving between stages so that I could truly understand the data. A Senior Māori colleague was then asked to review my analysis to ensure I was presenting accurate Māori data in a culturally competent manner.

3.2 Secondary data

The cross-country analysis of health promotion competency frameworks resulted in a wealth of data being obtained from the organisational websites of organisations that led on the competency developments. The websites consisted of the Australian Health Promotion Association (AHPA), Pan-Canadian Network for Health Promotion Competencies, IUHPE and the HPF; providing background papers, research articles and competency development reports for analysis.

The New Zealand published data was also supported by non-published reports stored at the HPF. This grey literature consisted of reports and consultation feedback gathered from the health promotion workforce to inform the development of the HPC2012. Personal communication with those that either led or were involved in the development of the competency framework provided additional clarity around the consultation processes undertaken.
The secondary data consisted of non-published or informally published reports such as internal reports and documents, known as grey literature (New York Academy of Medicine, 1999). Despite not being published grey literature is recognised as a valuable research source due to its currency and originality (Innovative Solutions, 2008). To gain access and use of this grey literature I gathered permission via a signed letter from the Executive Director of the HPF which granted me permission to access both the electronic and hard copy files that reported on the process of developing the HPC2012. Access was based on the understanding that an individual’s comments would be unidentifiable within the research. This signed authorisation was a requirement of the Auckland University Human Participants Ethics Committee and was provided as part of the ethics process.

Analysis of the secondary data consisted of identifying the processes undertaken to develop the four international competency frameworks alongside a comparative analysis of the consultation processes. The analysis focused on the approaches undertaken, consultation participants and the outcomes of the consultations with particular reference to inclusivity and cultural competence within the frameworks.

3.3 Conclusion

The chapter has outlined the approaches undertaken to answer the research question, validated the research methodology chosen and clarified the primary and secondary data used and cross-country and interview data analysis. The chapter has highlighted how Māori were meaningfully represented within the research which is not only ethical but pertinent as the research question and findings are significant for Māori. The following chapter presents the cross-country analysis of international health promotion frameworks.
CHAPTER 4 COMPETENCY DEVELOPMENTS: A CROSS-COUNTRY ANALYSIS

As noted, health promotion competency frameworks can facilitate the development of a culturally competent workforce and consequently all countries need to emphasise cultural competency and inclusivity within their competency frameworks. Anecdotally the New Zealand consultation process and framework is considered unique due to its cultural competence and inclusivity of Māori. To clarify this uniqueness this chapter will:

a. Describe the processes undertaken to develop competency frameworks within Australia, Canada, the CompHP project in Europe and New Zealand
b. Compare the consultation processes undertaken with a specific focus on the approaches undertaken, participants involved and outcomes
c. Identify any gaps related to cultural competence and inclusivity

The rationale for analysing these frameworks was based on the CompHP competency leadership in developing a European wide competency approach while the competency frameworks of Australia, Canada and New Zealand were identified for analysis based on the colonisation of their indigenous populations.

4.1 CompHP Project Competency Developments

The CompHP project has led the development of a competencies framework for Europe. The project has been supported by the IUHPEs Capacity Building, Education and Training portfolio and funded by the Health Programme of the European Union from 2009 until 2012. The project’s aim was to develop competency-based standards and an accreditation system for health promotion practice, education and training in Europe (Barry et al., 2012). With a goal of establishing consistency across Europe the project comprised of
The first draft of the competency framework was informed by an extensive literature review, workforce feedback, mapping processes to identify core competency domains and discussions at the IUHPE World conferences of 2004, 2007 and the Galway Conference in 2008 (Barry et al., 2012). The Galway Conference was organized by IUHPE, the Society for Public Health Education (SOPHE) and the US Centers for Disease Control and Prevention. During the conference a consensus meeting took place consisting of international health promotion leaders and capacity and workforce development experts to collaborate on developing workforce capacity (Allegrante et al., 2009). From the meeting proceedings a consensus statement was proposed that defined eight domains of core competencies alongside core values, principles and a common definition for effective health promotion practice (Barry, 2009).

Following the conference global consultation on the proposed consensus statement was undertaken by consulting at the IUHPE’s conference in Geneva 2010 and circulating the draft consensus statement to global health promotion experts through the IUHPE membership database, WHO regional offices and consulting with IUHPE Regional Vice Presidents (Dempsey, Barry, & Battel-Kirk, 2010).

To ensure extensive geographical reach and to “capture the diversity of views of the health promotion community in Europe” (Barry, Battel-Kirk, & Dempsey, 2012 p.650) further consultations consisted of two rounds of a Delphi survey with experts from 30 different countries, two focus groups at a pan-European level with health promotion leaders, alongside four country-specific consultations undertaken in Estonia, Ireland, Finland and the Czech Republic. To reach the extensive health promotion community within Europe (Barry, Battel-Kirk, & Dempsey, 2012) consultations were undertaken via IUHPE’s online dialogue
forum, SOPHE’s online discussion site (Dempsey, Barry, & Battel-Kirk, 2010) an online questionnaire, face book page and Twitter (Barry et al., 2012). Despite the range of consultations undertaken the consultation process was “restricted in its length and breadth because of the limited project time and resources” (Barry, Battel-Kirk, & Dempsey, 2012 p.677). Notwithstanding such restrictions, following four rounds of redrafting, the final competency framework was published in 2011, consisting of 11 core domains and 68 core competency statements based on unique health promotion concepts, theories, and research (Barry, Battel-Kirk, & Dempsey, 2012); as illustrated in Figure 4.1.

![Figure 4.1](image-url)

Figure 4.1 The CompHP Core Competencies Framework for Health Promotion (Barry, Battel-Kirk, & Dempsey, 2012)

The analysis of the CompHP process indicates that a comprehensive consultation approach was undertaken, led by health promotion experts and academics resulting in a graduate level competency framework for the European health promotion workforce.
4.2 Australian Competency Developments

Competency developments in Australia are consistent with the international health promotion developments taking place during the 1980s that consequently facilitated increased health promotion research and projects within Australia (Shilton et al., 2001). During the 1990s health promotion capacity building was prioritised, resulting in the establishment of a partnership between the Western Australian Centre for Health Promotion Research at Curtin University (WACHPR), the Health Department of Western Australia, the National Heart Foundation of Western Australia and the AHPA to undertake the first national competencies project (Shilton, Howat, James, & Lower, 2003); that resulted in the development of competencies for effective health promotion practice (Shilton, Howat, James, & Lower, 2002).

Further health promotion developments nationally and internationally elevated the necessity for these initial competencies to be reviewed during 2000/2001. The review was led by the AHPA, the National Health Promotion Workforce Development Task Group and a committee of the National Public Health Partnership Group. The review was undertaken to ensure that the competencies were relevant to current practice and to identify how competencies could advance health promotion practice (Shilton et al., 2003). Comprising of four stages the review consisted of a literature search, the establishment of an expert panel of health promotion practitioners, employers and trainers and a two-stage Delphi study (Shilton et al., 2003) to “enable a relatively large sample of key stakeholders provide their own interpretations” (Howat et al., 2000 p.34). Participants were recruited from organisational mailing lists such as the AHPA, Australian Public Health Association (APHA) and health promotion special interest groups (Shilton et al., 2008).

In 2005 further consultations consisted of a modified Delphi technique comprising of a five-stage process (Shilton et al., 2008) that resulted in input from several hundred people.
working in health promotion (James et al., 2007). The first two stages determined the practical use of competencies while the last three stages identified the core competencies required for practice regardless of workplace setting (James et al., 2007). The process consisted of reviewing and editing the 2001 competencies and was led by a project management group representing the AHPA, Public Health Association of Australia (PHAA), a health promotion special interest group and the IUHPE South West Pacific Regional Committee, (Shilton, Howat, James, Hutchins, & Burke, 2006). Stage two involved an electronic questionnaire undertaken with members of AHPA, PHAA, non-Government Organisations and State Health Departments. Practitioners were invited to provide feedback on the amended list of competencies via an anonymous, electronic, multiple-choice survey and using a rating scale to identify the relevance of each competency to health promotion practice. Parallel to these consultations comparison was also made between the results of the 2001 and 2005 reviews and undertaking discussions on the necessity for any additional competencies (Shilton et al., 2008).

Stage three involved the management committee travelling throughout Australia “visiting each state and territory” (James et al., 2007 p.4) to present consultation findings and facilitate competency workshops to “identify a wide range of potential uses of health promotion competencies” (James et al., 2007 p.5). However due to time constraints participants were unable to gain consensus on reducing the number of competencies so further feedback was obtained from participants at the 2007 National Health Promotion Conference (Shilton et al., 2008). Stage four of the process consisted of presenting updates and reviewing draft frameworks at the conference. The final stage of the process entailed the management committee reviewing conference feedback and finalising the competency list based on competencies that had received a minimum of 65% of support (Shilton et al., 2008). This identification of core competencies for health promotion was progressed by the AHPA
in 2008, resulting in a core competencies framework that is designed to be used across all areas of health promotion and is aimed at graduate level (Dempsey, Battel-Kirk, & Barry, 2011).

In relation to developing cultural competence, cultural competencies for health promotion have been developed in Australia but they are not linked to the health promotion competency framework (Dempsey, Battel-Kirk, & Barry, 2011). The Australian framework also lacks reference to Australia’s indigenous population and indigenous health promotion. A gap that is highlighted through personal communication with Dr Jenny Judd, Senior Research Fellow at James Cook University who states,

The answer to your question about competencies for Indigenous health promotion practitioners is a good one. There are a couple of sections that I have highlighted which allude to this but as you have pointed out it is not good (J.Judd, personal communication, August, 28, 2014).

Analysis if the Australian consultation process identifies that an extensive approach was undertaken that aimed to reach the health promotion workforce across a large geographical area. The process was led by health promotion leaders and academics resulting in a framework for graduate health promoters that does not acknowledge Australia’s indigenous populations.

4.3 Canadian Competency Developments

The competencies development process within Canada began at the Canadian Association of Teachers of Community Health symposium in 2000; where participants identified that broadly defined competencies could guide practice (Hyndman, 2009). Informed by increased demands for a competency based approach core competencies for the Public Health workforce were developed in 2004 (Moloughney, 2006); which consequently elevated the demands for health promotion competencies and the need to define health
promotion practice (Hyndman, 2007). The result was the establishment of a partnership between the Public Health Agency of Canada (PHAC) and Health Promotion Ontario (HPO) in 2006 to explore potential health promotion competency developments. Three significant documents were commissioned, a literature review, an environmental scan of health promotion organisations and a discussion paper. The discussion paper included a draft set of discipline specific health promotion competencies that were informed by reviewing job descriptions, gathering feedback from health promoters and revising national and international health promotion competency frameworks (Moloughney, 2006). Canada’s aim was to gain consensus on competencies that would truly reflect a Pan-Canadian perspective (Ontario Health Promotion E-Bulletin, 2008) and stimulate discussion on the required skills for health promotion practice (Hyndman 2007). Feedback was sought through the HPO and IUHPE conferences in 2007 (Ontario Health Promotion, 2007) followed by an online survey that was distributed to conference participants to identify the appropriateness and validity of the draft competencies. Recurring feedback from these consultations identified the need for competencies to “continue to reflect cultural competencies and diversity” (Ghassemi, 2009, p.17).

During 2008 further feedback was sought at the Canadian Public Health Association and HPO conferences alongside requesting health promoters to test-drive the competencies to identify their usefulness and appropriateness (Ontario Health Promotion E-Bulletin, 2008). An interactive workshop was also undertaken in Manitoba with health promoters from a range of settings where participants aimed for consensus on accepting, rejecting or recommending changes to each competency (Innovative Solutions, 2008).
Financial constraints suspended further consultations and developments until 2013 when the Pan-Canadian Committee\textsuperscript{4} on Health Promoter Competencies (Ghassemi, 2009) was supported by PHAC to provide strategic guidance on progressing competency developments. These developments consisted of a three-year project to validate competencies and undertake consultations in four Canadian provinces (Moloughney, 2014b). The initial consultation was attached to a pre-existing meeting in Manitoba in 2013 to discuss competencies, develop a competency-based workforce development toolkit and establish a pan-Canadian network of health promoters (Moloughney, 2014b). Workshop reports identify that “overall the level of agreement with the competency statements was quite high” (Pan-Canadian Committee on Health Promoter Competencies, 2014b p.17). A second consultation was undertaken in Nova Scotia during 2014 where participants used a 5-point Likert scale to identify whether each competency presented was an expected competency for all health promotion practitioners and whether it reflected their role (Moloughney, 2014a). The consultation report identifies that the “level of agreement with the competency statements was the highest to-date, which may reflect the incremental improvements in the competency set and the more recent addition of a glossary” (Pan-Canadian Committee on Health Promoter Competencies, 2014a p.18).

These consultations have informed the current draft competency framework, version 5; with further consultations planned to finalise the framework. Analysing the competency process identified a gap as none of the consultation reports presented ethnicity data, suggesting that no indigenous populations may have participated within the consultation process; however personal communication with Dr. Brent Moloughney, Public Health

\textsuperscript{4} The Pan-Canadian Committee on Health Promoter Competencies aims to enhance competency development through developing, implementing and using competencies across Canada, validating the competencies through consultation and creating and disseminating resources to support the application of competencies (Pan-Canadian Network for Health Promoter Competencies, 2014b)
Consultant and a lead author on Canada’s competency developments, highlights that some indigenous health promoters have participated in the consultation process.

Three of the provinces we consulted with have relatively large First Nations and Métis populations – two of Canada’s three Aboriginal groups. The nature of participation in the consultations varied by province. In one province, a representative from the federal government First Nations health services department participated, in another some participants were members of First Nations communities and in the third, staff from the First Nations Health Authority participated. To this point, we have not specifically attempted to engage any of the national or provincial/territorial or other Aboriginal organizations in this work, which would be a major project in itself, and be dependent upon whether these organizations would view such an endeavor as a priority. After we complete our commitment to conducting the four provincial consultations, we will be considering next steps to this work that may include engaging other parts of the country and population groups including Aboriginal populations (B. Moloughney, personal communication, May, 2015).

Analysis illustrates that the draft Pan-Canadian framework is distinctive in its specific diversity and inclusiveness domain within the framework; however despite obviously valuing diversity and culture the framework has no specific reference to Canada’s indigenous populations.

4.4 New Zealand Competency Developments

HPF is a national organisation that provides leadership and workforce development opportunities to develop an effective health promotion workforce. The organisation has been contracted by the Ministry of Health (MoH) to lead on the development of the health promotion competencies within New Zealand; where initial competency developments were prompted by workforce discussions at HPF’s annual conference in 1997. Two years of
extensive consultation followed resulting in the Health Promotion Competencies for Aotearoa 2000 (Health Promotion Forum of New Zealand, 2000). Developed to strengthen health promotion practice and informed by Te Tiriti o Waitangi and specific Aotearoa values and ethics the competencies consisted of seven knowledge clusters, nine skills based clusters and a values and ethics statement (Health Promotion Forum, 2000). The framework was regarded internationally as a valuable, ethical and culturally sensitive framework informed by Māori and Pacific Islanders and identified as appropriate for a diverse and global audience (Battel-Kirk, Barry, Taub, & Lysoby, 2009).

Following their publication consultations were undertaken in 2001 to identify the usefulness of the framework via a feedback form positioned within the framework document, a survey placed within HPF’s newsletter and through a specific competencies workshop. During 2003 further consultations consisted of meetings, discussions and a competency analysis to identify enablers or barriers to their use. A Māori specific focus group and telephone discussions were also undertaken to gather indigenous views from Māori health promotion leaders (Rance, 2014).

Informed by the initial consultation feedback the MoH contracted HPF to undertake further competency based consultations. Commencing with an internal organisational review in 2004 feedback identified that global and national developments alongside “the necessity of strengthening the content and context related to Māori values and working with Te Tiriti o Waitangi should be considered in any future competency frameworks” (Rance, 2009a). In 2006 the MoH funded seven discussion papers to facilitate capacity and capability discussions and inform future workforce developments. The authors identified that workforce development needed to be driven by a broad and inclusive definition of health promotion that draws on both Māori and Western health promotion knowledge and experience (Rance, 2014) which also informed competency development discussions.
In 2007 the Generic Public Health Competencies (GPHC) were developed for the wider public health workforce, which influenced health promotion competency developments as they were identified as underpinning and complementing the discipline specific health promotion framework (Rance, 2009b). Consequently a review of both competency frameworks was undertaken by HPF that recommended that the initial health promotion competencies be re-written to align with the GPHC to support the use of both documents and to reflect national and international health promotion developments (Rance, 2009a).

These discussions and developments resulted in the MoH contracting HPF in 2010 to undertake a full review of the 2000 competencies and to develop competencies that truly reflected national and international health promotion developments and a framework that would strengthen the capability and capacity of the workforce (Rance & Tu'itahi, 2011).

Initial consultation was undertaken with HPF staff and a few selected health promotion leaders resulting in the development of a first draft of competencies which then informed a range of broader consultations undertaken throughout 2010-2012. Consultations consisted of discussions within pre-existing meetings where participants clarified their use of competencies and reviewed draft frameworks. These discussions reiterated the importance of competencies maintaining the New Zealand context with health promotion leaders emphasising that while there might be political advantage in aligning the New Zealand competencies with the international scene it is important to keep the New Zealand special context (Health Promotion Forum, 2011). Specific competency workshops were also facilitated in four cities throughout New Zealand consisting of invited participants from HPF’s mailing list where again participants highlighted the need for competencies to reflect the unique New Zealand context and Māori health promotion, emphasising “the expectation that all health promoters are culturally appropriate to work with Māori” (Rance, 2011).
During 2011 four draft frameworks and further sub-cuts guided consultations undertaken within pre-existing meetings due to lack of specific consultation funding; “where feedback consistently referred to the need for the competencies to consider the specific New Zealand context; particularly for Māori” (H.Rance, personal communication, July 15th, 2014). Feedback collated from these consultations culminated in the launch of the penultimate draft of the competency framework at HPF’s annual symposium in 2011; where facilitated discussions enabled members of the workforce to participate in the consultation and “engaged some members of the workforce in the process for the first time” (H.Rance, personal communication, July 15th, 2014).

The range of consultation approaches undertaken to develop the HPC2012 are identified in Figure 4.2.
Figure 4.2 Process to review the 2012 Aotearoa Health Promotion Competencies (Health Promotion Forum of New Zealand, 2012a)
The outcome of the consultations was the development of the HPC2012 which consists of nine clusters of competence underpinned by knowledge, values, ethics and Te Tiriti o Waitangi as illustrated in Figure 2.3. Consistent with Te Pae Mahutonga the HPC2012 is informed by a holistic approach to health, Māori values and underpinned by cultural competence. The value of the framework is noted by Hall (2014) who suggests that the HPC2012 “demonstrates a stronger emphasis on culture, and the relationship to workforce competence, than is seen within the European context and recent related work programme. New Zealand is particularly progressive in this regard and could offer guidance to Europe (and globally), for integrating these aspects into the recently-produced competence model” (Hall, 2014, p.6). Analysis indicates that the HPC2012 has been informed by Te Tiriti o Waitangi resulting in a framework that is developed for the New Zealand context.

Figure 2.3 Aotearoa Health Promotion Competencies 2012 (Health Promotion Forum of New Zealand, 2012a)
4.4 Discussion

Based on the descriptive overviews, in this discussion section I present the findings from my comparative analysis. The analysis as noted focused on 3 aspects (a) approach, (b) participants (c) outcomes.

In terms of the approaches used, the analysis indicates that all the consultation processes were led by national organisations; however there are differences within the processes to note. The CompHP and Australian processes were not only led by national organisations but were also informed by academics and international experts. The result of this approach is that the Australian and CompHP frameworks have been developed for and aimed at graduate health promoters, “the Australian Health Promotion Association’s national competencies framework is aimed at a graduate level of competency” (Australian Health Promotion Association, 2009 p.2), the CompHP are for those “who hold a graduate or post graduate qualification in health promotion or a related discipline” (Barry et al., 2012 p.3). The implication of developing competency frameworks with an academic focus is that it potentially reduces the validity of the framework amongst the non-graduate workforce. This is particularly significant for grass roots and indigenous health promoters such as Māori who are less likely to hold graduate qualifications (Wylie & Howearth, 2012).

The Canadian consultation process is distinctive as the process was initially led by national organisations but is currently led by the Pan-Canadian Committee on Health Promoter Competencies. Having the process led by a committee of health promoters is a more inclusive approach as the committee seeks broad representation across Canada and invites the workforce to contribute either as organizational support as a network partner or as an individual active member on the committee (Pan-Canadian Network for Health Promoter Competencies, 2014a).
The New Zealand consultation process was led by a national organisation, whose work is based on human rights and Te Tiriti o Waitangi with a vision of ‘hauora- everyone’s right’ (Health Promotion Forum of New Zealand, 2010). Consequently the consultative process aimed to be inclusive by ensuring that the process was not led by academics or ‘experts’ and was an equitable process that valued and prioritised Māori participation as illustrated in chapter five.

All consultation approaches aimed to be inclusive by offering a range of consultation opportunities; however the inclusivity of the processes was hampered by limited consultation resource. Limited funding placed the Canadian process on hold until further funding was sought and limited resource reduced the scope of the CompHP consultation process that consequently was unable to gather contributions and representation from all European countries. The implications of limited consultation resource impacts on the inclusivity of the approach by restricting the opportunity to gather diverse feedback from the workforce and consequently risks the validity of the competency frameworks.

Analysis of participant diversity within the consultation process proved difficult as consultation reports presented minimal demographic data. Consequently it proved difficult to analyse the inclusivity of indigenous populations within the process. While the Canadian consultation reports identified that competencies were being developed to reflect a Pan-Canadian perspective no specific consultations were undertaken with Canada’s indigenous populations to gather indigenous perspectives. Personal communications with Public Health Leader Dr. Brent Moloughney as previously presented however does identify that some of Canada’s indigenous population had participated in consultations and further consultations are being considered. Within the Australian and CompHP process there were no specific indigenous consultations undertaken; while the New Zealand process clearly demonstrated
that specifically targeted consultations were undertaken with Māori to gather indigenous viewpoints.

The analysis indicates that all four international frameworks recruited consultation participants from organisational databases and conferences. This was particularly evident within the CompHP process where participants were invited to participate through the IUHPE database and WHO conferences. The implication of this approach is that excludes non-members or those unable to attend conferences from the consultation process. This is a resource and equity issue that is significant for grass roots health promoters who generally work in community organisations that have less workforce development funding (Wylie & Howearth, 2012) and is consequently an exclusive approach. Consultation with indigenous populations is a gap within the CompHP process. As researcher I acknowledge that consulting with indigenous populations across Europe would be challenging, it does however require noting and is acknowledged within personal communication with the IUHPE president Dr Michael Sparks who states that

The European model doesn’t really address working with indigenous people however cultural competencies for working with indigenous peoples are being designed to complement the more globally conceptualised competencies (M.Sparks, personal communication, May, 18th 2015).

The content of the four frameworks was also analysed with reference to the language used and competencies that related to diversity, culture and indigenous populations. The CompHP framework identifies that ethical practice and knowledge is based on respect for diversity including ethnicity, race and culture alongside the need for cultural diversity knowledge. In relation to practice the framework identifies the need for health promoters to consider the cultural context within assessments and to use culturally appropriate and culturally sensitive implementations and to “use culturally appropriate communication
methods and techniques for specific groups and settings” (Barry et al., 2012 p.10). The Australian framework refers to culture and diversity and identifies the need for health promoters to “apply culturally-relevant and appropriate approaches with people from diverse cultural, socioeconomic and educational backgrounds” within the program planning, implementation and evaluation competencies alongside the need to have cultural competency knowledge (Australian Health Promotion Association, 2009 p.4) The framework does not refer to indigenous populations specifically except a mention that in the future the competency framework will be expanded to cover more specialist areas such as working with Aboriginal and Torres Strait Islander. This comment clarifies that the framework is not inclusive to Australia’s indigenous population but rather identifies them as a separate population.

The current Canadian framework, version 5 is distinctive as it contains a specific diversity and inclusiveness competency domain that identifies how health promoters should interact with diverse individuals, groups and communities by recognising the need for cultural knowledge and how the determinants of health such as cultural influences the health and well-being of specific population groups and to address “population diversity when planning, implementing, adapting and evaluating public health programs and policies, applying culturally-relevant and appropriate approaches”(Pan-Canadian Committee on Health Promoter Competencies, 2014a, p.2); despite acknowledging the need to respect culture and diversity the framework does not have any specific reference to Canada’s indigenous populations.

The HPC2012 refers to Māori values and ethics and is informed by Te Tiriti o Waitangi throughout. The framework identifies the need to respect diversity of all peoples,

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5 In Aotearoa New Zealand, the traditional values inherent within whānau, hapu and iwi social structures are important aspects of health promotion action. These core values and ethical practices are consistent with the provisions, principles and articles of Te Tiriti o Waitangi. Respect for, and commitment to, and protection of Te
with specific reference to ethnic and cultural minorities particularly Pacific populations that have a special relationship with the New Zealand Government (Health Promotion Forum of New Zealand, 2012a). Respect for culture and diversity are positioned within the ethics section alongside the need for cultural diversity knowledge; while culturally appropriate approaches are positioned within the enable, communicate and assess competencies identifying that health promoters need to “work with the principles and provisions of Te Tiriti o Waitangi integrating Māori values of identity, collective autonomy, social justice and equity into health promotion action” (Health Promotion Forum of New Zealand, 2012a p.13). The need to integrate cultural requirements and Māori world views are also identified within the assess, implement, evaluation and research competencies. Illustrating that while all the frameworks refer to diversity and culture in some form or another it is only the HPC2012 that considers culture throughout the framework ensuring it is appropriate for the New Zealand context. The major findings from the analysis are presented within Table 4.1.

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Tiriti o Waitangi, including the application of Te Tiriti o Waitangi to the actions and everyday practice of health promotion (Health Promotion Forum of New Zealand, 2012a).
<table>
<thead>
<tr>
<th>Competency Framework</th>
<th>Approach Undertaken</th>
<th>Participants Involved</th>
<th>Outcomes: Diversity &amp; culture</th>
</tr>
</thead>
</table>
| Australian           | Led by national organisations, experts & academics | • Extensive workforce consultation  
• No specific indigenous population consultations undertaken  
• Ethnicity of consultation participants not identified within consultation reports | • A couple of specific statements on culturally appropriate practice, cultural competence and recognition of diversity  
• Reference to an ethical framework for competencies that values diversity  
• No specific core competencies specific to indigenous populations  
• Reference to working with Aboriginal and Torres Strait Islander populations as a specialist area of practice requiring specialist competencies  
• Language used: culture & diversity  
• For graduate health promoters |
| Canadian             | Led by national organisations initially, now led by the Pan-Canadian Committee on Health Promoter Competencies | • Extensive workforce consultation  
• No specific indigenous population consultations undertaken  
• Ethnicity not identified within consultation reports  
• Recent personal communication identifies participation from some indigenous populations within recent consultations | • A draft framework v 5 with a specific section on diversity & inclusiveness  
• No specific reference to indigenous populations within the framework  
• Language used: culture, diversity  
• No educational level identified |
| CompHP               | Led by national organisations, academics & international experts | • Extensive workforce consultation across European countries although not all countries participated  
• Ethnicity not identified within consultation documents | • Statement within the framework that knowledge & ethical practice is based on the respect for diversity, ethnicity and culture  
• Language used: diversity, ethnicity, race, culture  
• For graduate health promoters |
| New Zealand | Led by a national organisation | • Extensive workforce consultation  
• Māori targeted consultations undertaken | • A framework informed by Māori health promotion, Māori values & ethics throughout; resulting in a framework that is specific for the Aotearoa context  
• Language used: diversity, Māori, ethnicity, culture  
• Educational levels provided for guidance |

Sources: Core Competencies for Health Promotion Practitioners (Australian Health Promotion Association, 2009); Pan-Canadian health promoter competencies - Version 5 (Pan-Canadian Network for Health Promoter Competencies, 2014b); CompHP Core Competencies Framework (Dempsey et al., 2011); Ngā kaiakatanga hauora mō Aotearoa Health promotion competencies for Aotearoa New Zealand (Health Promotion Forum of New Zealand, 2012a).
4.5 Conclusion

The analysis illustrates that all competency frameworks identify the need for health promoters to value and consider diversity and culture to be able to deliver effective health promotion practice. Despite these claims it was only the HPC2012 that acknowledged and valued indigenous populations within the consultation process and framework. It was only the New Zealand consultation process that gathered and valued indigenous worldviews through ensuring that the Māori voice was heard and Māori values were represented and situated throughout the framework. This inclusive approach illustrates that New Zealand’s indigenous population was embedded throughout the process and within the framework. This clarifies that this equitable approach was not an ad-on as it was clearly not possible or appropriate to separate Māori from the competency developments unlike the Australian framework that appears to see their indigenous population as an addendum.

Situating Māori as core illustrates what makes the New Zealand consultation process and framework unique from other international examples. Clearly the New Zealand approach was systematically planned to ensure inclusivity, illustrating that competency frameworks do not just happen to become inclusive and culturally competent but are carefully considered from the onset and throughout the process.

These findings present the New Zealand consultation process as an example of best practice that truly reflects cultural competence, resulting in a capacity building tool that can effectively address indigenous health inequities. As researcher I am interested in clarifying what aspects within the New Zealand process facilitated the development of this competency framework that is appropriate and specific for the New Zealand context. Consequently the following chapter analyses interview data obtained from health promotion and public health leaders that were involved in the development of the HPC2012; identifying the barriers and enablers for Māori participation within the consultation process. The findings from this
deeper analysis will be valuable in informing future competency developments that wish to meaningfully hear the voices of indigenous populations and diverse or disadvantaged communities.
CHAPTER 5 MĀORI COMPETENCY

DEVELOPMENTS IN NEW ZEALAND: BARRIERS & ENABLERS

As noted, the inclusivity of the consultation process has identified that the HPC2012 is unique when compared with the other international examples. However, while this is illuminating, as researcher I am interested in studying and understanding the consultation process further to identify what led to the uniqueness of the approach through interviewing health promotion and public health leaders that were involved in the development of HPC2012.

This qualitative data analysis generated a number of themes from which two overarching themes were identified; enablers within the consultation process that facilitated Māori participation and allowed Māori voices to be heard alongside the barriers that could have hindered Māori participation. Within these two overarching themes four thematically distinct topics emerged namely, an inclusive process, inclusion of Māori values, limited consultation resources and lack of diversity; within which sub-themes are also presented.

Participant feedback provides the context of the competency consultation process, quotes to illustrate the findings are presented and a summary of the findings is provided at the end of the chapter.

Table 5.1 Themes related to the enablers and barriers to Maori participation

<table>
<thead>
<tr>
<th>Enablers:</th>
<th>Sub-Theme</th>
<th>Barriers:</th>
<th>Sub-Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inclusive process</td>
<td>Tikanga Māori</td>
<td>Theme</td>
<td>Sub-Theme</td>
</tr>
<tr>
<td>Adequate time</td>
<td>Empowerment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Māori values</td>
<td>Equity</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

49
5.1 Aspects of the process that enabled Māori to participate in the consultation

All participants identified that it was the inclusivity of the consultation process through the use of culturally safe practices that had enabled Māori participation. These prominent themes related to tikanga Māori practices, provision of adequate consultation time and inclusion of Māori values of empowerment and equity within the process. The most dominant theme related to the appropriate use of Māori protocols and practices (tikanga Māori) identifying that it was the use of Māori cultural practices alongside the implementation of Māori values within the process that had enabled Māori to participate effectively and safely.

5.1.1 (a) Use of Tikanga Māori protocols & practices

All participants identified that tikanga Māori practices had been considered and used within the consultation process. This is significant for Māori as tikanga practices are processes that guide behaviour and interaction in Māori culture that are based on experience and learning handed down over time and associated with a Māori worldview. An essential aspect of tikanga relates to the Māori value of manaakitanga or hospitality which when placed within the context of research relates to ensuring that participants feel comfortable and safe to participate. The sharing of kai is an aspect of manaakitanga that enhances the status of the host, the food lifts the tapu (sacred or restricted) and allows matters to become noa (unrestricted) that paves the way for good discussions (Tipene-Matua, Phillips, Cram, Parsons, & Taupo, 2012). Regarded as an important Māori value it relates to how people are

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6 Tikanga has been described as what makes Māori unique as a people. It is placed within all aspects of life and sets the codes of conduct for all situations. Examples are, interacting with people, preparing medicine, gathering kai (food), building marae, performing kapa haka, Māori language (Korero Maori, nd.).
cared for, how relationships are nurtured and has been described as the most important aspect of the consultative process (Barlow, 1991).

The significant role of manaakitanga for Māori was emphasised by participants, indicating that the provision of food within the consultation process had supported discussions, developed relationships and enabled conversations to take place “kai for healthy conversations, partnerships and forming a bond kai plays a huge part of who we are as Māori” (participant 4 Māori, female) and illustrated the role on manaakitanga throughout the process.

Karakia before hui, having kai afterwards which is part of manaakitanga and manaakitanga is not just about being a good host, all those things that come with manaakitanga- friendship... so yes tikanga Māori right throughout the process.

( Participant 4 Māori, female)

Another aspect of tikanga relates to the appropriate use of Māori consultation approaches such as face to face consultations. The significance of this approach is reflected in the Māori phrase of kanohi kitea which translates into a face which is seen and within the context of research is described as being prepared to show one’s face and share of oneself (Jones, Crengle, & McCreanor, 2006). The approach is a preferred consultation approach by Māori that subsequently results in more effective communication (Ministry of Health, 1997).

Participants emphasised the importance of the face to face consultation within the approach and how consideration of undertaking this approach had supported participation.

…from the Māori point of view the face to face meetings were very important in the whole thing so by even acknowledging that that’s important is I think gave Māori a feeling that they were well involved in the development of competencies.

( Participant 2, Māori, male)
Participants emphasised that these appropriate consultation approaches for Māori were considered from the start of the planning process, clarifying that such consideration was not an afterthought but central to the planning process “these appropriate consultation processes for Māori was discussed, this item was always about using the appropriate process” (Participant 5, Māori, female). Indicating that appropriate consultation approaches were undertaken because it was the correct way of working and that consultation with Māori was not undertaken in a tokenistic way.

I think at the planning phase it was already there and so from the onset we were assured that Māori would not only adequately feed into the development of the competencies but they were a key element really throughout the whole thing.

(Participant 2, Māori, male)

This feedback clarifies the significance of appropriate consultation approaches for Māori, indicating that the use of cultural practices is central to enabling Māori to participate in a meaningful and safe way. The feedback illustrates that these approaches were positioned within the New Zealand consultation process; demonstrating that the consideration for and use of cultural protocols and practices within the New Zealand approach is unique when compared with the other international health promotion competency frameworks.

5.1.2 (b) Provision of adequate consultation time

Participants indicated that the provision of adequate time within which to consult enabled Māori to have a voice within the consultation process. The significance of hearing the Māori voice is significant as the oral transmission of knowledge relates to identity and provides a place for Māori to stand (Walker, 2003). Within research it also refers to the Māori principle of whakawhanaungatanga (developing relationships) which allows time and space to build relationships (Jones, Crengle, & McCreanor, 2006) enabling indigenous people to
participate freely and engage in their decision-making processes and cultural protocols (Australian Human Rights Commission, 2011).

This provision of adequate time was significant for Māori health promoters as it facilitated a Māori voice throughout the process “consideration of providing adequate time for consensus had enabled Māori to participate with one participant highlighting that rushing the consultation process risked missing indigenous and cultural aspects “there is a danger there in that those important indigenous elements might have been missed” (Participant 2, Māori, male); while another participant emphasised how the process was consistent with Māori values.

I think it was done in a way where Māori values, Te Reo Māori and Tikanga Māori were used throughout the process. There was a good length of time to sit down and wānanga (discuss) to talk about different competencies particularly pertaining to Māori. It is about karakia (reciting prayers), Māori worldview those sorts of things we express throughout the process. (Participant 4, Māori, female)

The provision of adequate consultation time and partaking of cultural practices communicated to Māori that their contributions were valued as these consultations were planned throughout the process and extra resources were allocated such as time and food. Participant feedback clarifies that the adequate time to build relationships and participate in cultural practices provided a culturally safe environment that facilitated effective communication for Māori resulting in a consultation that was meaningful and not tokenistic.

5.1.3 (c) Equity and Empowerment within the process

Participants indicated that the consultation approach was informed by the Māori values of empowerment and equity which is significant as these values are positioned within Te Tiriti o Waitangi (Kingi, 2007) and the founding international health promotion
frameworks the Alma Ata Declaration (World Health Organisation, 1978) and Ottawa Charter (World Health Organisation, 1986). Frameworks that acknowledge empowerment as vital for all people to have control over their health (Green, Tones, Cross, & Woodall, 2015) which Ratima (2010) suggests is particularly important for indigenous peoples, relating empowerment to having control over the determinants of health, developing capacity and social action.

Participants indicated that the consultation process empowered Māori through enabling Māori to exercise control, have a voice throughout the process and share indigenous knowledge. Participants highlighted the value associated with gathering cultural knowledge within the process and the necessity for developing competencies that recognise the indigenous population of New Zealand which is vital and ethical due to their role in addressing inequalities.

Māori in addition to their status as tangata whenua as first inhabitants of New Zealand it’s their human right to have their cultural knowledge you know considered, included and done in the right way. (Participant 1, Pacific, male)

Another participant illustrated empowerment through highlighting the extensive consultation process that took place that had enabled the Māori voice to be heard “we had a very good broad reach throughout the public health sector in terms of Māori voice, having input into the competencies was another way of ensuring that the Māori voice was heard in the development of health promotion” (Participant 2, Māori, male).

Equity within the consultation process was highlighted through valuing the contributions of the non-qualified health promotion workforce. This value is significant for Māori who experience poorer educational outcomes compared to non-Māori (Cunningham, 2012) where only 9.1% of Māori achieve a Bachelor degree or above compared to 18.6% of European New Zealanders (Marriott & Sim, 2014) and where Māori health workers are less
likely to hold tertiary qualifications (Ratima, 2010). This contribution of the unqualified workforce is a moral issue, and equitable and inclusive approach that also acknowledges the future health promotion workforce within New Zealand as currently 50 percent of new health promoters are Māori who consequently inform health promotion developments through Māori experiences, concepts, values and worldviews (Lovell & Egan, 2011).

Participants illustrated that the approach had been inclusive and that it had valued the contributions and feedback from the non-qualified workforce recognizing that “they have skills that they brought which didn’t come with a qualification, but those were valued and those were deemed to be important” (Participant 5, Māori, female). Participants also emphasised that the approach valued the non-qualified workforce through ensuring that the approach was inclusive and not led by an exclusive group of academics and academic institutions.

There could have been a danger that academia sort of could have taken over the process and as we know a lot of the Māori working in health promotion in New Zealand they might not be at that level never the less they would have has some valuable input into them. (Participant 2, Māori, male)

This equitable approach of gathering feedback from the non-qualified workforce alongside ensuring that the process was not led by academics ensured that Māori had a voice throughout the process and valued the contributions of grass roots health promoters that tend to have fewer qualifications consequently prioritising lay health promotion and indigenous knowledge. Having academics lead on the process like other international frameworks would have excluded Māori from aspects of the consultation process, resulting in academically focused competencies that would have been irrelevant for some sections of the New Zealand workforce.
It was this equitable approach that participants were particularly forthright in emphasising, highlighting that it was this approach that made the New Zealand process unique from other international competency consultation processes “I am aware of how we have right from day one included indigenous knowledge, acknowledged the rights of tangata whenua compared to Canada or for that Australia” (Participant 1, Pacific, male). Participants proposed that the New Zealand process could be an example of best practice that could inform other countries with indigenous populations “so the hope is for me is to use the competencies to inform how other nations may do the same thing” (Participant 2, Māori, male) and was reiterated by participant 1.

Our competencies are potentially relevant internationally while at the same time it caters for our national needs; that is rather unique I think so we are not imposing our model we design a model that is inclusive and collaborative. (Participant 1, Pacific, male)

As this section illustrates, the HPC2012 is unique in the way it considered and planned appropriate consultation approaches, facilitated the use of cultural practices and valued both indigenous and lay knowledge; enabling Māori to have a voice throughout the process.

5.2 Aspects of the process that were barriers to Māori participation

Alongside identifying aspects of the consultation process that had enabled Māori participation participants also identified aspects of the consultation that were potential barriers to Māori participation. These themes related to the limited resources allocated to the consultation process and lack of recognition of diversity within Māori communities.
5.2.1 (a) Limited consultation resource

Participants indicated that the scope of the consultation process had been constrained by limited consultation resources which is significant as effective consultations require time and financial resources invested to minimise the risk of domination by special interest groups and ensuring equity within the process (Synnott & Katscherian, 2006). This highlights the need to recognize potential risks associated with inadequate consultations namely, criticism by stakeholders, bias, ill-informed comments, lack of buy-in and lack of information for thorough analysis (Allen & Clarke, 2007). Such risks suggest the necessity for a targeted and direct consultation process with diverse engagement opportunities (Synnott & Katscherian, 2006).

Diverse opportunities were provided within the consultation process however limited resource did affect the consultation scope as it was “influenced by time and financial resources” (Participant 1, Pacific, male). Consequently a reduced number of specific competency consultations were undertaken and many consultations were undertaken in an ad-hoc manner by adding competency discussions into pre-existing meetings “most of the consultation and review was undertaken as agenda items as part of existing meetings, there was no funding for separate consultation” (Participant 3, pakeha, female).

Some participants reported that this ad-hoc manner had enabled further consultation opportunities as participants took draft competency frameworks into organisations to discuss within their teams, while other participants remained critical of the lack of specific consultation resource “I felt that it wasn’t adequately funded. We had to build it into other things, make other things look like, no we made it look like other things and in fact it was competency consultation (Participant 3, pakeha, female).

The informality of the ad-hoc approach may have facilitated further discussions but consequently it presents difficulty in defining the scope of the consultation process as there is
limited demographic data recorded. The result is difficulty in identifying whether the ad-hoc approach had been an enabler or barrier to Māori participation.

Clearly the limited consultation resources would have impacted on meaningful Māori participation as it reduced the number of face to face consultations and consequently the opportunities for Māori to contribute within culturally safe environments; illustrating that limited consultation resources were a barrier to Māori participation.

5.2.2 (b) Limited recognition of Māori diversity

Participants indicated that the consultation process did not acknowledge the diversity of Māori communities, while the consultation approach aimed to be inclusive through facilitating Māori participation there were no specific and distinct iwi consultations undertaken. The consultations targeting Māori were generically open to anyone who self-identified as Māori; potentially lacking recognition of the diversity within Māori communities.

This lack or recognition of diversity is significant for Māori communities and consequently health promotion competency frameworks as it does not acknowledge that different iwi, hapū and whānau have differing cultural traditions and health beliefs (Best Practice Journal, 2008) with different applications of tikanga Māori, differing worldviews and bodies of knowledge (Te Papa National Services Te Paerangi, 2006)\(^7\). Clarifying that a one size fits all approach will fail Māori and will increasingly do so with growing diversity within Māori communities due to increased self-identity, ethnic migration and mixed ethnicity (Cunningham, 2012).

\(^7\) Many Māori view hapū and iwi identity as a prerequisite to Māori identity, however this is not essential or accessible for some. Some Māori acknowledge their iwi but do not identify their ethnicity as Māori while others may know their iwi but it is not central to their identity. Therefore Māori express a range of identities in different contexts that can be dependent on the situation and or change over time. Validating Māori rights to name and claim individual and collective identities (Robson & Reid, 2001)
Participants highlighted different iwi identities and consequently questioned the impact of the competency framework that regarded Māori as a homogenous group “Maori are still very strong with their iwi identities one wonders at that you know deeper level of details whether our competencies are able to address that” (Participant 1, Pacific, male) while one participant also emphasised the diversity within iwi but considered that there was consensus gained within the consultation process.

…There is some diversity in the way different iwi see things too so although that could have been problematic it doesn’t seem to have sort of occurred. That was a risk from the onset but I think there was sort of general consensus from Māori working in health promotion. (Participant 2, Māori, male)

As this section illustrates the consultation process was not flawless as there were constraints and gaps that presented barriers to meaningful Māori participation. Resource constraints limited the scope of appropriate and safe consultation approaches for Māori and situating Māori in one homogenous group potentially hindered the gathering of diverse indigenous viewpoints and the consensus necessary to develop appropriate and effective competency frameworks. To explore the scope of diverse Māori communities see appendices.

5.3 Conclusion

The chapter presented the enablers and barriers for Māori participation within the New Zealand consultation process, illustrating positive and negative aspects within the process that can inform future competency developments in New Zealand and globally, to improve indigenous health and reduce indigenous health inequities. The analysis has identified best practice approaches that can facilitate the inclusion and voice of diverse cultural groups within future competency consultations and frameworks. The findings clearly demonstrate that the New Zealand consultation process was unique, resulting in the
framework’s content being unique and consequently the HPC2012 can be identified as a unique framework. To conclude the study the following chapter presents the conclusion of the study and recommendations for future research.
CHAPTER 6 CONCLUSION

Anecdotally the New Zealand consultation process and framework is considered unique due to its inclusivity of Māori. Therefore the primary aim of this study was to clarify if there was sufficient evidence to underpin this claim. The study consisted of two stages, a comparative analysis of the HPC2012 against other international examples and identifying aspects of the New Zealand consultation process that enabled Māori to have a voice though interviewing health promotion and public health leaders that had been involved in the development of the framework.

The analysis has clarified that both the New Zealand consultation process and competency framework have been informed by an inclusive approach that has prioritied Māori. This inclusivity refers to the framework’s content that is informed by Māori health concepts and Te Tiriti o Waitangi alongside the consultation process that was informed by the values of empowerment and equity; resulting in a process that valued lay and Māori knowledge and facilitated culturally safe environments to capture Māori worldviews.

The reason for studying the development process extends beyond stating that a process existed but rather probes into the nature of the process undertaken within New Zealand and how this process is different from other international frameworks. The New Zealand process is significant for Māori as an effective framework goes beyond simply referring to cultural competence but actually contemplates how the consultation and development approach refers to and considers cultural competence.

This study has demonstrated that to develop an appropriate and effective health promotion competency framework that can address Māori health inequities an approach is required that goes beyond just having Māori present and participating in name only, but relates to meaningful Māori participation with involvement at a much deeper level. The
findings illustrate that to ensure representation of Māori voices there needs to be a clearly stipulated pathway that allows Māori to be present that is clearly inclusive and clarifies who needs to participate to ensure that participation does not happen arbitrarily. Consultation and participation needs to happen on Māori terms through the use of tikanga practices such as manaakitanga and importantly, the voice of the grass roots health promoters and not the voice of the academic need to be heard.

The findings illustrate that the New Zealand approach positioned Māori as core throughout the consultation process, demonstrating that within New Zealand cultural competence is not considered an appendage but is fundamental, therefore making the HPC2012 unique when compared to the other international health promotion competency frameworks.

The analysis also identified gaps within the process, illustrating that the lack of dedicated consultation resource potentially hindered Māori participation; clarifying that effective and appropriate consultation remains susceptible to funding priorities, institutional constraints and political will. The lack of consideration for Māori diversity within the process is also a finding that should inform future competency developments within New Zealand.

The findings presented are particularly pertinent with the increased developments of health promotion competency frameworks that are informing health promotion practice and will prove particularly valuable for health promoters addressing indigenous health inequities.

The strengths of the research refer to its contribution to the currently limited knowledge on the role of health promotion competencies as an effective capacity development tool to address inequities and improve indigenous health. It also illustrates a consultation process as an example of best practice for appropriate and effective consultations with Māori that can inform future consultations with indigenous populations both within New Zealand and globally. A potential limitation of the research relates to the information rich
data that was gathered from those involved in the development of the HPC2012 which has the potential to influence findings as participants may have a personal interest in reflecting that the consultation process was effective and an inclusive approach.

As researcher I increasingly became aware throughout the study of the challenges of consulting across the large geographical areas of Australia, Canada and Europe and the scope of indigenous populations, languages and cultural practices across these areas; however despite such challenges I suggest that the values, principles and approaches illustrated within the New Zealand consultation process should inform future competency consultation and development processes globally.

Based on the findings of the research, the following recommendations for action and for future research are proposed. The present research undertook to identify the factors that facilitated (and disabled) the formulation of a Maori-centred competency framework for health promoters. The effective and appropriate processes of consultation offer some clear guidelines for good practice for future competency developments within health promotion that can be used in other country contexts, but equally within allied practices in New Zealand as well. However, the development of the HPC2012 is part of the wider process of creating health promotion workforce and methodologies that are inclusive. Consequently, the construction of this framework alone will not necessarily ensure improvement in the levels of health inequities experienced by Maori. Given that a reasonable timeframe has elapsed since the HPC2012, further research is required to identify how effective the culturally-sensitive competency framework is in improving health outcomes for indigenous and marginalised communities. Finally, as was revealed in the interviews for this research, there are also other non-Maori areas of ethnic diversity within New Zealand such as Asian and Pacific peoples consequently future health promotion competency frameworks need to apply cultural
competency within their consultation process and outcomes to develop a framework that meets the needs of increasingly diverse populations.

6.1 Conclusion

The study has answered the research question and clarified that the HPC2012 is unique; providing an example of best practice that is values driven and inclusive. The analysis illustrates that it is the inclusivity of Māori and Māori values within the consultation process alongside positioning Māori throughout the competency framework that makes the New Zealand approach and framework unique. This positioning of Māori as central illustrates that the framework is appropriate for the New Zealand context resulting in a framework that is an effective capacity development tool to improve Māori health and reduce inequities.
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Appendix 1 Health Promotion Forum of New Zealand

The Health Promotion Forum of New Zealand - Runanga Whakapiki Ake i te Hauora o Aotearoa (HPF) is a national organisation based within New Zealand that was established in 1987. The organisation is founded on the principles of Te Tiriti o Waitangi and the Ottawa Charter with a vision of Hauora - Everyone’s Right through health promotion. It is a non-profit organisation consisting of over 100 organisational members that is managed by a board of health promotion and public health experts. Identified as an umbrella organisation for all those who identify health promotion as part of their work it offers training, publications, research and health promotion competencies to build the workforce and health promotion leadership.

HPF also co-hosts the South West Pacific Regional Office of the International Union for Health Promotion and Education (IUHPE), and is a member of the Global Executive Board of IUHPE.

http://www.hauora.co.nz
Appendix 2 Consent form

CONSENT FORM
THIS FORM WILL BE HELD FOR A PERIOD OF 6 YEARS

Master in Public Health Dissertation

Research Question: What is so unique about the Aotearoa New Zealand health promotion competencies?

Researcher: Karen Anne Hicks

- I have read the Participant Information Sheet; have understood the nature of the research and why I have been selected. I have had the opportunity to ask questions and have them answered to my satisfaction.

- I agree to take part in this research.

- I understand that I am free to withdraw from participation during the interview without giving a reason and can withdraw my data up to a month following interview.

- I understand that I will be offered the transcript of my interview to be edited within two weeks after receipt of the transcript.

- I agree / do not agree to be audiotaped.

- I wish / do not wish to receive the summary of findings.

- I understand that data will be kept for 6 years, after which they will be destroyed.

Confidentiality and your participation is an important part of this research; however your confidentiality cannot be guaranteed. However to protect your interests, no information that could identify you will be used in any of the research outputs.

Name

Signature

Date

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 5.5.14 FOR (3) YEARS REFERENCE NUMBER 012951.
Appendix 3 Consent form for Employee

CONSENT FORM
THIS FORM WILL BE HELD FOR A PERIOD OF 6 YEARS

Master in Public Health Dissertation

Research Question: What is so unique about the Aotearoa New Zealand health promotion competencies?

Researcher: Karen Anne Hicks

• I have read the Participant Information Sheet; have understood the nature of the research and why I have been selected. I have had the opportunity to ask questions and have them answered to my satisfaction.

• I agree to take part in this research.

• I understand that I am free to withdraw from participation during the interview without giving a reason and can withdraw my data up to a month following interview.

• I understand that my Executive Director has given written assurance that my participation or non-participation will not affect my working relationship or employment status within the company.

• I understand that I will be offered the transcript of my interview to be edited within two weeks after receipt of the transcript.

• I agree / do not agree to be audiotaped.

• I wish / do not wish to receive the summary of findings.

• I understand that data will be kept for 6 years, after which they will be destroyed.

Confidentiality and your participation is an important part of this research; however your confidentiality cannot be guaranteed. However to protect your interests, no information that could identify you will be used in any of the research outputs.

Name ________________________________

Signature ____________________________ Date __________________

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 5.5.14 FOR (3) YEARS REFERENCE NUMBER 012951.
**PARTICIPANT INFORMATION SHEET**

**Project:** What is so unique about the Aotearoa New Zealand health promotion competencies?

**Supervisor:** Dr Jennifer Hand

**Researcher:** Karen Anne Hicks (Masters of Public Health student)

Kia ora,
My name is Karen Anne Hicks and I am a Masters student at the School of Population Health at the University of Auckland.

Internationally health promotion is being guided by competencies that inform knowledge and practice that is critical to the efficient and effective delivery of health promotion. Within Aotearoa New Zealand competencies have been developed reflecting specific Aotearoa New Zealand health promotion practice and knowledge.
The research will explore if this consideration of indigenous health promotion within competency development is unique and will help answer the question: what if anything, is unique about the Aotearoa New Zealand health promotion competencies?

You are being invited to participate in this research as you have been identified by the researcher as a health promotion leader within Aotearoa New Zealand with specific knowledge related to the development of Nga Kaikatanga Hauora mo Aotearoa-Health Promotion Competencies for Aotearoa New Zealand 2012.

**What the research involves for you:**
The research involves a one on one interview with the researcher at a time and place that is convenient for you. The interview will consist of open ended questions related to the topic that is tailored to your area of work and/or expertise. During the research process you may identify documents or evidence relevant to the research that you are willing to share with the researcher. These documents will be used by the researcher in conjunction with the interview data to develop a broad, contextual understanding of the issue. Following the interview the researcher may contact you via e-mail to discuss issues that arise from the data analysis.

Your participation is expected to require no more than 2 hours of your time, over 1-2 months. This includes an hour for an interview, time to review the transcripts and some follow up emails to clarify any issues that may arise. You will be offered the transcript of your interview to be edited within two weeks after receipt of the transcript.

There are no physical or mental risks anticipated as a result of your participation in this project. However there is a risk that you may share some personal or confidential information by chance, or that you may feel uncomfortable talking about some of the topics. We do not wish for this to happen. You do not have to answer any question or take part in the interview if you feel the
question(s) are too personal or if talking about them makes you uncomfortable.

There may also be no benefits to you directly as a result of your participation. However the findings from the research may inform future health promotion competency development and may contribute to supporting an effective health promotion workforce. The community of Aotearoa New Zealand will benefit from health promotion best practice and an effective health promotion workforce.

Use of the data:
The interview itself will be recorded on an audio recorder and analysed by the researcher. Data collected will be used to form part of the researcher’s dissertation for the Masters in Public Health. It may also be used for wider publication including reports, articles and conference presentations. Any physical copies of data will be kept in a secure lock box. The electronic data will be kept on a secure computer and any physical data will be kept in a secure lock box. If you have provided documents or evidence to the researcher and have indicated that these are to be kept confidential, these documents will not be referred to in any of the project outputs. Nor will the information contained within be shared with anyone outside of the research team. If you require, these documents can be returned to you at the end of the research period.

Protecting your rights:
As colleagues of the researcher please note that you still have a choice to participate in the research or not; participation is completely voluntary and you should not feel that you have an obligation to participate because you are a colleague. Should you choose to participate you can withdraw from participating during the interview without giving a reason and you can withdraw your data for up to a month after the interview. Your Executive Director has given written assurance that your participation or non-participation will not affect your working relationship or employment status within the company.

Confidentiality, anonymity and your participation is an important part of this research. To protect your interests, no information that could identify you will be used in any of the research outputs.

Thank you for your participation and contribution to this research. If you have any questions or concerns about the research, contact details are provided below.

Contact details:

Researcher:
Karen Hicks
Auckland University (via Dr. Jennifer Hand)
Department of Social and Community Health
University of Auckland, Tamaki campus
Email: Khic309@aucklanduni.ac.nz

Supervisor:
Dr Jennifer Hand
Department of Social and Community Health
University of Auckland, Tamaki campus
Email: j.hand@auckland.ac.nz
“For any queries regarding ethical concerns you may contact the Chair, The University of Auckland Human Participants Ethics Committee, The University of Auckland, Research Office, Private Bag 92019, Auckland 1142. Telephone 09 373-7599 extn. 87830/83761. Email: humanethics@auckland.ac.nz.”

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 5.5.14 for (3) years, Reference Number 012951.
Appendix 5 Iwi Tribes of New Zealand (New Zealand Trade & Enterprise, 2014)