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

MŪori health promotion ï a comprehensive definition and strategic considerations

Prepared for the Health Promotion Forum of New Zealand

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May 2010

Acknowledgements

We acknowledge and thank those experts in MŪori health promotion practice who have contributed to the preparation of this paper by discussing with the author their views on strategic considerations in MŪori health promotion. Thanks to;

Grant Berghan, CEO, Hauora.com,

Kathrine Clarke, Manager Keeping Well Project, Hutt Valley DHB,

Dr Heather Gifford, Director, Whakauae Research Services,

Edith McNeill, Planning and Funding Manager MŪori Health, Waitemata DHB,

Tereki Stewart, CEO, TŪmaki Healthcare, and,

Megan Tunks, Kairautaki/Kairangahau, Hapai te Hauora Tapui Ltd.

Nei rŪngŪmihi ki a koutou i tautoko mai i tŪhei mahi.

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Executive summary

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

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

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

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

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

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

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

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

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

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

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

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

Introduction

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

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

A comprehensive definition of Māori health promotion[1]

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

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

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

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

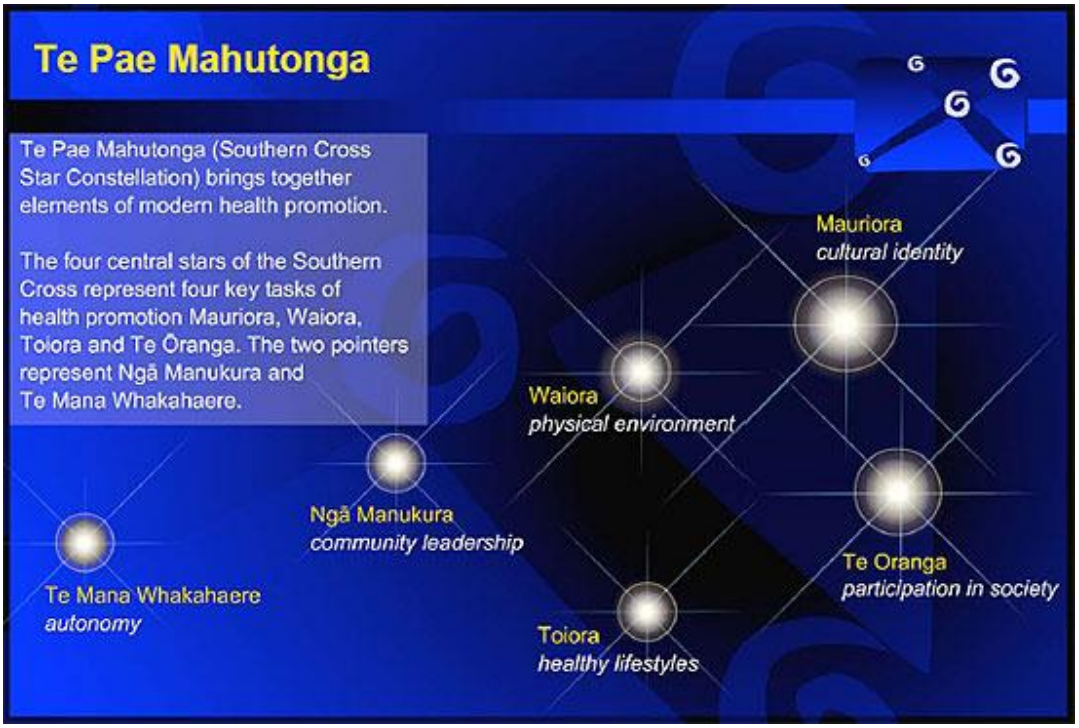
The four key tasks of MŪori health promotion identified in the model are mauriora (access to the MŪori world), waiora (environmental protection), toiora (healthy lifestyles), and te oranga (participation in society).

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

[1] This section of the paper is largely drawn from the doctoral thesis óKia Uruuru Mai a Hauoraô (Ratima 2001)

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

Figure 1.



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

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

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

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

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

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

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

Characteristics	**Māori health promotion**
Concept	The process of enabling Māori to increase control over the determinants of health and strengthen their identity as Māori, and thereby improve their health and position in society.
Concept of health	A balance between interacting spiritual, mental, social, and physical dimensions.
Purpose	The attainment of health, with an emphasis on the retention and strengthening of Māori identity, as a foundation for the achievement of individual and collective Māori potential.
Paradigm	Māori worldviews
Theoretical base	Implicit
Values	Māori identity, collective autonomy, social justice, equity
Principles	Holism, self-determination, cultural integrity, diversity, sustainability, quality
Processes	Empowerment, mediation, connectedness, advocacy, capacity-building, relevance, resourcing, cultural responsiveness
Strategies	• Reorienting health systems and services towards cultural and health promotion criteria • Increasing Māori participation in New Zealand society • Iwi and Māori community capacity-building • Healthy and culturally affirming public policy • Intra- and inter-sectoral measures to address determinants of health • Effective, efficient, and relevant resourcing of Māori health
Markers	Secure Māori identity, health status (positive and negative), health determinants, strengthening Māori collectives

Source: (Ratima 2001)

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

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

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

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

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

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

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

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

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

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

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

Six MŪori health promotion strategies identified in the framework are:

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

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

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

Strategic issues in Māori health promotion

The changing political environment

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

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

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

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

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

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

Community action

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

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

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

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

Evidence-based Māori health promotion

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

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

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

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

Workforce development

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

A profile of the Māori health promotion workforce

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

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

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

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

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

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

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

An optimum Māori health promotion workforce

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

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

Strengthening workforce competencies

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

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

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

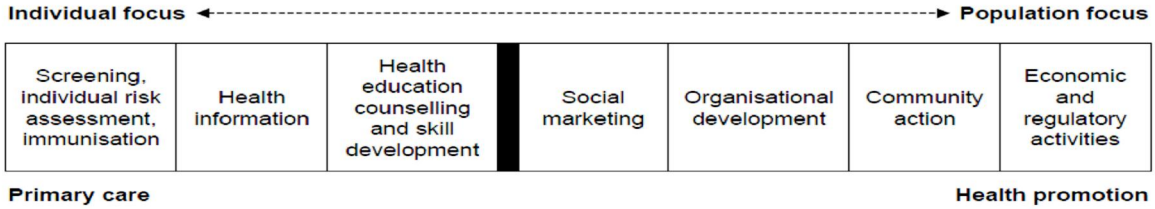
The capacity of the MĀori health promotion workforce to contextualise their work within broader public health frameworks and to utilise health promotion theory to inform practice is limited by a lack of formal training in public health and health promotion. Despite the potential benefits of theory in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

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

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

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

Figure 2. Activities used to improve individual and population health



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

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

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

Access to training

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

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

Table 2. Barriers to Māori access to health promotion training

Categories	Barriers
Structural	social factors economic factors institutional racism poor alignment between health and tertiary education sectors
System	primary and secondary school education barriers poor access to quality health career information tertiary education system • high cost and low awareness of funding sources • location of courses • long course lengths/heavy study workloads • narrow entry criteria that does not take account of prior learning • inadequate MŪori specific support programmes • poor promotion of training opportunities among MŪori providers • low MŪori representation • lack of formal links between MŪori stakeholders and academic departments • system is not ôMŪori friendlyô
Organisational	low educational institution commitment • lack of availability of courses • institutions/programmes not ôMŪori friendlyô • lack of MŪori specific study pathways or programmes delivered in a way that is appropriate to MŪori and that facilitates accelerated study • poor integration of MŪori health promotion course content • lack of value attributed to MŪori health promotion models, frameworks and concepts • lack of or limited access to programmes delivered in a way that is appropriate to MŪori • limited opportunities for practicum placements with MŪori providers • personally mediated racism low health institution commitment • lack of support for study and other professional development
Individual	limited whŪnau experience in tertiary education work and whŪnau commitments MŪori community expectations

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

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

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

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

Table 3. Facilitators of Māori access to health promotion training

Categories	Facilitators
Structural	social factors economic factors alignment between health and tertiary education sector
System	enhanced responsiveness of primary and secondary school education access to quality career information and advice enhancement of the tertiary education system • financial support available • course provision in workplaces and MŪori contexts • part time and short length courses available • flexible entry criteria that take account of prior learning • promotion of training opportunities among MŪori providers • a strong MŪori presence within the sector • clear and accelerated study pathways • formal strategic alliances between MŪori stakeholders and academic departments
Organisational	educational institution commitment • MŪori health promotion content well integrated into papers that are relevant to the workforce • MŪori health promotion papers delivered • bridging programmes, staircasing and MŪori student support • formal partnerships with MŪori health promotion providers • working with MŪori health promotion stakeholders to determine MŪori health promotion needs health institution commitment • employer study expectations and support • culturally safe and supportive, valuing MŪori competencies • clear career pathways • placements and internships • provision of workplace training • cultural supervision and mentoring
Individual	whŪnau encouragement and support practical experience and links to the health sector desire to work with MŪori and make a difference to MŪori health desire to improve health system responsiveness to MŪori

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

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

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

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

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

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

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

Leadership

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

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

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

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

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

Concluding comments

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

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