A Dynamic Evidence-Base: Service and Clinical Quality Initiatives addressing Pacific Peoples' Health Needs

Prepared for Pacific Perspectives on behalf of
Te Puni Kōkiri
Ministry of Māori Development
and
Ministry of Health
Manatū Hauora

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For further information about or to contribute to this dynamic evidence-base, please contact Dr Ryan –pacificperspectives@clear.net.nz.

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1. Executive Summary

The New Zealand Government is determined to turn around poor Pacific health outcomes by providing better services closer to home, supporting effective Pacific providers and models of care, and better enabling Pacific peoples and communities to be healthy. In response to these priorities, the Ministry of Health has setup the Pacific Grants Fund to be managed and supported by Pacific Perspectives. The purpose of the Pacific Grants Fund is to support the objectives of 'Ala Mo'ui and Whānau Ora by providing funding to assist with their implementation.

The Pacific Grants Fund will enable selected health and disability service providers to undertake initiatives that will lead to service and clinical quality improvements and innovation to address Pacific peoples' health needs. Funded initiatives should therefore demonstrate evidence of what works in improving Pacific peoples' health outcomes so that successful practice can be shared and applied across the health sector through a **dynamic evidence-base**.

The goal of this stocktake and literature review is to start this process by showcasing recent initiatives that seek to improve service delivery and/or clinical quality to address Pacific health needs in New Zealand. Over the next two years, the Pacific Grants Fund will help grow and disseminate this evidence-base by including reports from funded initiatives.

In completing this stocktake and literature review it is evident that across New Zealand innovative initiatives are being undertaken that seek to improve service and clinical quality to improve Pacific people's health outcomes. However, many of these are not formally written up and are not being evaluated, or this information is not being made available to the wider health sector.

Early review of four Pacific initiatives seeking to apply the principles of Whānau Ora show some promising alignment with Pacific models of care and 'Ala Mo'ui. The four Pacific demonstration models offer the health sector an opportunity to gain insight into how the principles underpinning Whānau Ora service delivery may apply within a Pacific context. Through the use of action research, the four Pacific demonstration models will contribute significantly to the evidence-base of effective practice to achieve desired outcomes for Pacific peoples.

In this context, the Pacific Grants Fund's dynamic evidence-base will become an important source of information to inform sector-wide practice in the future.

2. Introduction

2.1 Background

The New Zealand Government is driving significant change in the health and disability sector through its increased focus on evidence-based decision-making and by prioritising resources for frontline services. In response, the Ministry of Health has set-up the Pacific Grants Fund to be managed and supported by Pacific Perspectives, a consultancy that advises government agencies on policy and implementation in relation to Pacific populations in New Zealand and the Pacific. The purpose of the Pacific Grants Fund is to support the objectives of 'Ala Mo'ui and Whānau Ora by providing funding to assist with their implementation[1].

The Pacific Grants Fund will enable selected health and disability service providers to undertake initiatives that will lead to service and clinical quality improvements and innovation to address Pacific peoples' health needs. Funded initiatives should therefore demonstrate evidence of what works in improving Pacific peoples' health outcomes so that successful practice can be shared and applied across the health sector through a **dynamic evidence-base**.

The goal of this stocktake and literature review is to start this process by showcasing recent initiatives that seek to improve service delivery and/or clinical quality to address Pacific health needs in New Zealand. Over the next two years, the Pacific Grants Fund will help grow and disseminate this evidence-base by including reports from funded initiatives.

This stocktake and literature review therefore supports the objectives of 'Ala Mo'ui by:

- summarising health service quality improvements in New Zealand
- analysing health service quality improvements in New Zealand to identify effective approaches and initiatives that the health sector may apply more widely
- delivering findings that may be integrated into health services to address service delivery and clinical quality improvements to address Pacific health needs
- stimulating a focus on innovative quality improvement initiatives more generally
- promoting the Fund and its specific objectives by disseminating the report to providers working with Pacific peoples and mainstream health service providers
- maximising the likelihood of applications that reflect new and innovative practice.

Working with Te Puni Kōkiri, the stocktake and literature review will also contribute to sector understanding of the use and effectiveness of Whānau Ora in addressing Pacific peoples' health needs.

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[1] *'Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2010–2014* (Minister of Health and Minister of Pacific Island Affairs 2010) sets out the priority outcomes and actions for the next five years that will help achieve better health outcomes for Pacific peoples, families and communities. Whānau Ora is an inclusive approach to providing services and opportunities to all families across New Zealand. It empowers families as a whole, rather than focusing separately on individual whānau members and their problems. It requires Government agencies *to work together with families, rather than separately with individual family members.*

2.2 Stocktake and literature review approach

A stocktake of New Zealand health initiatives targeting Pacific peoples and any accompanying evaluation was undertaken, together with a review of national and international literature, to address the following questions:

- What are the existing targeted service and clinical quality initiatives and other innovations that seek to address Pacific peoples' health needs in New Zealand?
- What is the evidence that these Pacific initiatives are effective?
- What are the constituent elements and factors of effective initiatives that contribute to service and clinical quality improvements that address Pacific health needs?
- What are the existing (Pacific) targeted initiatives that use Whānau Ora approaches to address service and clinical quality?
- What does Whānau Ora look like in a Pacific context?
- What evidence exists that Whānau Ora approaches address Pacific health needs?

For the purposes of this review, **targeted initiatives** were defined as initiatives that:

- demonstrate Pacific models of care
- are delivered by either Pacific or non-Pacific providers
- are innovative projects/programmes and not business-as-usual contracts
- are undertaken in New Zealand
- commenced in the last three to five years
- are located in primary health care, including: Mental Health; Disability; Public Health; Aged-care; Immunisation; Screening; Child Health; Chronic Disease; Health Promotion; Interface of Primary and Secondary Care.

Stocktake: Initiatives targeting service and clinical quality and other innovations that seek to address Pacific Peoples' health needs in New Zealand were identified by contacting and seeking information from:

- 18 District Health Boards, including the seven that have relatively high numbers of Pacific peoples in comparison with other regions – 6 responses were received
- 41 Pacific providers– 17 responses were received.

Stakeholders were asked to provide descriptive information about their initiative/s, including purpose, objectives, target audience/s, duration, and implementation, and any evidence that demonstrated effectiveness.

Literature review: The literature review identified published reports using academic electronic search processes. 'Grey literature' was sourced via systematic searching of government websites and unpublished material[2]. References in identified documents were searched for material not already identified.

[2]Grey literature is papers, reports, technical notes or other documents produced and published by governmental agencies, academic institutions and other groups that are not distributed or indexed by commercial publishers. These documents are often difficult to locate because basic information such as author, publication date or publishing body may not be provided.

Appendix 1 outlines the search mechanism and search terms. The Bibliography details the literature used in this report.

2.3 Review limitations

It is acknowledged, that the information contained in this report is a starting point and does not represent **all** the service and clinical quality initiatives seeking to improve Pacific health needs undertaken in New Zealand in the last three to five years. Our aspiration is that over time more information and evidence will be shared and added to this document. Thus, the goal of a dynamic evidence-base that is shared and used to enhance health services and clinical quality to improve Pacific peoples' health outcomes will be achieved.

2.4 Report structure

This report has been structured to directly respond to the stocktake and literature review questions:

- Section 3 presents an overview of the identified targeted service and clinical quality initiatives and other innovations that seek to address Pacific health needs, and their known effectiveness.
- Section 4 describes the four Pacific health projects that have received Whānau Ora funding. Using these demonstration models, early reflections on the principles underpinning Whānau Ora approaches in a Pacific context and their potential effectiveness are considered.

3. Initiatives Addressing Pacific Health Needs

3.1 Rationale for targeted initiatives for Pacific peoples

Over the last few decades, differing strategies have been adopted to seek to improve Pacific peoples' health outcomes. In the 1990s, focus was placed on the translation of health education resources as the main 'intervention' for Pacific peoples. The 2000s saw the emergence of cultural safety and competence (Wright and Hornblow 2008). Regardless of these strategies, Pacific peoples living in New Zealand continue to have a lower life expectancy, and a higher rate of avoidable and amenable mortality[3] when compared with the New Zealand population (Ministry of Health 2008b). From 1981–84 to 2001–04, Pacific amenable mortality improved the least of any ethnic group (Tobias and Yeh 2009).

Significant health disparities include (but are not limited to):

- for Pacific adults living in New Zealand, cardiovascular disease, ischemic heart disease, stroke and congestive heart failure, diabetes, respiratory illnesses, specific cancers and mental health issues (Blakely et al 2007, Connolly et al 2009, Craig et al 2007)
- for Pacific youth aged 15–24 years, obesity, cardiovascular disease, diabetes, physical health injuries, sexual health and mental and emotional health issues (Blakely et al 2007, Connolly et al 2009, Craig et al 2007)
- for Pacific children aged 0–14 years, infant and child mortality and morbidity, respiratory disease such as asthma, bronchiectasis, bronchiolitis, pneumonia, tuberculosis, gastroenteritis, rheumatic fever, kidney and urinary tract infections, oral health and obesity (Ministry of Health 2008b).

Pacific peoples' health is shaped by cultural, social and economic factors. Lower incomes, lower educational attainment and poorer housing contribute significantly to the health status of Pacific peoples. Strong links to cultural homelands in the Pacific region can influence beliefs about health and illness, and access and use of health services in New Zealand (Minister of Health and Minister of Pacific Island Affairs 2010).

The New Zealand Government is determined to turn around poor Pacific health outcomes by providing better services closer to home, supporting effective Pacific providers and models of care, and better enabling Pacific peoples and communities to be healthy. *'Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2010–2014* (Minister of Health and Minister of Pacific Island Affairs 2010) sets out the priority outcomes and actions for the next five years that will help achieve better health outcomes for Pacific peoples, families and communities[4]. 'Ala Mo'ui's six priority outcomes and actions and four guiding principles are shown in Figure 1.

[3] Amenable mortality is a measure of the deaths associated with the non-availability or use of appropriate healthcare and is also higher for Māori populations (Blakely et al 2007).

[4] 'Ala Mo'ui replaces the Pacific Health and Disability Action Plan of 2002, the Pacific Health and Disability Workforce Development Plan 2004 and the Joint Action Plan for the Ministries of Health and Pacific Island Affairs 2008, as the key overarching document for improving Pacific health outcomes.

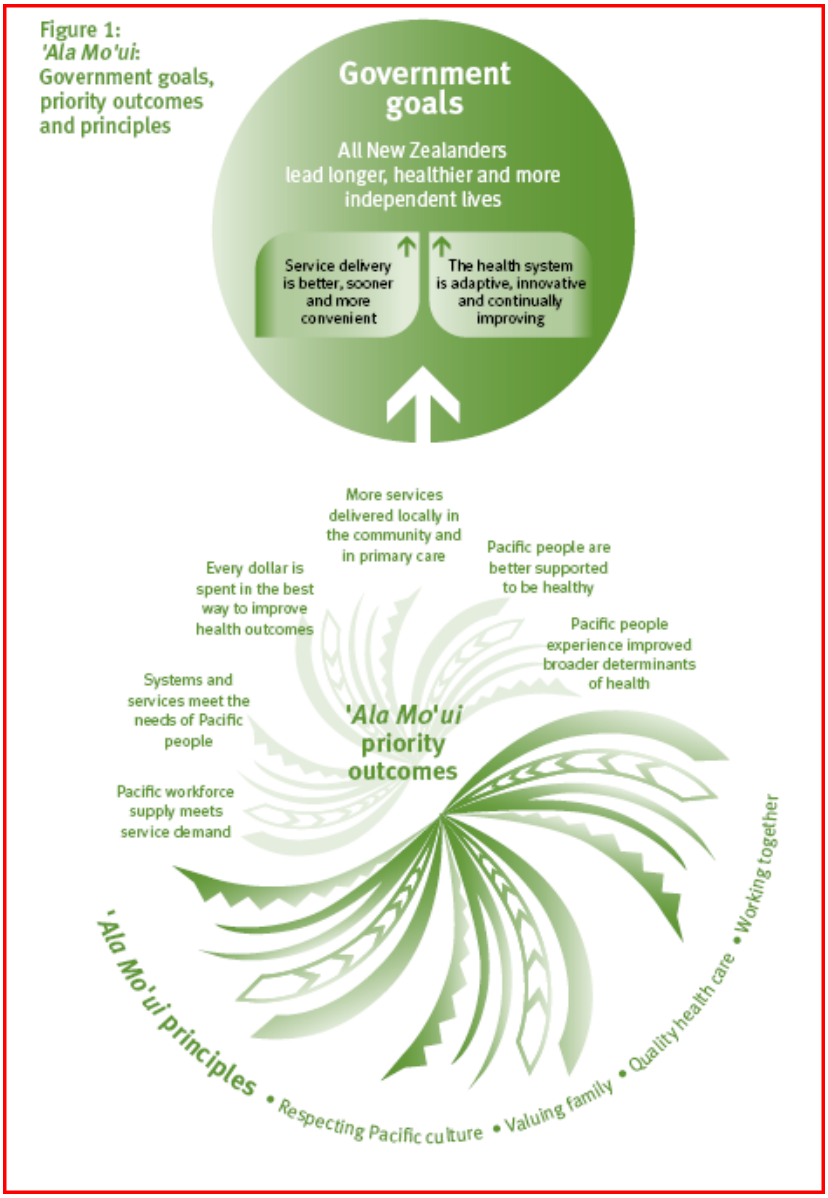

Figure 1: 'Ala Mo'ui– Government goals, priority outcomes and principles

Evidence suggests that improvements in 1) access to appropriate healthcare and 2) quality of healthcare[5] will make a difference to the poor health status of Pacific peoples in New Zealand (Tobias and Yeh 2009).

[5] The American Institute of Medicine defines quality of care as 'the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge' (Lohr 1990).

3.2 Range of sourced initiatives targeting Pacific health needs

This section presents an overview of some of the initiatives undertaken over the last three to five years to improve service and clinical quality and thus enhance the health outcomes of Pacific peoples. It provides an analysis of the types of initiatives undertaken and their effectiveness, where known.

Extensive efforts were made to address the question *'What are the existing targeted service and clinical quality initiatives and other innovations that seek to address Pacific peoples' health needs in New Zealand?'*. Information on initiatives was sourced from District Health Boards, Primary Health Organisations, Pacific providers and government agencies, as well as peer-reviewed journal articles and grey literature sources.

In sourcing information on targeted initiatives, **it became evident that an open and accessible culture of sharing information and evidence about both successful and less successful initiatives is still to be created**. As a result, it is acknowledged that the list of identified targeted initiatives is likely to be incomplete (refer to Section 2.3). However, those identified offer a starting point to understand the health sector's focus for the last three to five years in seeking to improve Pacific health outcomes.

The initiatives sourced have been classified into broad health area categories to get a sense of the types of service and clinical quality projects and programmes that are targeting Pacific peoples' health needs. Each initiative has been included only once in the classification focusing on their key goal. It is acknowledged that many of the initiatives are multi-factorial and therefore could have been entered into several categories[6].

In total, 87 service and clinical quality initiatives that sought to address Pacific health needs were identified. Table 1 provides an overview of the types of initiatives being undertaken over the last three to five years. Please note the following key points

- Reflecting government policy, there is a predominant focus on:
  - health promotion, including projects focusing on healthy lifestyle behaviour change (as summarised in Table 2)
  - access to primary care, with a focus on nursing initiatives and outreach services
  - immunisation, with a view to achieving key health targets and equitable uptake of new vaccines (i.e. the Meningococcal B and Human Papillomavirus vaccines).
- Of the initiatives sourced, only a few focused on child health and chronic disease, and only one or two were found in the areas of mental health, screening, alcohol & addiction services, aged-care, disability, and public health initiatives.
- Reflecting the location of the Pacific populations, more than half of the initiatives targeted Pacific peoples living in the Auckland region and around a quarter were located in the wider Wellington region (including Porirua and the Hutt). Positively, some initiatives targeted the health needs of Pacific peoples living in more provincial areas (e.g. Rotorua, Taranaki, Mid Central and West Coast).
- More than half of the initiatives were led by District Health Boards and over a quarter by Primary Health Organisations. Pacific community-based organisations (such as churches) and Pacific peoples helped deliver a number of the initiatives.

[6] Following feedback on this draft report, consideration will be given to further refining these classifications.

- The duration of the initiatives varied from one year to more than four years; although there was more clustering around a period of one to two years. The latter may reflect that some of the initiatives are fairly recent developments and therefore it is uncertain how long they may continue. Further, a number of initiatives were pilots and so their duration tends to be more limited.

Table 1: Initiatives targeting Pacific health needs by health areas[7]

Health area	No. of targeted initiatives	% of targeted initiatives
Health promotion	35	40%
Access to primary care	16	18%
Child health	7	8%
Chronic disease	6	7%
Immunisation	4	5%
Mental health	4	5%
Screening	4	5%
Holistic providers	4	5%
Alcohol & addiction services	3	3%
Aged-care	2	2%
Disability	1	1%
Public health	1	1%
Total	**87**	**100%**

Table 2: Breakdown of initiatives in the health promotion area

Breakdown of health promotion	No. of targeted initiatives	% of targeted initiatives
Workforce development	10	29%
Health education	8	23%
Exercise	7	20%
Holistic programmes	5	14%
Gardening	3	8%
Weight management	2	6%
Total	**35**	**100%**

Summarised below are the range of initiatives included in the broad classifications in Tables 1 and 2.

7 Refer to *Summary of All Targeted Initiatives Identified by 25 July 2011* (Sika-Paotonu2011a) for a comprehensive overview of all the initiatives sourced.

- **Health promotion initiatives**:
  - **Workforce development** initiatives focused on cultural competency training for health professionals to understand Pacific values, health priorities and social determinants of health. Pacific cultural competency training featured in a variety of contexts. Several initiatives also included Train-the-Trainer components to build capacity and empower members of targeted Pacific communities to create greater impact and sustainability of programmes within a community. A few initiatives also focused on increasing the number and competency of Pacific people in key health professional roles.
  - **Health education** featured in some initiatives targeting Pacific populations in Pacific languages, including health literacy. At times, this was as a component of a general population campaign, e.g. the Wise Use of Antibiotics campaign by Pharmac.
  - **Exercise initiatives** targeted Pacific populations to elicit change in activity and lifestyle behaviours. One example is the Lifestyle Champions Project, which highlighted the weight loss journey of high-profile community leaders to promote healthier lifestyles and weight loss in the community.
  - **Holistic programmes** included the Health Eating Healthy Action programmes targeting Pacific people, **Lotu Mo'ui** (a church-based healthy lifestyle intervention programme) and the Tongan Community Action Programme (which targeted predominantly Tongan communities).
  - **Gardening initiatives** targeted healthier lifestyle and activity behaviours for individuals, families and communities. Outcomes for the gardening initiatives included provision of vegetables for families and neighbours, exercise and, to some degree, the promotion of Pacific cultural community lifestyles. One example is the Let's Beat Diabetes gardening programme in the Auckland area, which involved the establishment of large community gardens.
  - **Weight management** projects were typically accompanied by other lifestyle and activity components, such as nutritional education to focus on the multi-factorial nature of obesity. One example is the Pacific Obesity Prevention in Communities Project that was conducted in New Zealand, Australia, Fiji and Tonga.
- **Access to primary care** included nursing innovation projects, such as community health workers, mobile and outreach nurses, to advocate, translate and provide transport and health education on a range of health conditions. The establishment and workforce development of primary care nursing specialists focused on Māori and Pacific high-needs communities. These initiatives sought to improve access to primary care by removing financial, transport, cultural and other barriers.
- **Child health** included the Kids in Action Obesity intervention programme, hand-washing promotions in schools, childhood asthma education pilot, aural health screening and intervention, promotion of breastfeeding and support for new mothers, and child oral health programme.
- **Chronic disease** included the Let's Get Checked Diabetes programme, One Heart Many Lives programme focusing on cardiovascular health screening and awareness amongst men at risk in Māori and Pacific populations, and a Pacific self-management programme to increase knowledge about chronic conditions.
- **Immunisation** initiatives sought to increase the uptake of Pacific childhood immunisation, and apply health equity strategies to increase uptake of the

Meningococcal B and Human Papillomavirus vaccines, e.g. by home visits and outreach services.

- **Mental health** initiatives included seeking to improve access to mental health services by using a Community Liaison Officer, and interventions relating to youth suicide.
- **Screening** initiatives tended to be mainstream programmes, such as cardiovascular risk screening and annual review, breast screening and cervical screening, tailored to improve access for Pacific peoples.
- **Holistic providers** covered Pacific health providers who offer a holistic wrap around service to Pacific families and communities embedded within a Pacific cultural health framework.
- **Alcohol & addiction services** were a range of tailored services focusing on brief drug and alcohol interventions, smoking cessation and gambling addiction education and support.
- **Aged-care** included collaborative support programmes for older Pacific peoples in the community to ensure social interaction, support and, for some increasing knowledge of health conditions and treatment with the goal of effective self-management.
- **Disability** included Lu'i Ola Auckland Regional Disability Project, which is an interagency collaboration to increase access to services for disabled Pacific peoples.
- **Public health** included a healthy housing initiative aimed at insulating homes to make them warmer, healthier and drier.

3.3 Refined targeted initiatives

The87initiatives that were initially identified were then checked against the search criteria for this stocktake and literature review. Specifically:

- That enough information was provided to clearly demonstrate that the targeted service and clinical quality initiatives used a Pacific model of care to address Pacific peoples' health needs.
- The initiative was not a business-as-usual service contract (e.g. outreach and mobile services to improve access to services for Pacific families are now integrated into service contracts).

Following this review, **26 of the 87 initiatives** were included in this stocktake and literature review.

Exclusion from this review does not indicate that initiatives have no value or merit. Some excluded initiatives were proven to increase Pacific people's access to services (e.g. outreach services). However, these services tend to be more business-as-usual, operating within mainstream service philosophies and not within a wider Pacific model of health care. Further, a significant number of initiatives were removed because only very high-level descriptive information was available. Ideally, the information needed to clearly articulate the initiative's purpose, goal and desired outcomes, target audience and the Pacific model of care used in the design and delivery, as well as any information on the initiative's effectiveness.

The stocktake and literature review has identified two inter-related challenges for the sector 1) ensuring sufficient information exists about initiatives targeting Pacific health needs, and 2) having a process to disseminate this information.

Table 3 summarises the 26 targeted initiatives that met the search criteria for the stocktake and literature review. As they did in the original list of 87 sourced initiatives and reflecting government policy, access to primary care and health promotion initiatives dominate.

Table 3: Informed targeted initiatives by health areas

Health area	No. of initiatives	% of initiatives
Health promotion	9	35%
Access to primary care	4	15%
Chronic disease	4	15%
Holistic providers	4	15%
Child health	1	4%
Alcohol &addiction services	1	4%
Aged-care	1	4%
Public health	1	4%
Immunisation	1	4%
Total	**26**	**100%**

Refer to *Summary of Targeted Initiatives Identified by 25 July 2011* (Sika-Paotonu 2011b) for a comprehensive overview of the 26 initiatives.

3.4 Effectiveness of Pacific initiatives

This section describes the core 26 targeted initiatives and considers their effectiveness. Given the stocktake and literature review requirement for detailed information, it is not surprising that 18 out of the 26 targeted initiatives have been formally evaluated (69% – refer to Table 4). In comparison, 36 out of the 87 originally sourced initiatives (41%) have been formally evaluated. This finding suggests that **while New Zealand is investing in and implementing approaches to improve service and clinical quality and enhance Pacific health outcomes, the evidence-base of what works and does not work is incomplete.**

A review of international literature suggests that the reverse may hold in countries like Australia, where fewer initiatives are being undertaken amongst migrant communities but they are being evaluated.

Table 4: Number of targeted initiatives formally evaluated

Health target area	No. of initiatives	No. of targeted initiatives evaluated

Health promotion	9	9
Access to primary care	4	3
Chronic disease	4	4
Holistic providers	4	1
Child health	1	1
Alcohol &addiction services	1	–
Aged-care	1	–
Public health	1	–
Immunisation	1	-
Total	**26**	**18**

While the evidence-base is incomplete, there is evidence in some areas of effective service delivery and clinical quality initiatives for Pacific peoples. A summary of this evidence is presented below across key health areas, including a brief description of the initiative, health outcomes achieved and factors identified as contributing to success. Again the caveat is applied that this is a dynamic evidence-base and not all existing information is presented below.

Access to primary care

Often-cited barriers to primary care for Pacific peoples include language, family commitments taking priority, difficulty in meeting appointment times, difficulty in understanding nature/necessity of appointment, and complicated or multiple providers (Gribben 2007,Grey 2010). Reference is also noted to higher prevalence of co-morbidities, where patients presenting with multiple health issues can lead to greater reluctance to engage with health services. As noted by Ape-Esera et al (2009), younger populations may not want to use Pacific providers/services because of confidentiality concerns within a close-knit community. Interventions may counteract these barriers by engaging more personally and offering more flexible service arrangements.

Ryan, D., Beckford, N., & Fitzsimmons, M. 2010. *Lalaga: Pacific providers making a difference*. Wellington: Ministry of Health.

Ryan et al (2010) use health service case studies in Pacific communities across New Zealand to showcase targeted approaches to improving health outcomes. Most examples in this report describe Pacific models of care or targeted service delivery, rather than specific interventions. The community-owned and/or Pacific Primary Health Organisations have adopted new ways to cater to the health and cultural needs of their enrolled populations. For example, 'Langimalie' (a Tongan community-owned Primary Health Organisation) offers longer appointment times and services that 'go to the people' (p.14), and targets the most at-risk segments of the population (NZ Deprivation Index 9–10). This Primary Health Organisation met 2009 targets for vaccination coverage of two year olds and detection of high-needs diabetes ahead of both District Health Boards and national levels for the same measures. Other Primary Health Organisations using similar models of service delivery (e.g. Te Pasefika and Bader Drive) also reported improvements in chronic care/

maintenance indicators for 2009 (HbA1c, statin use, blood pressure); again, ahead of overall Counties Manukau District Health Board indicators.

Some case studies only give examples of 'reach', and do not provide information about clinical outcomes. The Family Life Education Pasifika programme uses dance, music and Pacific art to deliver sexual health messages and education to young people from Pacific communities. The programme has since been rolled out to medical schools to help train future providers (e.g. workforce capacity), cited as another indicator of programme 'success'.

Common to all those Primary Health Organisations who cite success in indicators described above are integrated services, single sites or 'one-stop-shop' premises, and church-based delivery.

Gifford, H., P. Crampton et al. (2006). *Improving Access to Primary Care in Porirua (PIA) Evaluation*. Report from the Public Health Consultancy, Department of Public Health, Wellington School of Medicine and Health Sciences.

This initiative targeted Pacific, Māori and low-income families living in the Porirua area of Wellington to reduce health inequalities by improving access to general practice services through the use of mobile nursing services and community health workers. Five service contracts were held by Wellington Independent Practitioners Association, Porirua Union and Community Health Service, Pacific Health Service, Maraeroa Marae Health Clinic and Ora Toa Health Services.

The initiative was evaluated in 2006, and the following outcomes were achieved: increased use of general practitioner and nurse services in practices involved; a high annual check rate for diabetes detection and control endeavours; and no increase in use of the emergency department by Pacific populations between 2004 and 2005 when compared with Māori, non-Māori and non-Pacific. Although ambulatory-sensitive hospitalisations increased for Pacific peoples overall between 1994/95 and 2004/05, rates were reported to have remained steady during the introduction of new funding streams associated with this project.

Factors identified in the evaluation as critical to these outcomes were: leadership; experience in working with Pacific communities; and workforce development. 'Leadership' referred to both vertical and horizontal leadership and included leadership by the Ministry of Health, the District Health Board and the Primary Health Organisation and strong community leadership.

Grey, C. 2010. 'Reducing presentations to emergency departments by Pacific peoples'. A report prepared for the Chief Advisor, Pacific Health and the Pacific Innovations Team. Wellington: Ministry of Health.

This report highlights the lack of ethnicity data for national or District Health Board emergency department use in New Zealand, and poor recording of diagnostic information in emergency departments. Both of these factors create a challenge in reviewing and monitoring emergency use and care for Pacific and other population groups. The author searched the literature for examples of interventions to reduce 'inappropriate' presentations to emergency departments by Pacific peoples (as instead of using primary care services, patients present at secondary services once a condition is serious).

Emergency department presentations for childhood cellulitis are highest among Pacific groups – three times that of non-Māori non-Pacific children. This example showed that the usual access issues to primary care (transport, cost, language) need to be addressed, along with a 'normalisation' of skin infections in some communities, and that programmes need to be long term.

It was raised that communities and practitioners alike are wary of short-term 'one-off' projects, where no relationship or trust has been established. In addition, certain medication/after-care delivery services could be more mobile (especially for geographically dispersed populations like Pacific people in Auckland).

Health promotion

Utter, J., Warbick, et al (2010). Design, development and achievements a youth-led nutrition and physical activity intervention in a Pacific Community in New Zealand. Journal of American Dietetic Association 100 (11): 1634-1637.

The Pacific Obesity Prevention in Communities (OPIC) project was a whole-of-community intervention programme carried out in four countries – Fiji, Tonga, New Zealand and Australia. The target audience in New Zealand was youth in predominantly Pacific communities living in Mangere, Auckland and was known as the Living 4 Life Programme. Four secondary schools in Auckland were selected as 'intervention sites'. From 2005 to 2008, Student Health Councils were established, developed and supported to drive initiatives based on activity and nutrition within their local school environment.

This initiative was based on the Youth Development Aotearoa Strategy's guiding principles of promoting positive youth development by encouraging full participation of youth and quality relationships, and ensuring engagement and connectedness. A strengths-based approach is central to the strategy, acknowledging that young people create positive changes in their lives by drawing on their own capacity and skills (Ministry of Youth Affairs 2002).

Training and support was offered to the adolescents involved with the project, and cost and transportation barriers were removed. Participants attended a Train-the-Trainer course and completed a 10-week gym session to gain confidence and help develop goal-setting skills.

The final evaluation results for this project are due in late 2011. However, initial results suggest that participants in two of the four schools showed a significant decrease in time spent watching television and significant improvements in eating breakfast. Three of the four schools showed an improvement in the schools' own encouragement of activity and healthy eating behaviours.

Early findings suggest that the use of youth development principles in the Living 4 Life project are conducive to engaging adolescent teens in an obesity prevention school-based research programme.

Marinerway Consulting Group Limited. 2006. *Evaluation of Kai Lelei Food & Nutrition Course for Pacific Communities*. Auckland: Counties Manukau District Health Board.

This report details the evaluation of church-based community nutrition education sessions with Pacific communities in Counties Manukau, as part of the **Lotu Mo'ui** church programme. The authors used 'objective analysis' and participant opinion to evaluate programme effectiveness, using measures of knowledge about nutrition and engagement with the programme. Participants were also asked about key messages that might be used to change health behaviours in Pacific communities. After the delivery of ethnic-specific modules, participants gave positive feedback overall and found the church-based delivery method especially acceptable as a way to teach food shopping and cooking decision-makers. Participants also recommended that the scope of the course be widened to get the messages out to men, Pacific young people and Pacific people born in New Zealand. The authors note that innovative approaches will be needed to target these groups, especially youth.

Healthy Community Schools Initiative: a subset of the Achievement in Multi-cultural High Schools Initiative (AIMHI), ministry of Education initiative to support nine low-decile schools in Auckland (Kool et al 2008).

This initiative was profiled in the evaluation of the AIMHI pilot study that examined the effectiveness of interventions addressing under-achievement in low-decile schools in Auckland between 2002 and 2005. Specifically, the role and practice of the school nurse was investigated to identify the impact (if any) on academic outcomes of secondary school students and determine the degree of effectiveness of healthcare treatment they received.

The target audience for this initiative was nine secondary schools in Mangere that contained high proportions of Pacific and Māori students. Specific types of school nurse practices were identified and examined for impact on the academic outcomes of students receiving treatment under their care.

In addition to describing effective patterns of nursing practices, the involvement of school nurses in undertaking innovative health promotion activities was also reported (e.g. running a Health Focus week for the students, the development of health food policies for school shops and canteens, healthy lifestyle groups, Living 4 Life Programmes, breakfast clubs, weekly aerobics classes, removal of vending machines, emphasis of healthy foods at staff functions).

Two main types of nursing practice were identified:1) an embracing style, and 2) a Band-Aid approach. The embracing style of nursing incorporated both the primary healthcare needs of students and school-based health and wellbeing promotion. In contrast, the Band-Aid approach focused more on providing primary first-aid basics to the students. The use of 'embracing' nursing practice resulted in an increase in staff identifying students with issues related to health that might be impacting on academic performance, increased numbers of staff consulting with the school nurse regarding personal health issues, and healthier food being made available at the schools.

The personal attributes of school nurses that contributed to the delivery of effective school healthcare were cultural sensitivity, an innovative and flexible nursing style, excellent communication skills, computer literacy, sound knowledge of the community services available, and the ability to work autonomously within a team environment.

Counties Manukau District Health Board. 2011. *Creating a Better Future – Our Stories: July 2010 – April 2011*. Auckland: Counties Manukau District Health Board.

This report presents a series of 'success stories' from the Counties Manukau District Health Board, with a focus on work in primary health care, nutrition, physical activity and chronic care management. Many of the interventions are based in Pacific communities and church/community-owned Primary Health Organisation settings, given the high Pacific population in the area.

The interventions described in the report tend towards lifestyle and health promotion programmes, and several use chronic care management (e.g. Type 2 diabetes) as a prompt for health and well-being behaviour change. Key anecdotal/participant case studies in the report include a community nutrition course (Franklin Tongan Community), gardening grants (Potu Makutafea, reaching 40 families/600 people in Pukekohe; Peteli Community Garden, reaching over 40 families plus a waiting list in Papakura), physical activity interventions (Ola'anga Lelei in Papakura; Fonua Mo'ui Health Project in Manukau Tongan Parish of Methodist church), general Lotu Mo'ui church-based health promotion grants (over 25 separate projects funded in 2010). The outcomes measured are largely output-focused (numbers attending programmes, or 'satisfaction' in the community), with very few clinical indicators. However, when read alongside the 'Lalaga' report examples from the same communities, the 'acceptability' and 'reach' outcomes appear to translate into improved clinical outcomes (Ryan et al 2010).

While the report itself makes no comment on which aspects of the interventions may be the reason for their success, all seem to use a community-led, family-oriented, 'pass it on' style of delivery to health promotion, and use community champions/leaders to promote key messages and encourage behaviour change.

Chronic disease

Hotu, C., B. Warwick, et al. (2010). "A community-based model of care improves blood pressure control and delays progression of proteinuria, left ventricular hypertrophy and diastolic dysfunction in Maori and Pacific patients with type 2 diabetes and chronic kidney disease: a randomized controlled trial." Nephrology Dialysis Transplantation 25 (10): 3260-3266.

This project explored the impact of a novel model of care for Pacific and Māori patients on management of their diabetic kidney disease and hypertension. Monthly community visits were made by a nurse-led, culturally appropriate health care assistant who would measure blood pressure, encourage uptake of anti-hypertensive medications and provide general support for the patient within the home setting.

The impact of community-based care delivery was tested against a control group of patients who received routine family doctor and renal/diabetes hospital outpatient clinic care. Results were obtained by comparing blood pressure readings and monitoring kidney and cardiac disease progression measures over 12 months. Kidney disease progression was monitored using proteinuria measures, while cardiac dysfunction was monitored using left ventricular hypertrophy and diastolic dysfunction.

Results showed that, after 12 months, the test group of patients who received community-based culturally appropriate care delivered by a Pacific or Māori healthcare assistant had reduced systolic blood pressure and urine protein measures, with no progression in cardiac

dysfunction reported. The control test group showed elevated systolic blood pressure readings plus progression in cardiac and renal dysfunction.

This initiative demonstrates an innovative model of healthcare delivery for Pacific peoples and provides evidence that culturally appropriate healthcare delivery is influential in health-related behaviours and outcomes for Pacific patients.

Sinclair, G. 2007. *Evaluation of the Chronic Care Programme*. In *Chronic Care Management & Let's Beat Diabetes Open Day, November 2007*. Auckland. (presentation based on report by Kenealy et al 2007)

The Counties Manukau District Health Board's Let's Beat Diabetes initiative, while not targeted specifically at Pacific communities, has a strong Pacific element due to the population distribution and burden of disease. This report shows clear positive outcomes for Pacific peoples who have been part of the Chronic Care Management stream of the programme.

The Chronic Care Management initiative was originally started as a component of diabetes management for enrolled patients of all eight Primary Health Organisations in the District Health Board, and later expanded to cover congestive heart failure, chronic obstructive pulmonary disorder and cardiovascular disease. A depression module was recently added.

The programme uses enrolment and engagement as top-line measures of reach in the community (target of four visits a year). The most dramatic results in the HbA1c were seen for Pacific enrolees (see Figure 2). In addition, a non-significant but clear downward trend in reduced smoking prevalence was seen among Pacific patients. The author of this presentation makes a note on integration of service delivery and workforce, stating that '*integrated teamwork is fundamental to changing the current model of primary care from acute services to chronic care model'* (section 9).

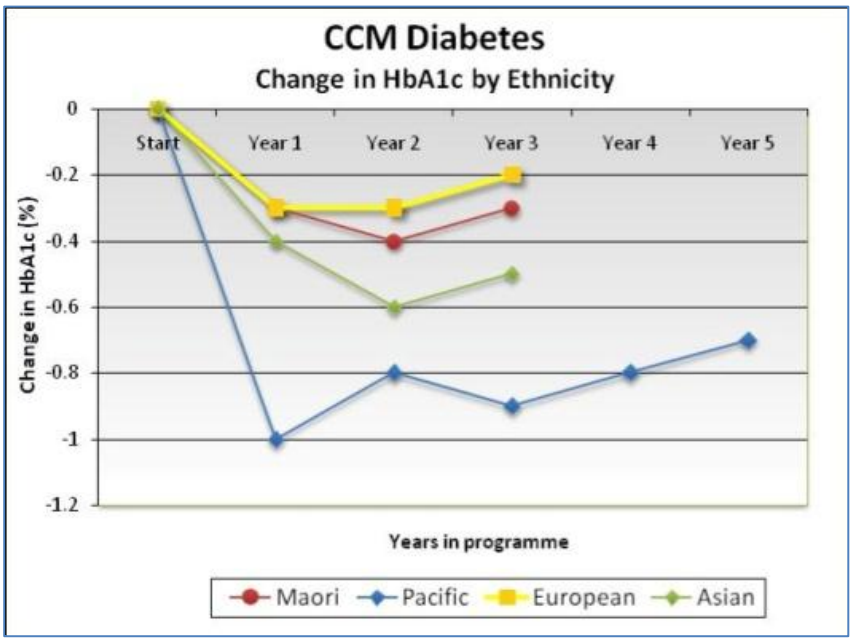

Figure 2: Chronic Care Management Diabetes – change in HbA1c by ethnicity

Mental health/workforce

Parsonage, P., Sio, L., Mariner, T., & Leger, N. 2009. Development of a mental health and addiction Pacific cultural practice framework for the Auckland region: Promoting expertise that is "visible, valued and understood". *Pacific Health Dialog* 15(1): 131–137.

Suaalii-Sauni, T., et al. 2007.*A Documentation Review of the Set-up of 'Malaga-a-le-Pasifika' Service: A report prepared for the Pacific Mental Health and Addictions Services (PMHAS), Waitemata District Health Board*. Auckland: Waitemata DHB.

These reports highlight 'Tupu' clinical services, and the use of 'cultural liaison services' for Pacific peoples presenting for mental health care in New Zealand. In the 'cultural competence' section, the authors emphasise the need for a benchmark of care for Pacific providers, and greater consistency across services delivering mental health care for Pacific communities.

3.5 Factors that contribute to successful targeted initiatives

Overview of identified factors

Having showcased the effectiveness of some targeted initiatives, consideration is now given to whether it is possible to identify common factors that contribute to service and clinical quality improvements in addressing Pacific health needs. A simplified meta-analysis was conducted across the evaluated initiatives seeking to isolate the range of factors acknowledged as contributing to their success. The factors identified were then grouped into overarching categories of: organisational factors, design features and implementation (refer to Table 5).

Again the caveat is applied that this analysis is very preliminary, due to the limited number of initiatives that have been evaluated. Further, the evaluations ranged from those that can be considered valid and reliable in assessing whether desired health outcomes and impacts were achieved to those that offer more indicative findings based on outputs. The factors are therefore not presented in any particular order bar seeking to present the information in an accessible manner.

Table 5: Factors identified as contributing to initiatives creating a positive outcome for Pacific health needs

Organisational factors	Design features	Implementation factors	Results
Leadership	Overcoming barriers	Ownership	Monitoring
Cultural competence	Flexibility	Personal engagement	–
Experience	Mobile service	Communication	–
Training and support	Nurse-led	Family-focused	–
Pacific workforce development	Strengths-based approach	Role models	–
Primary healthcare environment	Collaboration	Church-based	–
Computer literacy	–	–	–

Organisational factors

Leadership: Horizontal and vertical leadership demonstrated by community leaders, local project leaders, church leaders, District Health Boards and the Ministry of Health were factors that contributed to the success of targeted initiatives. (Gifford et al 2006, Clinton et al 2009, Mahoney et al 2008, HEHA 2009)

Cultural competence: A common feature noted as important for achieving effectiveness within targeted initiatives is cultural competency (Kool et al 2008, Hotu et al 2010). Tiatia (2008) raised an important challenge to these claims, specifically that it can be hard to define and measure cultural competence. Further, there is a lack of evaluation of the concept and no standards of 'best practice' (Tiatia, 2008, p.viii). Tiatia also notes that building a practitioner's cultural competence is a 'lifelong process', not something that can be picked up on a day-long workshop or course (p.30). Pulotu-Endemann et al (2007) talk about mental health workers as progressing along a continuum from cultural awareness/sensitivity (core) to cultural engagement (advanced) and cultural leadership (specialist). Ways to measure and 'test' competencies at each level are included in this document.

Experience: The use of an experienced workforce was shown to contribute to effectiveness. (Gifford et al 2006, Kool et al 2008)

Training and support: The provision of training, mentoring and education for project leaders and others involved with project implementation was also noted as a key feature for effectiveness. Specialised training was considered vital for the sustainability of community and church-based initiatives. (Utter et al 2010,Hotu et al 2010, Clinton et al 2009, Mahoney et al 2008)

Pacific workforce development: Pacific workforce development was a notable feature of many projects and emphasised the desired outcome of having persons of Pacific origin leading projects and targeted initiatives. Project information obtained suggested that Pacific-led initiatives were a powerful stimulus for effectiveness and participatory behavior. (Clinton et al 2009, Gifford et al 2006, HEHA 2009). However, Ape-Esera et al (2009) note

the shortage of Pacific workers in primary health care. Ape-Esera et al (2009) also comment that some Pacific people would prefer not to have a Pacific health care worker due to living in a small community and confidentiality issues. Advantages and disadvantages of 'by Pacific for Pacific' services are noted by Ape-Esera et al (2009).

Primary healthcare environment: Ensuring the primary healthcare environment is culturally relevant, and that work is done to overcome psychological barriers such as lack of familiarity with primary care staff, alleviating waiting room discomfort caused by appearance and other factors, and language-specific healthcare resources can build up trust between primary care providers and Pacific patients. Schlotthauer et al (2008) describe the use of computer-based information using language and cultural presentation for patients with cardiovascular disease, piloted with Hispanic communities in California. Patients were given access to computers in the clinic waiting room, allowing them to explore language-specific information about their condition, treatment and frequently asked questions, at their own pace and without the constraints of appointment times.

Computer literacy and sound IT structure: Being computer literate and having a sound IT structure within a primary healthcare environment were seen as important elements for effective healthcare delivery (Kool et al 2008, CBG Health Research Ltd 2005).Effective IT systems and the ability to use them are also critical in being able to track and monitor the implementation of initiatives. These findings also suggest the need for organisational capacity and strong governance to enable the delivery and monitoring of effective initiatives to address Pacific health needs. The latter is an area for further exploration to determine whether or not this is an important factor.

Design features

Overcoming barriers cost, transport, language: The identification of barriers to access and suggestions for overcoming them were a key feature highlighted in multiple evaluations and international reports. The top three barriers identified related to cost of primary healthcare, transportation issues associated with accessing primary healthcare and language barriers. Improving transportation to primary care and hospital appointments was one approach used to address these barriers. Other projects provided language-specific resources regarding health-related issues to overcome language barriers and improve communication (CBG Health Research Ltd 2005).

Flexibility: Retaining a degree of flexibility within primary care delivery was noted as contributing towards effective primary care delivery. An example was increased access to primary care for Pacific peoples noted when scheduling of appointments remained flexible to accommodate timing restrictions and issues for Pacific families attempting to keep appointments (CBG Health Research Ltd 2005, Kool et al 2008).

Mobile primary care services: This feature of primary care delivery within the home setting was a common component for effectiveness described in a number of evaluations and was key in helping to overcome the transportation and cost barriers for Pacific patients/participants within the community. To be effective, home visiting services needed to be closely linked with clinical services. (CBG Health Research Ltd 2005, Hotu et al 2010)

Nurse-led: Nurse-led programmes were noted within evaluations and provider information as contributing towards effective primary care delivery of services to Pacific communities (Hotu et al 2010, Gifford et al 2006).

Strengths-based approach: Encouraging and empowering participants and individuals to implement and sustain positive behavioral changes is a key factor (Utter et al 2010).

Collaboration: Collaborative efforts between different groups including providers and communities were seen as effective approaches when targeting Pacific populations (Compass Research 2011).

Implementation factors

Ownership and commitment: Instilling a sense of ownership, responsibility and commitment for the implementation of initiatives and participation was seen as an important factor for success and effectiveness (Compass Research 2011, Utter et al 2010, ENUA OLA 2010, Mahoney et al 2008b).

Personal engagement: Knowing participants and having personal engagement with them was identified as a key factor for effectiveness. (CBG Health Research Ltd 2005; Mahoney et al 2008b).

Communication: The ability to communicate effectively was noted as one of the factors contributing to effectiveness (Kool et al 2008, Clinton et al 2009).

Family-focused: Initiatives that targeted the family as a whole were also seen as a factor contributing to effectiveness. Key to this was the support provided by family members and the encouragement of behavioral changes within the home setting necessary for successful implementation of specific initiatives (Mahoney et al 2008a, Mahoney et al 2008b).

Role models: The importance of role models and role modeling behavior by project leaders were identified as being important for effectiveness (Clinton et al 2009, Mahoney et al 2008a).

Church-based: Church-based initiatives were seen as contributing to the successful implementation of selected targeted initiatives (Mahoney et al 2008a, Clinton et al 2009).

Results

Monitoring: The improved monitoring of outcomes was specifically referred to within the HEHA evaluation report (HEHA 2009).

Effectiveness is multi-factorial

Table 6 summarises the factors identified across a number of initiatives targeting Pacific health needs. The multi-factorial nature of successful is evident. The evaluations demonstrated that it is a combination of factors that create effective targeted initiatives. At this point, the relative weighting of each factor in contributing to success is unknown. Further, it is unknown whether the factors differ across Pacific nations (e.g. will what works for Tongans also work for Samoans?) and by health areas (i.e. health and well-being initiatives versus chronic disease, primary versus secondary care).

Table 6: Factors contributing to effectiveness across the targeted initiatives

Initiative name	Evaluation and literature derived effectiveness factors	Reference
	Health Promotion	
Kids in Action	Parental involvement Variety of activities and foods being promoted as part of the programme Kids in Action team approach Getting to know the children involved personally Commitment Focus on improvement Special health promotional programmes Drama sessions	Clinton 2008
Health Promoting Church Health Promotion Programme	Importance of the Minister's participation and leadership with congregation and programme Support provided by Pacific Islands HeartBeat team Usage of church hall Engagement of church congregation as a whole Role models Losing weight (visual measures of success) Participants being open-minded to change habits	Mahoney et al 2008
Pasefika **Lotu** Mo'ui Church Health Programmes	Communication Support and resourcing Provision of incentives Role modelling Leadership	Clinton et al 2009
	Access to Primary Care	
Improving Access to Primary Care Porirua	Leadership Experience Workforce development Collaborative effort between Ministry of Health, District Health Board and providers important Strong community leadership of providers Community collaborations Provision of funding	Gifford et al 2006
Community Health Worker Projects	Removal of cost barriers Overcome transportation barriers IT capacity Training support Sufficient resourcing Community development	CBG, 2005
Improving Pacific Child Health	Overcoming language barriers Improving the cultural competence of care delivery by Pacific Health and non-Pacific health care workforce Community education to increase understanding of respiratory and infectious disease amongst Pacific children Cultural-specific approaches Improve uptake of Well Child Services for children	Minster et al 2010

Table 6: Factors contributing to effectiveness across the targeted initiatives

Initiative name	Evaluation and literature derived effectiveness factors	Reference
Improving Access to Primary Care Services	Overcoming language barriers for older Pacific patients Understanding that family commitments are an important component of Pacific families and may take precedent over healthcare needs Pacific peoples may not be prepared to engage with multiple agencies which are sometimes required when dealing with specific healthcare needs It has been reported that younger Pacific patients may avoid primary healthcare services altogether for fear of breached confidentiality regarding their specific health needs	Grey 2010
Aged-care		
Health of Older People Service Pilot Program	Collaborative approach used to support and work with Pacific elderly Recognition that social interactions are vital when working with Pacific The installation of sense of ownership for the programme amongst participants	Compass Research 2011
Immunisation		
Strategies for general practices	Enrolment of Pacific patients early Competent patient management systems to target and identify Pacific children regarding immunisation Collaboration efforts with midwives, lead maternity carers, Plunket nurses and Pacific providers Effective communication Community outreach services Updated knowledge regarding vaccines	BPJ 2010

In summary, a variety of targeted initiatives were identified seeking to address Pacific health needs with some noted success. The search process identified a number of sector challenges: 1) a lack of detailed information about initiatives being implemented to address Pacific health needs; 2) only a limited number of evaluations to access whether initiatives are achieving the desired health outcomes and impacts; 3) a lack of willingness and/ or no process to share lessons about effective practice to inform those providing services to Pacific peoples.

4. Whānau Ora in a Pacific Context

4.1 Whānau Ora

The New Zealand Government is driving significant change in the health and disability sector through its increased focus on evidence-based decision-making, by prioritising resources for frontline services, and through the philosophy of the policy *'Better, Sooner, More Convenient*[8]*.* This applies to Pacific populations through two strategic policy settings: 'Ala Mo'ui and Whānau Ora:

- 'Ala Mo'ui sets out the ways in which the Government expects that health and disability services for Pacific peoples will be enhanced and improved.
- Whānau Ora is an inclusive approach to providing services and opportunities to all families across New Zealand. It empowers families as a whole, rather than focusing separately on individual family members and their problems. It requires Government agencies to work together with families rather than separately with individual family members.

In June 2009, Cabinet approved the establishment of the Whānau Ora Taskforce. Its main role was to develop a framework for a whānau-centred approach to whānau development. The framework developed was based on a review of literature, a review of the experiences of health and social service agencies, an analysis of oral submissions received at 21 hui throughout the country, and over 100 written submissions from individuals and organisations (Durie et al 2010).

The Taskforce report, *Whānau Ora: Report of the Taskforce on Whānau-Centred Initiatives*, also addressed co-ordination of services and support, funding arrangements to support more coherent, whānau-centred service and delivery, and the potential impact of Whānau Ora on service providers and government agencies.

Whānau Ora is founded on the following Principles:

- ngā kaupapa tuku iho (the ways in which Māori values, beliefs, obligations and responsibilities are available to guide whānau in their day-to-day lives)
- whānau opportunity
- best whānau outcomes
- whānau integrity
- coherent service delivery
- effective resourcing
- competent and innovative provision.

Where these principles underpin the design and implementation of programmes and service they increase the likelihood that outputs will contribute to the Whānau Ora Outcomes Framework.

[8] http://www.moh.govt.nz/moh.nsf/indexmh/phcs-bsmc/ accessed 23 July 2011

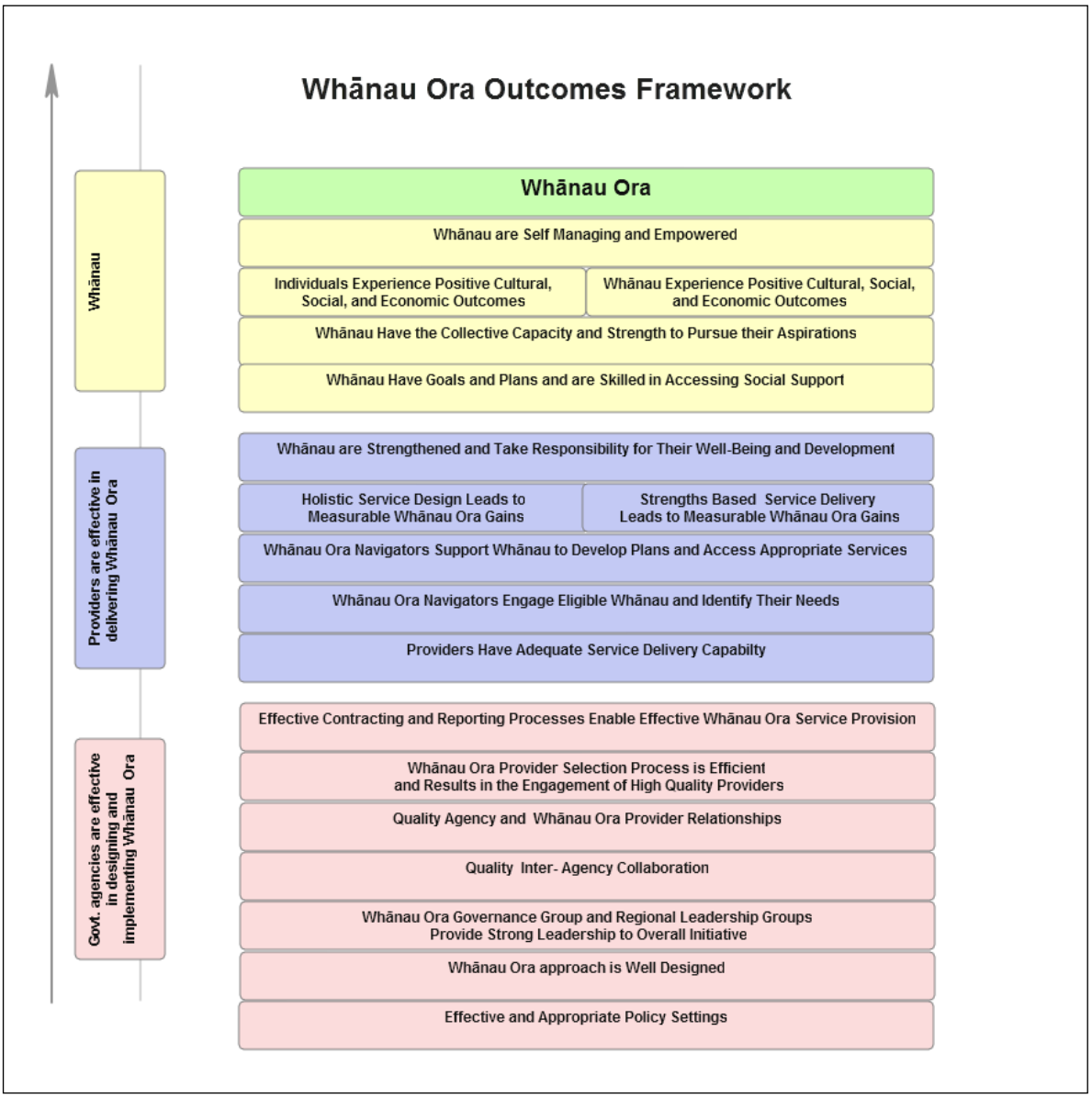

Figure 3: Whānau Ora Outcomes Framework[9]

4.2 Seeking to define Whānau Ora in a Pacific context

The underlying aim of Whānau Ora, as described by the Whānau Ora Taskforce, is to empower families to make decisions for themselves. This concept provides a useful context for 'Ala Mo'ui, because both documents ask the health and disability sectors to recognise that:

- people are interdependent
- health and well-being are influenced and affected by the 'collective' as well as the individual

[9] *Expression of Interest for Whānau Ora Action Research* (Te Puni Kōkiri 2010)

- it is important to work with people in their social contexts, not just with their physical symptoms.

In a Pacific context, Whānau Ora would see Pacific families supported to achieve their maximum health and well-being, to recognise Pacific cultural values and beliefs that help reduce health inequalities, and to influence services that could enable Pacific families. Providers using Whānau Ora approaches would seek therefore to apply the goals of Whānau Ora through a Pacific world view to achieve outcomes that meet the needs of Pacific whānau, families and communities – to achieve self-management, healthy lifestyles, full participation in society, confidence in participating in their Pacific culture(s), economic security and wealth creation, and enhanced cohesiveness, resilience and nuturing.

The literature review and stocktake highlighted **no existing service or clinical improvement initiatives targeting Pacific peoples' health needs that explicitly use Whānau Ora approaches**. This is not surprising, given the recent policy development underpinning Whānau Ora. However, it is acknowledged that anecdotally many Pacific health providers perceive that their initiatives align with or are consistent with the principles of Whānau Ora.

As a starting point, this section therefore considers what Whānau Ora may look like in a Pacific context by presenting an overview of four Pacific initiatives that have recently been awarded contracts by Te Puni Kōkiri to implement Whānau Ora approaches. The assumption was made that, if awarded Whānau Ora funding, their service delivery models are demonstration models of Whānau Ora in a Pacific context. It is acknowledged that these four Pacific initiatives are at the very early inception stage of their development. Consequently, the information presented is based on their project designs, which may evolve through the implementation process.

Using the insights gleaned from the four demonstration models, consideration is given to whether evaluated targeted initiatives containing elements of Whānau Ora offer any evidence that Whānau Ora approaches address Pacific health needs. Again caution is required in interpretation as the transferability of the findings from projects not explicitly set up to apply a Whānau Ora approach is unknown.

4.3 Demonstrating Whānau Ora approaches in a Pacific context

A total of 25 Pacific providers applied for Whānau Ora funding in 2010. The following four Pacific providers are currently negotiating to become Whānau Ora providers in 2011:

- Taeaomanino Trust/Pacific Health Service Wellington
- Pacific Trust Canterbury
- Pacific Island Safety and Prevention Project
- Alliance Health Plus.

At the time of drafting this report, these providers have been allocated funding and are in the final stages of developing Action Research programmes.

Pacific language terms for Whānau Ora

The four Whānau Ora Pacific providers have suggested Pacific language terms for whānau ora concepts for use with Pacific communities.

Table 7: Pacific providers' Pacific language concepts for Whānau Ora

Provider	Pacific Language Concepts
Pacific Island Safety and Prevention Project	*Nu'u a le Project* (Samoan). Village of the Project relationship and service model *Fonotaga a le Aiga* (Samoan). Meeting with family
Alliance Health Plus (AH+)	*O le aiga ma le fanau ia ola* (Samoan). Philosophy underpinning AH+ focus on holistic model of care, in context of relationship, social and wider determinants of health
Other – Pacific Island Safety and Prevention Project community fono	*Puhala moua tupe, Eke taha ke moua* (Niue). Families want access to educational and employment opportunities *Tau agamotu* (Nuie) *Fa'a Samoan, galulue fa'atasi, va fealoa'i, tautua fa'alemafaufau* (Samoan) *Anga Ofa, faka'apa'apa, tahi vaha'a, loto to, mamahi'i mea* (Tongan) *Anau aro'a, kitepakai, ko toku reo te i'o taku peu tupuna* (Cook Islands) Families desire to maintain their culture and strengthen family value in New Zealand.
Theme for the Ministry of Social Development's community fono (Tofa Suafole Gush, Manager Pacific, Child, Youth and Family)	*So'oso'o le upenga* (Samoan). Strengthening the net.

4.3.1 Taeaomanino Trust/Pacific Health Service Wellington

Background

Taeaomanino Trust is a Pacific social service and health provider based in Porirua, Wellington. It was formed to meet the increasing demand for social and health services for Pacific aiga[10] in the Porirua region. The organisation was registered as a charitable trust in 1993, and established a formal alliance with Pacific Health Service Wellington in 2010 to permit a joint application for Whānau Ora funding.

Pacific Health Service Wellington provides a wide range of general practitioner and community-based health services throughout the Wellington region, including Porirua. It was established and registered as a charitable trust in 2000 and is a member of South East and City Primary Health Organisation.

[10] Extended family

Taeaomanino Trust and Pacific Health Service Wellington provide a wide range of social and health services for Pacific peoples in Porirua and the Wellington region. They use a strengths-based approach to support Pacific aiga across the region.

Taeaomanino Trust has a Board of six, and a management staff of four (CEO and three managers – Practice, Operations and Finance/Administration). Pacific Health Service also has a Board of 6, and has a relatively flat structure of one manager.

Services provided

Integration of services

In their Expression of Interest (EOI), Taeaomanino and Pacific Health Service outlined how they place the aiga at the centre of all customised services. The EOI refers to the current use of the 'Sulu Model', which provides a coherent, customised, seamless and high-quality wrap-around approach to services. This model centres on high-quality relationships with other service providers, and allows swift intervention to ensure a safe environment for aiga.

The Sulu Model is based on the metaphor 'O le tele o sulu e maua ai figota' ('many lights will achieve a great catch', a reference to the use of a burning light and a spear to fish in the early dawn). This evokes the need for a village to work together to achieve better outcomes and results.

The EOI provided an example of the Sulu Model, where a Cook Islands male is referred to the Trust after domestic violence. The couple have New Zealand-born children aged 10–17. The following comprehensive wrap-around steps were taken:

- Parents receive counselling.
- Mother receives medical check-up.
- Dad receives alcohol and drug counselling.
- Father assisted to complete legal aid application.
- Children followed up by school social workers.
- Eldest child taken to enrol in Whitireia performing arts.
- 10 year old referred to clinical assessment with Health Pasifika.
- Mother registered in job search programme with Work and Income.
- Family enrolled with the Primary Health Organisation (PHO).

Contracts stated in EOI

Programmes delivered by Taeaomanino and Pacific Health Trust include the following:

- Social Work Services (funded by Ministry of Social Development, Child, Youth and Family, and Family and Community Services)
  - Family Start Programmes
  - Family Violence/Family Therapy
  - Gambling Education and Gambling Intervention
  - Home Based support
  - Social Workers in schools

  - Parents as First Teachers Programmes
  - Youth Services/Taulogologo Programmes
- Primary Health Care Services (funded by Ministry of Health and Capital and Coast District Health Board)
  - General Practitioner Services
  - Smoking Cessation Services
- Mental Health, Alcohol and Drug Services (funded by Ministry of Health and Capital and Coast District Health Board)
  - Alcohol and Other Drug Services
  - Child and Youth Mental Health.

Whānau Ora for Taeaomanino Trust and Pacific Health Service Wellington

Taeaomanino Trust and Pacific Health Service specified that their key principle driving the development of their new operational/transformational model is:

Families are the centre of what makes us Pacific.

This key principle is supported by five other guiding principles:

- Principle of Self-Determination – Pacific aiga must be able to manage their own futures for themselves.
- Principle of Cultural Connection – Pacific aiga must be supported through connection to their genealogy, culture and practice and participate fully in society.
- Principle of Guiding Support – Pacific aiga should have access to support that enables aiga to achieve their desired outcomes and live healthy lifestyles.
- Principle of Sustainability – Pacific aiga will retain sight of their dream, and be resilient.
- Principle of Reciprocity – Providing opportunities for Pacific aiga to rebuild their mana and give back in a positive and appropriate manner.

Guided by these principles, Taeaomanino Trust and Pacific Health Service Wellington proposes a new service delivery model to support Pacific aiga to achieve self-determination, become resilient and cohesive, and ensure that children are nurtured.

The new service delivery model is designed to ensure aiga are supported and empowered to set dreams, goals and milestones. The intention is to provide access to high-quality co-ordinated service delivery, aided by a combination of advanced technology and traditional cultural practices.

The proposal is to use a technology system called a Virtual Portal. This system uses Second Life, an online virtual reality currently being piloted by Auckland University as a learning environment for students.[11] This virtual reality permits the creation of an 'avatar' that allows a person to navigate interactive scenarios intended to help them identify their

[11] A number of virtual realities are available online. Second Life is a free, three-dimensional service currently favoured by educators (www.secondlife.com).

own Ideal World/Auala Fou. This will in turn allow them to collectively create an Aiga Plan, complete with individual milestones needed to achieve the desired outcome for the fanau[12].

To support this system, Taeaomanino Trust proposed a four-phase model called *Talatalaga A Aiga* ('Talking with Families'). The phases are:

- *Talatala* (Untangle) – The first phase is to establish a strong rapport with the family and help them identify and break down the issues that have led to dysfunction.
- *Toelalanga* (Re-weave) – The second phase involves reweaving the strands of the family's lives, so that they are left in a stable position. This may mean identifying all the support, assistance and other agencies required to assist with healing, recovery and/or rehabilitation.
- *Uluulumatafolau* (Re-mend) – The third phase is about healing or equipping Aiga and individuals with the skills and knowledge to minimise and/or eliminate the occurrence of the issue or problems.
- *Fa'aleleiga* (Reconciliation) – The final phase is to celebrate the journey of change to recovery and healing. This allows closure and enables the family and/or child to reflect on where they have been and how they feel now that they have achieved their goals.

Three key roles are required to support *Talatalaga A Aiga*: Community Guides who work alongside aiga to help them develop their Plan; Navigators who help aiga turn their Plans into programmes of actions, co-ordinate required services and advocate for the aiga; and Chief Advisors who provide specialist capability and expertise across key areas, thereby leading the delivery of services.

4.3.2 Pacific Trust Canterbury

Background

As described in their 2010 Whānau Ora Expression of Interest, Pacific Trust Canterbury was established in 1999 to deliver quality health and social services to improve primary health care, mental health and social services to Pacific peoples in the Canterbury region. Their founding vision is:

> *'Pacific Trust will be the provider of choice in health, social and educational services to Pacific children, young people and families delivered by Pacific people with Pacific values.'*

Their main objectives have been to improve, empower, enhance and promote the health and well-being of fanau, and to respect the culture and values of the Pacific community.

At present, the Trust is the largest Pacific health and social work provider in the South Island, and caters for the diverse Pacific communities in the Canterbury region. It also employs the largest number of Pacific health and social workers in the region, with 33.5 full-time equivalent positions.

Pacific Trust Canterbury has a Board of eight, and a management team of five supported by three distinct service arms (General Practice, Child Health and Family Services, and Mental Health Service).

[12] Families

Services provided

Integration of services

Pacific Trust Canterbury offers all its programmes in one location, and has specialised staff delivering culturally appropriate health and social programmes especially tailored to Pacific fanau. It links to other key government agencies, and offers wrap-around support programmes from multiple sectors. The intent is to provide a core of health and social services, while linking to external providers for education, respite, child protection, anger management and other services.

Pacific Trust Canterbury's EOI outlines an example of their wrap-around support programme in operation, where an elderly Tongan man who cannot speak English is admitted for breathing problems (fanau caregiver was a grandchild who translated for the grandfather).[13] The following steps were taken:

- Elder was registered through the GP service by clinician and assessed.
- Use of screening tool uncovered asthma, and that he did not have access to medical support.
- Treated by GP and given medical prescription.
- Caregiver worked with Primary Care to ensure the grandfather took medication and was monitored regularly.
- During treatment, it was identified that the family home had no insulation and the fanau wanted a 'warmer home' because they were getting sick.
- Their primary case manager worked with fanau and Housing New Zealand to address the housing problem and they were eventually shifted to a warmer state house with insulation and a heat pump.
- Fanau are now warmer and feel they have achieved their aspiration of having a warmer home.

Contracts stated in EOI

Programmes delivered by Pacific Trust Canterbury fall into three categories:

- Social Work Services (funded by Ministry of Social Development and Child, Youth and Family)
- Primary Health Care Services (funded by Ministry of Health and Canterbury District Health Board)
  - Pacific Health Clinic
  - Refugee Service
  - Child Services-Well Child/Tamariki Ora/Whānau Ora
  - Early Childhood Promotional Programmes
  - Out Reach Immunisation Service
  - Pacifika Nutrition and Physical Activity for Fanau/Whānau
  - Pacifika Smoking Cessation & Health Promotion.

[13] Pacific Trust Canterbury did not appear to submit 'actual' examples of their wrap-around service in their EOI. But it is likely that the theoretical examples provided are based on real scenarios and so this case has been included.

- Mental Health, Alcohol and Drug Services (funding by Ministry of Health and Canterbury District Health Board)
  - Adult Mental Services
  - Adult Alcohol and Drug Service
  - Mental Health and Alcohol & Drug Services for Child and Youth
  - Like Minds Like Mine.

Whānau Ora approach for Pacific Trust Canterbury

Pacific Trust Canterbury uses a service delivery model where all health needs and social services are integrated into a seamless service. This centres on the entire fanau/whānau being provided access to social programmes, GP and primary care services, mental health programmes and community support.

In their proposal for Fanau/Whānau Centred Services, Pacific Trust Canterbury emphasised the incorporation of the principles, values and beliefs of Pacific communities into service delivery. To do so, Pacific Trust Canterbury proposed a new service delivery model. The implementation of this new delivery model involves structural change to their organisation, and focuses on providing fanau with seamless service and access to social programmes, GP and primary care, mental health programmes and community support.

Pacific Trust Canterbury's new model is informed by holistic, fonofale concepts in which the fanau gathers strength from spiritual, physical, mental and other support. These supports provide the pillars on which sit Pacific cultural beliefs and ways of life. In practice, Pacific Trust Canterbury attempts to ensure that all Pacific peoples who present for primary care are not treated in isolation, but are instead contextualised by their fanau. This means that fanau themselves are approached and assessed, with services often expanded from the individual to wrap around the family.

Pacific Trust Canterbury's proposal also emphasises working across sectors to empower fanau. This involves Pacific Trust Canterbury maintaining current (and establishing new) links with other specialist services (including education, justice, and both primary and secondary health services). Fanau and patients are referred to these services by a Principal Case Manager, where appropriate.

4.3.3 Pacific Island Safety and Prevention Project

Background

The Pacific Island Safety and Prevention Project (the Project) was established in 1995 and services the Greater Auckland Region. The Project works to create a sense of responsibility within families by including awareness and education about Samoan cultural concepts and traditions in their practice.

The Project works to motivate families to genuinely accept and be responsible for their actions. This is primarily done by teaching traditional Samoan family/aiga lore alongside the obligations of New Zealand law. The Project believes that reclaiming Samoan traditions will allow aiga to reclaim values and strengths, thereby empowering Samoan men and increasing their safety, which is in turn filtered through to the safety of their entire family.

The Project's EOI states that it currently has four Board members, and a management team of two (CEO and Project Manager – Urban Youth Development Project), and supporting staff.

Services provided

Integration of services

In their EOI, the Project states that they are committed to delivering a sustainable model. This model will use the right skills and services to ensure Pacific peoples in the Greater Auckland Region receive the best possible access to services addressing both individual and aiga needs. The Project intends to:

- co-ordinate the delivery of services to families based on their needs
- monitor the delivery of services to families and ensure they have received the services required
- contract other providers to deliver services to support the implementation of Whānau Ora.

The Project aims to link with housing, education, health, employment, justice and social services.

The Project views clients from a cultural stance and uses academic knowledge to help achieve better outcomes for aiga. The Project's intervention process works from a strengths-based model that puts the aiga at the front of any therapeutic process.

In their EOI, the Project outlines an example of their practice. A 21-year-old Cook Islands/Fijian woman is referred to the Project by the Police after family violence. She has a 4-year-old child and is 7 months pregnant. The following steps were taken:

- The family is visited and, though she was not there, discussion with the family took place. The family expressed concern about the woman and her pregnancy, the anger felt by the uncle who was forced to twice call Police, and the violence occurring in the home.
- The woman met with a social worker and the underlying causes of the violence were revealed (the father of her child was a gang prospect and had been intimidating her), and deeper unresolved issues were uncovered.
- Health and housing issues were also identified within the family, and a plan of action established with the young woman.
- Liaison was established with stakeholders and the woman was moved to a refuge.
- A multi-agency safety plan was made for the young woman and the family.

Contracts stated in EOI

Programmes delivered by the Project include the following:

- Social Work Services (funded by Ministry of Social Development and Child, Youth and Family)
  - Counselling for children and young people who witness family violence, individuals and couples

  - Advocacy for children and youth people who witness family violence
  - Family Violence Awareness and Prevention Programmes for groups, families, couples, individuals – men, women, youth
  - It's Not Okay Campaign
  - Family violence prevention community education programmes
  - Programmes for adult, and youth perpetrators of violence
  - Programmes for adult victims of violence
  - Crisis accommodation
  - Anger management programmes
  - Relationship counselling with couples, families, youth and children
  - Abuse prevention programmes
  - Support for Elders Group (Faliu Le La Samoa, Mohe Taha Tonga)
- Family Violence Programmes (funded by Ministry of Justice and Department of Corrections)
  - Family violence and anger management programmes

Whānau Ora approach for the Pacific Island Safety and Prevention Project

The Project uses a model called *Fonotaga* ('Meeting') to support families. *Fonotaga* is used to allow the aiga to participate in the decision-making process about any issue that affects an individual member of the aiga. This process is intended to enable discussion by each family member present and usually ends in consensus. *Fonotaga* is also used within the aiga to alert members of situations that occur, in an appropriate and effective way. *Fonotaga* enables the aiga to take ownership of problems, and to share responsibility in finding solutions.

The Project argues that the process of *Fonotaga* can be hampered by the notion of confidentiality and western practices of only working with the individual. The Project worker's role for a successful effective outcome includes:

- ensuring meetings are conducted appropriately
- identifying key family members
- encouraging the family towards consensus (principles of *Fonotaga*)
- identifying family strengths
- offering support
- encouraging families to work together
- strengthening and encouraging the voice of all aiga members, especially the vulnerable.

Well-conducted *Fonotaga* should result in the following:

- identification of strengths and challenges within the family
- healing and restoration for all those involved
- a platform for changed behaviour within the family

- aiga sharing responsibility for their collective well-being
- self-development within the cultural framework
- aiga self-managing within the family context
- maintenance of aiga integrity
- consensus.

4.3.4 Alliance Health Plus

Background

Alliance Health Plus is a newly formed Primary Health Organisation that was established in response to the government policy 'Better, Sooner, More Convenient primary and community health services'. Alliance Health Plus was incorporated as a charitable trust on 10 June 2010, as an umbrella organisation for the collaboration of three Auckland Pacific-led PHOs (Ta Pasefika, AuckPac and Tongan Health Society).

Alliance Health Plus is currently in a transition phase to combine the three Primary Health Organisations into one single entity, but has significant experience from within the three Primary Health Organisations. The best practices identified from these three Pacific-led Primary Health Organisations have been transitioned into Alliance Health Plus with an aim to develop an improved and more whānau-centred PHO and alignment with the Whānau Ora model.

Alliance Health Plus' EOI does not state their likely governance structure.

Services provided

Integration of services

Services to be provided under Alliance Health Plus will involve strengthening existing core GP services and gaining consistency across Alliance Health Plus to improve health outcomes and integration and interdisciplinary teamwork within a multidisciplinary team.

In their EOI, Alliance Health Plus provides one example of how their practice might work. The case was handled by a public health nurse and centred on a clinically depressed widow caring for three children (including a newborn) and her elderly mother. The following steps were taken:

- The oldest son was identified as missing school to work two jobs to support the family and being under severe stress.
- Connection was made to a social worker, who identified eligibility for a sickness benefit and two years of associated payments owing.
- Links were established to Anglican services for food parcels and equipment for the newborn.
- This freed the son to return to his studies
- The family was subsequently immunised.

Contracts stated in EOI

At the time of drafting this report. Alliance Health Plus was not providing services (these were provided by the three individual members). Alliance Heath Plus did however state health targets it wished to address:

- shorter stays in emergency departments
- improved access to elective surgery
- shorter wait times for cancer treatment
- increased immunisation
- better help for smokers to quit
- better diabetes and cardiovascular services
- the development and establishment of three Integrated Family Health Care Centres.

Whānau Ora approach for Alliance Health Plus

Alliance Health Plus has developed a Pacific framework called *O Le Aiga ma le Fanau ia Ola.* This philosophy allows Alliance Health Plus to focus on a holistic model of care that places health and well-being in the context of relationships, special environments and the wider determinants of health. Alliance Health Plus' approach includes but is not limited to:

- consumer and Aiga ma le fanau/whānau-centred approaches to care that incorporate family/whānau into care planning processes
- empowerment of Aiga ma le fanau/whānau though education and improving health literacy to enable greater control over their health and well-being
- a commitment to providing culturally competent practice to improve family experience with health and social services
- developing new and strengthening existing inter-sectorial relationships with other non-government organisations and government agencies on behalf of families with high and complex needs.

Alliance Health Plus intends to embed *O Le Aiga ma le Fanau ia Ola* into their model of care and thereby enhance clinical, social and holistic outcomes for the communities they serve. Four key outcomes are sought by Alliance Health Plus:

- Accessibility – A range of health and social services are closer to home and/or in one location.
- Affordability – Cost barriers are minimised or removed.
- Quality of Care – Quality technical, social and culturally appropriate services are delivered.
- Continuity of care – A seamless service minimises families repeating their stories to different providers and agencies.

Alliance Health Plus also proposes to establish a navigator to help families find their way around the range of appropriate and quality health and social services.

4.4 Early reflections on Whānau Ora in a Pacific context

Existing targeted initiatives that use Whānau Ora approaches

This section considers what Whānau Ora may look like in a Pacific context.

The seven Whānau Ora principles that underpin whānau-centred service delivery are:

- Ngā Kaupapa Tuku Iho
- Whānau opportunity
- Best whānau outcomes
- Whānau integrity
- Coherent service delivery
- Effective resourcing
- Competent and innovative provision.

Section 4.3 provided an overview of four Pacific initiatives that have recently been awarded contracts by Te Puni Kōkiri to implement Whānau Ora approaches. Analysis across the seven principles of whānau-centred service delivery demonstrates the values, design, intended implementation and desired outcomes of the four Pacific initiatives are closely aligned.

Ngā Kaupapa Tuku Iho

This principle is defined as 'the ways in which Māori values, beliefs, obligations and responsibilities are available to guide whānau in their day-to-day lives'.

Each of the four Pacific initiatives provided at least one metaphor or operating model that could be considered to be culturally equivalent versions of Ngā Kaupapa Tuku Iho. The prevailing theme in these models was the primacy of Pacific cultures as means to ground and/or empower Pacific families and individuals. Usually, norms such as fishing parties, fale (house) construction and weaving are used as vehicles for Pacific cultural concepts, and subsequently guide the operationalisation of services.

Whānau opportunity

This principle states 'all whānau will have chances in life that enable them to reach new heights, do the best for their people, engage with their communities and foster a strong sense of whānaungatanga – connectedness.'

For the four Pacific providers, 'whānau opportunity' tended to mean that Pacific families were given or gained access to health and social programmes, and if necessary associated wrap-around services. Based on the cases outlined by each provider, it appears important that Pacific families are not only given opportunities, but are made aware that opportunities exist (e.g. the widow who was unaware that she was eligible for a sickness benefit, or the elderly man who was unaware that he could source treatment for his asthma).

Best whānau outcomes

This principle states 'the success of Whānau Ora interventions is measured by increases in whānau capacities to undertake those functions necessary for healthy living, and shared contributions to the well-being of the whānau as a whole, as well as the well-being of the whānau members.'

As with **whānau opportunity**, the emphasis for the four Pacific providers under this principle was the engagement of aiga or fanau in their own solutions. Usually, this took the form of all-of-family meetings seeking consensus on actions required to increase the health of the family unit *and* its constituent individuals. Furthermore, health was not solely considered the domain of the individual, with the requirements of the family itself frequently featuring in delivery methods and desired solutions (e.g. discovering that a warmer home was a requirement of the family whose grandfather has asthma, or removing a young pregnant woman to a refuge to ensure not only her safety, but that of her family as well).

Coherent service delivery

This principle 'recognises a unified type of intervention so that distinctions between services … are not allowed to overshadow wider whānau needs'.

Providers outlined requirements such as beginning with the individual and extending wrap-around services to the family as a whole, with concurrent co-ordination of different agencies by a representative or advocate from within the Pacific provider. Providers also specified requirements such as having a single provider site, or minimising any required travel distance to prevent dislocation of services.

Whānau integrity

This principle 'acknowledges whānau accountability, whānau innovation and whānau dignity … [and]... assumes that a code of responsibility is present in all whānau, though it may sometimes be masked by events or circumstances …'.

The threads of Pacific culture binding families and clarifying roles and responsibilities was common to all Pacific providers. Case studies, for example, frequently identified a behaviour that brought an individual to the attention of the provider (via referral) or Police. Each case outlined how the problematic behaviour or poor health of the individual could be linked to wider environmental or personal problems. Once these were addressed (and either fully or partially resolved), the family was able to manage the issues themselves, or at least minimise their dependency.

Effective resourcing

This principle recognises the need for the level of resourcing to reflect the 'size of the task', and that resourcing is tied to results.

The four Pacific providers are receiving Whānau Ora funding therefore it is assumed that the resources are adequate to enable delivery of desired results. The four Pacific providers use outcome-focused language, and will be applying an action research approach to enable the ongoing refinement of their service delivery to achieve agreed outcomes. However, it is currently unclear whether resourcing is tied to results. Further, it is currently too early to determine whether the Pacific providers will report based on outcomes and not outputs.

Competent and innovative provision

This principle 'recognises a need for skilled practitioners who are able to go beyond crisis intervention to build skills and strategies that will contribute to whānau empowerment and positive outcomes'.

Providers were clear in their ability to take practical steps to go beyond crisis intervention. Their emphasis on broader means to address individual health or behaviours inevitably depended on the abilities of their social or health workers to identify environmental and/or circumstantial causes. These causes were then addressed via Pacific cultural filters and co-ordinated interventions applied with minimal disruption to families or their members.

4.5 Effectiveness of Whānau Ora in a Pacific context

At this point in time, there is no explicit evidence that a Whānau Ora approach will be effective in addressing Pacific health outcomes. However, with the implementation of the four contracted projects this evidence will become available over time. Action research is being used to inform their implementation, and through this cyclic process of planning, action, observation and reflection insights will be gained on outcomes achieved as well ways to continue to transform practice.

Consideration was given to whether any of the 26 targeted initiatives contained implied elements of Whānau Ora principles in their delivery, and whether their evaluations may provide insight into the effectiveness of this approach in achieving desired health outcomes for Pacific people. While some initiatives contain elements of Whānau Ora principles, none demonstrated all seven.

For example, Lotu Mo'ui is a church-based healthy lifestyle intervention programme which seeks to use a holistic approach to address the problem of obesity, with a specific focus on nutrition and physical activity, and to promote smoke-free environments (Clinton et al 2009). In 2009, the programme was considered to represent 'a significant landmark in … strengthened vision, commitment, and a process of collaboration between District Health Board and Pacific church community (p.18).

The programme's goal was to use a grants scheme to build healthier environments in Pacific churches in the Counties Manukau District, with a particular focus on:

- improving nutrition
- increasing physical activity levels
- promoting healthy weights
- reducing smoking prevalence
- improving engagement with health systems
- implementing community education.

Churches were charged with developing health promotion activities against obesity, and promoting SmokeFree environments.

Review of **Lotu Mo'ui against the seven underpinning** Whānau Ora **principles highlighted only limited alignment. While the church was a key conduit to access**

Pacific people in a Pacific context, there was no articulated model for Pacific health care. Further, service delivery focused on health and did not offer a unified type of intervention that seeks to empower and achieve holistically focused outcomes.

An evaluation of the **Lotu Mo'ui** programme was conducted in 2008 and published in 2009. Among the many findings of this evaluation are a number of points from which **Lotu Mo'ui** may have benefited from the application Whānau Ora principles. Selected findings include:

- Communication and modes of communication was important to the success of the programme. A noted barrier was the use of non-culturally appropriate communication, including text or email reminders in English (p.293), while greater reciprocation was noted as an enabler (p.277).
- Appropriate resourcing was noted as an issue for both successful and unsuccessful church-based programmes.
- 'Successful' implementation occurred where "churches expressed a more holistic (i.e., more than just physical activity and nutrition) vision of Lotu Mo'ui involving intergenerational changes for a healthier and happier Pacific population (p.275).
- A "one-size fits all approach … is not conducive to success", and "[g]oils, benchmarks and indictors need to be developed according to the churches' specific needs and levels of readiness and ability…" (p.294).

The emphasis on better communication, of holistic approaches to health, and culturally appropriateness are all precursors for the delivery for Whānau Ora. The **Lotu Mo'ui** evidence seems to indicate that had Whānau Ora principles been incorporated into the design and maintenance of the programme it may have had even greater success.

In summary, the underlying aim of Whānau Ora is to empower families to make decisions for themselves. This concept provides a useful context for 'Ala Mo'ui. The four Pacific demonstration models offer the health sector an opportunity to gain insight into how the principles underpinning Whānau Ora service delivery may apply within a Pacific context. Importantly, through the use of action research, the four Pacific demonstration models will contribute significantly to the evidence-base of effective practice to achieve desired outcomes for Pacific peoples.

Appendix 1: Literature Search Approach

Search mechanisms

A search of the published literature was undertaken by searching three large databases – Pubmed/Medline, Science Direct and The Cochrane Library. Other relevant databases were also searched.

Internet searches were undertaken to obtain additional reports and papers of interest using Google (www.google.com) and by screening websites of government research centres with a Pacific focus.

Grey (unpublished) literature was sourced through websites and government agency literature searches. Relevant citations within the selected articles obtained via the above-specified searches helped locate additional articles, which were then screened for relevance. The databases and other sources listed yielded a number of papers, with each resultant article individually screened for relevance to the review topic.

Search terms

The search terms used were:

- Pacific people
- Service quality health
- Service clinical
- Quality clinical health
- Quality initiatives health
- Quality innovation health
- Family centred initiatives
- Family models of care
- Wrap around services
- Strength based services
- Culturally appropriate health
- Health equity service deliverables
- Whānau Ora Pacific health
- Migrant communities.

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