Proceedings of the 2013 Public Health Association Conference

Partnership or Collaboration;
is there a difference?

17 - 19 September 2013
Devon Hotel
New Plymouth, Taranaki

Public Health
ASSOCIATION OF NZ INC
KĀHUI HAUORA TŪMATANUI

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"Dreams become reality when we take action"

Tihewa mauri ora ki te whai ao, ki te ao mārama. Ka tū te ihi-ihi, ka tū te wana-wana, ki runga i te maunga o Taranaki, te mana-whenua o Taranaki, te Iwi o Taranaki. Ngā mihi rangatira ki tēnei huihuinga tino ātaahua rawa, ngā taketake i hora-hia, ngā tikanga i tuku ai ki te mano i kotahi mai ai, mai te marae o Owae, ki te papa-noho o Devon Hotel, ngā tohunga kōrero pērā ia Dame Anne Salmond, ki ngā wāhine-toa, Annette Sykes/Mihi Rātima ki tēnei o ngā Rangatira rongo nui i a Moana Jackson me ērā atu i TŪ ai ki runga o te atamira, tēnā koutou, ā tēnā tātou katoa. Ko te tūmanako a te Māori Caucus, i kē wā koutou kete, i pai tā koutou noho, me tā mātou tiaki i tēnā, i tēnā o koutou, He Mauri Ora, He Hau Ora, ki a tātou katoa.

'Partnerships and Collaboration - is there a difference?' was developed and promoted as an opportunity to challenge the status quo, to encourage innovation and to support aspirations. The programme promised much and delivered way more than what we had hoped.

The amazing history lesson we received from Dame Anne Salmond, politics 101 with Hon. Meteria Turei, a masters lesson in colonisation from Moana Jackson, an inspirational yet challenging moemoeā session from Annette Sykes, a grass roots reality check from Dr Mihi Ratima, a humbling lesson in cultural diversity from our amazing panel of Dr Damon Salesa, Dr Anwar Ghani, Dr Elsie Ho, and Sanjeewanie Kariyawasam, then to end on a message from Dr Susan Devoy on our collective responsibility to and for change. But that's not the whole picture. Every workshop session had something new to add to the way in which we viewed the world, the difference we could make, the difference that had been made, the encouragement to do better, "that our individual and collective contribution to change can, will and does make a difference"!

There were many key messages from the conference and the committee believes everyone who attended left with their kete well and truly filled. For some it would be a reminder of what and who is important in all that we do, *He tangata! He tangata! He tangata!* For others it might be, "what contribution to change could I individually make? Give up three coffees a month and send the $15 to KidsCan". It might be a better understanding of what is happening with grass roots, tamariki ora, whānau ora, research, policy developments, homelessness... the list goes on. Whatever messages you took away from the conference, remember the words of Annette Sykes, 'dreams can become reality when we take action'.

Let's not forget the hau kāinga – whānau of Taranaki and our venue that supported and facilitated a real sense of belonging and participation regardless of where you were throughout the whole hui. Ngā mihi tino rawe ki a koutou katoa!

To all of you who supported the Māori Caucus conference committee, nga mihi, and to everyone who attended, who shared their hopes and aspirations, who shared their learning's, who shared their excitement, energy, commitment and passion we thank you. To each and every one of you we say thank you for making the 2013 PHA conference the wonderful success that it was.

Marty Rogers
2013 Conference Abstract & Programme Chair

Tireless health advocate named Public Health Champion

Celebrating Dr Lance O'Sullivan

One of New Zealand's most inspirational General Practitioner's (GP's) has been recognised for his dedicated and courageous efforts to eradicate poverty-related illnesses in the Far North. Dr Lance O'Sullivan was named the Public Health Association's Public Health Champion for 2013 at this year's conference.

Upon hearing he had been nominated for the award, Dr O'Sullivan said he was both humbled and blown away, especially considering the high calibre of Public Health Champions in the past.

"It's such a privilege to be recognised as having contributed to public health. As a GP I have the opportunity to work on a personal level with people, but so many GPs aren't aware of the potential they have to impact the health of the entire population.

While I'm immensely proud to accept the award, I'm also excited about the fact that the issues relating to the work I'm doing will be highlighted."

Dr O'Sullivan's work as a GP in Northland gave him a first-hand glimpse of the impact poverty was having on the health and wellbeing of entire families. Preventable diseases, such as rheumatic fever and skin infections, were rife, and little action was being taken in terms of treatment and prevention.

As well as setting up a health clinic at Kaitaia Hospital, Dr O'Sullivan has been instrumental in developing a number of different programmes to provide medical care for more than two-thousand children across fourteen schools in Northland.

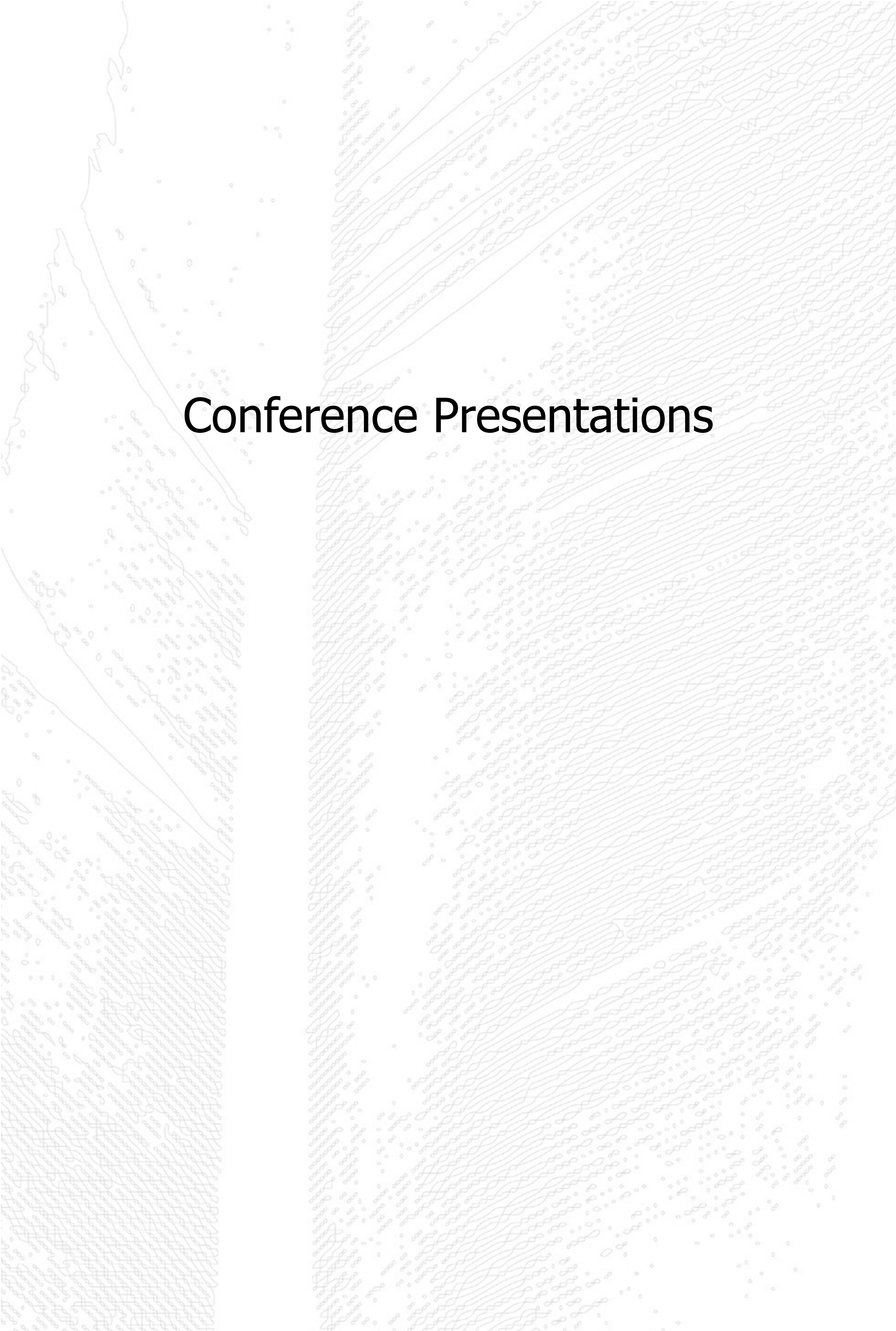
It has been a year of awards for Dr O'Sullivan. He has also won Māori of the Year (in the Health category), and the supreme Award for Māori of the Year. He has also received a Sir Peter Blake Leadership Award.

Dr O'Sullivan says he is honoured by the awards, but that they have not been the highlights of the year for him.

"For me, it's not about the awards or the recognition. My highlight has been seeing the great results and positive outcomes from the work we've been doing. It's been seeing the health of entire communities improving. That's what makes me really chuffed."

Over the next few months, Dr O'Sullivan's attention will be turned to a new initiative he's working on: an iPad app to help diagnose and treat skin infections.

"The idea behind the app is to be able to reach the unreachable. We're aiming to get it out early next year, which will allow us to help people by identifying early potentially disabling skin diseases."



Conference Presentations

Ora: on philosophies of health, prosperity and wellbeing

Dame Anne Salmond - University of Auckland

In contemporary New Zealand, the idea of ora – health, prosperity and wellbeing – is everywhere. It applies to individuals, families, communities, ecosystems, rivers – even the nation or the planet. Its converse, mate – sickness, a state of misfortune or ill-being – also confronts us on a daily basis. It shows up in high rates of illness and mortality, youth suicide and incarceration, dysfunctional families and communities, collapsing ecosystems, species dying out at an unprecedented rate and biophysical systems out of kilter, causing widespread damage.

Distilled to their essence, these ideas are simple. In a state of ora, the relations among people and between people and other life forms and forces are in a state of positive balance, generating peace, prosperity and wellbeing. In a state of mate, on the other hand, the relations among people and between people and other life forms and forces are out of kilter, generating violence and poverty, a sense of insecurity and alienation. Exchanges are negative and unequal. Reciprocity has failed.

These ideas are also profound. According to the experts in the old schools of learning, the world began with a surge of energy, followed by knowledge, thought and memory and aeons of darkness. It was not until hau ora and hau tipu, the winds of life and growth, blew through the void that Rangi and Papa, the sky and earth, emerged, followed by stars, plants, animals and people.

Here, the world is animated by winds of life and growth. People are one element in the cosmic networks, linked with all other forms of life. This complex system is driven by reciprocal exchanges among complementary pairs – earth and sky, men and women, land and water, for example. These include phenomena considered to be inanimate in commonsense Western thought:

From nothingness (te Kore) was generated
Unpossessed nothingness,
Unbound nothingness
The wind of growth, the wind of life (ko hau tupu, ko hau ora)
Stayed in clear space
And the atmosphere emerged
The sky (te rangi) which floats
Above the Earth (te whenua)..

Just as the wind of life brings the world into existence, it brings life to each human being. As a child is born, they emerge from Te Po, the dark, invisible realm of ancestors, into Te Ao Marama, the world of light. In the old days, when someone spoke of something that happened before they were born, they might remark, ‘I was in the Po at that time.’

If a baby sneezed after birth, people would exclaim ‘Tihei, mauri ora!’ [I sneeze; it is the spirit of life!] This phrase is still often used at the beginning of a speech on a marae. These ideas are also reflected in the hongi – the pressing of noses in which the breath of life is mingled.

The wairua or spirit, then, gives life to the tinana or physical body, making a child tapu (a term that simply means that their ancestors are present). In addition, each person has a hinengaro or mind-heart in which thought and feeling intermingle. As the kanohi ora or ‘living face’ of their ancestors, children are vital to the continuity of descent lines and the wellbeing of kin groups, and as such, were strongly protected.

Contrary to popular opinion, in early times child abuse of any kind was extremely rare in Te Ao Māori, a fact attested to over and over again by early European visitors to New Zealand. Its presence in some Māori families today testifies to the collapse of a philosophy, and a whole way of being.

In the old days, it was understood that the health and wellbeing of land, sea and people were intricately interwoven. The most senior tohunga, trained in the Schools of Learning, conducted the cycle of seasonal rituals that ensured the fertility of land, plants, animals and people – performed when root crops were planted or harvested, or the season for particular fish or sea foods began.

The Matariki rituals were among these ceremonies, signalled by the stars and involving offerings to the ancestors, with brilliant gatherings featuring sports, music, dancing and feasting. Such rituals contributed to the wellbeing of individuals, communities, land and the ocean.

In a state of ora, then, life is peaceful, supplies of food are abundant, mana is high and relationships with kinsfolk, other groups and ancestors are in good heart. Body, spirit and mind-heart are in balance, giving health and wellbeing for individuals, groups, land, sea and waterways alike.

A state of mate, on the other hand, is one in which relationships are out of balance, life is dangerous, food is scarce, mana is in decline and people are suffering, ill or dying. When a person or a group is humiliated or harmed, or their ancestral lands and waterways are lost or degraded, this is a patu wairua – a blow to the spirit. At the Waitangi hearings for the Whanganui River, for example, an elder lamented:

> ***It was with huge sadness that we observed dead tuna [eels] and trout along the banks of our awa tupua [ancestral river]. The only thing that is in a state of growth is the algae and slime. Our river is stagnant and dying. The great river flows from the gathering of mountains to the sea. I am the river, the river is me]. If I am the river and the river is me – then emphatically, I am dying.***

Here there is no fundamental division between mind and matter, or mind and heart, or individuals and the network of relationships with other forms of life that define them. This is a relational theory of how the world works, which differs from those modernist medical theories that separate out body, mind, heart and spirit, culture from nature and people from the environment. In such philosophies, the body is understood as a material system, to be treated by physical and mechanical interventions – medicines, surgery, manipulation, drugs and the like – although this is changing; while the mind is understood as an immaterial system, to be grasped by psychology or psychoanalysis, although this is being transformed by neurology and neuroscience. The heart or emotions are something of an anomaly while the spirit is largely ignored.

Because of these divisions, many scholars have been tempted to argue that Western ideas about health are fundamentally mechanistic, based on binary oppositions between mind and matter, intellect and the emotions, observer and observed, nature and culture. It is not this simple, however. When the first European ships arrived in New Zealand, the Enlightenment was in full swing in Europe, with a flurry of innovation in philosophy, science, industry and commerce. They brought with them a cargo of colliding cosmological ideas.

Some of the first voyages to arrive were scientific expeditions, at the cutting edge of the Enlightenment. On board those ships, the best observers had medical training. At that time, medical students in London, Edinburgh, Montpellier and Leyden were taught to observe and describe plants, landscapes and climates as well as people and their diseases, and to reflect upon the relationships among them. The Surgeon's Company in London, which employed the distinguished physician William Hunter, offered a more specialised training in anatomy and surgery, but candidates were often already well educated, with a keen interest in natural history.

If one examines Captain Cook's visits to New Zealand, for example, the journals of men like William Monkhouse (who had studied with William Hunter), William Anderson (who trained at Edinburgh) and David Samwell are superbly detailed, covering the full gamut of natural history. Their accounts of Māori people and their ways of living are set in the wider context of local landscapes, including geology, plants and animals and climate. From the outset, European understandings of Māori life were set in a wider web of relations between people, land and ocean.

This is important, because this helped to set the scene for relations between Māori and Europeans in New Zealand. These medical men represented one major strand in Enlightenment thinking – the Order of Relations, one might call it. As Hans Peter Reill has argued recently, thinkers including Erasmus Darwin, Joseph Priestley and many of those involved in the Scottish Enlightenment in Britain, Buffon in France, Boerhaave in Leyden, Benjamin Franklin in the United States of America and the Humboldt brothers in Germany understood the universe as made up of complementary forces and elements linked in complex networks of relations, striving towards equilibrium. As we will see shortly, this way of thinking has many resonances with Māori philosophies.

Their ideas contributed to the French and American revolutions, the emancipation of slaves and women, geology, ecology and evolutionary theory, and participatory democracy. In cutting edge contemporary science, one can discern these forms of order in the World Wide Web, the science of complex networks and systems, including brain science and the environmental sciences; and quantum physics, for example.

On the other hand, during the Enlightenment, Cartesian dualism led to the separation of subject from object, culture from nature, people from the world around them, and eventually from each other. This 'Order of Things,' as Michel Foucault has named it, was the other major strand in Enlightenment thinking. Here, one iconic model was the idea of the cosmos as a machine, made up of distinct, divisible working parts. Another was the grid, as expressed in Linnaean taxonomy, for example.

In the latter part of the eighteenth century, Cartesian logic, which divides mind from matter, the observer from the observed, and culture from nature went viral. The law of identity (A=A), the law of difference (A≠B) and the law of the excluded middle (A B) were used to divide up reality into arrays of bounded, replicable units. Many aspects of life were transformed - administration (with censuses, surveys, and bureaucratic systems), industry (with mechanical processes)and science (with the use of instruments and quantification and the increased specialisation of knowledge). In medicine, this eventually led to those bio-medical models that split subject from object, mind from matter and thought from the emotions.

Sometimes the grid was hierarchical. In an older cosmic model, the Great Chain of Being, for example, elite beings at the top of the chain – the divine King, the aristocracy and commoners in 'civilised' societies, ruled over a cosmos in which 'lower' beings – slaves, barbarians, savages and 'wild nature' with its animals, plants, minerals and rivers - could be exploited almost without limit. In New Zealand, this idea led many Europeans to suppose that as a higher form of life, they were entitled to rule over Māori and nature alike. At the same time, the more liberal-minded Europeans thought they were obliged to offer them protection – through the post of Protector of Aborigines or reservations, for example.

In many ways, one can grasp the colonial history of this country as exchanges between these competing philosophies – the relational order of Te Ao Māori on the one hand, and the contradictory, entangled models of the Order of Things and the Order of Relations from Europe on the other.

As Damon Salesa has shown, for instance, about the time of the Treaty of Waitangi in 1840, the British authorities became concerned about reports of rapid depopulation among Māori. The House of Lords sought out medical men who had visited New Zealand to try and discover what was happening. They described a robust, healthy group of people who were reeling under the impacts of European arrival, including the introduction of venereal diseases, muskets, alcohol and epidemic diseases, the adoption of blankets and inadequate food and shelter when felling timber or cutting flax for visiting vessels.

In fact, these accounts are quite close to Māori understandings. Pre-contact times are often seen as a kind of Utopia, and there is some justice in this perception. Earlier claims about short life spans, malnourishment, low birth rates and the like are being undermined by more recent findings in archaeology and physical anthropology. As early European accounts testify, people were generally robust and healthy. There were no epidemic or venereal diseases. At the same time, warfare and fighting did occur (although they were less lethal than is often supposed), causing wounding and death and there were aspects of the cosmological theories that caused severe distress, even terror.

Mate was thought to be caused by harm to the wairua or spirit of the person. If a person felt insecure or uneasy, suspected that they had broken a tapu and offended the ancestors, had suffered a spiritual attack of some kind, or were out of sorts with their whānau and other relatives, they entered a state of mate, or illness. This brought them in touch with Te Po, and for that reason they were tapu and not allowed to eat cooked food, and were secluded from others.

One can readily imagine the horror associated with the onset of epidemic and venereal diseases. New kinds of mate spread rapidly from one person to another, and entire families and kin groups were devastated. Warfare in which only one side had firearms disrupted the old system of checks and balances between kin groups; and guns made many of the fighting forts obsolete.

The introduction of European plants and animals had negative effects as well as advantages, such as potato plantations cropping several times a year, requiring more continuous labour, especially from women, and pigs and other domestic animals destroyed cultivations and contaminated water supplies. Over the first years of intensive contact with Europeans, in any case, much of the new produce was traded for guns and ammunition.

As people left their pa and shifted to lower ground, water supplies were contaminated by latrines in the villages, shallow wells, and swampy ground. There were epidemics of typhoid and dysentery. The bush was cut down, and its bird and animal life (another source of ora or livelihood) decimated by introduced animals (European rats, cats, pigs, goats and dogs), so that it too, became mate.

In response to these concerns, the Aboriginal Protection Society in Britain argued for the protection and sovereign rights of Māori people, and many rangatira reciprocated by signing the Treaty. A spirit of mutual respect led to an alliance that promised a new kind of colonial history. Hospitals were quickly established and medical men despatched to try and deal with Māori health problems. Some of these men held fast to relational approaches, for instance Dr. George Rees, with his 1851 report on the 'Medical Topography of the Wanganui District', which discusses local landscapes; the climate; local soils, animals, fish and plants; Māori life and communities; the settlers; and the river, as well as local diseases.

At the same time, however, the conventions associated with Western medical treatment often involved breaches of tapu. The idea that the body that was ill, and its symptoms had to be treated apart from the wairua of the person, made no sense in Māori cosmological theories; and some forms of treatment seemed guaranteed to damage the wairua.

Hospitals, for example, brought a number of people who were mate together in one place, rather than isolating the sick person and when people died, the bedding and even the building, which would formerly have been destroyed, continued to be used for sick people. In the old days, an invalid was fed with special foods, especially raw food, since they were tapu; but in hospital food was cooked in the same building where sick people lay; the toilets were inside, rather than in a separate place; and in a multi-storied hospital, people walked over the heads of chiefly patients; blood was kept in refrigerators etc. This is not to say that these practices were wrong, but that they were inimical to beliefs in tapu.

In these ontological clashes, however, perhaps the most fundamental collision of all was between ideas of tapu, mana and ora, and the hierarchical theories associated with the Order of Things in the Enlightenment and later, ideas of social evolution. These conceptions, which placed Māori at a low level in the 'Great Chain of Being,' worked (and still works) as a patu wairua of a particularly virulent kind. They led to a blanket assumption that all European ways of life were superior to those of Māori, and that Europeans had nothing to learn from Māori ideas.

Shortly after the Treaty of Waitangi was signed, for instance, British ideas of property and land as a commodity were imposed in a system of governance from which Māori were excluded. From about the 1850s, when clashes over land became common, some Europeans began to argue that 'the black savage shall disappear before the white settler' – a patu wairua if ever there was one. The settlers began to take land by force, and then by confiscation. At first Māori resisted with considerable success, but eventually they were forced to retire from fighting, and the Native Land Court set about partitioning the land. The Māori population plummeted, with Māori prophets and healers attempting to offer them solace.

In the wake of the Land Wars, however, ideas associated with the Order of Relations remained powerful in New Zealand. Even during the fighting, there were European leaders who strongly protested the injustice of these proceedings, for instance Sir William Martin, the first Chief Justice of New Zealand, who held fast to Enlightenment ideas of the law as an instrument for justice.

Admiration for Māori intellect and art forms remained strong, and this had wider impacts. When the Land Court was established, for instance, it retained some respect for Māori relational principles. Despite the fact that European women had no property rights at this time, shares in land were awarded to Māori women, and many women appeared as advocates and leaders of their kin groups. When in 1893, women in New Zealand became the first in the world to be granted the vote, the fact that Māori women had retained their leadership and property rights was influential.

At about the same time, too, a new group of young leaders emerged from Te Aute, a Church of England Māori boarding school. These visionaries included several doctors (the most prominent being Peter Buck, also an ethnologist and reluctant politician) and Maui Pomare, along with a brilliant lawyer and Cabinet Minister, Āpirana Ngata. These young men dedicated themselves to reversing the fortunes of Māori people and worked to introduce new methods of sanitation and health promotion, build cultural pride and re-establish a viable economic base for Māori communities.

As these young Māori leaders forged alliances with influential scientists, artists and intellectuals, New Zealand became known as 'Māoriland,' a most unusual settler nationalism based on a distinctive indigenous presence. This planted the seeds for contemporary bi-culturalism, the second Māori Renaissance and the Treaty settlements of recent times. At the same time, the Māori population reversed its decline, and the prospect of imminent extinction vanished.

Since the 1980s in New Zealand, however, the Order of Things has been reasserted. The Great Chain of Being has been given a new twist in neo-liberal ideologies that presuppose that human beings are in charge of the cosmos, separated from Nature and entitled to exploit it without limit. At the same time, wealth, tribute and deference flow upwards from the lower ranks of the cosmic ladder to a small elite at its pinnacle. In this model, any form of redistribution is regarded as a favour.

The assumptions on which these ideologies are based are mythical in the strict sense, however, radically contradicted by the findings of contemporary science. According to brain science, quantum physics and the environmental and life sciences, for instance, mind is not split from matter, nor the observer from the observed, nor nature from culture. Human beings are just one species among many, entangled in complex biophysical systems that we only partially understand.

As a result of a combination of 'trickle down' economics and 'command and control' politics, another reflex of the Great Chain of Being, wide and increasing disparities have arisen between rich and poor, with Māori and Pacific people disproportionately sitting at the bottom of the graphs (more gridded hierarchies!) for educational underachievement; arrests, convictions and imprisonment; poverty and poor health outcomes, along with severe environmental degradation and associated health problems.

The idea that Māori are 'less advanced' than the incoming Europeans, also based on the Great Chain of Being, has also proved remarkably resilient in New Zealand, although the rhetoric is now usually muted. The notion of collective inferiority is enacted every day in our schools, for example, in the commonplace assumption that Māori (and Pacific) students are not able to tackle the most challenging subjects, or are destined for low income, low status jobs, or physical pursuits such as manual labour or sports.

Many of these young people come to internalise the idea that their intellectual abilities are limited. The frustration and humiliation generated in this way acts as a peculiarly malignant form of patu wairua, associated with the loss of mana, whakamā (shame) associated with failure and too often, whakāmomori (withdrawal, mental disorder or suicide).

Not surprisingly, many of the students affected in this way (especially boys) leave school early without formal qualifications, and the brightest are often particularly disaffected. Hence, I suppose, the attraction of gangs, drugs and alcohol, a resort to violence, and the extraordinarily high rates of youth conviction and incarceration among Māori, especially Māori males. The growth of income inequality in New Zealand (which despite our egalitarian ideologies, is very rapid), at least in part, must be a reflex of these pathologies. From where I stand, the old ideas of ora and mate have considerable explanatory power.

As these conceptions would suggest, there is a powerful statistical correlation between health and wealth. It would be interesting to track the soaring increase in income inequality in New Zealand against the indicators for health and wellbeing. As Papaarangi Reid and Mason Durie among others have eloquently argued, health statistics show sharp inequalities in life expectancy between Māori and other New

Zealanders, with Māori males having shorter life spans than Māori women, and both less than non-Māori men and women; significantly higher rates of many diseases and disorders; and differences both in access to health care and in the quality of care they receive. This should be a national scandal.

Like the disparities in educational outcomes, however, there is often a curious passivity in responses to disparities in such statistics, which I would argue is also based on the old myth of a ranked cosmos, which gives elites a sense of entitlement and explains away differential life chances for the 'lower orders' as due to a want of merit. At the same time, however, disparities in health, wealth and educational achievement between Māori, Pacific and other New Zealanders are closely linked with negative economic indicators, such as relatively low GDP, low incomes and low levels of labour productivity, which detrimentally affect national prosperity. Not only do these assumptions work as a self-fulfilling prophecy, then, they are self-destructive for all New Zealanders. When one finds (as one does) this passivity among those responsible for forming policies for and managing the education and health systems, it should be a cause for widespread consternation.

The insight that radical inequalities in wealth are linked with negative indicators in health, justice, social welfare and economic performance and a recipe for social pathology is increasingly being explored in contemporary economic and social theory, as are relational philosophies. Here in New Zealand, however, such ideas have indigenous precursors that we might investigate to our collective benefit. In health, Mason Durie has been a leader in this regard, and in the law, Moana Jackson; but one might note that this task is generally left to Māori scientists and scholars. Ironically, those non-Māori who are most dismissive of Māori ideas invariably know little about them, having decided in advance that they are not worth close examination – a kind of prejudgement that indicates 'closed minds' and ideological thinking.

In this talk I have argued that in contemporary New Zealand, there are still many powerful echoes of the old ideas of the Great Chain of Being, social evolution and the collective inferiority of Māori and Pacific people, which serve to prop up and reproduce discriminatory and exclusionary practices. Usually, there is no deliberate ill will involved. These ideas are so deeply embedded that they are largely invisible, rarely coming to conscious attention. This makes them extremely difficult to deal with, and all the more powerful.

In the Starpath project, for example, established at the University of Auckland to confront and change educational inequalities, we have tried to tackle these hidden assumptions through collaborative relations with teachers, students and parents, based on shared goals and a relentless shared focus on tracking outcomes for students over time. By this process, many implicit assumptions and self-serving justifications come to light, where they can be challenged (often by the professionals themselves) and replaced by more accurate insights. I'm sure that similar approaches are being trialled in public health.

For on its own, it seems unlikely a biomedical approach – itself a reflex of the Order of Things – will transform health inequalities in New Zealand. What is needed, perhaps, are thought experiments that draw upon the rich and various strands of relational thinking in New Zealand – Māori and Pacific philosophies, for example, along with the Order of Relations from the Enlightenment with its emphasis on dynamic interactions and complex systems that ignore disciplinary divisions, and aspects of cutting edge science – Complex Network Theory, for example.

As the quantum physicist David Bohm has urged, 'What is primarily needed is a growing realisation of the extremely great danger of going on with a fragmentary process of thought". A flurry of philosophical innovation is required, new ways of thinking that traverse mind and matter across the disciplines, helping us to better negotiate the intricate webs of relations in which our lives are entangled, and upon which we depend for our wellbeing and survival.

It is possible that medicine, understood as it was in the Enlightenment as a wide ranging reflection on health as a state of being in ecosystems and human groups as well as in individuals, along with Māori, Pacific and Asian philosophies and relational models from cutting edge science can provide a springboard for these kinds of experiments in New Zealand. The idea of ora can offer a positive beginning, yielding new insights into how health and wellbeing are linked with the quality of our relationships with others, with social and economic prosperity and with other forms of life in the wider environment.

It also places the onus where it belongs – on those of us who are thinkers, to draw on relational insights and come up with new and more adequate theories to inform medical, educational, judicial and economic practice; and on us all, to ensure that such new ways of thinking are put into action – in programmes such as Whānau Ora and Hau Ora, for example. If they are to achieve its promise, however, as in Starpath, collaborative processes based on shared goals and objectives, and evidence that tracks the outcomes for participants over time will be vital.

Māori philosophy requires that in the search for ora, relationships should be based on reciprocity and balanced exchanges. At the same time, outcomes have to be rigorously tracked if we are to discover which kinds of interventions actually work, and change lives for the better. Philosophies of whakapapa in conjunction with the science of complex networks may yield new, world-leading insights into the dynamics between individuals and families, and among families, communities and the wider social and biophysical systems of which we are a part.

The best way to achieve this is by generating new philosophies, overcoming the silos that divide us and working together towards shared goals, moving from the darkness of mate to the world of ora and light. As my mentor and kaumatua Eruera Stirling used to chant:

Whakarongo! Whakarongo! Whakarongo!	*Listen! Listen! Listen!*
Ki te tangi a te manu e karanga nei	*To the cry of the bird calling*
Tui, tui, tuituiaa!	*Bind, join, be one!*
Tuia i runga, tuia i raro,	*Bind above, bind below*
Tuia i roto, tuia i waho,	*Bind within, bind without*
Tuia i te here tangata	*Tie the knot of humankind*
Ka rongo te po, ka rongo te po	*The night hears, the night hears*
Tuia i te kawai tangata i heke mai	*Bind the lines of people coming down*
I Hawaiki nui, I Hawaiki roa,	*From great Hawaiki, from long Hawaiki*
I Hawaiki pamamao	*From Hawaiki far away*
I hono ki te wairua, ki te whai ao	*Bind to the spirit, to the day light*
Ki te Ao Marama!	*To the World of Light!*

Building a good society

Hon. Metiria Turei - Green Party

It's very nice to be with you today. Thank you for that introduction, Helen Herbert, and to the Māori Caucus- Lisa and the whole team- there's a heap of you who have being doing all this work organising this conference and I really appreciate the invitation to come and speak with you as well.

I'm going to talk for about 20-25 minutes and it's an unashamedly political speech about our view around public health, and then hopefully I will have time for questions and some korero. I'm very pleased to be here with my colleague Kevin Hague, the next Minister of Health, I like making him blush, and you may also want to ask questions of him as well, for more details about our health policy and particularly on public health.

Legend has it that Albert Einstein once described insanity as "the practice of repeating the same mistakes over and over again and expecting different results." Funnily enough, Mark Twain and Benjamin Franklin have also been credited with this quote and no doubt many more, but when I had a look at it, I found that it was first written down, at least, in a 1981 Narcotics Anonymous pamphlet, which I think is quite right, actually, about health again.

As a lawyer, I'm pretty sure that repeating the same mistakes and expecting different results is not the legal definition of insanity and I'm sure that you all agree from a public health perspective that it's not a very scientific description of insanity either. But what I think we can all agree on, you and me, Einstein, Ben Franklin, Narcotics Anonymous, is that it really is stupid to keep making the same mistakes over and over again and expecting a different result. So the question for me is, in my job, why do politicians keep doing that? Why do we keep doing that?

Roger Douglas and Ruth Richardson were wrong. There was no trickle down and you as a group of people working with communities every day understand this more than most. There was certainly a trickle away, away from those in the middle, and there was a great gush away from those at the very bottom, whose numbers grew and grew and grew during that time. Roger and Ruth's 1980s dream was a grotesque mistake and after thirty long years and record levels of inequality in Aotearoa, we are all pretty clear that that was a huge mistake. The tragedy of this, of course, the crime in this, is to keep on ploughing ahead making these same mistakes when all the evidence of the last thirty years shows that it's failing. The challenge for all of us here, especially for those of you who work with the human misery of those thirty years, the effects of those thirty years every day, is what are we going to do to make things better?

I get asked this all the time actually. What is it that we need to do to make people care? Actually, people do care, they really do care, and they care about this compassionate, potentially egalitarian, certainly beautiful country, the first to give women the vote- which we celebrate a hundred and twenty years of women's vote on Thursday. They care about this place that once did top the best indicators, where everybody was doing their bit and where few, that is some, but few, were left out. They care that it is different now. And they care so much that I think there is a real momentum for change gathering. One that is going to deliver real transformative change in Aotearoa. I truly believe that time is coming. Those thirty years of mistakes is coming to an abrupt end.

We are on the cusp of a profound and real change here in Aotearoa. The desperation from people who want to rebuild this country into a good and fair and decent place, the place that we all believe it could, and should be, is very real. I think that part of that momentum is leading us towards the next general election in 2014. We have the righteous winds at our back, to borrow a phrase from Barack, it is blowing a gale. So I reject the notion that New Zealand has become all about the 'me' and the individual, because the people that I meet every day and the work that I do, in schools, in the streets, at the supermarket, all those places, they are deeply concerned about poverty and deeply concerned about increasing inequality. Things that for most people, though not all, were strange in the past but are now very present in all of the communities that they deal with. In their own family, in their own schools.

It doesn't feel right, any of it- and it's certainly not right, for example, that despite working really hard for forty or fifty or sixty hours a week, nearly half of all families with kids are still so poorly paid they need public subsidies just to pay the rent. It's not alright. That's not the Aotearoa New Zealand we believe in. We are the kind of country that does look after our kids, that does take care of our old people, which does have compassion for the ill and which believes that it's possible for somebody like me, who grew up in a working class Māori family with no money, who has no school qualifications whatsoever, who was a young Māori mum on the benefit, the DPB, to eventually become a lawyer, an MP and a political leader.

The truth is if I had been unlucky enough to have been a single mum today, the exact same twenty-two year old, if I had been her today, I would have been denied all of these opportunities. I would have been forced to look for part-time work to justify the meagre benefit that I could get. I would have been denied the opportunity to go to university and get a law degree because the National government has deemed that going to university was too big, is too big a dream for a Māori woman like me.

This young Māori woman on the benefit, there's every chance that my daughter would have been deemed at risk under the National governments new vulnerable children screening tool. So both of us, at such an early stage in our life and our development, both of us would have been written off before we had even gotten started. And then, of course, if I had managed to get a job, without qualifications, in order to make a little bit more and get off the benefit, I would have been told to wait quite possibly forever before I was being paid enough to adequately support myself and my child. But Aotearoa is better than that? Our country is better than that?

Over the last ten years, the Greens have been working to build a smart plan. A smart Green plan for a compassionate and sustainable future, for what is a genuinely equitable country. We don't pretend to have all the answers but we do have a clear and contemporary vision for how we can achieve social cohesion based on mutual concern for each other and a collective sense of responsibility in which we all do our bit to protect the environment, to be responsible citizens, to contribute to our economy and our community. And so together in a partnership, we can create the kind of country that we all want to live in. This is about those old values- whanaungatanga, manaakitanga, about caring for your neighbour and living up to your responsibilities. It's about a fresh, new appreciation of the environment. It's about cooperation, not competition.

Today's topic asks - in order to effect a change in attitude and practice, should we consider a collaborational partnership approach to support that change? Now, I'm in politics, in Parliament, so from my point of view to drive political change - absolutely we do. Collaborative politics as opposed to the more competitive politics that we see playing out. I do believe that the Green Party's inclusion in a future government is a core part of seeing that solution play out and releasing us from the burden of the past thirty years.

What would a genuinely collaborative government look like? It's very hard to know at this stage what that might mean. A government where it wasn't just a whole lot of disparate interests finding the way to get their own individual political power for their own individual purposes - but a government of different political views with a common purpose. Perhaps one that was built around Michael Joseph Savages quote that I heard last night: "The people's wellbeing is the highest law."

That's a nice place to start. But where all parties are committed to a single clear vision around how best we can create an equitable and compassionate, sustainable country. You can have your disagreements about the different kinds of paths to get there, but the vision is a collaborative one based on equity in government between parties. Just as we want to see equity across our country. So the leadership for that starts from parliamentary level, at least. Why not? That is another way of us constructing a collaborative partnership-based approach from every level. In fact what it really is, is us learning from you. At the end of the day, you do this all the time. And we in the political realm who keep making the same mistakes over and over again aren't learning the lessons that you keep showing us.

I'm really heartened that in the selection process that we've seen with Labour for a new leader, we have seen more and more of their senior leader MPs coming out supporting a living wage, supporting more compassionate policies towards the most vulnerable, particularly in welfare, and that is a vision that we agree with. But Labour certainly can't do it on its own. So what do the Greens bring to this? We bring to the table an intrinsic understanding of interconnectedness. We put the community first, not the state or business. The state should support and facilitate the community in its decisions about how it wants to operate in the world. It must not dictate those. Business in our view is a subset of the community, not its master. Yet it has been elevated to be so.

We understand that communities don't function in isolation from social forces, that marginal communities need to have control of the definition of the problems that they may face and then the design and then the implementation of the solutions. We've got people who have been steeped in this kaupapa for many years; I refer to my colleague Kevin Hague with his many years of work in public health. So we have people who understand the interconnectedness and the complexity, at times, of this kind of work at a very deep level. For all of us, for the Green Party, the Ottawa Charter means government creating a supportive physical, social and economic environments around marginalised communities, getting out of the way at times, actually, empowering them and resourcing their own problem identification and solutions.

I was interested in reading through the charter and thinking more and more about public health and the whole philosophy around public health. Because it is crucial to the most marginalised communities to bring them into the centre rather than keeping them on the outside. I have a personal example; I believe that my father's early death at forty-eight of a stroke was the result of the economic policies of the 1980s, which robbed him of a decent job, and the welfare policies of the 1990s that robbed him of dignity.

This belief has driven my political ambition, for myself and for my Party and for the country I live in. The charter, the whole purpose of public health has been really the only structural articulation of my personal experience that I've ever seen, and it is a personal experience that is felt by thousands of New Zealanders. But I don't think we always understand it as a structural issue, rather, just as an injustice that's done to us on a personal level. So I have this incredible opportunity and a real privilege to be able to work in politics to help build that concept around public health. That structural understanding that the decisions that we make in Parliament affect every single individual in this country and their kids, and their families. That those effects are very personal to every single one of those people and those kids and those families.

So if New Zealand wants to improve the health of communities, the Greens believe we must improve our social and physical environment and give communities better control over their own lives. But too often we see the government acting in isolation from public health objectives and even more to the point, in opposition to those public health objectives.

I'll give you a political example. Building a convention centre in Auckland by the by and trading off the public health protections in the Gambling Act in order to pay for it is a classic example. There is no evidence- none- that the public health consequences of increasing gambling at SkyCity were even considered before the Prime Minister offered the casino this opportunity to massively increase gambling in exchange for building the centre. The social and health consequences of the deal were never costed, and it's a very short jump then from never costing them to saying that they're unquantifiable, those harms, and then just another small step to the right to simply write off those harms as irrelevant. So this is what happens when a government doesn't consider social forces, but rather sees society as an aggregate of individuals affected by the singular force of their own individual willpower. Everybody has got the right not to gamble, everybody should make choices for themselves about what they do and there is no societal or community influence or impact at all. That's the philosophy.

This attitude was also evident in the National government's response to the White Paper and on children and child vulnerability. It completely ignored poverty, but how is it even possible to address the vulnerability of children if you don't address the social forces that create that vulnerability in the first place? It ignored family violence, how is it possible to address violence against children if you don't also address violence against women? And in both cases they ignored these things in the face of overwhelming evidence of the interconnectedness of these things - the structural, the community, the family, the child.

The Green Party remains committed to the principles of the charter and of public health. Our promise to repeal the New Zealand International Convention Centre Act, if it is finally passed, and to continue to fight against child poverty and increasing inequality are two examples of our commitment. Rather than water down the public health protections in the Gambling Act by exempting SkyCity from it, we will increase the obligations on casinos to prevent and detect problem gambling. Problem gambling, particularly pokies, accounts for something like 40% of the profits of these companies, so it's no small thing to really introduce harm reduction measures. We look forward to it.

In the spirit of the second charter principle, we will put more energy into, for example, the social marketing that denormalises gambling behaviour. I noticed in Dunedin, I was at home yesterday, and Dunedin, the casino there has got these huge posters, they're really big, of women in little gold lamé outfits promoting the casino and they're all over not just the casino building, but all around Dunedin. And the image of those women is being used to promote the casino. It's only one example of the kind of promotionalising that is just ethically wrong.

We would strengthen community action by working with, for example, the communities in South Auckland, to support them to run their own anti-gambling campaigns, and also to reorient health services to look at what health services need to do, what they need in order to prevent harm in the first place. And of course, this room... you are the experts on these issues, so when we want to, for example, deal with gambling harm, you are the people we need to talk to about how to train both your own workforce and those who work in casinos about gambling behaviour, risk behaviours, spotting the danger signs and the kinds of interventions that we can use to help people who are in trouble.

Meanwhile, we are focusing heaps of our efforts on child poverty and particularly on the huge potential of schools to act as anchors, as centres of their communities in this battle. We have long advocated that schools can be and should be the heart of their communities where both minds and bodies are nurtured so they can achieve everything that they were born to achieve. We think that this involves equipping communities to look after the wider needs of children and their whānau and acknowledging the whole of the forces that shape their lives. So our policy for a public health nurse in every school was, and is, a key part of that plan. We see that nurses are the backbone of what we've been talking about, and school hubs. Responding to and coordinating specific health and social needs of the communities in which they work.

School nurses are already a vital part of many school communities but schools should not have to dip into their operations grant to fund them. We surveyed low decile schools after we announced this policy in June and many are doing just that- either seeking funding from outside, raising money where they can, getting into their operations grant, just to help maintain a constant level of service because there are many places where there are public health nurses in schools at different levels of engagement.

But our survey showed that many of the kids are missing out of these vital first points of call for health care when their school nurses are spread so thinly and having to deal with so many different kinds of programmes. Often its government programmes. If they're called away to respond to an immunisation programme for example, then they are pulled out of those schools and aren't able to support those kids when they need it the most. So there's a whole lot of need there that we can fill, actually, it's perfectly possible to fill it, it's not that expensive, it's just saying "we will make a commitment to having kids being able to access the health care they need in the place where it's trusted and where their family have the most connection."

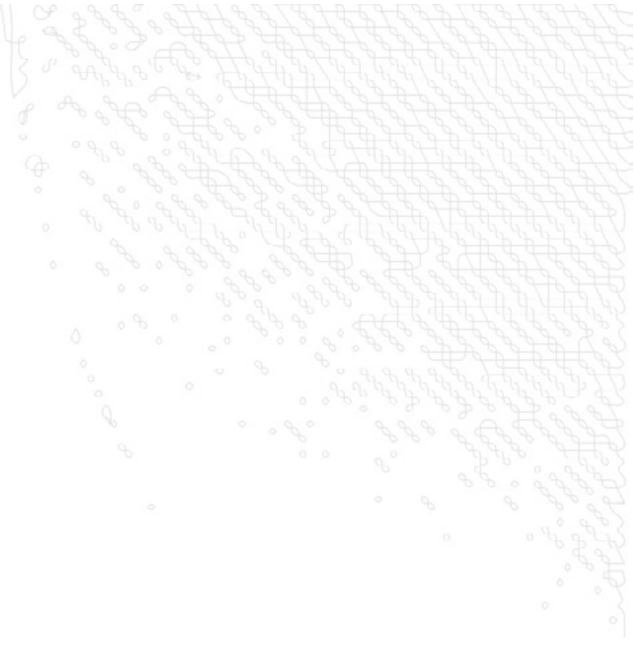
So we're working on other ways to build schools to function as community hubs across the board, as magnets for the community and health services, and if you've got other ideas about the kinds of services that should be provided, will you let us know? We are going to make some more announcements soon, probably in a months' time about this as well, but we're always looking for ideas on how to make this work more effectively.

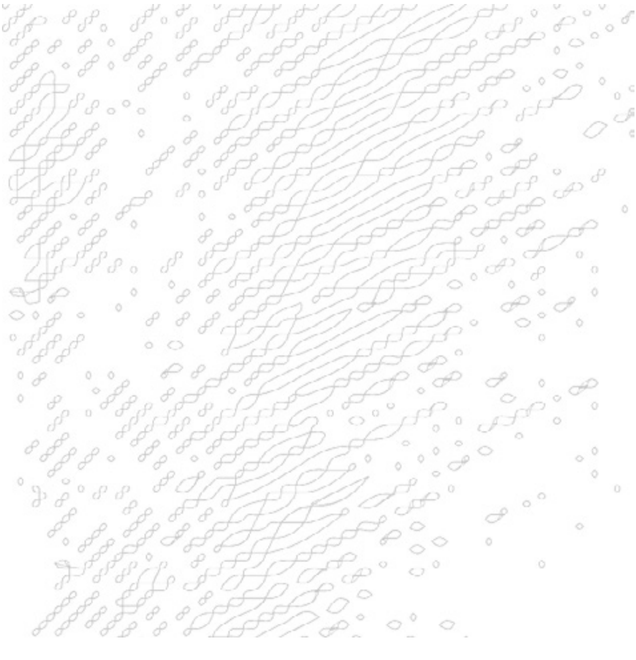
Fundamentally these winds are blowing at our back, the momentum for change is about New Zealand reclaiming its core values and all of us working together to become the good, decent, equitable society that we believe we should be. Grounded in fairness, grounded in genuine equity and sustainability and wellbeing and which understands we can't have an economy if we don't have a healthy environment.

Mother Theresa... yeah I've got heaps of different quotes in here... Mother Theresa had it right when she said that we belong to each other. This is the kind of society that I think we do all want. For hundreds of years Māori have been embodied in a deep sense of whakapapa and whanaungatanga, where we recognise the extent to which we are interconnected and rely on each other and our environment to survive. Our culture has always been about reciprocity and about empathy and I think maybe that's why, in the 20th century at least, Aotearoa was attempting to reclaim some of these values and as we reflect back on seventy-five years of the Social Security Act, as of yesterday, it was a genuine attempt to do that.

But Roger Douglas and Ruth Richardson changed everything in the 1980s. Yesterday was the seventy-fifth anniversary of the passing of the Social Security Act, it enshrined in law the fundamental right to a reasonable standard of living for everybody, no matter what social forces blew them, and no matter what mistakes they might have made in their lives. It's a good reality check for us all. It's time to throw off those shackles of the past thirty years to genuinely learn from our mistakes and to remember who we really are - a country that cares.

Kia ora koutou katoa.
Thank you.





He wawata noa, he moemoeā rānei

Annette Sykes - Aurere Law

"Ko te puawaitanga o nga moemoeā, me hakamahi." Dreams become reality, when we take action.
Te Puea Herangi

Kia ora te whare, kia ora hoki taatau kua oopiti mai nei ki raro i te tuara totara o teenei o taatau whare, ki oona kawenga, ki oona maunga kaarangaranga, ki oona wai matarau, kia koutou hoki o teenei rohe o Taranaki teena koutou, mihi mai whakatau mai.

Let us celebrate. It's thirty-eight years since the Māori land march last Friday, and I'm sure many of us remember that, and walked those roads. I know that as a child at Kawerau college, it was one of the most significant historical events of this nation that shaped me as a woman, shaped my vision as a Māori, and shaped the strategies that I went on to achieve in my adult life.

This is also Māori language week, so let us celebrate the fact that, Te Reo Māori notwithstanding, the processes of colonisation have survived and in that celebration let us remember that perhaps the struggle for Māori language revitalisation must be seen in a parallel struggle to the struggle for the wellbeing of our communities which is at the heart of our kaupapa today.

The third thing is that I'd like to thank this week, because I've just come from floods in Raglan, where I was fighting for Eva Rickard's families claims under the Waitangi Tribunal, I want to thank Tama-nui-te-ra, to come from the desolate of Aramiro Marae and the waters that prevented me from leaving there for two days, to this beautiful place of Taranaki to be nestled beneath the Koro Taranaki, who has blessed us today with an environment that can only bring us an opportunity challenge to listen, to think, and to provide an opportunity for strategies for change.

Also in the last week you may or may not have seen that Māori Women's Welfare League met in Whakatane and their theme of their hui is really pertinent and I've chosen it as the whakatauākī for my korero today. It comes from one of my Sheroes, Te Puea Herangi and I think it's one of the key important aspects that guides many of us activists in the darkest of moments.

"Ko te puawaitanga o nga moemoeā, me whakamahi- dreams become reality when we take action"

Health is a social, economic and political issue and above all, a fundamental human right. At the heart of my address today is the concept of wawata, and how it relates to the ongoing desire to ensure the nurturing and maintenance of wellbeing by individuals, whānau and their communities. A process that I understand Dame Anne Salmond outlined at the commencement of this symposium is a quest for the state of ora, as opposed to the state of mate. But perhaps we should remind ourselves that Papatūānuku is integral in both states and it is our respect for her that is ultimately the defining part of how we achieve balance.

I will then turn to consider how, in the context of the theme of this conference, these values. How they give force to notions of collaboration and partnership, as opposed to independence, in the health sector at a time when the privatisation of services in the sector is on the rise and where there is a growing concern among Māori and the wider community that the health sector continues to perpetuate notions of treating Māori health so then, more so than empowering Māori to control their own processes for being healthy. Moreover, where there is a clear recognition that a major shift, constitutionally, that is, towards self-determining the right to be healthy; as well as institutionally, that is, developing approaches to greater access to health provision, is required to enable Māori to achieve better health outcomes moving forward. Sadly, it is my thesis and this is what I want to develop in my korero- this recognition is not being matched by policy preferences by either central government or quasi providers of health services in the guise of iwi or whānau ora providers and is, in fact, limited by new constitutionalism, which potentially undermines community preferences in favour of transnational corporations and neoliberalism.

Discussions about cultural issues in Aotearoa New Zealand perhaps unwittingly reflect the same paradigms of colonisation which have shaped the history of our country since 1840. The culture of the white English coloniser is not only superior to that of the indigenous Māori, it is also the norm by which Māori culture must be judged, the standard with which it must be compared. This observation is as cogent when we look at Te Tiriti o Waitangi and how it's been treated by successive government administrations over the past one hundred and eighty years or so, as is the use of the English language to explain Māori terminology which, forgive me, I am about to engage with in exploring the theme of this session. The contradiction is not lost on me. One would have thought that after one hundred and eighty years of colonisation I could address this hui for all of us, Māori, Pākehā, Asian, Pacific islanders, in the official language of this nation, the first language of this nation, Te Reo Māori. But that's not possible. And we have to ask ourselves why has that possibility not been achieved after one hundred and eighty years?

In Aotearoa New Zealand, the Treaty of Waitangi has variously been a document ceding absolute sovereignty with no recognition of residual Māori rights, a simple nullity of no meaning in the colonisers domestic law, a sacred pact imbued with a unique constitutional spirit, and in its most recent reincarnation, a session of sovereignty balanced by limited Māori authority in areas circumscribed by the Crown. One of those areas where it is deemed relevant but is limited by Crown definition and practice is the health sector. This of itself has set the limits of collaboration and partnership that is possible in the sector, but even more significantly denies Māori the right of an independent Māori health system from even being revived.

The naming of the session by the overarching term, wawata, created a number of challenges for me. It is not a term I often use, preferring another adjective, hiahia, in my own daily conversation for the range of meanings that word, hiahia, conveys is more natural to me. A term I admit that has sexual overtones: "kei te hiahia koe i ahau?" And food, you know, the food of love, eating… hiahia is a much more desirous term for me. The plain and ordinary meaning of wawata, however, and this is very subjective, my definition is "want". But in certain contexts it can mean "need". It is a term consistent with the capitalist philosophical paradigm of the use of wants and needs that can be determined by the market and can be used interchangeably in an economic sense, but is quite distinct from the term moemoeā, which carries an added nuance and is one more profoundly used by our great leaders of the past and the present as an indicator of things they desire to be changed. Dreams that desire to be facilitated as oppose to wants that just need to be satisfied. A nuance which connects our moemoeā with our past as much as our future.

So while I would've liked moemoeā to be the overarching theme of this session, I've stuck with wawata, and I've decided to put my wawata to you in this sector in simple ways.

Firstly there needs to be a change of attitude towards what are regarded as Māori problems by non-Māori. An adequate level of housing, a liveable income and a job with good work conditions where people are in charge of their lives are key determinants for whānau health and wellbeing. Acknowledgement by all organs of the state that working to bring about higher standards are critical in addressing the health issues that Māori currently face and I don't need to tell this forum them, but you know, diabetes, cancer, heart disease, respiratory conditions like asthma and emphysema, rheumatic fever, these are all prevalent diseases of Māori and diseases of the poor.

Other contributing factors of poor health status of Māori are smoking, alcohol, poor diet and the lack of access to non-discriminatory quality care. The public health system needs to be more comprehensive and include oral, visual and aural health care and we need free access to health care. As a nation we need to look to the international and national human rights instruments to which we are signatories and understand that it is the duty of the state to intervene with legislation and affirmative action programmes when you have such systematic inequalities.

I wish to be clear that I do not see these wawata as aspirational goals either, that's the latest Crown speak, you know? "You have a desire, but that's really just an aspiration Annette, it's out of reach,"

Too often the Crown has categorised the achievement of international human rights, such as the right to self-determination or the right to development, as highly aspirational, with some officials even suggesting them as very unachievable:"you've got to be realistic, you Māori."

My wawata requires courage and commitment to social justice, and a recognition that tino rangatiratanga is implicit and necessary in order to avert the venality of kāwanatanga if our wawata are to be obtained. We need to recognise in the plain language of Dr. Papaarangi Reid, another one of my sheroes, that

"there has been a misappropriation of our resources, which are ours as a right, a citizen's right in this country and it has been stolen. We don't need to talk about foreshore and seabed; we need to talk about health being stolen. Years of life being stolen. Not because of smoking, nah nah nah, that's too simplistic, no, because people get a fast track through the queue, and they aren't brown people. So the privileging, we are first of all to label it as that, there is an inequity in the privileging that occurs in this society. Pākehā people in general are being privileged and they are misappropriating resources to the katoa, the language of the treaty, everyone, not just to them."

The difficulty though is that in the present structure of government, the wawata of the health sector are more complex and Māori expectations are subsumed to that complexity. What are the needs of health workers, providers in communities at this time, and more importantly, who defines those needs, allocates resources to meet them and then develops tools of analysis to assist in working out whether there has been appropriate use of those scant resources, is too often dictated by politicians worried about a life beyond the three year term. I thought the question yesterday was great, to Meteria- which you never got an answer to. Or the faceless technocrats in treasury more worried about a budget blowout than some of the more simple requirements to sustain healthy lifestyles and wellbeing in traditional communities.

I found a mental barrier to effective change is that inequality, poverty, exploitation, violence and injustice are at the root of ill health and the deaths of poor and marginalised people. Health for all means that powerful interests have to be challenged, that globalisation and neoliberalism has to be opposed and then political and economic priorities have to be drastically changed.

The power of transnational corporations quite often is an inhibitor to policy develop as the TPPA agreement illustrates. The Trans-Pacific Partnership Agreement being negotiated is presented as a straightforward free trade agreement but it is more than that, it is much more than that.

Under these arrangements, an American corporation, for example, would be given far more extensive rights against our government than any New Zealand company would ever have. It would mean that a future government, perhaps elected to change policy in an area like environmental protection or health and safety, would actually be threatened with a crippling lawsuit unless it backed off from its policy promotion. Some of the potential issues for inclusion in the TPPA have important implications for health. A whole swathe of health related policies is potentially subject to the TPPA. Ranging from foreign ownership of aged care change to health and safety rules for products to health qualifications, among the most important New Zealand targets of course is our Pharmac scheme that makes medicines affordable, the no fault accident compensation scheme for workplace and other accidents and proposed restrictions on cigarette packaging and sales.

This 'new constitutionalism' supersedes and goes beyond domestic constitutional norms and agreements countries have with Māori and other indigenous peoples and places legal limits on the authority of governments and the way that they can privilege international capital. I also want to talk about the health inequities. I read Dame Anne Salmond's page in the papers last night and I have to concur with everything that she highlighted there. But I want to start where the reflections took us this morning in 1978.

Well, in 1980, following the furore engendered by the publication of the Māori sovereignty articles, Bruce Jesson, a Pākehā hero of mine said this:

"Essentially, Māori sovereignty is about the incomplete incapability of the Māori and Pākehā ways of life and the incompatibility of the Māori and Pākehā ways of life and about how economic and political power has resolved this conflict in favour of the Pākehā."

At the time there was this strident group of Māori radicals who readily identified with the concept of Māori sovereignty and with Māori resistance to Pākehā intrusion into their territories, their values, their mindscapes, and their landscapes. The call was drawn from an urban underclass, from the communities of South Auckland, Hastings and Wellington. Their message was simple- Pākehā have colonised our hearts and our minds and have substituted our traditional systems and institutions with ones that Donna Awatere described at the time as exploitative, oppressive, dehumanised and spiritually deficient. It was time for the nation to turn the page on an era of greed, irresponsibility and injustice and an era of change was demanded.

The Māori world responded over the next two decades with a number of initiatives that were initially resisted by the Crown and in general by the Pākehā public. These initiatives included widespread development activity and the revitalisation of Te Reo Māori, autonomous kura kaupapa education initiatives, control over kura kaupapa Māori health and social service delivery mechanisms, independent Māori media, and demands for redress within the treaty settlement arena. The struggle transformed from one of simple confrontation with the state to one that sought the reclamation of kaupapa Māori theory practice and methodologies with the assistance of the state.

The character of Māori interventions and government responses also changed. Treaty settlements were structured in ways that locked iwi into market regimes that they previously opposed. Once the furore over the fiscal envelope died down in 1996, so did a lot of Māori dissent until the confrontation over the foreshore and seabed erupted in 2003. New players, Māori and Pākehā, were empowered to frame Māori demands, argue for cases for both sides and administer the resulting settlements. An entrepreneurial elite of executives, consultants, lawyers like me, you know? Let's be really clear, we're the ones that have benefitted from this last decade. Economists, advisors and policy analysts trained and expected to think within the market paradigm were fettered as the new generation of Māori leaders. I don't know if you saw on Te Karere last week, even actively promoting that these Māori leaders should go to Harvard and learn their new brand of leadership from Harvard capitalism.

Sadly, many of this ilk now dominate the discourse on and for Māori providers in the health sector. Moving on from the past and recognising the special place of tangata whenua has become a journey not of constitutional change, but of devolution and the authority of the state to devolve or permit iwi to manage certain resources subject to government funding and rules of contract, we've all become contract experts. Wawata has been transformed from a desire for an independent Māori health system to one of self-management of Māori expectation within a unitary system designed and resourced by the state.

Māori providers are forced into a competition for resources with all the contingent isolation that such a process requires- remember, don't talk to your mates, because your expression of interest is going to get the money and the dollars for you. You can't talk to your whānau about how you can actually provide better healthcare for our communities. That secrecy, that shroud of secrecy is actually very damaging to relationships between and amongst Māori. The request for proposals and expressions of interest, in contract terms of reference, limit Māori wawata to that which those contractual tools require. Innovation and independence have become subsumed to those prescribed limits. It's innovation that's permissible in state guidelines to free market ideology.

Colonisation imposed the terrible separatism on us- separated us from our land, separated us from our rights, separated us from our power, indeed, as this process of contracting is illustrating it has separated us from each other, and indirectly, from the philosophical underpinnings that guide us.

The quest for ora that we heard yesterday from Dame Anne Salmond. All in the name of competing for resources, to ensure not an independent Māori health service, but a better integration of Māori into a Pākehā health service, assimilation in a new guise.

Given these factors, what are the strategies for change that are now required? As the conference evolves over the next few days, there will be some important issues discussed and debated, I hope time devoted to finding solution, rather than just examining the impacts of cost cutting initiatives, or why someone else missed out on a contract and someone else's expressions of interest was better than the others, or how we can actually frame our expressions of interest better than those to get that requested proposal, how we can get a preferred provider status better than our mates over the road- you know, this is where the discussions have gone, away from independence.

So what you need to ask yourself as a public health association is:

a) What kind of foundations and what kind of institutions are needed in order to meet the needs of Māori? To actually meet this inequity that everyone talks about.

b) What kind of institutions do Māori need to meet their cultural needs as well as provide the skills and pathways needed to function at the various highest level of professional development?

c) How does the Public Health Association need to adapt to assist this? Because frankly, if you don't, you're on the pathway of mate that Dame Anna Salmond has quite clearly articulated.

The answers to these questions will largely determine the nature of collaboration, partnership or independent development that will be embarked upon to ensure ora, community and individual wellbeing. More fundamentally, it is clear that Māori sovereign status as the tangata whenua of this land must be respected more than it is in this contractual paradigm and provided for the management philosophy and regimes of the New Zealand health system.

The crucial issue that remains unaddressed but requires attention urgently, is the need for constitutional adjustment to occur which reflects these rights.

You need to:

a) Challenge the TINA syndrome, you know, "There Is No Alternative." I come from the coast in Te Aroha, tupuna tia, there is an alternative, okay? Convince people individually and collectively that there are alternatives, carefully analyse these present barriers like trans-national corporations and preferences to them in international treaties and provide reasons why we should not enter those obligations.

b) Promote informed debate and critique, we need to build a constituency for change, through information networks and media, tribal community workplace… Facebook is a wicked decolonisation tool if you've got the time to spend on it, but we need kanohi ki te kanohi engagement as well.

c) Embrace the Treaty of Waitangi as a liberating force, not as a sacred document of the past. Moving forward means facing up to the past, healing the wounds of over the last hundred and eighty year's means restoring Māori to their economic and political power. Constructive debate on a treaty based republican constitution can provide a liberating framework within which Māori, Pākehā, Asian and Pacific Islander can coexist.

d) Encourage progressive counter nationalism, celebrate diversity rather than uniformity. Work to build identities and values which replace xenophobia, racism, and nostalgia with progressive visions for the future of this nation.

e) Take action! I'm so sick of your armchair revolutionaries watching TV and going, "go Annette, go Moana, lovely to see you," I've never seen you fellows at Waitangi for the last 30 years, I've been going every February the sixth, I know who comes and who's just a casual visitor watching and observing us. You need to actually physically make a commitment. I think Parekura Horomia, and this is something that the Labour Party have picked up is he said, you've got to hold the line. The structural adjustment programmes aren't over, they're continuing, and you in the public health sector have to fight to keep those public health initiatives in place.

f) Fight to ensure that there is free health care for children and the most vulnerable, but that it's expanded to include a free health care system for all, no matter of race, creed, or persuasion.

g) And finally, you can support those who speak out. I didn't hear too many emails coming out to us when we were called the haters and wreckers in the foreshore and seabed debate by the Prime Minister, or when there were people who were unfortunately targeted by the GCSB and their surveillance processes. It's all very well to have a whakaaro a wairua but we need to have legitimisers like yourself speak out so that those that have the courage and the fortitude to take an independent stand can say, "we are supported by those who had the vision, just as our ancestors were supported when they signed Te Tiriti."

I finish with a whakatauākī that was used by Hohepa Kereopa in the WAI 262 claims. It's says this. He cautioned in the WAI262 hearings that

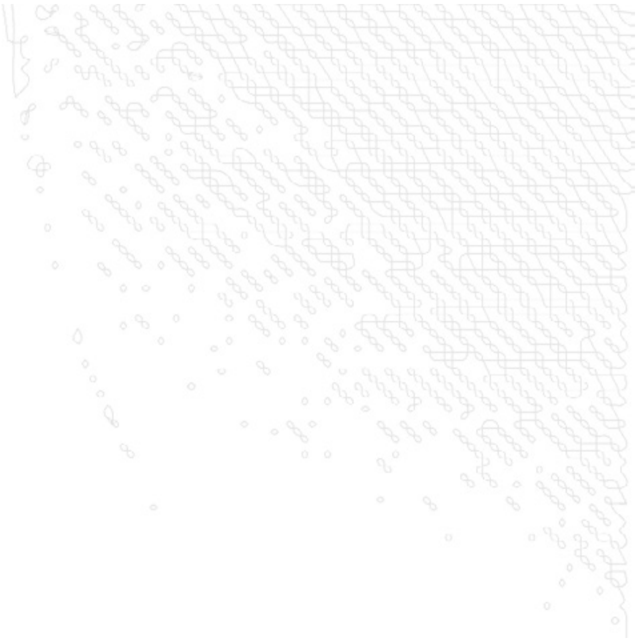
"We should actually stand steadfast to the beating

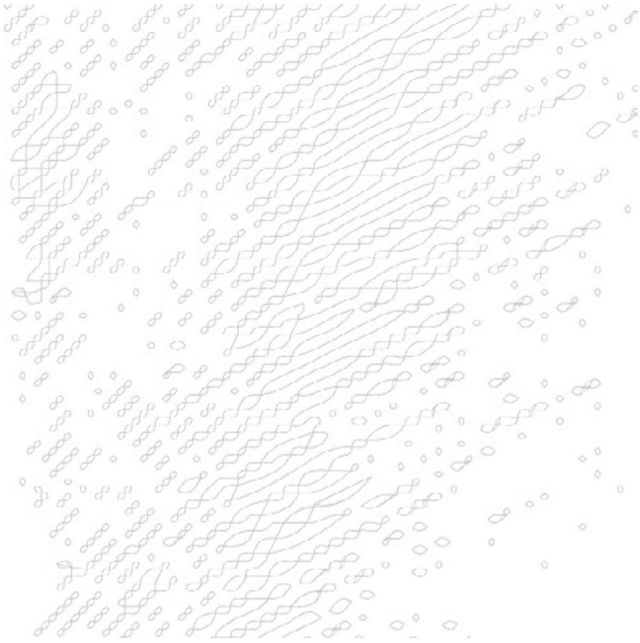
passion of our hearts, to the ancient philosophies that Maui bought to this treasured place in the world so that our dreams do not die."

I hope at this conference you take that philosophy as you go forward.

Kia ora.

He koi ngakau hotahota,
Kia mau a te mau a Maui,
Kaua e makere mai i o moemoeā





Power sharing in research partnerships

Dr Mihi Ratima - Taumata Associates

Introduction

In a research partnership, each party brings to the relationship their own mana or power. We need to recognise the power of small parties and what they may bring to a partnership. It is often the small community organisations who bring community credibility and the knowledge necessary to ensure that evidence generated through research has local relevance and is able to lead to translational outcomes. However despite this, when community organisations partner with universities or other large research institutions, there is a substantial imbalance in power.

Partnership and power sharing

The term partnership has been variously defined. Craig and Courtney (2004) use a partnering continuum, as shown in Figure 1, in explaining the meaning of partnership. At one end of the continuum is coexistence – parties know about each other, but there is no need to collaborate. From left to right across the continuum relationships become increasingly formalised – coexistence, networking, cooperation, collaboration and at the far right is partnership. Partnership involves 'hearts and minds' and works from an agreed values base. At its core partnership is a formalised relationship based on common goals and power sharing. This is the concept of partnership adopted in this paper.

The key message today is that power sharing will better enable you to improve health outcomes. This paper explores power sharing in health research through the lens of partnership with Māori, though the messages have wider relevance to other groups.

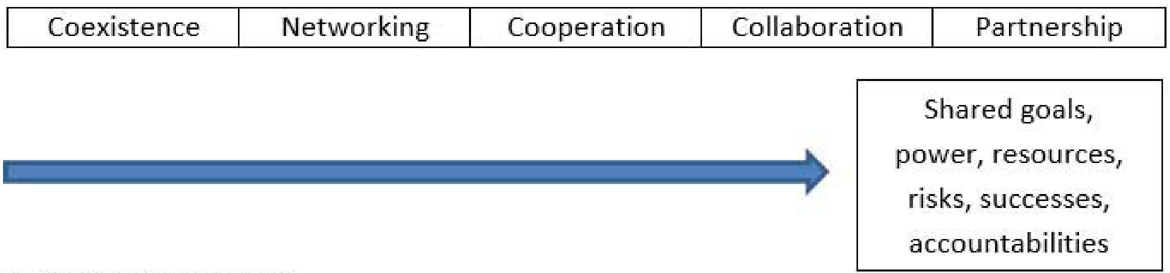
There is no one agreed upon understanding of the concept of power. In discussing how power sharing may be expressed in research partnerships I have adopted, with some amendments, a framework developed by Puzan (2003). Her framework was used in an analysis of white cultural privilege in nursing. She describes diffuse but interconnected domains of power that exert influence. The structural domain, the domain of scientific hegemony, the disciplinary domain – which is relabelled for the purposes of this paper as the organisational domain, and the interpersonal domain.

The structural domain is concerned with the underlying organising systems of society. As an example, Annette Sykes in her presentation discussed neoliberal approaches to economics which set up a contracting system that mitigates against partnership and instead fosters competition.

Scientific hegemony is about ideologies that reflect a dominant group's thoughts and become unquestioned, as accepted universal truths or 'common sense'. That is, a set of ideas, beliefs and values that shape our understandings of the world. Ideology shapes how we understand health, what we think are priorities for research, how we do research and how we interpret and apply research findings.

The organisational domain recognises that organisations exert control through, for example, hierarchies and conventions like the rules around attributing authorship of publications. And finally the interpersonal domain, which considers factors that influence power relationships between people.

Figure 1. Partnering continuum



Source: Craig and Courtney, 2004.

In the following sections three New Zealand research projects that are planned or have been conducted are used to identify attributes of power sharing in research.

The New Zealand Cot Death Study

The value of partnership and the importance of power sharing is perhaps most starkly obvious in its absence. The example of cot death research is used here to show how a lack of partnership between Western research institutions and Māori may diminish the value of the research. That is, the extent to which research findings are relevant to Māori and can be translated into interventions that improve health outcomes for all. As Anne Salmond said in her presentation "It's all about outcomes".

The context for the study

Cot death is currently the largest area of preventable post neonatal mortality in New Zealand and there are wide and enduring ethnic inequalities. During the period 2003-2007, 61.6% of infants who died from Sudden Unexplained Death of an Infant (SUDI) were Māori. Māori rates were more than four times that of non-Māori non-Pacific infants (Child and Youth Mortality Review Committee, 2009). Cot death remains a major public health issue in this country and should be high on the public health agenda.

In the late 1980s New Zealand had one of the highest SIDS rates in the world at four cases per thousand live births. New Zealand rates of SIDS deaths were twice as high as Australia, the United Kingdom and the United States, and around five times the rate experienced in Sweden and the Netherlands (E Mitchell, 2006).

The risk factors for SIDS were not well understood, and while it was known that babies with a Māori mother had an increased risk, the extent of the impact on Māori communities was not fully appreciated. Māori rates in the 1980s were consistently higher than those of the total population, and peaked at 9.9 per 1000 live births. This is shown in Figure 2, page 28. Māori rates are represented in the top line and the middle line is the total population.

The value of partnership with Māori

The New Zealand Cot Death Study was a landmark research project. A case control study that ran from 1987 to 1990. It was conducted by a team of predominantly senior paediatric researchers located in centres throughout the country.

The study did not involve partnership with Māori, and there was no substantive or consistent Māori input. The role of Māori in the study was limited to that of research participants. This reflected gaps in knowledge and the dominant models at the time. There was limited understanding of the high prevalence of SIDS among Māori communities and the full extent of ethnic disparities. Western scientific hegemony meant that research institutions had faith in the capacity of Western Science to generate knowledge and interpret and apply findings in a way that would lead to equitable health outcomes for all population groups. This in turn results in a lack of appreciation of the value of collaboration with Māori in order to enable translational outcomes. Further, an apolitical perspective was the norm, favouring a focus on surface causes such as lifestyle and behaviours as opposed to basic causes - socio-economic, cultural, historical and political determinants of health.

Partnership with Māori should enable a Māori analysis to be applied throughout the research process. That is, understanding and interpreting the phenomenon being studied drawing on Māori knowledge and from within a Māori worldview. This is of particular importance in interpreting data and achieving translational outcomes – applying research findings through interventions that will be effective for Māori and impact equitably across population groups. The two examples below are areas where a Māori analysis would have pointed to an alternative approach to intervention among Māori communities.

The first example differentiates basic and surface causes of inequalities. That is, determinants like socioeconomic status that are basic causes, versus surface causes like lifestyle and behaviours (Williams, 1997).

The Cot Death Study identified a range of risk factors relating to social determinants of health (e.g. lower socio-economic status and young maternal school leaving age), demography (e.g. ethnicity and maternal age), health service provision (e.g.

poor access to antenatal classes and care) and baby wellbeing at birth (e.g. birth weight, prematurity and admission to neonatal intensive care). The researchers highlighted three risk factors that they labelled 'modifiable'. That is, placing babies to sleep on their fronts, smoking and not breastfeeding. Bedsharing was later added as a 'modifiable' risk factor (McManus, Abel, McCreanor, & Tipene-Leach, 2010; E Mitchell et al., 1992; Scragg et al., 1993). These behavioural risk factors became the focus of intervention efforts, and by default the remaining risk factors tended to be considered non-modifiable and did not feature in intervention efforts (Reid, In press).

Interventions focusing on the risk behaviours were very effective nationally and internationally. The 'Back to Sleep' campaign, promoting sleeping baby on the back, was launched based on the first year's findings of the project and showed an immediate impact. Within two years the SIDs mortality rate had halved in New Zealand, and the campaign was then initiated in other developed countries with similar results. It has been calculated that around 3000 babies lives have been saved in New Zealand in the period 1990-2008 as a result of the change in infant sleep position as recommended by the research (EA Mitchell & Blair, 2012; Taylor et al., 2002).

Interventions that focus on surface causes will always have more effect for those who face fewer barriers and have greater access to resources to make the recommended behavioural changes (Reid, In press). It is therefore not surprising that the benefits of interventions were not shared equally across population groups in New Zealand (Taylor, et al., 2002). Following the introduction of the intervention campaigns in the late 1980s, as shown in Figure 3, page 28, there was a sharp decrease in SIDS rates among the total population (middle line). Māori rates also decreased (top line), but not to the same extent. The interventions worked much better for non-Māori than Māori. For the period 1985 to 1994, there was a 62% reduction in Māori SIDS rates compared to a 13% reduction for Māori. The extent of ethnic inequalities increased substantially.

The relative mix of risk factors differed between Māori and non-Māori, with Māori households characterised by hard to change risk factor profiles (Tipene-Leach, Everard, & Haretuku, 2001). Later research determined that low socio-economic status was a significant factor in SIDS mortality (Blakely, Atkinson, Kiro, Blaiklock, & D'Souza, 2003). To conceptualise these types of risk factors as non-modifiable impedes the development of relevant intervention strategies that will make a difference to the socio-economic deprivation that characterises the living conditions of Māori mothers and babies (McManus, et al., 2010). McManus et al (2010) note that SIDS prevention strategies have not seriously focused on upstream factors. Further, they state that "…strategies aimed at reducing health inequalities in a population need to include structural strategies that challenge the social and political frameworks that relegate indigenous and ethnic minority groups to poverty and other forms of exclusion." (p 644).

The second example relates to cultural hegemony and the promotion of appropriate prevention messages that will engage Māori communities. The Cot Death Study provided an explanation for disparities in Māori SIDS rates that focused on high rates of maternal smoking and bed sharing (Blair et al., 1996; E Mitchell, 1995). Māori advocates in the field strongly and consistently argued over some years for intervention to take account of Māori cultural co-sleeping norms. In the context of a strong cultural imperative to co-sleep as the healthy option for baby, they were strongly concerned that the conventional safe sleeping message 'do not bedshare' would be rejected by Māori. It was only in 1994 with the establishment of the Māori SIDS Prevention Programme that Māori cultural norms and preferences were seriously and consistently considered in intervention efforts. The impact of the new approach on health outcomes was demonstrated in substantial reductions in Māori SIDS rates, though ethnic disparities remained (see Figure 3).

A recent example of a culturally relevant prevention strategy promotes wahakura (a woven flax bassinet that can be placed on the bed with adults). Promotion of wahakura is based on both customary Māori co-sleeping practices and SIDS prevention messages. The strategy seeks to make the co-sleeping environment safer. To support use of the wahakura some simple 'rules' are provided, including, for example, 'Face up, face clear' (Tipene-Leach, 2010).

Strong and persistent advocacy from Māori cot death leadership, reinforced by lessons learnt in the New Zealand Cot Death Study have meant that this was the last major study in this field that did not include collaboration or partnership with Māori. The

Figure 2. SIDS death rates per 1000 live births, 1980 - 1986

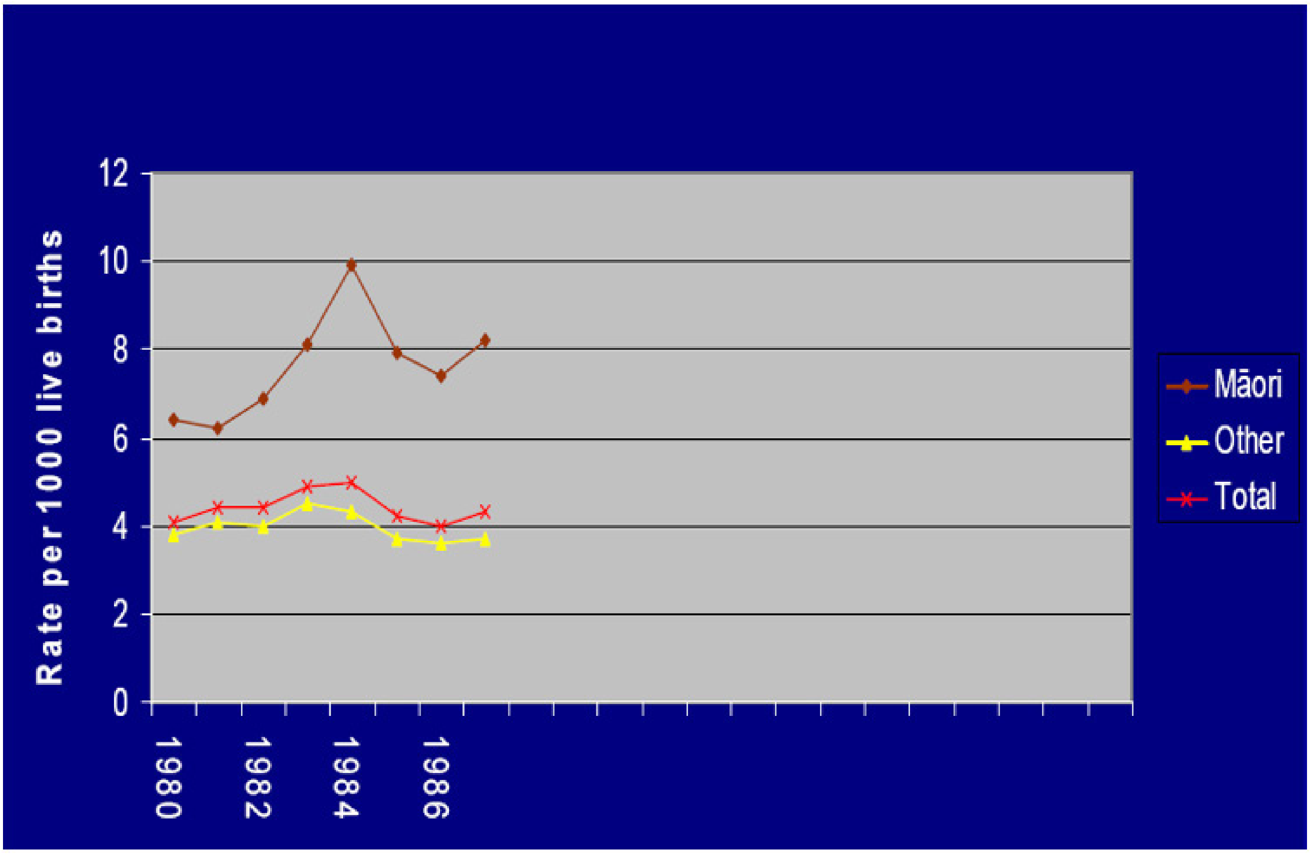
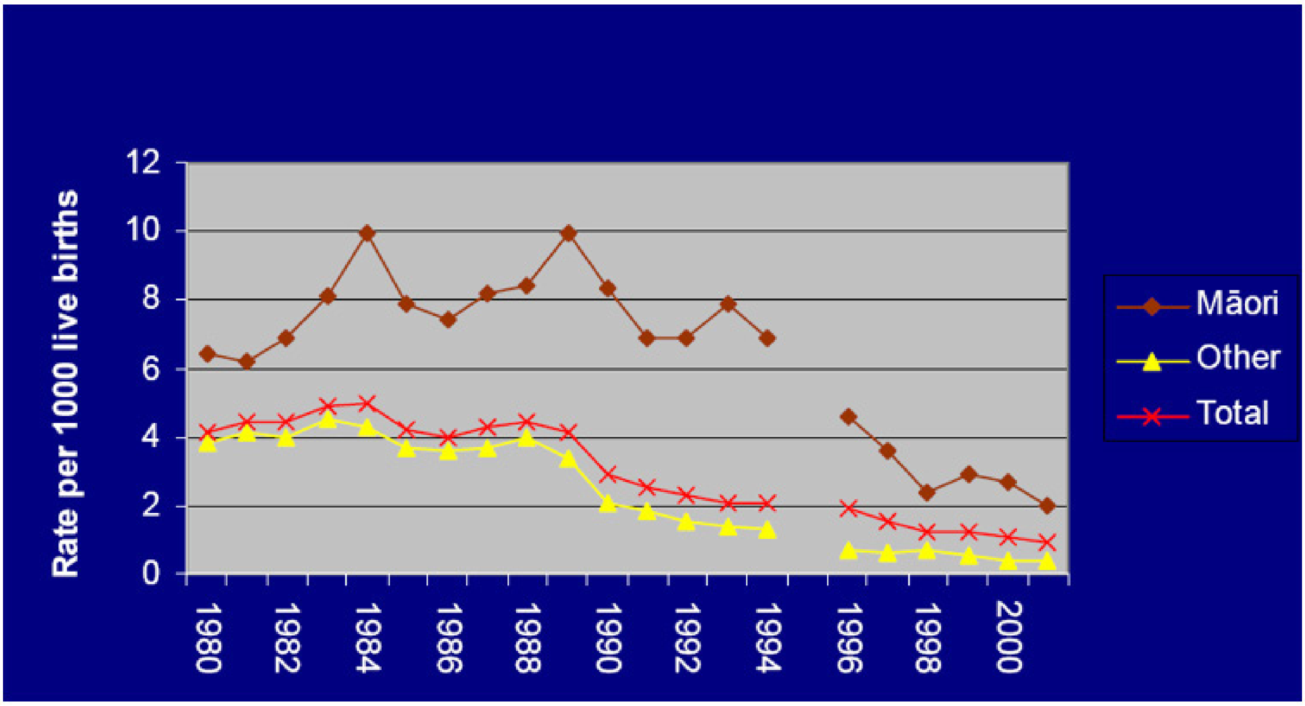


Figure 3. SIDS death rates per 1000 live births, 1980 to 2002



New Zealand SUDI study, which is run out of the University of Auckland, started in 2012 and will be conducted over a three year period. Whakawhetu, previously Māori SIDS, are partners in the research.

A power analysis

Data have demonstrated that the health outcomes that were largely attributable to the research were not distributed equitably. That is, Māori did not benefit to the same extent as non-Māori. When we reflect on the research using Puzan's four domains of power and try to understand why that was the case, two points become obvious. First, the Western scientific hegemony or dominant scientific ideologies of the time did not recognise the value of Māori input, and therefore there was no power sharing with Māori. The implication here was that there was no consistent Māori cultural analysis throughout the research process to ensure that findings were relevant to Māori and could be applied through interventions that would lead to equitable outcomes. Second, the interpretation of research findings gave little attention to the structural factors that are the basic causes of inequalities in cot death outcomes, such as socio-economic factors. From a Māori perspective, the lack of a structural analysis is a somewhat obvious omission that would likely have been identified early if a partnership approach based on power sharing had been adopted.

The Wairarapa Māori Asthma Project

Introduction

It is important that we learn from past experiences. Those examples of research projects that would have benefited from the inclusion of partnerships with Māori and those that successfully used a partnership approach and showed an impact on Māori health outcomes and the potential to reduce inequalities. The Wairarapa Māori Asthma Project (WMAP) is an example of the latter. The project was a joint initiative of the Hauora Rūnanga (an iwi health council) of the Wairarapa Māori Executive/Taiwhenua o Ngāti Kahungunu ki Wairarapa and the University of Otago Wellington Asthma Research Group (WARG). Also involved in the initial project were Te Manawa Hauora (later renamed Te Rōpū Rangahau Hauora a Eru Pōmare), a Māori health research centre based at the University of Otago Wellington School of Medicine.

The partnership

The project was a response to findings of the Māori Asthma Review that ethnic inequalities in Māori morbidity and mortality from asthma were due to poor access to culturally appropriate and culturally safe health care and asthma education. The review recommended that marae-based asthma clinics with strong Māori management be set up and that a user-friendly asthma self-management plan be introduced to Māori communities (Ministerial Review Team to Consider Asthma among Māori People, 1991). The proposal for the study initially came out of a joint meeting of Māori community health workers from the Wairarapa, the Māori Resource Unit and other sections of the Wellington Area Health Board, and WARG. Therefore, well before the establishment of the formal partnership between the organisations, relationships had been developed between Hauora Rūnanga health workers and WARG leadership.

The programme was a partnership between an iwi and Western academic institution with shared decision-making, access to resources and authorship of publications. This approach, while unusual for the time, was essential to leverage the resources of both organisations. The iwi provided an access point to Māori community networks that facilitated the participant recruitment. Community credibility was essential in making the programme acceptable to the community and maintaining their commitment for the duration of the research. A partnership with the iwi was also necessary to enable use of marae-based clinics. While it wasn't unusual for Māori community health workers to work alongside other health professionals, what was distinct at that time was that control and decision making was shared equally between the two parties. This approach recognised that Māori community health workers and other health professionals brought complementary skills to the partnership.

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*This section is drawn largely from 'Ratima, M., Fox, C., Fox, B., Te Karu, H., Gemmell, T., et al. (1999). Long-term benefits for Māori of an asthma self-management program in a Māori community which takes a partnership approach. *Australian and New Zealand Journal of Public Health*, 23(6), 601-605.'

Partnership with iwi also enabled the project to be consistent with Māori processes due to the cultural competence of the Māori community health workers. As well, the Māori community health workers were credible within the community and therefore were well positioned to co-ordinate the researchers and the community, arrange clinics and provide ongoing support to participants. The university researchers and doctors contributed technical expertise to the programme, including providing the clinics.

The project

The six-month project was launched in 1991 through hui on marae and sixty-nine people enrolled in the project. In essence the project involved the introduction of a credit-card sized asthma self-management plan through a series of Māori community based (usually on marae) asthma clinics with doctors and Māori community health workers. Participants were taught how to maintain daily diaries of asthma symptoms and how to use peak flow meters and record peak flow rates. The Māori community health workers provided follow-up support in the community (Te Hauora Runanga o Wairarapa, Te Pūmanawa Hauora ki Manawatū, & Wellington Asthma Research Group, 1999).

Asthma control was assessed before and after the introduction of the self-management plan through interviews and review of the diaries. Significant reductions in asthma morbidity were found following the introduction of the self-management plan and participants expressed preferences for the marae clinic setting (Beasley et al., 1993; W D'Souza et al., 1994). Follow-ups at one, two and six years after the original programme (WJ D'Souza et al., 2000) demonstrated that some benefits were maintained over the long-term, with participants doing better than before the programme (Beasley, et al., 1993; WJ D'Souza, et al., 2000; WJ D'Souza et al., 1998). The rate of major problems like hospital admissions was lower than before the programme started, but less serious problems (e.g. waking at night) were beginning to recur. Findings of the six year follow-up indicated that the partnership approach had also led to wider benefits of the intervention - cultural affirmation, better access to other health services, an increased sense of control among participants over their own health, and positive impacts for wider whānau members (Ratima et al, 1999).

Power analysis

When reflecting on the project using Puzan's four domains of power, a number of attributes of power sharing in research can be discerned. Structural factors underpin the imbalance of power between community groups and universities. It therefore takes time to develop partnership relationships in order to best enable the community groups to engage at their own pace and as genuine partners. In order to address Western scientific hegemony, the partnership involved not only a Māori community partner but leading kaupapa Māori academics (who could bring a kaupapa Māori analysis to the partnership) located within the university consistent with an interface approach (working at the meeting point of Western science and mātauranga Māori). Also, in practice, precedence was given to Māori worldviews and process in delivery of the intervention and this was reinforced through marae clinics as sites of research and the involvement of Māori community health workers in delivery. As well, the project was developed to address a community priority area identified by Māori.

Within the organisational domain, there were mutual benefits for the community and the university and shared decision-making. The iwi health group envisaged improved asthma outcomes for their people and a chance to further develop health service and research capacity. The university had the opportunity to trial an intervention in an innovative way and demonstrate measurable impacts among a 'hard to reach' group. Work that, if successful, would generate publications and wide interest among its stakeholders. There was also sharing of resources and community partners were named investigators on research grants and publications.

Aligned to the interpersonal domain, a relationship of trust was developed over time between members of the respective teams. This was reinforced by the long-term nature of the project which included one, two and six year follow-ups.

A developing partnership – Te Pou Tiringa and the National Centre for Lifecourse Research

To better understand the development of research partnerships, it is also useful to examine a new relationship that has built on the lessons of the past. A research partnership has been developed between

Te Pou Tiringa and the National Centre for Lifecourse Research (NCLR).

The planned research programme

A long term research programme is planned that will investigate what constitutes effective intervention in the early years to improve outcomes for children in later life. The transformational research focuses on the potential of quality early life and whānau development programming to impact health and social wellbeing over the life course. Specifically the research will generate evidence around a specific model and approach (Te Kōpae Piripono) that may be scaled up and implemented in a range of contexts. The two initial projects in the planned research programme have been funded or provisionally approved for funding by the Health Research Council of New Zealand and an education sector body respectively.

Te Pou Tiringa and the NCLR

Te Pou Tiringa is the governance body for the Taranaki Māori early childhood education and whānau development initiative Te Kōpae Piripono. Established in 1994, Te Kōpae aims to revitalise Taranaki Māori language use and cultural practices and identifies whānau development as its priority. The initiative is grounded in a belief in the transformative power of collective development achieved through commitment to educational excellence, Māori language revitalisation and reinforcement of a secure cultural identity (Hond, 2013). Alongside academic expertise in education, health and kaupapa Māori research, the Te Pou Tiringa part of the partnership also provides a point of entry to the local Māori community given its long history and credibility with Taranaki Māori communities.

The NCLR, based at the University of Otago, is the partnering academic institution. It is a collaboration between six universities and a Crown Research Institute. The NCLR undertakes etiological-development research (examining early life factors that impact health outcomes across the lifecourse) to inform policy and practice and intervention research. As a research partner the NCLR contributes infrastructure, expertise in Western scientific research and a range of other resources.

The research provides mutual benefits for the partners. Te Kōpae had an interest in building evidence to inform its ongoing work and facilitate sharing the model more widely to support improved outcomes for children and whānau. The NCLR was looking for an early childhood intervention that would instil positive behaviours that its research had linked to improved lifecourse outcomes.

The research also provides for both organisations a vehicle for capacity and capability building. Te Kōpae is seeking to develop research skills among whānau (this includes kaitiaki/teachers) to facilitate ongoing engagement as equal partners throughout the planned research programme. Members of the Te Pou Tiringa team have actively explored opportunities to develop their research capacities, and two members will seek provisional enrolment in 2013 in the University of Otago doctoral research programme and be jointly supervised by researchers from both sides of the partnership. Another is a current recipient of an HRC Hohua Tutengaehe Postdoctoral Fellowship, and this research is contributing to his postdoctoral work. The NCLR aims to develop and strengthen Māori competencies through formal and informal learning opportunities. The three members of the NCLR part of the team have expressed a commitment to developing their reo Māori, and two are enrolled in a reo Māori course this year. One of the NCLR researchers has secured an HRC Erihapeti Murchie Postdoctoral Fellowship. A joint aspiration of the partnership is to enhance members' critical awareness, and this applies to both sides of the team.

Growing a partnership

Once Te Pou Tiringa and the NCLR had agreed a shared interest in working together, regular SKYPE hui were established and preliminary site visits of at least two days were held at Te Kōpae in New Plymouth in early 2011 and later the NCLR in Dunedin. While concrete outcomes were achieved, most importantly the site visits provided an opportunity for respective team members to gain a 'feel' for the day to day environment and context within which one another works. A key objective was getting to know one another and spend time in each group's respective day-to-day environment. Strong interpersonal relationships between members of the team are vital to the success of a partnership. Growing trust between members is the basis for meaningful relationships. As well, there needs to be an openness to new learnings, including how best to work collaboratively, to negotiate and to compromise. Role conflict may also be a potential issue, that is, coming to terms with the differences between roles held in an individual's own organisation and expectations within the partnership.

At the first NCLR visit to Te Kōpae, a weekend wānanga was held with Kōpae whānau members. The wānanga provided an opportunity for open discussion with the Kōpae whānau as a collective about the developing relationship, research potential and the role of whānau. Whānau endorsement of the research was conditional upon ongoing updates of progress and expectations were expressed that the research needed to be of direct benefit to Kōpae children and whānau. Alongside further site visits to both Te Kōpae and the NCLR, the research is a standing agenda item at regular Kōpae whānau hui and weekly kaitiaki (teacher) meetings.

The pace at which the relationship has developed has accommodated the capacity constraints of the community partner. Building the partnership relationship has not been rushed, and it has taken time. Allowing sufficient time is critical. Extensive discussions over an almost two year period contributed to development of a Memorandum of Understanding (MoU) between the parent organisations - Te Pou Tiringa Trust and the University of Otago. The MoU laid out the negotiated terms of the relationship including shared objectives and commitments, and was an expression of the partnership's power analysis. It documents tikanga, or the rules by which the partners engage. Two considerations were at the forefront of thinking in developing the MoU. First, awareness of the inequitable power relationship between a small Māori community organisation and a large academic institution. Second, recognition of the mana or power that both organisations bring to the relationship and the importance of maintaining that mana throughout the research process, particularly for the small organisation. The MoU contains several examples of how the partnership seeks to address the power imbalance.

"Diversity of input to this partnership…is one of its strengths and an inclusive approach will be promoted at all times."

A commitment to joint leadership, and "In line with Te Kōpae core philosophy, we expect everyone to take on some kinds of leadership responsibilities, and that hierarchies of leadership should be avoided where possible."

"All parties to this contract recognise the special nature of Māori intellectual property…Indigenous peoples are entitled to the recognition of the full ownership, control and protection of their cultural and intellectual property."

"The prerogative over commercialisation…rests at all times with Te Pou Tiringa."

"Resourcing will be determined from the principled approach of the equitable sharing of resources."

On this last point, Associate Professor Bill Ryan of the Victoria University School of Government summed up the notion well in this quote "Organisations know they're collaborating when they put resources on the table, then take their hands away" (Personal communication, 2013).

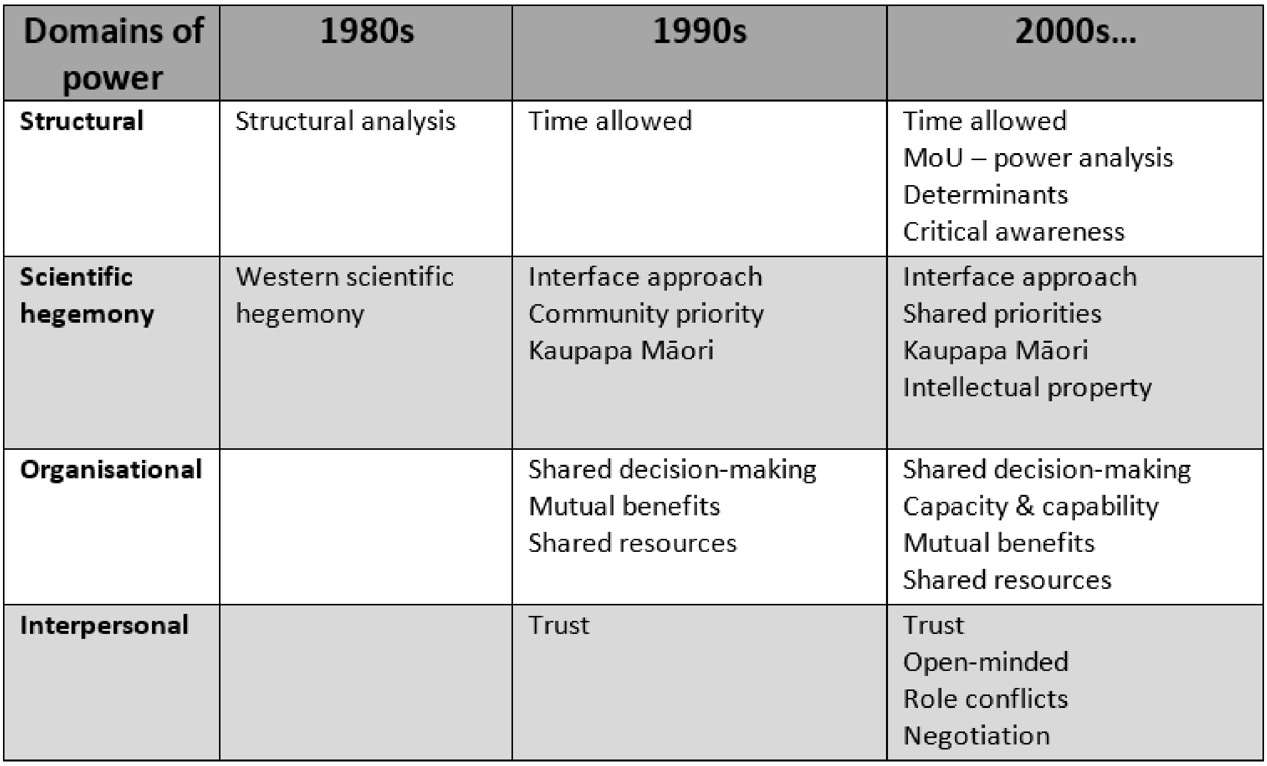
A formal negotiated position on the nature of the relationship and how it will work in practice provides an approach to dealing with structural issues impacting the relationship and thereby the research, and enables the team to move on and focus on the theory and practice of conducting the research with a clear vision and direction.

The research team is currently developing a version of an interface approach to the research that accepts the inherent differences and tensions between mātauranga Māori and Western science and seeks to relocate those tensions from the philosophical level to the kaupapa rangahau/methodological level. This is based on the belief that both knowledge systems are equally credible and relevant to disciplined inquiry in the Aotearoa/New Zealand context (further detail is provided in the paper by Edwards et al included in these conference proceedings).

Power analysis

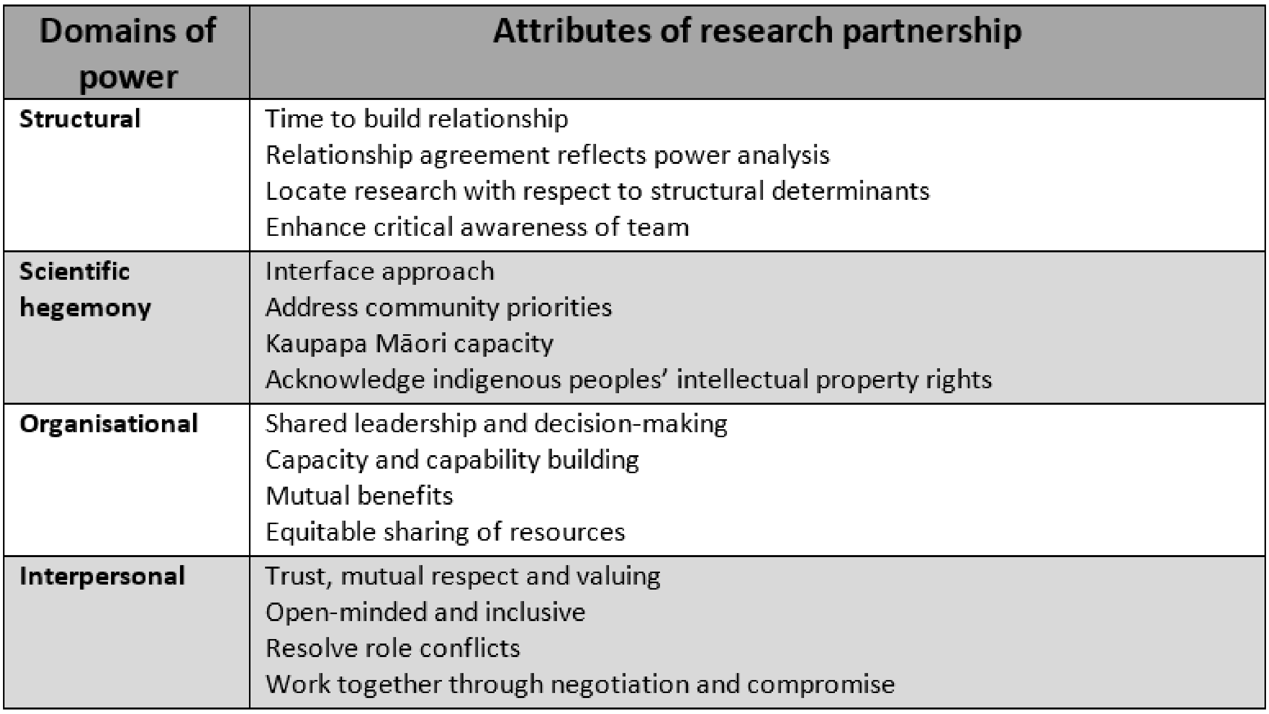
When reflecting on the project using Puzan's four domains of power, a number of attributes of power sharing in research can be discerned. While there are unique features of the Te Pou Tiringa and NCLR partnership, there are also attributes that are likely to be relevant to many groups planning to partner. Some of those attributes, additional to those identified with

Table 1. Evolution of power sharing attributes in research



Domains of power	1980s	1990s	2000s…
Structural	Structural analysis	Time allowed	Time allowed MoU – power analysis Determinants Critical awareness
Scientific hegemony	Western scientific hegemony	Interface approach Community priority Kaupapa Māori	Interface approach Shared priorities Kaupapa Māori Intellectual property
Organisational		Shared decision-making Mutual benefits Shared resources	Shared decision-making Capacity & capability Mutual benefits Shared resources
Interpersonal		Trust	Trust Open-minded Role conflicts Negotiation

Table 2. Expression of power sharing in research partnership



Domains of power	Attributes of research partnership
Structural	Time to build relationship Relationship agreement reflects power analysis Locate research with respect to structural determinants Enhance critical awareness of team
Scientific hegemony	Interface approach Address community priorities Kaupapa Māori capacity Acknowledge indigenous peoples' intellectual property rights
Organisational	Shared leadership and decision-making Capacity and capability building Mutual benefits Equitable sharing of resources
Interpersonal	Trust, mutual respect and valuing Open-minded and inclusive Resolve role conflicts Work together through negotiation and compromise

respect to the Māori Asthma Project, are noted here.

There is recognition of the structural determinants of power imbalances between the partners and formal documentation (through an MoU) of the rules or tikanga of the relationship (e.g. recognition of Māori intellectual property rights) was explicitly based on a power analysis. As well, there is an explicit focus in the research programme on developing the critical awareness of team members and this includes recognition of the determinants of wellbeing. To address scientific hegemony much attention has been given to figuring out how an interface approach applies to this research and the partnership. In the organisational domain, both groups are developing their capacity and capability to engage as equals in the research process.

Of critical importance to the team is the interpersonal domain – learning how to work together and resolve tensions. That is, developing relationships that are based on trust, approaching the partnership relationship in an open-minded way, being comfortable with the complementary nature of individual contributions and roles, and being willing to engage in an ongoing process of negotiation which includes compromise.

Expression of power sharing in research partnership

Moana Jackson, in his korero, talked about how norms have changed over time and there is a better appreciation of the need for approaches that address the specific concerns of Māori and other groups. He reminded us of how twenty or thirty years ago the notion of holding separate Māori or other caucuses caused a flurry, whereas now it is the norm. Similarly, in research the views towards power sharing with Māori in research partnerships have evolved over time and that is obvious when we look at the three projects together as representative of models and approaches over the recent past. Table 1 summarises the evolution of power sharing in research in New Zealand in terms of learnings drawn from the partnership attributes of the projects discussed.

The Cot Death Study was conducted in the 1980s, before kaupapa Māori research had begun to gain acceptance within the academy. The study did not involve partnership with Māori, and the health outcomes attributable to the research were not distributed equitably. The dominant scientific ideologies of the time did not recognise the value of Māori input and, perhaps as a consequence, little attention was given to the structural factors that are the basic causes of ethnic inequalities in cot death outcomes or Māori cultural preferences.

By the beginning of the 1990s, some academics were coming to accept the value of Māori perspectives and input and this is reflected in the Māori Asthma Project where there are obvious expressions of power sharing.

Today, there is an expectation by funders like the Health Research Council that Māori will be contributing to research involving Māori. This is reflected in the attributes of the current Pou Tiringa/NCLR research partnership.

Bringing together partnership learnings from past and current research enables an articulation of how power sharing may be expressed in research partnerships. While the detail is provided earlier in the paper, it is summarised here in Table 2. The identified attributes relate most directly to research partnerships with Māori, but will have wider application.

Concluding comments

The three research projects discussed collectively reflect the evolution of power sharing in research in the recent past. The discussion indicates that power sharing may be critical to transformational research that contributes to the achievement of equitable health outcomes. Power sharing in research is underpinned by trust and respect. It takes time to develop partnership relationships based on power sharing, and it takes effort. But the rewards are substantial. Power sharing in public health research will better enable you to improve health outcomes for all New Zealanders.

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Learning to live with difference: race and wellbeing in New Zealand

Dr Damon Salesa - University of Auckland

Kia ora tātou. Thank you for having me. I'm not a public health person, so it's been a very thick moment of learning for me, to be here and to hear what you all do. It's kind of humbling that you actually do stuff, whereas at the university, I just talk, and I talk to rooms that look a lot like this, where you have a perfectly empty front row and everyone sort of fills up from the back forwards. But what I wanted to say, what I thought I might be able to contribute to the conversation as I understand it, is really around the question of race. I had something which I prepared to talk about when I came, and I'm still going to get there, but I'm going to shrink it.

I wanted to talk about the way in which race powerfully shaped history in New Zealand and the way that it consequently conditions our present, even as it doesn't constrain, hopefully, our imaginations. Such a moment can be seen in the origins of the first hospital in New Zealand. What was effectively the first state hospital was actually built as an initiative by Governor Grey, whose reputation was as sterling then as it is deeply troubled now. The superintendent was one of those doctors who was a true believer, his name was John Patrick Fitzgerald and he loved his hospital. He wrote to everyone about his hospital, he had images made of it and he wrote to his patron, who was Earl Grey—the third Earl Grey, the son of the Earl Grey whose name is connected to the tea—about it.

"My hospital is a beautiful one," Fitzgerald wrote in 1855, "as fine as any you would see in England for its size. It is a powerful engine for gaining an influence over the native mind, for an alleviation of suffering. Those alone who have seen the warlike chiefs prostrated on the bed of sickness can estimate the power of the physician amongst an aboriginal race." (Fitzgerald to Earl Grey, 2 March 1855, Third Earl Grey Papers)

So in Fitzgerald's conception, the hospital was a powerful engine, not just for health care, but for the work of empire; the 'power of the physician' was very direct. I think the thing that I want us to notice is that in this scheme, sickness was not just something wrong with a people or person; sickness represented an opportunity for certain things to happen. Now what has happened since then is I think the discovery of the truth of that, but in reverse; that hospitals are indeed very powerful places, physicians are very powerful people and healthcare is a very powerful process, but this power doesn't only belong to the people who once claimed it.

I was thinking as I arrived yesterday of one of the great sons of Taranaki, a Pacific person as well as a Māori person: Te Rangi Hīroa, Sir Peter Buck. I recalled a letter he received from one of his friends, Sir Āpirana Ngata, as they were just beginning their adult lives. Ngata was waiting for Buck's exam results in his first year of medical school, praying that he and Tutere Wi Repa would make it through. "Our circle will then be fairly complete", Ngata wrote, "Hector, Kohere & Bennett, parsons, Hei & myself lawyers, you & Tutere doctors—these are the men on whom a tremendous responsibility has devolved … We the parsons & lawyers will do the talking and some practical work, we will 'clear the land, drive the road & bridge the ford' for you that come after … to lay the foundations of a healthier, more compact, more powerful social opinion among our people, that your future work may be easy." (Ngata to Buck, 30 January 1899 in Sorrenson, v.1, p.15) It is hard to believe that at the time men of such vision and responsibility were so young: Ngata was 24, and Buck not yet 22.

These two young men saw that the power recognised and produced by colonial and imperial actors, such as that inhering in the practice of medicine, might possibly be claimed for indigenous and colonised people. The 'power of the physician' might potentially be available to physicians who were not allied to colonial projects. In the Pacific this is apparent as well, and the dramatic example in many parts of the Pacific is the way that the lead profession in health care, from the very origins of indigenous engagement with biomedical health care, has been nursing. And nurses have been people who have constructed models of health care which very seamlessly combine these imported biomedical ideas with indigenous or local concepts and practices.

In New Zealand the concept and term of 'the Native' was central to this contested realm of colonial medicine, and it was a very persistent idea. From its origins with the colonial foundation of New Zealand, the term 'native' carried through to the 1960's. There was one key moment, however, where it began to be undone and that was when the Labour Government was in trouble after the Second World War. From the 1946 election, Labour held power by only a slim margin of four seats, one that was effectively dependent on their four Māori MPs. The party had to give their Māori MPs something, and one of the things Māori had wanted for some time was to be called Māori, and not 'Natives'. Shortly after the election the Ministry of Native Affairs became the Ministry of Māori Affairs—magically, in 1947, even though Māori have been calling themselves this for a century (Salesa, 2009, pp.167-8).

But one of the things that this change in words reveals is that for New Zealand, the word 'Native' wasn't just about Māori. 'Natives' were all the people that New Zealand colonised. In 1930, for instance, almost half the people that New Zealand colonised did not live in New Zealand. They lived in Sāmoa, the Cook Islands, Niue and Tokelau, so when they changed that word from 'Native' to Māori, they actually had to acknowledge something else, which is that the state was also colonising people who were not Māori. This is a really important moment, because it opens up that opportunity to name what is there. I think this is often very revealing. Various people had to acknowledge that there was a New Zealand colonialism that was directed, not only at New Zealand, but also elsewhere.

And as we move forward from 1947, towards a moment where I think these things begin to be addressed, we see a process which I call the 'Great Polynesian Migration'. This was when the cities of New Zealand, which were overwhelming white up until World War Two, were suddenly opened up to brown—Polynesian—people. And they were people coming from what I call New Zealand's 'Polynesian periphery', which means Tokoroa, which means Awanui, but it also means Aitutaki, it means Samoa, and Niue. Those people all came into the cities in New Zealand and they all came in actually to pretty much the same neighbourhoods, and they were often neighbours and they typically went to work in many of the same places (Salesa, 2009, pp.165-171). I think these Polynesians revealed, in the way they lived when they went to work in the factories of East Tamaki and Petone, Porirua and Penrose, they revealed a commonality of not only a shared Polynesian whakapapa but a shared history of New Zealand colonialism, which was another kind of genealogy they shared, even if they didn't know they shared it until they moved into their state house.

One of the things that I think we can draw out of this is that this shared legacy of colonialism was also about a shared legacy of other more specific things. New Zealand colonialism was, characteristically, a triangulation of three core projects. As elsewhere, New Zealand's colonialism targeted three main fields: one of them is education, one is public works and the other is public health. This engagement with the colonial state was one of the legacies that Polynesian people brought to New Zealand cities and some of those legacies are with us still. The legacy of education is the most dramatic and shocking. We know that secondary education was very poor for most Māori until very recently, except in the cases of a handful of outstanding Māori schools, but matters elsewhere under New Zealand colonialism were even worse. For instance, in the Cook Islands for many decades there was no secondary school at all, so there was zero chance of being properly educated there. In New Zealand Samoa, there were also very few education opportunities, and so on.

Along with that colonial platform of education was rudimentary health care and, more generally, very limited public works and public provision. These were amongst the many legacies that these Polynesian peoples brought to the city. Of course, they didn't leave these contexts 'up there', wherever their homes had been, they brought them as part of their cargo and their selves. If we put health care in this longer genealogy or whakapapa of colonialism and health practice, we can see something which is obvious, which is that race wasn't an accident in these systems (and those that followed them). Race was part of the design. It was part of the purpose. If we understand that race was what I call an 'organisational principle', none of us should therefore be surprised that today we see its residual power (Salesa, 2012). Race was part of the purpose and design of these systems until very, very recently and when I say recently, I mean that in some cases it came right through to the 1970s. It's only after that period where we see increasing capacity to mobilise health care and medical practice as some sort of emancipatory practice.

There is an irony that for most of our history of New Zealand state health care, it has been invested in producing inequalities, and now it's invested in the opposite—trying to erase them and remedy inequalities. The inequalities, however, are now very stark and are obvious to all public health professionals and most ordinary Polynesians. I often throw scary numbers out to make this point—I like my numbers, like a good public health professional—but folks here are already aware of most of these numbers. You know how depressing the situation can seem for Pacific peoples. It is a sad truth that if you are born as a Pacific child in this country, you will not be expected to live as long as a Pākehā child, but it is less surprising when put alongside other sad numbers. Pacific people have twice as many strokes as others, and three times the diagnosis rate of diabetes. They are four times more likely to be admitted to hospital with meningococcal disease and over eleven times more likely than Pākehā to suffer from respiratory illnesses such as asthma or pneumonia. Even these seem small differentials when compared to rheumatic fever, for which Pacific people are admitted to hospital at fifty times the rate of Europeans. (Yes, fifty.) These are kind of things that we should find really disturbing and I'm sure you all do find such indicators disturbing. I put them here to map them, to map the ways in which particular disease formations avow these older senses of inequality.

I'll whiz through these statistics because what I'm really trying to show is that that old triangulation of inequality, which was part of the design of government, continues through to the present and that, as I hope I have begun to make obvious, it is not an accident. The inequalities are no less obvious in education. Although we see some closing of some of the differentials in education, Māori and Pacific U.E. pass rates are distressingly low. We see it in unemployment, where the Pacific unemployment rate is the highest in the country and like the Māori unemployment rate is more than twice that of the general population unemployment rate. The Pacific youth unemployment rate (fifteen to nineteen years old) is at the moment above 40%. These are disturbing numbers.

For me, there is another barrow I want to push and which I've been trying to push at this moment when Auckland is revisiting its future through the unitary plan, which is to offer a different way to see Auckland. What I'm suggesting is that we might see Auckland the way it actually is—that is, as a deeply segregated place. Now every Aucklander knows this: they know where the Pākehā live, they know where the Māori and Pacific people live. But if you read the Auckland plan, you would see almost no mention of it. There is only one map in the recent draft of the Auckland plan. What it shows that is perhaps most disturbing is not just that different people live in different places, which can happen, but that Māori and Pacific people live together in deprived circumstances, to the point where maps of deprivation and maps of Pacific households coincide. The Pacific population is almost perfectly housed within spaces of deprivation in Auckland.

Now when we think of places which New Zealanders imagine are highly segregated, like apartheid South Africa or pre-civil rights America, they were typically driven by laws. Auckland has managed to do this without any such laws defining where different groups should live. So in response, New Zealand has to do something to address it which doesn't involve legal redress, because laws aren't the problem here, although I do think there are public policy causes and solutions. I've been harping on some classic segregation measures, to put them in front of the council and other decision makers and they've heard me and probably mostly ignored me, but there are ways we can measure segregation and I think if we can measure it, we can see it.

And by these lights the picture of Auckland city jars with many commonplace images, for instance through a classic (if crude) segregation measure, 'dissimilarity'. This index asks how much of a group would we have to move in order to have a distributed population that models the larger population? How many Pacific people would we have to move so that there are Pacific people distributed evenly across the city? Well, once we take out the Pacific families that actually have a European in them, we realise we have to move about half of them. (Grbic, Ishizawa & Crothers, 2010)

What about this one? I think this is a statistic that often wakes people up. It's called the exposure index, or the index of isolation. It asks what the probability is that a randomly drawn member of an ethnic minority, in this case a Pacific Islander, shares a neighbourhood (a 'meshblock' in the census terminology) with a Pākehā person? What do you think the probability of that is in Auckland? It's about one third. So two thirds of Pacific people, in this model, will not have a Pākehā in their neighbourhood, in their mesh block. That's what the 2006 census data tells us (Grbic, Ishizawa & Crothers, 2010). I think that's a distressing statistic, but it's probably less astonishing when we put it alongside the things that most Aucklanders know. We see this most dramatically in Auckland's schools, where the public data suggests that there are many schools—and many of them very large—which have no Pākehā students at all. Zero.

In education we see a dimension of New Zealand segregation that is quite striking and which passes almost without comment and almost entirely unaddressed. Though, as analysts sometimes observe, overseas there are cities that are more segregated—to even be placed in the company of these cities, most of which have histories of formal and legal segregation—should be seen as extremely worrisome. We should, however, move past these 'indexical' measures towards more sophisticated measures of racial segregation, especially towards those that measure the spacialised distribution of ethnic groups. But even these tell us that this is getting worse in Auckland.

The story often told in Auckland is that Asians that are the ones that cluster and are separate, but this is not what the data shows. Asians are actually comparatively well distributed across Auckland, so even though the last few decades have been a period of great growth of the Asian population in Auckland, they actually are quite evenly distributed, including in Pacific neighbourhoods, which is worth noticing (Johnston, Poulsen & Forrest, 2008). This contrasts with Māori and Pacific who are becoming more and more isolated or segregated from other groups.

By one count, in 2006 there are four hundred and seventy seven 'meshblocks', which I've been calling neighbourhoods, which were predominantly Pacific. There were, however, only sixty one that were predominantly Asian, even though the Asian population is substantially larger than the Pacific population (Grbic, et al, 2010). We have a state of affairs in Auckland where the Pacific population is highly segregated and it is getting worse.

But I think leads us to the defining question, which is, "who is the most segregated population in Auckland?" and it is not Pacific people. On a map of ethnic concentrations in Auckland, the one with the most dark concentrations, well, that's the Pākehā population. The most segregated population in New Zealand is the Pākehā population. The great majority of Pākehā in Auckland live in neighbourhoods which are predominantly Pākehā. A substantial proportion of those who do not live in overwhelmingly Pākehā neighbourhoods may well be those who are actually married to Māori or Pacific or Asian people. So we only have a very small group of Pākehā people who are living in diverse neighbourhoods.

I guess this is a key challenge I see for Auckland's future: to talk openly and honestly and reasonably about the way in which inequality is embodied in residential, health and educational activity, and to think about how to address it. Residential segregation in particular is an enormously challenging problem but it's almost beyond solution if we won't admit it exists, which I think is the state of affairs in Auckland at the moment— where we pretend that it's just natural that brown people live in South Auckland or West Auckland and Pākehā live on the North Shore or in Kohimarama and the inner city fringes. Yet it is not a natural situation, obviously, and if we look at some of the studies done elsewhere (there's been one study on access and racial segregation in Auckland) it seems there's been very few on the whole. Elsewhere all these studies suggest that one of the master questions is, "is racial segregation bad for your health?" Spoiler alert—the answer, at least for minorities, is yes (Kramer & Hogue, 2009), and it's particularly bad for your health if you're the poor person. This is one of the challenges I see for Pacific people in the future, and for Aucklanders in general.

One of my favourite scholars who I often turn to for insight is Stuart Hall, and he suggested that the problem for our generation and the next— is the 'capacity to live with difference' (Hall, 1993, p.361). I think this is one of his many great insights and I think when we look at Auckland we realise that many Aucklanders don't have this problem, because many of them aren't living with difference, they're actually living in separate parts of Auckland and have very little interaction with each other, which has all sorts of public health and public policy and particularly educational consequences.

It's often tempting to talk about racism in New Zealand and I find that it can be really counterproductive. This is not because I think there isn't racism in New Zealand, but because New Zealanders are so invested in considering themselves non-racist that they often shut down at the point the question is raised. I think that what we have is public feeling which is very much against racism, that almost all New Zealanders think racism is bad. But this uniform disapproval of racism is taken as the acid test that the lives people lead are not racist. This does mean that there's actually an incentive to disavow patterns of racism or de-legitimise them, because they don't fit with New Zealanders' self-understandings of who New Zealanders are or how New Zealanders live. But by understanding how New Zealand remains, in key ways, racially organised, we can harness New Zealand's celebration of 'non-racism', which could potentially be galvanising.

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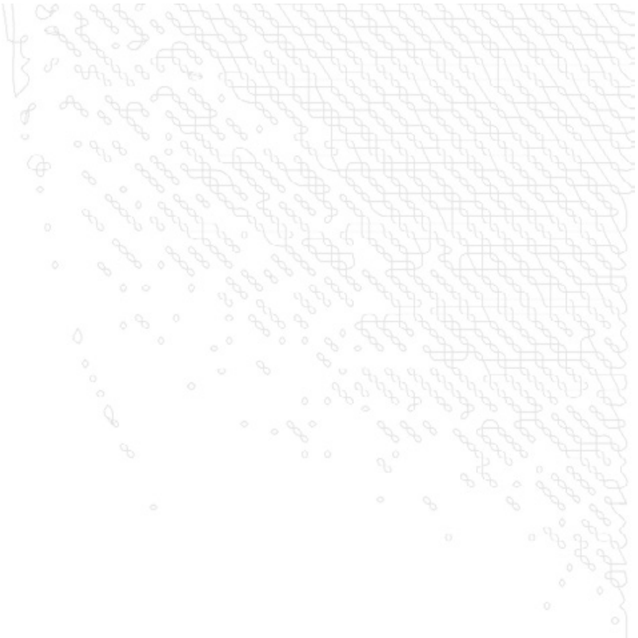
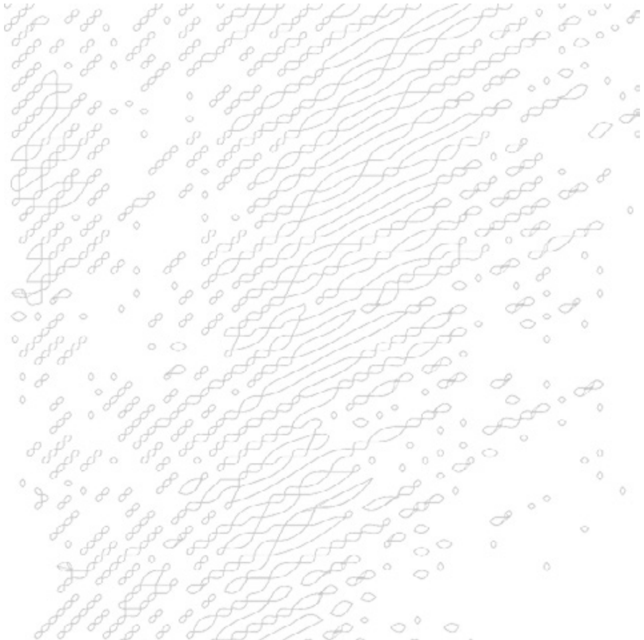




Environment and human health: partnership and collaboration in protecting natural capital in New Zealand

Dr Anwar Ghani - AgResearch

Kia ora tātou, good morning and I'll also convey my traditional greeting, which is as-salaam alaikum-may peace be with you all. This is my first interaction with the Public Health Association and I'm really honoured to be here with you. I'd like to thank PHA for their gracious invitation.

My interaction with the health professionals has been mainly at a time whenever I have been sick, or whenever my children or someone else in my extended family have been sick, for medical treatments. But last night I saw a different face of the New Zealand health professionals. I have to say that amongst you, you have got a very talented and creative bunch of people who are very eloquent and confident speakers. I'm not too sure whether you will be able put up with me, usually scientists are very poor communicators and I am one of them, so you will have to bear with me this morning.

Today, in the next fifteen minutes or so, I will endeavor to convey to you my passion about the preservation of natural resources, which are a God-given gift to us. I'm going to be speaking from the perspective of someone who is a practitioner in that area. I would like to share my world view with you on the need to ensure natural resources are used most responsibly. I think that we are all here as custodians of our natural resources, no matter which race, which colour, which religion, which language we speak-that is our role. We need to ensure resources that are handed over to us by the earlier generation are given to the next generation in better condition, or at least in the same condition, or same productive capacity as what we inherited.

I will start with a very basic concept of natural resources. When I say the natural resources, I am talking about the land, the water and the air. These three things are essential for our existence on this planet Earth. We need to make sure that they are well looked after. When the Māori came here, they had plenty of unexploited resources. Their numbers were smaller, there were lot of resources, there was very little disturbance of land and the overall pressure on natural resources was small, so the bounce back period would have been relatively short. In today's New Zealand, where we are supporting a population of about five million or so, obviously the pressure on natural resources for variety of reasons is growing. We are a nation which thrives on, or whose wellbeing is dependent on primary productions and the sale of those primary products to the affluent markets. The pressure on our natural resources, particularly on land and water, will continue to intensify and the need to manage these resources skillfully will grow. We must fulfill our responsibilities and be diligent custodians.

In New Zealand we produce enough food to feed about forty million people. About 90% of our food and fiber products are exported overseas and this is likely to continue and grow even more in the future. We need to be really passionate about protecting the quality of the natural resources that were handed over to us. If we neglect our collective responsibility of custodianship, then the consequences of this neglect will affect not only our productive capacity but our health and wellbeing.

I am somebody who was born and bred in India, and I've seen what pollution is and the consequences of polluted environments on human health and quality of life. I went to China a couple of weeks ago, I saw there how quickly natural resources deteriorate if you don't look after the environment. We humans think that it is our God-given right to go and pollute and do whatever we want to do. We live in a free country, a democratic country; we do whatever we feel is right, "right only for me". We need to develop the attitude of custodianship of natural resources which belong to all of us. That's the attitude.

The pressure on these natural resources now is more and varied. The three resources which I talk about are the land, water and air. Obviously I talked about pressure on land due to agriculture, which contributes a lot to our Gross Domestic Product (GDP), and this pressure is going to continue for the foreseeable future. We are one of the few countries in the world that have been blessed by highly fertile land, a lot of free water by way of frequent rain and good temperature to grow pastures, crops, vegetables and fruits. This is a privileged position which we have been blessed with, therefore we have greater responsibility to ensure we use our land more efficiently.

Pressure on land resources

Obviously, the earliest settlers could live in small surroundings with a very small footprint on land and surrounding environment. With an increased population and the need for more land to be used for infrastructure, pressure on the land being used for non-productive purpose but supporting essential services is increased. As land use for non-agriculture activities increases, the more natural filtering capacity of rain-water through land is reduced. Over a period of time, it will have consequences in terms of more floods and less volume of ground water recharge, resulting in some areas having a reduced water table. It will also affect our biodiversity. The little fish which are spawning in the smaller creeks or shallower rivers will be flushed out from their natural habitat by the gushing water which is coming from the non-filtering area because it has nowhere else to go – ultimately ending up in the sea. So over a period time, we will lose the diversity in the system as a part of pressure on land.

The other pressure on land is likely to be through mining activities. Government is seriously considering excavation of large areas of land for mining to grow our economy, creating new jobs and support the lifestyles we've got in this country. Thanks to Mother Nature, we've got some hidden treasures, but we have to ensure that whatever mining we agree to as a tradeoff which we have to ensure not to lose productive capacity and minimise degradation of land, water and air .

Mining for energy- our appetite is growing, we all want the biggest and fastest car, and we need the warmest house, we need all the luxuries that we can afford, and that puts pressure on energy production and creates the requirement for greater energy. I think we can live within our means, but when we go for higher production it puts more pressure on our natural resources. We need to be smarter, more considerate, look at all the options which are available before we really go and affect our land; land which has been given to us by the creator.

Pressure on water resources

Similarly, pressure on water resources, both in terms of quantity and quality, is on the rise. Early settlers, tangata whenua, caused very little water pollution because their numbers were smaller and they had a simpler lifestyle. First colonisers will always have early advantages of utilisation of natural resources, in an unexploited productive landscape. Their need of food and shelter would have been met with minimum impact on water.

New Zeala scientists have calculated the water footprint of primary products. Our animal production system has a considerably higher water footprint than the cropping or fruit production systems. As we expand our animal based farming operations e.g. Southland and McKenzie Country, demand on the surface and ground water will increase pressure on our water bodies. All parameters of water quality (nutrient loadings, e-coli, and sedimentation) measured by scientists show deterioration in water quality. Fresh water resources are not only for drinking and leisure but also used for energy production. As the demand for clean food grows globally, there's going to be more pressure on our water sources.

Energy is a huge driver and I think that using water for electricity generation is a good idea and it is something which is sustainable but in terms of looking after the quality of water, which has got a direct effect on human health, we have to up our commitment and evaluate alternatives and low cost mitigation methods for keeping our freshwater clean. We are fortunate that we live in a country which gets lot of rain throughout the year and, unlike other countries, we don't have neighbours who can affect our waterways. Therefore we have sole control on keeping the quality of our water resources; we can control our destiny as far as the water is concerned. We don't have a lot of heavy industries which can pollute rivers and lakes with heavy metals and chemicals which can destroy the life of water.

Pressure on air resources

The third natural resource is the air, of which we have plenty. The air that we breathe is among the cleanest air in the world. Again, low industrialisation and isolation is working in our favour. Wind velocity in most parts of New Zealand is relatively high and increasingly energy companies are taking advantage of this feature and generating greater amounts of electricity. Again, it's a gift which has been given to us by Mother Nature. We should not take air quality for granted and rely on shifting our air pollution to some other parts of the world.

Air pollution in certain parts of Asia and India is so severe that you cannot breathe the air. Driving and flying becomes difficult. Suspended particles can block sunlight totally. When you fly in some of these air pollution affected countries, you can see, from the sky, a thick layer of suspended particles floating and blocking sunlight. Aren't we blessed to be living in this country! So we need to look after it. Until or unless we have volcanic eruptions, we're not going to have that type of air pollution in our lifetime in New Zealand, but nevertheless that is what we could end up like if we become complacent in recognising the dangers of air pollution. I went to study my bachelor degree at a university located in the city called Kanpur, India. It is one of the industrial towns in India and therefore has poor air quality. If you don't wear a mask in the winter months, you will be choking with the air pollution.

So those who are wealthy and affluent, they can look after themselves. What about those who are not that resourceful? It is their health and their lives which are cut short. I don't want to sound like a preacher but that is what it is. I read the European Union (EU) report on the environmental pollution (EU's Clean Air for Europe) and its impact on human health published in 2009. It suggested that 348,000 premature deaths per year are caused due to exposure to fine particle (PM2.5). It estimated that industrial air pollution cost Europe up to 169 billion Euros in year 2009. This report highlights the facts that air pollution can become serious drain on the economy and human health.

I haven't got any statistics on air pollution related disease in New Zealand, but it will be many magnitudes lower than EU or Asia because we are a significantly cleaner country. This was one of the many reasons why I chose to live in New Zealand, because I came from India where I saw the industrial pollution and population pressure on air and water. The first thing I noticed when I was driven from Auckland airport to University of Waikato was, "oh gosh, this is a very scenic country." The space to play on lush green fields, the space on beaches and the freedom to explore natural forests- it essentially captured me on my very first look of this beautiful landscape. It's a very precious resource and the kindness of god which is on us; we need to make sure we do continue to look after these natural resources with judicious stewardship.

Just briefly touching on the side of collaboration, or partnership, in marinating the Manaaki in New Zealand, we have got at least a framework Te Tiriti o Waitangi. It has been the basis for our relationship in the past and it should be used as a reference point for going forward, as well as a basis which we can use to protect our resources for the greater good of New Zealand.

Using the New Zealand Department of Statistics 2050 predictions, the predictions are that, demographically speaking, New Zealand would look like a very different place. It will be a different population dynamic, where the Māori community would feature quite strongly. Therefore the Tiriti can be used to protect natural resources for future generations, as Matua George said in his summation of presentation at the conference, I think there is certainly a change in attitude needed to see the Tiriti not as a threat, but as an opportunity to move forward more constructively.

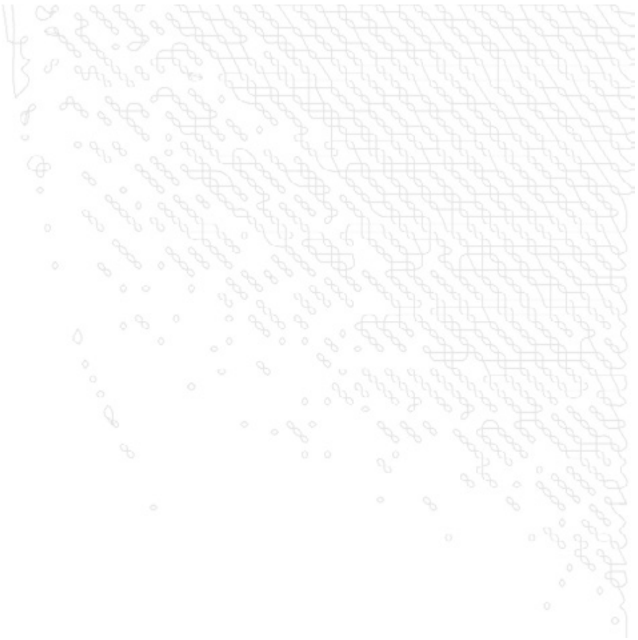
Again using 2050 predictive demographics, the non-Pākehā ethnic communities will be about 20-25% of New Zealand total population. So in the stewardship and caring of the natural resources, we need to make sure that we take this segment of our population on board in promoting sustainable use of natural resources. We, the community, need to ensure that policy developments will not destroy the condition of natural resources and people's wellbeing should be on top of the agenda, regardless of which party has charge of the nation. The emphasis needs to be to handover over our resources to future generation in better shape than what we received or at least as good as what we got. We need to keep an eye on emerging technologies which can help us in our goal of better stewardship, prosperous and productive New Zealand.

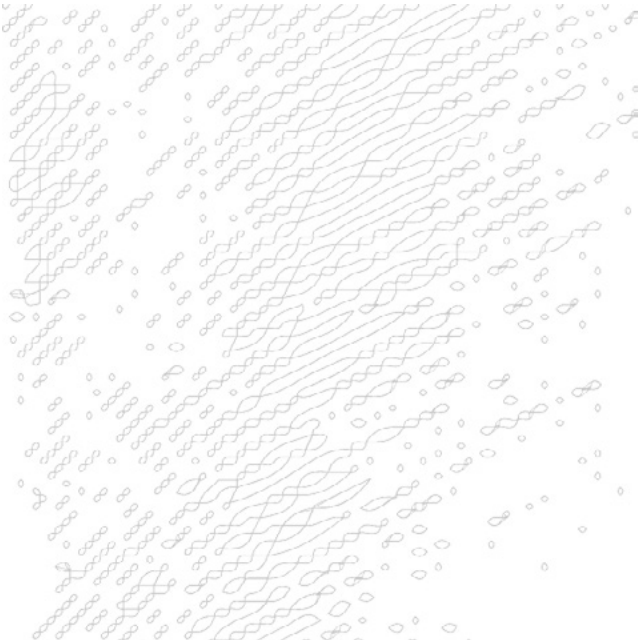
Protection of natural capital is extremely important. If we lose quality of the natural capital, consequences of that loss can lead to poor economic return on investment and deterioration in human health and quality of life. Recovery of natural resources can take many decades, so we need to be mindful that we don't go on exploiting our natural resources on the basis of short term gain which may cause us long term pain. The human race is very good at making a mess of natural resources and we are getting even better at it.

I work as a scientist for AgResearch in the Land and Environment Group. It's mainly concerned with improving primary productions of the food and fiber from grassland agriculture . Our group is responsible for developing mitigation technologies which can help in reduction of the environmental footprint of this production system.

From my perspective, one of the key environmental issues in New Zealand is the protection of water quality. Any adverse use of land resources is expressed in the receiving water bodies (lakes and rivers). Say, for example, if applying excessive nutrients in our grazed pasture systems, overstocking or grazing animals closer to waterways then it will cause algal bloom. Further down the stream, this algal bloom and associated pathogens will affect human health. Increased greenhouse gas emissions from agriculture systems is another pressure point, however, it may not affect human health directly but will bring economic pressure as we may end paying for per unit of production. Demand for energy would put pressure on our natural resources.

Tēnā koutou, tēnā koutou, tēnā koutou katoa.





Asian health service development in Aotearoa: progress and challenges

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Abstract

As one of the fastest growing population groups in New Zealand today, the health status of the Asian population has been the subject of investigation in a number of large scale reports published in recent years. These reports highlight the substantial differences in health status for diverse Asian sub-groups. Of particular concern for all Asian groups is their under-utilisation of health care services compared to other ethnic groups, notably primary health services, cancer screening, mental health services and disability support services. This paper examines the development of Asian health services in the Auckland region over the past decade and discusses the challenges ahead to further improve Asian health outcomes.

Introduction

The Asian population is the fastest growing ethnic population in New Zealand today. In the 2006 census, the people who self-identified with ethnicities associated with the vast region of Asia (from Afghanistan in the west to Japan in the east, and from China in the north to Indonesia in the south) totalled 354,553, or 9.7% of the New Zealand population. This was a 558% increase since 1986 (Ho, 2008). In contrast, the total population of New Zealand grew only 23% from 1986 to 2006.

By 2026, the Asian population is projected to reach around 800,000 – more than double the number in New Zealand in 2006 - and will make up 16% of the total New Zealand population (Bedford & Ho, 2008; Statistics New Zealand, 2008). In the Auckland region, the projected increase is even higher. The Auckland Asian population currently represents 22% of the total population in the Auckland region, and is projected to increase more than 60% by 2026 (Mehta, 2012).

Despite the common tendency to cluster all Asian people into one single category, it is important to acknowledge that the term 'Asian' as used in New Zealand refers to very diverse communities with origins in the Asian continent, and includes over 35 ethnicities such as Chinese, Indian, Korean, Filipino, Japanese, Sri Lankan, Cambodian, Thai, Malay, Indonesian and Laotian (Rasanathan, Craig & Perkins, 2006). Each group is distinctive and differs from the others in language, religion, migration history, culture and health beliefs. Among the myriad Asian sub-groups in New Zealand, Chinese are the largest, followed by Indians and Koreans (Ho, 2008). In terms of geographical distribution, two-thirds of Asian New Zealanders lived in the Auckland region in 2006.

A majority of the Asian population in New Zealand were born overseas. In 1986, a fundamental change in government policy abolished a traditional source country preference (the United Kingdom, Europe, North America and the Pacific) and opened up immigration to non-traditional sources. This policy change, together with the introduction in 1991 of a points-selection system which rated prospective migrants on their qualifications, work experience, age and settlement factors, led to much larger and increasingly diverse immigration of people from countries in Asia to New Zealand (Bedford, Ho & Bedford, 2010; Bedford, Ho & Lidgard, 2005; Trlin, 1992, 1997). Between the censuses of 1986 and 2006, the percentage of overseas born within the Asian population increased from 55.6% to 79.3%.

The growth of the Asian population in the past two and a half decades has brought significant changes to New Zealand's demography, economic activities and cityscapes (Spoonley & Bedford, 2012). It also has impacts on New Zealand's health delivery system. This paper examines the specific health needs of the major Asian ethnic groups in New Zealand, and outlines the development of Asian health services in the Auckland region over the past decade. The paper concludes with a discussion about the challenges of improving health outcomes for New Zealand's Asian populations.

Health concerns in Asian Communities

In recent years, a number of large scale reports on the health of Asian people in New Zealand have been published. These include:

- *Asian Health Chart Book 2006* (Ministry of Health, 2006);
- *Asian Health in Aotearoa in 2006-2007: Trends since 2002-2003* (Scragg, 2010);
- *Youth '07: The Health and Wellbeing of Secondary School Students in New Zealand* (Parackal, Ameratunga, Tin Tin, Wong & Denny, 2011); and
- *Health Needs Assessment of Asian People Living in the Auckland Region* (Mehta, 2012).

These reports analysed the health status of Chinese, Indian and 'Other Asian' separately. The stratification of the Asian population into three ethnic groups was done in recognition of the diversity that exists within the Asian population, and to reduce the problem of the 'averaging' effect – that is, the good health for Asian people overall may mask the health concerns of some smaller groups when data are averaged (Abbott & Young, 2006; Rasanathan, Ameratunga & Tse, 2006). The reports have found that, when compared with the rest of the New Zealand population, the Chinese, Indians and Other Asians have better life expectancy, lower avoidable mortality and lower prevalence of hazardous alcohol consumption (Ministry of Health, 2006; Scragg, 2010). Besides, Asian women and youth are less likely to be current smokers than their European counterparts (Ministry of Health, 2006; Scragg, 2010; Parackal et al., 2011).

These results are partly due to the 'healthy immigrant effect', that is, the health of first generation immigrants are relatively better than that of comparable native-born population. There are a number of explanations for this phenomenon, including health screening of immigrants, self-selection of immigrants who tend to be younger, have higher socioeconomic status and higher levels of education (these factors are associated with better health status), under-reporting of health conditions, as well as acculturation effect when immigrants take on ways of living in the new host countries (McDonald & Kennedy, 2004; Tse & Hoque, 2006).

However, the healthy immigrant effect tends to diminish over time, as the health of immigrants converges to native-born levels. There is emerging evidence in New Zealand of the apparent worsening of Asian immigrants' health over time. For example, current statistics indicate that South Asian people, who are predominantly Indians, have double the risk of being in treatment for high cholesterol and a four-fold increased risk for diabetes compared to European New Zealanders (Scragg, 2010). Evidence also indicates that the burden of diabetes is increasing among Chinese and Other Asian communities, and that Asian people born or residing in New Zealand for over ten years are more likely than recent immigrants to be alcohol drinkers, be overweight or obese, and less likely to be non-smokers (Scragg, 2010). The Asian Health Chart Book 2006 also found that after controlling for age, sex, deprivation and ethnicity, longer duration of residence is associated with increased likelihood of self-reporting high blood cholesterol and high blood pressure (Ministry of Health, 2006).

There are specific health concerns among the Asian sub-group populations, which include the following:

- Among Indians: high prevalence of Type 2 diabetes, cardiovascular disease (Ministry of Health, 2006), low birth weight deliveries (Mehta, 2012), mental health issues among female students (Parackal et al., 2011) and low levels of fruit/vegetable consumption (Parackal et al., 2011; Scragg, 2010).
- Among Chinese: diabetes among older men and middle-aged and older women, termination of pregnancy among teenage women (Mehta, 2010), mental health issues among female students (Parackal et al., 2011) and low levels of physical activity (Parackal et al., 2011; Scragg, 2010).
- Among Other Asians: high stroke and overall cardiovascular disease hospitalisation (Ministry of Health, 2006; Mehta, 2012), diabetes (Scragg, 2010), and low levels of fruit/vegetable consumption and physical activity (Parackal et al., 2011; Scragg, 2010).

The reports have also noted that all three Asian sub-groups are not accessing the health services to the same degree as other New Zealanders. They are less likely to have a primary health care provider, and less likely to have seen in the last 12 months a range of health professionals, including medical specialists, pharmacists, and social workers (Scragg, 2010). They also have low mammography and cervical screening uptake (Ministry of Health, 2006) and lower rates of access to mental health services and disability support services compared to other ethnic groups (Mehta, 2012). In the Youth ’07 study, 14% of Chinese students and 17% of Indian students were reported facing barriers to accessing health care, including lack of knowledge about the health care system, cost of care and lack of transport (Parackal et al., 2011). Lack of English language proficiency, fear and distrust of Western medical practices, intense stigma and shame attached to mental illness and disability, as well as lack of cultural competence on the part of service providers are additional key barriers confronting Asian people when seeking health care (Abbott, Wong, Williams, Au & Young, 2000; Ho, Au, Bedford & Cooper, 2002; Lai & Chau, 2007; Tse, Wong, Hong & Rasalingam, 2013).

The pattern of under-utilisation of health care services among Asian people can lead to under-reporting of health needs and delays in treatment. When Asian people are unable to gain access to timely and appropriate services, this can result in more severe and lengthy illnesses, and greater disparities in health status. Hence, developing policies and services to overcome the access barriers confronting Asian people is essential for achieving equity in health, as equity in access and the utilisation of health care services among immigrants and ethnic minorities is essential for attaining the same health status level as the dominant population (Braveman & Gruskin, 2003).

Policy and service development in the past decade

At the national level, the New Zealand Health Strategy (Ministry of Health, 2000) and the New Zealand Settlement Strategy (Department of Labour, 2004) are two key policy documents guiding the development of Asian health services in the last decade. The goals of the New Zealand Health Strategy are to improve the health status of all New Zealanders, reduce inequalities and ensure quality services. Thirteen priority areas for service development have been identified, namely smoking, nutrition, obesity, physical activity, suicide, alcohol and drugs, cancer, cardiovascular diseases, diabetes, oral health, violence in families, schools and communities, mental illness and child care. The priority groups for reducing inequalities in health status include Māori, Pacific Peoples and people from lower socioeconomic groups. Asian people are not identified as a priority group, however, they have poor health status in a number of prioritised areas and low access rates to a range of health and disability services. Therefore, there is an increasing need to respond to this population group to ensure quality and equitable access to services.

The New Zealand Settlement Strategy was launched in 2004 to provide an integrative framework of services to improve settlement outcomes for new migrants, refugees and their families and to promote social cohesion (Department of Labour, 2004). In the 1990s, despite the substantive increase in the diverse flows of new immigrants to New Zealand, settlement support services were inadequate, piece-meal and ad hoc, resulting in poorer than hoped for health and social outcomes (Department of Labour & Ministry of Social Development, 2003). The New Zealand Settlement Strategy is a whole-of-government national initiative, which involves the collaboration of a range of government agencies, including the Department of Labour (now part of the Ministry of Business, Innovation and Employment), Office of Ethnic Affairs, Ministries of Health, Education and Social Development, Te Puni Kōkiri, New Zealand Police, New Zealand Qualifications Authority and Career Services.

In recognition of the fact that the Auckland region has the largest Asian, refugee and other new migrant populations, an Auckland Regional Settlement Strategy (ARSS) was developed in 2006 (Department of Labour, 2010; Mortensen & Wong, 2008). The ARSS is a partnership among local and central governments, non-government organisations, refugee and migrant communities and other stakeholders with an interest in settlement issues. It addresses particular priority areas which are considered barriers to the settlement of newcomers, such as health, information, language skills, employment, education, housing, connection and participation. In the area of health, an Auckland Regional Settlement Strategy Refugee and Migrant Health Action Plan has been developed, and the goals are to enhance health outcomes, ensure that healthcare services are accessible and responsive to the health needs of migrants and refugees and that they do not create health inequalities (Mortensen & Wong, 2008).

Over the past decade, the New Zealand Health Strategy, the New Zealand Settlement Strategy and the Auckland Regional Settlement Strategy have provided the policy directions for actions to improve access and the responsiveness of health services for Asian people. A number of local initiatives in the Auckland region have been developed. For example, to improve communication and the engagement process with Asian clients, health information has been translated into multiple Asian languages. In addition, free interpreting services (phone and face-to-face) are available in all health and disability services, including general practices, primary health organisations, pharmacies, community laboratory services, Plunket and Family Planning (Primary Health Interpreting Services Newsletter, Issue 2, May 2012). To address the significant barriers preventing Asian people from accessing and utilising mental health services, the three Auckland-based District Health Boards (DHBs), Waitemata DHB, Auckland DHB and Counties Manukau DHB, have all developed culturally and linguistically appropriate mental health support services for their Asian clients and families (Ko, 2013; Lim, Mortensen, Feng, Ryu & Cui, 2012; Wong & Au, 2006). Their services include cultural input in assessment and treatment, cultural advice to mainstream health professionals to assist with management and treatment planning, coordination of access to Asian community resources, provision of psycho-education workshops to Asian service users and their families, and the promotion of health and wellbeing to Asian communities (The Asian Network Incorporated, 2013).

As part of the recommendations made under the ARSS Refugee and Migrant Health Action Plan to develop mainstream capacity and capability, a Culturally and Linguistically Diverse (CALD) Cultural Competency Training Programme was introduced in 2010 to improve the cultural awareness, sensitivity, knowledge and skills of health practitioners working with CALD patients and their families (Lim & Mortensen, 2010, 2012). The programme uses an evidence-based approach and the Hofstede's (2001) internationally recognised cultural dimensions model to provide the theoretical framework for understanding differences in values between diverse cultural groups. The training programme, which is delivered face to face or as online, self-paced courses, is made available free-of-charge to all primary and secondary care health workforce in the Auckland region.

Between 2010 and 2012, 4,000 health care workers in the Auckland region have enrolled in the training programme and the evaluation has been very positive. Health practitioners who have attended the courses reported high levels of satisfaction with the content, delivery and quality of the resources. There were significant increases in overall cultural competency scores on completion of the courses. Participants also reported that the training had helped them establish better rapport with their Asian clients and families and improved cross-cultural interactions in health settings (Lim & Mortensen, 2012).

There are also health interventions and health promotion projects targeting specific Asian groups. For example, the Kai Xin Xing Dong (KXXD) is a component of the national 'Like Minds, Like Mine' campaign developed by the Mental Health Foundation to counter stigma and discrimination associated with mental illness in Chinese immigrant communities in Auckland (Jackson, Yeo & Lee, 2008; Tang & Cooper, 2010). The project also provides community-based education to improve knowledge of mental disorders and available services.

Another example is a pilot South Asian Healthy Eating Healthy Activity (HEHA) project in 2010 to promote awareness of heart disease and diabetes risk and to support changes in healthy lifestyle behaviours in the South Asian community of Mt Roskill, Auckland (Parackal & Sobrun-Maharaj, 2010). The project was funded by the Auckland DHB and was done in partnership with The Asian Network Incorporated (TANI). To ensure that the programme was culturally appropriate and sustainable for the South Asian population, the New Zealand Food and Nutrition and Physical Activity guidelines were specifically modified to incorporate healthy food habits specific for South Asians. A participatory approach was used to ensure participation of the South Asian community in all stages of the project (Parackal & Sobrun-Maharaj, 2010).

To address the barriers to access to primary health services, cancer screening and disability support services among Asian people, there are tailored interventions developed to improve primary health organisation enrolment (Anderson, Parackal, Ricacho

& Zhou, 2012; http://www.yourlocaldoctor.co.nz/Home.aspx), breast screening uptake (Lim et al., 2012; Lim & McLeod, 2010) and cervical cancer screening uptake (Davy, 2008; Gao, DeSouza, Paterson & Lu, 2008). Parent support groups are formed for Chinese, South Asian and Other Asian families with disabled family members (Waitemata DHB CALD Child Health & Disability newsletter, Issue 17, July 2013).

There are many more local initiatives and projects that are not discussed in this paper. The snapshot of initiatives given here is to demonstrate that a range of more culturally and linguistically responsive services have been developed in recent years to improve Asian people's access to health and social services, and these services are better coordinated than the services developed in the early 1990s. Besides, many of these services are strengths-based, capacity building, and across the sector: they have involved collaboration among government agencies, DHBs, NGOs, settlement support agencies, academic institutions, service providers and Asian communities, etc.

Challenges in advancing Asian health

Over the past decade, the development of more culturally responsive services in the Auckland region has improved Asian people's access to, and utilisation of, health services. However, much remains to be done to achieve the goal of removing inequalities in health for this population group. Until now, Asian health needs have not been prioritised in national policies and planning, despite evidence indicating an elevated risk for Type 2 diabetes and cardiovascular diseases among South Asian migrants. The overall good health of Asian people may obscure the health needs of specific sub-groups. Besides, as new immigrants make up a large proportion of the New Zealand Asian population, the current high health status of the total Asian population may be the healthy immigrant effect of new migrants. However, the healthy immigrant effect diminishes as length of residence increases.

Over time, Asian communities will resemble other New Zealanders' risk status for major chronic illness. Studies have already indicated that Asian populations show particular risk factors for chronic illness, such as their low levels of physical activity and insufficient daily fruit and vegetable consumptions. Combined with their under-utilisation of healthcare services, the chronic disease burden in New Zealand's Asian population could increase quite dramatically over the next decade or so (Rasanathan, Ameratunga & Tse, 2006). It is also important to note the increasing prevalence of obesity and diabetes of Chinese people in the People's Republic of China (International Diabetes Federation, 2012). Hence, the increase in chronic disease burden may not be seen only in South Asian groups, but also among Chinese and Other Asian communities as well.

There are other areas of unmet needs. Of particular concern for all Asian groups is their under-utilisation of health care services compared to other ethnic groups, notably primary health services, cancer screening, mental health services and disability support services. Current efforts to address the access issues facing Asian communities tend to be focused on addressing language issues and providing cultural competency training to health professionals. From the service users' perspective, this is still a passive process because their ability to utilise appropriate services are dependent on the willingness and capacity of the health system to adapt and change to meet their needs. There is a need to improve the health literacy among Asian communities, to build their capacities to advocate for their needs, and to approach host country agencies and the health system to shape service development and policies leading towards greater social justice in health for all New Zealanders.

Finally, the lack of national funding for Asian health research is another challenge. For example, in the area of mental health, Te Pou had, in 2008, developed a research agenda which identified key knowledge gaps in Asian mental health and addiction research. Yet there has been no funding available to undertake research. These knowledge gaps include the prevalence of mental health and addiction in New Zealand's Asian communities, information about the most effective types of mental health and addiction care for Asian populations, the most effective ways to promote mental health in Asian communities, as well as developing the workforce to provide culturally appropriate mental health and addiction care for Asian communities (Te Pou, 2008). There are other knowledge gaps identified in the recently published Health Needs Assessment of Asian People Living in the Auckland Region, including continuous monitoring of Asian health data and identifying health outcome and service utilisation trends over time (Mehta, 2012, p.112). Importantly, the Asian population is a diverse and fast-growing population group in New Zealand. Greater recognition of Asian health needs is required in national and regional policy and service development.

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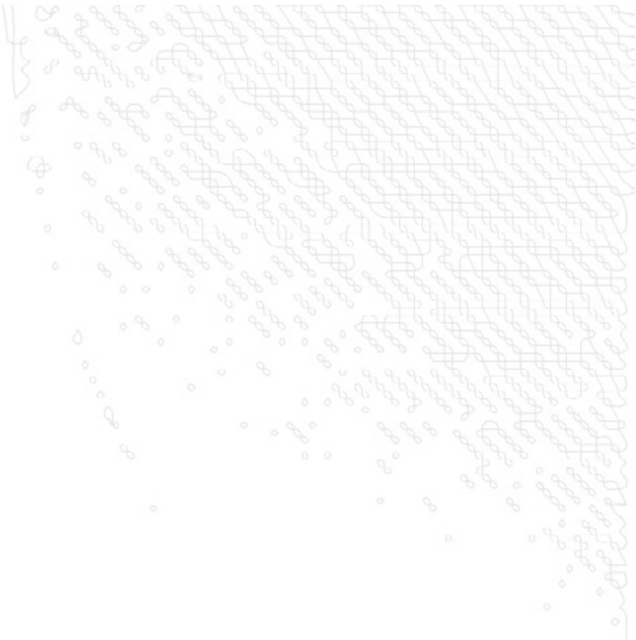
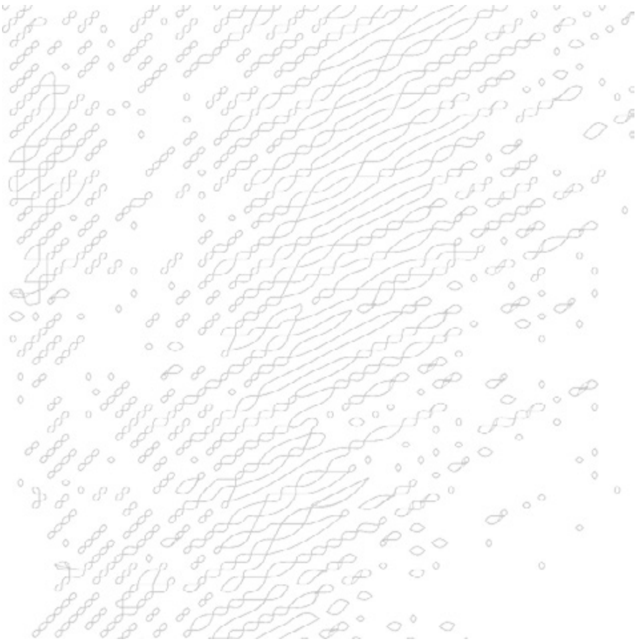




Understanding gender differences in mental wellbeing in the context of poverty analysis in Sri Lanka

Sanjeewanie Kariyawasam - Centre for Poverty Analysis

Tēnā koutou, tēnā koutou, tēnā koutou katoa. Good morning to all of you, I'm Sanjeewanie Kariyawasam from Sri Lanka. This is my third day in New Zealand and this is my first visit to New Zealand. I'm so honoured and privileged to be here today to present some of my research work in Sri Lanka at this conference.

Before that let me introduce you to my organisation, The Centre for Poverty Analysis (CEPA), where I am currently working. The Centre for Poverty Analysis is an independent professional service provider established in 2001, working on poverty related development issues through applied research, advisory services and training. At CEPA, our emphasis is on providing independent analysis, capacity building of development practitioners as well as seeking opportunities for policy influencing.

We are influenced by a strong orientation towards service provision that is grounded in sound, empirical evidence, while responding to the needs of the market. We maintain this market orientation through client requests as well as independent research, based on five broad thematic areas such as, post conflict development, infrastructure, vulnerability, migration and poverty and environment. We also provide services through three skilled programme teams - the Poverty Impact and Monitoring programme (PIM), Poverty Assessment and Measurement programme (PAM) and the Communication and Policy programme (CAP). Poverty assessment and measurement is one of our core competencies, relating to understanding what causes poverty, who are affected by it, how it has evolved over time and the impact of development policies and programmes on poverty. Our approach on poverty has always been multidimensional and it will remain the same.

To set the context for my research work, I would like to give you a little background information about Sri Lanka in relation to the post-war development. Sri Lanka is a beautiful country and is known as the pearl of the Indian Ocean. It is officially known as the Democratic Socialist Republic of Sri Lanka, and is an island located in the Northern Indian Ocean. It is a former British colony that gained its independence in February 1948. Sri Lanka has a population of around 20 million, which is 48% males and 52% female. We have a diverse ethnic mix of Sinhalese, Tamils and Muslims, the majority being Sinhalese (75%). The official languages are Sinhala and Tamil with English used as a link language.

One of the current debates in Sri Lanka is on female labour force participation. Our economically active population is about 44%, out of that 35% are women compared to 65% of men. If you look at the economically inactive population, 75% is comprised of females. The main reason for females being economically inactive, based on the 2011 National Census, was their engagement in household work and in studies.

Let's focus on the social economic background of Sri Lanka. As you may or may have not heard, Sri Lanka is going through several social, cultural, political and economic changes as it recovers and rebuilds from a 30 year internal conflict between the separatists, Liberation Tigers of Tamil Eelam (LTTE) and the government of Sri Lanka (GoSL). This conflict ended in 2009. Sri Lanka was also one of the many Asian countries to have been hit by the tsunami of 2004. These factors contributed to the existing geographical disparity in Sri Lanka's development, especially in the war torn areas which were inaccessible for long periods of time. As a result, populations in these areas had little access to basic services, let alone entrepreneurial related ones.

Sri Lanka's population, especially the women, faced a lot of problems. Women in conflict areas of the north had to step in and undertake the responsibility of bringing up children single handed, while engaging in generating income, because many women lost their husbands to the war. There were many war widows even in the south, because of the losses in the Sri Lankan army. As a result, people were directly affected through exposure to the war as well as indirectly through widespread fear.

In terms of the displacement that took place during the final stages of the war when the fighting was exceptionally fierce, great challenges arose for women because they had to stay in refugee camps which resulted in many social issues.

Looking at Sri Lanka in general, the role of women in society has often been complex. While Sri Lanka was the first country to elect a woman as a Prime Minister in 1960, most of the important leadership roles are still held by men. There is also a traditional division of labour within the family unit, with women managing the household and men being the main wage earners. There were very few women headed households in Sri Lanka, earlier, but now as a result of war, the numbers have increased to 34% according to 2011 National Census statistics, with the majority of these being between 40 - 59 years of age.

The basic services of education and health are an important part of Sri Lankan society because the government provides free health and education for its citizens. As a result, the literacy rate of 92% in Sri Lanka is relatively high compared to the other countries in the region, while 61% are eligible for university admissions. But unfortunately, actual admissions to the universities are around 15%. The latest statistics show that one of the shortcomings of Sri Lanka's education system is limited space for university placements, with many poor youth being left without alternative avenues of education and professional training.

In contrast, the percentage of Sri Lankan women enrolled in higher education has increased steadily. The percentage of women in the total student enrolment at Universities in Sri Lanka is around 55%. There are also certain areas of study in which women dominate university admissions; namely, law, indigenous medicine and arts, where female enrollment is about 75%. However, their presence in the fields of engineering and computing are around 20% - 30%.

Considering the poverty situation in Sri Lanka, we have moved to being a middle income country from a developing country during the last decade, following the end of the civil war. However, poverty exists in different pockets of the country. One such area is the estate sector. The estate sector mainly consists of descendants of Tamil workers who were brought in from India during the colonial era to work on the tea, coffee and rubber plantations. These people are trapped in generational, long term poverty due to historical circumstances and a variety of other factors. The women who are engaged in providing labour on the estates count for the high involvement of women recorded in agricultural related work in Sri Lanka. The latest poverty figures show that the poverty levels of Sri Lanka have declined from 15.2% reported in 2006/07 to 8.9% in 2009/10.

In relation to the current economic situation, Sri Lanka is now moving on from a thirty year civil war, and the macro economic situation in the country has also improved considerably. Becoming a middle income country has increased our credit-worthiness with improved access to foreign investments. Even during war time Sri Lanka was able to maintain a growth rate of 7.7% which dropped to 3.5% during 2009, which was the peak of the war. But post conflict Sri Lanka has been able to recover, and a growth rate of 8.3% in 2012. This growth is driven by the renewal of agriculture in previously conflict affected areas as well as increased investment and more confidence as security concerns decrease, and a booming economy in the tourism industry.

Sri Lanka is a well known tourist destination because of its tropical beach resorts, water sports, deep-sea fishing, under-water photography and scuba diving at ship wrecks and coral reefs. Other major tourist attractions include ancient heritage sites, Wild Life Sanctuaries. Tourism is an important source of foreign exchange for the Sri Lankan economy. Tourism has accounted for 2.6% of foreign exchange receipts in 2009. Foreign exchange earnings from tourism increased 49.9% in 2010 amounting to 56.24 billion Sri Lankan rupees. The Sri Lankan Government is prioritising tourism and has started taking a number of steps to strengthen the sector. The development of an island-wide road network at national, provincial and rural level, city beatification programmes and the recent creation of leisure and recreational opportunities within cities attracts both local and foreign tourists.

Sri Lanka is working towards achieving the Millenium Development Goals. The United Nations Development Programme has recently identified Sri Lanka as an early achiever on ten out of their twenty one indicators, including those relating to the goals of universal primary education and gender equity. Sri Lanka is also moving towards meeting the goals of maternal health and HIV/AIDS prevention, but it is making slower progress on the goals related to malnutrition and child mortality.

Considering the health sector, as I mentioned previously, we have a free public health system in Sri Lanka, but there is an issue of awareness about access to primary health care services. To address this, the government is now taking on the challenge of reforming the primary health care model for the country. Sri Lanka has an extensive network of public health units and hospitals which in general are well staffed and equipped. However, the health system in the northern and eastern provinces, the war affected areas, has been severely affected by the war. As a result, focused attention on these areas is considered as ideal to pilot the primary health care models.

Sri Lanka has made great achievements in reducing communicable diseases. The country has been eradicating and following a vaccination programme against diseases like malaria, Japanese encephalitis, measles etc. But diseases such as dengue and some neglected tropical diseases such as leptospirosis and leishmeniasis continue to be a challenge. Non-communicable diseases are on the rise, particularly cardio-vascular and cerebrovascular diseases, cancers, diabetes, diseases related to alcohol and substance abuse and chronic kidney diseases. Traumatic injuries continue to be the leading cause of hospitalisation. However, the government is trying to make significant progress in curbing the use of tobacco by the banning of smoking in public spaces and increasing the tax limit on cigarettes. Mental health problems are also a priority in the community particularly in post conflict areas.

Given the understanding of the current context in Sri Lanka, let me take your attention to some study findings. CEPA was commissioned by the Partnership for Economic Policy Network, in Canada to undertake this research, in collaboration with the Oxford Poverty and Human Development Initiative in the University of Oxford, on the "missing dimensions of poverty". This was a pilot study done in Badulla district, located in the hill country, representing three sectors - urban, rural and estate - and with varying levels of consumption poverty rates. This is a gender analysis of one of the 'missing dimensions of poverty' – Psychological and Subjective wellbeing or Mental wellbeing, which tried to understand how men and women experience wellbeing differently. The outcomes of this study provided some explanation for the low participation of women in our labour force and indicated the patriarchal values and gender stereotyping that permeates society in the Sri Lankan context.

In this study we looked at mental wellbeing as a composite of two dimensions called psychological wellbeing and subjective wellbeing. Subjective wellbeing was looked at as a composite of 'happiness' and 'life satisfaction', and psychological wellbeing as a composite of 'meaning in life' and 'self-determination'. We considered self-determination as a composite of three indicators - autonomy, relatedness and competence.

Overall, we found in this research that 97% of the total population was happy and satisfied in the Badulla district. But it was very interesting to see that even though these people were happy and satisfied, there were some significant differences on how they experienced it, between males and females.

Although it was not statistically significant, an important finding was that there were more females, than males, who considered themselves as unhappy. One aspect of the unhappiness was linked with socio-economic characteristics such as income, employment status and children. There were females who thought that if they had a chance of being employed, they could contribute to family income and increase their quality of life. Also, those females who have children with a better education, who were employed and had better socio-economic wellbeing are happier with the changes in their life over time. The other aspect of unhappiness can be seen as the effects of social comparisons, irrespective of gender. Because poorer individuals tried to compare themselves with others in the community, they felt unable to gain resources that could adjust perceived inequalities.

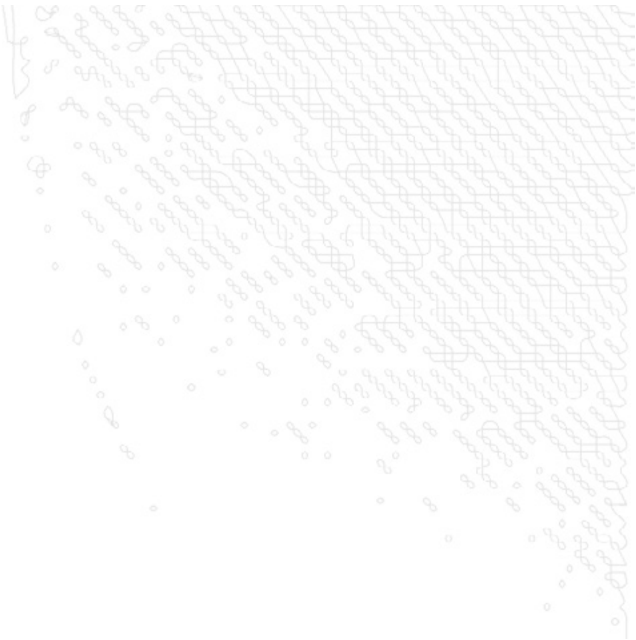
Our findings showed that both women and men are satisfied with their overall lives and 90% are satisfied with the aspects relating to food security, family dignity, ability to help others and religion. But there were more women dissatisfied with their ability to make free choices when compared to men. Exploring this further, the research found that lack of economic independence, low education and unemployment had discouraged women's ability to make choices. But despite that, interestingly, women accept the traditional male dominance in their households and have admitted that in most cases they allow the men in their family to make decisions regarding their situations and that they support their decisions as a mark of respect.

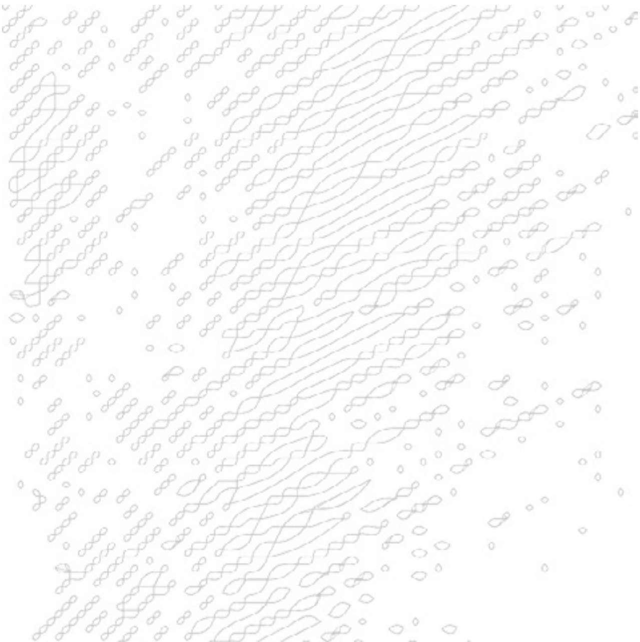
When we looked at gender stereotyping, there were statistically significant indications that men were not very satisfied, or alternatively, they were not very comfortable with their social networks. It appeared that women were only concerned about health, not necessarily their own, but of their family members. Also, there were men who have no clear meaning or purpose in life and were confused as to what gives their life meaning. They strongly felt the pressure of being the breadwinner under difficult circumstances and have little job satisfaction. Women, on the other hand, seem to derive their meaning to life from different angles, by looking at the successes of their children. The research showed that women feel that they are more educated and competent than men in their families. They feel that given the cultural context, they are expected to stay home and look after their family, which they have done at the expense of economic independence. Therein lies an important issue for future consideration.

Despite the gender stereotyping, we have seen that women and men are not miserable. The majority of both genders consider that they have control over their lives. However, men feel less related to society and women unsurprisingly, feel less able to make choices. Men are less confident about their capabilities than women, even though women are better educated but less likely to talk about what they can do. It is believed that the males lack of confidence stems from the pressure to earn money to support their families and to do jobs that are well beyond their capacity. Because Badulla is a hilly area and most of the wages are based on agriculture employment, men find it is difficult to control the outcome of their labour.

These were the main findings and we are now in the process of looking at possibilities of developing this as a national study, because this study raised interesting issues for household patriarchy, masculinity and feminism and also raised some contradictions about Sri Lankan society. The findings highlighted the importance of understanding the values in social systems when designing programmes and policies, to address certain deprivations, because individual choices often depend on the effects of the socialisation process. There is a growing debate on how government and private sector collaborations and initiatives can assist in getting more women into labour force participation. The government is currently promoting micro-entrepreneurship among women and home based livelihood options by providing some micro-finance options.

CEPA has done other studies and is currently working on studies related to poverty and wellbeing. You can access information through www.cepa.lk and the CEPA poverty portal www.povertyportal.lk which carries different documents related to wellbeing and poverty, along with other publications. Kia ora!





Our dreams for race relations in New Zealand

Dame Susan Devoy - Human Rights Commission

Hayden [Wano], thank you for that very kind and true introduction. Thank you to the Māori caucus of the PHA for inviting me to speak at the conclusion of your conference. It obviously must have been a really good party last night, because I think Hayden's just using the excuse of flights for the reason why most of the people have run out of energy and aren't here today.

I've looked at the calibre of presenters you've had over the last few days and I know that it will be a hard act to follow. Apologies if I stray from the notes that I've provided, or someone else provided. Since I started my role I've either been told to stop saying things or to start saying things, and as you can imagine, after the baptism of fire that I had after my appointment I've taken time, unapologetically to find my mojo and the path that I will walk. Every day presents a new challenge and a new opportunity and I just wish to acknowledge Hayden. Hayden and I, as he mentioned, worked together on the board of what was then the Health Sponsorship Council, Hayden bought great mana to the role as chair. When I look back now, Hayden, I realise that we were probably an exemplar of a board without even intending to be. We were mixed culture, mixed gender, mixed skills- I provided the humour, as was mentioned. We had a great relationship with the Chief Executive Officer (CEO) and with the staff, we were aware of the importance of whānau, we were aware of the importance of cultural competency and we were really aware of the inequalities.

Our Health Sponsorship Council as you know was disestablished and amalgamated with the Alcohol Advisory Council New Zealand and has gone on to form the Health Promotion Agency (HPA). I hope it still remains the same. But as I've said, I've had a lot of people give me wise counsel since I started, even if I didn't want it at all, but I'm happy always to take advice and I think that's a real strength, to be able to always ask for help. I recall meeting Dame Claudia Orange who told me to consider very carefully the path that I will walk over the next five years of my term. Judge Becroft told me that I needed to be very bold and courageous, and get used to being unpopular. Dame Iritana Tāwhiwhirangi last week at the Māori Women's Welfare League sought me out and said, "Susan, I can tell you how to do your job," a very wise woman at eighty-four years of age, but she said, "first you will have to let me beat you at golf."

So as I said, it's early days into my role and I will find my way and I will make a difference, but it will take time. I think just as you're here today, and I've looked at the theme of your conference, is partnership vs. collaboration- what is the difference? Well, I'm not here to debate that, but what I would say is that organisations don't collaborate, people do. Your organisation leads the public health approach for health equity, underpinned by the Treaty of Waitangi. The organisation I work for, the Human Rights Commission, of which I am one of five commissioners, leads the approach where everyone should matter, and everyone deserves to be treated with respect and dignity. The two primary functions of the Human Rights Commission are to advocate and promote respect and an understanding and appreciation of human rights in New Zealand, and particularly from my role, to encourage harmonious relationships between the diverse people in New Zealand society. You can understand that's only about twenty words, but the breadth is about as broad as the diverse communities that we serve.

The primary functions of advocacy, promotion and encouragement are no different to the role that you play, and all require strong relationship development. Like the PHA, the commission wants to play its part in reducing inequalities. We know that the notion of everyone getting a fair go in New Zealand is a deep rooted principle. This, perhaps, arose from many New Zealand's migrant's origins and from them seeking a better life, and certainly finding expression in the Treaty of Waitangi's promise of equal entitlement to the rights and privileges of everyone. But do all New Zealanders, regardless of the colour of their skin, ethnicity or national origin, get the same opportunity for good health, good education, decent work and an adequate standard of living?

We know, and the figures clearly say, that they don't. It doesn't happen. The question to ask is, 'What are the barriers to the people of different ethnicities and cultures getting the same start in life, having the same opportunities, and having the broad similar outcomes?'

Over the past decade, several key United Nations bodies have expressed concerns about ethnic inequalities in New Zealand, calling for greater understanding of the causes of inequality and for a continued focus, increased efforts and actions to overcome these. The United Nations Human Rights Council conducted its Universal Periodic Review (UPR... I'm learning more acronyms as this job goes on) of New Zealand human rights in 2009 and nearly five years later New Zealand is about to present its next UPR. In 2009, recommendations included government actions to understand the causes of inequality and to address the socioeconomic disparities suffered by vulnerable groups.

Whilst I acknowledge it isn't all bad news and you are all out there doing terrific work, can we honestly say we've made significant gains? We know that in health, education, criminal justice and in public services, Māori and Pacific peoples and ethnic communities are disproportionately disadvantaged by a "one size fits all" model of provision. Put simply, Māori and Pacific peoples and ethnic communities are not getting a fair go.

We know that structural discrimination, unconscious bias, institutional racism, call it what you like, is an ongoing issue and the future of New Zealand depends on solving this issue. We can no longer deny that racism is a key determinant of people's experience of health service, and we know that racism, both interpersonal and institutional, contributes to health losses.

I'm sure that one of the challenges that you all face, and that I think we face at the Human Rights Commission is expressing this message in a way that people can relate and understand. We need to move from denial and apathy to recognition and engagement. We actually need for people to understand and address what racism really is, to look at them in the mirror and to at least be able to identify it. But getting that message across is really important. I look at the constitutional review as a classic example. When you ask people walking down the street what they think about our constitutional arrangements, they either look like stunned possums or look for someone to talk about why no rugby franchise wants Ma'a Nonu.

The Commission has worked hard to support the constitutional advisory panels work because it is important. Their report will feed back on the scope and status of the Bill of Rights Act, Māori electoral representation, the role of the Treaty of Waitangi in our constitutional arrangements and indeed whether New Zealand should have a written constitution. We set our theme in plain language. It is "What is my dream for Aotearoa New Zealand?" What kind of country do we want our children and grandchildren to live in, is it a place where all people are treated with respect and dignity?

More than thirteen hundred people took the trouble to tell our Commission what their dream was, and what did they want? They wanted a place where people didn't experience discrimination because of their race, they wanted government that reflected the needs of all communities, they wanted to feel safe in their homes and in public places and they wanted the many peoples of New Zealand to have a shared sense of belonging. Looking at the responses, it's inescapable that as a country we share many values. We believe in nonviolence, we believe in the rule of law, we believe that people deserve a fair go and we believe that when inequalities are addressed, our society is the better for it.

Yet as Race Relations Commissioner I am only too aware that the numbers of complaints of discrimination, particularly of discrimination due to race, remain persistently the same from year to year. The figures need to be looked at with caution. We only need a few instances of public figures having a brain fade for complaints to come rolling in. Even so, the general pattern cannot be ignored. Every single day in this country, people experience abuse and harassment because of their ethnic or cultural identity. As Race Relations Commissioner, it is my role to speak out about behaviour that is unacceptable and in doing so I've learned a lot about how questions of race polarise our communities and that sometimes the worst conversations I've had, and the letters I receive on a daily basis begin with " I'm not racist, but..."

What has been interesting to me is not so much how offended anyone should rightly feel when accused of racism, but also how casually racism happens, through thoughtless stereotypes and jokes and abuse and harassment that have no place in a country that seemingly prides itself on good race relations. The Commission seeks to replace racism with resolution. We do this in many ways, through mediation and dispute resolution when the Commission receives and accepts complaints, and at the other end of the spectrum in education and awareness. My job involves both advocacy and promotion of human rights and harmonious relations. The role is about leading the debate and bringing in a human rights approach that ensures respect, dignity and participation to the heart of decision making.

I didn't accept this job because I thought it would be easy and if you believe what you've read I was the last man standing anyway. Despite those challenges, I found this role to be a true privilege because it has enabled me to meet so many wonderful New Zealanders who have shown, by their actions, their passion to make this country a better place. I have felt overwhelmed by the good will and positive support I have received from many of the people in organisations here today.

It's been an honour to be welcomed on Tūrangawaewae Marae to break bread with a multi-faith group hosted by Wellington's Jewish community, and enjoy a special iftar meal to mark the end of Ramadan at parliament, to name a few experiences. I was moved to my core by the way the New Zealand defence force, the New Zealand police and the people of Hamilton welcomed the Afghani interpreters onto Kirikiriroa marae and in experiencing that, I thought how great it would be if we could treat all new New Zealanders this way.

My predecessor left his legacy by encouraging people to celebrate diversity; after all, the role of the Race Relations Commissioner is to foster harmonious relations. One of the things I'd like to start is a conversation. I'm sure each us of say we acknowledge diversity but what does that really mean? I want people to consider the breadth of diversity. Certainly, acknowledging diversity is celebrating culture, but culture is broader than ethnicity. We can each claim many identities and ethnicity is only one. We have gender, sexual orientation, disability. These are some of the sources of identity and pride which can also because the basis of discrimination for others.

My second point is how can we make our difference a strength? We can work to celebrate and acknowledge diversity but how can we make recognition of the value this brings a part of the DNA of all New Zealanders? A term I hear that belongs to this conversation is "social cohesion". It's a buzz word in many circles and has a long academic history. But like all words, it's about who owns it, who uses it, and what people mean by it. Some define it as the balance between freedom, equality and solidarity; others put forward a framework that applies in the economic, political and social spheres. Statistics New Zealand have produced excellent work in this space, they have produced indicators based on a person's sense of belonging, and that's what I hear most from the migrants that I meet when I tour through New Zealand. Their ability to express their own identity, their experience of discrimination and their tolerance of diversity.

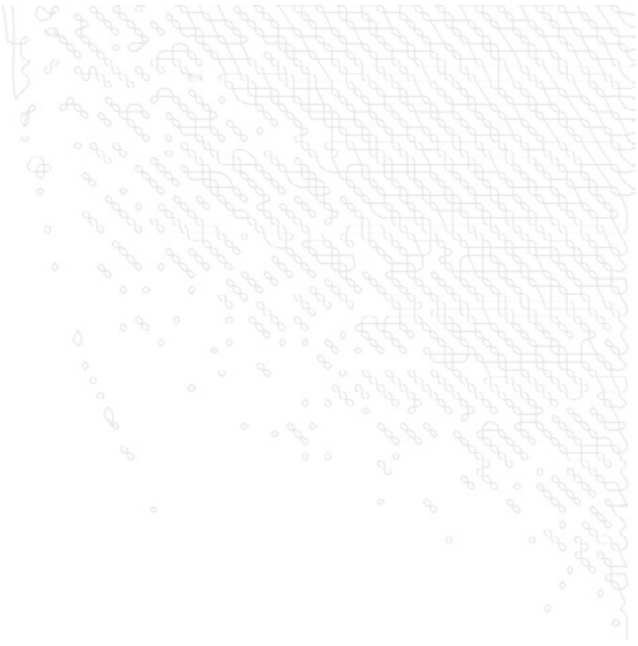
Social cohesion is about belonging, inclusion, participation, recognition, legitimacy. When these are reversed, a society begins to fall apart because of isolation, exclusion, apathy, rejection, or illegitimacy. Nor can social cohesion be a one way street. It's too easy for the majority to impose conformity on a minority, and in doing so, the minorities groups voice can be silent, its identity buried. I'd like to think there can be mutual respect based on shared understanding on what makes up a cohesive society.

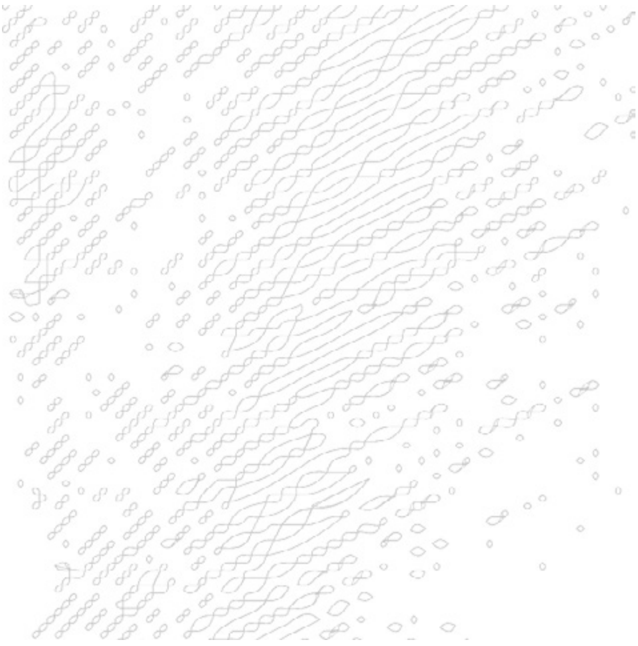
At an everyday level this is about the ties that bind, the things that unite us. It's what brings us together, whether that is a faith based community, an ethnic organisation, a school community, a sports team, these are a part of the building blocks of community and the challenge in each of these spaces is to recognise and acknowledge the values about identity and culture that we share. By building a community we can create a sum greater than its parts. An individual can be ignored and isolated but a community must be listened to, and by belonging to a community you leverage your involvement in wider society.

The challenge that I make today is for each of us to have that brave conversation about the ties that unite us, what do we mean, in our everyday world how can we put into action what it means to create belonging, exclusiveness, participation, recognition and legitimacy? Can we translate these shared values into our workplaces, families and homes? Should they be something every child learns about in school, or is built into the thinking of policy makers at a local and national level?

Finally, I want to say that neither I nor any one person has the answers. Most of the social determinants of health lie beyond the mandate of purely the health sector. Actions are required and many non-health sectors, including central and local government, finance, education and justice. Your organisation does a fine role in advocating and actively encouraging partnerships and collaboration in addressing the social determinants of health. The whole of society need to be involved, along with the whole of government. And remember- that organisations don’t collaborate, people do.

Tēnā koutou, tēnā koutou, tēnā koutou katoa.





"... However hard a person works, things just keep coming up": an evaluation of the effect of BPharm student participation in the Missouri community poverty simulation

Dr Trudi Aspden, Dr Janie Sheridan, Anne Rew - University of Auckland

Background

Since 2012, pharmacists in New Zealand have been obligated by the Pharmacy Council of New Zealand (PCNZ) to practice pharmacy in a culturally competent manner. The PCNZ's range statement describing culture includes socioeconomic status. The School of Pharmacy at the University of Auckland looked for innovative teaching material to incorporate into the BPharm curriculum and found the Missouri Community Action Poverty Simulation, an American simulation which aims to sensitise participants to the realities of life faced by those living on low incomes. The simulation provides a safe environment to assist participants begin to understand what living in a low-income family might be like.

We envisaged that participation in this experience may result in those of our students unfamiliar with issues associated with living on a low-income developing a non-judgemental, more compassionate attitude towards those in this situation and, as a result, becoming more empathetic, effective pharmacists once in practice.

Method

A kit was purchased from the Missouri Association for Community Action, shipped to New Zealand and modified to accommodate one hundred students and reflect the New Zealand environment. Changes made included "translations" of American welfare terms, and using New Zealand statistics. The Auckland City Mission, which provides specialised health and social services to marginalised individuals, was approached for advice, asked if they thought it was a worthwhile exercise and whether they would be willing to provide staff to role play six key roles: two social workers, a social welfare receptionist, two social welfare agency staff and the pawn broker. We trialled and evaluated the simulation with our year two pharmacy students in 2012. The questionnaire used was that included in the kit, with minor amendments being made to reflect the New Zealand context. Students completed anonymous paired (using a unique identifier known only to individual students), pre and post simulation questionnaires. Sixteen statements with Likert scale response options were used to monitor changes in beliefs and attitudes towards those living in poverty. In order to collect students' views on the simulation, what they had learnt from it and how it could be improved, four additional free text questions plus a section for additional comments were added to the post simulation questionnaire.

Results

Eighty-eight out of ninety-four students completed the pre and post questionnaires and gave permission for their responses to be included in the evaluation. Free text comments indicate that the simulation was well received and that many students had their views and assumptions about poverty, and those living in poverty, changed through participation in it.

"The poverty simulation has given me an insight to just how frustrating the cycle of poverty is. However hard a person works, things just keep coming up."

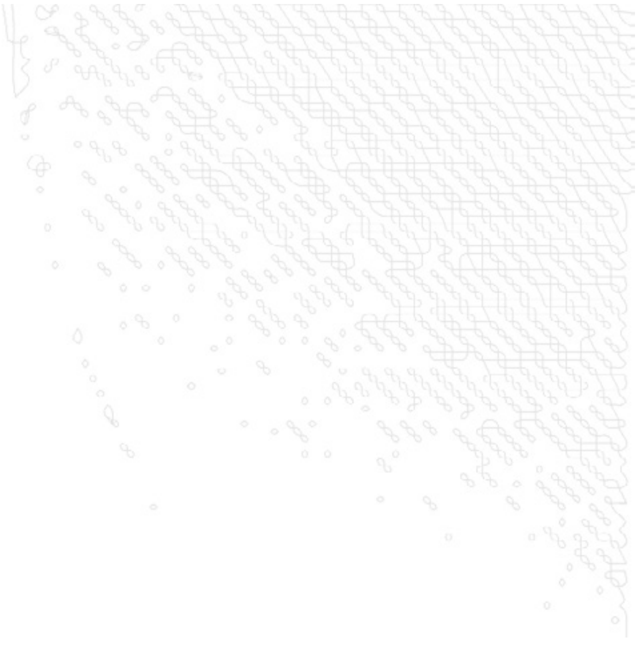
"Gave me an emotional experience and understanding of the situation, much more effective than just a lecture or list of facts."

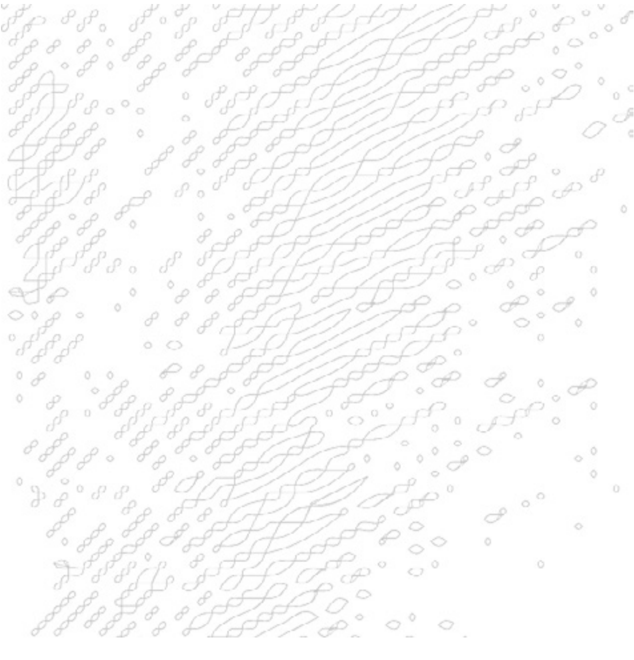
The changes in attitudes measured using the pre and post responses to the sixteen statements varied in magnitude and direction and proved difficult to analyse statistically.

Discussion

Despite the mixed responses collected from the quantitative data, when looked at together with the free text responses the results indicate that for many students, participation in the poverty simulation sensitised them to the realities of living on a low income and challenged and changed some of their negative stereotypical views. The differences measured in the quantitative data perhaps reflect a combination of a range of experiences during the simulation, varying life experiences and a limitation of the survey instrument used.

The involvement of The Auckland City Mission was crucial with regards to the provision of advice on the appropriateness of running the simulation, in addition providing authenticity and credibility to the exercise. This involvement has resulted in the development of a productive relationship between The School of Pharmacy and The Auckland City Mission. The School of Pharmacy made a donation to the Auckland City Mission to reflect their sincere appreciation, fed back the results of the evaluation to the Mission, and sought the opinion of the participating staff as to how the simulation could be further improved. These suggestions were incorporated in the next iteration of the simulation and the School of Pharmacy is hopeful that this could be the beginning of a long-term collaboration, beneficial to everyone involved.





Health Promoting Schools and oral health promotion collaborative school toothbrushing programme in Northland

Shareen Ali and Jo Dones - Northland District Health Board

Abstract

Northland reports one of the highest rates of tooth decay among age five and year eight children in New Zealand. Fluoride delivery is recommended by the New Zealand Ministry of Health to prevent tooth decay. In the absence of water fluoridation here, there is a need to explore if supervised toothbrushing programmes can be an effective oral health promotion strategy.

Four decile four Health Promoting Schools agreed to be part of the year long supervised tooth brushing programme in Northland. Children were taught how to brush their teeth. Reinforcement sessions were done using plaque disclosing tablets. Healthy diet and Northland District Health Board (DHB) School Dental Services were also promoted.

Whilst regular tooth brushings continued in isolated rural-based kura, the trend was not the same for the remaining three schools. The reasons were that teachers had other health intervention programmes running concurrently and tooth brushing programmes were cumbersome to manage.

School-based tooth brushing programmes do have a place in oral health promotion, but stringent selection criteria for these schools need to be developed. Strong relationships within the multi-skilled health promotion team and externally to the community has to be established for successful outcomes

Introduction:

Northland reports the worst dental health status in New Zealand (Gowda and Croucher, 2011). In 2011, nearly 65% of Māori five year old children living in non-fluoridated areas in Northland had experienced decay, whereas children in this age category in the rest of the country had only 41% decay (Ministry of Health, 2011). The Northland Health Needs Assessment showed that dental admissions were among the highest of the Ambulatory Sensitive Hospitalisations (ASH) among zero to fourteen year olds during 2008-11 (Northland DHB, 2012a).

To protect tooth surfaces from decay, fluoride delivery is recommended by the New Zealand Ministry of Health, with water fluoridation and toothpaste laying the foundation of intervention strategies (Ministry of Health, 2009). Water fluoridation is one of the ten great public health achievements of the twentieth century (Moimaz et al, 2013). The 2009 New Zealand Oral Health Survey found 40% reduction in tooth decay for children who were exposed to water fluoridation (Ministry of Health, 2013).

Water fluoridation was introduced in Kaitaia and Kaikohe, Northland in 2007. After a two year trial, it was removed after the majority of the residents voted against it (Sharma, 2010). Supervised tooth brushing programmes have been demonstrated to reduce dental decay (Frazao, 2011). The Opononi Area School tooth brushing programme in Northland showed initial dramatic decrease in plaque levels, but there was a mixed trend during the three year project cycle (Gowda and Croucher, 2011).

Health Promoting Schools was established in New Zealand in 1991. World Health Organization defines Health Promoting Schools as one that constantly strengthens its capacity as a healthy setting for living, learning and working. It addresses physical, mental, social and spiritual wellbeing (Health Promoting Schools, 2012). Decile ratings are done for New Zealand Schools according to socio-economic status. A decile one school has most students from the lowest socio-economic community whereas a decile ten would have the lowest proportion of these students (Ministry of Education, 2013). Decile four schools were chosen for this project, as they tend to miss out on government funding yet are catering for low-socio economic students.

This was a one year pilot study. The purpose of this project was to introduce tooth brushing programme in four decile four schools in Northland using collaborative health promotion team approach.

The key objectives were:

- To build relationships with the selected decile three health promoting schools through an oral health promotion intervention.
- To ensure daily tooth brushing is done in the classrooms.
- To obtain feedback on the project.

Method:

This is a descriptive cross sectional study. Two hundred and forty students were enrolled to do daily tooth brushing for one year.

Principals of all decile three schools in Whangarei/Kaipara region were approached to find out if they were interested in having a supervised tooth brushing programme. The first four decile four schools that said "yes" were selected for the project. Tooth brushing sessions were planned to be delivered for Year one to three students only. We met school teachers during their staff meeting and discussed the project. Information about the tooth brushing programme was sent out to the parents via the school newsletter and invitation was given to them to attend the first tooth brushing session in the classrooms. Our contact details were given to parents, in case they had any queries.

The Oral Health Promotion Advisor and Health Promoting Schools Advisor introduced the tooth brushing sessions in classrooms at the beginning of each term. Teachers learnt how to do tooth brushings by observing this session. A plaque disclosing session and reinforcement of tooth brushing was done at the end of second term. At the end of term three, healthy diet messages and a plaque disclosing session was done. A combination of tooth brushing, plaque disclosing and diet messages were given at the end of fourth term. In addition, information about access to Northland DHB Oral Health Services was given. A new set of toothbrushes, toothpaste and toothbrush caps were given to the children at the beginning of each term.

Brushing Session

A toothbrush, toothpaste, toothbrush cap and paper towel was given to each child. Their name was written on each piece of resource. A pea-sized amount of toothpaste was dispensed onto the paper towel. This toothpaste was swiped onto the toothbrush. Circular method of brushing was taught. Children brushed making ten circles per tooth on the outside and inside surfaces of the teeth. For the upper and lower inside surfaces of teeth, flicks were done. The biting surfaces of the teeth were scrubbed. Lastly the tongue was cleaned. The key message was "Brush, Spit, and Don't Rinse". Children wiped their faces after brushing for two minutes. Paper towels were disposed in the garbage bag provided. Toothbrushes were rinsed under running water, toothbrush caps placed and everything was stored in a spice rack. We emphasised the importance of keeping the set of resources allocated for each child separate to avoid cross-infection.

Plaque disclosing session

A plaque disclosing tablet is a food dye that colours dental plaque pink. The colour can be easily removed by rinsing. Children were given a tablet each and asked to chew, swish it around their teeth using the saliva and tongue and then spit it out. They then compared their "pink colours" with their peers using face mirrors provided.

Diet session

Demonstrations of amounts of sugar in fizzy and electrolyte drinks were done, together with healthy food samples. Children worked in groups to identify healthy foods and had peer group discussions around diet and drinks.

NDHB Oral Health Services

Information on how to access NDHB services using the 0800 MY TEETH number was given. The general public can enquire about the clinical and preventive services, make, reschedule or cancel dental appointments and enrol zero to seventeen year olds into the service.

Evaluation

One of the shortfalls of this project was that we did not have a robust evaluation plan. Even though we did plaque disclosing, we did not clinically measure any change in gum health or quantity of plaque over the one year period. The reason for this was that we did not have sufficient clinical staff to commit to a community project of this nature.

Therefore we used the Photo Voice Technique to document visible plaque. This is a technique where a series of photos are taken during the participatory phase of the project and narratives are written (Palibroda, 2009). We took photos of children with plaque disclosing tablets and during the brushing and diet sessions. Again, these photos were taken on an ad hoc basis, as we had to accommodate the appointment time given to us by the schools. Some photos were taken early in the morning when the school started, while others were taken after morning tea break or after lunch. This may have a confounding effect on our assessment as plaque tends to build up after food consumption.

In addition we obtained feedback from teachers, children and, where possible, from parents. We asked: what are your thoughts around the tooth brushing programme?

Consent was not obtained to use photos or the names of the schools for publication purposes. Therefore, we will use “alphabets” to name the school.

Findings

Of the two hundred and forty students enrolled at the beginning of the study, one hundred students completely withdrew at the end of the first term. The other hundred students did tooth brushings on an ad hoc basis for six months and then withdrew from the programme. Only forty students continued brushing their teeth until the end of the project.

The students were predominantly Māori, five to fourteen year olds. We incorporated the whole school to do tooth brushings where there was only two-classroom schools.

School A was a two-classroom mainstream school with predominantly Māori children. We allowed for flexibility and involved the whole school to do tooth brushings. School B was a large kura and only four Year one to three classrooms were selected to do tooth brushing. School C was a large mainstream school, again only four Year one to three classrooms participated. School D was a small two classroom kura, so we did tooth brushing for everyone.

We developed our programme around teacher’s suitability, which was a key in building strong relationships with the school. The tooth brushing sessions started well in the four supervised settings. However, after the second term we saw a “declining trend” in regular tooth brushings.

School A: Junior students did the tooth brushings regularly and were supervised by their teacher. It was noticed that by the end of the year children had improved self esteem and performed better at school. Also, there was an improvement in their general wellbeing. The junior students said that they did not like “spitting after brushing” and preferred “rinsing after brushing”. This was taught to them at some point in their lives. For senior students, teachers’ transferred the responsibility of daily tooth brushing during lunch breaks to them. These students wanted more time to socialise with their peers and missed the tooth brushing session.

School B: This kura requested for the tooth brushing to be delivered in Te Reo Māori, so we approached the Public Health Nurse and the Kai Āwhina to do this for us. The brushings started well, however it was very much teacher dependent. In the classrooms where the teacher was very proactive about dental health, regular tooth brushings happened. In other classrooms, the programme collapsed and children took the dental resources home. During the initial phases of the project, parents said that their children asked them to buy toothbrushes and toothpaste which they can use at home.

School C: The tooth brushing in this school was driven by the school principal, who had lot of passion for oral health promotion. However, the teachers told us that they had to create a balance between teaching numeracy and literacy in schools in addition to the health initiatives. At the beginning of the day, “Breakfast in Schools” was provided for students, then milk during morning recess, as part of the “Milk in Schools” programme. There was leftover milk which teachers had to store, and also had to help children fold the milk cartons in the appropriate way for recycling. The “Tooth brushing in Classrooms” was very time consuming and required a lot of effort. “Spit was all over the classroom” and with the “tummy bug” and “winter flu”, it was a cause of concern for cross-infection. The school ceased to do tooth brushing in schools and gave the dental resources for children to take home. We were invited to do one-off oral health education sessions but there was no commitment to a school-based tooth brushing programme.

School D: This was a whānau kura. The principal ensured that her whānau did tooth brushings everyday. The programme is still well maintained and children have developed a habit of taking responsibility of cleaning their teeth. Parents commented that the dental team had told them there was an improvement in their child's gum health.

The findings of this study are similar to the Opononi Area School tooth brushing programme in Northland, where in the beginning there was a lot of enthusiasm from teachers and children to do daily tooth brushing in the class and then the programmes start falling apart (Gowda and Croucher, 2011).

Visiting the schools regularly, "to be seen", was essential for the sustainability of the tooth brushing programme. Plaque disclosing sessions were an "eye-opener" to the children. In our subsequent visits, when they saw us coming they would clean their teeth before we arrived in their classroom, in attempt to get "less pink" on their teeth compared to their peers. We felt this was the first step to increase awareness among children. Similarly, Schafer et al (2003) suggest that when feedback devices are provided after a dental hygiene session, it can lead to increased removal of dental plaque and higher motivation.

Including healthy diet messages and promotion of NDHB Oral Health Services as part of the programme was an attempt to deliver a "total health promotion package". Children were able to identify and name the healthy foods and drinks. They also shared narratives of how much fizzy and electrolyte drinks they consumed and were keen to share this with their parents. While the diet sessions and visual aids were very popular with the new entrants, there is a need to develop more sophisticated lesson plans for senior students. The shortfall in having appropriate oral health education materials for classroom session in Health Promoting Schools has also being recognised by Kwan et al (2005).

Conclusion

A multi-skilled team effort maybe one of the strategies to build strong relationships with the schools and kura. We have found mixed results about the success of our brushing programme. However, in the absence of water fluoridation in Northland, we believe there is a place for supervised tooth brushing programmes as a fluoride delivery mechanism. For the long term sustainability of the programme, it is instrumental to have support from the teachers and not having the programme to be driven by school principals or the health promotion team. Perhaps there is a need to have robust "selection criteria" for schools that will ensure long term sustainability of such school-based tooth brushing programmes.

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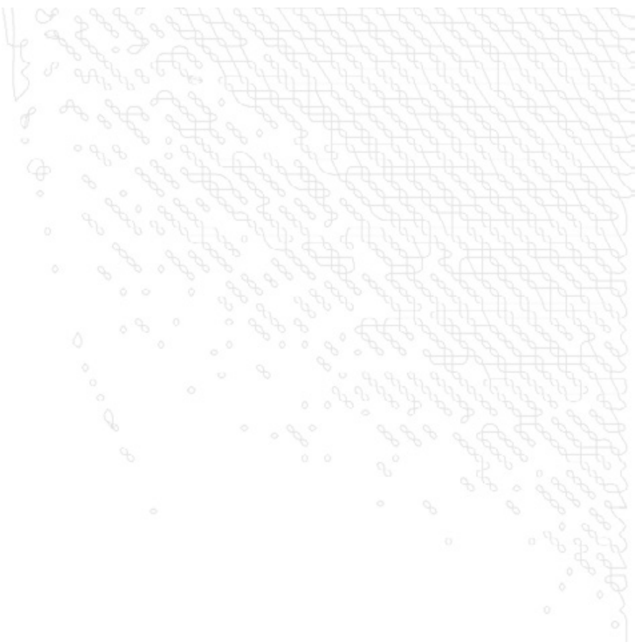
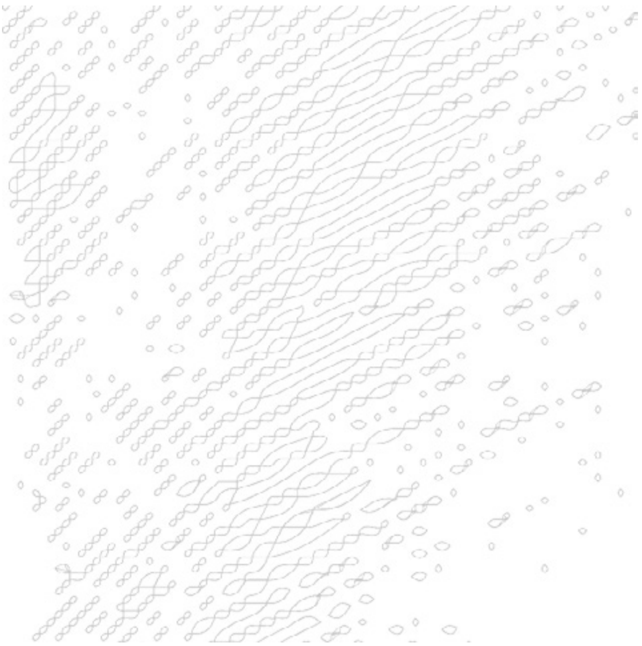




Initial thoughts: building a social movement to transform institutional racism

Dr Heather Came, Claire Doole - Auckland University of Technology
Dr Nicole Coupe - Kereru Research, Development and Education
Trevor Simpson - Health Promotion Forum

In the 1980s public servants exposed systemic institutional racism within the administration of the public sector through a series of reports, the most well-known of which being Puao te Ata tu (Ministerial Advisory Committee on a Māori Perspective on Social Welfare, 1988). The health sector had earlier drawn a line in the sand with a memo from the then Director-General of Health, Dr George Salmond (1986), requiring sector engagement with the Treaty of Waitangi. More than twenty years on, the health system continues to produce inequitable health outcomes between Māori and non-Māori (Robson and Harris, 2007), in part because of persistent institutional racism within the administration of the health system itself (Came, 2012). Last year the Public Health Association (PHA) (September 2012) passed a remit at the Annual General Meeting (AGM) committing us (the public health sector) to take action to address institutional racism within our sector. The costs of inaction are high and fundamentally incongruent with the stated values of the public health sector (Public Health Association, 2012). It is time for courage and to draw a new line in the sand - let's eliminate institutional racism within our sector by 2017.

Background

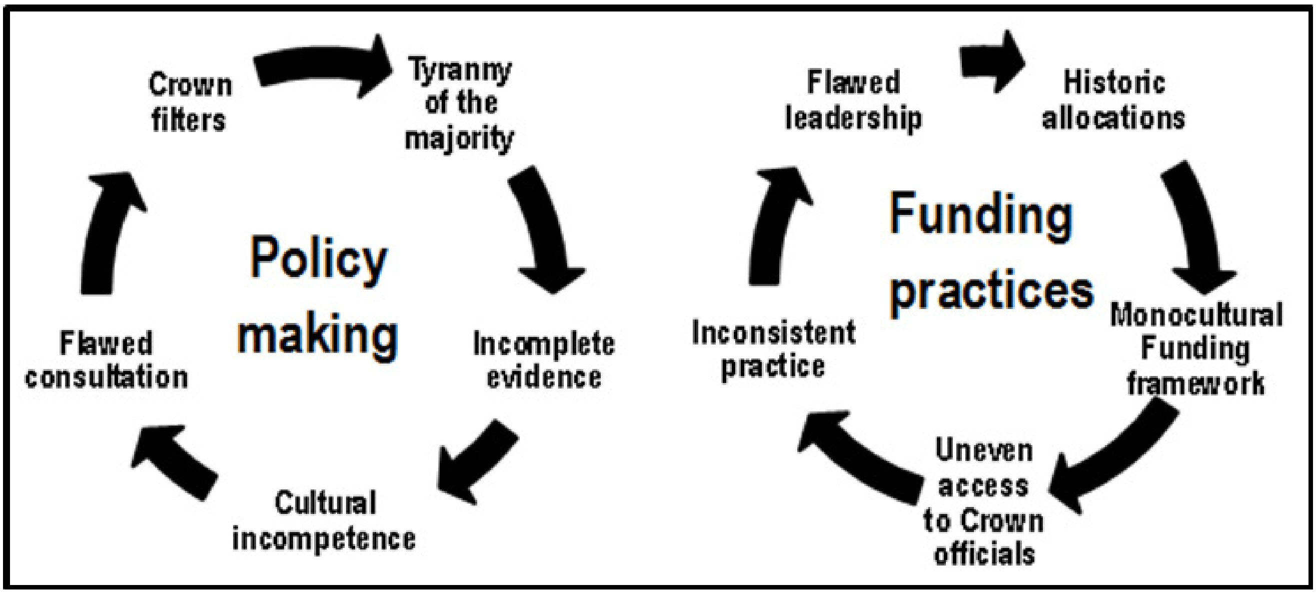
Institutional racism has been recognised by New Zealand's Ministry of Health since the 1990s. Racism has been passionately debated at public health conferences for decades. These debates have been informed by the work of Camara Jones (2010), Papaarangi Reid and Bridget Robson (2007), Ricci Harris (Harris et al., 2006), Robin Kearns, Helen Moewaka Barnes, and Tim McCreanor (2009), among others.

Institutional racism is a pattern of differential access to material resources and power determined by race, which advantages one sector of the population while disadvantaging another (Jones, 2000). It manifests within policy making, funding practices and service delivery which disadvantages Māori and other ethnic minorities, contributes to inequitable health outcomes and represents a barrier to aspirations for health equity (Sheridan et al., 2011; Signal, Martin, Cram, and Robson, 2008). Health disparities between Māori and non-Māori such as life expectancy gaps of 7.3 years are well documented (Statistics New Zealand, 2013).

Came's (2012) research provided clear evidence of how institutional racism manifests within public health policy and funding practices. The research was guided by a predominately Māori research whānau and used activist scholarship to identify ten sites of institutional racism (see figure one). Racism within policy making can be detected in the decision making processes that determine the policy agenda and what evidence is used to inform policy. It can also be revealed through deficiencies in cultural competencies and consultation process and the filters that guide Crown sign-off processes. Within funding practices, racism manifests in historical funding allocations that have not been opened up for retendering, through the utilisation of mono-cultural funding frameworks, through inconsistencies in Crown practices and health leadership that does not successfully detect or prevent racism.

Since April 2012, a group of public health practitioners have been meeting to discuss institutional racism, with a view to formally establish a Special Interest Group under the umbrella of the PHA. Current members include Nicole Coupe (Kereru Research, Evaluation and Development), Heather Came (Auckland University of Technology), Claire Doole (Auckland University of Technology), Rohan Jaduram (Human Rights Commission), Trevor Simpson (Health Promotion Forum), Tim McCreanor (Te Rōpū Whāriki), Lisa McNab (Navilluso Medical Ltd) and Ngaire Rae (Manaia primary health organisation). At this time, we are based in Kaitaia in the North through to Wellington in the South.

Figure One: Sites of institutional racism within public health policy making and funding practices. Adapted from Came, H. (2012). Institutional racism and the dynamics of privilege in public health. Unpublished doctorate, Waikato University, Hamilton, New Zealand. Retrieved from http://researchcommons.waikato.ac.nz/handle/10289/6397



Our group proposes to be the backbone of the campaign to end racism, with accountabilities to the PHA, the Māori caucus and the currently forming 'governance' whānau. The group will be a co-ordination and communication hub and hopes to establish a web presence, regular updates via the PHA e-bulletin for people to follow and contribute to the progress of the mobilisation.

To date, the group has drafted a terms of reference and has begun to passionately debate how we can achieve our bold goal of ending institutional racism by 2017. We lodged an expression of interest with the Health Research Council for funding to explore

i) how to strengthen existing efforts by Crown agencies to reduce, minimise, eliminate institutional racism and

ii) how systems theory might be a useful platform for anti-racism interventions,

but on our first attempt, we were unsuccessful. We are currently considering other avenues to advance applied research in this area to support change efforts. We have begun the process of establishing a work plan, complete with a program logic model, and are committed to evaluating this work.

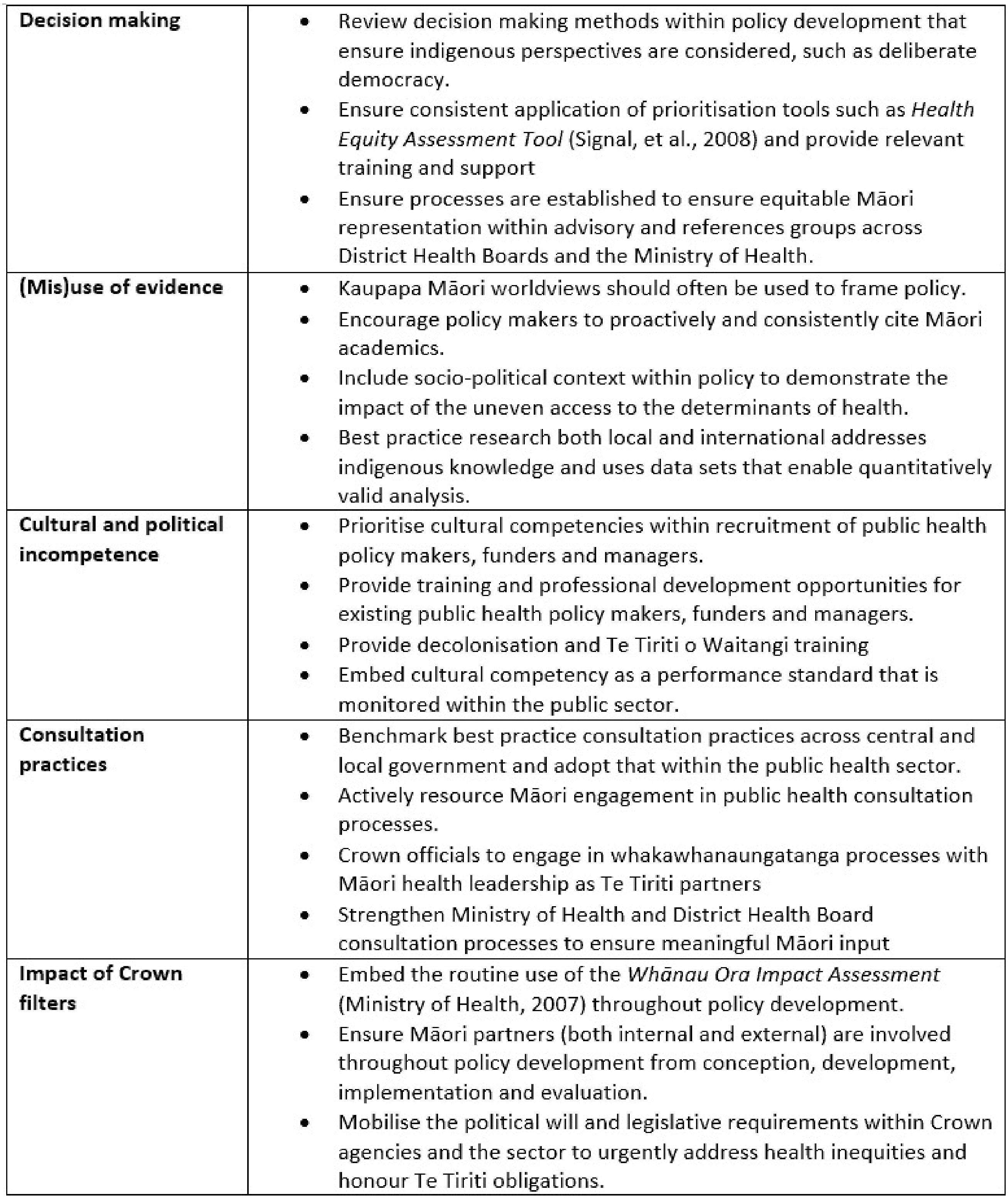
The following is our initial thoughts of what needs to be done and how we can move forward with mobilising the public health sector.

Te Tiriti o Waitangi – decolonisation

As identified in the pioneering reports from the 1980s (see Berridge et al., 1984; Herewini, Wilson, and Peri, 1985; Jackson, 1988; Ministerial Advisory Committee on a Māori Perspective on Social Welfare, 1988), institutional racism within a New Zealand context has profound colonial elements. Addressing institutional racism at a macro level thereby requires re-engagement with Te Tiriti o Waitangi, the honouring/respecting of Te Tiriti obligations and the normalisation of Te Tiriti-based practice (Health Promotion Forum, 2000). This realignment needs to occur at all levels of the public health sector and ideally will involve ongoing processes of decolonisation.

Decolonisation is both an individual and collective process of analysing the impact of colonisation, mono-culturalism and institutional racism, combined with a political commitment to take action to support indigenous sovereignty. It is about a reconfiguration of the power dynamics imposed through colonisation. Within such processes Nairn (2002, p. 203) argues, "…the descendants of the colonisers have different decolonisation tasks than the descendants of the colonised". Huygens (2007) describes decolonisation for some as an active process of reconciliation and ongoing attempts at power-sharing, for others an expression of resistance, or a commitment to healing. It is unclear at this time what this might look like within the context of the public health sector.

Table One: Recommendations for Anti-Racism Policy Actions



Decision making	• Review decision making methods within policy development that ensure indigenous perspectives are considered, such as deliberate democracy. • Ensure consistent application of prioritisation tools such as *Health Equity Assessment Tool* (Signal, et al., 2008) and provide relevant training and support • Ensure processes are established to ensure equitable Māori representation within advisory and references groups across District Health Boards and the Ministry of Health.
(Mis)use of evidence	• Kaupapa Māori worldviews should often be used to frame policy. • Encourage policy makers to proactively and consistently cite Māori academics. • Include socio-political context within policy to demonstrate the impact of the uneven access to the determinants of health. • Best practice research both local and international addresses indigenous knowledge and uses data sets that enable quantitatively valid analysis.
Cultural and political incompetence	• Prioritise cultural competencies within recruitment of public health policy makers, funders and managers. • Provide training and professional development opportunities for existing public health policy makers, funders and managers. • Provide decolonisation and Te Tiriti o Waitangi training • Embed cultural competency as a performance standard that is monitored within the public sector.
Consultation practices	• Benchmark best practice consultation practices across central and local government and adopt that within the public health sector. • Actively resource Māori engagement in public health consultation processes. • Crown officials to engage in whakawhanaungatanga processes with Māori health leadership as Te Tiriti partners • Strengthen Ministry of Health and District Health Board consultation processes to ensure meaningful Māori input
Impact of Crown filters	• Embed the routine use of the *Whānau Ora Impact Assessment* (Ministry of Health, 2007) throughout policy development. • Ensure Māori partners (both internal and external) are involved throughout policy development from conception, development, implementation and evaluation. • Mobilise the political will and legislative requirements within Crown agencies and the sector to urgently address health inequities and honour Te Tiriti obligations.

We also encourage all public servants go through regular Tiriti o Waitangi and decolonisation training.

Working with systems theory

Systems theory is an approach to change Midgley (2006) recommended, for use when dealing with 'wicked' or complex problems such as addressing institutional racism or child poverty. It is suited for situations when change needs to be sweeping and achieve sustainable transformative impact. Such approaches are familiar to the public health sector via the Ottawa Charter (World Health Organization, 1986, November), which embodies a multi-level

Table Two: Recommendations for Anti-Racism Funding Actions

Historic public health funding allocations	• Retender historical public health contracts to enable Māori providers to potentially extend their coverage of services. • Ensure both the Ministry of Health and District Health Boards actively monitor public health service delivery to Māori communities. • Establish mechanisms to ensure prioritisation policies such as the application of the *Health Equity Assessment Tool* are consistently followed.
Mono-cultural funding frameworks	• Urgently develop a kaupapa Māori public health service specification. • Reframe and reorientate existing service specifications to ensure they: - *Cite Māori academics and are inclusive of Māori worldviews* - *Include socio-political context that address the determinants of health* - *Review international best practice to ensure relevance for Māori communities*
Inconsistent practices of and access to Crown officials	• Deliberately foster relationships with Māori health providers. • Establish sector-wide funder-provider communication strategy. • Establish equitable contract terms and auditing practices that are publically available. • Ensure monitoring processes, financial reporting and compliance costs are proportional for providers. • Ensure a consistent level of flexibility is exhibited to providers during contract negotiations. • Ensure there are equitable opportunities across providers to access discretionary and one-off funding. • Promote a culture of greater transparency and consistencies around operational practice. • Publicly report the difference between funding streams to Maori communities, Maori organisations to Non-Maori
Leadership	• Consider anti-racism expertise when recruiting public health managers. • Ensure support and relevant training is available for public health leaders. • Embed addressing institutional racism within quality improvement planning and make it a key performance indicator for managers.

systems approach to affect change. Likewise, the New Zealand health systems quality assurance strategy (Ministry of Health, 2003) utilises a systems approach to quality improvement.

As part of a system-based approach, the coalition leading this work proposes to advocate for anti-racism praxis to be embedded within existing management and quality assurance. At this point we have identified an initial range of remedies to neutralise the sites of racism identified in Came's (2012) research, firstly in relation to policy making (see table one) and secondly in relation to funding practices (see table two).

Regional mobilisation: local action

Clearly this body of work cannot be achieved by a handful of people; it requires a groundswell of support from the sector and beyond. The coalition leading this work is currently collecting the names of those interested in getting involved in the campaign and has been pleased by the response and offers to date. We would like to see Public Health Association branches around the country contributing to the campaign. In order to be successful, we believe this work needs to utilise our collective networks and resources to influence decisions makers and change agents inside and outside Crown agencies.

To support regional mobilisation, work has commenced developing a resource that attempts to clarify institutional racism. It will define institutional racism and outline why it is important, how it operates, how to detect it and how to challenge it. It is hoped that a number of branches will take up the opportunity to host a training session on institutional racism to raise awareness and strengthen anti-racism capacity.

Our vision is the core coalition is the hub and a range of broadly co-ordinated activities are undertaken simultaneously across the country. For the politically inclined, a project needs to be developed to gain cross-party political support for a major campaign to eradicate institutional racism across the public sector, with a view to the forthcoming general election.

For those with international aspirations, others have suggested it is timely that we utilise the reporting mechanisms of the International Convention on the Elimination of All Forms of Racial Discrimination (United Nations, 1966) to expose the racism within our sector. Others are ready to campaign for the upsizing of the Declaration of the Rights of Indigenous Peoples (United Nations, 2007) from a declaration to a convention, so state parties are required to report in relation to it.

We have lots of ideas, lots of passion and lots of commitment and welcome your contribution to this important work. Feedback is welcome.

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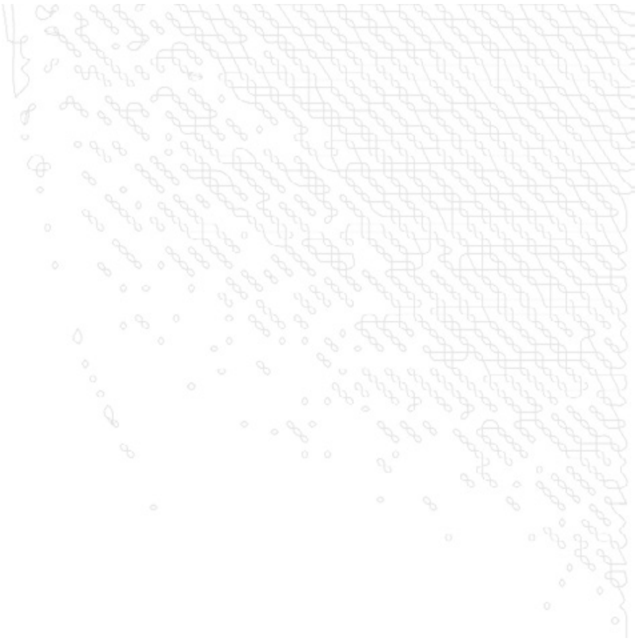
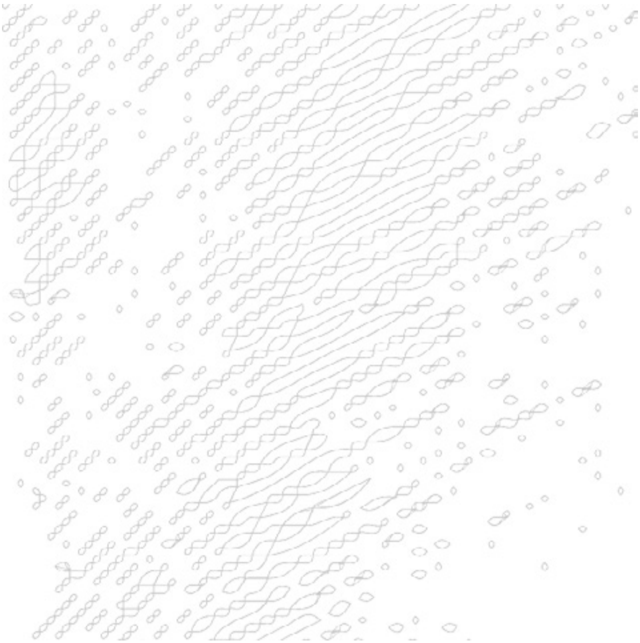




Health literacy: resource evaluation tool – ensuring that health information is clear and appropriate for its intended audience

Simon Chiaroni - Learning Media

Abstract

Health literacy is the degree to which individuals have the capacity to obtain, process and understand the basic health information and services they need to make appropriate health decisions (Kickbusch et al 2005). How can health providers be sure that their health information publications (brochures, posters, websites etc) align with the health literacy of their intended audiences and will speak clearly and appropriately to them?

In 2012 and 2013, Learning Media and the New Zealand Council for Education Research (NZCER) worked together to develop a tool for assessing such publications in relation to current international understandings about health literacy. The tool recognises that the assessment has to include the judgments of someone with expertise and experience in health information. It facilitates those judgments and provides a comprehensive report on the strengths of a publication in four areas: content, literacy challenges, design, and suitability for the intended audience. The tool can be used during new resource development as well as for reviewing existing resources.

This paper introduces the tool, gives examples of its use, and describes its development, especially the challenge of benchmarking categories from very good to poor. (Note that Learning Media was wound up as State Owned Enterprise at the end of 2013. Its Health Team and the Health Literacy: Resource Evaluation Tool are now situated within Cognition Education Ltd.)

Introduction

The Health Literacy: Resource Evaluation Tool is an interactive digital device that allows an editor of a health communications resource to assess the resource's suitability in relation to the health literacy of its intended audience. It can be used with both hard copy resources such as brochures and posters and soft copy resources such as websites and apps.

"Health literacy" can be defined as the degree to which individuals have the capacity to obtain, process and understand the basic health information and services they need to make appropriate health decisions (Kickbusch et al 2005). It is a critical consideration when developing a health communications resource, because the resource will have little impact if its intended audience cannot readily access and comprehend the information it contains.

The Health Literacy: Resource Evaluation Tool was developed by Learning Media in 2012 and 2013. Health materials Editor Vikki Cheer and Senior Analyst Simon Chiaroni worked with Charles Darr from the New Zealand Council of Educational Research throughout the development process and with business analyst Joanne Turpie to then build an Excel version of the tool.

What drove Learning Media to develop the tool? Its health team was finding that as it worked on health publications for groups within the general public, certain questions were repeatedly arising – for example:

- What are the strengths and weaknesses of this resource?
- How well will it align with the health literacy of its intended audience?
- Will it speak clearly and appropriately to them?
- What's the basis of our judgments on the resource's strengths and weaknesses?
- Would that basis be the same tomorrow with a different resource? Would it be the same for someone else looking at the same resource?

Figure 1, Page 69, is an example of the health communication resources Learning Media worked on. It will help your understanding of what follows if you take a moment to consider the above questions.

Figure 1. Lead and Lead Poisoning brochure

LEAD and LEAD POISONING

Lead and Lead Poisoning

People living in industrialised societies like New Zealand have some lead in their bodies. Lead is taken into the body through food, water and air. Most of this lead is not absorbed by the body. However, some people will develop health problems or lead poisoning if they are exposed to enough lead. If untreated, lead poisoning can be serious.

Where does lead come from?

Lead may come from a number of sources. These include old paint and some industries, for example, battery manufacture. With the removal of lead from petrol in 1996, the main source of non-occupational exposure to lead in New Zealand is lead-based paint on and around houses built before about 1970, but particularly before 1945. On many older houses, the old paint may still be in place, painted over or flaking off. When old paint is removed, the lead in it may settle in dust or soil.

Why are young children at risk of getting lead poisoning?

Infants and preschool children in contact with flaking paint or lead-contaminated dust or soil are particularly at risk of developing lead poisoning. This is because they often put into their mouths objects (such as toys or their fingers) that may be contaminated with dust or soil. Paint on old cots or old toys, such as rocking horses or blocks, could be lead-based. Young children absorb more of the lead they take in than older children and adults.

Are adults at risk?

Adults are exposed to lead by breathing it in as dust from activities such as restoring and cleaning older houses. Not washing lead-contaminated hands properly before smoking or eating may cause exposure to lead. The highest levels of lead in adults' blood occur in industrial workplaces.

The lower blood lead levels generally found in non-occupational settings may have a small effect on blood pressure; they can also be a cause of cataracts in men 60 years and over.

The early stages of lead poisoning are non-specific and affect the gastrointestinal and nervous systems. Symptoms of lead poisoning that affects the nervous system can include mood changes (such as depression or irritability), memory impairment, sleep disturbance, headaches, and tingling and numbness in fingers and hands. Symptoms of lead poisoning that affects the stomach and intestine can include lack of appetite, nausea, diarrhoea, constipation, stomach pains and weight loss. In later stages, symptoms may develop in the blood, kidneys, bones, heart and reproductive systems and may, in extreme cases, cause death.

Evidence base

Learning Media ensured a sound evidence base for the tool in two ways:

Drawing on international research and practice

The development of the tool drew on international and New Zealand research and practice in relation to the assessment of health communications materials. At the time, Learning Media's librarian, Jane Thomsen, was completing a Masters in Information Management looking at the use of health literacy tools by primary care practitioners in New Zealand. She drew on her literature review to identify relevant research into how health materials can best meet the health literacy needs of their intended audience. She also located the other major tools that were currently available for evaluating health communications materials, many of them developed by researchers.

Working with NZCER

Throughout the development of the tool, Learning Media worked with senior researcher Charles Darr at the NZCER to review the approaches they were using to develop the tool, to analyse findings and results, and to solve the various problems that arose.

Development process

At the start of the project, Learning Media listed its aims for the tool as:

- to establish shared understandings of effective processes for evaluating the health literacy demands of health resources
- to capture editors' professional knowledge and expertise in a formalised, rigorous process available for others to learn and use
- to use an evidence-based approach, underpinned by what is known from research about health literacy evaluation, tested and refined via trialling, and challenged and improved by research experts
- to develop credible evaluation processes that will give providers of health information confidence that the literacy demands of their resources are appropriate for the target audiences
- to build a framework and tool that both supports editors to work through the evaluation process and provides a record of the results.

In order to achieve these aims, the project team agreed on a six-phase process for developing the tool:

A. Develop and edit criteria
B. Create a draft hard-copy version of the tool incorporating the criteria
C. Trial, refine and finalise the tool and its criteria
D. Establish benchmarks
E. Design and build an e-version of the tool
F. Write up the evidence base, the development process for the tool, and instructions for users.

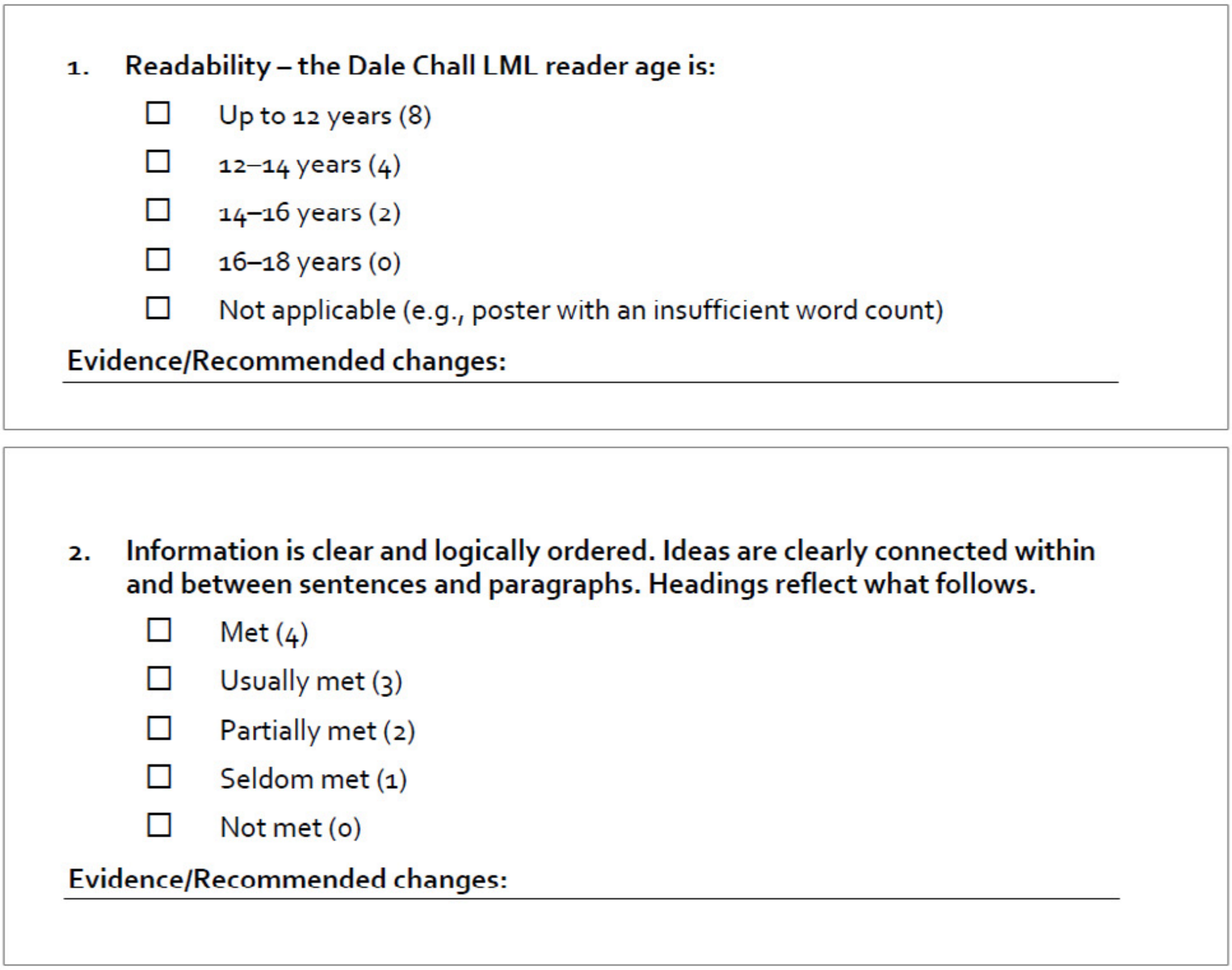
A. Developing and editing criteria

As noted above, the tool's developers reviewed the research into health materials meeting the health literacy needs of their intended audience, and they examined the other major tools available for evaluating health communications materials. The references provide the full details of these tools. They included the Expanded Evidence-based and Quality Information for Psychiatrists (EQUIP) scale (2008), Suitability Assessment of Materials (SAM) assessments (2008), the Discern handbook and instrument (1999), New Zealand's Rauemi Atawhai (2012), and a range of guidelines, particularly from Harvard University.

The project team used the review to identify the factors that are consistently identified as key considerations in health communications materials. They then spent considerable time writing and editing criteria for the new tool. They saw this as a key task, because they knew that the rigour, distinctiveness, and clarity of the criteria would determine the effectiveness of the tool. For example, they knew that the tool would score a resource in relation to the criteria; this meant that, for appropriate weighting and balance, they needed to delete some incidental criteria and combine or split others.

The team also explored a range of options for grouping the criteria. They recognised that there were a number of valid options for doing so, but decided to group the criteria under four dimensions, each incorporating 6–8 items/questions that embodied the criteria.

Figure 2. Excerpt from the Literacy Challenges dimension of the tool



1. **Readability – the Dale Chall LML reader age is:**
   - ☐ Up to 12 years (8)
   - ☐ 12–14 years (4)
   - ☐ 14–16 years (2)
   - ☐ 16–18 years (0)
   - ☐ Not applicable (e.g., poster with an insufficient word count)

Evidence/Recommended changes:

2. **Information is clear and logically ordered. Ideas are clearly connected within and between sentences and paragraphs. Headings reflect what follows.**
   - ☐ Met (4)
   - ☐ Usually met (3)
   - ☐ Partially met (2)
   - ☐ Seldom met (1)
   - ☐ Not met (0)

Evidence/Recommended changes:

The dimensions were:

- Content
- Literacy Challenges
- Design
- Suitability for the intended audience.

B. Creating a draft hard-copy version of the tool incorporating the criteria

The tool had to practically and credibly allow for the application of the criteria to a text to produce a useful measure. This stage therefore required decisions on:

- how the tool would score criteria
- how the tool could capture the rationale for decisions and judgments
- initial instructions for editors on how to use the tool.

The project team also had to find a way to integrate a Dale-Chall rating within the tool. Dale Chall is a well-established readability formula that provides a 'reading age' for a given text. It gives a useful measure of a document's difficulty in relation to sentence length and vocabulary, but like all readability formulae, it does not take account of the many other factors that affect the difficulty of a text. The following excerpt from the tool's Literacy Challenges dimension shows how Dale Chall was weighted and incorporated within the tool and how the tool scores the editor's judgments and allows them to add evidence and recommendations in relation to them.

Trialling was designed to test the rigour, distinctiveness, and clarity of the criteria and the ease of use of the tool (for example, too many criteria might make it too difficult or impractical to use.)

Four editors used the tool independently with four diverse existing health resources. They each completed an evaluation of the tool and then met with the project team to review results. The editors gave a strong endorsement of the tool, along with some suggestions for change. However, trialling provided quite a spread of results across the four editors. A retrial of the updated tool reduced this spread, but still not to what the project team considered desirable.

Discussions with NZCER helped the project team to accept that "evaluation is part art, part science" and that the spread of results reflected diversity in editorial knowledge and judgments and, at times, personal preferences (for example, around design). It was agreed that the most appropriate way to resolve such differences would be through discussion to arrive at a consensus (rather than any attempt to 'average' differing results from two or more reviewers of a resource).

At this stage, it was also agreed that it wouldn't produce a meaningful result to add or average the scores from the four dimensions of the tool (content, literacy challenges etc.) to produce a single score. Often, such an approach would disguise strengths and weaknesses in the four dimensions. Instead, it was agreed that reports should instead present a profile with the results for each dimension.

With regard to the criteria, during phase D below, NZCER conducted a Rasch analysis of the data from our use of the tool with 40 health resources. The Rasch computer program is valuable for testing the items/questions/criteria in a tool. All the results are entered and the program compares the results for each item with other results (e.g., those for similar items, for that item's section, or for the whole tool) to identify anomalies. Overall, the analysis provided a positive result, with only two small amendments required to address minor anomalies.

D. Establishing benchmarks

This was undoubtedly the most difficult stage in the tool's development. Fundamentally, it needed to address questions such as "A resource has been put through the tool and achieved the following scores: content 75%; literacy challenges 90%; design 45%; suitability for the intended audience 65%. What do these scores mean? How 'good' is the resource?"

The project team worked closely with NZCER throughout this stage, agreeing on and then working through the following process. This integrated two approaches to benchmarking, the first working from a hypothetical basis (step 6 below) and the second from an experiential basis, using a sample of health resources (step 7 below). For the second, a key part of the process was ranking the resources for each dimension, so that boundaries could be identified between categories (or degrees) of quality such as very good and satisfactory.

Step 1. Selecting a sample of resources

The health editor selected 40 resources with a spread of 'quality' across each of the four dimensions (content, literacy challenges etc). The team recognised that the larger the number, the stronger the benchmarking would be, but also the more expensive. It was agreed that forty was an acceptable number for benchmarking purposes.

Step 2. Ranking the resources for each dimension

The health editor used her professional judgment to rank the resources for each dimension. "Professional judgment" was a very important consideration throughout the tool's development. During discussions, NZCER would frequently check that results from using the tool 'felt right' and were in accord with editors' judgments. If this wasn't the case, it signified that something wasn't right, most likely with the tool.

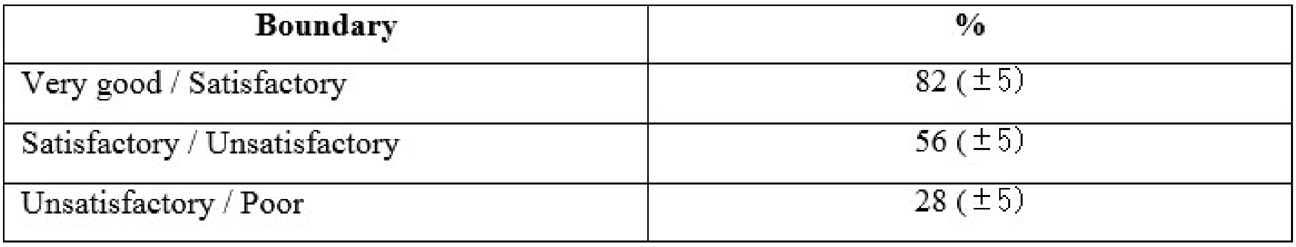
Step 3. Applying the tool to the resources and charting the data

The health editor now undertook the considerable task of putting each resource through the tool. This gave an alternative set of rankings of the resources for each dimension.

Step 4. Checking for correlation between steps 2 and 3 and deciding on a final ranking for each dimension

The correlation between the two rankings was 'fair, pointing towards good', which was acceptable to NZCER. When the project team examined the differences, it was clear that it was due to the editor's ranking in step 2 occurring too quickly. For each dimension, she had been required to rank 40 resources (corresponding to at least 160 judgments), and so, for example, hadn't read every word of every resource in doing so. Ranking using the tool (step 3)

Figure 5. Common category boundaries following benchmarking



Boundary	%
Very good / Satisfactory	82 (±5)
Satisfactory / Unsatisfactory	56 (±5)
Unsatisfactory / Poor	28 (±5)

forced her to be more thorough; for this reason, she was adamant that she had more faith in the rankings resulting from the tool.

Figure 3, page 71, shows an example of one of the graphs arrived at during step 3, the rankings for content, using the tool. As is apparent, for content, none of the 40 resources scored very low on the tool. This was similar for literacy challenges, with neither result surprising the health editor. In all her work on health resources, she has found that developers tend to get those two dimensions right more than they do "design" and "suitability for the intended audience". This is demonstrated by Figure 4, page 71, the rankings for suitability for the intended audience, where there's a much wider spread of results.

Step 5. Agreeing on categories

After discussion, the project team and NZCER decided that they should choose either three or four categories of quality. They agreed that two (for example, satisfactory and unsatisfactory) would not provide sufficient distinction and that five or more would not be feasible. They decided on four: very good, satisfactory, unsatisfactory, and poor.

Step 6. Conducting a thought experiment to identify category boundaries

With the help of NZCER, the project team conducted an extended Angoff procedure in order to define cut off points. This involved imagining 100 resources and working systematically through every item/question in the tool, hypothesising the numbers of resources that would fall into each category (very good, satisfactory etc.), given certain circumstances.

This proved to be a time-consuming but very worthwhile exercise, with the results suggesting that common boundaries were possible across the four dimensions (see Figure 5, above).

Step 7. Identifying category boundaries using tool rankings

As an alternative to step 6, the project team looked at the 40 actual resources that had been ranked in steps 2–4. Drawing on her intimate knowledge of the resources, the health editor identified the boundaries for each category in each dimension. Effectively this meant drawing vertical lines through Figures 3 and 4 (and the graphs for the other two dimensions) to show the points, for example, above which she was confident that the resources were definitely very good and below which the resources were definitely satisfactory. At times the two points co-incided, but in other instances, there were 'grey areas' with one or more resources that fell between the two categories.

Step 8. Reviewing steps 6 & 7 to establish boundaries

There was a close match between the results from steps 6 and 7. Discussion with NZCER confirmed that it was valid to establish common boundaries across the four dimensions. Given the grey areas discussed above, it was agreed that it was important to treat the boundaries as a range or band rather than as a single figure. Figure 5 shows the final boundaries, and page 2 of Appendix 1 shows how they are displayed in the Client report.

E. Designing and building an e-version of the tool

The project team expected in the long run to work with technical specialists to program and build a one-off interactive digital version of the tool. Initially, they elected to create a prototype in Excel, which is working so successfully that it may not prove necessary to program and build a one-off version.

For a given resource, the editor creates an Excel document that incorporates the tool. The editor

Figure 3. Rankings for Content

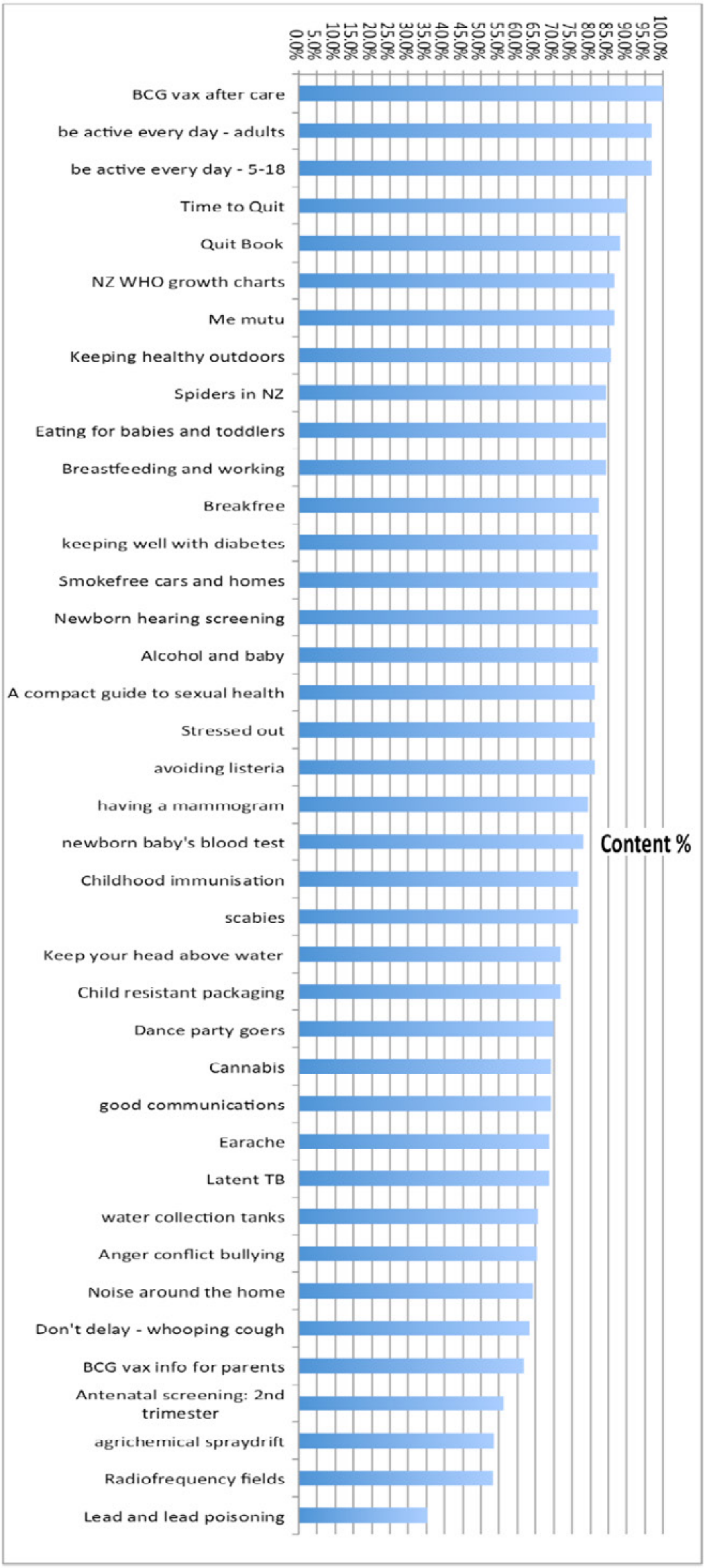
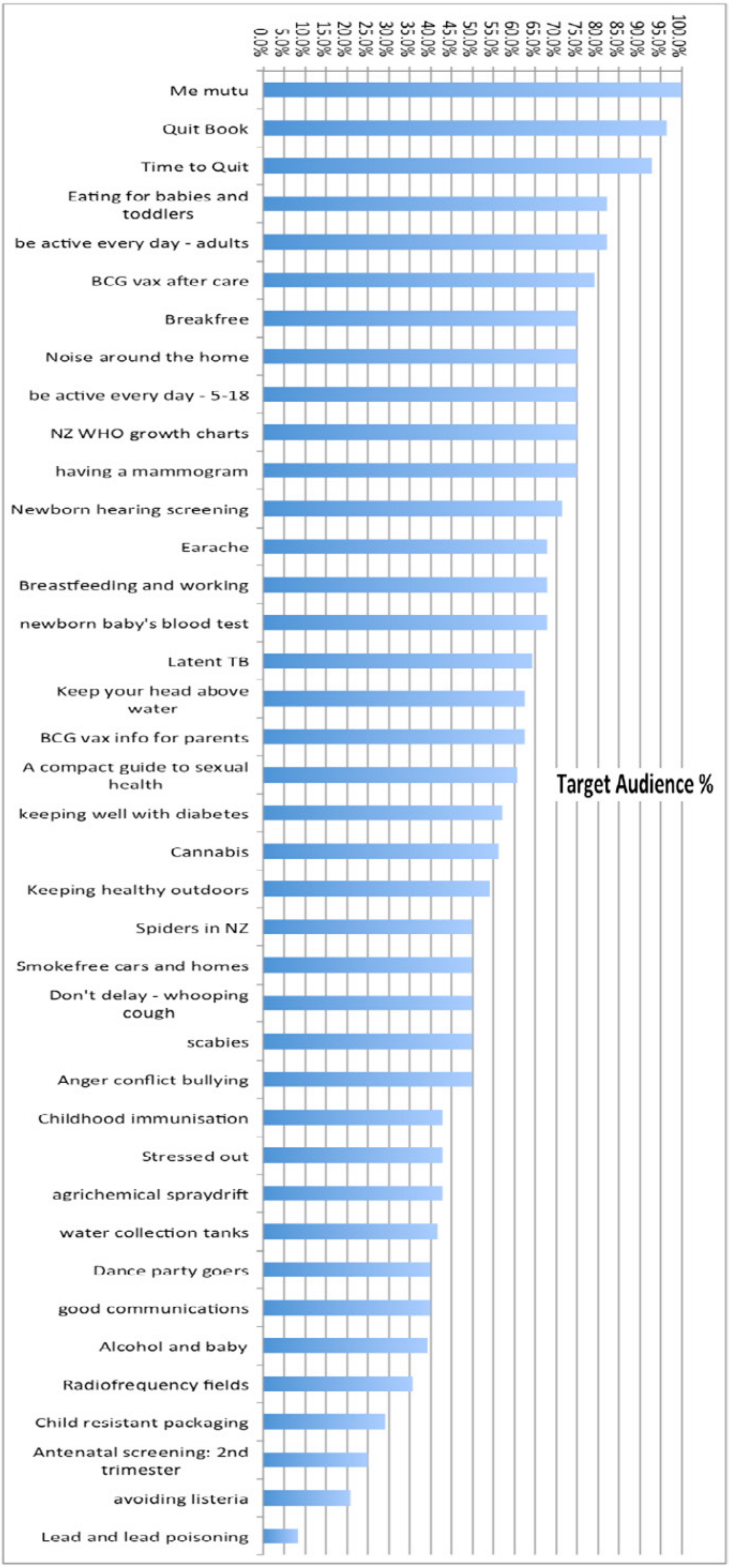


Figure 4. Rankings for Suitability for the intended audience



then works through the questions and items in each dimension, inputting their judgments and including their evidence and recommendations for change. The tool then automatically 'scores' the resource and produces a comprehensive report for the editor's records and a summary report for the client.

F. Writing up the evidence base, the development process, and instructions for users

This paper serves in part as the write up of the evidence base and development process, supplemented by the comprehensive records that the project team has kept throughout the development of the tool.

The Excel version of the tool incorporates detailed instructions for new users of the tool. Also available are annotated examples of resources at each category of each dimension, as a further guide for users of the tool (i.e., annotated examples of Very good Content, Satisfactory Content, Unsatisfactory Content, Poor Content, Very good Design, Satisfactory Design etc).

Conclusion

At the outset of the development of the Health Literacy: Resource Evaluation Tool, the project team explored whether it would be possible to develop a program or app that would automatically assess the suitability of a health information resource.

It quickly became apparent that it would not be possible to develop such a tool. An assessment has to include the judgments of someone with expertise and experience in health information. However, it is possible to develop an evidence-based tool that facilitates those judgments and ensures they are comprehensive and underpinned by research into health literacy.

The project team believes that it has successfully created such a tool. The Health Literacy: Resource Evaluation Tool captures editors' professional knowledge and expertise in a formalised, rigorous process available for others to learn and use, and it gives providers of health information confidence that the literacy demands of their resources are appropriate for the intended audiences. The tool can be used both when reviewing existing resources and when developing new ones.

The collaboration with NZCER was challenging but highly productive, and they too are confident in the final outcomes. Charles Darr, Manager Assessment Design and Reporting says:

> ***"NZCER believes that Learning Media have worked systematically to develop a robust tool to assess and categorise the quality of health literacy resources. We believe processes were applied appropriately to develop benchmark scores and that the tool provides a valid approach to classifying resources according to their quality as health literacy resources."***

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New wāhine / whānau-centred service model for reducing inequalities in population screening

Jenny Clawston - Hawkes Bay District Health Board

Achieving equality in breast and cervical screening has been the main focus for the Hawke's Bay DHB. Screening coverage in Hawke's Bay has been steadily improving, with national screening targets achieved for all population groups- with the exception of Māori. In June 2012, Hawke's Bay's breast screening coverage for Māori sat at 60.2% and 71.7% for cervical screening. The BreastScreen Aotearoa (BSA) target is 70% and for the National Cervical Screening Programme (NCSP) it is 80%.

Hawke's Bay DHB realised it needed to do something about improving engagement with wāhine Māori to address inequalities in screening coverage. In 2011, the Hawke's Bay DHB Population Screening Team conducted a survey of three hundred and five wāhine Māori to understand the needs of wāhine Māori when accessing cervical screening services. The survey findings indicated that wāhine want a range of services options - nurse smear takers, after hours services and outreach services performed in community settings such as in the home, workplace or marae. Tailoring services appropriate to wāhine Māori was the basis of the service model redesign.

The new service model was introduced in July 2012, with five Hauora providers contracted to provide breast and cervical screening support to services. Because the providers are based in Wairoa, Napier, Hastings (x2) and Waipukurau, greater geographical service coverage is provided for wāhine across Hawke's Bay. Hauora providers have strong relationships and links with the whānau they work with and are able to provide whānau-centred, whānau ora, holistic care. This means they have a greater impact on achieving positive health outcomes for whānau.

Services delivered under the contract are to support Māori and Pacific women and unscreened and under screened women to BSA mammography, assessment and treatment and NCSP smear taking and colposcopy.

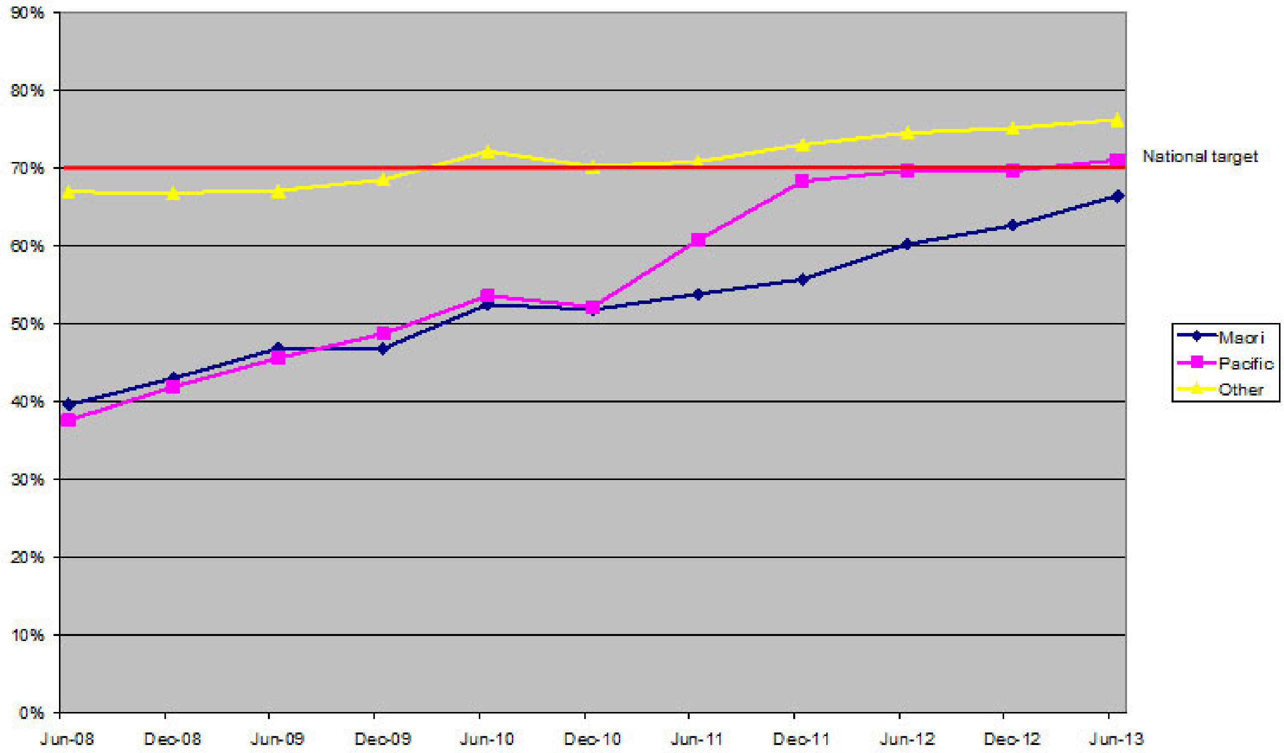
The contracts are based on a fee for service, with incentive payments for achieving targets. This arrangement would not be financially viable for providers without funder support to integrate the breast and cervical screening contract with mobile primary nursing and whānau ora contracts. It is a matter of breaking down contract silos. In order to do this, Hauora providers need to reorganise priorities and schedules to meet other contractual obligations such as auahi kore, immunisation, diabetes checks, cardiovascular disease assessments etc. as well as breast and cervical screening support services.

At the commencement of the contract term, Hauora provider staff, including managers, nurse smear takers, community support workers and administration staff attended orientation on the NCSP and BreastScreen Aotearoa Programme, learning about the screening pathways and visiting the Hawke's Bay DHB colposcopy service at Villa four and Hawke's Bay Radiology at Royston to learn about the procedures and to meet staff. The orientation set out the expectations of the contract regarding supporting wahine Māori to attend breast and cervical screening services.

Under the contract service specifications, there is a strong emphasis on collaboration and working in partnership with population screening stakeholders, including Hawke's Bay DHB Population Screening Team and the Colposcopy Service, Health Hawke's Bay primary health organisation, general practices, Hawke's Bay Radiology and BreastScreen Coast to Coast. Regular meetings are held with stakeholders and each Hauora provider participates in joint planning and implementation of recruitment and retention strategies.

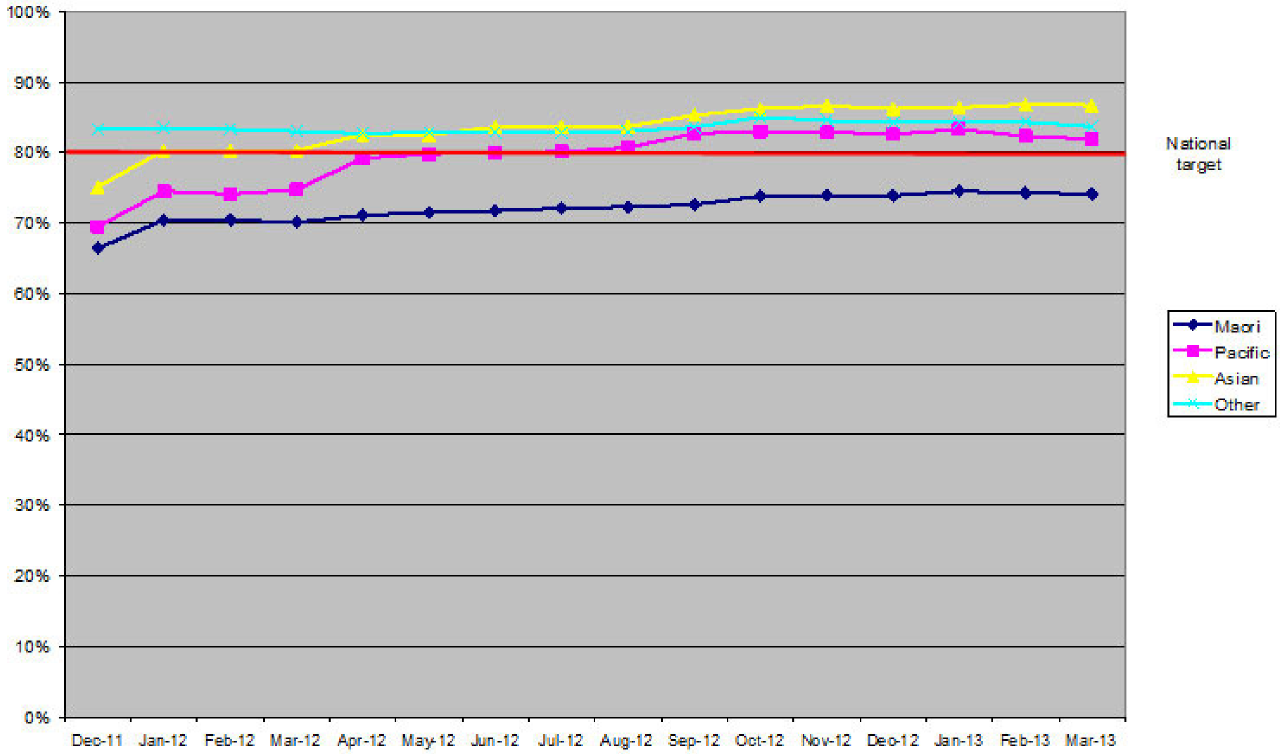
During the past year, joint ventures targeting wāhine Māori have been held with associated health promotion activities and smear clinics. Some of these promotional events have been held at supermarkets, Waitangi Day celebrations, food processing plants and fruit packers, where large numbers of wāhine Māori are employed.

Figure 1. Hawke's Bay DHB BSA 24 month coverage for women aged 50-69 by ethnicity



Source: National Screening Unit

Figure 2. Hawke's Bay DHB NCSP 36 month coverage for women aged 25-69 by ethnicity (hysterectomy adjusted)

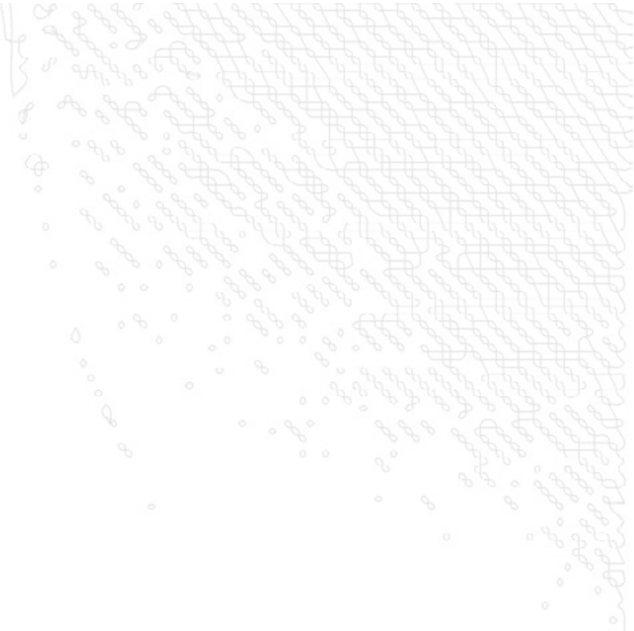


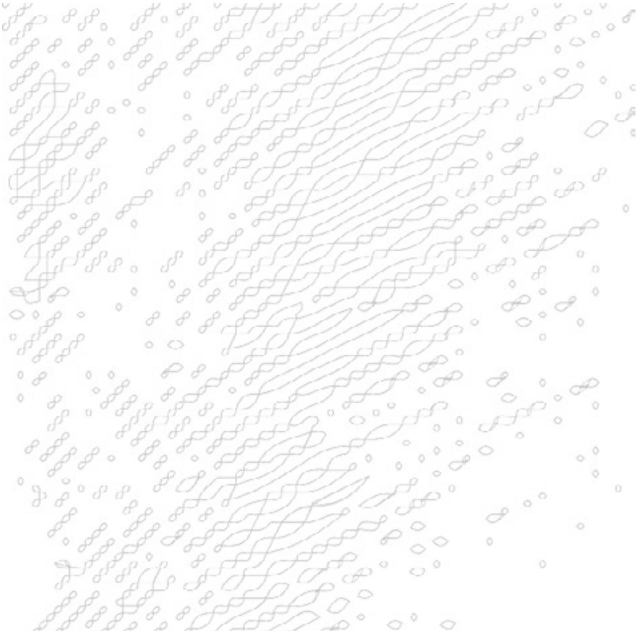
Source: National Screening Unit

Hauora providers have developed working relationships with general practices, contacting their enrolled Māori patients who are unscreened or overdue for screening and supporting them to attend screening. This has benefitted general practices by improving achievement of their primary health organisation primary performance targets.

In the twelve months to June 2013, actual volumes delivered by Hauora providers exceeded the National Screening Unit contracted volumes. 950% more women were supported to mammography, 194% more women had cervical smears tests performed, and 173% more women were supported to colposcopy.

Figures one and two, page 78, show the overall screening coverage rates for Hawke's Bay women.





Healthy homes through Whānau Ora

Melanie Dalziel - Manaia Primary Healthcare Organisation

Introduction

Northland, New Zealand is a unique and diverse region with its ethnicity population being made up from predominately 24% Māori in the Far North and 65% New Zealand European in the urban centres (Whangarei), with 11% being other (Northland Primary Healthcare Organisation data, 2012).

There are two Primary Healthcare Organisations in Northland. Manaia Health Primary Healthcare Organisation, based in the Whangarei area and providing primary health care services and support to general practices within and around the outskirts of Whangarei, and Te Tai Tokerau PHO, which is based in Kaitaia and Kerikeri and delivers services to the Mid to Far North region. The geographical health needs of Northland range from Decile 4-10 (ranking system to determine high to low health needs, 10 being the highest with 1 being the lowest) and has an overall enrolled General Practice population of 154,721 people.

Northland, like many other regions within New Zealand, has been working towards addressing housing inequalities and acknowledges that of the 270,000 children in poverty in New Zealand, over 70% live in rental accommodation, 20% in state housing and 50% in private rental (Ministry of Social Development, 2013).

Solution for Northland

One of the solutions for addressing cold, damp homes in Northland has been insulating (providing polyester insulation) homes. This service was provided by Healthy Homes Tai Tokerau. Healthy Homes was established in 2008 with the intent to insulate (retrofit) five thousand homes in Northland over a five year period. Initially, the service was only available to full paying customers or through a Government subsidy. Leading on from this initiative was the realisation that although homes in Northland were being insulated, the largest individual contributions in hospitalisations for medical conditions in children (zero to sixteen years) included acute bronchiolitis, asthma and upper respiratory tract infections. These facts were confirmed with an analysis undertaken in 2012, confirming that two thousand and five hundred children (zero to sixteen years) were admitted to Whangarei Hospital with respiratory related health conditions.

It was also identified that a significant proportion of these admissions could have been reduced through improved quality housing. No children from New Zealand Decile 1 (most privileged) were admitted to the children's ward at Whangarei Hospital in the three months of May to July 2012, whereas 75% of admissions were children from New Zealand Decile 7-10 areas within Northland (Northland DHB, 2012).

To support the existing Healthy Homes Programme, and as a strategy to reduce the number of children (zero to sixteen years) presenting with respiratory related admissions to secondary based services in Northland (Whangarei Hospital), was the development of the Regional Health Coordinator, Healthy Homes position.

Planning of the Health Referral Pathway

Planning of the health referral pathway through Healthy Homes needed to be creative, innovative and at times provocative, asking the right questions including, whose responsibility is it to support a healthy home for whānau? Does the responsibility lay with health promoters, or is this an opportunity for others, including nurses, doctors, teachers and social workers to step up as part of initiating and supporting change? Could the service be holistic, therefore using a "Whānau Ora" model of service delivery?

The programme also needed to ensure that it would be targeting the appropriate population, families residing with Decile 7 to 10 socio economic areas within Northland. The programme needed to be able to work within the confines of the existing criteria which included:

- House must have been built prior to the 1st January 2000.
- Client must have or be eligible for a

Community Services Card.
- Client must have a health condition (respiratory condition).
- Client must be the homeowner, or have the permission by their landlord to have the house insulated and the landlord be willing to make a one off financial contribution of $500.00.

Unfortunately, if whānau/families did not meet the criteria they would not qualify for the programme.

The main questions asked were, was the service intending to be more than just home insulation? Was the programme also a vehicle to encourage families to become empowered, gain rangatiritanga and strive to identify whānau/families aspirations? If so, how would the role of the Regional Health Coordinator, Healthy Homes enable this to occur?

Other questions raised in the planning process included:

- What existing services were already available in communities in Northland
- The referral pathway needed to be accessible for whānau/families to access- what were some of the possible barriers for whānau/families
- The referral needed to be user friendly, not time consuming for health practitioners and other possible referring agencies
- Who were going to be referrers to the programme, were relationships required to be developed with Primary and Secondary services, Māori health providers, Social services, Education, Childcare providers and Real Estate Agencies? Real Estate Agencies would play an important role in identifying whānau/families living in rental properties that could benefit from the programme.

The success of the referral pathway would depend upon partnership and collaboration, with the service providers being Healthy Homes Tai Tokerau and other agencies and services.

Outline of the Health Referral Programme

The Health Referral Programme would include a user friendly referral form that referrers would complete, an information sheet for both the client and the referrer clearly explaining the referral pathway, and other relevant information about the programme. Engagement with the whānau/family would be undertaken by the Regional Health Coordinator. This would enable discussions to occur and other support systems to be identified, with the intent to support the whānau/family to create a holistically healthier home.

The programme itself includes insulation of the house (under floor, ceilings, wrapping of the hot water cylinder and lagging of the pipes to the hot water cylinder, ground matting and draught stopping). The programme would also enable a “Whānau Ora” perspective to be taken. What this would mean is that referrals to other services outside of insulation could be arranged through the discussion with the client and their whānau/family. An example of this: if a child has been recently diagnosed by their Medical Physician for asthma and an active asthma plan had not been developed for this child, a referral could be sent to the Asthma Society to have a Registered Nurse visit the whānau/family and develop a plan for the child. This is what would make this programme different to others operating nationally.

Evidence that the programme was making a difference

During the later part of 2012 a satisfaction survey was provided to clients of the service. The survey looked at areas of the programme including:

- Satisfaction of engagement with the Regional Health Coordinator
- Culturally safe and responsive to Whānau/family needs
- Informed of process
- Workmanship by providers (installers)
- Overall satisfaction of the programme

The methodology used was to randomly select one hundred and ten clients that had taken part in the programme, this enabled a geographical representation of clients to be included in the survey. A total number of forty (36.6%) of the surveys were returned, however five of the forty returned uncompleted due to various reasons. From the (36.6%) completed returned surveys, clients were extremely satisfied with the programme, and the service that they received. Comments also included that clients had wished they had known about the programme earlier, and that they were going to share their experience about the programme with others, including their friends and family, and those that could also potentially benefit from the programme.

The results from the survey provided sufficient evidence that the programme was working and that it was meeting the needs of Whānau/families in Northland. The success of the 2012 programme included seven hundred referrals being received into the programme, with over 50% of the referrals being accepted. The remaining 50% that were not accepted were declined due to clients not having a Community Services Card, residing in a Housing New Zealand home, not completing and returning paperwork, or had in fact already had their house insulated.

Referrals were received from all of Northland with the majority being from the Whangarei and Kaipara area. The referral rate from these communities was due to the programme being newly introduced into these communities. Main health reasons for referrals included asthma, bronchiolitis, skin infections, rheumatic fever/strep A and chronic obstructive pulmonary disease.

Ethnicity breakdown of referrals received

- Māori 54%
- NZ European 40%
- Pacifica 3%
- Other 2%

Labour Party Policy - Budget 2013: Warm Up New Zealand: Healthy Homes, confirmed that government would be investing in a new three year insulation programme delivering warmer, drier and healthier homes to communities most in need. The allocation of $100 million of operating funds over three years to the Warm Up New Zealand: Healthy Homes programme targeted low-income households for home insulation, particularly those families with children and high health needs.

Warmer, drier homes provide real benefits to New Zealanders. As well as energy efficiency gains, insulating homes reduces health risks caused by cold, damp housing such as respiratory illnesses and serious diseases like rheumatic fever (www.eeca.govt.nz, 2013).

What this meant was that the programme would be guaranteed to continue for the next three years in Northland. However, only health referrals would be accepted for the programme. Along with meeting the previously outlined criteria, this would mean that all health referrals would need to be sent to the Regional Health Coordinator for follow up and approval prior to being sent on to the service provider Healthy Homes Tai Tokerau for processing.

Conclusion

Referring means more than just accepting and processing paperwork, it means engagement with your stakeholders, partners and families, and communities. You cannot build a relationship with your stakeholders, partners and families through phone calls alone; you need to be actively engaged face to face with everyone. This ensures that consistency in your messages is being relayed and questions that are raised are able to be answered.

Relationships are fundamental to success. How can you achieve anything without successful relationships?

Being innovative can be rewarding. Thinking outside the square, we have all heard of this phrase but how do we do this, or even consider thinking outside what the normal day to day practice is? Review/discuss/consult/review and implement are all part of innovation and quality. And yes, innovation can definitely be rewarding, not only for yourself but for the people that you are supporting.

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Exploring the knowledge interface: partnership in a Taranaki Māori community health research programme.

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Dr David Craig - National Centre for Lifecourse Research
Dr Moana Theodore, Dr Richie Poulton - Dunedin Multidisciplinary Health & Development Research Unit
Hinerangi Korewha, Aroaro Tamati -Te Kopae Piripono Whānau
Erana Hond-Flavell - Ministry of Education
Dr Mihi Ratima - Taumata Associates

Introduction

Te Pou Tiringa Incorporated and the National Centre for Lifecourse Research (NCLR) have developed a formal partnership relationship in order to conduct a long-term research programme. The first project in the planned research programme has been funded by the Health Research Council of New Zealand and will start in early 2014. The second project has received provisional approval for funding from an education sector organisation and is also due to commence in early 2014. It is intended that the research programme will be positioned at the interface between mātauranga Māori and Western Science.

The interface approach is a developing area and there is little published work. Te Pou Tiringa and the NCLR are working together to clarify and articulate the interface approach as it relates to the research partnership. Our initial thinking around what, in terms of our research programme, constitutes an interface approach is being prepared for submission to He Pukenga Kōrero (Massey University Journal of Māori Studies). The current paper arises out of a workshop run at this conference. The workshop provided an overview of the research partners and the proposed research, located indigenous knowledge/ mātauranga Māori in relation to an interface approach and discussed the value of an interface approach and its importance in research partnerships between Māori community and Western academic institutions.

Te Pou Tiringa

Te Pou Tiringa is the governance body for Te Kōpae Piripono, a Taranaki Māori early childhood and whānau development initiative that is committed to the cultural integrity and wellbeing of Taranaki Māori. Te Kōpae was established in 1994 as early childhood education (ECE). This structure enabled self-management, secure funding and work on the range of envisaged activities (Hond 2013). Te Whāriki, the Ministry of Education's early childhood curriculum policy statement (Ministry of Education 1996) is deliberately all-embracing, enabling both whānau development activity and also the expression of Māori understandings of child development.

The name, Te Kōpae Piripono, expresses concepts fundamental to the organisation. Kōpae is the Taranaki word for kōhanga (nest) and this reflects a parallel association with the Kōhanga Reo principles of reo and tikanga revitalisation among whānau. Piripono refers to the high level of commitment required from all of those involved to build a robust and functional collective (Tamati, Hond-Flavell, Korewha 2008). Since its establishment, whānau development has been at the core of Te Kōpae Piripono's activities. The underpinning purpose, however, is to respond to the ongoing and devastating impacts of social and cultural historical trauma experienced by Taranaki Māori communities and contribute to efforts to restore cultural integrity, social cohesion and wellbeing (Tamati, Hond-Flavell, Korewha 2008). While Māori language, culture and immersion education have been key factors influencing whānau to enrol their children in the centre (Te Kōpae is one of the few ECEs that strictly maintain a 100% reo Māori immersion environment), its priority is whānau development (Hond 2013).

Te Kōpae was recognised by the Ministry of Education in 2008 when it was designated as a 'Centre of Innovation' (CoI) and funded to carry out research to explore '…how whānau development fostered leadership across all levels, and enhanced…fulfilled lives for Māori children and their families" (Tamati, Hond-Flavell, Korewha 2008).

The Pou Tiringa team is led by the Kōpae Directors, Hinerangi Korewha and Aroaro Tamati. They were part of the Kōpae establishment group. The team includes parents, teachers and governance board members with expertise in education, Māori health, kaupapa Māori research and an interface approach, Taranaki reo and tikanga and Māori development. As well, Te Pou Tiringa brings to the partnership access to the community, a high level of credibility locally and knowledge of the lived realities of the community.

National Centre for Lifecourse Research

The institutional research partner is the University of Otago National Centre for Lifecourse Research (NCLR). NCLR undertakes and applies lifecourse research that informs policy and practice (http://www.nclr.org.nz/). It is an umbrella organisation for research collaborations between six universities and a Crown Research Institute. Two of the University of Otago internal partners are the Dunedin Multidisciplinary Health and Development Research Unit and the Christchurch Health and Development Study – which conduct the two most longstanding longitudinal research studies in New Zealand. Lifecourse research carried out by NCLR falls into two main categories. First, etiological development research to inform policy and practice, that is, studies that examine factors from early life that impact on long term outcomes. Second, intervention research.

The NCLR team is led by Professor Richie Poulton and its two other members are a senior academic and a research fellow who is the recipient of an HRC Māori health postdoctoral fellowship. The university partner brings infrastructure, resources and expertise to the partnership.

Motivation for the research

The seed for the partnership was sown in discussions between Aroaro Tamati (Te Kōpae Co-Director) and Richie Poulton (NCLR Co-Director) who served together on the Ministerial Taskforce on Early Childhood Education in 2010-2011. Together they saw the potential for a mutually beneficial partnership that could further each of their organisation's aspirations while leveraging off their collective strengths.

Te Kōpae had for some time recognised the need to build on findings of its CoI research. That is, to further articulate, investigate and generate evidence around its model and approaches using robust processes. Kōpae leadership also saw the potential to share the model more widely among Māori and non-Māori early childhood initiatives, particularly given the wide and enduring ethnic inequalities in outcomes experienced by Māori in Taranaki and other regions (Ratima and Jenkins, 2012).

At the same time, from an NCLR perspective, its own research and international studies had shown that influences in early life shape an individual's access to determinants of health (e.g. education, employment, wealth etc.) and health status later in life (e.g., Danese et al., 2009; Fergusson et al., 2005; Moffitt et al., 2011). It is well recognised that high quality early childhood interventions are one of the best investments a society can make to ensure an optimal start to life, with health and other benefits over the lifecourse (e.g., Aboderin et al., 2002; Heckman, 2006; Paul, 2011). Central concepts that underpin good health and prevention from a public health and prevention science perspective are concerned with early childhood behaviours, self-control being a key construct (Moffitt et al., 2011).

From a Māori perspective, concepts that relate to but are distinct from self-control are often identified as underpinning healthy development for Māori children. These concepts tend to be strengths-based, emphasise responsibility to and for others, and express a concern for reinforcing values and developing the 'character' of children. Examples of these types of concepts include manaaki (caring), awhina (support) and whānaungatanga (reinforcing relationships). As well, whānau development has long been recognised by Māori and is increasingly recognised by other groups as an appropriate vehicle for intervention to improve outcomes (King and Turia, 2002; Taskforce on Whānau Ora, 2010; Ministry of Health, 2011).

While there is clear evidence around the potential for early childhood interventions to lead to improved health and other outcomes, what is largely missing is proven interventions that address inequities and can be scaled up for wide implementation. The NCLR was looking for an early childhood intervention that, in practice, could support and reinforce those important positive behaviours among young children that had been identified in their longitudinal research. Further, its interest was in an intervention that had the potential to be scaled up for implementation in other settings to complement broader measures to address determinants of health, such as poverty. Te Kōpae provides a 'real world' kaupapa Māori child and whānau intervention, supporting and reinforcing positive behaviours among young children, and has the potential to be scaled up.

Proposed research programme

The intention is to conduct a long-term research programme to generate an evidence base around what constitutes effective intervention in the early years, to improve outcomes for children in later life. A key focus will be on the transformative power that quality early life and whānau development programming has in relation to a number of measures of health and social wellbeing. The research programme places high value on indigenous knowledge and has sought an approach to the research that would reflect that position, that is, an interface approach. It is therefore important to understand what indigenous knowledge is.

Indigenous knowledge

Indigenous knowledge has been variously labelled as 'native knowledge', 'local knowledge', 'ecological knowledge', and 'traditional knowledge'. Some of these terms, such as 'traditional knowledge' are broader, incorporating Indigenous and other types of knowledge. Generally however, these terms, rather than capturing the essence of Indigenous knowledge as a whole, describe some core aspects.

Indigenous knowledge is considered to be distinctive from other types of knowledge and harbours insights that are not yet part of 'scientific' inquiry (Nakashima, 2000). A central characteristic of Indigenous knowledge is that it is knowledge generated by Indigenous peoples. It is not only generated at the community level, but may be developed by Indigenous researchers working in a variety of contexts including academic settings (Cajete, 2000).

It is distinct from knowledge that may be generated about Indigenous peoples or their concerns by non-indigenous individuals or groups. Essentially, this distinction is concerned with the paradigm within which Indigenous knowledge is generated and that Indigenous knowledge can only be generated from within an Indigenous paradigm and therefore framed by Indigenous worldviews.

Indigenous knowledge may be local in nature in the sense that it has been generated by a particular Indigenous group, within their own unique context, with the primary purpose of benefiting Indigenous peoples themselves. There is some concern that Indigenous peoples should remain the primary beneficiaries of Indigenous knowledge, but that this does not exclude wider application and benefits for other population groups (Stewart-Harawira, 2005). Further, Indigenous knowledge should be able to be used in whatever way Indigenous peoples determine. Victoria Tauli-Corpuz (2007, p. 6), as chair of the United Nations Permanent Forum on Indigenous Issues, stated:

> If indigenous peoples choose to use their traditional knowledge to engage with local, national, international economies in a commercially viable manner, then they should be provided the tools and instruments to do this to their own benefit.

Lakota scholar Vine Deloria (1999) asserts that Indigenous conceptions of knowledge are intrinsically connected to the lives and experiences of human beings, individuals and communities. Further, Indigenous knowledge is considered to be based within real life experience (Kawagley, 1995) and to be closely connected to the relationships between human communities and the natural world, in particular seascapes and land (Durie, 2005). In contrast to Western science, Indigenous knowledge emphasises relationships and is therefore cross disciplinary, seeking connections rather than categorisation and disciplinary divisions. Royal (2005, p. 4) points out the holistic, ecological nature of Indigenous knowledge:

> …Indigenous knowledge is 'holistic' in the sense that knowledge is interconnected and relational in the same way that all life is interconnected and relational…A 'holistic' view of the world and of knowledge is not blind to parts, boundaries, borders and thresholds but rather sees these parts both as 'wholes' in themselves as well as parts of larger wholes.

While the conceptualisation of Indigenous knowledge is very much connected to the customary beliefs and values of Indigenous peoples, it is not a form of knowledge that is locked in the past. Instead, Indigenous knowledge can be generated at any time and can be applied to contemporary matters. For example, Indigenous knowledge may be applied in diverse fields such as biotechnology, pharmacology, sustainable agriculture, resource management and understanding or addressing social issues. There are risks in using terms such as 'traditional knowledge' as an umbrella term that includes Indigenous knowledge, in that it may lead to the misconception that Indigenous knowledge only concerns ancient matters and has limited relevance to modern times.

While there is no single agreed upon definition of Indigenous knowledge and there is wide diversity between Indigenous peoples, there is generally consensus about a number of characteristics. This consensus relates to similarities in the worldviews of Indigenous peoples, for example the strong emphasis on links between the physical environment and identity, and more recently to some shared experiences of colonisation that may influence knowledge generation. Common characteristics of Indigenous knowledge are that it is generated by Indigenous peoples and it is ecological, integrative and holistic in nature, rather than reductionist.

Western science at the interface

The nature of Western scientific knowledge has been closely defined and critically studied. Given that it is well documented elsewhere, it is not detailed in this paper. Leading Māori scholars including Mason Durie (2004) and Linda Tuhiwai Smith (1999) have contributed work in this area. Their work provides a foundation to build on and explore, within a specific research programme, how Western scientific constructs such as epistemology (and especially positivism, scepticism and other significant Western traditions) can be redefined in research practice, at the interface.

The tensions between hegemonic, Western science and mātauranga Māori that come from unequal power relations, the institutional power of Western knowledge, and community based knowledge and language systems are already becoming clearer as we engage in the research.

Realising the value of an interface approach

We are currently developing our version of an interface approach to this research. Our work on the interface approach has been undertaken by the research team through a combination of face-to-face wānanga, Skype workshops and directed reading and draws on the PhD and postdoctoral work of Dr Will Edwards, who is a member of the Pou Tiringa part of our team. We recognise that at the philosophical level there are inherent differences between a mātauranga Māori (i.e. a localised form of indigenous knowledge) and Western scientific approach to research. Our view is that we accept some of the philosophical differences between Western science and mātauranga Māori and negotiate those differences at the practical, localised and applied level. In this way we draw on both knowledge systems in order to enable us to generate credible and relevant evidence to inform intervention and thereby positive transformation for communities.

It is intended that the interface approach will relocate tensions from the philosophical level to the kaupapa rangahau – methodological level. The assumption is that both knowledge systems are equally credible and relevant to disciplined inquiry in the contemporary context. The approach will leverage the strengths of both Western science and mātauranga Māori, reflecting the lived realities of Māori who move between Te Ao Māori and Te Ao Whānui. The interface approach facilitates the generation of new knowledge, which is sourced from both knowledge systems and is applicable to current situations by Māori and non-Māori. The approach may enable researchers to draw on the best of both knowledge traditions.

Consistent with the themes of this conference, the interface approach facilitates research and evaluation activities that build credible and relevant evidence to enhance public health for all of Aotearoa/New Zealand. Māori live in both worlds and this should be reflected in research. From a Māori perspective, the evidence is credible in that it is generated from within a Māori worldview, using processes that fit with Māori expectations and is guided by culturally competent researchers.

The evidence is relevant in the sense that research at the interface specifically seeks to address Māori community identified priority areas and enables research to reflect the contemporary lived realities of those in the community that we are ultimately aiming to serve. Also, knowledge translation utilises mechanisms that are culturally Māori. For example, research findings may be codified into waiata, haka, karakia and whakatauāki. Therefore, Māori narratives, constructs, terminology and language are utilised in such a way as to enable knowledge translation within the day-to-day lives of whānau. From a Western science perspective, likewise evidence generated is credible and relevant in the sense that the research processes meet Western scientific standards.

Research partnerships and the interface approach

Research relationships between Māori communities and Western academic institutions have tended to be sites of major power imbalances, where Māori involvement has often been limited to the role of research participant. Increasingly, Māori community expectations have grown and this has been reflected in the emergence of kaupapa Māori research and a growing number of Māori academics located both within universities and Māori community research bodies. In other spheres such as local government, work has been undertaken to decipher how partnership can be articulated and implemented (Craig and Courtney, 2004). In the academic domain, a natural progression has been the expectation that all institutions will create space for mātauranga Māori. That is, that there will be meaningful research partnerships with Māori that draw on mātauranga Māori and Western science simultaneously – the interface approach.

The interface approach is a mechanism to enable genuine research partnerships between Māori communities and Western academic institutions. Māori are engaged as equals and mātauranga Māori is valued for its potential to contribute knowledge that will advance Aotearoa/New Zealand. In combination, perspectives from mātauranga Māori and Western science enable richer insights, broader interpretations and application to a wider audience. Further, mātauranga Māori is rooted in Aotearoa/New Zealand (and in this case, in mātauranga Taranaki), and therefore is inherently centred on the generation of localised solutions to the challenges that we face. The interface approach is the obvious vehicle for robust research partnerships between Māori community and Western academic institutions.

Concluding comments

The interface approach uses a partnership model to create space for a knowledge tradition that has, for a long period of time, been marginalised. It contributes to efforts to rebalance the major inequities in power (i.e. infrastructure, access to financial resources and workforce capacity) between the two knowledge systems – mātauranga Māori and Western science. The approach claims space for the generation of knowledge that reflects the contemporary lived realities of a South Pacific nation in the 21st century and informs transformational action towards the goal of enhanced public health for all Aotearoa/New Zealand.

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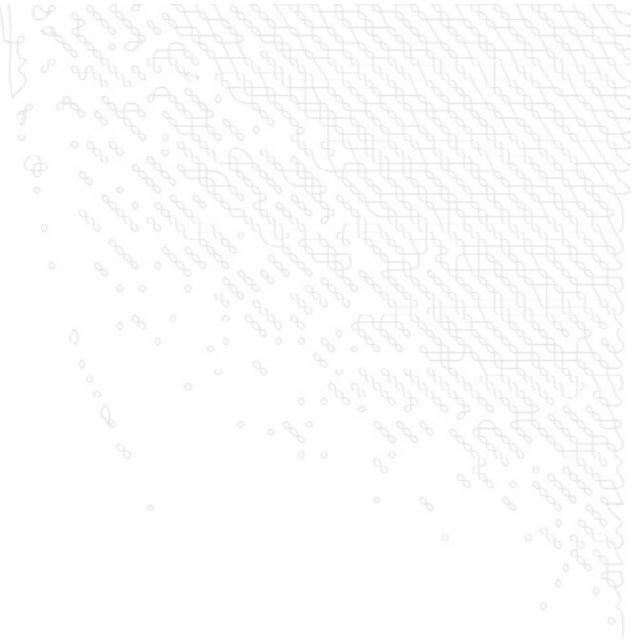

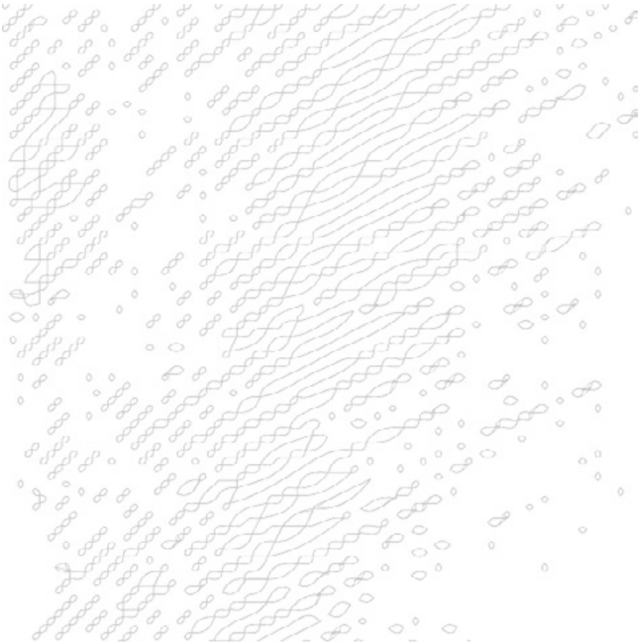

Lessons from the tobacco industry: what problem gambling services can learn and next steps for public health

Sara Epperson - Problem Gambling Foundation

"Interests of the tobacco industry are fundamentally incompatible with the interests of public health." No other quote stood out as starkly in Dr Ruth Malone's presentation on her research with the Centre for Tobacco Control Research and Education (2012). Although there are differences between the problem gambling field and tobacco control, the similarities between the two are plain—and if considered in the context outlined by Dr Malone, then public health work in the problem gambling sector is essentially given permission to see the gambling industry as an enemy.

That statement, that candid declaration of incompatibility, opens up a world of analysis. The wealth of research she presented to demonstrate just how systemically true that statement is, over and over again, and the commonalities with the gambling industry should not be surprising. In many other facets of public health work, the similarities to industries like "big food," the infant formula industry, the oil industry, etc. are apparent.

How can public health position itself against these industries? There are plenty of possibilities. First though, it is imperative to reflect critically on the actions of the gambling industry, based on knowledge of tobacco industry strategy. Doing so may present as a long, slow call to arms—but it is party of a necessary process in an environment where public health is often told to play nice and that that is what innovation looks like. Looking critically at the industry makes room for a different position. Carefully reasoning through the ways that industry has shown that their interests are in opposition to those of public health teases out the reasons that suggest public health should perhaps not play nice. It gives us permission to organise a different game.

Product of an industry

As with tobacco harm, the spread of gambling harm is the product of an industry. Based on the materials available, the gambling industry may be as coldly calculating as tobacco and it causes a great deal of harm to the public through aggressive advertising and highly engineered products that have been designed to be addictive.

In a speech dismissing stronger gambling policy, a Member of Parliament (Wagner, 2012) disputed the effectiveness of controls by claiming that people had been gambling since caveman days, implying that gambling is natural and impractical to regulate. However, the gambling industry and its products are not "caveman gambling." Pokie machines are highly engineered (Orford, 2012)—the intent of the designers may be unclear, but the intent of the industry is. "You've got really intelligent guys focused on making technology work," researcher Natasha Dow Schüll says in her 2012 book, "and they don't think about the larger consequences… not one of these people is sitting there saying, 'How can we addict people?' They are talking about how to increase profits… [and they] insulate themselves ethically from the outcome as best they can." Industry's responsibility is to itself and its shareholders, and it is important to realise that this fundamentally interferes with its ability to act in the interests of public health.

The gambling industry will pay lip-service to the idea of "gambling responsibly," yet pokie machines are designed, using industry terminology, to keep people playing "to extinction" (Schüll, 2012). Extinction is not the limit set by the gambler beforehand—it means gambling until there is nothing left. The industry does their job well, it is why two in five regular pokie machine gamblers develop a problem at some point (Devin & Watson, 2012) and it is why about 80% of Problem Gambling Foundation clients have suicidal ideation (2013).

The industry's advertising has contributed to the growth of harm. Pokie machines gambling in particular has been rebranded as "gaming" and reframed as "play." This subtle change of words has been an effective marketing technique for Lotto (Veer, 2013) and has been a deliberate tactic for the pokie industry; these labels conceal gambling in name and nature, and conceal the harm as well. The harms are far-reaching, and the industry must be aware of that. All it takes is to peruse a few advertising images to see what gambling claims to offer—laughing blondes in front of machines ([The lurk and pop slots strategy], n.d.), men with ladies draped around their shoulders while they gamble on the pokies ([Enjoying the fun with slot machines], n.d)—relationships, financial success, confidence. Yet we know that these are rarely the fruits of gambling and instead usually the harm are relationships breakdown, financial ruin, depression (Abbott, 2001). The industry might as well market Mars bars as the new diet fad.

The gambling industry in New Zealand, especially pokie machines, has also had some clever advertising successes in associating gambling with charity. The industry has a statutory obligation to return some of the money lost in pokie machines to the public, and they have seized this as an opportunity to link themselves vehemently to the notion of philanthropy. One example of this would be after the earthquakes in Christchurch- barely days had passed, but the Department of Internal Affairs' leading site banner was already marketing gambling as a way to "raise funds for Christchurch earthquake relief," suggesting that even the regulatory body has bought in to the industry's charitable framing- positioning public health precariously against the industry and also a public institution.

Through the industry's design and promotion of its products, particularly pokie machines, we have seen a rapid expansion of gambling and gambling harm. Dr Malone (2012) likened the harms of tobacco to an "industrial-produced epidemic." The gambling industry seems to be observing the same play book.

Merchants of doubt

Using some of the best research available, we can make a compelling case for the truth about gambling harm. Meanwhile, the industry has the power to commission its own research, challenge our research, promote contradictory claims and ultimately cast enough doubt on our story to prevent meaningful change from taking hold. Our experiences echo those of the people arguing for tobacco controls so many years ago and are similar to many health promoters, whose goals are at odds with those of an industry. We are pointing to the heavens and the industry is convincing people to examine our fingertips.

Within the realm of research some institutions depend on corporate money, which can skew results or skew the framing of an issue—the latter has been a success of the gambling industry (Adams, 2004). There are many examples of research that pathologise gambling, distracting from factors such as design and availability. When gambling problems are seen as a pathology, a small and discreet group can be examined as a rarity. This misrepresents the extent of gambling harm (Borrell, 2008). Furthermore, it means gambling problems are seen as an exceptional outcome (rather than the desired outcome), and consumption of the product begins to be seen by default as "good."

Industries like the tobacco industry and gambling industry have profited from their ability to formally influence research- but the industry can just as successfully undermine public health work by discrediting science and creating doubt. Anecdotally, a lawyer speaking on behalf of the TAB has challenged the trend lines identified by researchers in peer-reviewed journals and has even gone so far as to question the legitimacy of the entire field of statistics (True, 2010). Stimulating though this discussion may be, in a Council chambers, it serves to disempower decision-makers, rendering them content with inaction. Inaction is still a success for the gambling industry.

The gambling industry also has a special knack for misrepresenting the issues. While what they present is often suspect, it is still enough to justify those opposed to gambling controls and weaken potential allies. One of the industry's favourite tactics is the red herring: the industry likes to suggest that a decrease of pokie machines will result in an increase in online gambling (for example: Lion Foundation, 2011) despite no research backing this claim (Lund, 2009 & Abbott, 2006). Conflating two separate statistics is another tactic, for instance, making a case for inaction, for the reason that nationally the decrease in pokie machines has been accompanied by an increase in help-seeking. Of course, help-seeking is mediated by many variables- but delving into this explanation is more complicated than the initial argument and the argument starts to seem too complex to take hold. Decision makers get nervous. Courage is dulled. The industry wins with inaction again.

We are the enemy

The quote from the tobacco industry about public health being an opponent will not have surprised many in public health. It should embolden the sector.

Knowing this permits thinking more critically about the way that the industry would like to engage in "public health," and whether or not public health will indulge it. Additionally, public health has the option of living up to the industry's framing and choosing to become a truly formidable threat.

One way the industry chooses to engage in public health work is to defer to the sector while stoking division and internal conflict. The tobacco industry executed this expertly, pitting a variety of solutions against each other rather than permitting them to exist as a part of a whole complex solution. The most effective way we see the gambling industry do this is through division of the non-profit sector. Many non-profits are seen as natural allies in the work that organisations like the Problem Gambling Foundation do; where these organisations accept money from pokie trusts, however, they have been pressured to speak out against measures designed to curb gambling harm (McClure, 2013). Trusts can link themselves to work being done by some non-profits, dismiss the impact of gambling harm, and entice allies to do the same. This has happened in calculated and deliberate ways.

The gambling industry, like the tobacco industry, also adores the notion of "harm reduction." It is easy to understand why health promoters might want to be a part of these efforts, where "good corporate citizens" are demonstrating "social responsibility." Before participating in these efforts though, the other side of harm reduction needs to be examined—harm production (Sinclair, 2000, as cited in Borrell 2008). The industry's harm reduction efforts centre around individuals who made a bad choice. This is in an environment where the industry truly believes they are providing "enriching experiences" (Stanley Leisure's Annual Report, 2003, as cited in Borrell 2008) knowing that no regular pokie machine gamblers become richer in the long-term, and that many report little enjoyment from their gambling (Marketing Science Centre, University of South Australia, 2000, as cited in Borrell 2008). We know that product design and proliferation diminishes the power of individual choice, but the industry refuses to take part in harm reduction strategies that involve altering machine design or reducing availability. Should public health settle for less?

The industry is sharp and unforgiving in its one-sided condemnation of problems. In a "Community Gaming Association" submission to a local council (2013), the CGA stated that those with gambling problems "exhibit a complete lack of control over their own habits and… take no responsibility for their own actions." The industry is so quick to blame the individuals for succumbing to actions the industry has provoked—but so reluctant to take responsibility for their own part in the production of harm.

The industry also tries to alienate opponents—real and perceived—and one way the gambling industry has done this with groups like the Problem Gambling Foundation is to assign labels such as the "anti-gaming lobby" or the "anti-gambling lobby." The Problem Gambling Foundation knows explicitly and contractually that this label is not appropriate. But given what is known about the industry's behaviour and the harms they produce through manipulation of design, availability and culture, it may be appropriate to accept that the industry is an enemy. When public health thinks about collaboration, it could be with the freedom to imagine what could be accomplished if the intent was to curb harm production.

Well, now what?

Looking at the industry tactics- the strategy of an enemy- can present a bleak picture. Fortunately, there is a bigger picture and in it there is real opportunity to grow public health work and invigorate its impact.

Reframe choice. The branch of the Health Promotion Agency which deals with problem gambling has developed marketing campaigns around the banner of "Choice not Chance." This slogan must be used properly. It will be easy for the industry to hijack this messaging so that the "choice" is one for individuals to make. Public health can be more assertive or even subversive with this, rightfully restoring part of the expectation around choice to Councils, Government, and of course the industry. How much longer will the conversation be dominated by problem gambling, when for many the issue is with problem machines? (Orford, 2010)

Challenge social responsibility. This shiny badge for the industry is covering up too much- an industry demonstrating true social responsibility would not market products that addict and kill. True social responsibility would be socially sustainable. True social responsibility would not condone funding so many community services with money from the least well-off and the addicted. It is crucial to remember that true social responsibility is just as much at odds with the industry as public health. When done well, both are a serious threat to profit.

Eradicate complacency. Industry's devotion to itself is no surprise. Industry is doing exactly what industry has been expected to do. But this is no time for a "boys will be boys" adage and a shrug. It is time to eradicate complacency in order to truly counter an industrial-produced epidemic. Complacency is sometimes an accident; often it becomes a part of the practical and social systems in the everyday life. Public health needs to take a closer look at these systems, and make courageous decisions about what to challenge—together.

Public health, too, may need to name an enemy.

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Switching off sunbeds: why should we care?

Barb Hegan - Cancer Society of New Zealand

In 2011, the second Melanoma summit was held. Delegates at this meeting agreed that action needed to be taken on reducing the avoidable risk of Ultra Violet Radiation (UVR) exposure from sunbeds. For action to be effective, a working group was formed. The Sunbed Action Group consisted of The Cancer Society of New Zealand, the Society's Social Behavioural Research Unit, Melnet, Melanoma Foundation and the New Zealand Dermatological Society. The call was made for regulation of sunbeds to be made a priority. This call was supported by a number of professional health associations, including the New Zealand Medical Association, Royal New Zealand College of General Practitioners, General Practice New Zealand, New Zealand Association of Plastic Surgeons, the New Zealand College of Appearance Medicine and Consumer New Zealand.

Good background work had already been undertaken by Consumer NZ, whose annual surveys of commercial sunbed operators had consistently found poor industry compliance with their voluntary code of practice.

The sunbed action group met with Hon. Simon Bridges, then Hon. Maggie Barry and subsequently Dr Paul Hutchison to find a champion within Government, to highlight the avoidable danger of sunbeds. The evidence base showing that sunbeds cause skin cancer, including melanoma, was also provided to Minister Ryall and officials. This included a meta-analysis by Boniol et al (2012) that found the risk of getting skin cancer from any sunbed use increased risk by 59%. The evidence prompted Minister Ryall to instruct Public Health Units to educate sunbed operators about their voluntary code of practice in mid-2012 and to report back to the Ministry of Health in early 2013.

The contact with key Government MPs/ministers, coupled with serendipitous announcements of total sunbed bans in some Australian states[1], resulted in Dr Hutchison placing a private members bill in the ballot in November 2012 to regulate sunbed and laser operators by amending the Health Act.

The sector welcomed Dr Hutchison's action but noted that a private member's bill, though a great personal initiative, had an uncertain outcome. Work continued by the sunbed action group, including the group writing to Minister Goodhew (Minister for Public Health) in advance of the third New Zealand biennial Melanoma Summit in April 2013. In this letter, the group noted that many delegates would be seeking a mandate to switch-off-sunbeds (a strapline adapted by the Cancer Society from colleagues at Cancer Council Victoria) as many Australian states had resolved to 'switch off solaria' and asked the Minister whether she too had the resolve to commit to switching off sunbeds.

At the third melanoma summit in April 2013, the Government stated its commitment to skin cancer control. Part of this commitment was the Government's announcement that they would bar under 18s from commercial sunbed premises and regulate these businesses. The plenary keynote speaker at the Summit, Professor John Hawk, supported this initiative as a good start but ultimately called for a total ban, as 'sunbeds are dangerous and unnecessary'.

After the third summit, the sunbed action group wrote to Minister Goodhew congratulating her on her initiative as a good start and to ask for details as to how a partial ban and regulation would work in practice. Minister Goodhew confirmed that a new bill with elements of Dr Hutchison's private members bill would be drafted for inclusion in the legislative process.

In August 2013 the Society met with Minister Goodhew, who confirmed her commitment to regulate sunbed operators and ban under 18s from using sunbeds with a likely timeframe for her new bill's introduction being in 2014. This satisfied and reassured the sector, as there was concern that a recent Auckland City Council's by-law to regulate commercial sunbed premises in their jurisdiction might derail a national response.

To date, four Australian states are adopting total sunbed bans to commence by the end of 2014. The time lag gives sunbed operators time to exit the industry and the public time to adjust to a total ban.

The sunbed action group will continue its work to ensure sunbed premises are regulated in New Zealand as an important step in effective skin cancer control in New Zealand. The group will also continue to call for effective monitoring of sunbed lamp output (not currently undertaken) and safe disposal of discarded sunbeds. We should care about switching off sunbeds as they emit an avoidable source of UVR and contribute to skin cancer.

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[1] Australia has already announced total sunbed bans in three states (NSW, Victoria and South Australia) and the NSW Environmental Protection Agency has announced a $1000.00 bounty ahead of their ban. Their position is in response to their public wrongly thinking that regulation afforded safety; finding sunbed operators failed to comply with age and skin type restrictions; and the expense and ineffectiveness of regulation.

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Ultra Violet Radiation: a hazard in the outdoors needing universal action

Barb Hegan - Cancer Society of New Zealand

The Society has for many years worked to raise awareness that ultraviolet radiation causes skin and eye damage and skin cancer. The health promotion slogan we are all hopefully aware of is to slip into appropriate clothing and shade, slop on a broad spectrum water resistant sunscreen of at least SPF30+, slap on a broad brimmed hat, and wrap on sunglasses when the ultraviolet index is 3 or greater. Despite this knowledge, skin cancer rates remain high.

However, only melanoma registrations are required to be reported to the cancer registry in New Zealand. There is no measure of the number of non-melanoma skin cancer (NMSC) cases each year being seen mainly by doctors working in primary care. So we continue to rely on a 2006 estimate of 67,000 cases per year of NMSC. The latest data for melanoma shows it remains relatively stable. If we rely on the figure of 67,000 NMSC we can say 97% of skin cancers are not being reported and therefore their true burden continues to fly under the radar. Irrespective of the exact numbers we can say with confidence that skin cancer (melanoma and NMSC) is our most common cancer, and with an aging population it will continue to be so.

Research has shown that settings have a key role to play in many health promotion initiatives. The Society has already instigated a Sun Smart Schools Accreditation Programme in New Zealand primary schools (http://www.sunsmartschools.co.nz) and has been looking for traction in outdoor workplaces to encourage a SunSmart culture. This is because outdoor workers receive 5-10 times greater dose of UVR than indoor workers.

The Society identified an opportunity to gain traction at a national level about the importance of managing UVR hazard through the announcement of the Independent Taskforce on Workplace Health and Safety in 2012. This work resulted in the Society presenting a submission to the Taskforce that solar UVR is a serious workplace hazard which needs to be prioritised. A complementary submission on other cancer-causing agents in the workplace was also presented. We have subsequently linked with the DoL/MBIE Sector Engagement Team, resulting in a January 2013 media release about sun safety and employment responsibilities.

Research from the Social Behavioural Research Unit supports the ideas we've recommended to the Taskforce i.e. that a safety culture should include SunSmart practice. A recent report by Massey University's Centre for Public Health Research (CPHR) concluded that UVR was one of nine cancer causing agents in New Zealand that should be prioritised for immediate management and monitoring.

We have linked with CPHR to work to ensure cancer causing agents in the workplace, including solar UVR, are on the new Worksafe New Zealand's work programme. Together we are hosting a Forum on Workplace Carcinogens on the 28 November 2013 at Te Papa. The purpose of the Forum is to ensure there is better management and monitoring of workplace carcinogens in New Zealand.

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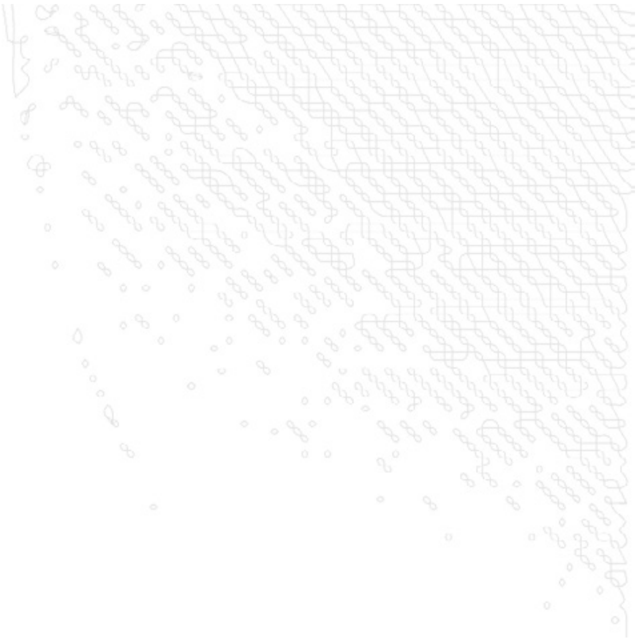
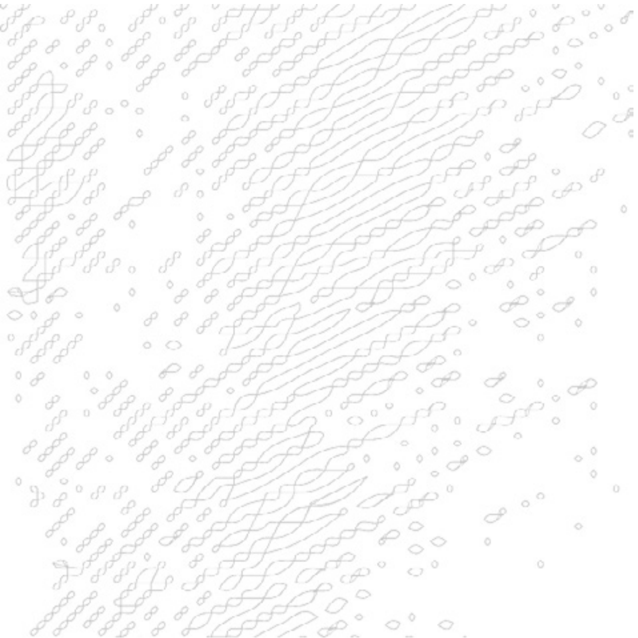




What shade? Working with your local council to improve community health

Kerry Hocquard - Manawatu Cancer Society

Every summer thousands of New Zealanders swim at their local outdoor swimming pool, having fun, relaxing in the fresh air and enjoying an activity that has many physical and mental health benefits for all stages of life. However, many outdoor pools have little shade available and with the extreme levels of UVR during our summer months, families are at risk of sunburn and potential skin cancer. For schools, swimming sport timetables often meant students were outside in peak UVR periods for long periods of time.

This knowledge provided powerful motivation to address this as a community and involved a collaborative approach to address the lack of shade at our local outdoor swimming pool complex.

Progress was hindered by challenges arising from the amendment to the Local Government Act, which removed local government's focus on promoting social, cultural, economic and environmental wellbeing of communities and reoriented local government towards cost effectiveness and financial prudence. Over one hundred submissions were made to the Palmerston North City Council Draft Annual Plan, creating competing financial demands on Council funds. A previous Cancer Society submission had resulted in a Council Sun Smart policy being adopted and the policy was a crucial step in establishing sun protection as a key principle of the Palmerston North City Council's commitment to the health of our community. It showed the council was prepared to take positive action to reduce the alarmingly high rates of skin cancer in New Zealand. The policy was an opportunity to demonstrate that safety is important for all using parks, reserves and swimming pools. It also demonstrated that healthy environments are created in PNCC recreation areas. However, there remained real concern that without evaluating and prioritising actions identified in this policy, the intended SunSmart progress would not eventuate and our community would continue to be at increased risk of skin cancer.

Palmerston North City Council aspires to have the city recognised as a vibrant, caring, innovative, and sustainable city where people want to live because of its lifestyle and its many social, cultural and recreational opportunities. The Council's role has been identified as shaping our social and physical environments, including public spaces, recreation and sports facilities, outdoor staff health and safety, community events and planning and building approvals. In terms of City Council Draft Annual Plan submission process, there were opportunities for change in the physical environments, staff knowledge and protective practices and institutional policies and practices.

Local government core services have been identified as including the "avoidance of mitigation of natural hazards"- in this instance, this particularly applies to minimising the impact of solar UVR (at peak times of September to April, especially between 10am-4pm.) The Cancer Society of New Zealand, Manawatu Centre, aims to reduce the rate of melanoma and other skin cancers in the Manawatu region caused by harmful exposure to the sun. This goal can only be achieved with a community commitment to reducing the risks of skin cancer through SunSmart policies in schools and workplaces, SunSmart behaviour in the outdoors and the creation of SunSmart environments in which we live, work and play.

While there has been an emphasis on raising awareness of the need for sun protection among individuals through media campaigns, there is also a need for public policy for skin cancer control. One of its key areas of focus is increasing the provision of shade in public areas and settings.

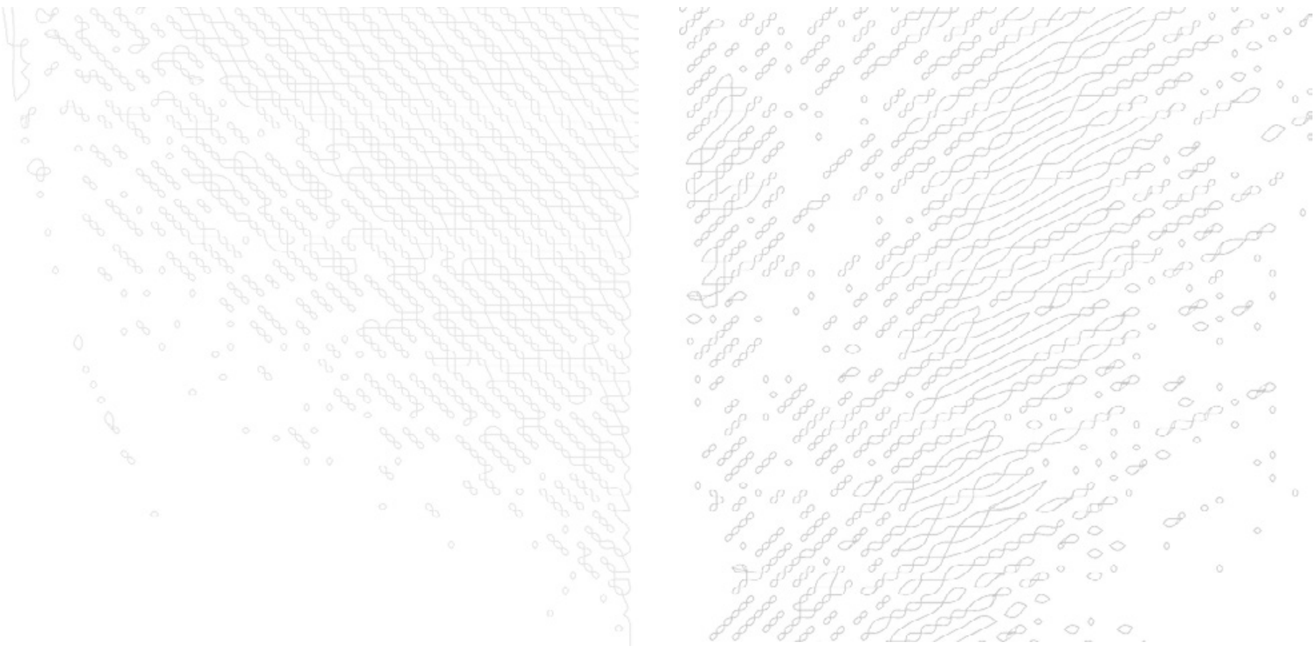
In this project, initial discussions were held with key stakeholder groups including Council staff, councillors and those affected by the lack of shade. These discussions revealed community, council staff and health professional champions who have been tireless in their support. The Ottawa Charter framework helped ensure that the process was strategic, linking local government's responsibility to community health and wellbeing with Specific

Measurable Achievable Relevant Timeframed (SMART) goals and objectives. Personal stories, discussions, a community survey undertaken to determine satisfaction levels with the present shade available at the Lido Outdoor Pool Complex, possible shade solutions that the community recommended and supporting evidence-based research informed the Cancer Society submission made to the Palmerston North City Council Draft Annual Plan.

The Palmerston North City Council agreed to support the shade project through community SunSmart education, a commitment to providing a sunsafe outdoor work environment for their pool staff, and funding for a shade feasibility study.

The shade project momentum has been built on promoting to all those consulted the benefits of increased satisfaction of the community and a safer work environment for council staff, including Palmerston North City Council, interested stakeholders and survey participants.

By committing to shade provision, Palmerston North City Council will be investing in reducing the economic, physical and social impact of skin cancer in our community.



All for one and one for all: working together for a common purpose

Sandra Innes, Emma Lamb and Shona Tiatia - Plunket
Christine Morey - Family Works Northern

This paper is based on an oral presentation given by Sandra Innes and Emma Lamb. It includes excerpts from an audio-tape, played during the presentation, of two staff sharing a case-presentation regarding one family that they worked with as part of the pilot.

Pilot description

The Plunket Family Works Early Intervention Partnership Pilot is a collaborative initiative between two Non-Governmental Organisations (NGOs). The two NGOs are Family Works Northern https://northern.familyworks.org.nz/ (FWN) and the Royal New Zealand Plunket Society www.plunket.org.nz/ (Plunket). The overarching aim of this partnership pilot is to provide early intervention to vulnerable families, and more specifically to:

- improve family health
- help families identify goals and meet them
- promote positive family relationships
- strengthen parental attachments
- increase family and community connections.

This particular partnership began when Nicola Brehaut (General Manager, Community Initiatives Presbyterian Support Northern) and Helen Connors (General Manager Service Development, Plunket) spoke together about early intervention support for vulnerable families - work that both of their NGOs do. Helen and Nicola both felt that if both services worked together, there would be a synergistic effect and collectively better health outcomes could be achieved than if each service worked alone.

The pilot was planned to run from March 2012 to September 2013 and by June 2013 it had been extended through to December 2013. After initial discussions, the two key locations of Glen Innes/Panmure (within Auckland City Plunket area) and Manurewa (within Counties Manukau Plunket area) were identified. These two locations were characterised by having multicultural, high needs, high deprivation, high mobility families, who were being served by organisational staff who were identified as having built strong community connections.

FWN used bequest money to fund the employment of a family worker - a qualified social worker - to be integrated into a Plunket Well Child service team. Recruitment and selection of the Plunket Family Worker (PFW) was done by representatives of both NGOs. One full time equivalent PFW was employed for each location.

The PFW is employed by FWN and accountable to their FWN service manager for their practice supervision while working within the Plunket team and documenting within the Plunket held health record. Being integrated into the Plunket clinical team meant that she was also accountable to the Plunket clinical first line manager (Plunket Clinical Leader). To ensure clear lines of communication, both FWN and Plunket first line managers meet together monthly. This ensured that staff felt well supported and any issues could be addressed proactively to ensure everyone was 'on the same page.'

The Plunket nurse identifies families within her case load who are experiencing significant challenges that impact adversely on the children and family and, with consent, refers the family to the PFW. When working with families, the PFW employs their social work skills within a strength based approach, which aligns with both Plunket and Family Works philosophies and guidelines.

A formal evaluation is being done by Impact Research NZ. The research includes data from both Plunket and FWN electronic databases, staff focus groups, client face to face and phone interviews and client written (or oral) questionnaires.

The Glen Innes/Panmure location

The Plunket enrolled population in this location consists of 65% of families being resident in Deprivation 10 households. Deprivation is a term used by the Ministry of Health to predict socio-economic disadvantage and is used as one indicator to assess the level of support parents and whānau may need. Deprivation 10 indicates families/whānau who may need considerable support and Deprivation 1 indicates families that may only need minimal support. Self-declared ethnicity of the Plunket enrolled population in this location is 25% Māori and 45% of Pacific ethnicity.

The Early Intervention Partnership Pilot participants during the first year of the pilot were 80% resident in Deprivation 10, and 28% of Māori and 48% of Pacific ethnicity. This highlights that the most vulnerable families were accessing the service.

"I was visiting a mum for the first time with her new baby. She was a lovely mum, shy. She has a history of depression and partner abuse in a previous relationship. This was her 6th child although 2 were not living with her. I noticed there were lots of holes in the walls and floor and the whole family appeared to have been sleeping in the living room. I asked mum about the holes and she told me about the rats and mice that were running around through her house. She couldn't store any food in her pantry because the rats would eat it and she was embarrassed to have family visit in case a rat ran across the room."
(Shona Tiatia, Plunket nurse)

One of the challenges Plunket staff had long highlighted was the gap between identifying a need with the family, the family then agreeing to a referral to a support agency and the subsequent time lag before the other agency was able to make contact. Further time was then required for Plunket staff to then confirm that contact had been made, and that assistance had been provided that met that families need. This pilot has shown that that gap can be addressed and has enabled families to access immediate support.

"So I talked to her (the mum) about the PFW service and she agreed to have Christine visit. I went back to the office, spoke to Christine about it, did the referral paperwork for her and Christine arranged to go and visit her."
(Shona Tiatia, Plunket nurse)

Furthermore, because the PFW was sharing the health records and was able to have a face to face conversation with the nurse case manager, families did not have to repeat their stories, the repetition of which is often painful and distressing to them. The PFW also identified that the Plunket logo and sometimes a personal face to face introduction was key to the PFW having a positive initial interaction with the family.

Often initial contacts were because the families had requested support for tangible reasons such as the provision of vital furniture, transportation to appointments, WINZ (Work and Income New Zealand)/HNZ (Housing New Zealand) advocacy and support, early childhood education entitlements and enrolment and engagement with Family Group Conference (FGC) and other Child Youth and Family services (CYF) processes.

"I went to see this mum. I noticed that there was lots of food piled up on the table. Mum told me that she had to shop every day because it wasn't safe to store anything and this was difficult for her particularly because she had transport problems and had to take the young children with her. So I got out my phone, dialled H for Housing (the family were HNZ tenants) and spoke to the HNZ case worker. HNZ visited and fixed the holes within a couple of days. I wish all family issues could be resolved so promptly."
(Christine Morey, Plunket Family Worker)

Once the PFW has earned their trust through timely support with these issues, many families have gone on to being more open about their thoughts, feelings and aspirations for the future. This has led to referrals being made to parenting programmes, anger management programmes, community linkages, mental health support and, at times, Child Youth and Family services. Both the nurses and the PFW have felt that many of the families engaging with the PFW would not have previously accepted the support of a Social Worker in such a proactive way.

"During this time we got to talking and mum told me some of her other worries. She said that the school were hassling her because the older children were going to school without lunch and were missing a lot of school. And CYFs were involved. CYF had been having difficulty making contact with mum, and an FGC had been planned as their next step. Mum explained to me she had been avoiding contact with CYF because she was scared. I was able to ring both the school and the CYF social workers and explain some of mum's situation. After a period of

time with all of us working together, CYF were able to downgrade the FGC to a whānau meeting and a family whānau agreement. CYF have since closed the case. Last time I spoke to mum she said the children were attending school more regularly - and with their lunches."

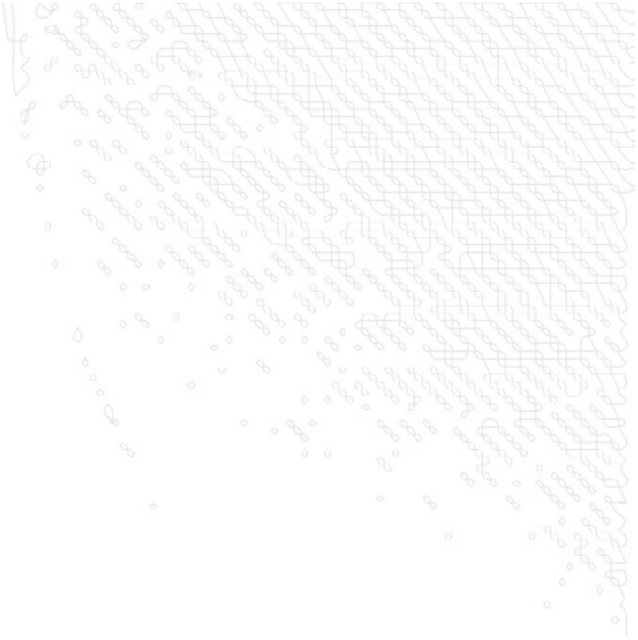
(Christine Morey, Plunket Family Worker)

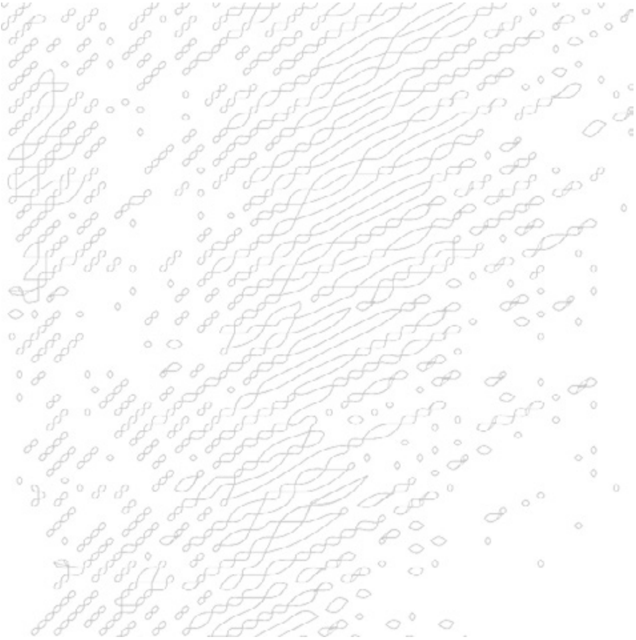
Where to from here?

Collaborative innovation amidst challenging times is possible, but it does take time and commitment from everyone. At the time of writing this, the programme is still underway and a final formal evaluation report is in progress.

"I've seen the family several times since as part of the Well Child contacts and other family members have moved in to support her. Mum feels really happy about that and things are going well for the family."

(Shona Tiatia, Plunket nurse)





Kids deserve smokefree air everywhere

Elaine Jamieson - Heart Foundation
Jill Nicholls - Taranaki District Health Board

This presentation describes the partnerships used by the Taranaki Smokefree Coalition to engage with local government during election year and to get smokefree back on their agenda. Gaining public support and awareness for smokefree local spaces was explored. The coercing, the challenges, the partnerships made, the slow gains and ultimate successes as well as the lessons learnt were shared. Community engagement was achieved through collaboration with child health organisations, groups advocating for the elderly and young people passionate about being heard, as well as all sectors of our Coalition working towards the one goal of increasing smokefree public places.

The process in our presentation was described as a recipe for a cake- assembling ingredients, mixing, measuring and adding in the right order and the right amount. The finished result- a successful collaboration cake!

Workshop participants were divided into three groups and invited to ponder the following in relation to their own experiences:

- Who are your key stakeholders and partners?
- How are you going to involve them?
- How will you present to council and evaluate your outcome?

Responses to stakeholders ranged from the obvious Non-Governmental Organisations through to councillors and even included workers who sweep the streets of cigarette butts. Some other suggestions included parents and children, tourism groups, Māori health providers, policy analysts in council and tertiary institutions.

Ways of involving stakeholders and partners included identifying what strengths stakeholders could bring, what motivates decision makers and gathering personal stories. Telling of the successes from other councils, using social media and blogs and holding community meetings were all suggested.

Presenting to council required a mix of information to appeal to different audiences, involving children, the media and using evidence and data. Identifying people with passion, finding a point of difference and providing something visual to leave them with were other ideas shared.

The analogy of making a cake was to encourage people to think creatively, as well as an easy way to remember the process of collaboration. Lucky participants finished with a slice of real cake.

Their voices speak louder than ours: using public opinion research to engage media in influencing smokefree Auckland policy

Beth Jenkinson - Cancer Society
Dr Allan Wyllie - Wyllie & Associates

Auckland Council has recently adopted a comprehensive Smokefree policy for the Auckland region. This paper outlines the Cancer Society Auckland (CSA) strategy to ensure there was a strong public health voice in the policy making process. We wish to also acknowledge the other organisations that have supported this campaign, including Auckland Regional Public Health Service, the Heart Foundation, Action on Smoking and Health (ASH), Hāpai Te Hauora Tapui, Tala Pasifika, the Health Promotion Agency and many others.

Cancer Society Auckland (CSA) Smokefree Auckland strategy

Right from the start, CSA always talked about a Smokefree Auckland. The model shown below was used to communicate what a Smokefree Auckland could look like, taking into account how Council structures its business. Under green spaces there were already Smokefree regional parks, playgrounds, and sports fields, but there was a need to go further. Next on the model, high density places cover not only outdoor eating areas, but also town centres and high pedestrian areas. Under the title on the model 'Council', we also wanted Council to take on Smokefree as an organisation by having Smokefree Council facilities and Council housing as well as cessation services for staff.

This Smokefree Auckland model also includes extending from the few transport hubs that were already Smokefree, to all bus stops, train stations and transport waiting areas. The last component of the model is about Council influencing Central government policies. As the biggest Council in New Zealand and representing 1.5 million people, Auckland Council is politically influential. For Council to achieve its smoking prevalence targets (see figure one), it will require local and central government to work together for stronger policies.

This model was a useful tool to keep Council on track and thinking of the big picture and a comprehensive policy and this big picture is ultimately what Auckland Council has committed to.

Smokefree Auckland model developed by Cancer Society Auckland

In April 2011, about a year into the campaign, after hundreds of written and oral submissions and meetings with key Council staff and Councillors, Council adopted two key Smokefree targets:

1. To make all public spaces Smokefree by 2025
2. to reduce smoking rates to less than 3% in Local Boards in South Auckland, which has the highest levels of smoking rates.

You can see from these two targets that Auckland Council have strongly aligned with the Smokefree New Zealand goal and have identified priority communities to work with to ensure that reducing smoking rates to 3% or less is achieved. Most importantly, the targets provided a platform for our Smokefree Auckland (SFA) campaign and a mandate for Council to action their commitment.

The SFA campaign was a strategic advocacy campaign which was carefully planned to have the greatest impact. The project involved many processes, including reviewing and utilising the latest evidence, getting organisational buy in, developing a communication plan and evaluating how effective the campaign was at regular points along the process.

The key parts of the campaign which will be addressed throughout the rest of this paper are:

1. Building relationships with key Council staff, Councillors, Local Boards and key stakeholders.
2. Community mobilisation, which involved

training a committed team of volunteers to write, present and generate submissions.

3. Public opinion research CSA commissioned and how it helped us engage media and influence Council to adopt a comprehensive Smokefree policy for Auckland.

CSA focused on developing trusted relationships with key decision makers at all levels of Council, from Local Boards to Councillors to Māori Statutory Board members to Parks Managers and Policy staff. This enabled ‘pick up the phone at any time’ relationships, which meant that we could influence on a number of levels (e.g. formally, informally and up to the last minute before key decisions were being made). At times, we were allies with Council and a key source of information and evidence, while at other times we were staunch advocates and challenged them on their direction and approach.

The voices of the Cancer Society and other health organisations were respected, but Auckland Council needed to hear the voices of the Auckland community on how they felt about Smokefree and we needed to provide that local public opinion to Council. This is where our community advocates came in. They are a group of CSA volunteers that support our small Health Promotion team of four. We trained them in giving written and oral submissions and writing letters to the editor. They told their personal stories to Local Boards and Council about why Smokefree was so important to them. They also mobilised their family and friends to write submissions.

They are completely engaged with the concept of Smokefree Auckland and help us to spread the word. Decision makers have told us time and again how much their authentic and courageous stories have influenced them to make change. As a result, of all the submissions made by the CSA Community advocates, staff and other organisations, Smokefree was in the top ten issues submitted upon in the development of Council’s ten year plan, and the only health-related issue.

For Council, public support is a prerequisite for taking action. We invited people at one of our Cancer Society Relay for Life events earlier this year to tell us what a Smokefree Auckland meant to them. Their comments were documented on a video, which was shown to Councillors and Council staff and was picked up in the media. This video is available on the CSA website: http://www.cancersocietyauckland.org.nz/smokefreeauckland

Public opinion research

Earlier this year, CSA commissioned two public opinion research surveys. The first was in the Southern Initiative area, which is made up of four local boards: Otara-Papatoetoe, Manurewa, Mangere-Otahuhu, and Papakura. We focused our research in the Southern Initiative because we wanted to ascertain the level of support for Smokefree policy in the area with the highest smoking rates and health inequalities. Also, Council had set that very important target to reduce smoking rates to less than 3% in the Southern Initiative.

Because of the success of this research in gaining rich local data, as well as the effectiveness in generating media interest, we then repeated the research across Auckland later in the year. The research was undertaken by Allan Wyllie from Wyllie and Associates, who organised for Reid Research to undertake the data collection. A CATI (computer assisted telephone interviewing) methodology was used as it provided the most cost-effective option. Online surveys were avoided because of the bias that comes from interviewing only people who agree to be on panels, have internet and respond to an emailed invitation. Tight quotas were imposed, to ensure numbers in each ethnic group (Māori, Pacific, Asian, Other) in each of five Auckland regions were a close match to Census data. There was also a quota of 40-60% males within each ethnic group within each region.

There were 400 interviews in the Southern Initiative survey and a further four hundred and forty in the rest of Auckland survey. These two surveys were combined to report data for the whole of Auckland. Prior to reporting, the data was weighted to reflect the correct proportions by gender within ethnicity within region. The data was also weighted so it had the correct proportion of smokers.

As shown in figure two, there was a high level of support for Smokefree public places. All had more than 50% support, with almost all supporting Smokefree playgrounds (96%). There was also strong support for Smokefree policy in some key high density areas: entrances outside buildings (84%), bus stops/train stations (82%) and outdoor eating areas (76%).

Support for Smokefree public places

For several of the items people were asked if they would be more or less likely to visit these places if they were Smokefree, or whether it would make no difference. For "outdoor eating places at restaurants, pubs or cafes," 51% of the people were more likely to attend if they were Smokefree and 87% were as or more likely. These findings showed that that not only do people support places being Smokefree, but by making these places Smokefree they will increase attendance and, ultimately in the case of outdoor eating areas, increase business. This supports what we already know. Since Australia introduced Smokefree outdoor eating areas and New Zealand bars and restaurants went Smokefree, there is clear evidence that making these places Smokefree is good for business.

Another question asked, "Smokefree bans can be voluntary and rely on the public to make them happen, or the Council can have by-laws, which means there is a possibility people could be fined if they were smoking in a Smokefree area. Which option do you prefer?" There were 57% who wanted the by-law option, while 37% wanted the voluntary approach.

A key finding from the research was that people wanted the policy implemented sooner than had been proposed in the policy. Council's draft Smokefree policy proposed an incremental roll out of Smokefree over five years, in three phases. However, our research showed people wanted shorter timeframes.[1] The majority (55%), wanted it implemented within two years or sooner, and almost two-thirds (64%) wanted Smokefree Auckland policy fully implemented in the next three years or sooner. People who smoke were also supportive, with 55% wanting the policy implemented within three years.[2]

Use of public opinion survey results

In order to communicate the findings CSA developed infographics, which proved a very useful

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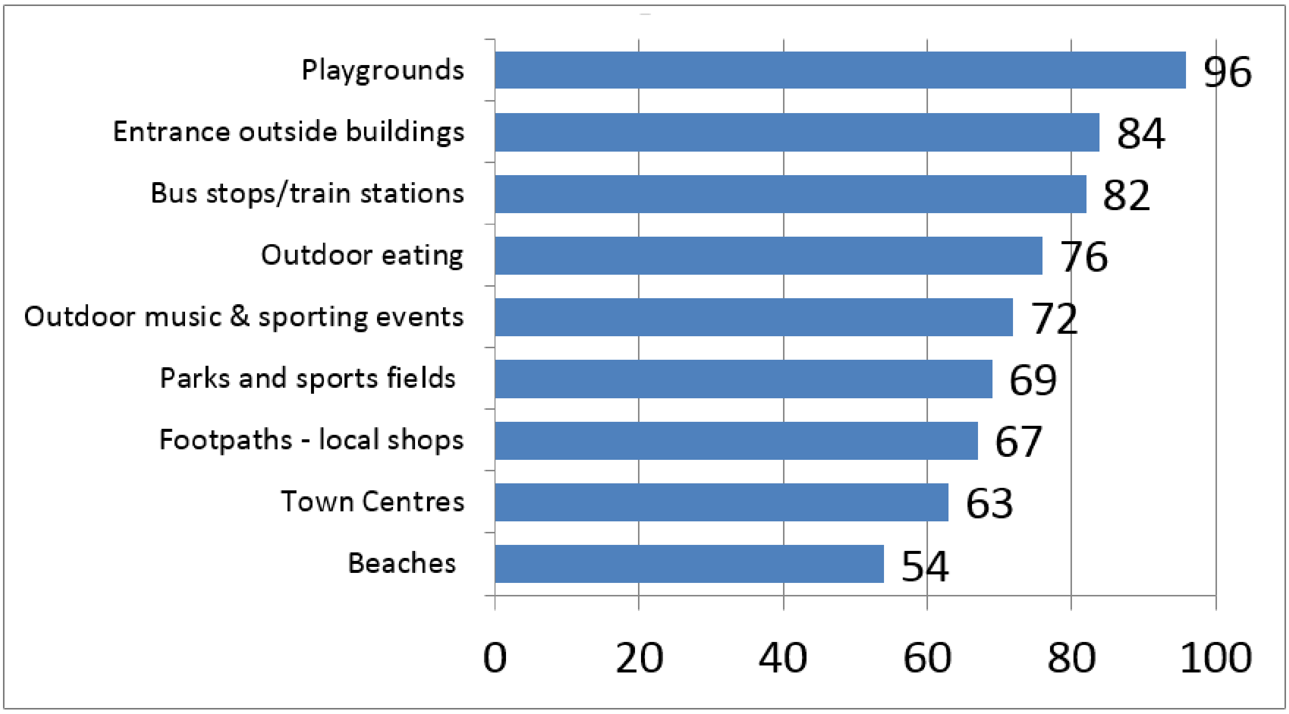
[1] This question was not included in the Southern Initiative survey; the timeline became a bigger issue between the two surveys, so was added to the second survey.

[2] Copies of the research report are available from Smokefree@akcansoc.org.nz

Figure 2. Support for Smokefree public places



tool, especially for engaging media.

Influencing our decision makers came down to a practical decision, as we couldn't get around to all Councillors and Council staff and Local Boards at every decision point. We then focused on how we could get these results out, so they were being discussed in the public domain and so that pressure was being placed on Council, not just from us and other public health organisations, but from the wider Auckland community.

The first round of the public opinion research, the Southern Initiative results, generated a lot of media interest. Breakfast TV picked up the story, different angles were presented in the New Zealand Herald on three consecutive days and the CSA Chief Executive was interviewed on National Radio.

Prior to the media, we shared the Southern Initiative research results with our key Council contacts. This was because we wanted to be transparent, to ensure that our trusted relationships were honoured and so that there were no surprises for them. It also gave them the chance to amend the policy in line with what the public wanted, prior to it going to Council.

Due to the success of this part of the campaign, we decided to conduct the second round of Auckland wide research prior to the final adoption of the policy and this generated even bigger media pick up. For this research we had: a breakfast TV interview with the CSA Health Promotion Manager, TV1 news, two New Zealand Herald articles, Māori TV and four radio interviews. In addition, the local newspapers loved the local data and this was covered extensively across Auckland.

The media meant that Smokefree Auckland was everywhere and it was timed to align with Council going into vote on the policy. Obviously you can't control what media pick up or what else is happening nationally and globally; our main media 'competition' was the birth of the royal baby, which may have increased numbers watching Breakfast TV and increased exposure to the Smokefree coverage.

So overall, the research enabled the strong support from communities to be highlighted to decision makers. The Councillors were reassured to know local people unanimously supported this policy.

As planned, the advocacy did positively impact the policy and Council voted through a comprehensive policy in line with our Smokefree model. Timeframes were brought forward after the public opinion survey results were publicised. Smokefree Auckland is being rolled out in 3 phases. It is being implemented immediately for stadiums, swimming pools, outside of Council building entrances and transport hubs. Shared spaces, plazas and civic squares go Smokefree in 2015 and sports clubs, outdoor dining, urban centres, beaches, and Council housing by 2018. However, our research shows that two thirds of Aucklanders want the policy fully implemented by 2016, and we will continue to advocate for sooner implementation. Another aspect that we advocated strongly on was introducing bylaws for enforcement, as that is what is working effectively overseas, and the policy does include a bylaw review in 2016.

One of the key highlights of the policy was the acknowledgement of Council's role in advocating to central government for effective national tobacco control policy. That this is now written into Council policy gives us an opportunity to keep tobacco on their agenda. Given the target the Auckland Council have set for reducing smoking rates in the Southern Initiative to less than 3%, we will continue to advocate that this area is prioritised.

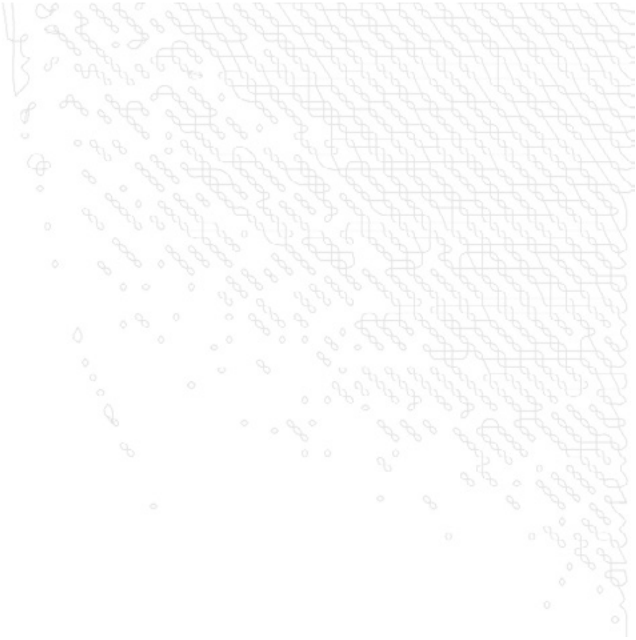
Conclusions

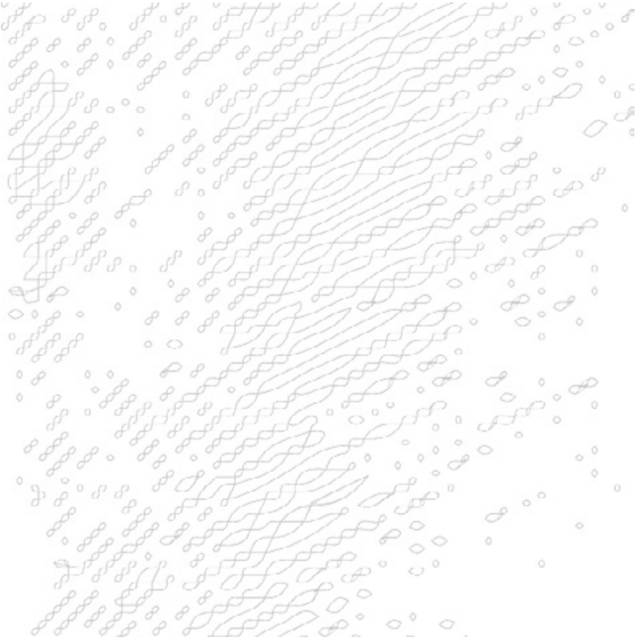
So you can see there were many different aspects to the Smokefree Auckland campaign and we have briefly touched on some and highlighted the importance and impact of the public opinion research and media. We'd like to share a few of our reflections on what worked:

- We built trusted relationships with Council by maintaining regular contact and providing them with what they needed to make good decisions.
- Mobilising the community was about finding people who were committed, passionate and aligned with our vision and then providing them with the necessary training and tools to make a difference.

- The catalyst for our last round of advocacy to Council really was the public opinion research. The research findings gave us local data that showed Aucklanders wanted a comprehensive policy for the city. It gave Council the confidence to make the right decision, own it and run with it. Not only that, it was critical to have something that would be relevant and newsworthy; the research was timed precisely for media pick up to influence Council.

- The public opinion research and media gave the Auckland public a collective voice, and strengthened our advocacy to Council. After all, their voices speak louder than ours alone – and bringing community and agency voices together is a powerful combination.





Tautoko Rheumatic Hearts: to support those with rheumatic hearts, public health needs innovation, collaboration and evaluation.

John Malcolm - General and Community Paediatrics Whakatane
Sandra Ball - Acute Rheumatic Fever Primary Prevention,
Eastern Bay Primary Health Alliance and District Nursing
James Beharry - University of Auckland
Russell Ingram Seal - Eastern Bay Primary Health Alliance
Lindsay Lowe - Toi Te Ora - Public Health Service
Sunshine Biddle - Te Kaokao o Takapau Rheumatic Fever Team Taneatua
Liisa Wana, Melissa Bennett, Jacqueline Godfery - Eastern Bay Primary Health Alliance, Kawerau.

Introduction

The Eastern Bay of Plenty is characterised by outstanding scenic beauty, talented people, the impacts of raupatu (land confiscations), low employment rates, educational achievement and health challenges. Fifty years ago, rheumatic heart disease featured in Dr Ian Prior's 1962 health review of the Tūhoe village of Ruatahuna. This area and the entire Eastern Bay of Plenty is now mapped as one of high deprivation (Salmond, Crampton, Atkinson, 2007). Toi Te Ora public health registrar Dr Belinda Loring's 2008 report cited that one in thirty-nine children in the village of Murupara contracted acute rheumatic fever between five and fifteen years of age.

Today, collaborative partnerships in the Eastern Bay of Plenty are supporting primary, secondary, and tertiary prevention of acute rheumatic fever and its sequelae, rheumatic heart disease. In the Eastern Bay of Plenty, 10-20% of school children are colonised with the bacteria group A streptococcus. When this bacteria causes sore throats, for some individuals acute rheumatic fever follows, and for those with existing acute rheumatic fever, the likelihood of further heart valve damage results in increasing severity of rheumatic heart disease.

When the children of the Eastern Bay of Plenty acute rheumatic fever prevention programme schools say they have a sore throat, community health workers swab their throats, checking for group A streptococcus. This, among other strategies, is frontline primary prevention. If results are positive a ten day course of oral penicillin follows. Secondary prevention involves children in these communities with a confirmed diagnosis of rheumatic fever receiving an intramuscular injection of Benzathine Penicillin. This prevents rheumatic fever recurrence and further heart damage. Tertiary prevention relates to prevention of complications for those with rheumatic heart disease. It also relates to early recognition and treatment to tautoko heart health (manawa ora).

Primary prevention of ARF

Primary prevention in the Eastern Bay of Plenty (EBOP) is implemented through school based sore throat swabbing for the bacteria group A streptococcus (GAS.) This programme is founded on partnerships with Hauora, Eastern Bay of Plenty Health Alliance (EBPHA), Pathlab, GP's, practice nurses, pharmacists, school leaders and whānau. These key partnerships support innovative access, rapid interaction, best practice prescribing, dispensing and delivery (at no cost to whānau), plus follow-up. The process is based on Ngati Hine and public health practice demonstrated in Whangaroa (Jarman, 2006).

Locally, school sore throat swabbing for GAS began with Whakatohea in the Opotiki area in 2009; EBPHA Kawerau in 2010; Te Ika Whenua Murupara in 2011; and Ngai Tuhoe, Te Kaokao o Takapau Taneatua in 2012. They are variously funded by the Bay of Plenty District Health Board DHB and the Ministry of Health, with EBPHA funding one clinical lead to provide support. The Wiri Project handbook (Lennon, Farrell, et al 2011) has been adapted for local use as a quality manual.

The Community Health Workers (CHW) staff meet quarterly at sector group hui, alongside the clinical lead, Toi Te Ora acute rheumatic fever (ARF) coordinator, EBPHA analyst, and clinicians. These hui bring together representatives from eight iwi. These colleagues share wawata, innovations, experiences, quality data and offer collegial support. Clinicians share findings from ARF and rheumatic heart disease (RHD) presentations. Shared innovations and experiences have included Te Ika Whenua presentations of school children's visits to Pathlab to see streptococcus under the microscope; the clinical lead led pig heart muscle and valve dissections; Toi Te Ora health literacy; oral health education; antibiotic use and resource sharing. Examples of resource sharing included "Anaru te Aruhe", a ten lobed caterpillar sticker chart designed to support ten day antibiotic adherence. Whakatohea Health workers promoted ARF prevention at Valentine's Day in high schools, kapa haka regionals, and Te Matariki festival. Kawerau shared surveys of student knowledge, mapping ARF education needs. The health workers carried out hands on educational activities for primary schools and are in the process of developing a college ARF curriculum. The Kawerau Community Health workers supported Whānau Ora with kanohi ki te kanohi whānau korero and focused home visits for those with first time streptococcal sore throats.

The school based projects and Toi Te Ora public health campaigns have achieved increased awareness of ARF prevention, utilising iwi radio, local newspapers, and panui such as Te Manu Taiko (Lowe, 2010). Most effective have been ARF leaflets fronted by local champion tamariki who have had ARF. Most of those champions have had RHD heart surgery.

RHD clinical follow-up, admissions, and deaths audits and research (Beharry, Ingram-Seal, Malcolm, 2011, 2012) informed practice. All children with newly diagnosed ARF in the Eastern Bay are admitted to Whakatane Hospital. Their secondary care case notes provide quality improvement feedback to primary care and vice versa. Whakatane Paediatrics identified no ARF cases in 2013 from the sore throat swabbing primary schools. Eight new ARF cases were mainly from high schools, supporting the EBPHA's secondary school ARF curriculum development. This case review process revealed the older age of recent ARF cases (thirteen-fourteen years), inspiring the creation of a teaching unit for college students.

Audits also reinforced best practice of correct oral penicillin prescription and administration for patients who presented with GAS sore throats (Atatoa-Carr, Lennon, Wilson 2006); three ARF cases had inadequate prescribing and two had not completed their correctly prescribed course.

The Public Health Alliance analyst tracked regional GP practice sore throat swabbing, which has increased six fold from 2006-2011, with associated 20% GAS positivity (compared with schools findings nearer 10%). GP's are significantly increasing their screening for GAS. This is needed in EBOP, because many at risk children live outside the ARF primary prevention school areas.

Primary school sore throat swabbing appears to be helping prevent ARF cases. Using quality improvement tools (Nelson, Batalden, & Godfrey, 2007), there is an encouraging trend of the number of cases declining in the EBOP primary prevention ARF school areas. The rate of decline appears to be greater than Lakes and DHBs as a whole, and greater than that for Western BOP. While there are inherent reliability and validity risks in small number analysis, with time, trends will be identified and interpreted with greater confidence and validity.

Secondary prevention

Historically, RHD was detected only when cardiac murmurs were audible by stethoscope, but now RHD is identified also with echocardiography. The first RHD community research in our area was a partnership of Dr Ian Prior of Wellington Hospital's Epidemiology Unit, the predecessor of the Eru Pomare centre, and John Rangihau, Ngai Tūhoe (Prior 1962). Kawerau and Ngai Tūhoe collaborated in 2010 with Dr Nigel Wilson's Starship Cardiology team and the authors (Lowe and Malcolm, 2012) on echocardiographic school screening for the ARF sequelae RHD. Wilson had picked up RHD in 2% of South Auckland children (Webb et al. 2009), whereas they found 0.5% in the Bay, identifying one new case of RHD for each one known (Malcolm, Hartley, Harawira, 2010).

Streptococcal throat prevalence (without sore throats) was checked at the same time as echo screening in the wider Kawerau school community in 2010, before primary prevention programmes in these schools started, and was close to 20%. Repeat surveillance was undertaken in 2013 after three years of the ARF primary prevention programme, with lowered GAS prevalence found. A further community follow-up is planned in 2014. The Health Research Council funded community follow-up studies of GAS prevalence and those screened with echocardiogram for RHD in 2010, this will take place in 2014, more than fifty years after Prior's (1962) inaugural work. The connection between GAS, ARF and RHD is often made in the Bay with the slogan 'Sore throats can break your heart.'

Paediatrics review new ARF cases and have done three-monthly audits since 2007 when prescribing Benzathine Penicillin for each District Nursing Service (DNS) office. Primary and secondary ARF preventable elements are identified, informing providers who are responsive. These audits documented demographics; numbers, age distribution of ARF, ethnicity and years of follow-up. The audits found several children whose initial presentation was in one town and diagnosis in another city or country. For several children, intellectual disability, behavioural or attention issues meant a sore throat did not get identified. Health workers also know that some GAS sore throat infections go below the radar, not presenting with ARF but with the acute inflammation settled and established RHD.

In 2007 the authors identified high percentage on oral penicillin for secondary prevention, rather than the more effective Bicillin injection, improving to fewer oral prescriptions in 2012. Several cases of ARF were due to too short a course of penicillin prescribed by doctors and others, with limited adherence for five rather than the full ten days. Dr Bryce Kihirini also found 33% under-prescribed antibiotic duration prescriptions for GAS sore throats in Tauranga Emergency Department in 2012. The DHB district nursing service delivers the twenty-eight day Benzathine Penicillin G (Bicillin) injections. Some injections are delivered late and some patients are lost to follow up, often related to the patient's fear of the painful procedure. The commitment to multiple visits of DNS and whānau is often exemplary.

Secondary prevention works well in the Bay. ARF hospitalised recurrences are rare, but those with ARF recurrences have RHD complications too. Public health and Paediatrician collaborative preparatory data and chart review for ARF registry showed that half the BOP ARF recurrences were correctly coded at discharge from hospital 2000-2010. The discharges most commonly miscoded were first ARF, RHD, or RHD sequelae endocarditis, stroke, and arrhythmia or surgery. Paediatrician chart reviews showed trajectories for several children and young adults with recurrences of ARF, early RHD surgery and multiple RHD complications. Identifying someone with ARF recurrence is seldom a single issue. A one page check list for ARF recurrences has been developed.

Strategies are being implemented to help immediate analgesia and ongoing Bicillin adherence. The Buzzy bee, an ice pack with vibrating device (Inal S, Kelleci M. 2012), used initially in the Bay without the local anaesthetic Lignocaine, is one such strategy. In South Auckland, Buzzy bee is used with Lignocaine (Russell K, Nicholson R 2012) added to Bicillin injections. For many Eastern Bay children, there has been improvement in analgesia. Other work on injection sites, speed, distractors, enablers and consideration of NSAID for those with soreness several days after the injections has also helped lowered pain scores. DHB appointed the DNS leader as "ARF Champion" for the Bay. DNS are well positioned to evaluate and improve analgesia for Bicillin, the main tool of secondary ARF prevention.

Eastern Bay Paediatricians work with the DNS and their Bicillin files as proxy registers at present. However, it is hoped that with implementation of a regional ARF/RHD register, manaakitanga/patient support will be embedded in systems design. This will assist and support clinical follow-up, contribute to tertiary prevention and lower RHD morbidity and mortality.

Currently, in the absence of a functioning regional rheumatic fever register, there is three-monthly prescribing by paediatrics. This has provided regular audit of patient notes. Audits identified children managing well and those needing improved analgesia. Themes also noted include parental tragedy, ill health and challenged circumstances, which resulted in changing/grandparental and wider whānau care for several children. The nurses are encouraged to maximise the effectiveness of the monthly korero with patients and whānau, providing manaakitanga and promoting matauranga knowledge of manawa ora.

Tertiary prevention

Tertiary prevention means prevention or early recognition and treatment of complications for those with RHD. Tertiary prevention needs person specific care. The public health systems need innovative collaborations and partnerships of Hauora, GPs community nursing and hospitals to achieve health access. Within New Zealand, RHD costs many millions, especially for cardiac surgery (Milne and Lennon 2012). Gilbert Wilson and Finucane (2012) calculated the paediatric cardiology costs, all potentially lessened by primary, secondary and tertiary care.

Beharry (2011, 2012) researched RHD admissions and deaths in the EBOP 2005-2009. Surprisingly, a third of patients add other heart diseases to ARF, such as ischaemic or alcohol related Heart Disease, weight issues, and smoking related Chronic Obstructive Pulmonary disease. The Waikato finding of Chang (2012) that troponins are elevated in COPD exacerbations identifies that COPD morbidity is as much a cardiac disease as it is a respiratory disease. We are likely to have under-counted obesity and not counted diabetes mellitus. Those findings are useful feedback in secondary and tertiary care ARF/RHD clinic discussions, as we recognise the need for a whole hearted approach.

In the Eastern Bay, audits showed suboptimal follow-up of some young adults with RHD against National Heart Foundation Cardiology benchmarks. Some young people with moderate RHD had three to four year and longer intervals between clinics, while needing yearly follow-up. Loss to follow-up meant some needed surgery when next seen. To guide timely and appropriate follow-up, a condensed one page ARF/RHD/NHF follow-up table developed with Starship cardiology has been used at discharge, outpatient clinics, and circulated to DNS, GPs, adult physicians and cardiologists.

Beharry (2011, 2012) detailed the impact of RHD for adolescents, young adults and later adulthood as seen in the Eastern Bay admissions from 2005-2009. The methodology and findings may assist whānau, physicians and public health professionals to promote appropriate care for those with RHD. Where Milne and Lennon JPCH (2012) provided national figures, Beharry's study used the same potential RHD codes for the Eastern Bay, adding chart review and thus excluding non-cases, diagnosing RHD more confidently, then broke down the admissions by specific complications.

A third of RHD admissions are from the teenage years to the forties. Of Whakatane admissions to the only hospital within the region, 50% presented with congestive heart failure, approximately 14% each of endocarditis, stroke and arrhythmia and 8% with medication complications such as thrombosis from inadequate anticoagulation or cerebral bleeds from excess warfarin. The RHD admission prevalence was 25.42/100,000/year, Maori 55.58, Pakeha 3.9, RR 14.25. Ministry of Health data over those five years documented eleven EBOP RHD related deaths, a third before the age of fifty. The youngest was nineteen and the next was twenty-eight years old. Close scrutiny of these RHD patients' courses identifies individuals with operative mortality, bacterial endocarditis, infection of the heart valves presenting with arrhythmia, presentations to emergency department many times before diagnosis, early secondary heart disease, myocardial infarction and obesity. A third of the Eastern Bay deaths were in their mid-sixties, illustrating Milne's New Zealand findings that Maori with RHD die fourteen years before Maori without it. The EBOP regional RHD mortality was Maori 6.84/100,000/year, Pakeha 0.26/100000/year; RR 26.

Conclusion

It is startling that one third of the RHD patients had a further heart disease added, such as Myocardial Ischaemia, smoking related COPD, and alcohol associated cardiomyopathy or renal impairment. A multiple, sequential cardiac morbidity model starts, for some, with RHD in childhood and early adult years (Beharry 2012).

The implications for health promotion are to encourage a "whole hearted" approach to ARF and RHD rehabilitation by trimming hinau (fat), getting physically active, and being auahe kore (smoke free); addressing the risks by taking a holistic approach. Therefore, identifying someone with ARF recurrence is seldom a single issue. The diagnosis is a red flag for comprehensive whole hearted patient care and whānau follow-up of recurrence prevention with Bicillin, heart disease complications and social challenges.

A web-based ARF and RHD register is planned with the aim of improving follow-up within the Lakes and DHB, as well as serving public health surveillance (DHB Rheumatic Fever Prevention Plan 2013-2017). As well as improving Bicillin timeliness, it may, with evaluation, optimise Bicillin analgesia and support inter-DHB transfers and education, answering frequently asked questions. The register may provide a framework for text recall and DNS and patient reminder dates for cardiology and echo cardiology follow-up. Patients may access appointments and clinic letters. National Heart Foundation principles for ARF registers (Atatoa-Carr et al 2006) are

> "to improve coordination of ongoing care requirements and follow up, using local evidence based guidelines, as part of a partnership of Clinicians and Public Health to support the needs of people with ARF/RHD. Registers assess and monitor the burden of disease, educating health workers and whanau about ARF/RHD. A follow-up system of dedicated clinics to ensure ongoing care is delivered especially to high risk patients."

Diana Lennon (2012) described rheumatic heart disease as the long shadow of rheumatic fever. Within the EBOP, in a five year period (2005-2009) there were 20 ARF admissions, 3 ARF recurrences, 93 RHD admissions for 44 patients, 15 RHD operations and 11 deaths (Beharry 2012).

When ARF prevention is a reality, no new cases will occur. However, those with its sequel, RHD, will still present to hospitals for 20 years or more. Bay of Plenty ARF prevention partnerships are actively collaborating, promoting, treating, and evaluating and early promise of a decline in ARF in the primary prevention primary school areas is shown. Secondary and tertiary improvable elements have been found and are being addressed to lessen potentially avoidable ARF/RHD morbidity over the life course of those affected. Public health methods of coordination, quality improvement approaches and system design add effectiveness and consistency to primary, secondary and tertiary prevention of ARF and RHD. We have shown how public health planning benefits from primary and secondary partnerships, including clinician ARF case scrutiny using quality assurance methodologies and feedback to partners.

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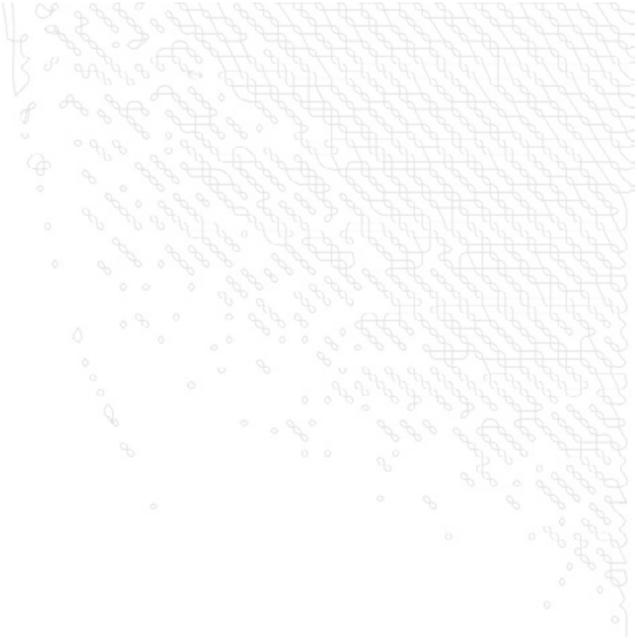

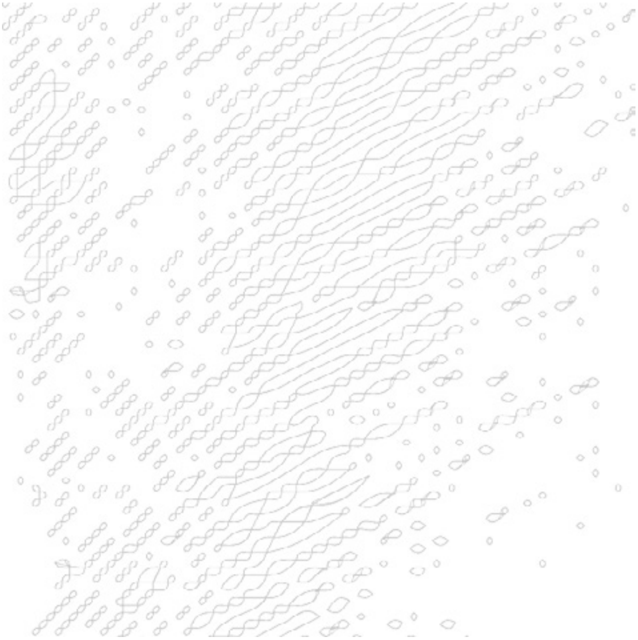

Working together in an integrated environmental health framework: the advantages of collaborative decision making and planning

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Environmental health combines public health and environmental planning in a multidisciplinary approach that acknowledges the intrinsic link between human health and the environment. Recognising its multidisciplinary nature and mobilising a "whole-of-government" approach is important in monitoring, promoting and improving environmental health.

As addressed in my presentation, New Zealand's environmental health framework has undergone ad hoc development, which has resulted in a fragmented system with a large number of interested parties and a plethora of relevant legislation. While the Resource Management Act 1991 (RMA) and the Health Act 1956 contain core environmental health functions, there are over 70 different statutes which relate to environmental health. These factors contribute to environmental health being difficult to collate into a complete and discernible framework.

My presentation focused on collaborative decision making and planning between the core parties in environmental health and how current environmental health legislation influences the nature of these relationships (including the lack of lateral connections in legislation). My presentation also discussed potential reform options to address these issues, including regional service plans, health impact assessments and coordinated environmental health bodies or forums.

Environmental health is concerned with understanding, assessing, monitoring and controlling the impact of the environment on people. The local government/central government relationship is core to environmental health management. Central government functions include researching and taking advice on environmental health priorities, incorporating environmental health goals and actions into policy and plans for implementation, developing environmental health legislation and coordinating national leadership through a collaborative planning "whole-or-government" approach.

Local government is responsible for the implementation of these plans at local community level. Local government's functions also include setting goals and plans for implementation, creating bylaws to regulate and enforce and monitoring, controlling and improving environmental health at the community level.

This split in government responsibility has allowed New Zealand to enjoy advantages through both levels of environmental health management. Coordinating environmental health approaches at a national level ensures alignment of national strategies and goals, whereas coordinating at a local level ensures alignment of strategies across regions, while allowing local flexibility, local community input and local autonomy.

Collaboration is an important requirement for successful environmental health management. Links must be established (or strengthened) between the various parties involved. This includes legislative provisions which support coordination. Government is beginning to recognise this as a preferred solution. This has been reflected in the "whole-of-government" approach adopted by central government since 2000 in government health strategies and legislative developments.

Two key hierarchies of environmental health planning documents help enforce the roles of central government and local government. The first is provided for in the RMA involving environmental planning documents. The second is provided for in the Health Act 1956 and the Health and the New Zealand Public Health and Disability Act 2000 (NZPHDA) involving health planning documents.

The RMA provides for central government supremacy by stating that all regional and district planning instruments are subservient and must be consistent with national instruments. The standards allow for a uniform national minimum standard to be applied. Interestingly, no analysis takes place to determine which instrument (the NES or regional or district plan) is the most effective at achieving the objectives of the Act. Instead, the local authority must always be subservient (RMA 1991, s44A(5)).

The Ministry of Health (MoH) adopts a policy driven role and is focused on gathering information (NZPHDA 2000, s23(1)(k)). This information is then used to create health targets and establish (and revise) national health and disability strategies which must be addressed in a DHB's yearly plan (NZPHDA 2000, s38(2)(i)). Before a DHB's plan can be finalised, the Minister will check the plan and must be satisfied that the national direction incorporated in strategies and regulations has been followed (NZPHDA 2000, s38(4)(b)).

Both hierarchies provide a 'top down' approach, with local government planning documents required to be consistent with central government planning documents. Enforcement mechanisms are in place to ensure compliance. While there are clear "top-down" connections linking central government to local government, it is harder to identify clear lateral connections at local government level (connections between local authorities, connections between DHBs and connections between local authorities and DHBs).

While central government has recognised the importance of collaboration between DHBs there has been little discussion of the importance of collaboration between DHBs and other local government bodies. This lateral connection is very important for environmental health planning, which is managed by each body with a traditional health focus taken by DHBs and a traditional environmental or resource management focus taken by local authorities. Currently, the connection is largely unsupported by statute, albeit for a general commitment to work together to fulfil their duties. Even the framework for public health action under the New Zealand Health Strategy provides for coordination on an objective or policy level without providing any statutory incentive.

There are two lateral connections, between DHBs and local authorities, which are stated in legislation. The first is under the Health Act 1956. This act implies that Medical Officers of Health (appointed by the Ministry of Health) will work with local authorities on a variety of public health matters and provides for requisitions under section 25, requiring local authorities to provide sanitary works.

The second example is in The Local Government (Auckland Council) Act 2009 (LG(AC)A) which requires the Auckland Council to provide a spatial plan to "contribute to Auckland's social, economic, environmental and cultural wellbeing through a comprehensive and effective long-term…strategy for Auckland's growth and development" (LG(AC)A 2009, s79(2)). In preparing and implementing the plan, Auckland Council is required to consult and cooperate with various parties including central government, local communities and "other parties (as appropriate)" (LG(AC)A 2009, s80(1)&(5)). The inclusion of the three DHBs in the Auckland area should be inferred here as "other parties".

Epidemic regulations also provide for coordination between EHO and Medical Officers of Health, however this is more to coordinate the officers during an outbreak to make sure they cover the different areas rather than establishing links in their relationship (Infectious and Notifiable Diseases. Health Regulations 1966).

This lack of coordination is very evident when examining the planning provisions for DHBs, regional councils and territorial authorities. In considering consultation requirements, all three local government bodies are required to consult with central government and their local community during the planning process. The provisions also require DHBs to consult with other potentially affected DHBs (NZPHDA 2000, s38), regional councils must consider the need to be "consistent with the policy statements and plans of adjacent regional councils" (RMA 1991, s61(2)(b)) and territorial authorities must consider the need to be "consistent with the plans or proposed plans of adjacent territorial authorities" (RMA 1991, s74(2)(c)). This requirement to be consistent with neighbouring authorities is common sense and simply avoids practical problems in applying the plans (particularly where they may be overlapping jurisdictions or shared management agreements in place, for example, the shared management of a river by two territorial authorities on opposing riverbanks).

Territorial authorities are also required to ensure that their plans are consistent with regional policy statements and plans (or proposed statements and plans) (RMA 1991, ss73&74). However this reflects the hierarchy of planning documents, rather than any sort of collaboration or cooperative relationship between regional and territorial authorities in planning. Even the requirement for both regional authorities and territorial authorities to take into account iwi planning documents, while creating their plans, does not involve any real collaboration or discussion between the parties (RMA 1991, ss61(2A)(a)&74(2A)).

It is extraordinary that there are no express provisions requiring DHBs, regional councils or territorial authorities to meet and collaborate with each other or consider each other's planning documents (unless it is strictly required as part of the hierarchy of planning documents). Considering all three bodies are carrying out functions and powers over the same communities, it would make sense for there to be legislatively enforced connections between the three parties. This change is fundamental to ensuring that regional plans, district plans and health plans are consistent with each other and avoid unnecessary overlaps or gaps. Even a requirement for consistency is not sufficient, as plans can be "consistent" or "have regard" to each other while still overlapping. This is counterproductive and wastes finances and resources. Requirements to be efficient and effective in planning, or to be fiscally responsible are still not specific enough to address these problems.

The Health Committee in their recommendations on the Public Health Bill 2007 supported the inclusion of a statutory provision which recognised "the importance of relationships between DHBs, territorial authorities and regional councils" and provides for "non-binding protocols" (Public Health Bill, 2007, p. 3). Unfortunately, the Public Health Bill 2007 has failed to progress since the Committee reported back on 26th of June 2008 and is still awaiting its second reading in parliament.

Incorporating express consultation and collaboration requirements into the legislation will encourage further DHBs to be actively involved in collaborative agreements and will ensure that all parties at local government level meet and are aware of each other's goals and objectives. It would provide an opportunity for parties to share gathered data on their communities and compare whether joint initiatives are possible to address certain issues (including environmental health issues). A statutory provision that required consultation and, where feasible, collaboration would further consolidate administrative tasks, pool resources and skills and maximise the potential for local government to be effective in their environmental health management.

It is important to note that legislative connections between parties do not necessarily equate to parties working together in a collaborative fashion. There is also a difference between parties being "instructed to follow" or "have awareness" of the actions of other parties and "working collaboratively" with others on joint initiatives. In the absence of strong legislative lateral connections and encouragement, many parties still work together on joint or cooperative projects which reflect the "whole-of-government" approach advocated by central government (but not yet fully integrated into legislation).

Reforms in this area tend to pull in two directions – increased consolidation through central government, and increased collaboration through local government. While consolidation at central government level may appear to be the simplest option, it fails to recognise the value of local flexibility which allows plans to be tailored to the local community. Community "buy-in" can ensure added support for an initiative. To remove the power from local government level also invalidates "local democracy", which is a central tenet of local government. Accordingly, collaborative planning options should be encouraged. These options will strengthen the links between parties (including clarifying lateral legislative connections) and encourage parties to work collaboratively which will improve consistency and reduce costs and resource use.

My presentation discussed several options to encourage collaboration in environmental health. These options include regional service planning, health impact assessments and introducing a cooperating environmental health national body (similar to the EnHealth Council model adopted in Australia) or a national environmental health forum (similar to the Land and Water Forum).

In 2011, the Minister of Health's "Letter of Expectations to DHBs" provided that "regional collaboration" was a top national priority to be built into all DHB planning initiatives via the use of regional service plans. Regional service plans are expected to have their first substantial impact on services in the 2012/2013 period. One of the first regional service plans was a collaboration between Auckland DHB, Counties-Manukau DHB, Waitemata DHB and Northland DHB, providing a regional service plan aimed at providing a standardised level of "heart health" treatment in the "northern region" of New Zealand (Ministry of Health, 2012, p.5). This has allowed for patients over the northern region to all receive the same standardised level of care and has increased efficiency by concentrating medical expertise in the one area.

Auckland and Waitemata DHB have entered bilateral agreement and describe themselves as having "agreed a special governance and working relationship" (Auckland DHB, 2012, p 16). Both boards have made "regionalisation through collaboration" a key priority for providing health services (Auckland DHB, 2012, p 16).

This regionalised approach has not detracted from the importance of localised input. Each DHB uses health information from their local population to determine their needs and used localised planning and initiatives to respond to these situations as necessary. This concept of regionalised collaborative planning approach could be extended to joint planning between local authorities and DHB's to improve planning consistency and avoid overlap.

Health Impact Assessment (HIA) is another useful tool most commonly used at the project level in New Zealand to consider the impacts of a proposed project during the resource management process. However, the concept of HIA can have an important impact on policy making by providing a tool which encourages collaboration between parties and recognising the connections between health and environmental planning when creating policies and plans.

HIA is effective at addressing two key problems in collaborative decision making. The first issue is the number of parties who are given the obligation of planning for health and community wellbeing in the one jurisdiction. HIA is the perfect tool for "cross-sectional working" (PHAC, 2005), allowing multiple parties to collaborate on integrated policy development which effectively incorporates health into environmental planning.

The second issue is that health is one of several other factors that is taken into account by these parties. This is actually one of the founding premises of HIA assessment, the idea that health is influenced by "factors that lie outside the health sector" (PHAC, 2005, p. 7), and takes place in a difficult environment with many factors influencing policy developments including political and administrative issues.

In following a HIA approach, local government bodies could gather together current data on their local communities and their list of goals and objectives together with basic plans or methods as to how these could be achieved. This could also involve identifying issues that require a cross-jurisdictional approach, or highlighting situations where joint or collaborative agreements could have the most effect. HIA would then require territorial authorities, DHBs, central government ministries, community groups, representatives and advisors to get together and consider the joint issues in environmental health faced by the community.

This could address some of the main issues in environmental health planning by identifying problems, encouraging joint initiatives (to avoid overlap), identifying "unintended negative consequences" (Blackwell, MacMillan & Tenbensel, 2012) of any proposals and establishing working relationships for the future.

However HIA has several drawbacks for local government. The process (as described above) can be very time consuming and, when coupled with community consultation requirements, can be a burden on a party's time and resources. There is often conflict between parties as to what is required to deal with a problem, who has jurisdiction or responsibility and who will be liable for problems if they occur. These problems can often deter parties from wanting to be involved in the process. Another issue or failure, with the success of HIA in environmental health planning, is the failure of parties to continue on with HIA recommendations in the long term (Blackwell, MacMillan & Tenbensel, 2012).

A further option to improve collaborative decision making in environmental health in New Zealand is to adopt an EnHealth Council (EnHealth) approach as used in Australia. EnHealth is an independent body to provide "national leadership on environmental health issues" (EnHealth, 2000, p. 3) by coordinating and facilitating environmental health programmes and ensuring coordination of the various parties involved. EnHealth, while having an independent chair, has representatives from all areas of environmental health management (EnHealth, 2000, p. 3).

New Zealand's current approach involves consultation with others, but central government sets the terms for consultation, determines who will be consulted, and ultimately holds discretion in making a decision. The EnHealth approach involves all parties at consultation and decision making stages. Accordingly the proposals will have more "buy-in" from the parties involved, with each party feeling represented throughout the process.

It is important to note that the concept of having one central body involved in coordination (like EnHealth) is very different to centralising environmental health management. A centralised body like EnHealth maintains independence and is free from political influence. The roles and responsibilities still remain with each party, however the coordination and facilitation of policies and programmes is done in a centralised manner. This may provide the answer to a coordinated framework with clear national direction (which is the most desired benefit of a centralised system), while still preserving local democracy and the ability for regional flexibility (as favoured in a central government / local government management system).

Another proposed reform is the adoption of a collaborative body similar to the Land and Water Forum (LWF). The LWF is a collective forum bringing together a "plenary," a "small group" and representatives from central and local government who carry out the role of "active observers". The forum is then used to provide advice to the government (LWF, 2012). The LWF has been praised for its use of "collective governance," which allows it to address "complex and intractable issues by bringing together the principle stakeholders… to seek agreement / consensus on a way forward" (LWF, 2000). The LWF has a positive impact on environmental health management by dealing with freshwater issues. The structure of the LWF could also be adapted and used to create a new Environmental Health Forum to consider environmental health management issues in New Zealand.

The LWF reports are regarded by government as succeeding in building "a wide consensus on a way forward for reform, based on more active and effective management of fresh water and stronger national direction" (Ministry for the Environment, 2013). Accordingly the creation of an Environmental Health Forum (following the same model as the LWF) may be a viable potential reform. The use of an Environmental Health Forum could enjoy the same positive benefits, by drawing on a collaborative approach of all interested parties in environmental health with representatives from government adopting a similar "observer role".

The use of a "forum environment," could also encourage the use of HIA in policy development. The forum environment (which could include community groups, industry groups, and others interested in environmental health management) could also help identify problem areas (Blackwell, MacMillan & Tenbensel, 2012). The establishment of an Environmental Health Forum could also result in a "national objectives framework" to co-ordinate and promote environmental health outcomes. This would give the forum a similar likeness to EnHealth in Australia. An Environmental Health Forum may also be the necessary catalyst for a renewed interest in a National Environmental Health Action Plan. The resulting plan could provide the necessary guidance and tools required to have a positive impact on environmental health in New Zealand.

As addressed throughout my presentation, New Zealand should focus on strengthening lateral legislative connections between parties, and / or adopting some of the approaches discussed above to encourage parties to engage in collaborative decision making when addressing environmental health issues.

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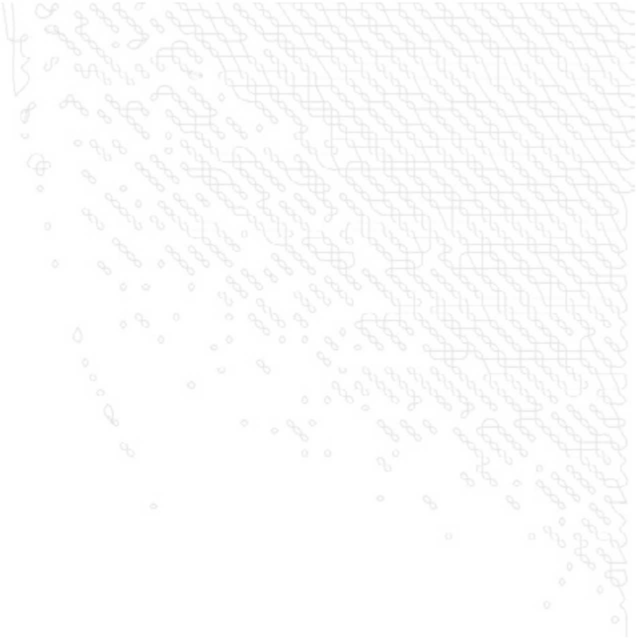

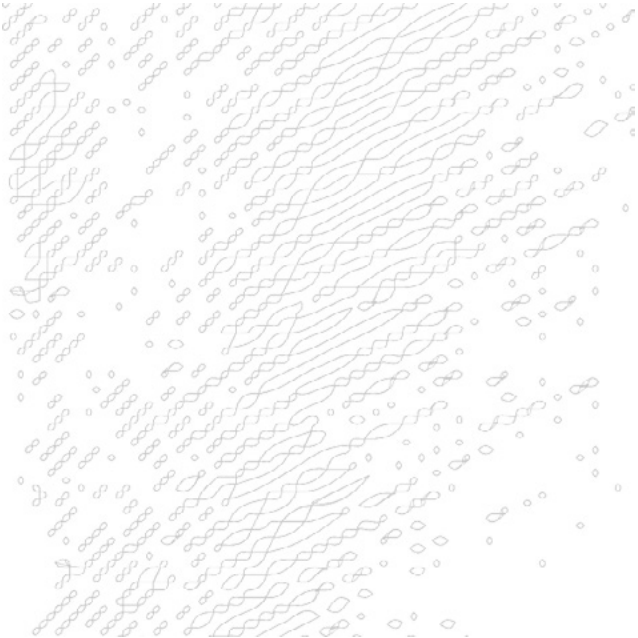

Take the colonising out of our public health partnerships and collaborations

Dr Raymond Nairn - Kupu Taea & Whariki Research Group

He tao rākau, e taea te karo; he tao kōrero, e kore e taea te karo.
The wooden spear can be parried, the spoken spear cannot be parried.

This interactive workshop is grounded in an extensive body of knowledge about the ways in which language in use: talking, writing and thinking, shapes our experience of people, places and events – creates our, individual and collective, understanding of our world's reality. The world is known and experienced this way because people do not connect directly to the world outside of their experiencing selves and, consequently, the world we experience is always a representation of the world. That representation depends upon categories, images and previous interpretations that utilise provided and interpretation of stimuli from that world – external and internal to our experiencing selves. The categories and interpretations employed are social-cultural creations constructed, understood and enabled by language in use. Rather than providing a detailed bibliography to support these assertions I have listed three sources that can assist readers to come to grips with this social action perspective on language.

One reason why we respond sceptically when first introduced to this way of understanding language in use is that the dominant culture in Aotearoa, and internationally, devalues talk and words. Take the schoolyard ditty that often passes as the preferred response to bullying:

> ***"Sticks and stones may break my bones***
> ***But words will never hurt me."***

This is a simple denial of the power of words to affect us and many of us know from experience that it simply isn't true. Participants were asked for other examples of such minimising of the power of language and provided the phrases in Table 1 that, through their common, unmarked upon use encourage all of us to overlook the social power of language. Not all cultures and languages are as dismissive of the power of language. Māori are emphatic that words can wound, build up, and tear down. The epigraph:

> ***"He tao rakau, karohia atu, ka hemo. He tao ki, werohia mai, tu tonu.***
> *The wooden spear is parried and flies wide. The spoken spear strikes home and stands"*

are two instances of this very different understanding of the power of language in use.

Table 1. Examples provided by participants

Talk fest	*Walk the talk*
Phoning it in	*Its just a joke*
Its all hot air	*He's all talk*

This minimising of the role and effect of language in use, as instanced by English speaking societies, is important because it undercuts efforts to decolonise how we talk (and think).

Following that introduction, participants were directed to consider common representations of Māori peoples, tikanga, values, and institutions. Settlers brought this discourse (language in use) here, where they extended the ways in which it denigrated and marginalised tangata whenua while naturalising settler domination of their culture, practices, and institutions as normal. Items in reference 2 provide detailed listings and discussions of this discourse. Participants were asked to talk with those nearby to identify examples (left hand column Table 2) of this language in use. Because of the ways in which it denigrates Māori peoples, sabotages partnerships and denies legitimacy to wairua, tikanga and mātauranga, settler language cannot provide a strong foundation for just and respectful relationships between Māori and settler peoples. Consequently, people who desire such relationships need to develop and use an alternative, decolonising discourse and participants, talking to those nearby, were asked to identify or make up useable alternatives to the earlier examples (right hand column Table 2).

The alternatives are not perfect but they suggest

Table 2. Settler language and suggested alternatives

Settler discourse	Alternatives
Māori stirrers	*Māori innovators*
Haters and wreckers	*Strong Māori advocates*
Māori time	*Taking time for the important things*
Stuck in the past	*Respect the gifts of our ancestors*
Māori day off	*Mental health day*
Māori privilege	*Undoing one colonial injustice*

what might be possible, as do the items listed in Reference 3. They also serve to remind us that languages evolve. The settler language cannot be eliminated by fiat but it can be rendered obsolete by those of us who wish for Māori and settler peoples to live together as envisaged in Te Tiriti o Waitangi; respecting each other in a culturally just society. That will happen if we work together, supporting and encouraging our colleagues, and are willing to give and receive helpful critical feedback about what we say and what we write. The two books listed in Reference 4 are offered in that spirit.

Ensuring that 'settler language in use' is relegated to a footnote of history and we are liberated from its insidious effects involves four interwoven tasks:

1. Looking out for 'settler language in use' and creating alternatives.
2. Using those alternatives so we say what we need to say differently.
3. Participating in decolonising speech communities where, as a matter of routine, 'settler language in use' is challenged and people say it differently.
4. Supporting members of those decolonising speech communities and encouraging all New Zealanders to say it differently.

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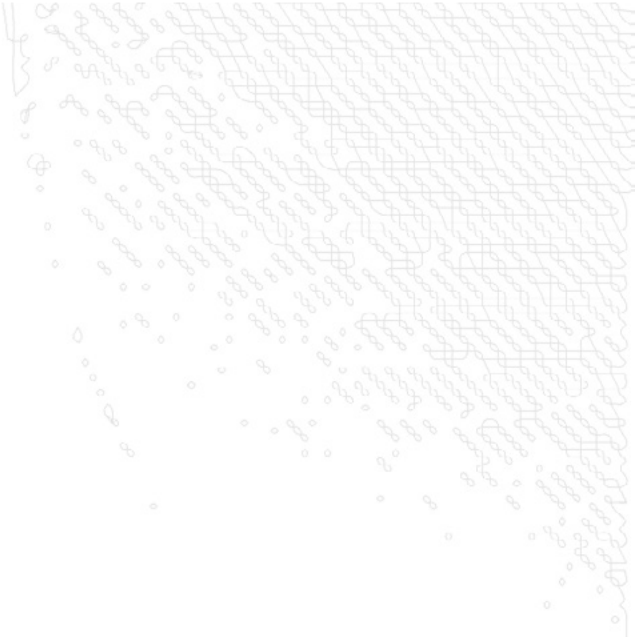

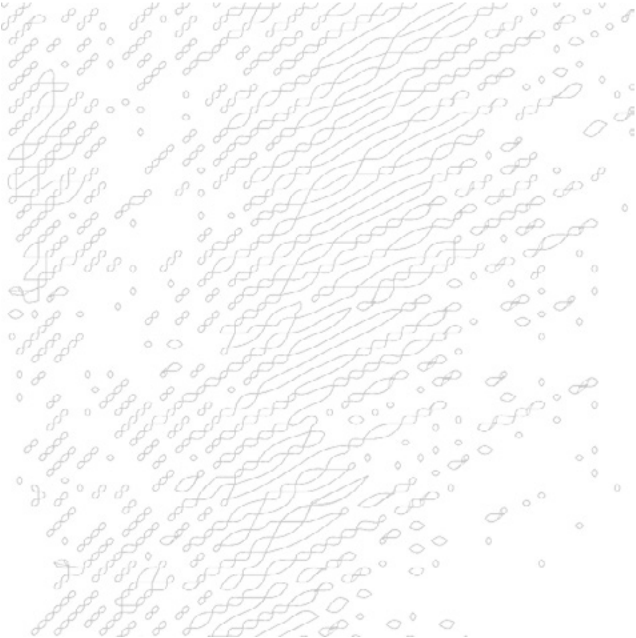

The Living Wage campaign: collaboration in practice

Annabel Newman - Service and Food Workers Union Nga Ringa Tota
Muriel Tunoho - Health Care Aotearoa
Eileen Brown - New Zealand Council of Trade Unions, Te Kaue Kaimahi

Introduction

Participants at last years 2012 Public Health Association Conference supported the adoption of a Living Wage as a measure to improve equity for children. The implementation of a Living Wage requires partnership, as faith- based communities, community organisations and trade unions come together to work collaboratively to influence employers and businesses to address poverty and eliminate low wages through practical and non-statutory means.

This presentation examines the history of the Living Wage and its establishment in New Zealand, it presents through personal stories the driving force behind the Living Wage and looks at how collaboration works in practice in the Living Wage alliance and campaign.

1. History, research, reasons

History

Following its strong establishment in the United Kingdom, Canada and the United States, the Living Wage campaign was launched in New Zealand in 2012. The Living Wage (LW) movement promotes the concept of a wage that is fair and is an adequate level of income that meets basic needs to be met and enables a dignified life. Living Wage Aotearoa is an alliance of 200 community organisations, faith based religious groups and trade unions. What is a LW and why is it necessary?

The Living Wage Aotearoa New Zealand uses the following definition:

A living wage is the income necessary to provide workers and their families with the basic necessities of life. A living wage will enable workers to live with dignity and to participate as active citizens in society.

Establishing a Living Wage figure

In February 2013, following a research process undertaken by the Family Centre Social Policy Research Unit, a LW figure of $18.40 was announced. A LW is distinguished from a poverty or income hardship threshold.

To calculate the LW the researchers took a household of 2 adults and 2 children (the most common New Zealand family size). The household was assumed to have 2 income earners, one working full time and the other half time. The researchers undertook focus groups and secondary research to establish the LW. The process calculated that a total gross income of 1.5 incomes of $57,432 was required to meet the estimated household income for the family. This in turn produced an hourly rate of $18.41. Two caveats were recognised: that regional variation exists, and secondly, that the calculation of the hourly rate is set on existing support entitlements and if any of these changes this would affect the calculation – either up or down.

Why a Living Wage?

A LW movement has been established because the statutory minimum wage of $13.75 is insufficient to provide for meeting basic needs. The LW movement was initiated by the Service and Food Workers Union (SFWU) – a union representing low paid workers, because the employment law does not provide low paid workers an adequate income. This is both because of the lack of power among this workforce, which is precarious in every sense, and also because of funding contracts, which are at arm's length from the workers, who are contracted out or employed in organisations that are essentially funded by government, such as aged care workers.

Context

The context for the LW is:

- 270,000 New Zealand children live in poverty – one in six of those is Pākehā, one in four Pasifika and one in three Māori.
- 90, 000 plus workers are currently on the

minimum wage of $13.75 and more than
- 31% of all waged workers earn less than $18.40 an hour (573,100 people).

- 40 percent of children living in poverty come from families where at least one person is in full time work or self-employed.

- New Zealand is now one of the least equitable countries in the OECD, with high inequality levels. The wealth of the richest 150 people in New Zealand grew by 20% in 2010 while wages moved less than 2%.

- People are concerned about the destructive effect from inequality in New Zealand

- The compelling evidence of the cost of inequality (see The Spirit Level) is that a more equal society is better and has fewer social problems and better quality of life for all.

The cost of low pay to society

As Deborah Littman, UK and Canadian Living Wage campaigner says, low wages and uncertain incomes also have hidden costs:

"You have your low-paid cleaner, she has children – because of the low pay she receives she can't feed them adequately. Those kids go to school without breakfast, they have less of an attention span, they get sick more often … people are doing two or three jobs and they're not around for their kids and [so] they get ill".

Society pays for this in the form of increased child poverty, reduced participation from people in their communities, greater levels of debt, poorer health and educational outcomes because of family instability, and weaker local economies.

2. Case studies of people on low wages

The following section profiles workers living in New Zealand on poverty wages and are typical of the many stories that have been told to Living Wage Aotearoa as the movement has gathered force and achieved public impact. These stories are a powerful way to inform the LW movement and the broader society of the reality of the lives and struggles of people who live on low incomes. Enabling workers to tell their stories can also be empowering for them.

Peniata

Peniata is seventeen years old and in his final year at college. He gets paid $13.85 an hour and works twenty hours a week, cleaning from Monday to Friday with his mother Emma, who works thirty-five hours a week on the same rate. He does his homework when he gets home at 10pm and gets up early the next day to go to school.

Peniata says he has no choice about working long hours because he has to help his mother look after the family and still they struggle to get by. His money helps pay school fees, school uniforms, and stationary for the two younger children. He says if they had a living wage they wouldn't miss out on school trips and he could take up music lessons and study at university.

Palutea Tafolo

Palu is employed by Spotless cleaners at Owens-Illinois (O-I) New Zealand, which manufactures glass bottles. However, she has been off work since December when she tore a muscle in her forearm while cleaning. She has not been compensated for her injury and times are getting tough. "I have nothing and I'm struggling."

Before she was injured, Palu worked thirty hours a week and earned $14.05 an hour. Her partner, Filipe, also works thirty hours a week for O-I and makes the same wage. Both of them want more hours, but have not been able to get them.

Palu liked her work but found it very physically demanding. "I think the job is too much. The specifications they gave us are too much for the hours allowed." What made her work especially difficult was that she was dealing with oil, a by-product of the glass-making process. "The oil is mostly from those who process the glass bottles. When they come out, they are all dirty from hair to boots. They touch everything – tables, computers, walls, doors, and it's my job to clean it. It's just a mess!" And cleaning oil is totally different from cleaning dirt. "It's like mud," Palu says, "If you reach out with a cloth to wipe it away, all you do is move it around. You have to dig in to clean it. I sometimes told my supervisor that when I go home and lie down to go to sleep, I feel like I'm not alive because of how tired I am from the job."

Palu and Filipe live with their four adult children who do factory work and make $13.50 an hour. None of them can move into their own flats because of the high costs of rents and utilities. The family's rent is $390 a week. Palu receives $5 per week subsidy from WINZ. She does the family grocery shopping and usually spends $200 a week. Recently, the family went to the bank to see if they could afford to buy a house together. "I could tell from the eyes of the loan officer that even with all of our incomes, it was not enough."

Tamara

Tamara is a community support worker who provides home help. She is also a solo mum. She's been working in the sector for over eleven years. Tamara has a teenage daughter and two cats. Tamara's work requires skills and patience. "These are the kinds of difficulties I face in my everyday work: People still asleep, not wanting help, wanting more done than I am allowed, the office ringing me about cover or new clients... People have heart attacks, need to call an ambulance, notify the office - and it's happened to me. It's all in a day's work! At the same time I have family demands, and all this for $14.80 an hour. I haven't had a pay review, let alone a pay increase for five years. We are really struggling to get by."

Maliki

Maliki Rahman cleans at Wellington City Council. He is paid $13.85 an hour. Maliki came to New Zealand with his wife Arifatul Ariff from Malaysia two years ago with their two children who are seven and nine. Now they have a little girl, one year old Amni Maisarah.

Maliki enjoys living in New Zealand. Arifatul is a student and she receives an allowance from the Malaysian government, but the high price of living in Wellington has been a shock, especially on a cleaner's wage. Money is tight and with power and other household concerns costs always going up, bill are always a concern. With winter there is heating and hot water to pay for, "We need to make sure the children are warm."

Arifatul and Maliki try to give their children healthy food but money is stretched. Arifatul agreed they are happy in New Zealand, but no one could deny that cleaners' wages are too low. "We're not complaining. We just want what's fair" she said.

Moli Fataua

SFWU member Moli struggles to make ends meet every day. Moli is raising six children on a cleaner's wage. For the last year she has been on $13.85 an hour, but was recently promoted to supervisor and earns $14.50. She says this is not enough to support her four children – aged from four to seventeen.

"I work full time but I am broke," she said. "Every day is a struggle to provide anything for my children." Moli said the family can only afford to eat vegetables once a week on pay day. "Otherwise all I can afford is bread and noodles and I have to ration how much I give my growing children." The family sleeps together in the lounge at night – the only time she uses the heat pump.

"It is heart-breaking when your child tells you they are sick or hungry or cold but you can't do anything about it," she said.

3. Building a broad-based alliance for a Living Wage

A survey of civil society groups

"Democracy is revitalised through an organised voice in civil society".

The Living Wage campaign in New Zealand has brought over two hundred faith-based, community groups, unions and employers together in cities and towns in New Zealand to work and implement a Living Wage in New Zealand workplaces, businesses and communities.

Working in coalition:

The LW campaign strategy was adopted by the SFWU after looking at the international experience of building a broad based coalition and developing principles from that experience and the union's own values. These included:

- The importance of a non-party political stance by the coalition.
- The joining of groups or organisations, rather

than individuals.

-
- The need to build local organisation around local relationships and issues.
- The importance of a community organising model that builds sustainable relationships across civil society, rather than rallying groups around an issue.
- Equal ownership of the Living Wage concept by community, faith and union groups.
- The creation of a separate identity for the Living Wage campaign so it was firmly grounded in a broad-based community alliance.

The new movement, Living Wage Aotearoa New Zealand, is a broad-based alliance of union, community and faith groups. Working across civil society toward a common goal is not usual in this country and so the reasons why diverse and often financially-stretched organisations have embraced a new approach to reducing poverty and inequality are worthy of exploring. Fourteen organisations responded to a survey consisting of five questions:

1. Why was your (Union/ faith based group/ or NGO) prepared to work together in this campaign to work in this way?
2. What are the considerations if you join in a broad based community based campaign requiring partnership?
3. What are the benefits from working in this way?
4. What are the risks?
5. What are the challenges?

There are four themes drawn from these responses that provide some insight into the organisation's participation in the alliance. These themes can contribute to a debate about the factors that might support a successful broad-based alliance. Firstly, respondents presented the interests of their organisation as a driver in engagement with the alliance; secondly, the values of each organisation were aligned with the values of the Movement; thirdly, the development of trusting relationships was fundamental to their perception of a successful alliance; and fourthly, working collectively provided opportunities for building power within and across the organisations, as well as the possibility of achieving goals of social change.

1. **Attending to interests**

The principle of equal ownership by community, faith and union groups depends on each organisation being able to serve its own interests through the new relationships and activity generated in coalition. All participants in the survey talked about their interests as organisations and the relevance of these interests to the Living Wage Movement. It could be expressed as commitment to the public service, fairness at work, reducing income inequality or delivering better health outcomes. From a faith perspective, one respondent said:

"Theologically, we believe that God is already present in the world, calling us to join with other people of good will to work for social justice".

The different but relevant interest of unions was expressed in the following way:

"With the LW [Living Wage] campaign, unions have the opportunity to significantly augment their efforts to raise living standards and build relevancy with broad tracts of the (unorganised) community as a force for fairness and justice at work and beyond".

A community representative articulated their interests as:

"Our members see health in the broadest sense. This means taking a holistic approach to primary health care. We view pushing income and employment [concerns] as integral parts of a person's overall wellbeing".

While each organisation is secure in its own purpose, they were also confident of the alignment with the interests of others. In fact, involvement was predicted on this alignment for one group:

"We tend to make decisions about issues and involvement depending on an emerging common mind of the nature of a form of oppression, a desired outcome, and with whom we can therefore form any

degree of partnership. Faith group respondent".

The next section explores the importance of the theme of shared values in the development of the broad-based alliance.

2. **Aligning values**

"We tend to make decisions about issues and involvement depending on an emerging common mind of the nature of a form of oppression, a desired outcome, and with whom we can therefore form any degree of partnership." Faith group respondent

The alignment of values is a strong driver of engagement in the broad-based alliance emerging to campaign for a Living Wage. For each organisation, there were strong links between the respondent's organisation's values and the values of the alliance.

One Union respondent said, "The aims and objectives of the Living Wage movement align perfectly with those of the union movement." A Faith group comment was that this was "consistent with our Church teachings" and a community organisation said, "Addressing health equity for our vulnerable communities remains our key focus. This vision resonates with the LW and LW partners."

Participating organisations are not profit-making businesses, they are often stretched for resources and most of those surveyed identified the importance of adequate resourcing for success, or the risk of failure because of inadequate resourcing. In light of this, the shared values between the organisations is likely to be more than just a consideration in the decision to be involved in the broad-based alliance, but the glue that holds the network together. That glue is likely to be ineffective without strong functioning relationships. The importance of relationships to a successful alliance is the theme of the next section.

3. **Investing in relationships**

"Broad-based campaigns bring together diverse organisations and therefore there is a period in which groups must invest in building relationships and not make assumptions about common values delivering a commitment..." Community respondent

Relationships are central to the success of the alliance for most respondents. Relationships were seen as so fundamental that in some cases, the ability to resource the development of the relationships would be a determinant in participation. One group asked itself, "Are there people within this parish who can 'carry' this campaign forward? With whom will the parish be allied in the campaign?" Others commented:

"Working in partnership takes time, and some investment of resources into building the relationships that hold the coalition together. A decision needs to be made whether we have the time, money or personnel to work in this way". Faith group respondent

"You need to build up trust, you need to understand and listen to the issues the other groups bring with them, you need to be in the campaign for the long-haul and you need to make an investment in money and resources that is not going to deliver immediate financial return to your organisation..." Union respondent

The challenges of building relationships across diverse groups were commonly articulated in the survey. On the one hand, there is an acknowledgment that this requires building on values that groups share and not those that divide: as a union respondent said, we must "leave our 'baggage' at the front door and sit at the table with our community partners, intent on genuine dialogue". On the other hand, it requires an acceptance of the value of divergent views, or particular beliefs and a faith group respondent noted this acceptance within the campaign:

"We were amazed that faith communities were considered to be a vital part of the Living Wage campaign. We are used to working in alliances but the particular contribution of faith communities in terms of both the people in the communities and the theological/justice basis of faith communities are not usually appreciated. So usually you join and "check your faith perspective at the door." Faith group respondent.

Building successful relationships across civil society can also have ripples through participant organisations, as this faith group respondent says:

"Because of our theology, we expect to find God's presence in others, and to learn new insights from them. We find that many of our assumptions about people who are 'different' to us theologically,

politically and socio-economically need re-examining".

The benefit of effective relationship development to participant organisations was a strong theme in the survey. Communities referred to the benefits of exchanging knowledge, skills and expertise. One community organisation listed "working with others who also share passion for [addressing] inequalities" and "access to inspirational people."

"The Unions are amazingly generous, hardworking and effective in the ways they are supporting the campaign. It's been wonderful to have their experience in organising…" Faith group respondent

The benefits to the movement as a whole were equally clearly articulated. One union noted that the ability of the alliance to generate "high trust relationships" would protect it against losing focus and a faith group respondent linked the effective relationships to the transformational goals of the movement:

"The relationships among people working together are great. It's not a charity model because the people who benefit directly are part of the movement rather than recipients, and the rest of us benefit indirectly by living in a more just society".

The goal of the Living Wage Movement is "to facilitate the organisation of communities in New Zealand to secure the income necessary to provide workers and their families with the basic necessities of life." The last section focuses directly on the question of why organisations might choose to work together to achieve societal change.

4. A collective approach

"It is a no brainer. By ourselves we are nowhere near as strong and powerful as in coalition with diverse groups linked in their pursuit of an agreed goal" Union respondent

The benefits of diverse groups working together in coalition are celebrated by the faith, community and union respondents to the survey. Despite the risks and the challenges, the respondents talked of benefits in both the process of working in coalition and the enhanced ability to deliver societal change. Challenges focused on lack of resources, such as time and money, but also the potential risk for diverse groups to experience philosophical tensions and a loss of direction. Nevertheless, all respondents identified advantages in working collectively as partners in an alliance.

Faith, community and union group respondents expressed a commitment to the purpose of the broad-based alliance - to deliver a Living Wage – but also to a collective approach to achieving their purpose. For one community group, the notion of working in coalition aligned with their kaupapa (expressed as "Collective knowledge - empowers communities to create change"). One faith group respondent said the broad-based alliance aligned with their tradition of "collaboration" and for another it aligned with their "experience in processes of partnership."

Working collectively and collaboratively in "partnership" assumes shared power and respondents did not shy away from expressing their views about this:

"We need to be prepared to work hard with our partners to build new strategies that involve working together to beat poverty wages. Unions will not have all the power in control in this process, it must be shared". Union respondent

Researcher Jane Wills refers to "identity-linking" as a key element in the success of the London Citizens broad-based alliance, in which the values of individuals and organisations that link up are reinforced in the alliance-building process. This notion of "identity-linking" was captured in a comment by one of the faith group respondents:

"For a potentially narrow-focused community (i.e., a religious grouping in this case) it can widen our focus and actually (in this case) remind us of some of our core values and teachings".

While organisations identified that they are strengthened in the process of working together in coalition, the combined power of the participant organisations also increased their hope of achieving their goals. One union group respondent says:

"What's revealing to date is the very significant amount of 'common ground' between the participating groups and organisations. It is clear that there is much we can work together on – and therefore build real synergies and power – to drive

consciousness and action around the realisation of the Living Wage agenda".

All respondents are part of groups that aspire to societal change and see the opportunity to work collectively as a way of overcoming isolation and powerlessness. This includes among the largest organised voice in the alliance - the unions.

"Very often union voices are isolated off from others who may actually share similar values or concerns. By building the strongest possible base of community support, we maximise the leverage and potential for success of the campaign". Union respondent 1.

"We cannot do this by our union alone or just with a group of unions. This needs to be a cross-society campaign if it is going to be successful and lead to long-term change. That is why we have enthusiastically been part of the wider coalition". Union respondent 2.

Working in coalition was also viewed by respondents as a practical way to achieve the goal of a Living Wage, even if the risks of losing the prize at the end of the day seemed high to some. For instance, one faith group respondent said the coalition "gives greater reach to the message and a breadth to the message", another said that "working together sustains momentum" and a community respondent noted that the diversity of the alliance was able to "unleash creativity and energy that is rare in any single organisation." It was a faith group respondent that captured the experience of many of these respondents in their engagement with the Living Wage movement:

[The] "only real way to make progress is through broad based alliances. This has been a wonderful movement to be involved with".

Conclusion

The broad based alliance that is forming under the banner of the Living Wage Aotearoa New Zealand comprises unions, faith-based religious groups and secular/community organisations. They have diverse constituencies but they share a common aspiration, which is to reduce poverty and inequality in New Zealand. More importantly, they link the aspirations of their organisation with the goals of the broad-based alliance and its participant organisations. In the words of one respondent, they have become "a functional group which has the ability to make effective change."

However, it is the investment in relationships that provides the greatest challenge and the greatest rewards for members of the alliance. The relationships between organisations that share divergent ideological, philosophical and religious perspectives can easily fracture, or the alliance can lose focus, but participants identified significant benefits from the investment of time and resource in building solid relationships. The experience of some was clear: "It's effective. We can see that already. It's inspiring. The relationships among people working together are great."

Working in coalition has raised the expectations of many respondents that they can grow in strength and they can achieve societal change, but they also express realism about the challenges and the risks. As one union respondent said:

"This is a huge struggle. The Living Wage presents a real threat to the (neo-liberal, market driven) establishment. They are not stupid. They know that the campaign potentially has huge ramifications for their agenda of small government, low taxes, weak labour law / weak unions, low wages, community atomisation, free-markets, etc. They will bite back hard and will not give up without a fight".

The notion of working collectively can be interpreted as "partnership", or "collaboration", but all respondents valued the potential for greater influence through a united voice across civil society. For one faith group it opened a door to a new way of working: "When we found out about the Living Wage Campaign we realised we could make a difference by collaborating with others". It was the reflections of a union respondent that captured the essence of why this alliance is important to their organisation:

"Only a broad coalition of community, faith and union organisations will be able to win the campaign for a living wage".

'Dipping a toe in the water': social media in public health

Debbie Phillips, Dr Neil de Wet and Dr Jim Miller - Toi Te Ora – Public Health Service

Social media has opened up new and engaging ways for public health professionals to communicate with people and organisations.

Social media is a collection of communication channels that include all of the various activities that combine social interaction and technology. These include, but are not limited to: texting, blogs, social network sites and podcasts. Social media is less about the technology and more about the way it enables people to interact online.

Communicating effectively with an audience includes identifying which channels enable the best reach. The 'Internet in New Zealand 2011' survey by Auckland University of Technology (Smith et al, 2011) showed 86% of New Zealanders use the internet and 64% of these internet users belong to a social networking site. Social networking sites are where people are conversing, talking, supporting each other, reading information and more. In the past, these conversations were in face-to-face settings, however, these conversations are now happening increasingly online. Additionally, the survey also found that 72% of people said they search for health information online at least occasionally. The use of the internet and social networking sites has transformed and expanded the ways people and organisations can communicate. Social media has unique communication features over more traditional channels. Information on social media can be disseminated in real-time and easily accessed from mobile devices. Users of social media can send information to and through their online networks.

Therefore, for public health services to communicate effectively with key audiences there is no choice - social media must be considered as part of regular communications planning. Toi Te Ora - Public Health Service, the Public Health Unit for Bay of Plenty and Lakes DHBs, chose to use social media as a complementary communications channel to support the purpose and goals of the organisation.

To do social media well, many factors required consideration including adequate resourcing especially in terms of skills and expertise, management commitment, strategy and planning, utilising best practice, measuring and monitoring activity, identifying the opportunities, understanding the benefits and identifying and managing the risks. Toi Te Ora – Public Health Service chose to examine these factors, initially by scoping the use of social media for the service and then developing a planned approach to social media use.

Firstly, the strategic direction for Toi Te Ora – Public Health Service's use of social media was established: ***"Toi Te Ora – Public Health Service will use social media to establish connections, maintain relationships with individuals and communities in order to provide information, updates and platforms for discussion that contribute towards the achievement of public health outcomes."***

Once the strategic direction was set, a plan to pilot social media was created. Within this plan, the following were considered: aims, objectives, channels, audiences, benefits, risks (and management of these), promotion, costs, resources and evaluation. The micro-blogging service 'Twitter' was selected as the most suitable social media channel for the two month pilot. A Twitter account was developed specifically for disseminating information on health warnings and alerts to the communities of the Bay of Plenty and Lakes districts. A range of tweets- short bursts of information limited to one hundred and forty characters- were posted on a variety of public health topics, such as the toxic shellfish health warning, whooping cough, a flooding event and meningococcal disease. During the pilot period, people and organisations active on Twitter followed the account and vice versa.

Evaluation of the pilot showed Twitter was a useful, complementary tool to augment communications work. The account was expanded to include disseminating a broader range of public health messages and information on the service.

In addition to Twitter use, Facebook advertising was used to promote the 'Protect our most valuable taonga' childhood immunisation awareness raising campaign. The advertising was highly targeted and easy to measure. It was found to be an exceptional driver of traffic to the immunisation campaign webpage.

Social media will continue to be considered by Toi Te Ora – Public Health Service as part of its regular communications planning and as opportunities arise.

Social media is continually evolving. As internet access becomes greater and participation in social networking sites becomes increasingly popular, public health services need to ensure they have a presence in these online communities.

Reference

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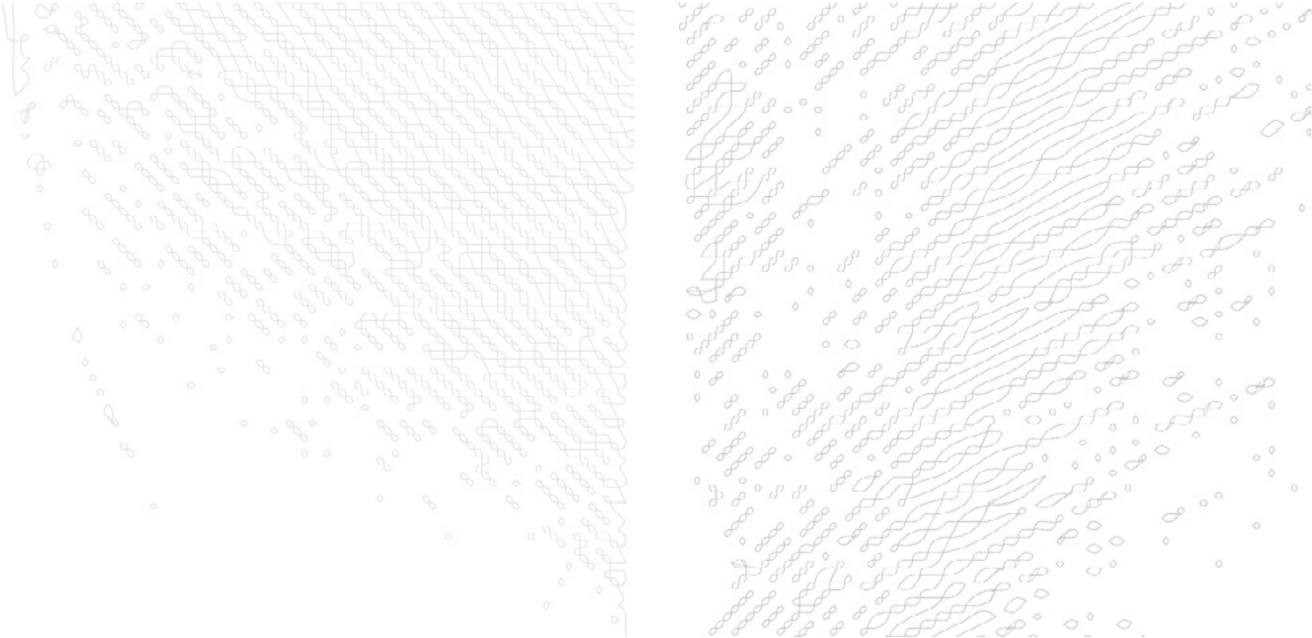


A whānau ora population based health needs assessment for Māori living in Taranaki

Dr Mihi Ratima - Taumata Associates
Becky Jenkins - Taranaki District Health Board

1. Introduction

A Whānau Ora Health Needs Assessment provides a systematic method to assess the health needs of Māori living in Taranaki. At the 2006 Census, 15,816 Māori were resident in Taranaki and Māori make up 15.2% of the total Taranaki DHB population. In the context of extensive and current Māori and Government support for Whānau Ora, it was the logical choice as the overarching framework for the HNA.

This paper outlines the rationale for undertaking an HNA, identifies key elements of the Whānau Ora framework of the HNA, briefly describes the methodological and data collection issues, summarises the priority areas identified for Taranaki Māori and provides examples of how the HNA has been used for health and health services development in Taranaki to date.

2. Rationale

DHBs are required under the New Zealand Public Health and Disability Act (2000) to regularly investigate, assess and monitor the health status of their resident population. This involves identifying factors that may adversely affect the health status of the population and assessing the health needs of the population (Clause 23(1) (g)).

A Health Needs Assessment is a systematic method to identify a population's unmet health and healthcare needs, identify inequalities in health and access to services and determine priorities for the most effective use of resources, taking into account the capacity of a population to benefit from intervention. Therefore, HNAs are a way for DHBs to meet the requirements of the Act while providing evidence to inform decision-making, with regard to health service planning, funding, contracting and provision.

Improving Māori health is a priority for the Taranaki DHB. Understanding the health needs of Māori living in Taranaki is necessary in order to determine priority areas for service planning for Māori that will lead to improved health outcomes and reduced inequalities in health. HNAs provide DHBs with evidence to inform decisions about the priorities for Health and Disability Services for their population. DHBs develop Regional Health Plans, Annual Plans and specific Māori health planning documents, using the evidence compiled in the HNAs.

3. Key Elements of the Whānau Ora Framework

3.1 Whānau Ora Philosophy

The core of the Whānau Ora philosophy, from a Taranaki DHB perspective, is a concern for whānau ownership of their own health development. The characteristics of a Whānau Ora philosophy that give Whānau Ora definition and distinctiveness, as it relates to health, are that it

a) Recognises a collective entity (whānau). Whānau Ora is not simply about the sum total of collective measures, but is primarily concerned with the ways in which the group functions as a whole to achieve health and wellbeing for its people.

b) Endorses a group capacity for self-management and self-determination. Therefore, Whānau Ora activities will transfer knowledge and skills to whānau, so that the group develops critical awareness and are best able to manage their own health and wellbeing.

c) Has an intergenerational dynamic. That is, Whānau Ora is about ongoing intergenerational transfers towards the goal of increasing the intergenerational sustainability of improved health outcomes.

d) Is built on a Māori cultural foundation. Wellbeing is closely linked to Māori cultural identity and the expression of Māori values. Therefore, identity-based whānau health development will be a central strategy.

e) Asserts a positive role for whānau within society. Health institutions should have the capacity to respond positively to whānau, and whānau should be able to negotiate freely with these institutions to achieve the best results.

f) Can be applied across a wide range of social and economic sectors. Whānau Ora is equally concerned with socio-economic wellbeing, and cultural and environmental integrity.

3.2 Conceptual Foundation

Conceptually, the HNA is located within the context of the Treaty of Waitangi and theoretical understandings of the determinants of ethnic inequalities in health. Features of the Treaty of Waitangi of high relevance to the HNA are provision for the protection of Māori wellbeing, a Treaty-based Māori right to equity in health outcomes, Māori participation that is most relevant in terms of Māori input into priority settings and protection of Māori custom, which includes whānau structures and cultural integrity.

Health inequalities are differences in health status between groups that are avoidable, unfair and unjust (Kawachi, Subramanian et al. 2002). The drivers of ethnic inequalities in health can be described in terms of basic causes and surface causes. Basic causes are the fundamental drivers of health outcomes (e.g. racism and economic and legal structures), while surface causes are risk factors and resources which mediate between ethnicity and health status (e.g. health practices and medical care). A focus on surface causes alone will be insufficient to address ethnic inequalities in health, if basic causes are not addressed. The 'Pathways to Inequalities' framework (Reid and Robson 2007, based on Jones 2001) provides further theoretical explanation for ethnic inequalities in health, which places a stronger emphasis on the need for access to quality health care. The following three key pathways to ethnic inequalities in health are identified:

I. Differential access to the determinants of health or exposures leading to differences in disease incidence.

II. Differential access to health care.

III. Differences in the quality of care received.

3.3 Monitoring Framework Derived from He Korowai Oranga

He Korowai Oranga provides key elements of the overarching Whānau Ora HNA framework. The rationale for drawing on He Korowai Oranga as the basis of the HNA framework is as follows:

a) Whānau Ora is the overarching aim of He Korowai Oranga, and therefore is consistent with the approach taken by the HNA. He Korowai Oranga is centred on Whānau Ora.

b) He Korowai Oranga sets the direction for Māori health development in the Health and Disability Sector and is therefore a known framework that is recognised and well understood within the sector by the range of Māori health stakeholders.

c) The Strategy makes explicit the public sector responsibility for supporting the health of whānau.

d) The four pathways for action identified in the Strategy lend themselves as the core of a monitoring framework which may be populated with health indicators relevant to Whānau Ora.

The monitoring framework adopted for the HNA is comprised of five domains, four of which are based on the pathways identified in He Korowai Oranga. The monitoring framework is populated with indicators classified under each of the five domains. This monitoring framework used in the Whānau Ora HNA report may be readily adaptable for use within a variety of accountability frameworks. One such framework is Results Based Accountability (RBA). RBA is increasingly being adopted in the Health and Disability Sector and the Whānau Ora HNA Framework can be applied in a RBA model.

3.4 A Life-Course Orienting Perspective

The HNA applies a life-course orienting perspective in two ways. The first is by considering the health risks and protective factors that are linked to various life stages (e.g. pēpi, tamariki, pakeke, kaumātua) within the context of an integrated life-course continuum. That is, each life stage is influenced by preceding stages in a cumulative way. Secondly, the HNA acknowledges the value of a life-course orienting perspective in terms of its application as a predictive tool that may be used to identify intervention points to address unmet health needs. At the whānau level, adopting a life-course orienting perspective enables whānau to plan and be proactive, as opposed to laissez-faire and reactive.

4. Methodological Issues

The Whānau Ora HNA draws on both quantitative and qualitative information sources. Quantitative data were in the main, drawn from sources through which routinely collected data are available. Qualitative data are drawn mainly from engagement (primary and secondary sources) with local Whānau Ora stakeholders including Māori whānau living in Taranaki, Māori health providers, Māori health professionals and iwi representatives.

Key issues with the data collection process include:

a) The wellbeing of whānau cannot be measured through the simple addition of measures of the health and wellbeing of individual members. That approach, instead, tells us about the health and wellbeing of a group of individuals.

b) The types of indicators of most relevance to measuring the vitality of other Māori social structures, such as iwi (e.g. Representative iwi structures, assets held by iwi on behalf of its membership) are not necessarily a direct reflection of the wellbeing of whānau. Rather, while measures that relate to other levels (e.g. individuals, marae, hapū, iwi and Māori communities) will be relevant, in isolation they do not capture Whānau Ora.

c) Indicators have not yet been developed to measure many of the concepts that underpin Whānau Ora, such as manaakitanga and kaitiakitanga.

d) It is unclear how to best capture the intergenerational transfer function of whānau, that is, for example, the capacity for intergenerational care and transmission of cultural values.

e) While government agencies, including DHBs, will continue to be most effective in collecting data related to adverse events, iwi and other Māori groups may be more interested and take a leading role in the development of indicators that reflect positive Whānau Ora achievements such as health literacy or te reo Māori usage.

Therefore, the extent to which Whānau Ora can be directly measured is constrained and there has been some reliance on proximate measures at a variety of levels while concurrently seeking to maintain a clear focus on the whānau collective. For these and other reasons, indicators included in the monitoring framework are not definitive. Given these limitations, data gleaned through engagement with Māori stakeholders have been important sources of information. The challenge remains as to how community goals and aspirations for Whānau Ora can be translated into measureable targets that the DHB and other stakeholders can affect within reasonable timeframes (e.g. that enable progress to be tracked over a five-year period).

5. Priority Areas

The factors used to guide the Whānau Ora priority areas for intervention were identified as:

- Responsiveness to intervention by the Taranaki DHB and service providers
- Burden on whānau
- Consistency with local Māori aspirations for Whānau Ora
- Whānau Ora efficacy
- Extent of ethnic inequality and data quality

Any process of priority setting relies on both best available evidence and the exercise of good judgement. Within the constraints of the project, this Whānau Ora HNA has sought to access the best available data and to draw on intersectoral and Māori stakeholder input throughout the Whānau Ora HNA, in an effort to ensure that identified priorities are evidence-based and reflect community aspirations for Whānau Ora. HNA findings are described below within the framework of the four pathways outlined in He Korowai Oranga.

5.1 Te Ara Tuatahi Pathway One – Development of Whānau, Hapū, Iwi and Māori Communities

According to the 2006 Census, 72% of Māori resident in Taranaki were able to name at least one iwi affiliation, which may reflect a felt connection among local Māori to iwi. More than 300 children were enrolled in Kōhanga Reo and Māori immersion Early Childhood Education Centres across Taranaki.

Preliminary findings from a local Te Puni Kōkiri marae development survey indicate that marae are a key whānau resource that are regularly utilised by whānau. While a number of marae offer wānanga to strengthen localised Māori knowledge and practices, there are widespread concerns for marae regarding the potential loss of history and tikanga/kawa.

In 2008, BERL Economics were commissioned by Venture Taranaki Trust and Tui Ora Limited to develop an economic profile of Māori in the Taranaki Region. The report estimated a total Māori asset base in Taranaki of around $770 million.

Whānau, hapū, iwi and Māori community development as a basis for Whānau Ora was identified as a priority area through Māori engagement. However, progress in these areas will necessarily be characterised by Māori ownership and will be driven by Māori, rather than by funders and providers. The challenge for funders and providers will be identifying ways in which they may take a facilitating role, without taking leadership and therefore risking engendering dependency.

5.2 Te Ara Tuarua Pathway Two – Māori Participation in the Health and Disability Sector

There are a number of mechanisms for Māori to participate in the governance and delivery of health services locally. Māori providers in Taranaki deliver a variety of health care services within kaupapa Māori frameworks. Taranaki DHB regularly collects information on its workforce. The proportion of Māori in the DHB workforce is 7%. Māori tend to be working in areas that require lower levels of formal qualifications and are particularly under-represented in key areas such as Medical, Nursing and Management categories. The highest proportions of Māori staff are found in Allied Health (10.9%) and Support (10.6%) categories.

Building the capacity and capability of Māori providers and the Māori health workforce were identified through Māori engagement as priority areas. The need to strengthen the Māori health workforce was also identified through data review.

5.3 Te Ara Tuatoru Pathway Three – Effective Health and Disability Services

There are substantial ethnic inequalities in health between Māori and non-Māori living in Taranaki, as measured by life expectancy, avoidable mortality, and self-reported health status. For Māori in the Taranaki Region, the leading causes of avoidable mortality are ischaemic heart disease, lung cancer, diabetes, and chronic obstructive pulmonary disease. The leading causes of avoidable hospitalisation in Māori are angina and chest pain, asthma, dental conditions and respiratory infections. The leading causes of ambulatory sensitive hospitalisation among Māori children and young people are dental conditions, asthma and respiratory infections such as pneumonia. These leading causes differ between Māori and non-Māori, indicating that priorities for intervention will differ between the two population groups.

In this context, it is not surprising that Māori living in Taranaki have a greater exposure to risk factors than non-Māori. For example, some 47% of Māori females and 38% of Māori males are regular smokers. Furthermore, Māori are under-represented in terms of utilisation of preventative care, such as breast screening and cervical screening.

These risk factors, protective factors, and patterns of health service utilisation are modifiable. Moreover, they all have a major impact on health conditions for which there are inequalities in morbidity and mortality and that were identified through data review as areas of demand and need for health services for Māori living in Taranaki.

Much more needs to be done to improve access to health services at all levels for Māori in the Taranaki region. This is evident from the review of patterns of health service utilisation for preventative care/screening, primary care and outpatient care.

Community engagement identified increased access to health services at all levels and particularly at the primary health care level as a priority. This is supported by the review of data relating to patterns of health service utilisation for preventative care/screening, primary care, DNA rates for outpatient care, and ambulatory sensitive hospitalisations. Improving geographically equitable access to quality health care across the Taranaki region and the implementation of Whānau Ora oriented service provision were also identified through community engagement as high priority areas.

The following have been identified as priorities in terms of protective and risk factors and preventative care: smoking, alcohol and drug issues, breastfeeding, immunisation, breast screening and cervical screening. The importance of health promotion for whānau to reinforce protective factors and mitigate risk factors was emphasised in community engagement. Priority health conditions identified in this Whānau Ora HNA were: diabetes, cardiovascular disease, lung cancer, breast cancer, respiratory disease (i.e. COPD and asthma), oral health, mental health and disability.

5.4 Te Ara Tuawhā Pathway Four – Working Across Sectors

There is clear evidence that Māori living in Taranaki have poor access to socio-economic determinants of health, and this is reflected in high relative levels of deprivation compared to non-Māori. There are different patterns of deprivation for Māori and non-Māori in Taranaki. Non-Māori are over-represented in the wealthiest socio-economic deciles (1 and 2) and Māori are over-represented in the poorest socio-economic deciles (9 and 10).

It is also reflected in barriers to health care and related needs (e.g. ability to pay for service provision and access to transport) identified through community engagement. The importance of addressing determinants of health through intersectoral collaboration (e.g. to improve access to social services) was consistently highlighted as a priority area during community engagement. There is much potential for Taranaki DHB to actively participate in, and in some instances take a leadership role as champions or advocates, in intersectoral activities that contribute to Whānau Ora.

6. Application of a Whānau Ora HNA in a Taranaki Context

The HNA recommended that the Whānau Ora Health Needs Assessment be utilised by the Taranaki DHB, health and disability providers and intersectoral partners to inform priority setting and action to support the achievement of Whānau Ora for Māori living in Taranaki. Examples of how the HNA has been applied to date include:

Within the health sector
a) The determination of local Māori Health priorities for Māori Health planning purposes within Taranaki DHB.
b) To provide baselines for special focus projects arising from the Māori Health Plan within Taranaki.

c) To inform the development of an outcomes-based contract with Te Kawau Maro the local Māori Health provider.

d) By Midland Te Tumu Whakarae to inform development of a DHB Whānau Ora Framework.

By other partners
a) Whakatipuranga Rima Rau Trust (Māori Health and Disability Workforce Development Project) to establish baseline data.

b) MSD Community Response Forum with regard to socio-economic status of Taranaki populations.

c) With iwi to raise understanding of health and socio-economic status of Taranaki Māori and as an example of a Whānau Ora monitoring framework.

d) Adoption of the Whānau Ora HNA monitoring framework by some DHB's and to inform discussions of the local Whānau Ora Regional Leadership Group.

7. Concluding Comments

The ultimate purpose of a Whānau Ora HNA is to provide an evidence base to inform action that will lead to improved Whānau Ora outcomes in health. Too often so-called 'evidence-based' decision making removes the social and wider context within which Māori whānau live their daily lives and resulting initiatives fail to address the drivers of poor health outcomes and inequalities. Whānau Ora HNAs provide a health sector input into collective efforts to better understand the needs and aspirations of whānau and inform action for the achievement of Māori potential.

A copy of the report is available on the Taranaki DHB website www.tdhb.org.nz

Healthy Kai Policy: Collaborating against the Multitudes

Antony Thompson, Malina Parkinson - Te Ha Oranga o Ngāti Whatua
Te Pora Thompson-Evans, Zoe Hawke - Hāpai Te Hauora Tapui

Abstract

For more than fifteen years Hāpai Te Hauora Tapui has sponsored the Māori stage at the annual ASB Polynesian Festival (PolyFest). PolyFest is an event that showcases the cultural talent of high school students in Tāmaki Makaurau, with thousands of people flocking to it every year. Alongside our shareholder organisations and sub-contractors Raukura Hauora o Tainui, Te Ha Oranga o Ngāti Whatua, Huakina Development Trust and Te Whānau o Waipareira, Hāpai delivers health promotion at the event through identifying and developing community champions and overall awareness raising.

In a move to positively clear a regional pathway to wellbeing, a collective effort was mobilised to develop a healthy kai policy at an event that has become famous for not only its rich cultural performances, but also rich and often unhealthy kai. The year 2013 was the first time that a healthy kai policy was developed and implemented. In previous years our efforts have seen such an event become Smokefree.

This presentation is the story of our journey towards the Healthy Kai Policy, our challenges, our duplicable learnings and our outcomes. We also feature feedback from whānau and food stallholders that attended the event and the impact that such a movement has had.

Introduction

In this presentation we provide a case study of a regional Māori public health approach to implementing a healthy kai policy in Māori and Pacific Island settings. Today we will provide some background on who Hāpai Hauora Tapui is and what we do in the Māori Public Health realm. We will also provide some background on PolyFest and our involvement in the Māori stage. We will explain the vision and goals we set ourselves to achieve and the timelines to do them, in relation to the actual Kai Hauora Policy created for the Māori Stage. The use of champions assisting in our kaupapa and the long term changes we hope to achieve.

Background

We are Hāpai Te Hauora Tapui (Hāpai), a Māori Public Health provider based in Auckland who invest in community and whānau wellbeing locally, regionally and nationally. Since 1996, Hāpai Te Hauora Tapui has supported communities to have a voice on issues that affect them and their whānau, so that whole communities can be well. On a day to day basis, Hāpai also provide infrastructural support to the hauora sector to strengthen public health action. Hāpai are supported by “Whānau Whanui” a collective of Māori Public Health providers whose aim it is to support their local communities on a takiwa (district) basis. Whānau Whanui consists of Te Ha Oranga o Te Runanga o Ngāti Whatua, Raukura Hauora o Tainui, Te Whānau o Waipareira Trust and Huakina Development Trust. Hāpai currently are the only Māori Public Health collective that spans a complete region, from North Rodney through Tāmaki Makaurau to Pukekohe and districts.

PolyFest

PolyFest is one of the largest annual Polynesian Festivals that specifically showcases Polynesian cultures of secondary students in the world. The once small festival began at Hillary College, Otara, Auckland in 1976. Each progressive year attracted more schools and in turn more cultures, so that by 1996, some twenty years later, the festival was officially moved to the larger Manukau City Velodrome to cater to the growing number of attendees and performances.

Polyfest is a cultural expression gathering of students from Auckland Secondary Schools. There are six unique cultural stages: Māori, Cook Island, Niuean, Samoan, Tongan and a diversity stage. More than one hundred and ninety two cultural groups, totalling approximately nine thousand performers from sixty-five schools, perform at the festival.

Current Situation

In 2013, Hāpai sponsorship of the PolyFest Māori stage ignited a stocktake of what factors, taken together, impact on the current PolyFest nutritional environment and the impact these factors have on whānau hauora. The current PolyFest nutritional environment is a combination of limited nutritional awareness, numerous stalls selling non-cultural high fat, high sugar and high salt content foods, high waste, mixed nutritional messaging and strategies involving the marketing of fizzy drinks, lollies, potato chips and toffee apples to attract customers. The impact of this is unsupportive of the positive Māori and Pacific Island nutritional environment we wish to influence and create. Historically, the festival had a nutrition orientated kaupapa that ran at PolyFest, but over several years of little or no monitoring and little support, this fell by the wayside. In an effort to gain mass traction toward healthier communities, Whānau Whanui identified PolyFest nutrition as a gap and an opportunity for Māori community action teams to work together collectively on a policy intervention.

Policy Intervention

The use of a policy intervention was recognised by all whānau whanui as being the most promising strategy for influencing change & creating wide improvement in attitudes to healthy eating choices. Discussion for this intervention commenced prior to PolyFest. Hāpai now have signed an agreement and memorandum of understanding with event management of the PolyFest for greater meaningful and proactive input into future festivals, which includes annual reviews, development and monitoring of the kai hauora nutrition policy. This agreement provides an active opportunity to work collaboratively on a community development project for the benefit of the community. The final product of months of negotiations, drafting and redrafting resulted in this kai hauora policy.

Community Champions

In order to drive this policy intervention from the ground level, this year we included the use of champions from the community. Champions enabled a greater canvassing of PolyFest through the gathering and conduction of survey, interviews rangatahi (youth) and their whānau based on their views of healthy kai at PolyFest. Champion involvement enhanced our intervention delivery, as they were on par with the rangatahi they spoke to and were able to get real world responses back that an older set of interviewers may not have in the same situation.

In the future, further development and inclusion of community champions in our delivery both regionally and locally will be implemented at PolyFest. The key outcome of involving the community in the form of champions was the increase in capacity and capability to promote community kaupapa. Their ability to relate more effectively with our audience ensured they were really well received. They definitely exceeded our expectations and left us feeling really energised at the prospect of future development.

2013 Model

This year, 2013, was an opportunity for us to identify areas of potential challenges and goals. Our model was simply tasking ourselves with firstly identifying simple, affordable and effective changes we can influence and initiate, and secondly, what opportunities for awareness existed. The outcomes of our tasking lead to the strong need to initiate conversations and increase our interaction with event management, kai vendors and the PolyFest community and attendees.

Long-Term Planning: The next five years

Planning for 2014 will focus predominantly on enforcing our priorities. Priority remains focused on overall restriction and monitoring sales of high sugar, high salt and high saturated fat content. We aim to initiate the "phasing out" of fizzy drinks and have an agreement with event management that we will work collaboratively with main beverage supplier Frucor to develop healthier drink options. A secondary initiative is the possibility of obtaining a potential sponsor in Fonterra. We envisage an opportunity for Fonterra and Hāpai to extend their community development efforts such as the "milk in school" programme, transposing some of that knowledge and resource to supporting our kaupapa.

Proactive Endorsement

By 2015, we hope to have developed and have begun implementing a "Hāpai Seal of Approval" – an audit of ingredients – initially for food sold within the Māori stage, with the intention to grow and develop this concept to the wider stages and stalls. The idea of a Hāpai endorsed audit is to encourage and influence the elimination of those ingredients not supportive of the Kai Hauora vision before they enter the PolyFest nutritional environment. We hope that the Hāpai seal of approval will confirm an action plan for healthier dishes and continue supporting the education of kai vendors to maintain and continue healthier improvements to their dishes and items sold. Additionally, we hope that this audit will endorse a menu which reflects the season. This year's observations and feedback identified an insufficient provision of "5+ a Day" meal options. Tamariki in particular were requesting more fresh fruit salads. Whānau Whanui have identified a number of opportunities around this – firstly, the opportunity to initiate a collaborative relationship with the 5+ a Day and Heart Foundation: Te Hotu Manawa Māori promotion teams, and secondly, we are considering approaching an endorsed supplier, or seeking sponsorship to increase the provision of fruit and veggies. We wish to make the Kai Hauora menu as much about culture as it is about celebrating the season.

By 2016 we hope to have achieved a degree of acceptance and understanding. Increased knowledge and awareness will have a significant impact on changing behavior and attitudes, in particularly kai vendor behaviour. Through our increased efforts on community education, advocacy and collaborations, we hope to be a step on the pathway to creating a change that is supportive of both our vision and our goal- Increasing access, attraction and steps towards improving the nutritional content at PolyFest.

By 2017 we aspire to have achieved a new acceptance of change. Undoubtedly, by this stage we will have experienced both success and failure, celebration and challenge. More specifically, by this stage we aim to be continuing our focus and emphasis on community education and awareness, with particular emphasis on increasing the capacity and capability of community champions. Also continuing the knowledge and learning of kai vendors to continue exercising their changed behavior.

In 2018 we will be five years into our journey. We ultimately aspire to have created a positive contribution to the nutritional environment and have achieved positive interaction and compliance with the policy. We hope to have achieved a community actively displaying the newly acquired patterns of thinking and behaving, with new found nutritional awareness and knowledge. We hope to have created a sense of collective responsibility and collaboration to promote the kaupapa and be witness to a PolyFest nutritional environment where the Healthiest Choice equals the easiest, most affordable, and most attractive option.

Attitude Change

Key attitudes we hope to have addressed include:

1. Increasing the number of stalls selling fresh fruit and veggie options (without the mixed messages of added fat and sugary sauces).

2. Healthier marketing strategies being undertaken by kai vendors (we hope to have put an end to the use of fizzy drinks, potato chips and lollies as a ploy to attract customers).

3. Increased the number of healthier beverage options (more access to water, more free water outlets and ideally more diary on the menu).

4. Addressed issues of portion size (one method we have discussed is the introduction of a festival price cap. We foresee that this will involuntarily encourage vendors to create smaller, snack type meals).

5. Additionally, this will address issues of waste and, most importantly, ensure that accessibility of kai remains within reach of the PolyFest community.

Undoubtedly we are expecting a firm degree of shock, misunderstanding, refusal and potentially confrontation over these changes. We hope to address and mitigate this by increasing the quantity and quality of advocacy through community education.

Building community resilience: learning from the Canterbury earthquakes

Louise Thornley - Otago University
Jude Ball - Quigley and Watts
Dr Louise Signal and Dr Keri Lawson-Te Aho - Otago University
Emma Rawson - Canterbury District Health Board

Acknowledgements

The Canterbury earthquakes have had, and continue to have, a huge impact on all who live in the region. The researchers gratefully acknowledge all the people who took part in this research. We thank the participants for giving their time during a very difficult period, and for sharing their views and experiences. Their reflections and insights have directly informed the potential learning from this research. We acknowledge and thank the local community coordinators who assisted with recruitment of participants. Thanks to our research advisory group for valuable input and advice, and to the Health Research Council of New Zealand and Canterbury Medical Research Foundation for funding the research.

Photo: '185 Empty Chairs' memorial art installation by artist Pete Majendie – a tribute to the 185 people who lost their lives in the February 2011 earthquake.

A copy of the full research report is available at http://www.quigleyandwatts.co.nz/

Introduction

Community participation is vital in disaster planning, response, and recovery. Around the globe, disaster experts agree on the need to increase the resilience of communities but limited research exists into what increases a community's ability to adapt after a disaster, especially from the perspective of post-disaster communities themselves.

Christchurch, New Zealand's second-largest city, was hit by a series of devastating earthquakes in 2010 and 2011. The Health Research Council of New Zealand and Canterbury Medical Research Foundation funded this research as one of five projects studying the health implications of the earthquakes.

Canterbury DHB (Community and Public Health), Mental Health Foundation, University of Otago, and Quigley and Watts Ltd carried out the research. Ethical approval was given by the Department of Public Health, University of Otago Human Ethics Committee.

Research purpose

The project gathered information from six affected Canterbury communities to understand what helped (and hindered) their resilience. The overall aim was to inform action, by communities and authorities, to better prepare communities for future adverse events.

Case-study communities

Communities are groups of people linked by a common bond. The six case studies focused on:

- Lyttelton
- Shirley
- Inner City East
- marae communities
- migrant and refugee communities
- Christchurch Community House (a workplace

community).

These diverse communities were selected on advice from local experts and included some of the hardest hit communities in Canterbury. The fieldwork for this research project took place from May to July 2012, fifteen to seventeen months after the destructive February 2011 earthquake.

Research participants

More than ninety community leaders and residents took part in the research, through focus-group discussions and interviews. Participants ranged in age from twenty-one to seventy-nine years and were ethnically diverse:

- New Zealand European – 55%
- Māori (indigenous New Zealanders) – 32%
- Other ethnic groups – 13%
- Most Māori participants identified as Ngāi Tahu, the largest South Island iwi (tribe).

Key findings

Our research identified four common influences on community resilience:

- pre-existing community connectedness and community infrastructure ,
- community participation in disaster response and recovery,
- community engagement in official decision-making, and
- external support from organisations and authorities outside the community.

Community connectedness and infrastructure

The research found that strong pre-existing community connectedness and infrastructure (e.g. local organisations, marae, and leaders) were critical in helping communities adapt after the disaster.

Differences in community responses and outcomes between the six case studies can be attributed largely to differences in community connectedness and infrastructure before the earthquakes. Communities that identified their own needs and solutions were well placed to adapt.

After the earthquakes, opportunities to connect with others were vital, through organised community events (e.g. concerts, anniversaries, and festivals) in community-based venues. Community connectedness was hindered in communities where most venues were closed because of earthquake damage.

Community participation in disaster response and recovery

In the case-study communities, community-based responses to the earthquakes included informal, spontaneous support and organised responses led by community and iwi (tribal) organisations.

Most organised responses were initiated by existing community groups or leaders, but some new initiatives emerged, such as the creative arts project Gap Filler and the youth-led Student Volunteer Army.

The pre-existing marae network was a key hub for recovery support, for both Māori and non-Māori.

Participants emphasised the importance of cultural practices and values in assisting recovery and adaptation. For example, core Ngāi Tahu/Māori values of manaakitanga (caring and hospitality, e.g. on marae) and kotahitanga (the iwi acting in one accord to support the people of Christchurch, regardless of race, culture or ethnic identification).

Effects of community responses on wellbeing

Community-based support, both informal and organised, enhanced the wellbeing and sense of belonging of both givers and receivers. This suggests that the act of contributing may be crucial in adapting after disasters and in building resilience to future adverse events.

In connected communities with strong pre-existing infrastructure and a comprehensive local disaster response (e.g. marae communities, Lyttelton, Inner City East), a 'virtuous circle' seemed to develop. Taking part in community support and responses enhanced wellbeing both individually and collectively – and gave rise to further community involvement. Many participants reported a heightened sense of community and continued to feel energised and empowered by a post-earthquake 'culture of possibility', where subsequent innovation and community action could more easily happen.

Community engagement in official decisions

Community engagement, in official decisions, is the process of building relationships between community members and authorities, as partners, to plan and work towards change in a community.

Participants in the more engaged communities said that their communities wanted to initiate local action and be involved in local and city-wide recovery, including planning for the future.

The contribution of community engagement and empowerment (e.g. self-determining actions, greater involvement in official decisions) to resilience is highlighted in our research and in international literature.

Some participants felt that engagement between authorities and communities needed to improve. They advocated for greater community participation and good communication about official decision-making.

They wanted officials to listen more to community perspectives, to explain the rationale behind decisions made, and to support the community to meet local needs.

Importance of external support

In all six case studies support from outside the community was vital, especially from local and central government agencies. In general, high levels of external support helped communities to adapt after the earthquakes. However, many participants also reported a lack of official support, especially early-on in the central city and in Shirley.

Suggestions for increasing community resilience
Our findings point to three broad strategies to increase community resilience:

- encourage community-led action,
- understand community complexity and diversity, and
- develop and strengthen partnerships between communities and government.

Our research highlights the key role of community-led action (e.g. through health promotion, iwi/tribal development and community development approaches), and informal social networks, in strengthening the resilience of communities.

Resilience-building efforts need to be developed by and with community leaders and supported by authorities. Getting to know communities and understanding community dynamics is vital. This may require new models of partnership and shared decision-making between authorities and communities.

Our research highlights a need for communities and authorities to work together to:

- Build strong, empowered communities through community-led action, e.g. marae development programmes, community development, and neighbourhood events.
- Strengthen community infrastructure by enabling and resourcing community-based organisations and iwi/tribal infrastructure, especially in areas where this is lacking.
- Promote volunteering, to enhance the wellbeing of givers as well as receivers.
- Better understand community needs and wants.
- Strengthen partnerships between communities and authorities to support resilience-building and engage communities in decision-making.

More research into effective ways to increase community resilience would be useful, especially kaupapa Māori research (from a Māori world-view).

Our research illustrates why it is important to build strong, engaged communities – because these communities cope better with crises. This is consistent with international literature on disaster resilience and mental wellbeing.

It's your life – play it! The Wellbeing Game – an innovative tool for promoting mental health

Michelle Whitaker - Canterbury District Health Board
Ciarán Fox - Mental Health Foundation

Games are the voluntary attempt to overcome unnecessary obstacles (Suits, 2005).

Collaboration and Partnership

The Wellbeing Game (TWBG) was created in partnership between Community and Public Health CDHB and the Mental Health Foundation (MHF) under the Healthy Christchurch umbrella (a CDHB-led collaborative initiative). TWBG was created in 2011 as a direct response to the need for psycho-social recovery following the 2010 and 2011 earthquake events in Canterbury. It continues to be developed for use as a nation-wide mental health promotion initiative.

Key factors in this successful collaboration included an existing and trusted relationship between the two partner organisations, the context of post-disaster psycho-social recovery needs, timely commitment and allocation of resources by both organisations and the vision to support an innovative new idea – one that had no existing models in New Zealand.

Five Ways to Wellbeing

'In cross-sectional, longitudinal and experimental studies, high levels of wellbeing have been shown to be associated with a range of positive outcomes, including effective learning, productivity and creativity, good relationships, pro-social behaviour, and good health and life expectancy' (Huppert and So, 2011).

The Five Ways to Wellbeing were developed by the New Economics Foundation (NEF) in a meta-analysis of the inter-disciplinary work of over 400 scientists from across the world (Aked, Marks, Cordon and Thompson, 2008). The purpose of this analysis was to identify strategies for improving wellbeing that were evidence-based, had universal application and were able to provide variety. The 5 Ways are designed to have resonance with the '5+ a day fruit and vegetable campaign for physical health. The Five Ways add to people's personal toolkits for flourishing and developing mental capital. TWBG enables participants to use this toolkit, track their progress and log their own 'wellbeing practice'.

Playing with Games

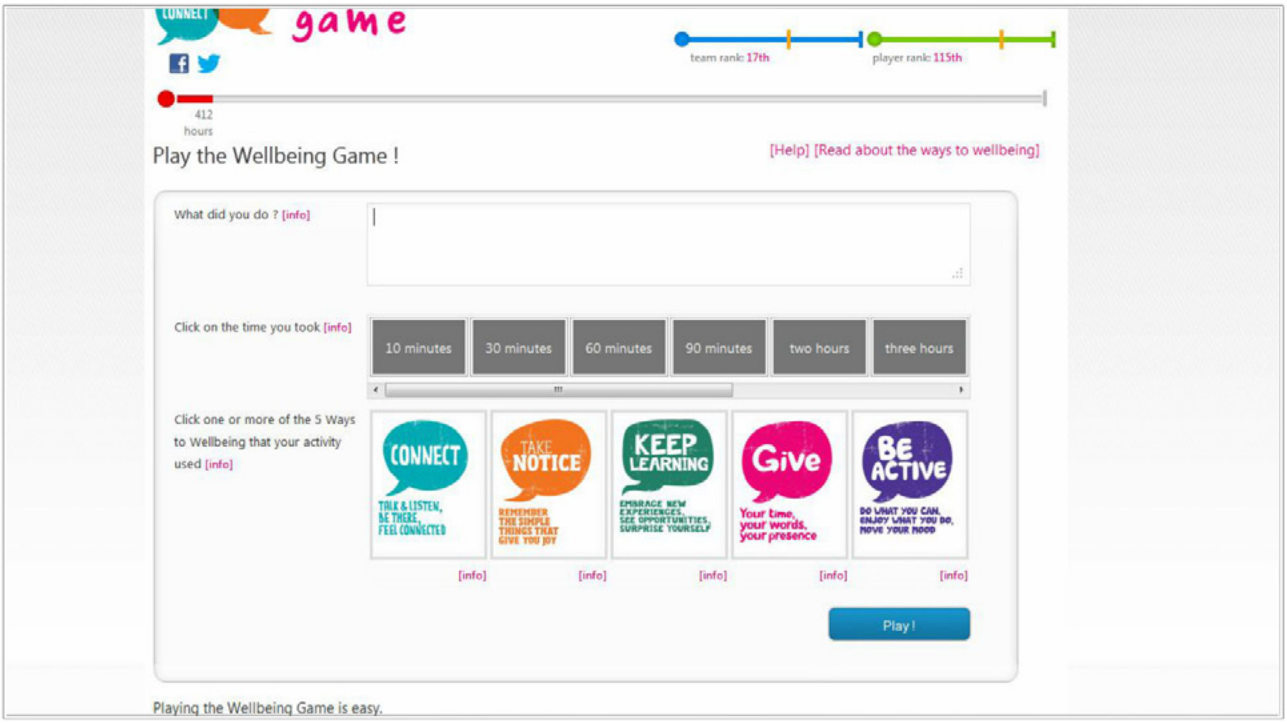
In her 2011 book Reality is Broken: Why Games Make Us Better and How they Can Change the World (McGonigal, 2011), Jane McGonigal makes the case for the use of games for social good because they are 'better than reality' – they come with better instructions, better feedback and better community. She describes them as the 'ultimate happiness engines'.

TWBG is an example of the use of gamification in mental health promotion. The game framework positions mental wellbeing not as a private struggle but a team pursuit, something to be shared, enjoyed and engaged with. The participants become champions of, and 'experts' in, their own wellbeing. This inclusive, strengths-based approach aims to encourage a positive, non-stigmatised understanding of mental capital as a common experience and not just a vague absence of illness.

TWBG enables health information to be actualised in daily life, highlighting and rewarding lived experiences of wellbeing. TWBG utilises The Five Ways to Wellbeing as its 'rule-set' for players to engage by. The interactive website (see figures one and two) gives real-time feedback such as visual graphs tracking accumulated wellbeing hours, badges for new levels of achievement and a public forum where wellbeing activities are acknowledged and endorsed by other players. TWBG also generates a personal 'wellbeing diary' of a player's activities that they can choose to download and print.

The 2012 edition of TWBG was the second time the game was made available to the general public. In 2012 there were over 1000 participants, a ten fold increase on the 2011 game. Participants logged in 21,221 activities adding up to 31,304 wellbeing hours.

Figure 1. Screenshot of TWBG game board



Play the Wellbeing Game !

Playing the Wellbeing Game is easy.

Figure 2. TWBG player-generated ‘word cloud’

Which words make you happy ?

A total of 49,448 words have been written by Wellbeing Game Players and analysed to date.

A total of 7,407 unique words have been used*.

The most popular words are:

with for time friend work out friends walk new walked lunch made family morning played dinner how good enjoyed helped coffee great home team dog talked read day people gave caught shared night tea watched colleagues old garden lovely rain colleague kids son catch mum learnt husband book nice gym run daughter really cooked meeting park breakfast class yoga chatted noticed bike fun house listened today being connected weekend chat ride see met make help first off birthday sister little walking best watching sunday wellbeing learning partner beautiful beach reading school lots week sat doing has afternoon break getting talking

* (word list doesn't include common "joining" words, such as "and","this","the","is". Word count is updated regularly)

The Wellbeing Game is a joint project from Healthy Christchurch, The Mental Health Foundation of New Zealand, and Community and Public Health - A Division of the Canterbury District Health Board.

Contact: gamehelp@thewellbeinggame.org.nz
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Figure 3. Screenshot of TWBG prezi presented at PHANZ conference 2013


Playing our way to wellbeing

Wellbeing Game ELEMENTS

it's your life - play it!

10% registered
58 organisations
31,305 hours generated

to frame mental health as not a private struggle but a team pursuit, something to be shared enjoyed supported and engaged with – a common experience not just an intangible absence of illness

Five Ways to Wellbeing

Datasets of people & their wellbeing

Development:
- psychosocial need
- timing
- expertise
- organisational commitment

... and it works!

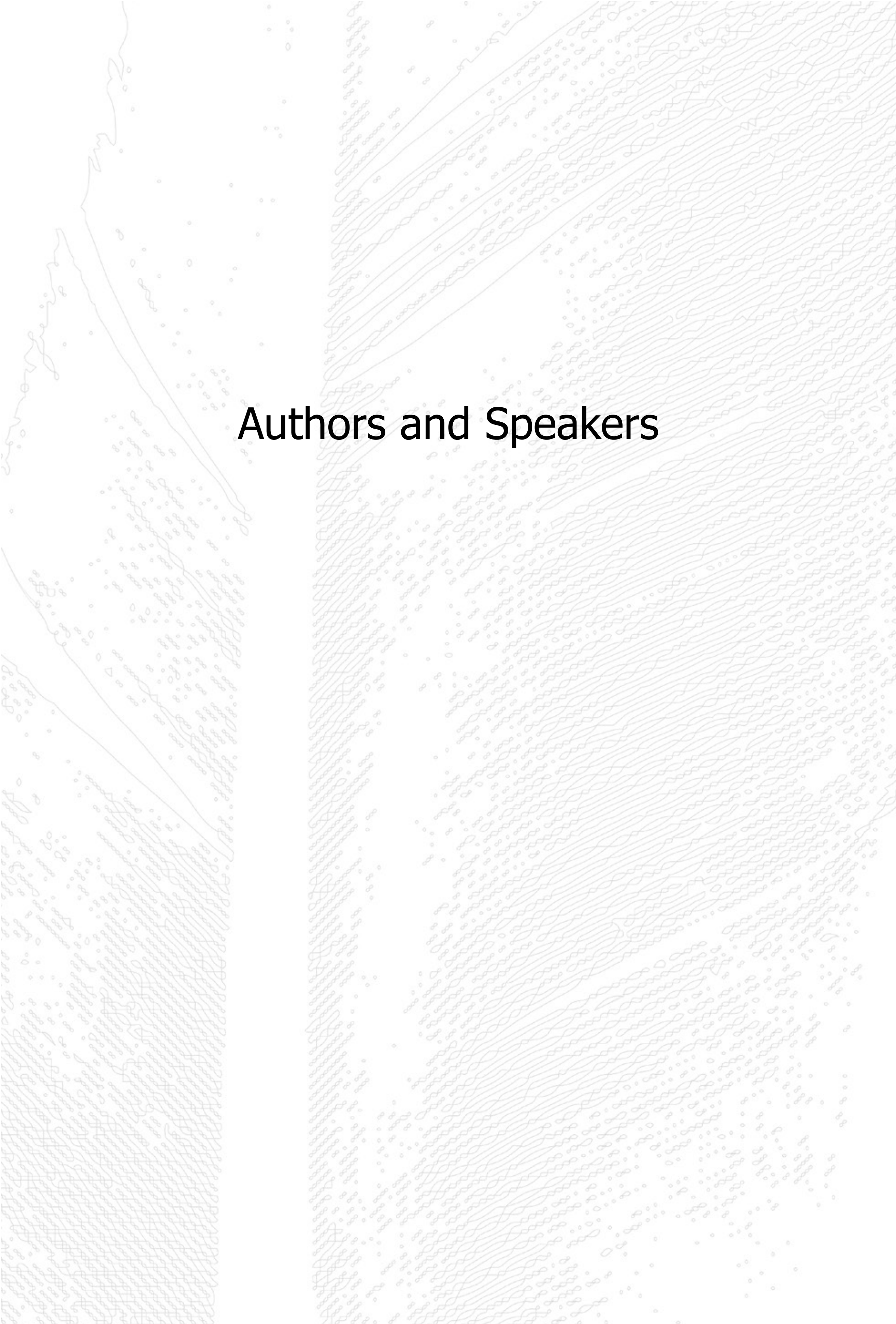
what next?

A validated psychological wellbeing scale (Short Warwick-Edinburgh Mental Wellbeing Scale – SWEMWBS) is used before and after the game. It found fully engaged players significantly improved their wellbeing. Post-game evaluation found:

- 72% of respondents said it raised their awareness of what supports their wellbeing.
- 56% said it actually improved their wellbeing
- 25% reported doing more activities for their wellbeing.

Since it was players in teams that were the most engaged and the most engaged players experienced the greatest benefit from playing TWBG, future promotion will focus on team participation.

Evaluation results show the game is a useful tool in promoting awareness of strategies that improve wellbeing and has potential to be an effective mechanism in engaging people in health promoting behaviour and lifestyles.



Authors and Speakers

Marty Rogers

Waitemata District Health Board

Marty Rogers has contributed to the growth of Māori public health in a host of ways. She has been President of the Public Health Association, and Chair of Te Tumu Whakaraae (National DHB Māori Managers Forum). She is also an integral part of Nga Ngaru Hauora o Aotearoa, an independent forum that advocates on behalf of Māori health providers. She has worked with numerous community groups and iwi organisations.

In 1986 Marty became involved with the Auckland branch of the Māori Women's Welfare League. In 1996 she was appointed Hāpai Te Hauora Tapui 's first CEO, her first formal public health role. Marty's next role as General Manager Māori Health for the Waikato DHB moved her more directly into the public service, and meant she had to balance her passion for community development with the responsibilities of administering public funds.

Keynote Speakers

In alphabetical order

Dame Anne Salmond
Distinguished Professor in Maori Studies
University of Auckland

Anne Salmond is a Distinguished Professor in Māori Studies and Anthropology at the University of Auckland, and the author of many award-winning books and articles on Māori life and early contacts between Europeans and islanders in Polynesia. She is a Foreign Associate of the National Academy of Sciences in the US and Corresponding Fellow of the British Academy, the only New Zealander to have won both awards.

As part of her scholarly work, Dame Anne has developed a strong interest in child rearing and education in cross-cultural contexts. She is the Project Sponsor for the Starpath Partnership for Excellence, aimed at enhancing educational outcomes for Māori, Pasifika and low income students.

Dame Anne is the 2013 New Zealander of the Year.

Annette Sykes
Senior partner
Aurere Law

Annette has been practicing law since 1984 and is a senior partner in the Rotorua law firm Aurere Law. She is a human rights lawyer specialising in the rights of indigenous peoples. She has been an active member of the New Zealand Criminal Bar, the Family Courts Association and Te Hunga Roia Māori (Māori Law Society) and is an advocate in the specialist jurisdictions of the Waitangi Tribunal, Māori Land Court and Appellate courts as well as the other general courts of New Zealand.

Annette assisted in the early establishment of Rape Crisis Centres and Māori Women's Refuges for women in the 1980's. She was the first Māori Woman lawyer to present to the Waitangi Tribunal jurisdiction in her role as junior counsel in the Te Reo Māori Claim.

Dr Anwar Ghani
Senior Scientist
AgResearch

Anwar Ghani is a Senior Scientist and as a specialist soil biochemist. He is involved in two main programmes: "mitigation of nitrogen losses" and "sustainable land use research initiatives".

He has expertise in microbiology, soil biochemistry and organic waste management. Over 20 years, he has worked among other things on the cycling of major nutrients (N, P, S) in soil-plant systems, the role of soil organic C in protecting soil functions, soil quality indicators and beneficial and sustainable reuse of organic waste.

Anwar is also a well respected community worker and has had regional and national leadership roles to discharging various responsibilities. He has recently been appointed as the first Chairman of the Halal Standards Advisory Council, advising government on standards to maintain market access to specific markets.

Anwar is well known for his research on sulphur cycling in soil-plant systems. He has patented a method for biological production of partially acidulated phosphate fertiliser. He has developed hot-water carbon test as an integrated measurement of soil biochemical health. This method is now used internationally as well as commercially in New Zealand. Anwar has authored over 70 scientific publications.

Dr Damon Salesa
Associate Professor of Pacific Studies
University of Auckland

Toeolesulusulu Damon Ieremia Salesa (born in Auckland, New Zealand) is a head Professor at Auckland University's Centre of Pacific Studies and the author of a number of books on the History of the Pacific, and on the British and U.S. empires. Trained as both an historian of nineteenth century empire, and as an historian of the Pacific Islands, his research and teaching interests still broadly follow these paths.

Salesa has a particular interest in the history of Samoa, particularly its social and cultural history, and he is currently working on two manuscripts that address its nineteenth- and early twentieth-century history. One of Salesa's most recent work, Racial Crossings, was published by Oxford University Press in April, 2011.

Salesa spent the last ten years from 2002-2011 as an Associate Professor at the University of Michigan, United States. He returned to New Zealand as Associate Professor at the University of Auckland's Centre for Pacific Studies.

Dr Elsie Ho
Director, Centre for Asian and Ethnic Minority Health Research
Associate Professor of population health
University of Auckland

Associate Professor Elsie Ho is Director of Population Mental Health and Director of the Centre for Asian and Ethnic Minority Health Research at the School of Population Health, the University of Auckland.

She is a leading expert in migration and mental health studies in New Zealand, and has published widely on the topics of Asian transnational communities, migrant and refugee settlement and diversity issues.

In 2007 she was made a Member of the New Zealand Order of Merit (MNZM) for her services to migrant communities.

Hon. Metiria Turei
Green Party Member of Parliament
Green Party Co-leader

Metiria holds the Society, Justice and Māori Affairs portfolios. Her focus is policy work that helps build a more equitable society. She is a member of the Parliamentary Services Commission and on the Māori Affairs select committee.

She's previously led campaigns to save our National Parks from mining, protect the Mokihinui River, and has fought for greater protection of marine animals and the marine environment.

With a law degree from Auckland, Metiria has previously worked as a lawyer at Simpson Grierson and as an advocate for the unemployed and beneficiaries.

Dr Mihi Ratima
Director
Taumata Associates

Mihi is a Director of Taumata Associates, a Māori health and development consultancy. She has held university leadership positions, such as associate professor in Māori health and director Māori health research. She was a Harkness Fellow with the Harvard School of Public Health and BWH; a Fulbright Scholar; a WHO analyst; and, a diplomat.

In 2006, Mihi and her husband Will Edwards relocated to Taranaki to work with their whānau to establish a reo-Māori immersion papakāinga. Three of her children and five others from the papakāinga attend Te Kōpae Piripono ECE, and Mihi is a Board member. Mihi works with the Taranaki Māori community to strengthen research capacity to inform decision-making. She provides supervision for community researchers, including four Māori community leaders undertaking PhDs in public health.

She is co-editing a textbook on health promotion, working with DHBs on the application of Whānau Ora and has a leadership role in research collaborations

Sanjeewanie Kariyawasam
Researcher/Statistician
Centre for Poverty Analysis

Sanjeewanie Kariyawasam is a Research Professional specialised in statistics at the Centre for Poverty Analysis (CEPA) assigned to the Poverty Assessment and Measurement Programme (PAM). She has studied social statistics along with economics and is currently reading for her Masters in Business statistics at the University of Moratuwa.

She has been involved in impact evaluations and poverty assessments by providing inputs in the conceptualisation of studies, data collection, analysis and documentation. She has done extensive research and advisory work relating to multi-dimensional poverty and wellbeing. She also works as an individual consultant in impact evaluations for multilateral agencies.

Sanjeewanie has also been involved in carrying out training on understanding and measuring poverty. Her areas of interest are applied statistics, international trade and finance, gender and research techniques.

Dame Susan Devoy
Race Relations Conciliator
Human Rights Commission

Dame Susan Devoy DNZM, CBE is a former world squash champion and was also a member and former Chair of the Halberg Trust.

Her time with the Halberg Trust was motivated by her wish for better outcomes for people with disability. The trust runs the country's major sports awards with the mission of raising funding to give disabled young people sporting opportunities. For similar reasons she has played an active role as a member of the Sustainability Council and is currently the patron of the Muscular Dystrophy Association of New Zealand.

From 2000 to 2003 she was the Chief Executive Officer and Chair of Sport Bay of Plenty. Dame Susan served as a board member of the Auckland DHB (2000-2003) and as Chairperson of the BNZ partners, Tauranga (2011-2013). She is currently a trustee of TECT (Tauranga Energy Consumer Trust).

(These proceedings do not include a copy of Moana Jackson's Keynote address.)

Featured presenters

In order of appearance

Dr Trudi Aspden

University of Auckland

Dr Trudi Aspden, Lecturer in Pharmacy Practice at the School of Pharmacy, at the University of Auckland. She was awarded her BPharm and PhD from Nottingham University in the UK. She worked as a community pharmacist in the UK and New Zealand for 15 years before beginning her academic career in 2009.

Her research and teaching interests focus mainly on the social aspects of pharmacy and currently include how, what and where to introduce cultural competence teaching into the BPharm curriculum and investigating effective ways that pharmacists can contribute to reducing health disparities.

Dr Janie Sheridan

University of Auckland

Associate Professor Janie Sheridan is research Director at the School of Pharmacy, the University of Auckland. She has been committed to quality education and curriculum development since starting as a teacher practitioner in the London School of Pharmacy ('The Square') in 1989.

Her research interests cover a number of fields of public health, mainly focusing on developing the role of community pharmacists in areas such as drug misuse and harm reduction through opioid substitution therapy and needle exchange programmes, reducing risky drinking and developing smoking cessation services through screening and brief intervention.

Anne Rew
University of Auckland

Mrs Anne Rew is a Professional Teaching Fellow at the School of Pharmacy at the University of Auckland. She works as a community pharmacist in addition to being the course co-ordinator of the second year Pharmacy Practice paper in which the poverty simulation occurs.

Shareen Ali
Northland District Health Board

Shareen Ali is from Fiji Islands. Having a dental and a public health background, Shareen is passionate in oral health promotion especially for indigenous, vulnerable populations.

Having worked in two major public hospitals in Fiji, teaching at the Fiji School of Medicine and managing the Health Research Unit for Fiji Ministry of Health, she moved to New Zealand in 2010. Since then, she has been with Northland DHB as an Oral Health Promotion Advisor.

Jo Dones
Northland District Health Board

Jo has been working for Northland DHB as the Whangarei Health Promoting Schools advisor for four years. She came to the health industry with a varied background mostly in education and sales.

The Health Promoting Schools philosophy allows perfectly for collaborative projects, such as oral health. The wider community, the school, and the health promoter can work together to achieve a common goal. Jo is passionate about reducing disparities and enjoys intertwining health into every aspect of the school curriculum.

Dr Heather Came
Auckland University of Technology

Dr Heather Came is a seventh generation Pākehā New Zealander and a recent graduate at Waikato Management School where her research focused on institutional racism. She currently teaches health promotion, evaluation and community development at Auckland University of Technology.

Claire Doole
Auckland University of Technology

Claire Doole is a senior lecturer at AUT University and an experienced nurse and community activist. She has learned more from her clients than she ever imagined. Claire is the tau iwi partner teaching Māori health and te Tiriti o Waitangi in practice in the undergraduate nursing programme.

Trevor Simpson
Health Promotion Forum

Trevor Simpson (Tūhoe/ Ngati Awa) is Deputy Executive Director for the Health Promotion Forum of New Zealand. He also holds the portfolio for Māori Health Promotion Development.

Dr Nicole Coupe
Kereru Research, Development and Education

Dr Nicole Coupe (Kai Tahu, Te Atiawa) is a kaupapa Māori epidemiologist working in Mental Health and Addictions.

Simon Chiaroni
Learning Media

Simon Chiaroni is a consultant in Cognition Education, where he works within the Research and Evaluation, Knowledge and Growth, and Business Development teams as an evaluator and a developer of new products and services. From 1996–2013 he worked in a range of roles in Learning Media – Editor/project manager, Publisher, Senior editor, Senior analyst/consultant, and most recently Manager, Learning design. From 2006–2008, he was on secondment from Learning Media to the Ministry of Education as senior adviser to the INSTEP project, allowing him insight into research, evaluation, and professional learning for educators.

Simon specialises in translating research and pedagogical knowledge into smart tools for students, teachers, school leaders, PLD facilitators, and developers of learning resources. Recent examples include interactive self-review tools on the Ruia websites, levelling tools and frameworks for the Ministry of Education's instructional series (e.g., Ready to Read and the School Journal), and the Health Literacy: Resource Evaluation Tool. He holds a BA Honours from Otago University, a Diploma of Business Administration from Victoria University, and a Postgraduate Diploma in Evaluation Research from Massey University.

Jenny Clawston
Hawkes bay District Health Board

Jenny Clawston is the Population Health Manager at the Hawke's Bay DHB, covering Population Screening, Immunisation and Health Protection. She has a Master in Business Studies (Management), Bachelor of Business Studies (Honours) and a Postgraduate Diploma in Health Service Management. She chairs the Hawke's Bay Cancer Network Group and is an Executive Member of the Cancer Society of New Zealand – Hawke's Bay Centre.

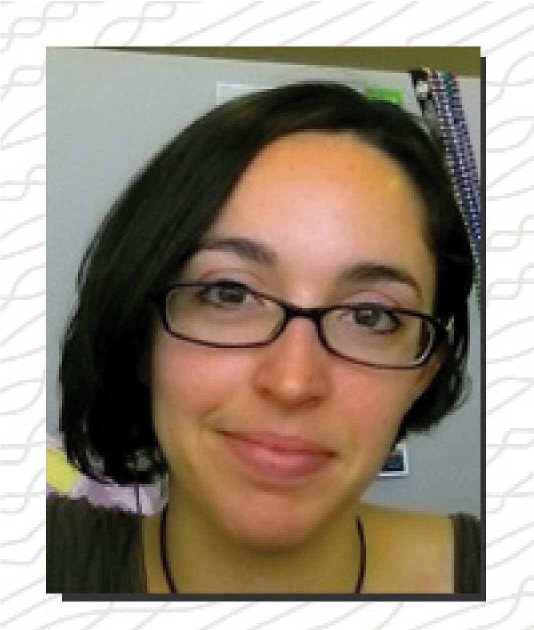
Melanie Dalziel
Manaia Primary Healthcare Organisation

Ko Tawhitirahi te maunga
Ko Awapoka te awa
Ko Parengarenga te moana
Ko Potahi te marae
Ko Waimirirangi te wharehui
Ko Te Aupouri, Te Rarawa me Ngati Kura nga iwi
Ko Mihi raua ko Pita Tahitahi oku maatua tupuna
No reira ki a koutou nga rangatira
Tihei wa mauri ora

Melanie Dalziel is currently employed by Manaia PHO based in a Regional role across Tai Tokerau, in the capacity of Regional Health Coordinator, Healthy Homes. Prior to this position she held a number of senior management positions, including overseeing nurse lead and GP services and being a Principal Advisor for an iwi organisation that was responsible for a number of various social, health, justice, and education contracts. She is currently studying a Post Graduate Diploma in Public Health through AUT Auckland, and has attained a Post Graduate Diploma, Business through the Auckland University.

She has a quality health background in accreditation, and spent a number of years as a surveyor for Quality Health New Zealand. She has previously held a position on the Executive council for the New Zealand Public Health Association.

Sara Epperson
Problem Gambling Foundation



Sara Epperson is a Health Promoter with the Problem Gambling Foundation of New Zealand. Sara earned a BA in Communication (Hons) at the University of Southern California and spent two years teaching high school English in Altadena before moving to Christchurch.

She has worked on several political campaigns as a volunteer, as well as PGFNZ campaigns to maintain a sinking lid in Christchurch and to achieve a sinking lid in Dunedin.

Will Edwards, David Craig, Moana Theodore, Hinerangi Korewha, Aroaro Tamati, Erana Hond-Flavell, Dr Mihi Ratima and Richie Poulton

Standing (Back row): Richie Poulton, Mihi Ratima, Reremoana (Moana) Theodore, Hinerangi Korewha, Aroaro Tamati
Seated (Front row): Will Edwards, David Craig, Erana Hond-Flavell

Dr Will Edwards is a Health Research Council of New Zealand Hohua Tutengaehe Post-Doctoral Research Fellow at the Research Centre for Māori Health and Development, Massey University. His work focuses on developing a localised approach to the interface between Mātauranga Māori and Western science. His doctoral research was on Māori positive ageing.

Aroaro Tamati is Co-director of Te Kopae Piripono Maori Immersion Early Childhood Centre in New Plymouth, Taranaki. Aroaro's PhD research will focus on the impact of core components of the Te Kopae Piripono approach to early childhood and whanau development.

Hinerangi Korewha is Co-Director of Te Kopae Piripono no Maori Immersion Early Childhood Centre in New Plymouth, Taranaki. Hinerangi's research interests include the role of whakawhanaungatanga, kaitiakitanga and reassurance in early childhood education settings.

Erana Hond-Flavell is an educational psychologist based in Rotorua, and was one of the founders of Te Kopae Piripono Maori Immersion Early Childhood Centre in New Plymouth, Taranaki. Erana's PhD research will focus on whanau participation and outcomes from involvement with Te Kopae Piripono.

Dr Mihi Ratima is a Director of Taumata Associates. See her full blurb on page 150.

Dr Reremoana (Moana) Theodore is a Health Research Council Erihapeti Rehu-Murchie Post Doctoral Research Fellow at the National Centre for Lifecourse Research at the University of Otago. Her current research focuses on how education impacts on Māori health and wellbeing over time.

Dr David Craig is Research Associate Professor at the National Centre for Lifecourse Research, University of Otago. His research considers the social, institutional and policy contexts of community and other development, in Aotearoa NZ and internationally.

Richie Poulton is Director of the Dunedin Multidisciplinary and Health and Development Research Unit, founder and Co-director of the National Centre for Lifecourse Research, located at the University of Otago. His research (and policy) interests lie in understanding vulnerability and promoting resilience across the lifecourse.

Barbara Hegan

Cancer Society

Barbara Hegan is based at the Cancer Society of New Zealand's national office where she works as a health promotion advisor for skin cancer control. As New Zealand has very high rates of skin cancer including melanoma, coupled with an aging population, the significant public health problem of skin cancer diagnosis and treatment will continue.

The Cancer Society continues to advocate for increased sun safety behaviour in outdoor workplaces and the removal of sunbeds as dangerous and unnecessary sources of ultraviolet radiation.

Kerry Hocquard

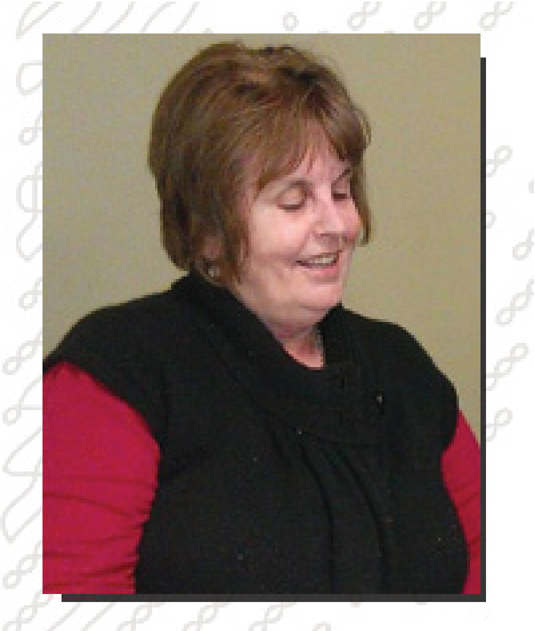
Cancer Society

Originally training as a primary school teacher, Kerry Hocquard has worked in the education sector, supporting information literacy both in the tertiary and primary education. Kerry has also worked in community health, supporting and empowering others for most of her adult life, both as a volunteer and in her present role as a SunSmart Advisor for the Manawatu Cancer Society.

Her interest stemmed from her own personal experience of melanoma, where she developed a deeper awareness of the importance of health being defined holistically and the impact of the physical and social environments in which we live.

These life experiences have seen Kerry involved in community and schools SunSmart education, SunSmart policy advocacy to local government and raising awareness of the need for patient-centred early detection, treatment and support for people diagnosed with melanoma.

Christine Morey
Family Works Northern



Christine Morey is a qualified social worker, employed by Family Works Northern and currently working as a Plunket Family Worker in the Auckland City area.

Sandra Innes
Plunket

Sandra Innes is a registered nurse. She worked in the Well Child health field as a Plunket nurse, and then for the last eight years as a Plunket Clinical Advisor based in the northern region.

Emma Lamb
Plunket

Emma Lamb is a registered nurse who has worked both as a Plunket nurse and a Plunket Clinical Leader in the Auckland City area.

Shona Tiatia
Plunket

Shona Tiatia is a registered nurse and is working as a Plunket nurse in the Auckland City area.

Elaine Jamieson
Heart Foundation

Elaine Jamieson is a Heart Health Advocate for the Heart Foundation's Taranaki branch. Prior to her two years with the Heart Foundation she worked as a Health Promoter and Regional Co-ordinator for the Cancer Society. Elaine has a strong community development background.

Jill Nicholls

Taranaki District Health Board

Jill Nicholls is an experienced health promoter with the Public Health Unit of Taranaki DHB. Elaine and Jill are both members of the Taranaki Smokefree Coalition. They share the philosophy of "together we can".

Dr Allan Wyllie

Wyllie and Associates

Allan established Wyllie & Associates in 2012, after working for 14 years as Director of Social Research at Phoenix Research and for 10 years at the Alcohol & Public Health Research Unit, University of Auckland. He has extensive experience in survey research, but also engages in qualitative research, evaluation studies, programme planning and enhancement.

Allan has been the lead researcher on numerous projects, including: public health workforce surveys; the National Depression Initiative (the John Kirwan campaign); the 'Like Minds Like Mine' campaign; evaluation of the roll out of the Meningococcal B immunisation programme; ABC Smokefree outcomes research with hospital patients; Mahi Ora and Mauri Ora distance learning programmes, 'Let's Beat Diabetes', breast and cervical screening campaigns.

Beth Jenkinson

Cancer Society

Beth Jenkinson is the Health Promotion Manager at the Auckland Division of the Cancer Society. Beth leads a multi-disciplinary team who have become leaders in influencing policy and legislative changes in the area of tobacco control through submissions and advocacy at local government level as well as supporting campaigns to central government.

Beth has a Masters Degree and Post-Graduate Diploma in Community Psychology. She is passionate about the work being done in advocacy and how we can positively influence our communities and decision-makers to make a difference to health.

John Malcolm, James Beharry, Russell Ingram Seal, Lindsay Lowe, Liisa Wana, Sandra Ball and Sunshine Biddle Kaimahi

Pictured: John Malcolm and Sunshine Biddle

John Malcolm, James Beharry- Medical Student, and **Russell Ingram Seal,** at that time evaluator researcher with Toi Te Ora Public Health Service, collaborated on Rheumatic Heart Disease admissions and deaths 2005-2009 research. It profiled the medical issues patients and whanau face.

Russell continues his evaluation & research with Eastern Bay Primary Health Alliance on the prevalence of Group A Streptococcus in the primary prevention of Acute Rheumatic Fever Projects.

Lindsay Lowe of Toi Te Ora Public Health service has assessed community knowledge of Acute Rheumatic Fever.

Liisa Wana, **Melissa Bennett** and **Jaqueline Godfery** run the Acute Rheumatic Fever Primary Prevention project in Kawerau with the Eastern Bay Primary Health Alliance.

The presenters at the Public Health Association Taranaki Conference were **John Malcolm**, **Sandra Ball** and **Sunshine Biddle Kaimahi** with Te Kaokao o Takapau a Ngai Tuhoe hauora, based in Taneatua.

Stephanie Mead
University of Auckland

Stephanie Mead is a Barrister and current PhD candidate at the Faculty of Law, University of Auckland. Her PhD thesis provides a critical analysis of the environmental health functions of central and local government with a view to reform.

Stephanie's core areas of teaching and research interest include torts, legal method, resource management and planning law, local government law, environmental health law, environmental law and civil defence and emergency management law.

Dr Ray Nairn
Kupu Taea and Te Rōpū Whāriki

Raymond is Pākehā New Zealander of Scots and English descent. He uses psychological knowledge in addressing oppression of persons and peoples in our society.

An anti-racism and Treaty educator for almost as long as he has been a psychologist, his published research analyses media depictions of those who live with mental illness and Pākehā (settler language in use) representations of Māori/Pākehā relations in New Zealand. As a member of Kupu Taea, he has contributed to articles documenting the reach and effect of settler language in use. Currently a Honorary Research Associate in SHORE/Whariki Research Group, Massey University operating Media Meanings consultancy.

Eileen Brown
New Zealand Council of Trade Unions

Eileen currently works at the New Zealand Council of Trade unions Te Kaue Kaimahi in a social policy and organising role. In that role she works with union and community groups and sector specific groups on many areas of social issues including human rights and also on social justice campaigns. Her background is nursing and she worked in many areas of the health sector including nursing and service management roles in Christchurch from 1980-2000. From 2000-2005 she worked in a policy role at the New Zealand Nurses Organisation and then commenced work at the CTU.

She has had an active role in the PHA Wellington Branch for many years and for the last four years have been on the Public Health Association Board. She holds a Master of Public Health and Diploma in Public Policy. My passion is community organising on social justice issues and working with unions,NGOs and other groups to taka community organising approach to social policy issues. The Living Wage is one such example and this paper demonstrates the linkages and the connections between public health and community organising.

Muriel Tunoho
Health Care Aotearoa

Ko Tainui te waka
Ko Maungatautari me Tararua nga maunga
Ko Waikato me Manawatu nga awa
Ko Ngati Raukawa toku iwi
Ko Muriel Tunoho ahau

Muriel has many years of experience working in primary health care and is currently employed by Health Care Aotearoa (HCA). HCA is a national collective of community and iwi owned primary health and social services with a particular focus on reducing inequalities.

Muriel has extensive governance experience including being a Board Chairperson for HCA member, Hutt Union & Community Health Service (HUCHS), Te Awakairangi Health Network Board member and Co President for the Service and Food Worker's Union. The union introduced the living wage here to address the plight of vulnerable workers struggling to live with dignity and survive on low pay.

The Living Wage Movement Aotearoa now has over 200 community organisations joining the movement with mutual concerns about the rising inequalities in Aotearoa and Muriel is a community representative on the Living Wage Movement Aotearoa Incorporated Society.

Annabel Newman

Living Wage Movement Aotearoa

Annabel Newman is the Convenor at Living Wage Movement Aotearoa New Zealand and the National Campaign Coordinator at Service and Food Workers Union. She has a Master of Public Policy from Massey University.

Debbie Phillips

Toi te Ora Public Health

Debbie has the lead role in coordinating and managing the communications of Toi Te Ora – Public Health Service, the public health service for the Lakes DHB and Bay of Plenty DHB areas.

This includes providing media management for the Medical Officers of Health and staff, developing communications strategies, plans and activities, advising staff on communications related matters, maintaining websites and social media, and developing quality improvement processes for communications work.

Dr Neil de Wet

Toi te Ora Public Health

Neil is a public health medicine specialist and one of the three Medical Officers of Health in the Bay of Plenty and Lakes areas.

He also has a management role in Toi Te Ora – Public Health Service including responsibilities for development of the communications functions of the organisation. Risk communication and effective communication of public health advice is one of his areas of interest.

Dr Jim Miller
Toi te Ora Public Health

Dr Jim Miller is a public health physician, trained in Scotland and England, and currently a Medical Officer of Health and Environmental Health Manager with Toi Te Ora – Public Health Service in the Bay of Plenty.

His interests are largely in Health Protection and include immunisation and the prevention of childhood infections. He is also active in regional and national public health activities, such as emergency management and public health policy development.

Becky Jenkins
Taranaki District Health Board

Becky Jenkins has a background in Social Science and Epidemiology and is a Fellow of the UK Faculty of Public Health. Becky holds responsibility for Public Health Services and the Population Health Portfolio Management with Taranaki DHB with a focus on public health Leadership and development. Becky has lived in Taranaki since 2007.

Antony Thompson and Malina Parkinson

Te Runanga o Ngati Whatua

Antony Thompson and Malina Parkinson currently work for Te Runanga o Ngati Whatua (Māori Public Health Unit).

Te Runanga o Ngati Whatua is the mandated Iwi organisation who deals with issues affecting Māori within the rohe of Ngati Whatua (from Waipoua to Whangarei in Te Taitokerau to Tamaki Makaurau).

Te Runanga O Ngati Whatua Māori Public Health Unit is a part of the "Whānau Whanui" collective of Māori public Health entities in Tamaki Makaurau including ; Hāpai Te Hauora Tapui Ltd, Raukura Hauora o Tainui, Te Whānau o Waipareira and Huakina Development Trust.

Zoe Hawke

Hāpai Te Hauora Tapui

Zoe has specialist expertise in leading strategic community engagement for problem gambling, nutrition and physical activity, tobacco control and alcohol and other drugs. She has been responsible for increasing the sector's knowledge and delivering best practice problem gambling initiatives. She has expertise in public health training and informing and engaging Māori in policy development at a local, regional and national level. Currently Zoe leads the newly established National Tobacco Control Leadership Service for Hāpai.

During her time at Hāpai Zoe has focused on growing and managing the problem gambling public health team and forging strong relationships with MOH funders. Additionally Zoe has managed the Māori Public Health Leadership contract and the National Public Health Workforce Development contract 'Te Kakano'.

Previous to being employed at Hāpai, Zoe worked for the Problem Gambling Foundation in Health Promotion and as the Manager of their National Host Responsibility and Healthy Fundraising Training programme.

Te Pora Thompson-Evans
Hāpai Te Hauora Tapui

Te Pora is of Ngāti Hauā blood and has led Research Development and Evaluation projects for Hāpai. Te Pora's research input is multi-faceted, complex and dynamic, and is undertaken primarily to improve the overall wellbeing of Māori through using diverse qualitative and quantitative methodologies. As an internationally peer reviewed published author who has undergraduate and postgraduate degrees from the University of Auckland, Te Pora's work is underpinned by kaupapa, Māori methodologies and guided by kawa and tikanga practices. Te Pora has a passion for developing and connecting together functional relationships for the purpose of creating and building research collaborations responsive to the needs of Māori and Indigenous people.

Dr Keri Lawson-Te Aho
Otago University

Dr Keri Lawson-Te Aho is a Māori social scientist. She has a PhD in Psychology from Victoria University, was a Fulbright scholar with the East West center in Hawaii and has worked in indigenous population based mental health research for over 20 years. Keri is currently a serving member of the International Taskforce of Indigenous Psychologists. She teaches Hauora Māori to undergraduate and graduate students in the Wellington School of Medicine, Otago University.

Louise Thornley
Otago University

Louise is an experienced social researcher with expertise in qualitative research, evidence reviews and facilitation of focus groups. Louise's work experience is in both government and community sectors. Before joining our team in 2006, Louise worked as a Senior Policy Analyst for an independent advisory group, the National Health Committee, and as Research Fellow for Otago University, Wellington. Louise has a Masters of Arts (Applied) in Social Work from Victoria University and a Postgraduate Diploma in Public Health from Otago University, Wellington.

Jude Ball
Quigley and Watts

Jude Ball is a Senior Research Associate at Quigley and Watts. She has a broad skill base including public health research and analysis, and mental health promotion. Previously, Jude was Wellington region coordinator of the 'Like Minds Like Mine' project to reduce discrimination associated with mental illness. She has worked as a researcher at the University of Western Sydney and as volunteer coordinator for an award winning mental health programme in Sydney. Jude has a Masters degree in Critical Psychology from the University of Western Sydney and an undergraduate degree in Psychology from Canterbury University.

Dr Louise Signal
Otago University

Associate Professor Louise Signal is a Director of the Health Promotion and Policy Research Unit (HePPRU) at the University of Otago, Wellington. She is a social scientist with a PhD in Community Health from the University of Toronto. She has worked, and done research, in public health for over 25 years in a range of roles, including Senior Advisor (Health Promotion) for the New Zealand Ministry of Health. Her research interests include promoting healthy eating and healthy action, tackling inequalities in health, healthy public policy and health impact assessment. Louise also teaches health promotion at the graduate and undergraduate level.

Emma Rawson
Canterbury District Health Board

Emma Rawson is a Māori Health Promoter based at the Canterbury DHB in Christchurch. Emma's passions are Māori workforce development and Te Reo Māori as an importantleadership tool for change, enhancing identity and wellbeing. She is a recent graduate of LeadershipTraining for Māori in Public Health, holds a B.A. Māori, University of Canterbury, Post Graduate Certificate in Public Health ,University of Otago and working on gaining a Masters in Health Science.

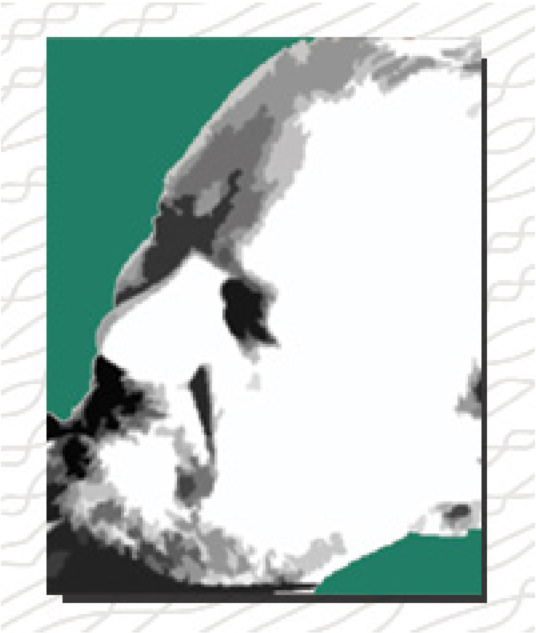
Emma is currently working on projects in Christchurch that support wellbeing and resilience in Māori communities and building sustainable community infrastructure in vulnerable communities.

Michelle Whitaker
Canterbury District Health Board

Michelle Whitaker is the Wellbeing Coordinator for Healthy Christchurch. Michelle has initiated and facilitated collaborative projects across New Zealand and the UK and has co-ordinated and evaluated four World Health Organisation Healthy Cities and Communities programmes.

Michelle has over 15 years working with communities and lately has developed successful projects in a psycho-social recovery setting including the annual 'River of Flowers' for February 22nd Christchurch earthquake anniversary, original concept and co-creator of The Wellbeing Game and is part of the All Right? wellbeing campaign. Michelle has a BSC and Post grad Diploma in Public Health.

Ciarán Fox
Mental Health Foundation



Ciarán Fox is a health promoter with nearly 20 years experience in public health, community and creative project development. He has been with the Mental Health Foundation for five years and specialises in the areas of positive mental health, wellbeing, social marketing and communication. He is the co-inventor of The Wellbeing Game, a world-first, online tool utilising the sciences of gamification, positive psychology and health promotion.