Facilitating whānau resilience through Māori primary health intervention

Final Report to the Health Research Council of New Zealand Partnership Programme

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The research team would like to thank all those involved with the facilitating whānau resilience through Māori primary health intervention (resilience) study; our research partners, advisors, and participants. We appreciate the time and assistance our research participants in particular have given to this study and the willingness with which they contributed their knowledge and expertise so that others may learn from their experience. The views expressed in this report are those of the authors and do not necessarily represent those of the research commissioners.

LIST OF ABBREVIATIONS

ACC	Accident Compensation Corporation
HRC	Health Research Council of New Zealand
HSRC	Health Services Research Centre, Victoria University of Wellington
NPM	Ngā Pae o te Māramatanga
RFP	Request for Proposals
TOIHA	Te Oranganui Iwi Health Provider Primary Healthcare Organisation, Whanganui
WRMHD	Whakauae Research for Māori Health and Development

1. EXECUTIVE SUMMARY

This report has been developed for the purpose of informing the Whānau Ora Steering Committee and the Partnership Programme of the results of the *Facilitating whānau resilience through Māori primary health intervention* (Resilience) study, HRC reference 09/627 in accordance with our contract of September 2009. The report presents the high level findings from a two year study conducted by Whakauae Research for Māori Health and Development, in conjunction with our research partners, the Health Services Research Centre, Victoria University of Wellington and Te Oranganui Iwi Health Provider Primary Healthcare Organisation, Whanganui.

The overall research objectives of the study were, first, to determine if the concept of resilience described in western academic literature holds resonance in Māori primary health approaches, and second, to determine in what ways whānau resilience is supported and enhanced by Māori primary health services.

The research design is exploratory qualitative research using a single case study, divided into two distinct phases of enquiry. Phase 1 sought to identify how concepts of resilience are incorporated into the TOIHA whānau ora programme approach, while phase 2 determined evidence of implementation of these concepts in the actual work of a Māori primary health care provider. In particular, we sought to understand how participation in Māori primary health services has impacted on whānau resilience capacity. In addition to a comprehensive literature review and a case study document search, two primary data sources were accessed; key informant interviews with case study employees and board members, and a series of focus group interviews with case study consumers.

Four research questions guided the research:

- How are concepts such as resilience reflected in Māori primary health approaches?
- What are whānau understandings of resilience?
- How has engagement with a Māori primary health provider impacted on whānau resilience?
- What are possible Māori primary health provider resources, mechanisms and interventions that contribute to enhanced whānau resilience?

The report is structured in such a way as to guide the reader through the process of how we came to answer these four questions and our very early conclusions. Consequently the report proper starts by providing a background to the study and how we developed the research project and formulated the research partnership (Section 2). In Section 3 a précis of the international and national resilience literature is presented. Section 4 presents the methodology for the study, outlining the methods used in the two phases of data collection and touching briefly on a novel methodology, used for the first time in NZ in this research; the Sequential Focus Group. The study results are presented in Section 6 and ordered according to the four research questions listed above. The data that addresses Research Question 1 comes exclusively from the document review of the case study documents and interviews with case study key informants; whereas the data that addresses Research Questions 2 -4 comes from both the key informant interviews and the Sequential Focus Groups.

In Section 6 we reflect on the findings and link these back to the wider research objectives. The research concludes that the term resilience is not necessarily one that our research participants were familiar with, but that both the whānau members and the staff and governance of Te Oranganui were able to provide concrete examples of how, as a Māori health care provider, TOIHA supported individuals and whānau to become more resilient. Consequently we contend that Māori primary health providers must use the full range of resources at their disposal to configure services to support those individuals and whānau who, recognising their own resilience, want to take the journey towards better health and achieve the ultimate goal of whānau ora.

Sections 7-9 report on the achievement of milestones and objectives and outline the outputs and outcomes arising from this project including publications, conference presentations and future, planned articles and presentations. As the research team is still in the process of writing for publication, further contributions to the discourse and theory may occur beyond the funded life of this project. A bibliography of references used in this report in included at the end of the report along with a set of appendices containing research tools and other associated material.

In closing it is fitting to highlight some of the key findings from this two year research project:

- The terms resilience/resilient are not easily found in New Zealand literature, nor are these term commonly used to describe Māori as a population. Despite a relatively large international literature, indigenous writers are wary of the term being used to describe indigenous populations as these descriptions tend to be uncritical, ignoring historical and contemporary oppression and structural inequalities;
- Resilience is not necessarily a term the participants in our case study were immediately familiar with nor comfortable using. When prompted participants described resilience in two ways: as a set of personal qualities which one is either born with, or which may be learned; and a process or journey towards empowerment, self determination and rangatiratanga;
- Features of an indigenous primary healthcare service provider which supports resilience include a whānau ora approach; culturally accountable and appropriate care; a focus on wellness and the ability to provide appropriate resources; and empowerment of staff, clients and their whānau;
- Engaging with a Māori primary health care provider impact on individual and whānau resilience in a number of ways; providers can be the trigger or the catalysts for change; they can act as the support for the individual or whānau on their journey; the can also role model healthy behaviour, to which the individual and whānau can aspire; and
- Māori provider resources that contribute to resilience include: highly trained and professional staff with an understanding of Māori people; advice, support and advocacy; the ability to role model; commitment to, and the implementation of a whānau-centric vision; the use of Māori values and processes to strengthen Māori identity; and seamless integrated services that cover the spectrum from population and public health through to primary health care.

It would appear from our research that Māori primary health care approaches do make some, as yet unquantifiable, contribution to individual and whānau resilience, through improved access to resources and by supporting whānau and individuals become more "empowered'. Furthermore, the links between resilience and our own indigenous concept, whānau ora, can be elucidated. If providers commit to, and deliver, healthcare using a whānau ora model, this

mode of service delivery will have an impact on individual and whānau resilience. Thus we contend that Māori primary health providers must use the full range of resources at their disposal to configure services to support those individuals and whānau who, recognising their own resilience, want to take the journey towards better health and achieve the ultimate goal of whānau ora.

2. BACKGROUND

THE CONTEXT

In recent years the New Zealand government has identified that a coordinated and collaborative effort is required on its part to reduce persistent health inequalities between Māori and non-Māori (Ministry of Health 2002a). A key goal of the New Zealand government in relation to Māori health has been articulated in He Korowai Oranga, the Māori Health Strategy, which aims to achieve whānau ora or Māori families supported to achieve their maximum health and wellbeing (Ministry of Health 2002b). The vision encapsulated in the concept of whānau ora has been adopted as a key strategy of New Zealand social policy development and intent, and is now firmly embedded in health service policy, planning and delivery (Ministry of Health 2002b; Families Commission 2009).

A number of mechanisms are used to encourage a focus on Māori health and whānau ora: incorporation of a focus on Māori health and reducing inequalities in legislation governing the health sector (New Zealand Public Health and Disability Act 2000); the provision of additional funding for Māori through funding formula to District Health Boards (DHBs) and, to a more limited extent, Primary Health Organisations (PHOs) (Ministry of Health 2003; 2002c); and requirements in accountability arrangements between the Crown and DHBs and between DHBs and PHOs to promote Māori health (Ministry of Health 2007; Ministry of Health undated).

Māori health service providers have been quick to respond to the opportunities provided by a government direction which positions the concept of whānau ora at the centre of health service delivery to Māori. Historically these providers have agreed to contracts as diverse as health promotion, community development and primary health care in order to provide culturally appropriate health services to Māori utilising a range of Māori health models in the implementation and execution of these contracts. Some of these models are clearly described in the literature and have even gained general acceptance amongst mainstream service providers (Ratima 2001; Durie 2004). Others are specific to individual providers and may have emerged from the unique tikanga (practice) of the organisation or from its associated iwi (tribe) (Gifford 1999; Boulton 2005; Boulton 2007).

The growing acceptance of whānau ora as a philosophical approach, as a strategy and as a model of service delivery has led to a concomitant increase in interest regarding the efficacy of the model, its relationship to other frameworks and its generalisability and utility beyond Māori health and social services. A further consequence of the "normalisation" and acceptance of whānau ora in the health and social service sector discourse has been the interest shown by research funders and government departments to fund research which explores aspects of whānau ora.

THE WHĀNAU ORA RESEARCH PARTNERSHIP

In 2008 the Health Research Council, through its Partnership Programme released a Request for Proposals (RFP) as part of the Whānau Ora Research Partnership[1]. The Partnership Programme is allows organisations, and particularly government departments, to pool resources to fund high quality research of mutual interest. Research undertaken as part of the Partnership Programme addresses questions of interest to specific groups of funders such as policymakers and other funders of research activity. The focus of the Whānau Ora Research Partnership is "whānau health within the context of positive development". The RFP released in 2008 specifically sought research that would focus on "whānau resilience", i.e. the collective health and wellbeing of whānau at a level beyond individuals, families and individual households, and address factors that both promote and contribute to whānau health by maximising whānau resilience (HRC 2008).

Research projects were sought which addressed one or more of five key interest areas:

- critical success factors that underpin community-based and local initiatives designed to promote whānau health and resilience;
- intergenerational contributions to whānau security and certainty;
- environments that contribute to whānau security and certainty;
- whānau capacity to promote full participate in society and the economy; and
- whānau engagement with tea o Māori /the link(s) between reliance, cultural identity and participation in Māori society.

[1] A joint research initiative funded by the Health Research Council of New Zealand, Ngā Pae o te Māramatanga, the Families Commission and the Accident Compensation Corporation

Our research team's response to the RFP sought to address two concerns. First we wanted to investigate whether the concept of resilience, as it is described in the international literature, actually has resonance in the New Zealand indigenous context, i.e. amongst Māori whānau and in Māori communities. Secondly our research sought to inform the first key interest area by examining how the concept of resilience is utilised in both the development and implementation of comprehensive Māori health programmes at a primary health level and how the concept relates to notions of whānau ora. Through the research we proposed to answer the following general questions: Is resilience a relevant term amongst iwi/hapū/whānau Māori?, Are we able to identify characteristics of resilience amongst iwi/hapū and whānau?, and Can iwi health providers contribute to enhancing an individual and a whānau's overall resilience?

There is an extensive literature relating to the concept of cultural resilience and a growing number of indigenous researchers interested in the topic (see literature review section). However, a preliminary search of the New Zealand literature conducted as we framed our proposal revealed little evidence or analysis of the relationship between whānau resilience and Māori primary health concepts and interventions. In addition, in the New Zealand context, we found very little literature that explored how primary health approaches may mitigate risks to the individual through enhancing their personal capacities and abilities or how engagement in Māori primary health services can strengthen whānau resilience through improved access to health resources. No literature was found which examined the concept of resilience and its application to Māori, whānau and communities or the extent to which the concept of resilience contributes towards the goal of whānau ora.

As noted above, many Māori primary health care providers have, since emerging as providers in their own right, developed their own unique models of whānau ora which guide their practice and service delivery. This research seeks to test the hypothesis that notions of resilience do, in fact, underpin Māori primary health and health promotion activity in New Zealand, and further, that Māori primary health approaches have the ability to assist whānau to increase their resilience by supporting individuals and whānau to access resources that sustain their wellbeing in culturally meaningful ways. For the purposes of the research, then, the research team adopted the definition of resilience employed by the International Resilience Project which proposes that;

> "Resilience is both an individual's capacity to navigate to health resources and a condition of the individual's family, community and culture to provide those resources in culturally meaningful ways"
> (International Resilience Project undated).

Accordingly, the definition moves away from pathologising an individual's behaviour (understanding errant behaviour as illness) to a more holistic understanding of well-being.

RESEARCH AIM

We hypothesise that notions of resilience underpin Māori primary health and health promotion activities in New Zealand and that primary health approaches in Māori settings have the ability to assist whānau increase their resilience, by supporting individuals and whānau to find resources that sustain their wellbeing in culturally meaningful ways. Further we contend that where positive cultural support mechanisms and advocacy are provided to individuals and whānau, then whānau ora may be achieved. In undertaking this research project we sought first, to determine if the concept of resilience described in Western academic literature holds resonance in Māori primary health approaches, and second, to determine in what ways whānau resilience is supported and enhanced by Māori primary health services. In order to meet the second of these broad objectives a Maori primary health care provider to partner in the research project and act as a case study site was essential. The following section outlines our broad research approach, the process of case study site selection and the role of our other, academic, research partner.

RESEARCH APPROACH AND PARTNERS

The research approach for this study was guided by the requirements of the various funders who released the joint venture call for research. The RFP document released by the HRC partnership programme sought research that would both be of benefit to end-users and make a relevant contribution to the growing evidence base on the effectiveness of whānau ora as a goal, philosophy and strategy to guide service provision (Health Research Council 2008).

In particular, the RFP document sought research that would a) focus on whānau health within a context of positive development; b) be consistent with an overall theme of whānau resilience; and c) take a collective or broad community approach to health and well-being.

This approach aligned easily with the philosophy of both the individual researchers on this project and indeed the philosophy of Whakauae Research for Māori Health and Development. Consequently this study is strongly based on a positive development model, i.e. working within a Māori health development framework; building on indigenous models of care; and assuming that whānau and providers together have the capacity to generate change and enhance whānau ora.

Early in the RFP process WRMHD negotiated to partner with two other entities in order to conduct the study. The first, Te Oranganui Iwi Health PHO (TOIHA) was brought on board as the case study site: i.e. the location in which the research would be based and from where we would draw our participants. Effectively this study examines the links between resiliency and whānau ora in this particular Māori primary health care provider, as it conducts its daily business.

Te Oranganui Iwi Health Authority is a mixed urban and rural Māori PHO in Whanganui with an enrolled population of some 7414 clients (Te Oranganui Iwi Health Authority 2008a). Features of the case study site which facilitated the effective implementation of the research included:

- Organisational maturity: TOIHA has been established since 1993 (Te Oranganui Iwi Health Authority 2007) and most programmes are well developed;
- Diversity of programmes reflecting a broad determinants approach: services include home ownership services, employment brokerage for people with disabilities, family support, mental health and rongoa and traditional healing services, injury prevention programmes and primary health care and community development programmes;
- Community representation: TOIHA represents a wider community of Māori who reside in the communities that make up the catchment for service, namely iwi members from Ngā Rauru, Whanganui, and Ngāti Apa as well as taura here from Whanganui City and the rural areas surrounding the city and the district of South Taranaki. It is these communities that will benefit most directly from the from the results of the research as findings are fed back into practice;
- Well developed data systems and infrastructure;

- A commitment to service improvement: TOIHA has developed a tikanga–specific whānau ora pathway for their enrolled whānau, a whānau ora service delivery pilot and are in the processing of training staff both of these models.

The second partner in the study is the Health Services Research Centre. Associate Professor Jackie Cumming was brought on due to her knowledge and experience in health services research, as well as her extensive experience working on primary health care and health policy-related health services research.

3. LITERATURE REVIEW

A literature review was undertaken at the outset of the project, as, in the process of developing our application in response to the RFP document, the research team found that very little was understood about the term resilience in the New Zealand context and particularly its use and application to Māori. Once the project proper started this literature review was augmented and written up for publication. A summary of the resilience literature we reviewed is presented below.

In addition to the material presented below a literature review specifically focusing on whānau ora and primary health was conducted as a separate piece of work within the project to inform phase 1 data collection. The review protocol for this piece of work may be found in the appendices to this report. Finally a review of TOIHA's own policy and service documentation was also undertaken in phase 1. The results of both these reviews are incorporated into the discussion of the findings in Section 6 of this report.

As part of the literature review the research team collected, reviewed and analysed materials, both formal and grey literature, using the following terms for searching: resilience, collective and self-efficacy, indigenous, primary health care, community-based services and resilience theory and models and evidence. Literature was restricted to publications from 1998 onwards. A range of widely accepted academic databases and websites was utilised.

A SUMMARY OF THE RESILIENCE LITERATURE REVIEW

Green notes that the term "resilience" has been borrowed from the science of physics and in the social sciences, its use can be traced to the longitudinal child health studies undertaken some forty years ago (Green 2008). In physics, the term resilience was used to describe the ability of an inanimate object (notably a coiled spring) to bounce back. Similarly in the social sciences, and particularly with respect to children, the term has come to describe the ability to bounce back, or overcome adversity (Green 2008).

In the field of social science resilience research, two quite distinct approaches to understanding resilience are apparent. The first has its origins in the Western discipline of psychology and particularly in social cognitive theory and asserts that individuals are agents; being both producers of experiences and shapers of events (Bandura 2000). The second

approach considers resilience in a broader, ecological sense, where resilience is dependent upon, or can be mitigated by, the relationship between the individual and their environment. Both approaches are discussed in more detail below.

The individual as agent

According to social cognitive theory, the mechanism of human agency is fundamental. In other words, unless people believe they can produce the desired effects in their lives they have little incentive to act (Bandura 2000). The concepts of self-efficacy (the belief in one's own ability to change hazardous behaviour) and collective efficacy (a group's shared understanding of its ability to meet its goals and complete agreed tasks) derive from this understanding of the nature of human behaviour.

In the international literature, it has been argued that a strong sense of personal or self-efficacy is related to better health, higher achievement and more social integration (Schwarzer 1994; Bandura 2000). The concept has been applied to such diverse areas as school achievement, emotional disorders, mental and physical health, career choice, and socio-political change (Schwarzer 1994; Maddux 1995; Bandura 1997). Perceived collective efficacy, as a mechanism of human agency, features less prominently in the international literature than personal efficacy; however, Bandura (2000) argues that collective efficacy is becoming increasingly central to how people live their lives as new social realities emerge along with technological advancement and globalisation. While the "collective efficacy" approach to resilience makes some attempt to understand the role of groups as a means to enhance personal efficacy or empowerment, it is limited as a theoretical construct for understanding the impact history, culture and environment have on resilience and particularly on resilience as displayed by Indigenous populations.

Up until the late 1970s, the study of resilience was largely concerned with understanding the mix of risk and protective factors which contributed to some individuals successfully remaining invulnerable in the face of adversity and able to withstand both on-going and acute difficulties (Wexler et al 2009). Resilient people, it was assumed, possessed fixed and immutable personal qualities. Emphasis was placed on determining whether these same qualities could be fostered in the less resilient and subsequently successfully incorporated in programmes of intervention, particularly with children (Green 2008).

Consistent with its origins in the traditions of Western psychological science and in a discourse of illness, resilience was initially positioned as an individual and relatively static construct, bearing little relation to historical or cultural context (Ungar 2005). Individuals 'failing' to demonstrate resilience could be 'blamed' for this failing as it was considered that one's life course was largely a matter of personal choice and personal discretion. Despite these shortcomings, this approach to constructing resilience continues to inform a segment of the contemporary literature on the subject (Fleming & Ledogar 2008).

Family and community as protectors of resilience

In recent decades, the resilience research and associated literature has moved from considerations of the individual as the focal point for analysis (Blackstock & Trocmé 2005) to incorporate broader concepts of family and community resilience. Writers and researchers in the field of social work for example, recognise that an individual's capacity to exhibit resilience depends on more than simply some innate characteristic within the individual themselves (Ungar 2005). Fleming & Ledogar (2008) note this shift in conceptualising resilience rests on the recognition that a number of external protective factors exist which contribute to an individual's resilience and capacity to cope with trauma and adversity. These protective influences, they argue, are found in family and community systems and processes and range from parental warmth, encouragement and assistance through to supportive peers, social support, communal coping and empowerment (Fleming & Ledogar 2008).

So-called "risk factors" however also exist in the community system and may include social, environmental and behavioural components. When protective factors outweigh the risk factors, a community resilience outcome is believed to result. Community resilience therefore is illustrated by characteristics such as health promoting physical environments, residents' wellbeing and positive social relations (Jackson et al 2003).

Families and communities which nurture individuals are in turn understood to demonstrate resilience. For example, school communities which consciously elect to implement social programmes which nurture the types of environments that are more conducive to better psychological health (Wong et al 2009) reflect community resilience. The focus here remains

however, on the psychological health of the individual, as part of a community or family system, and on what a 'resilient' community can deliver for that individual.

Cultural resilience

A further and related development in the resilience literature has been the growing interest in resilience as a feature of whole communities and cultural groups (Fleming & Lodegar 2008). Literature which includes a focus on culture may also address gender, sexual orientation and/or economic class in relation to resiliency. Ethnicity is also given consideration however much of the cultural resilience-related literature which considers ethnicity is written by non-Indigenous researchers and tends to focus on the impact of personal racism on youth psychological wellbeing. Frameworks or understandings of social inequality and inequity do not feature in these analyses.

The growing interest in how culture may influence individual, family and community resilience has provided an opportunity to explore new approaches to understanding the term resilience. One such reframing of the term seeks to reposition resilience as a process and as a practice, recognising that resilience is a dynamic and fluid concept with inextricable links to social, historical and cultural context. This approach is represented in the current work on youth resilience led by Canadian, Dr Michael Ungar of the Resilience Research Centre and in his work on the International Resilience Project (www.resilienceproject.org).

Indigenous resilience

Indigenous researchers and academics are also beginning to contribute to this "reframing exercise" with new work emerging from among Aboriginal and First Nations writers in the USA and Canada and more recently from Māori health researchers in New Zealand/Aotearoa. Globally, there is comparatively little published or unpublished material available which explores and critiques the concept of resilience from an Indigenous perspective. Iwasaki and Bartlett, for example, have noted only very limited effort within Indigenous health research "to directly explore the potential usefulness of a resilience framework from the perspectives of Aboriginal peoples (Iwasaki & Bartlett 2006: 17). Consistent with this finding, a recent search of Indigenous resilience literature carried out in 2009 by Whakauae Research for Māori Health and Development to inform the resilience research project discussed below, identified a dearth of relevant sources.

Furthermore a similar exercise was carried out by the research project partner[2] to identify international literature on youth resilience. Whilst this search identified and annotated approximately 300 youth-focused sources, the bulk of these approached the understanding of resilience from a largely psychological perspective. Few of the international sources identified offered an Indigenous perspective and those sources which did, tended to combine these with an individualistic approach to understanding resilience.

While the Indigenous body of knowledge on resilience is not well developed, Andersson (2008) notes that within the Indigenous discourse, a multiplicity of evolving views are evident. He suggests that the diversity of understanding and opinion may be influenced by the degree to which Indigenous peoples have integrated a Western worldview, along with the nature of their relationship to the land post-colonisation. However he argues that essentially an Indigenous perspective on resilience recognises the collective aspect to Indigenous culture accentuates the positive and is concerned with the relationship with success, as opposed to the relationship with failure implicit in the Western paradigm (Andersson 2008). Similarly Iwasaki & Bartlett (2006), emphasise the need to reveal the real views of Aboriginal peoples rather than merely imposing academic or professional assumptions about their "woundedness" and resilience; assumptions informed by the Western resilience discourse.

Only a small proportion of Indigenous literature engages with the concept of resilience uncritically. Green, for example, notes that from an Indigenous perspective a major flaw of resilience literature is its concern with understanding how the individual might cope and respond to disadvantage, rather than an analysis of how structures, systems and processes perpetuate disadvantage for Indigenous peoples (Green 2008). The majority of Indigenous writers recognise that Indigenous views of resilience go beyond the focus on the individual (Andersson 2008: 3), that our analysis needs to address both the historical and contemporary oppression that exists (Walters & Simoni 2002), and our theorising of resilience must place structural inequality at centre of the discourse.

In common with others using an Indigenous lens to consider the term resilience, Lavallee & Clearsky (2006) contend that there is danger in uncritically adopting a concept which places

[2] The Health Services Research Centre, School of Government, Victoria University of Wellington

the onus for wellbeing on the individual in a virtual vacuum. Re-appraisal and reconstruction of the concept of resilience are necessary, it is argued, if it is to have any level of relevance for Indigenous communities. Lavallee & Clearsky are among a few Aboriginal writers who question the value of attempting to fit Indigeneity into any framework of resilience at all and seek to challenge the adequacy of the concept for explaining and validating the experience of Indigenous populations (Lavallee & Clearsky 2006).

For some North American Indigenous writers, researchers and academics, the concept of resilience is intimately linked with an oppressive and destructive colonial history and cannot, as a result, be viewed without deep suspicion. Further, there is an implicit assumption that resilience is disconnected from the imposed systems of social power which shape the lives of Indigenous peoples. Health and healing are thus constructed as being largely within the control of individuals including those who are systematically disempowered. Accordingly, even adopting the language of resilience risks silencing Indigenous stories of success and failure. To counteract the prevailing hegemony, Lavallee and Clearsky advocate for an Aboriginal-centred process that allows health and healing stories to be shared within a decolonised analytical framework (Lavallee & Clearsky 2006). For these writers, resiliency in an Indigenous context must primarily be concerned with the realisation of self-determination (Lavallee & Clearsky (2006).

New Zealand/Kaupapa Māori resilience literature

In New Zealand resilience research primarily focuses on issues around youth resilience and empowerment, youth mental health and the misuse of alcohol and drugs (Fergusson & Horwood 2003; Clark 2006); resilience as a protective factor in contraception, managing sexually transmitted diseases and HIV in youth and adult populations (Clark 2006; Green 2008); and more generally, as a framework to understand the protective factors apparent in families and communities of immigrants and migrants (Dixon et al 2010). The examination of protective factors that promote good outcomes or "resilience" in youth health research is a relatively new phenomenon (Clark 2006) however the idea of a "resilience framework" which seeks to understand and identify factors that protect vulnerable youth, and encourages them to thrive is gaining attention in New Zealand. The resilience framework, acknowledges that behaviour is influenced by the complex interplay of individual, biological, social, cultural, environmental, societal, and historical influences (Flay 2002; Waller 2001) and

according to Clark, seems consistent with Māori aspirations for development of capacities and self-determination (Clark 2006).

Māori literature on the concept of resilience in the health and social sciences is limited and Māori critiques few. Green (2008) in contrast to Clark, notes that Western resiliency frameworks have limited relevance for Māori. Specifically Green argues much of the Western discourse assumes that changing the behaviour of non-resilient, disadvantaged individuals will effect resilience; an assumption which fails to recognise the structural factors which shape disadvantage in the first instance.

In their review of the literature on how the concept of "whānau resiliency" is defined, applied and understood by policymakers, practitioners and academics, Te Puni Kōkiri concluded conceptualising resilience simply in terms of "risk" and "protection", and how individuals mitigate and respond to risk does not take account of the continuing influence of socio-economic status, gender, culture and ethnicity on Māori (Te Puni Kōkiri 2009:5). Furthermore for Māori, understanding the role of whānau and whānau collectives is crucial.

The review we have undertaken of the literature indicates that, while there is growing interest in the term resilience and its relevance to the development of public policy and health and social service delivery, our understanding of the term resilience, its usefulness and applicability is still relatively unsophisticated. So too our understanding of the association between resilience and other indigenous concepts such as whānau ora or mauri ora, (concepts which are grounded firmly within a Māori worldview), requires further elucidation.

4. METHODOLOGY

STUDY DESIGN

The research design is exploratory qualitative research using a single case study. Case study methodology is particularly suitable for ' … gather(ing) comprehensive, systematic, and in-depth information' (Patton, 2002:447) with the aim of exploring both the complexity and uniqueness of the case selected. The study has two overall research objectives: first, to determine if the concept of resilience described in Western academic literature holds resonance in Māori primary health approaches, and second, to determine in what ways whānau resilience is supported and enhanced by Māori primary health services. To meet these two objectives a series of four research questions have been identified:

- RQ (Research Question) 1: How are concepts such as resilience reflected in Māori primary health approaches?
- RQ2: What are whānau understandings of resilience?
- RQ3: How has engagement with a Māori primary health provider impacted on whānau resilience?
- RQ4: What are possible Māori primary health provider resources, mechanisms and interventions that contribute to enhanced whānau resilience?

The study was divided into two distinct phases of enquiry. Phase 1 sought to identify how concepts of resilience are incorporated into the TOIHA whānau ora programme approach, while phase 2 determined evidence of implementation of these concepts in the actual work of a Māori primary health care provider. In particular, we sought to understand how participation in Māori primary health services has impacted on whānau resilience capacity. A comprehensive literature review, case study document review, key informant interviews and focus groups were conducted.

Participants for the study were selected purposively using a criterion sampling strategy. Participants comprised key informant interviewees representing TOIHA governors, managers and front line workers; and health service consumers from the primary health and community development programme areas.

PHASE 1 METHODS

Phase 1 of the study sought to address RQ 1: how concepts such as resilience are incorporated in Māori primary health approaches. This phase comprised a detailed review of the academic and grey literature, a review of case-study documents (TOIHA's internal policies and practice manuals), and a series of semi-structured, in-depth, key informant interviews. The case-study document review included strategic and annual plans, policy documents, service delivery contracts, whānau care plans, and staff training plans. The documents were analysed to determine in what ways concepts of resilience have or have not been utilised in the whānau ora approach being implemented by TOIHA. This information not only added to the body of knowledge about utilisation of concepts of resilience in indigenous primary care approaches but also assisted with development of an open-ended interview schedule for in-depth key informant interviews.

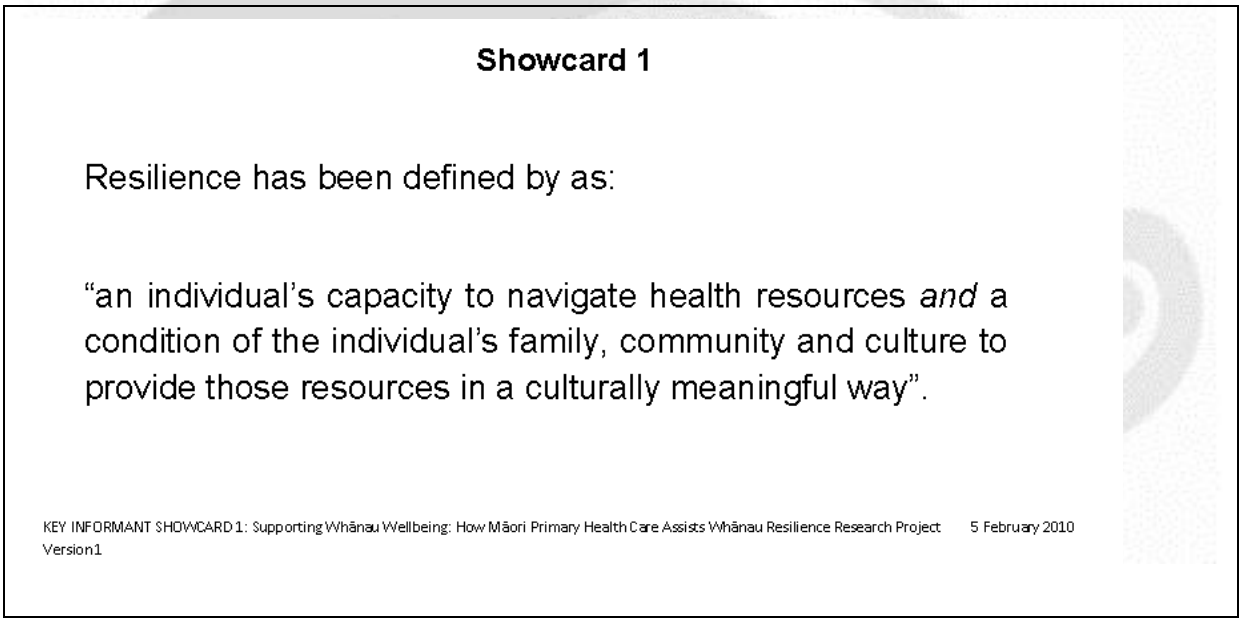
Data analysis began at the literature review stage when the findings from the literature review and the organisational document review were used to inform the development of an initial conceptual framework linking the concepts of "resilience" and "whānau ora" and an interview schedule for key informants. The purpose of the in-depth key informant interviews was to provide further opportunity to expand on the key concepts being used in the TOIHA whānau ora approach and in particular to explore the concept of collective resilience as it applies to the case study. The key informant interviews allowed us to probe fully for responses and seek more information of greater depth than could have been obtained from just a document review alone. Participants for the in-depth key informant interviews were selected purposively, using a criterion sampling strategy (Patton, 2002), and included at least two governance level representatives, two from a senior management or policy development level, two from a service implementation level as well as clinicians. The primary purpose of these interviews will be to explore the participants' understanding of resilience as it relates to TOIHA's whānau ora programme development. A total of 11 participants were interviewed.

The research attempts to draw two distinct and apparently disparate concepts together (i.e.: whānau ora and resilience), in order to answer the research questions posed. To develop the interview schedule our research team undertook a process of distilling information from two sources. First the team identified a set of principles or characteristics of "resilience" from the literature, we then reviewed TOIHA's internal policy and practice documentation to distil a

further series of principles which "mapped" or aligned with those principles of resilience as defined in the literature. Finally a series of questions for informants was devised that would explore the evidence of a resilience approach in TOIHA's service delivery.

In addition to an interview schedule, a set of showcards was used to assist key informants in the interview. Showcard 1 presented Ungar's definition of resilience (Ungar, 2008) which was adopted for this first phase of the research, while Showcard 2 outlined a series of principles, drawn from TOIHA's strategic, internal policy documentation which the team considered aligned with the concept of resilience as espoused by Ungar. In conducting the interviews, we expected that key informants would provide examples of how these principles were incorporated into the day-to-day practice of this particular primary health care provider.

Figure 1: Showcard 1 A Definition of Resilience



The showcards were placed in front of the participant so that they could refer to them as the interview progressed and, in the case of Showcard 2 participants were encouraged to discuss any aspect of the principles outlined on the showcard, in any order.

Interviews with key informants were recorded and the audio-recordings transcribed for analysis by the research team. The transcripts were offered back to participants for checking and then once checked, were prepared for analysis. A number of strategies were employed to

ensure authenticity and reliability of the information. The lead interviewer independently coded the data to reduce any potential loss of meaning from body language or facial expressions (Miles & Huberman, 1984). Then, using a process termed "Mahi a Roopu" (Boulton et al 2011), a team of four senior researchers acting as a group, undertook a further stage of analysis and synthesis. This involved the team reviewing all transcripts and draft themes that had been identified by the lead interviewer; analysing the transcripts thematically against the interview schedules to draw out the key messages and analysing transcripts for new, emergent themes. All data was considered in terms of its alignment to the conceptual framework. The Mahi a Roopu approach, while resource intensive, ensures analysis is strengthened through the critical input of an experienced Māori research team as opposed to being produced by a sole research practitioner in isolation.

Figure 1: Showcard 2 Principles Distilled from TOIHA's Internal Policy Which "Map" to the Concept of Resilience

Showcard 2

Principle	Descriptor
Whānau Ora Approach	Health service provision which restores and maintains Rangatiratanga; utilises kaupapa Māori approaches; and works towards best outcomes for whānau, hapū, iwi
Focus on Wellness	Clinical expertise, supported by the capabilities embedded in a whānau ora approach, to support whānau to build and optimise wellness
Cultural Accountability	The recognition that a Māori world view is the philosophical basis for the service
Whānau Empowerment	Whānau are encouraged to understand the responsibilities they have in creating whānau ora amongst their own whānau

KEY INFORMANT SHOWCARD 2: Supporting Whānau Wellbeing: How Māori Primary Health Care Assists Whānau Resilience Research Project 5 February 2010 Version1

PHASE 2 METHODS

Phase two sought to determine evidence of implementation of these concepts; in particular how participation in Māori primary health services has impacted on whānau resilience capacity. Phase Two therefore sought to answer the questions; What are whānau understandings of resilience?, How has engagement with a Māori primary health provider increased whānau resilience?, and What are possible Māori primary health provider mechanisms and interventions that contribute to this enhanced resilience?

Development of a new method – the Sequential Focus Group

Culturally safe research practice with indigenous populations is sensitive to the particular needs and context of indigenous participants, ensures that cultural norms and practices are respectfully acknowledged, and recognises that the social milieu in which the research is situated must be one that avoids the reinforcement of oppressive social hierarchies or power asymmetries. An ability to establish trust and rapport are critical elements in indigenous research and, for this reason research is often conducted by indigenous researchers. The importance of establishing an entrusting relationship between researcher and participant and among participants themselves is not simply a matter of polite acknowledgement of respective roles in order to ensure cooperation, but rather is vital to the integrity of research involving indigenous peoples (Gifford & Boulton 2007).

Additional time is often required to ensure culturally safe research practice. For instance, recruitment efforts may be prolonged due to participants' feelings of wariness, hesitation, or perhaps even hostility towards the research team. Also, considerable effort and commitment are required to establish relationships and gain the trust of individuals and the communities which they represent. Culturally safe research practice that strives to be participatory and that acknowledges the richness of knowledge found in people's everyday life often requires researchers to participate in various cultural practices such as the sharing of food, traditional ceremonies, or other social events where storytelling (a common way of exploring ideas using metaphor) may abound.

Research with indigenous populations is particularly challenging when the topic being researched is a complex concept arising out of western knowledge or is framed within non-indigenous theoretical constructs that appear to be vastly decontextualized, or entirely

foreign, to participants. This was the challenge to our research team as we sought to determine whānau understandings of the term "resilience". As a consequence we employed the Sequential Focus Group (SFG) method; a research approach developed initially by a team of indigenous researchers including Dr Gifford, to develop a cultural competency framework for indigenous primary care in Calgary, Canada. This novel approach to qualitative research with indigenous participants builds upon the well-established conventional method of conducting focus group interviews but allows sufficient time to establish rapport and trust and facilitate participation in cultural rituals.

The SFG method requires a number of participants who are willing to meet as a group, over a course of at least four sessions. An adaptation of the conventional focus group method, the SFG offers a way for researchers and participants to explore the issues in-depth by providing sufficient time for critical reflection. This in turn allows ideas and discussion to build upon each other from one session to the next and for a gradual process of relationship building and enhancement of trust to develop. Working with the same participants over a number of sessions allowed our research team the opportunity to introduce the topic, explore a variety of resilience concepts in more depth, conduct facilitated discussion on each research question, and test and re-test themes as they emerged.

Two SFGs were conducted, with each SFG comprising four separate focus group sessions. Group A, comprising six participants met in the morning, while Group B, comprising eight participants, met in the afternoon. The duration of each session was three hours, representing a total of twelve hours for an entire SFG data set.

Participants for the SFGs were self-identified Māori persons between the ages of 18-65; who consider TOIHA their primary place of health care; and who have accessed the health services a minimum of three times in the last two years. Of the final 14 participants, four were male and ten were female. All but one were Māori (one participant hailed from Fiji), and the majority (78%) were aged 26-55. Most of the participants (71%) accessed Te Oranganui services monthly or bi-monthly either for general GP services (i.e., to visit their family physician) or for other primary health care services.

The two SFGs were held over a course of four weeks (i.e. one session per week, held at the same time and same place every week). The aim of the first focus group was to introduce participants and researchers to one another and discover what led them to seek health care from an indigenous provider. In focus group two, we sought to clarify whānau understandings of resilience, while in focus group three, we explored people's experiences of the health service, such as how the service has impacted their lives; whether receiving health care from a Māori health service has contributed to them becoming more resilient and how; and whether this in turn has supported them in their efforts to achieve whānau ora or family wellbeing. It should be noted that the research was careful to elicit participants' own definition of whānau ora. The purpose of the fourth and final focus group was to understand the specific resources, mechanisms and interventions that this Māori primary health provider uses and which may directly or indirectly contribute to enhanced resilience and whānau ora.

A team of three researchers ran the SFGs. A senior researcher had responsibility for leading the discussion in each of the four sessions. Using a prepared plan which included the issues to be explored in each session, the lead researcher had the responsibility of starting the discussion, ensuring questions and objectives for each session were met, and facilitating the exploration of new and emerging lines of inquiry as needed. The lead researcher was supported by a second senior researcher who was responsible for note-taking and summarising the discussion on a whiteboard for participants to review and reflect upon. A third researcher "mind mapped" the group's conversations, thereby recording the discussion in a visual form.

Multiple methods of note taking allowed for a range of data to be collected during the SFGs. In addition to the note-taking and mind-mapping undertaken by the research team, participants themselves were also asked to "mind map" at various stages throughout the four sessions. Key themes arising from each session were summarised by research team members and visually displayed during the focus groups so that participants could see their thoughts and make additional comments. These visual summaries were used to gauge the strength of collective feeling around the issues identified.

At the conclusion of each session members of the research team undertook a debriefing. This proved useful for two reasons: first, the team's immediate impressions about the research

findings were recorded, summaries reviewed and preliminary analysis of the data undertaken; and second, gaps in data and areas for further exploration in subsequent focus groups were identified. The process of debriefing contributed to an early understanding of the data and ensured the discussions in each focus group remained on topic. At the debriefing a general impression of the participants, their interaction with the research team and fellow participants and observations regarding how the focus group flowed was also recorded.

Interim data from each of the sessions was fed back to participants at the beginning of the subsequent session. Doing so achieved two objectives: it provided the researchers with the opportunity to feed back to participants and it set the context for that day's session. The SFGs were audio-recorded but not transcribed; instead the audio-recording were simply used as a back-up to the handwritten notes and mind maps and as an archived resource to cross-reference for accuracy of interpretations.

DATA SYNTHESIS

Synthesising the data from the two phases occurred at two key points in the project. The initial process of synthesising findings occurred straight after the last of the SFG sessions had been conducted. At this time members of the research team met and reviewed the data collected in the two phases. The purpose of this initial review of the data was to identify any gaps in the data that had been collected with a view to determining whether more data was required. At this initial synthesis meeting the research team agreed that a point of data saturation had been met and that no new or additional data collection was required.

A further session to synthesis the data was held towards the end of the project, as material was being written up for publication. The data from both phases of research have therefore contributed to the findings outlined in the next section.

ETHICS

Ethical approval for the study was obtained from the Central Regional Ethics Committee on 17 March 2010.

5. FINDINGS

This section is structured so as to provide answers to the four research questions originally posed, namely:

- RQ1: how are concepts such as resilience reflected in Māori primary health approaches?
- RQ2: what are whānau understandings of resilience?
- RQ3: how has engagement with a Māori primary health provider impacted on whānau resilience?
- RQ4: what are possible Māori primary health provider resources, mechanisms and interventions that contribute to enhanced whānau resilience?

RQ1: THE PLACE OF RESILIENCE IN MAORI PRIMARY HEALTH APPROACHES

Generating a conceptual framework

The definition of resilience that we used for our research is taken from the International Resilience Project led out of Dalhousie University by Michael Ungar. In his more recent work, which recognises the need for a contextualised definition of resilience, Ungar describes resilience as being both the capacity of individuals to navigate their way to health-sustaining resources, including opportunities to experience feelings of wellbeing, *and* a condition of the individual's family, community and culture to provide these heath resources and experiences in a culturally meaningful way (Ungar, 2008).

As discussed above, our hypothesis at the outset of the research was that notions of resilience underpin Māori primary health activity and that Māori primary health approaches have the ability to assist whānau to increase their resilience by supporting individuals and whānau to access resources that sustain their wellbeing in culturally meaningful ways. However because the term "resilience" does not readily appear in local indigenous writing, in NZ primary health care literature, or in the policy documents of our case study site, our first task involved identifying aspects of a resilience approach from the written material provided to us by our case study site. In order to assess "resilience" as it related to Māori primary health we first had to align the underlying characteristics of resilience from the international literature with principles of Māori health service provision as espoused by TOIHA that reflected these same

characteristics. This exercise resulted in the generation of the conceptual framework which guided our analysis of the data in relation to our case study site.

TOIHA has developed its own approach to providing culturally appropriate health services for its enrolled population. During the period that this research was being conducted alone, (2009-2010) three pieces of work were being undertaken to consolidate TOIHA's approach to kaupapa Māori service delivery in the community. In the last two years, TOIHA has initiated a Whānau Ora Strategy; an organizationally-driven service delivery model which, rather than focusing on illness and disease, intends to promote wellness. The approach adopted by the strategy aims to focus on allowing whānau to "be who they are, incorporating a holistic and Maori worldview approach" which in turn would allow for "a positive outlook" in dealing with whānau wellness rather than illness (TOIHA 2008b). The Whānau Ora Strategy represents a kaupapa Māori model for health service delivery based on a set of ethical principles derived from Whanganuitanga and te ao Māori more broadly. Plans to redevelop and reconfigure services to best meet the needs of whānau, according to the Whānau Ora model are currently underway. In practical terms TOIHA intends to develop a wrap around service utilising the clinical expertise in the organisation as well as the whānau ora capabilities of kaimahi to support whānau in building and optimising their wellness. The integration of services is regarded as essential to ensure a service which better meets the health and wellbeing of whānau, hapū and iwi.

In addition to the Whānau Ora Strategy, a training curriculum was developed, and a service development model that focused on primary health care improvement through greater intervention and self management practices by whānau was piloted. Alongside the development of the service delivery model has been the introduction of Te Oranga; a model of practice, case management and cultural audit which complements and supports the service delivery model. Other measures to provide health resources in a culturally appropriate manner include employing highly skilled and well trained staff and investing in staff development.

The TOIHA PHO Whānau Ora Strategy acknowledges the strengths which are based in Iwi perspectives, and specifically recognizes that as an Iwi-based health service provider TOIHA has a role to support whānau, irrespective of size to:

- Be responsible for their future;
- Know from whom they are descended and therefore who they are responsible to;
- Understand their relationships to each other, including relationships within the whānau and to the greater community; and
- Become strong, confident and well educated in "both worlds" so to support future generational growth (ibid p6).

Figure 3: Conceptual Framework for the Understanding Resilience and Maori Primary Healthcare Approaches

Characteristics of a Māori development approach Primary Health Care in NZ[3]	**Definition and Features of Resilience[4]**	**Features of an indigenous primary healthcare service provider which supports resilience**
• Primary prevention • Population-based approach • Connecting people to resources (cf seeing people who are sick)	"An individual's capacity to navigate health resources and a condition of the individual's family, community and culture to provide those resources in a culturally meaningful way"	**MAJOR THEMES** • Whānau ora approach • Culturally accountable and appropriate care • Focus on wellness and the ability to provide appropriate resources • Empowerment of staff, clients and their whānau
		SECONDARY THEMES • Ability to refer on in an integrated manner if resources are not available in-house • Understanding of social and economic determinants of health

Thus, from literature reviews and case study document review we were able to develop a conceptual framework which aligns the key features or characteristics of resilience with key

[3] distilled from key government strategies such as the NZ Health and Disability Strategy, the NZ Primary Healthcare Strategy, He Korowai Oranga as well as the Horne Report

[4] primarily from Ungar

principles guiding the work of Te Oranganui Iwi Health Provider Primary Healthcare Organisation. Six features of Te Oranganui's approach to health service delivery related generally to the concept of resilience, while four principles in particular were regarded as strongly aligned to understandings of resilience derived from the literature reflecting an approach to service delivery which not only supported notions of individual resilience but importantly for Māori, notions of whānau resilience. The four principles are: a whānau ora approach; cultural accountability; a focus on wellness; and whānau empowerment.

In determining the place of resilience in Māori primary health care approaches we have structured the results according to six key themes; two of which are derived from Ungar's definition of resilience, whilst the remaining four are derived from the unique features of Māori primary health service provision, as described in the conceptual framework above (Figure 3). The themes are: assisting whānau to access health resources in a culturally meaningful way; whānau ora approaches; cultural accountability; a focus on wellness; whānau empowerment; and contribution to the overall health and wellbeing of the community.

Assisting whānau to access resources

Māori primary health care providers occupy a unique and important place in the delivery of health services in NZ. Most Maori health service providers are intimately and intricately linked to their communities through whakapapa and tikanga ties (Boulton 2007). Community-based kaupapa Māori service provision is, by its very definition, a culturally appropriate and meaningful way to provide health resources. It is perhaps unsurprisingly therefore that results from the analysis of provider documentation, key informant interviews and the sequential focus groups indicate that as a Māori primary healthcare provider, TOIHA, is aware of the need to provide health resources in a culturally appropriate manner, and, in its role as a community-based health service provider, seeks to assist its clients access culturally-appropriate health resources.

When asked what resources TOIHA had at its disposal or used to improve health outcomes and assist people to become more "resilient", the most important resource that respondents identified were the organisation's staff.

*The people resources are probably the main resource that they have, you know, when it comes to business I suppose, they have the assets, resources. We have resources, our land resources I suppose. Being part of the three iwi being part of it, of the health...the three iwi are very important because we're getting out not just in the Wanganui district but out into the wider community. Yeah very important we have the three involved, gets to more people. And I think we have a more stable opportunity like people are just dealing with the one organisation and maybe the one set of doctors, nurses, they get known by the users.*KI11:2

One of those resources are us, ourselves. As the worker, to be there as an advocate which is a real big resource for them cos of, for the likes of a client going to see a psychiatrist, um, having whānau support there or having a services support there, it gives them the ability to be able to speak freely knowing that they've got somebody there to speak for them if their korero is not getting across. KI04:1

Research participants were asked to consider whether TOIHA, as a health care provider, works in a way that is consistent with assisting individuals and whānau to access resources which sustain their wellbeing and whether they do this in a culturally appropriate way. There was general agreement that TOIHA did act in a manner that upheld the mana[5] or integrity of individuals and whānau. Importantly TOIHA was seen to provide resources in a way that best met whānau needs at the time, rather than simply providing what they, as clinicians or health practitioners, "thought best".

I mean we're speaking on their behalf pretty much – but then, in saying that, encouraging and empowering them to do it for themselves to show them, hey it's not that scary sort of buzz. KI01:7

Participants described a number of functions TOIHA staff perform which assist whānau to access the health resources they need and to do so in a timely and more importantly, culturally appropriate manner. Practitioners acted as navigators (assisting people through the various services that they needed); as advocates (advocating on behalf of consumers with other health care and social service providers outside TOIHA); as educators (both informing consumers of the role of various services as well as educating them about medications,

[5] Integrity, honour, authority or power.

procedures and how to make lifestyle changes to improve health outcomes); as brokers (finding and accessing wider community-based assistance and services); and in general as support people.

> *Within our service, the people that we support, not everybody has all of those, natural supports there to be able to meet those needs, to meet those special needs...we support people on that journey through the disability and health sector because it's a maze of you know, there's a whole lot of supports out there but when you're not feeling well, you are only just managing those need and then to have to cope with the community out there to find what you are eligible for, its hard work. It can be very tiring and draining unless you know the system ay? Because it's a culture on its own.* KI06:2

Whānau Ora approaches

When asked about the relative importance of working not just with the individual but also with their whānau, many of the respondents spoke of the organisation's whānau ora philosophy and the importance of demonstrating this philosophy in the day to day work of the provider. Working in a whānau ora manner had until recently only been practised by some services within the organisation as a whole, particularly by the Well Child Service and the Mental Health and Disability Services. With the introduction of the Whānau Ora strategy and accompanying training curriculum, respondents noted that the whānau ora model of practice would be rolled out across the whole organisation.

> *Just that, we are not going to talk about it, we're going to do it. So we will be walking the talk which is the best way for our people to see us, walking the talk. It'll be more important than anything else. That's why it's imperative that all our staff get on board with this. Cos nothing else has really worked has it?...You imagine for example, all the kids or all the mokos in the house telling their nanny and koro to stop smoking, after a while it will sink in and that's the family approach, that's the doctor saying you know you must give up smoking, he's just one cog, but when all the mokos or the kids start saying "give up smoking Nanny and Koko", it'll take its toll. It'll happen, the more of the families we get involved with that sort of korero, the better.* KI11:9

The culture of whānau ora, of taking a whānau ora approach, had, since the introduction of TOIHA's internal strategy document, been strongly promoted within the organisation. One respondent noted that he had seen a change in the sector as a whole where health was no

longer simply focussed on the individual and a health service treated an individual patient but rather "now it's to be the wider family, the wider whānau, the wider community helping in the health care of whoever" (KI04:3).

Being able to operate in a manner that takes cognisance of the wider whānau, which takes into account the whānau context in which an individual lives, was regarded as a unique strength of Māori primary health service provision, and of this provider. A particular strength of this provider was that many of its clinical and outreach nursing staff, staff that deal face to face with community members, are not only Māori but also whakapapa from the area. As one respondent observed:

> *And it goes beyond, just like, being Maori. There's that connection, that whānau connection there, I mean, yep they acknowledge whether you've been whatever colour for your skills, like professional skills, but there's a difference when they see a coloured face, I suppose and I think it's that whānau connection that makes them feel comfortable.*KI03:6

A further example of a whānau ora approach for this organisation was described by a staff member who noted that many of the kaimahi who work in the organisation are able to relate better with their clients because they are able to draw on experiences within their own lives, or the lives of their wider whānau which mirror those of their clients.

> *Our kaimahi would have been in similar situations of their own and they are able to transfer that into their work so they can relate straight away to it...so yeah it's just...for us [its] got to be able to have experiences to deal with that whānau out there you know?... If they didn't have experience then they wouldn't know what we are talking about so how do you ask people to deal with that, in outside Māori... when they don't get it ...I guess that in terms of the whānau ora approach that's kind of what I'm saying you know? Like every one of our kaimahi and people in Te Oranganui pretty much would have experienced something that they can relate to that's what makes the approach different for us or better.* KI10:7

Cultural accountability

Cultural accountability for the purposes of this research refers to the way in which TOIHA as an organisation remains true to its own cultural principles as espoused by its policy and

strategic documents (for example Te Piitau Whakarae Cultural Framework and Cultural Standards), and acts to provide both culturally accountable and culturally appropriate care to its clients. The governance of the organisation is shared between three iwi partners and ensuring that the organisation works in a culturally appropriate manner is therefore, a key interest of the board of governors. One respondent observed that as far as their iwi were concerned if TOIHA did not operate in a culturally appropriate manner then it was time for the organisation to close its doors (KI08:3). For this respondent the issue was particularly important because as an iwi organisation, TOIHA was the face of those three iwi, and by extension, the work of TOIHA was also seen to reflect on the iwi themselves.

Cultural accountability for the organisation starts at the board level, who comprise representatives of the three iwi that provide TOIHA with the mandate to operate. At an operational level, cultural accountability is maintained and manifest in a number of ways. One such way is creation of a Cultural Advisor position at the strategic management level. The role of the Cultural Advisor includes, amongst other things, working with and supporting staff to uphold the cultural principles of the organisation. The Cultural Advisor may be regarded as the lynchpin between the strategic directives to act in a culturally appropriate manner, such as those set out in Te Piitau Whakarae and the organisations ability to give effect to those directives in the day to day work of the organisation.

The organisation also supports staff to improve their reo and has encouraged the use of te reo more often in the workplace, especially in interactions with clients.

> *We've looked to enhance the reo of staff to help the kuia kaumātua feel a hell of a lot better when they come in and they start speaking the reo, and they go, excuse me we don't speak the language here, which we used to have some time ago.* KI08:5

Evidence of being a culturally accountable organisation included treating patients with dignity and respect; of providing information in a way that the client best understands it, whether this be using brochures, pamphlets or "teaching tools" (KI05:1); and of encouraging whānau participation and support for clients. It also included having an understanding of the Treaty principles and taking a partnership approach (KI05:2), as well as the "basics", which

underpin Māori culture, such as aroha and manaaki not simply for clients but also for colleagues and peers within the service itself (KI01:9).

A focus on wellness

For TOIHA, the drive to focus on wellness, rather than on illness, diseases, or medical conditions reflects the strength-based approach the organisation is trying to take in dealing with the health and wellbeing of its people.

> *I don't think, like, clinicians intentionally set out to focus everything on illness you know, the disease states. I just think that they get lost in it...and I guess the next best thing about Te Oranganui is you can play with that a lot, focusing on wellness as opposed to illness. Yeah and as soon as you change that around then the ability [to] give it back to the whānau is easier. Cause the wellness should come from that strength, from their whānau.* KI10:7

At a service level focussing on wellness can meant the difference between providing standard care or care that is more tailored to, and cognisant of the needs of the individual. In order to provide such care and develop these sorts of care plans, the clinicians themselves must work alongside the patient or client and their whānau in order to determine what they want to achieve from their care. An example provided by a staff member of TOIHA illustrated not only the focus on wellness, but other principles such as the whānau ora approach, whānau empowerment and cultural accountability:

> KI06: *So a referral came in on Monday to provide support for this kuia and she is at home by herself during the day and her whānau are at work. So the referral came in and so the Service Co-ordinator rang and spoke with the contact was with her daughter and made a time to go and meet. So when they went out to do the planning there were family members there as well as a lady that we're going to be providing the support. So re, the whānau ora, everybody was involved.*
>
> Interviewer: *So that was disability assessment?*
>
> KI06: *Yeah well, yes. She had the assessment had been done and some hours had been allocated to us or to her and she said that we provide the support because she chose our service. So we went out and you know, in hand with the hours that we had been given to provide and then we needed to talk with her and her whānau as to how would she like the support to be provided. So that's using that approach [whānau ora] and also whānau empowerment because we're saying*

this is what we have been given to provide the support, how do you think it will best meet your need? And so they explain how it best meets their need and that's how the care package was put in place and the focus was, yes on her wellbeing because there were some clinical, she was being supported clinically by the hospital as well and we were providing the community base support. So those two ways of supporting would be married up and with cultural accountability well we would be taking, how we provide that support, we were taking our direction from that lady, and whānau as in the most appropriate way.

At the personal level, the wellness focus is intimately linked to whānau empowerment. According to the organisations documentation, in order to focus on your own, and your whānau's wellness, you must first have acknowledged that you have a role to play in the achievement of wellness. This can only occur once you have reached a stage of personal responsibility for your health and wellbeing.

I think whānau empowerment or individual empowerment is one of the most important things you know because if you know how to empower yourself then you know how to bring about wellness for yourself. If a client that suffers from illness knows all of the triggers that set them off, then they know what to do. Yeah. KI04:9

Whānau empowerment

Whānau are encouraged to support individual clients when they access the service or receive care, however, it is also equally important that clients and whānau be given information so that they can make the best choices for themselves and for their families. One respondent noted that it was important for this organisation that people are given choices about their own care and treatment pathway, and that "we do not dictate what they should do" (KI05:1). Instead of directing what a client should do, this respondent noted that the role of the organisation was to teach and educate people on the better outcomes they might experience through, for example, modifying their diet, taking more exercise, quitting smoking and to provide support, encouragement and appropriate referrals. "Ultimately our clients are responsible for their own choices they make in life, and they can abide by our advice or not" (KI05:2).

Another respondent agreed noting that as a Māori organisation, they had to be realistic about how much help they could provide to individuals and to whānau if they were not ready to receive help and advice.

> *The way that we as Māori operate, we're very pragmatic when it comes to comes to things like that, it's like, you do what you have to do, you know? and as much as you can do. And that sometimes means, from my experience anyway, is that if that individual lets them into that part of their lives then, you know, then that can happen.* KI09:3

Readiness and willingness on the part of the individual to accept help, to modify their behaviour, and to aim towards the achievement of a healthier lifestyle or whānau ora, was an important step towards individual and whānau empowerment. Perhaps more importantly from an organisational perspective is that once clients decided they did want to change, the window of opportunity for the organisation to support them was very small. TOIHA had to be ready to respond, to provide appropriate advice and be willing to support the individual, as soon as the individual recognised the need for help. One respondent summarised the problem stating "it's that individual's choice, you know, when that individual is ready to make that choice then the services are there to give and assist" KI11:4.

Yet another respondent went on to note that whānau empowerment, while a laudable goal, was not the responsibility simply of a health service or indeed the health sector. Rather the responsibility for empowering whānau in their view was that of iwi and hapū. However, the respondent reiterated that to achieve whānau empowerment, whānau had to firstly indicate a willingness on their part to change.

> *Responsibility lies out there, on a personal level. Whānau empowerment is at the iwi and hapū level and what iwi and hapū do is they approach us and part of their package, they're saying, these are the services in terms of health that we need to ensure that we're fulfilling our role as hapū leaders and iwi leaders. But you know once we start owning this thing, you know, you start standing over the top of people who are responsible for whānau empowerment. So, yeah you know we are three iwi at the moment you know, that contribute I guess, to where iwi want to be, where whānau want to be and hapū want to be in terms of health. But the*

empowerment really is their role and our role is to ensure that they get some assistance. KI08:

At least one respondent noted that whānau empowerment was simply one aspect of whānau ora noting "whānau empowerment is, you know, whānau encouraged to understand responsibilities they have in creating whānau ora amongst their own, yeah" (KI11:7).

Contribution to the overall health and wellbeing of the community

Participants observed that as a Māori health provider, and a Māori PHO, TOIHA played an important role in contributing to the overall health and wellbeing of the community. Furthermore participants also noted that it was important for TOIHA to be seen by clients and the wider community making an active contribution.

You know there are public events that happen out there and Te Oranganui's got their face, you know, they've got a tent up, or they've got quit, smoking cessation, you now, healthy eating, everything...Te Oranganui is out there trying to get amongst the people and like, you know, a lot of them do it in their own time. They're trying to get out, to reach the people. KI11:10

Well yeah, I think we have, we're out there ay? As a service we're out there, we've been recognised for our skills, we partake in community events, not just Pakaitore, not just Waitangi Day but you know, Relay for Life...May Day Disabilities when they hold their wānanga in May, we're part of that. Um, mental health awareness week, we partake in that and that's dealing with all of the mental health services are coming together on that week. Um, yeh no I think we're out there, I think we're out there now. KI04:6

However another aspect to making a contribution to health and wellbeing in the community was in educating their colleagues in other, predominantly mainstream services, about the most appropriate ways to work with Māori whānau.

We liaise and network with other health professionals and [that] is so because we have an expertise in one area and they have an expertise in another...If we're supporting someone with special needs... and so our kaimahi have an expertise in that area and so they have that skill so that when they're going t, if they need to support them at WINZ, they can support them which also helps the person at WINZ. They have the expertise in how they sort their financial arrangements and

all those kind of things but they may not have that expertise on how to communicate with them effectively. KI06: 4

One final way in which TOIHA contributes to community health and wellbeing is by supporting individuals within the community to achieve better personal health outcomes, which in turn will impact on whānau health and the health of the community as a whole.

By gaining better outcomes for the individual, we are impacting not only on their lives but the lives of the family, for example, teaching healthy eating practices, benefits the whole family and the long-term health through the generations. If people live longer and have a better quality of life, they can be more productive in the whānau and wider community" KI05:2

RQ2: WHĀNAU UNDERSTANDINGS OF RESILIENCE

Introducing the Sequential Focus Group data

The data presented in response to Research Questions 2-4 draws upon the findings from the Sequential Focus Groups undertaken with current clients of TOIHA, in addition to the key informant material. The SFGs canvassed a range of questions beginning in Focus Group One with an introduction to the definitions used in the study, through to questions regarding the link between resilience and whānau ora[6] by Focus Group Four. This section of the report presents material that directly answers the final three research questions posed in the study, namely: What are whānau understandings of resilience?; how has engagement with a Māori primary health provider impacted on whānau resilience?; and, what are possible Māori primary health provider resources, mechanisms and interventions that contribute to enhanced whānau resilience?

The participants in the SFGs were asked about their understandings of resilience, what they thought resilience meant, and were asked to consider examples of individual versus collective resilience. We work-shopped the term with both Focus Group A and B and then summarised the combined finding and presented these back to both groups. The combined results from both SFGs indicate that the term resilience is associated with ideas of survival and

[6] the full suite of questions for each Focus Group is included in the appendix to the report

survivorship in the face of adversity. For our participants, resilience can take two different and distinct forms.

Resilience as a personal quality

One way in which our participants talked about resilience was that it referred to a quality in a person. A resilient person, for our participants, was someone who had a strength of character or spirit, who had certain values which allowed them to overcome adversity and trauma. Toughness, the ability to bounce back, resourcefulness, adaptability and flexibility were all regarded by our participants are characteristics of a resilient person. Our participants did not necessarily agree that resilience was an intrinsic characteristic, one we are born with; indeed there was a great deal of discussion as to whether resilience could be something that is learned through many trials and setbacks. Some of our participants spoke of the "school of hard knocks" and how people demonstrated resilience by surviving a hard upbringing to become upstanding members of society. Others meanwhile spoke about the values that are taught to Māori who were fortunate to grow up amongst their elders. It was the elders instilling values such as wairuatanga, kotahitanga, whanaungatanga, and kotahitanga; indeed "all the tangas", at a young age that enable people to survive and thrive in face of adversity. Respondents discussed this ability to survive and thrive in the face of adversity as being one of the enduring characterises of Māori who have survived in spite of colonisation, land losses and depopulation.

Being resilient or demonstrating resiliency, according to our participants, does not occur in isolation but relies on connections to other things and to other people. These things or people can perform a variety of functions for the person. They can variously act as catalysts for change; as mirrors to reflect back to the person the direness of the situation; as guides; as champions or advocates; as role models; and most importantly, as supports to assist the person should they embark on a journey out of adversity.

We asked our SFG participants why some people demonstrated greater personal resilience than others whereas others did not. Reasons for an individual appearing to have greater resilience included personal factors such as one's make-up and character; one's background and upbringing; the values that one had been taught; and whether that person had adequate moral, emotional, physical and financial support to allow them to make a significant change

in their lives. One participant spoke of their experience as a "battered woman" and that in order to get herself out of her risky situation she needed support and help from friends. However there was also recognition that, in her instance, she needed a degree of personal courage and the will to change. In her own words, "it took til I was 40 to grow a backbone".

This finding reflects that of the key informants who identified that among TOIHA's clients there are a group of individuals and whānau who they would describe as being more "resilient" than others. One key informant noted these more resilient whānau have greater access to "natural resources" including family (particularly extended family); friends; links to their marae[7] (meeting house, meeting place) and other institutions of culture, including places of significance. These whānau and individuals are often more educated (even if it is simply that they are more informed than earlier generations regarding the harm caused by drugs, tobacco and alcohol); and have a greater knowledge of their rights as consumers of health care services.

Resilience as a process

A second understanding of resilience then is that it is a journey or a process, whereby a person moves from a point of trauma, risk, harm, or simply a "bad" life to one which is healthier and safer. Participants spoke of the requirement for a catalyst or "trigger" to prompt the person to recognise the need to embark on their journey. These triggers may also take a variety of forms, although our participants gave examples of triggers taking the form of a traumatic incident, of a simple conversation with someone who is respected; the birth of a child, or the death of a parent. What was clear to our participants however was that in almost every situation, a person was not going to start the process of improving their life, and of becoming "resilient" unless there had been some form of catalyst or trigger.

Once one recognises the need to begin the journey, then according to our participants they have started on a process of empowerment and self-determination. The ultimate goal in this journey is to reach a point where one is "self-reliant", however self reliant in this context, and according to our participants, means individual strength as part of a strong, supportive and

[7] the meeting area of a Māori village or settlement, including its building and courtyard; also used to refer to the whole complex which may include the meeting house, dining hall and offices

functioning whānau. A resilient individual can only be resilient if they also have a resilient whānau, or a strong whānau supporting them in their journey.

We asked key informants to reflect on why some individuals and whānau appear more willing to leave behind unhealthy practices and seek assistance than others, and what makes a whānau choose a particular time in life to make these changes. Key informants indicated the reasons behind the decision to change are often not expressed, or are very personal and specific to the individual. As a result they noted that primary health care providers such as TOIHA must be ready to act at all times so they are able to work with an individual or whānau as soon as they signal their readiness. Key informants noted that the window of opportunity to assist whānau once they have decided to pursue a healthier life is incredibly small and if providers are slow to engage with a whānau or do not recognise signs of readiness to change, they may end up "turning the whānau off" and losing the opportunity and the whānau completely.

Recognising the need to begin the process is however just the first step on the journey and participants noted that the support and advocacy that assisted a person to begin the journey will still be required at various points along the way. Our participants noted that there are "ongoing layers of support" that are required by those who choose to improve their lifestyles and seek a healthier life, and these supports might be called upon at any time. Developing coping skills and strategies at a personal level to work through the process were regarded as important. Support while on the journey will also take a multiplicity of forms, however, participants all agree that there is a place for responsive and appropriate Māori health service provision for individuals and whānau who decide to embark upon the journey.

Finally, in considering the term "resilience" one informant cautioned us regarding the negative connotations of the word and how exhibiting resilience as an individual or a whānau may in fact be a "façade of deeper incongruence" within the family. This informant noted that in the medical discourse to be resilient means that people have necessarily undergone some trauma or hurt, which they have overcome. To be resilient therefore does not always equate to being healthy or whole, but rather could equally infer one is damaged and vulnerable. Resilience, or resiliency, according to this informant, is potentially harmful and may re-victimise those are already considered to be amongst our most vulnerable citizens.

Resilience and the collective

We asked participants to consider whether collectives such as whānau, hapū and iwi could be resilient. Examples that our participants discussed included iwi being able to "bounce back" from war and disease, however in a modern context participants noted that the idea of collective resilience has changed. Participants noted that contemporary whānau are having to be resilient simply because there are so many attacks on the family structure as a consequence of the modern lifestyle. Many spoke about the break-down of the traditional family unit, let alone the breakdown of the concept of whānau. It is not uncommon for blended families, for single parent families and for children to be raised by one parent who is not their biological parent.

Participants commented that the ties that have kept iwi, hapū and whānau strong in the past have broken down through the process of colonisation. The concept of a Māori collective resilience depends on whether Māori still regard their iwi, hapū, marae as their community, or whether other forms of community have now taken primacy. Participants noted that Māori are now mobilising themselves into new communities, with examples being the communities that are being formed in Australia, gang families and to some extent, the extended family one joins if one participates in some of the more evangelical churches. Whether these modern collectives will demonstrate the resilience of iwi, hapū and whānau remains to be seen.

RQ3: HOW ENGAGEMENT WITH A MĀORI PRIMARY HEALTH PROVIDER IMPACTS ON WHĀNAU RESILIENCE

Impact of engagement on resilience

The SFG participants were asked a series of questions regarding the link between resilience and Māori primary health service provision. In a previous focus group the participants had already defined and determine what resilience meant for them (described above). Given their understandings of resilience, our participants were then asked to describe how engagement with, accessing, and going to, a Māori primary health care provider would impact on their own or their whānau's resilience.

Our participants observed that for some individuals, going to a Māori health provider may be the "spark" that is required to move people from a place of risk, to a healthier life. The health service in this sense provides the impetus for an individual to recognise the place they are in.

Were a health service to play the role as a "spark" and provide the impetus for change, our participants also noted that it then became the responsibility of the provider to support the individual through their journey, to provide appropriate education, tools and resources so that the individual, having recognised the need for change, is not "abandoned" with their decision.

Our participants commented however on the fine balance that the health service must maintain between offering help and support, and dictating to the client. One focus group provided the example of health service giving "a whole lot of information you didn't want to know", which can be seen as "off-putting", and turn clients away from seeking further help. Managing the relationship between dictating ideas and providing practical support came down to the skills and experience of the staff within the health service, and in many cases the ability of staff to engage quickly and build rapport and trust with clients.

The health service can also act as a role model for whānau, and support individuals and whānau to become self sufficient. Once again, participants noted that health services had to maintain a balance between "doing for" clients and therefore making them dependent on the service and less self-reliant; and "empowering" individuals and whānau to make the necessary changes in their lives. Our participants spoke about "victim whānau" who may be engaged with a service for years, not necessarily because they need a high degree of support but because they have an attitude that they cannot help themselves. Ideally, according to our informants, independent, self motivated whānau who recognise the need for change and are prepared to do so will have the most to gain from engagement with a health service.

Our participants also noted however, that for some individuals and whānau, accessing a Māori health service would not influence how resilient they were, or became. Some Māori whānau who were living with adversity or in vulnerable circumstances (such as being unemployed, on the dole, and/or active in the underground economy) didn't want to change. Nor did they recognise a need to change or improve their situation. These whānau were considered to be ignoring their potential and content to do so.

For other Māori whānau, it was noted that they would not seek assistance from a Māori health provider or any other "outside organisation" were they ever in a state of adversity or

hardship. These whānau were extreme examples of self-reliant whānau, turning to their own whānau networks first for help, advice support and assistance.

Linking resilience and whānau ora

We asked participants in the SFGs how the concepts of resilience and whānau ora were linked, if at all. However in order to make the linkages between the two concepts, participants first had to define what they meant by whānau ora. To arrive at a definition we work-shopped the term "whānau ora" with both groups in a similar fashion to work-shopping the concept of resilience. We then drew the key themes from each of the groups together. The following table summarises the key elements that comprise whānau ora for our SFG participants. Themes from Focus Group A are on the left hand side of the table, whilst themes from Focus Group B are displayed on the right. Themes are presented in no particular order.

Figure 4: Characteristics of Whānau Ora from the Focus Groups

CHARACTERISTIC	
When one person is unwell the whole family is unwell	Capacity to be well within my own family
Paradise	A way forward, looking ahead, potential
Wellbeing	A sense of belonging
Happiness	Happiness, enough money to meet needs, involved in sports and school
Everybody having enough	Family wellbeing (where there is money, work, "good" accommodation, "good" kids and health)
Being well and together	Reliable support network
Healthy family (self-defined by the whānau)	A strong hold to home
When there are no major dramas	Identity, including participation
Whare tapa whā	A family peopled by those who make contributions
Stepping in to make change	A sense of achievement

The combined definition of whānau ora presents some interesting features. For many the wellbeing of their children and future generations was key element of whānau ora. Participants talked about wanting their children to experience a better life than theirs, providing their children with stability and security and providing them with a "decent" environment in which to grow up. Instilling values, including cultural values and for to

parents maintain their own personal levels of good health and be good role models were also important features.

Whānau ora for our participants was synonymous with health and happiness. Whānau ora was achieved when "everyone's healthy, everyone's happy...everything's happy". In many respects those who demonstrated whānau ora had the capacity to simply live an everyday life, to participate in normal activities, and having enough money to pursue these normal activities. Normal everyday activities that contributed to whānau ora included keeping their children happy, fed and clothed and having a decent standard of housing. Having sufficient money, a job, "good" housing and healthy kids was all seen to contribute towards happiness and therefore to whānau ora.

Participants spoke about the importance of participation as members of society, whether this be as a family that is active in their community, through to family participation in sports groups, and at the local school or marae. Having a sense of "place" and of "purpose" was regarded by some participants as crucial if one is to achieve whānau ora. One participant spoke about the "strong hold to home" and that their identity was forged through their ability to participate fully as a member of their community. Another participant viewed participation as broader than just family-based activity; noting that their family participates "in a lot of society stuff, with the community". A sense of achievement, or having contributed something tangible in some area of life was also considered by participants to be important to whānau ora, with one participant noting that a family that exhibited or had achieved a state of whānau ora was one which was "peopled by those who make contributions".

Whānau ora was also about giving and receiving support. When a whānau has achieved a state of whānau ora, everyone looks after one another, shares responsibility for each other, and in turn can expect to be supported themselves. One participant spoke about how in their family "everyone frets for one another when we all separate" and that separation from the whānau is regarded as less than ideal. The idea of a support network is also an essential attribute of whānau ora. Family connections aside, having a wider network of friends and community members who can be called upon when required was also regarded by participants as important.

Financial security appeared to be a further feature of whānau ora. Being financially secure meant there were fewer stresses or strains on the household. However participants were quick to maintain that financial security alone was not the key to whānau ora. Often having enough money was seen as necessary to achieve the other aspects (food, shelter, clothing) that aided in bringing about health and happiness. For some participants whānau ora also required a forward looking attitude and approach. One person, for example, spoke of whānau ora as being an aspirational goal; that whānau ora also embraced the ability "to meet whānau potential". Whānau ora for these participants might not be achieved by this current generation, but could be a goal that future generations strive to meet.

According to our participants whānau ora and resilience are connected. Both concepts were seen to involve a process or a cycle of growth and development both at the personal and at the whānau level. To achieve resilience or to reach the goal of whānau ora required the support help and assistance of others. Participants agreed that an individual could not become resilient, nor reach a state of whānau ora on their own. While some will seek support and assistance from outside of the family, through health and social service agencies, others will turn inwards and look to their own whānau and extended whānau for advice and assistance.

The role that services play in assisting people to achieve resilience or whānau ora is therefore very idiosyncratic and will be determined by the individual. However, our participants noted that the service will need to be responsive and the quality and timing of the response the individual (or whānau) receives can make a huge difference to the journey.

In further discussing the links between resilience and whānau ora, our participants noted that resilience may well be viewed as a stepping stone towards the achievement of whānau ora. Participants discussed needing a certain level of resilience as an individual or a whānau in order to reach the goal of whānau ora. Resilience and whānau ora are not necessarily static concepts; certainly individuals and whānau strive to attain whānau ora over the course of a lifetime. In summation, our participants agreed that whānau ora "is about being well", and that to be well you will need certain capacities and strengths. In combination, the multitude of capacities and strengths that individuals and whānau have to draw upon may be regarded as "resilience". Hence whānau ora cannot be achieved without a degree of resilience on the part of the members of that whānau.

RQ4: MĀORI HEALTH PROVIDER RESOURCES THAT CONTRIBUTE TO ENHANCED WHĀNAU RESILIENCE

To answer this question we asked participants to both consider the ways in which TOIHA as the Māori provider contributes to enhanced resilience and the ways in which a fictitious but "ideal" Māori health provider would contribute to enhancing whānau resilience. Our rationale in posing the question in this way was to provide TOIHA with information on how it might better tailor its services and improve service delivery to its clients.

Te Oranganui resources that contribute to resilience

When asked to reflect on whether TOIHA contributed to an improvement in individual or whānau resilience, we received a range of responses. Most equated the concept of resilience with the idea of bouncing back and the ability by people to bear pressures. In considering how TOIHA had contributed to the ability of people to bounce back a number of respondents commented on the crucial role TOIHA plays in health promotion and health education. In these two roles, kaimahi have the opportunity to inform, educate, teach, and demonstrate through role modelling, good health behaviours and practices.

> *We've grown as an organisation but in doing that, we've actually put that out there. There's more activity around the prevention, you know? The lifestyles and things like that, than there ever has been. And now staff are just starting to practice that stuff.* KI10:11

Other specific resources that TOIHA brings as a Māori health provider to enhancing individual and whānau resilience include supporting people to achieve their own goals in a manner that respects them and their own rangatiratanga; showing aroha and caring for people as if they were one's own; and being there for people in both the best of times and when people are at their worst.

> *There may be certain things, needs that we can meet, others where we need to look elsewhere and others that we simply can't and sometimes they appreciate that honesty as well. 'Cos again it goes back to that resilience, of them been resourceful for what they can, you know, live within their means and access...Yep. Which I think is quite good because it's a bit of equity in that mana...you know that, that rangatiratanga, they maintain that independence.* KI03:8

Specific services within TOIHA were identified as being particularly able to build resilience because of the contact that they had with families and the way in which they work with families at quite an intense level.

> *And I think Family Start again, they're good at building resiliency, I think, with their whānau. They have some real high need whānau and they work alongside them to empower them into...to accessing...resources that they might need, be it drug rehabilitation. They may do the first step, but then it's the direction that they take and they're really good because they have a graduation process at the end of [it]. [For example] these kids can only be on there 'cos the child is the client. But you're working alongside the parent how to, say, nurture this child I suppose. So if that parent has issues with themselves, that's where they work quite good, in this whānau base. They'll work on the parent to rectify their...be it addictions or what have you, which will then flow on to this child and they come back to the child about how best to look after this child...so get them to access whatever resources they need.* KI02:15

Another participant cited a similar example, where through the intense one-on-one support of the client, the ability to access a range of resources offered by the organisation, and an organisation-wide referral process, the service were able to enhance a client's resiliency to the point where they are eventually able to become a fully functioning member of society.

> *One person, she has been in our service for years. Huge drug and alcohol abuse, lots of trouble, spent lots of time in prison, you know, the whole thing. Lots of sad history in the whānau through abuse, murders. She has come right through our service, she's been with us about six years. She is now our consumer rep for both my services, she is at UCOL completing her mental health workers certificate yeah, and we just follow up on her and make sure she's ok. You know? She's, and it's all through the work that we've all done together...her care worker and the organisation as a whole because we're able to inter-refer and it's just through the supports that have been offered there.* KI07:9

There were two slightly different observations made regarding the Māori health provider resources that contribute to enhanced resilience. In one case the respondent observed that in one respect the service itself had to be resilient as it struggles to prove itself in a health sector dominated by the primacy of the western medical model.

> *I think we have a lot of struggles though eh? [as a service]. We have a lot of brick walls that start getting, that people start building around us you know we're for always ever having to prove that we're better than other services eh? You know, and it does get quite scary because now you have other services in the community that start hiring more and more Maori and start getting contracts in and to me I will always feel that you know, is that going to be at the expense of the kaupapa Maori service.*KI04:11

In a second example a respondent noted that while the concept of resilience can have "strengthening" connotations, it can also describe situations of hardship and survival. For example while resilience can be defined as the ability to recover easily and quickly from misfortune or illness, the bigger and more important question remains, why is the person having to be resilient? What are the conditions which continue to exist which require people to be able to bounce back from adversity and misfortune? A person could appear on the surface to be resilient however that resilience could be a facade masking a "deeper incongruence". The respondent went on to comment that people may seem resilient, and therefore be judged to be coping well and handling adversity but what is unrecognised is that this resilience may have been built up by a series of setbacks from which they have survived, and never exactly "bounced back" to their original state. They may in fact be weakened as a consequence of constant and continual pressure and stress KI05:2

Features of a resilience-promoting health service

We asked participants to describe the features of a health service that would, in their view, best promote and lead to resilient whānau. While views were mixed, across the two focus groups we were able to distil some common features of an "ideal", resilience promoting health service. Interestingly, rather than leap immediately to talk about the types of actual health services that would be provided, our participants talked firstly about three key features of an ideal service: the vision and focus of the service; the philosophy and values that drive the service; and the values of staff in the service.

Firstly the ideal service would be whānau-centric. In other words, the primary reason for its existence would be whānau and the maintenance of whānau wellbeing. Individuals could access the service; however the service's aim would be to improve the health and wellbeing of the individual within the context of their relationship to their whānau.

A second key feature for our participants was that the service had to use Māori processes and strengthen Māori identity. Ideally the service would have the mandate of the iwi in whose rohe it worked. While not necessarily an iwi provider per se, the service would need to understand the tikanga of the local people, and be able to demonstrate that awareness and understanding in their day to day practice. Recognising that the service will also have clients from outside the area and non-Māori clients, the service must be flexible enough to also meet the needs of these clients.

Thirdly the governance and management of the organisation need to be able to demonstrate strong leadership, be willing to carry out the vision of the organisation and role model the highest ethical, cultural, and professional values, alongside the staff of the service. Service staff would be required to have the right mix of professional and personal values which would contribute to an improvement in the health and wellbeing of the whānau in their care.

The service would ideally have the range of public health and primary healthcare facilities under one roof and therefore be physically located in one place. This would avoid the situation which is commonplace now where whānau have to arrange travel to the GP, then travel from the GP surgery across town to get a prescription filled out. Participants noted that the types of health care practitioners located within the service would include GPs, nurses, pharmacists, physiotherapists, occupational therapists, psychologists and dental services. While the clinicians are located in one place, this ideal service would also include an outreach facility, much like the District Nursing service whereby nurses could travel out to meet with the elderly and those too ill to travel.

In addition to the clinical service, the outreach component of the service would also include health promotion activity. Health promotion was regarded by participants as having a vital part to play in working with community groups to improve health and wellbeing at a population level. The service would also include social work and counselling staff as well as budgeting and parenting support staff and as a consequence provide a mix of support, advocacy, education, prevention and early intervention services.

Finally participants talked about the need for this health service to provide "wrap-around" services. In other words, an individual and their family would be assessed and a care plan

which addressed all the whānau needs would be developed. It might be identified that a whānau requires a range of primary medical services, alcohol and drug counselling, social work counselling and budgeting advice. These different forms of support would be offered to the client in an integrated and seamless manner.

6. REFLECTING ON THE FINDINGS

The concept of resilience is usually used to refer to an individual's ability to bounce back from hardship and adversity. Our literature review found two approaches to the concept of resilience: the first argues that individuals act as both producers of experiences and shapers of events (Bandura 2000). This approach argues that a strong sense of self-efficacy, or belief in one's own abilities to change, mould and adapt to a situation, will result in an individual who has higher education outcomes, experiences better health outcomes and is more socially integrated. The second approach considers resilience in a broader sense, where individual, personal resilience is dependent upon, or can be mitigated by, the relationship between the individual and their wider environment.

Very little academic literature exists which discusses the conditions required for *collective resilience* such as that displayed by indigenous peoples in the face of adversity. For indigenous peoples, the condition of adversity may be a consequence of colonisation or historical trauma however equally it may be the result of a contemporary trauma brought about by suffering bigotry or personal, institutional or systemic racism. In this study we assumed two givens: firstly, that for the most part the idea of the collective remains an important one to Māori and acts as a "protective factor", contributing to Māori individual, and collective resilience. Secondly we took as given that Māori primary health approaches in Māori settings have the ability to assist whānau increase their resilience, by supporting individuals and whānau to find resources that sustain their wellbeing in culturally meaningful ways. In this research we were able to test whether this latter assumption held true.

In undertaking this project we have discovered that resilience, in the setting of a Māori primary health care provider concerns access to resources, enabling personal autonomy, facilitating whānau-based problem solving and a whole-of-whānau perspective on health and wellbeing. Resilience as conceived of, and discussed by, our participants is not simply about personal attributes by which an individual can overcome trauma, but is also about the process or journey taken to overcome the trauma and the supports that are required when a person or whānau recognises there are changes to be made. Resilience therefore, is also about how as a collective, whānau, hapū and iwi, can respond to, and mitigate the effects of trauma, marginalisation and stress. For our participants, becoming resilient, as an individual or as a whānau, requires the reclamation of, and adherence to, some of our more basic and

fundamental values as indigenous peoples; acting as a collective, accessing culturally appropriate resources, whānau cohesion, whanaungatanga, and whānau ora.

Our findings also point to areas where further investigation is required, in particular, understanding under what conditions whānau and individuals decide to change behaviours towards more healthy choices, or "take initiative"; whether they make these decisions independent of the advice and assistance of their health provider; the factors that support these decisions and how "crisscrossing resources" may be used in a cohesive and systematic manner to improve health outcomes.

It would appear from our research that Māori primary health care approaches do make some, as yet unquantifiable, contribution to individual and whānau resilience, through improved access to resources and by supporting whānau and individuals become more "empowered'. In addition our findings indicate that if providers commit to, and deliver, healthcare using a whānau ora model, this mode of service delivery will have an impact on individual and whānau resilience.

In 2010, following on from a government-endorsed policy platform of whānau ora or whānau-centred service provision, the Whānau Ora Taskforce produced a set of generic whānau ora principles to guide service integration and delivery. These principles include: utilising a whānau or family approach to well being; active and responsive government; whānau-centred design and delivery of services that offer opportunities for engagement and action and resourcing available to achieve whānau ora (Whānau Ora Taskforce 2010). Our analysis suggests these principles of whānau ora service integration are highly consistent with Ungar's thicker description of resilience, where resilience, rather than being an intrinsic quality, may be considered as a;

> "seamless set of negotiations between individuals who take initiative, and an environment with crisscrossing resources that impact on one on the other in endless and unpredictable combinations"
>
> (Ungar 2005:95)

It may be challenging to link individualistic notions of resilience with the aspirational goals of whānau ora as on the surface they appear to be diametrically opposed. Being "resilient" still implies one must have overcome adversity, trauma and deficit. A resilience approach in discussion about Indigenous peoples is often underpinned by this focus on adversity and hardship and constructs a reality from a position of scarcity, hazard and risk. Whānau ora however, is used, understood, and applied in two different ways in the health and social services sector. First, whānau ora may be regarded as an aspirational goal. In this sense whānau ora does not assume a state of adversity as the norm; rather it is underpinned by a strengths-based approach to health and wellbeing, one which believes in and seeks to maximise the potential of whānau and individuals as members of whānau collectives. Second, whānau ora can simply be considered as a mechanism or set of guidelines for delivering health and social services.

Our participants were able to draw a link between these two apparently disparate concepts. They noted that essentially whānau ora "is about being well", and that to be well an individual and a whānau will draw on its own unique attributes, capacities and strengths. For whānau that are already well, these strengths will be many; however for the more vulnerable whānau, they will have very little within their immediate networks upon which to draw. It is the combination of these many capacities and strengths that individuals and whānau have to draw upon that determines how "resilient" one is as a whānau or as an individual. Whānau ora is linked to resilience according to our participants, because whānau ora will not be achieved without a degree of resilience on the part of whānau members.

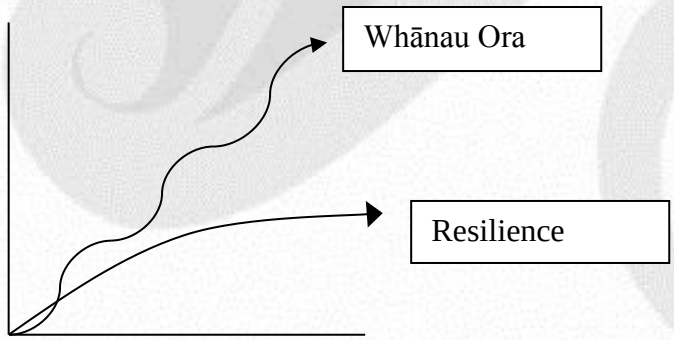
How the research has contributed to understandings of resilience

A key outcome of the research was to add to the growing body work regarding how resilience as a concept is understood by indigenous communities. We also sought to understand how the concept of resilience is utilised, if at all, in Māori models of health delivery.

Our findings show that resilience can be viewed as both a process and as an outcome of service intervention or engagement. On the one hand, to be resilient, to act in a resilient manner, may be describe a means of getting to a point of wellness. On the other hand to be resilient may be an outcome, or an end in its own right, i.e. to be a resilient person, or whānau

or community. Similarly whānau ora may be considered as both a process and as an outcome. At a process level whānau ora is based on high level principles (such as those outlined in the Whānau Ora Taskforce Report), however whānau ora is often individually interpreted by providers, and by the individuals that enter a service.

A theory which has emerged from our study linking resilience and whānau ora is that, unlike resilience which assumes a more static quality (i.e. once one is resilient one can't be more resilient), in striving to achieve whānau ora, one may never actually attain it. Its inherently multifaceted and complex nature means that the achievement of whānau ora, for any person, at any stage of their life, may never be reached. In our view, if you one were to consider whānau ora and resilience pictorially graphing the paths of whānau ora and resilience relative to one another, they might approximate the following diagram. In other words, resilience reaches a peak and then tapers off, indicating that one cannot be any more resilient, whereas one's efforts to achieve whānau ora, in spite of the occasional setback, will always result in the gradual improvement of one's condition or state of being.



Further research to test this theory of the relationship between resilience and whānau ora would be worthwhile in the New Zealand setting, given that whānau ora is a concept that derives completely from within a Māori worldview. Resilience and whānau ora are not synonymous, but they are linked. It is therefore highly likely that other indigenous peoples have better, and more appropriate ways of describing and explaining their experience of collective wellbeing than can be captured in the concept of resilience. We would encourage our indigenous colleagues in other nations and tribes to examine our findings and test them within their own unique settings and contexts.

Conclusion

Were we to consider resilience according to Ungar's "thicker description" (where resilience is understood to be an "ecologically dynamic and mutually dependent process" (Ungar 2005: 92) which takes into account differing worldviews and paradigms of knowing) and were we to view whānau ora as a mechanism for health service delivery, it becomes evident the concepts are based on similar principles. Both resilience and whānau ora acknowledge that trauma, risk and adversity exist for certain groups within the population, both acknowledge that whānau, families, collectives and communities have the ability to resist and overcome adversity, and both recognise that it is up to whānau, families, communities, collectives and governments to provide the resources that will enable whānau to bolster their wellbeing in a culturally appropriate and sustainable ways. By supporting Māori whānau to do so, so too may Māori whānau be supported to attain the aspirational goal of whānau ora. Te Puni Kōkiri note that understanding and acknowledging the distinctiveness of whānau, and their resilience, role and experiences when supporting whānau member(s) through adversity is a crucial step in the path to achieving whānau ora (Te Puni Kōkiri 2009:66). We would argue that Māori primary health providers must use the full range of resources at their disposal to configure services to support those individuals and whānau who, recognising their own resilience, want to take the journey towards better health and achieve the ultimate goal of whānau ora.

7. OUTCOMES

A number of intended and unintended outcomes have resulted as a consequence of conducting this study. In our initial research proposal we identified three intended outcomes, namely:

- that the project would provide us with a greater understanding of the link between whānau ora and resilience and the role of Māori health providers in strengthening individual, whānau and community resilience;
- that the practice of research would provide a mechanism for strengthening the role of research in Māori PHO health service provision, moving beyond evaluation studies to translational research, where research becomes part of programme development and bridges the gap between academic research and application in policy and service provision; and
- that the research findings would add to the international indigenous body of knowledge regarding resilience and provides a social-contextual baseline from which measures of resilience may be developed.

The first of these outcomes, to provide a greater understanding of the link between whānau ora and resilience and the role of Māori health providers in strengthening individual, whānau and community resilience, has been achieved, as is evidenced by and discussed at length within this research report. The second outcome we sought in conducting this research was that by being involved in the practice of research, the role of research in Māori PHO health service provision would be strengthened. Indeed as a consequence of participating in this project our community partner's awareness of, and interest in, research activity that can both inform practice and contribute to Māori development aspirations has grown. Through involvement in this project as a case study site, and research partner, the CEO of Te Oranganui (Ms Tamehana) has been encouraged to participate in a range of research activities, from participating in discussions regarding the development of conceptual frameworks, through to data analysis and dissemination. Ms Tamehana, as a Named Investigator, has participated as a presenter and Keynote at both national and international indigenous conferences, addressing conference delegates about the research partnership and the work of the provider more broadly. Furthermore, Ms Tamehana's personal interest in research has been fostered to the point where she submitted, and was successful in being awarded a development grant, to the Ngā Kanohi Kitea Fund in 2010/11 (Whānau

Sustainability Research Project, HRC Ref 11/831), and has expressed an interest in pursuing further personal, post-graduate study.

In addition to this work, in late 2010, Te Oranganui indicated a willingness to act as a site for the Whānau Ora Action Research Project being led by TPK. TOIHA are a confirmed site for the Action Research and are currently in the process of completing Stage 1 of this national evaluation exercise. It must also be mentioned that TOIHA have been able to use the results of this research in their own work as they reconfigure their services to best implement the government's Whānau Ora service delivery approach for health and social service providers.

The final planned outcome from this project was to contribute to the international literature on resilience and, in particular, to provide a greater insight into the use of the term by indigenous peoples. This project has produced six conference papers which have been delivered at international conferences and a book chapter which will be available both in New Zealand and further afield. While this technical report provides another resource for researchers, our research team's desire is to publish our results as academic papers that our international indigenous colleagues can more easily access. As a consequence, senior researchers from WRMHD, in conjunctions with our research partners in New Zealand and with colleagues in Canada are preparing a series of articles for domestic and international peer-reviewed journals. A monograph on the theme of Resilience is also being prepared with other Māori academics who have undertaken research on this topic. Some of the planned outputs from this project are listed in Section 10.

ADDITIONAL OUTCOMES

As a consequence of being involved in this research project a number of other, unintended outcomes have resulted.

Resilience Panel Discussion

On 8 November 2010 academic team members Boulton and Gifford participated in a Video Conference (VC) discussion entitled *'Maori researchers discuss concepts of resilience'* at the Massey University Campus. The meeting was convened by Alison Green and Mera Penehira, researchers from the Mauri Tu Mauri Ora Research Project, the HRC-funded International Collaborative Indigenous Health Research Project (ICIHRP). The meeting arose due to the

degree of interest expressed by Maori researchers who attended the HRC Hui Whakapiripiri 2010, regarding the concept of resilience and what it means for Māori as a population group.

The aim of the meeting was to provide Maori researchers with the opportunity to discuss diverse understandings of resilience, hear about how those understandings have been derived, and consider the relationship between methodologies and resilience. The video discussion was chaired by Carl Mika and in addition to Drs Boulton and Gifford attendees included Dr Clive Aspin, Associate Professor Helen Moewaka-Barnes, Jarrod Haar, Ngaropi Cameron, and Dr Terryann Clark.

Video recording of the panel discussion is available from the website, http://www.kaupapamaori.com/action/15/

Links to other work

At the end of 2010 WRMHD submitted an application to become a Whānau Ora Action Research Team, involved in the evaluation of the Whānau Ora programme as it is being implemented nationally. We were successful in our bid to become Whānau Ora Action Researchers and are consequently engaged as such in three sites. While our success in this process was not a direct consequence or outcome of the Resilience Study, WRMHD have been able to build on the research findings from this and other research projects framed around whānau ora approaches and contribute to a growing evidence base on the effectiveness of whānau ora as a goal, philosophy and strategy to guide service provision. Senior staff are currently engaged in a range of projects which investigate various aspects of the whānau ora model and continue to write, present and publish in the area.

8. ACHIEVEMENT OF OBJECTIVES AND MILESTONES

The following tables indicate achievement against project objectives and milestones.

#	Objective	Status
1	Case study site engaged	Completed
2	Phase 1 data collected	Completed
3	Phase 2 data collected	Completed
4	Analysis completed	Completed
5	Findings Disseminated	Completed

Year	Milestone	Objective	Status
1	Research plan confirmed and signed off by all partners	1	Completed
1	Ethics approval granted	1	Completed
1	Literature review completed	2&3	Completed
1	Participants recruited	2&3	Completed
1	Document search completed	2	Completed
1	In-depth interviews completed	2	Completed
2	Focus groups completed	3	Completed
2	Data analysis completed	4	Completed
2	Findings disseminated at hui	5	Final Hui Oct 2011
2	Report for Funders completed	5	Completed

9. PUBLICATIONS AND DISSEMINATION

The following hui presentations, conference presentations, conference papers and publications have arisen from this project.

2010-2011

Boulton, A. (2010) Presentation of Phase 1 Research Results to the Te Oranganui Iwi Health Authority Hui A Iwi, Whangaehu Marae. October 2010.

Boulton, A., Pirikahu, G., & Tamehana, J. (2010). International Network of Indigenous Health Knowledge and Development Conference, Poulsbo, WA, USA, 25 May 2010. Consolidating our Strengths: Collaboration as a means to further contemporary Indigenous knowledge.

Boulton, A., Tamehana, J., Cumming, J., & Cvitanovic, L. (2010). Families Commission Research Seminar 2010, Wellington, 3 June 2010. Supporting Whānau Wellbeing: How Māori Primary Health Care Contributes to Whānau Resilience.

Boulton, A., Gifford, H., Tamehana, J. (2010) Resilience and Whānau Ora: Seeking Understanding Beyond Our First Impression. Presentation at the Ngā Pae o Te Māramatanga 4th International Indigenous Conference, Mātauranga Taketake: Traditional Knowledge, 6-9 June 2010.

Boulton A., Gifford H., & Tamehana, J. (2010). Resilience and whānau ora: Seeking understanding beyond our first impression. Full paper in Proceedings of 4th International Traditional Knowledge Conference: Kei Muri i te Awe Kāpara he Tangata Kē, Recognising, Engaging, Understanding Difference, The University of Auckland, Auckland, NZ.

Boulton, A. Presentation of Full Research Findings to the Te Oranganui Iwi Health Authority Hui A Iwi, Whangaehu Marae. October 2011.

Boulton, A., Gifford, H., Tamehana, J., Cumming, J. The contribution of Māori health service approaches to whānau resilience: findings from a collaborative research project.

Presentation for the Ngā Pae o te Māramatanga Horizons of Insight Seminar, 28 October 2011.

Boulton, A. We can't actually help them unless they want to be helped": The extent to which Māori health service providers contribute to building more resilient whānau. Presentation to the 7th Health Services and Policy Research Conference, Adelaide, 6 December 2011.

Submitted, pending decision

Gifford, H., Boulton, A. Whānau ora; he whakaaro ā whānau: Māori family views of whānau ora. Submitted to Global Health Promotion, the journal of the International Union of Health Promotion and Education.

Forthcoming

Boulton, A., Gifford, H., Resilience as a conceptual framework for understanding the Māori experience: Positions, Challenges and Risks. In Māori and Social Issues (Working Title) edited by Malcolm Mulholland. Due for release early 2012.

Currently being written for submission

Boulton, A., Ly A., Gifford, H, Crowshoe, L. The Sequential Focus Group Method in Health Research with Indigenous Populations: Reflections on its use in Canada and New Zealand. For submission to the Journal of Social Research Methodology

Boulton, A., Gifford, H. Exploring notions of resilience in an indigenous context: Māori understandings of a "foreign" concept. For submission to Social Science and Medicine.

Boulton, A., Cumming, J. Resilience and Primary Health Care. For submission to Health and Social Care in the Community.

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11. APPENDICES

Primary health and whānau ora literature search and review (April 2010)

1. Overview and aims

The purpose of this review is to document the results from an in depth review of the literature undertaken to ascertain the evidence of a relationship between primary health and whānau ora to inform Whakauae Research for Māori Health and Development's Māori resilience and whānau ora exploratory research project work. It will enlighten the researchers as to what is known and by whom, if at all, and to what extent the relationship is evident in current primary care practices /services / future developments.

With the advent of the Primary Health Care and Māori Health strategies in the early 90's giving direction to the development of services in the primary health sector, it was hoped that the inequalities in access to services and ultimately health outcomes for 'high needs population groups especially for Māori would be reversed. Early indications were positive but reports ('Hauora'. Māori Standards of Health IV, 2007) throughout the following decade were less convincing. The concept of 'Whānau ora', although referred to in earlier documents has re emerged in 2009 (Royal & Mason) as an holistic whānau centred model of health care aimed at directing future primary health activities and programmes. These, it is hoped will address more effectively the unequal status of Māori health outcomes still evident today. To ratify the Whānau ora movement the Hon. Tariana Turia was elected in April 2010 by the Government to be the Minister of Whānau ora commissioned to augment the Whānau ora Taskforce recommendations.

2. Methods/results

Prior to carrying out the literature search and review, a research protocol was formatted to determine the 'search terms', the 'search engines/databases' to be used, the coverage dates (2000-2010) and the 'grey literature' sources to be searched. (refer to section 8). Only articles written in English were to be sourced.

Defining the key terms was necessary to clarify and to ensure that all likely sources of information could be covered.

Definitions:

Primary health :(Service model)

Health care provided in local communities as opposed to secondary or tertiary care which is provided in hospital settings.

Primary Health Care (PHC): (population management)

> "…means essential health care based on practical, scientifically sound, culturally appropriate and socially acceptable methods that is
>
> - universally assessable to people in their communities
> - involves community participation
> - integral to and a central function of New Zealand's health system
> - the first level of contact with our health system (MOH, 2001, p. 1).

Primary Health Organization (PHO):

> "PHOs are the local structures through which DHBs will implement the Primary Health Care Strategy" … "funded by DHBS to provide primary health care services for an enrolled population" (MOH, 2002a, p. 1)

Whānau ora:

> "Māori families supported to achieve their maximum health and wellbeing" (MOH 2002, p. 1).

In the 'Taskforce report' (Whānau ora Taskforce, 2010) it is noted that it is also a term used for 'whānau wellbeing'.

Of the search engines/ databases used, only Medline, CINAHL, PsycINFO and Health Source Nursing/ Academic Edition registered the terms whānau ora and Primary Health/care and the results commonly revealed published articles by Wilson (2009), Boulton, Gifford, Potaka-Osborne (2009) and O'Connor (2005).

No new results of note were unearthed using alternative search terms such as 'indigenous' or 'native' instead of Māori, nor when using 'whānau wellness/wellbeing' or 'Māori health services'.

Two other articles (Turia,2003; Earp & Matheson, 2004), which combine both primary health and whānau ora concepts were found by tracking the authors from other published reference lists.

Although the concept of primary health and primary health care is now commonly referred to in the literature, 'whānau ora' in its entirety is not. 'Whānau' (defined as 'extended family') is more commonly cited, as for example, in these three articles which documented whānau inclusive approaches, outcomes (Grigg, Waa & Bradbrook, 2008; Broughton, 2000) or recommendations (Arlidge et al, 2009).

A survey of the wider literature as listed below was also completed using the 'search terms', key subject areas (Primary/ Māori health) or links to already cited authors;

- Google Scholar/Mednar
- National Library of New Zealand (Kiwi Research Information Service (KRIS): on line listings of theses from all New Zealand Universities.
- Australian Medical Index (AMI)
- Ministry of Health (MOH) (Publications list/ Māori/ Primary Health Care)
- Ministry of Social Development (MSD)
- Māori Health www.māorihealth.govt.nz
- Te Puni Kōkiri (TPK) www.tpk.govt.nz
- Mauri Ora Associates www.mauriora.co.nz
- ERU Pomare Māori Health Research Centre
- Families Commission http://www.nzfamilies.org.nz/research/publications
- Medical Council of NZ
- Public Health Advisory Committee
- Research Reviews www.researchreview.co.nz (Key search words used: Primary Health, Māori Health and Whānau ora)
- Counties Manukau District Health Board
- Index New Zealand (INNZ)

This search elicited the following sources of information pertaining to the key terms:

- Primary Health Care and Māori Health strategy documents (MOH, 2001, 2002),
- Improving Māori Health: A guide for PHO's (MOH, 2004)
- Whakatātaka Tuarua. Māori Health Action Plans (MOH, 2002b; 2006),
- Whānau ora Health Impact Assessment (2007),
- National Māori PHO Coalition Expression of Interest (EOI) document (Royal & Mason, 2009),
- Whānau ora: Report of the' Taskforce on Whanau- centred initiatives' (2010)
- Families Commission Whānau Strategy 2009-2012 / Literature review (2010)
- Thesis[8]

Although this research project is also concerned with the concept of 'resiliency', this review didn't include a combined search of the three related concepts.

3. Founding Documents

Either or both of the two founding documents, The Primary Health Care Strategy [PHC](MOH, 2001) and 'He Korowai Oranga' ,[HKO],the Māori Health Strategy
(MOH,2002) are referred to as a base line in most of the literature sourced for this review, (Boulton, Gifford and Potaka Osborne, 2009; Earp & Matheson, 2004; Families Commission, 2010; Gray, 2006; MOH,2002a,2002b, 2004, 2006;Turia, 2003; Wilson, 2009).

The Primary Health Care Strategy (MOH, 2001) was developed by the Government to give direction to primary health services to work with local communities to improve, maintain and restore peoples' health thus addressing health inequalities. PHO's are tasked with development and coordination of services which are culturally competent and reflect the needs of each community. Reference is made to Māori and Pacific peoples' health inequalities and the existing Māori Development Organizations (MDO) and services supported by DHBs. Although all of the strategies overearching goals, objectives and priorities for improving health are relevant to Māori, there is no specific evidence of

[8] Gray, K. (2006). 'Taniko': Public Participation, Young Maori Women and Whānau Health. Master's thesis submitted for MA in Maori Studies, Massey University, Palmerston North.

‘whānau/ whānau ora concepts. Instead, the Māori Health Strategy is referred to as the guide for Māori communities to gain
“control over their health and wellbeing” (MOH , 2001, p.11).

The overall aim of the Māori Health Strategy, He Korowai Oranga is

> “Whānau ora: Māori families supported to achieve their maximum health” (MOH, 2002, p. 1).

In addition, whānau ora

> “is a strategic tool for the health and disability sector, as well as other government sectors, to assist them to work together with iwi, Māori providers, Māori communities to increase the lifespan of Māori and improve their quality of life and reduce disparities with other New Zealanders” (MOH, 2002, p. 2).

Four pathways of action are outlined to specifically address “how the aim of improved Whānau ora is to be achieved” (MOH, 2002, p.9). These relate to collaboration with whānau, participation in governance in all health sectors, and provision of timely and accessible health services. There is specific reference to mainstream providers such as PHOs to identify the broad determinants of Māori whānau health needs and to ensure that barriers to access are removed.

Turia (2003) outlines the reasons for and her role in the development of ‘He Korowai Oranga’. She believes that health workers need to embrace the concept of ‘whānau’ instead of an individualized focus and to collaborate with other sectors in a multi disciplinary approach to enhance health outcomes.

Gray (2006) discusses the strategies in relation to Whānau ora, PHOs’, Māori and health promotion, and then in relation to Māori women’s sexual health. She expresses the notion that a ‘whānau centred’ approach is presumed but is not necessarily evident or suitable in this instance.

The Whakatātaka Tuarua or Māori Health Action Plans (MOH, 2002 & 2006) evolved from ‘He Korowai Oranga’ to provide a framework and guide for the implementation of the

strategy. Their purpose is to "weave together existing and innovative activities across a number of health and disability sectors and across other relevant sectors" (MOH 2006, p. 3). The priority areas identified by the MOH include developing whānau ora based models and improving primary health care (access) to remove inequalities in health. (Note: A key lesson listed from the Whakatātaka: Māori Health Action Plan, 2002-2005, was that the concept of whānau ora had not been realized in this earlier plan).

4. Application and Implementation of Whānau ora concepts in Primary health

Earp and Matheson (2004) appraise the interplay between the two strategies (PHC & HKO) and reiterate the "revolutionary way" (ibid, p. 214) of placing whānau ora at the core of these guiding documents. They suggest that the health objectives outlined in the Primary health care strategy could be successfully addressed using for example Māori models of health, and consideration of the broader or 'non health' elements that Māori also consider important such as 'food, water, warmth, companionship and social existence. Examples are given of PHO's successfully engaging in preventative health projects; 'Korowai Aroha health Centre, Rotorua; Te Kupenga A Kahu Trust PHO and Te Oranganui, Whanganui.

O'Connor (2004) describes the professional development and working experiences of the first nurse practitioner endorsed in the whānau ora scope of practice. Adrianne Murray practices in the Northland region of New Zealand. Her work encompasses all age groups, is conducted in a variety of community based locations and includes collaboration with all sectors.

Boulton, Gifford, Potaka- Osborne: Role of community health workers. Vital link

The overarching vision of the 'Whānau Strategy 2009-2012'(2010) developed by the Families Commission as a platform for 'whānau ora', is that whānau are supported to be the best that they can be by recognizing that whānau are the "key site for change and a critical place to focus efforts to improve social outcomes for Māori"(Families Commission, 2010b p.62). The strategy aims to promote whānau ora through the activities of advocacy, engagement, policy development and research.

The priorities for the strategy include

> "the constituents of whānau resiliency, what does it mean, how can it be developed and what does it offer in terms of intervention design and development opportunities for whānau"
>
> "Whānau resiliency in times of crisis, including whānau engagement with schools; and the interface between whānau and the criminal justice system" (Families Commission, 2010, p. 10).

To inform this Whānau Strategy 2009-2012, a literature review was undertaken titled 'Definitions of Whānau' (Families Commission, 2010b). This review is sectioned into definitions and models of whānau and Maori models of health, iwi development, applications for policy development and health and social services.

Included in the section on health and social services are brief statements about the interpretation of, the funding models, and the application of the term whānau ora to health and to service delivery. For example, the Nelson Marlborough DHB refers to 'whānau focused' health services such as management of chronic conditions and smoking cessation, delivered to whānau in their homes.

The final section explores and defines whānau ora.

The Families Commissions' brief working definition of whānau ora is:

> "Whānau ora is achieved when whānau are the best that they can be." (Families Commission, 2010b p 41).

A more comprehensive definition is,

> "Whānau ora is said to comprise of a balance between physical, psychological,

emotional, spiritual, familial and environmental domains (Durie, 2009). It is much more than the absence of disease or having health needs met although good health is critical for whānau ora" (ibid, p.41)

Reference is made to the influence everyday working relations with whānau can contribute towards building whānau strength, resiliency and wellbeing , which in turn impacts on whānau ora (ibid,p.51). However one size doesn't fit all.

5. Evaluation of Outcomes

Recommendations in the Whānau ora Health Impact Assessment (MOH, 2007) are that either the Health Lens or the Health Appraisal Tool are used by a multi disciplinary team to identify the impacts of policy changes on the determinants of Māori health and outcomes. There is no specific direction for evaluation of the impact of changes within the Primary Health Care setting.

6. Future Directions of Whānau ora and primary health

Wilson's (2009) editorial published in the Nursing Praxis journal sets the scene for the current viewpoint, (Cited in Morgan and Simmons, 2009) that the disparities and inequities in health outcomes for Māori compared to others remain high and are unacceptable. She believes that the funded targeted programmes delivered by mainstream organizations haven't produced the required results and that the adoption of the whānau ora policy throughout the health sector will provide health professionals with the opportunity to provide alternative models of care.

This viewpoint was 'given legs' with the published 'Expression of Interest' (EOI) document collated by the National Māori PHO Coalition Inc.(2009). Titled, 'Implementing Whānau ora to deliver better, sooner, more convenient Primary Healthcare for Māori & high needs populations in Aotearoa', the primary aim is to develop whānau ora models of care which will enable the Primary health care providers to reduce health inequalities.

A Whānau ora model of care has six key elements:

- Single or managed point of entry
- Whānau ora needs assessment and goal oriented plan
- Assigned kaimahi/ case manager

- Integrated service delivery, coordination and management
- Planned exit or discharge
- Achievement of Whānau ora outcomes

Three key areas of activity have been identified to enable effective implementation of whānau ora within the primary health care environment

- Mama, Pepi and Tamariki programme: (unify services from preconception, pregnancy, birth, and children from 1-4 years)
- Long term conditions management (diabetes, CVD, mental health)
- Whānau ora centre

The EOI document outlines the nature of the Coalition, the background and rationale for development of the Whānau ora business and model of care, barriers, risks, funding, relationships, partnerships and the three main programmes, listed above.
This EOI has been incorporated into the 'Whānau ora: Report of the Taskforce for Whānau – centred initiatives', (2010). From a brief scanning of this document there appears to be no direct reference to whānau ora and primary health but presumably the framework developed for whānau-centred approaches to service delivery with whānau includes that of health service delivery. There are five key elements included in this framework which include whānau engagement/ownership, whānau centred design and service delivery, iwi leadership, governmental agencies alignment with whānau, hapū and iwi aspirations and supportive funding arrangements.

Note:
The Whānau Ora Taskforce has not defined whānau ora, it has instead developed a set of principles which are aligned with Whānau self-defining Whānau ora and exercising control over the way they work out solutions and actions for the achievement of wellbeing.

The Whānau Ora Taskforce's principles align with Māori health frameworks and the need for effective resourcing and innovation in service design if services are to be repositioned from being agency-centred to Whānau-centred" (Families Commission, 2010b, p.58).

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8. Research protocol April 2010

Terms to use:

- Primary health
- Or Primary health care
- Or Māori / Indigenous or Native Primary health (care)
- Or Māori / Indigenous or Native health providers/provision/services
- And Whānau ora
- Or Whānau wellness/ wellbeing

Dates to cover: 2000-2010

Search Engines (data bases)

- Medline (Pubmed)
- CINAHL
- Cochrane
- Proquest Medical Library
- Rural (and remote health) NB: Kathy's suggestion
- Sage Premier Journal Collection NB: Kathy's suggestion
- Health Reference Centre Academic (Health Source Nursing, Academic Edition)
- Psychinfo
- AMI (Australian Medical Index)
- Mednar (/Google Scholar)

Grey Literature

- National Library /thesis' KRIS)
- Ministry of Health Links/ research reviews
- Government reports/ PHO unpublished material

Articles to Include

Seminal: The PHC Strategy/ He Korowai Oranga: the Māori Health Strategy

Articles to exclude: No suggestions made

How to appraise articles :(questions to ask)

What is known about Whānau ora and PHC?

Who knows it? (Evidence)

Te Oranganui Iwi Health Authority Case Study Document Review

In order to understand whether the concept of resilience has any relevance in the context of health care and service provision for Māori in New Zealand we must initially assess whether health care providers understand the term resiliency or act in a manner which supports and strengthens resiliency.

Following on from our literature review which sought to define the term; understand its usage and implementation in the health and social service fields; and determine its relevancy for indigenous populations more broadly, we then conducted an analysis of local level data (the TOIHA case study) to conceptualise the potential links between theoretical understandings of primary health care services, resilience and primary health care service provision in practice.

Our theoretical model can be illustrated thus:

Characteristics of a Māori development approach Primary Health Care in NZ[9]	**Definition and Features of Resilience**[10]	**Features of an indigenous primary healthcare service provider which support resilience**
• Primary prevention • Population-based approach • Connecting people to resources (cf seeing people who are sick)	Resilience may be defined as "an individual's capacity to navigate health resources and a condition of the individual's family, community and culture to provide those resources in a culturally meaningful way"	• Culturally appropriate care • Whānau approach • Understanding of social and economic determinants of health • Ability to provide appropriate resources • Ability to refer on in an integrated manner if resources are not available in-house • Internal culture of empowerment

[9] distilled from key government strategies such as the NZ Health and Disability Strategy, the NZ Primary Healthcare Strategy, He Korowai Oranga as well as the Horne Report

[10] primarily from Ungar

2. Review of TOIHA Policy documents:

If resilience is defined as an individual's capacity to navigate health resources and a condition of the individual's family, community and culture to provide those resources in a culturally meaningful way, TOIHA, as part of an individual's wider community has a role in providing health resources in a culturally meaningful way. Our research seeks to assess how TOIHA facilitates the provision of culturally appropriate health resources and what form this might take.

In essence then, we are attempting to understand how TOIHA provide culturally meaningful resources and what these resources are, with a view to being able to make some comment on the effect of the provision of these resources on the resilience of indigenous individuals, their families and their communities in one locality. Furthermore we seek to determine why the resources and services that TOIHA provide may be different from those provided by other, particularly non-indigenous, health providers.

A number of search terms, phrases and concepts were derived as a consequence of reviewing the resilience literature and the NZ primary health care literature which were then used to review TOIHAs internal policies and practice manuals. Search terms included:

- Resources
- Facilitation of resources to whānau
- Health services as resources for whānau
- Whānau access to resources
- Self efficacy
- Whānau connectedness
- Empowerment
- The empowerment of whānau by the service
- Protective factors

The following TOIHA documents were reviewed:

1) The TOIHA PHO Whānau Ora Strategy. Prepared by the Quality Improvements Manager. Date May 2008

2) The TOIHA Whānau Ora Implementation Plan. Prepared by the Quality Improvements Manager. Date Sept 2008
3) The TOIHA Te Oranga Model Plan. Date June 2009
4) The TOIHA Whānau Ora Assessment Tool. Developed by Atamai Ltd 2009. No date
5) The Te Puawai Whānau Whānau Ora Desk Manual. Date Sept 2009
6) The TOIHA Annual Business Plan. Draft Three. 2009-2010
7) TOIHA Te Ara Kaupapa o Te Waka Hauora. Strategic Plan (version iv). Draft 2001-2010. Date: Feb 2009
8) Project Management Contract Brief for the implementation of the Whānau Ora service delivery model into TOIHA services. Developed by Atamai Ltd 2009. No date
9) Whānau Ora Workforce Development Plan 2009-2010. Date: October 2009
10) Whānau Ora Study Guide Plan. Date: October 2009
11) Te Piitau Whakarae Cultural Framework. Prepared by Mata Concepts for TOIHA. Date: Jan 2005
12) Ministry of Health Performance Monitoring Returns for the Whānau Ora Maori Community Health Services Contract. Date: Oct 2008-Sept 2009
13) Whanganui DHB Contract for the Whānau Ora Maori Community Health Services Contract. Date: Aug 2006
14) Te Ritenga Hauora 2009

TOIHAs Policy, Protocols and Procedures documents contains information for all staff regarding the services policies for consumers, clinical activities, health and safety, he tangata (i.e. staff), finance and resources and organisation and management.

Four principles in particular emerge from the TOIHA documents which align with the definitions of resilience found in the literature and which are particularly important in the navigation of health resources:

- whānau ora
- a focus on wellness
- cultural accountability
- whānau empowerment

Ethics Approval Letter and Forms

Health and Disability Ethics Committees

Central Regional Ethics Committee
Ministry of Health
Level 2, 1-3 The Terrace
PO Box 5013
Wellington
Phone: (04) 496 2405
Fax: (04) 496 2191
Email: central_ethicscommittee@moh.govt.nz

17 March 2010

Ms Amohia Boulton
Senior Researcher
Whakauae Research for Maori Health and Development
PO Box 53
Whanganui 4500

Dear Amohia Boulton

Ethics ref: **CEN/10/EXP/05**
Study title: Facilitating Whanau Resilience Through Māori Primary Health Intervention

The above study has been given ethical approval by the Central Regional Ethics Committee.

Approved Documents

- Information sheet, dated 5 February 2010, Version 1
- Consent Form, dated 5 February 2009, Version 1
- Key Informant Questions for Governors and Managers of Te Oranganui Iwi Health Authority

Certification
The Committee is satisfied that this study is not being conducted principally for the benefit of the manufacturer or distributor of the medicine or item in respect of which the trial is being carried out.

Accreditation
The Committee involved in the approval of this study is accredited by the Health Research Council and is constituted and operates in accordance with the Operational Standard for Ethics Committees, April 2006.

Progress Reports
The study is approved until **30 September 2011**. The Committee will review the approved application annually and notify the Principal Investigator if it withdraws approval. It is the Principal Investigator's responsibility to forward a progress report covering all sites prior to ethical review of the project in **4 December 2011**. The report form is available on http://www.ethicscommittees.health.govt.nz. Please note that failure to provide a progress report may result in the withdrawal of ethical approval. A final report is also required at the conclusion of the study.

Amendments
It is also a condition of approval that the Committee is advised if the study does not commence, or is altered in anyway, including all documentation eg advertisements, letters to prospective participants.

Please quote the above ethics committee reference number in all correspondence.

The Principal Investigator is responsible for advising any other study sites of approvals and all other correspondence with the Ethics Committee.

It should be noted that Ethics Committee approval does not imply any resource commitment or administrative facilitation by any healthcare provider within whose facility the research is to be carried out. Where applicable, authority for this must be obtained separately from the appropriate manager within the organisation.

We wish you well with your study.

Yours sincerely

SScott

Sonia Scott
Administrator
Central Regional Ethics Committee
Email: sonia_scott@moh.govt.nz

Information Sheet

"Supporting Whānau Wellbeing:
How Māori Primary Health Care Assists Whānau Resilience" Research Project
Research Project

What? This is a two year study funded by the Health Research Council of New Zealand. We aim to look at how, and in what ways, whānau resilience is supported by the work of Te Oranganui Iwi Health Authority (TOIHA).

How? We will gather information by:

1) asking a range of key TOIHA people about how resilience is included in TOIHA policies and practices;
2) holding group discussions about whānau understandings of resilience and to find out whether being a service user of TOIHA has increased whānau resilience;
3) surveying TOIHA service users to about their understandings of resilience and how TOIHA contributes to their resilience and that of their whānau and wider community.

Who? The study is being done by Whakauae Research for Māori Health and Development (WRMHD); an iwi-based research centre in Whanganui along with Te Oranganui Iwi Health Authority and the Health Services Research Centre (Victoria University, Wellington). WRMHD is leading the project.

What will happen if I take part? If you decide to take part in this study, we will discuss the consent process with you and confirm your consent to participate. If you are interviewed, your interview will be audio-recorded (with permission), and a written copy sent to you to check. Any information that you provide will be confidential. You may withdraw from the study at any time.

What will happen with the results? The results of this study will be written up for a final report for the Health Research Council. We will also disseminate the results in academic journals, policy forums, to key stakeholders, and locally through community-based networks and Hui a Tau. You are welcome to receive copies of the interim findings, the final report and any other shared material produced.

He mihi nui ki a koe

Dr Amohia Boulton, Senior Researcher and Project Lead, Whakauae Research for Māori Health and Development, PO Box 102, Wanganui, ph 06 347 6772, email: amohia.whakauae@xtra.co.nz

CONSENT FORM

for the "Supporting Whānau Wellbeing:
How Māori Primary Health Care Contributes to Whānau Resilience"
Research Project

English	I wish to have an interpreter	Yes	No
Deaf	I wish to have a NZ sign language interpreter	Yes	No
Māori	E hiahia ana ahau ki tetahi kaiwhaka Māori/kaiwhaka pakeha korero	Ae	Kao

I have read and I understand the information sheet dated dd/mm/yy for volunteers taking part in the ***Supporting Whānau Wellbeing*** study. This study will look at how, and in what ways, whānau resilience is supported and enhanced by the work of Te Oranganui Iwi Health Authority. I have had the opportunity to discuss this study with the researchers and I am satisfied with the answers I have been given.

I have also had the opportunity to use whānau support or a friend to help me ask questions and understand the study.

I understand that my participation in this study is entirely voluntary (my choice), that I can withdraw from the study at any time, and that, if I do withdraw from the study, this will not affect my current or future health care.

I understand that my participation in this study is confidential and that no material that could identify me will be used in any reports on this study.

I have had time to consider whether to take part in the study.

I know who to contact if I have any questions about the study.

I consent to my korero being audiotaped Yes ☐ No ☐

I wish to receive updates about the study Yes ☐ No ☐

I wish to receive a copy of the final results Yes ☐ No ☐

I _____(full name)

hereby consent to take part in this study.

Date_____ Signature_____

Project explained by _____

Project Role _____

from Whakauae Research for Māori Health and Development, ph 06 347 6772, email

amohia.whakauae@xtra.co.nz

Date_____ Signature_____

Ka nui te mihi ki a koe

CONSENT FORM: Supporting Whānau Wellbeing: How Māori Primary Health Care Contributes to Whānau Resilience Research Project 5 February 2009 Version 1

Key Informant Questions for Governors and Managers of Te Oranganui Iwi Health Authority

"Supporting Whānau Wellbeing:
How Māori Primary Health Care Assists Whānau Resilience" Research Project

Give the Key Informant Showcard 1 and read out the following:

Resilience has been defined by international researchers as "an individual's capacity to navigate health resources *and* a condition of the individual's family, community and culture to provide those resources in a culturally meaningful way".

State that the questions we will ask are seeking to discover whether this definition has relevance to the local, Whanganui, context and that Key Informants may refer to the showcard at any time.

Question 1) In what ways do you think Te Oranganui, as a primary healthcare organisation, assists individuals to access health resources? Can you describe this?

Question 2) In what ways do you think Te Oranganui, as a primary healthcare organisation, assists whānau to access health resources? Can you describe this?

Question 3) Are there tensions between providing individual care and care to whānau and if so, what are the issues and how important is this as a principle?

Question 4) In what ways do you think Te Oranganui, as a primary healthcare organisation, contributes to an individual's ability or a whānau's ability to access health resources in a culturally meaningful way?

Question 5) In what ways, if any, does Te Oranganui as an organisation contribute to the overall health and wellbeing of hapū, iwi and the wider community?

Question 6) In what way(s) is the work that Te Oranganui does to assist individuals and whānau to access or navigate health resources different from any other health provider and particularly from any mainstream health provider? Please explain.

Show the second showcard and state that we have distilled a set of principles from Te Oranganui's policy documents. Read out the principles. State that the next set of questions seeks to understand how these principles are applied in the day to day work of Te Oranganui.

Question 7) How does Te Oranganui demonstrate a whānau ora approach in its day to day work?

Question 8) How does Te Oranganui demonstrate a focus on wellness in its day to day work?

Question 9) How does Te Oranganui demonstrate cultural accountability in its day to day work?

Question 10) How does Te Oranganui support whānau empowerment in its day to day work?

Question 11) Reflecting upon this interview and the answers you have provided, would you say that Te Oranganui *does* contribute to building individual and whānau resilience?

If yes, please explain why and how (if not already clear)

If no, please explain why not

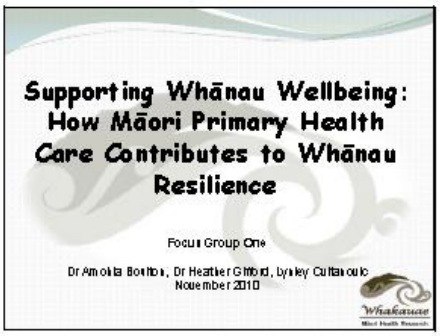
If unsure, please explain why.

Question 12) Finally, is there anything further you would like to add, or to ask of me?

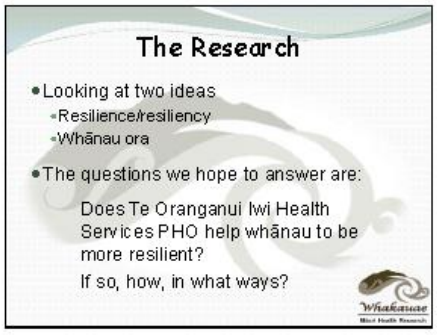
Thank the Key Informant for their time and remind them that they may have a copy of their transcript for checking and a copy of the final report if they wish.

Focus Group Slides for Focus Group One

Slides 1&2

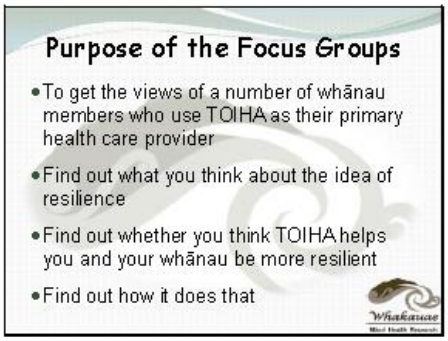


Slides 3&4



Slides 5&6

Slides 7&8



Slides 9&10

Slides 11&12

TOIHA RESILIENCE STUDY: FOCUS GROUP ONE

Timetable for the day

Begin at 9.00am for first focus group, 1pm for second

Item	**Lead**
Welcome	Heather/Amohia
Whanaungatanga/mihimihi	Heather/Amohia
Introduce the Research	Amohia
Introduce the research partners	Amohia
What we have done to date	Amohia

The purpose of the Focus Groups

- Your role
- Note that this is the first in a series of focus groups and so this first one is just to get to know each other and how you came to be enrolled in this particular service
- Expectations (ours/theirs)
- Information, Consent and Demographics Forms

Tell us about yourselves — Heather

- What is your story?
- How did you come to be involved in this service
- Why this particular service, and does it have anything to do with being a Māori service?

TOIHA Resiliency Project Focus Group 1 9 Novermber 2010

TOIHA RESILIENCE STUDY: FOCUS GROUP TWO

Timetable for the day

Begin at 10.00am for first focus group, 1pm for second

Item	**Lead**
Welcome	Heather
Debrief re "rules of the group"	Heather
Recapping what we did last week	Amohia
Questions of queries	Amohia
What we have done to date	Amohia

This week's session

- The topic this week is – **What are your understandings of resilience?**
- May explore individual versus collective understandings of resilience, ie: is an individual's resilience different from a groups resilience?, eg a whānau , a community, a people?
- So what do you think resilience means?
    - Break into pairs and discuss the idea with your neighbour. Jot down any ideas on butcher's paper and be ready to feedback to wider group
    - Write what is said on the white board for people to see
    - Group discussion about what everyone has said
- If people are still stumped, or if the discussion is languishing, use the scenario prepared earlier

Close with a wrap of the day, last comments and an indication of what we will discuss next week.

Next week's topic is - **How has engagement with a Māori primary health provider impacted on whānau resilience?**

In this session we need to explore peoples experiences of the service, how the service has impacted their lives and whether it has contributed to them becoming more resilient (and how) and whether it has lead them to achieve whānau ora (and how) and whether these things are mutually exclusive or inextricably linked.

TOIHA RESILIENCE STUDY: FOCUS GROUP THREE

Timetable for the day

Begin at 10.00am for first focus group, 1pm for second

Item	**Lead**
1) Welcome	Heather
2) Recapping what we did last week	Heather

- **Key themes in common include**
  - Resilience is a journey or process
  - Being resilient does not occur in isolation but relies on connections to other things, other people
  - There are many influences
  - There are many layers and types of support one can and does access
  - There are many triggers to progressing along the path of resilience

- In recapping last week's session we need to further explore and tease out
  -) the differences if any between individual and community or whānau resilience. Exploring individual versus collective understandings of resilience, ie: is an individual's resilience different from a group's resilience, eg a whānau, a community, a people?
  - What is the role of whānau in resilience, and an individual's resilience
  - What is the role of community in resilience and an individual's resilience
  - **What is particularly Māori about any of this?**

3) This week's session — Amohia

- The topic this week is - **How has engagement with a Māori primary health provider impacted on whānau resilience?**

- How health services and in particular how Māori health services assist in supporting individuals, whānau and communities to be resilient
  - peoples' experiences of health care services?
  - how health care service has impacted their lives?
  - whether it has contributed to them becoming more resilient (and how)

- This part of the focus group will involve some group work around the scenario "if you had $20 million dollars what would an iwi health service look like that assist people to be resilient:
  - what would the vision be? what would be the services core values?
  - what would the operating style oF the service be?
  - What services would be delivered and how?

- Split up into groups and imagine what this type of service would be like, what it would focus on, what would be important to it, and how would it ensure Māori and Māori whānau are being resilient as Maori

4) Close with a wrap up of the day, last comments and indication of what we will discuss next week

Next week's topic is: **what are specific resources, mechanisms and interventions that a Māori primary health provider uses that contributes to enhanced whānau ora/resilience?** This focus group drills down to look at whether TOIHA provides resources in a culturally meaningful way (according to Ungar's definition) and whether what a Māori health provider does is unique or can be replicated by any provider. We also need to explore the link between resilience and whānau ora and whether these things are mutually exclusive or inextricably linked.

TOIHA RESILIENCE STUDY: FOCUS GROUP FOUR

Timetable for the day

Begin at 10.00am for first focus group, 1pm for second

1) Welcome Heather

2) Recapping what we did last week Amohia

Common themes of the ideal service that promotes resilience:

- Mix of services across disciplines, "wrap around services", closely integrated
- One physical location
- Out reach into communities
- Strong leadership
- Right people – personal qualities and values
- How?– support, educate, advocate, using Māori processes, strengthening identity
- Whānau are the reason for the service's existence

In recapping last week's session we need to ask the group "**How do these components contribute to Māori whānau or community resilience?**"

3) This week's session Heather

a) What are specific resources, mechanisms and interventions that a Māori primary health provider uses that contributes to enhanced resilience? Does TOIHA provide resources in a culturally meaningful way (according to project definition)? Is what TOIHA does unique, or can be replicated by any provider?

- **Given the ideal vision above, what happens for you as users of TOIHA services?**
- **Are there aspects of the vision within TOIHA services?**

b) **Exploring the link between resilience and whānau ora** and whether these things are mutually exclusive or inextricably linked.

- **What is whānau ora in your view?**
- **How does resilience fit with whānau ora?**
- **How much difference does a service make to resilience? How much influence can a service have?**

5) Close with

- a wrap up of the day and the four sessions
- last comments
- process from here
- thanks for participating
- koha

TOIHA Resiliency Project Focus Group 4 30 November 2010