Whānau Centred Primary Health Care Project

Te Piringa
Insights into ensuring effective whānau-centred, primary health care services and support

2020

Results from a preliminary
integrative literature review

ISBN 978-0-473-52610-8

Insights into ensuring effective whānau-centred, Māori and Pacific led, primary healthcare services and support

Results from a preliminary integrative literature review Te Puni Kōkiri Project, Whānau Centred, Māori and Pacific Led Primary Health Care 2020,

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Print and Design: Create Design Studio www.createdesignstudio.co.nz

The Whānau Ora Primary Health Research Project (Research Project) is a step toward understanding and improving whānau centred, Māori Pacific led, primary health (WCMPLPH) care. The primary objective of the Research Project was to leverage the achievements of Whānau Ora to improve the efficacy of health services and care to Māori and Pacific whānau and to build on the 'whānau-centred approach' - a culturally grounded, holistic approach focused on the wellbeing of whānau and addressing individual needs within a whānau context. Te Puni Kōkiri engaged three research groups, Moana Research, Ihi Research and FEM 2006 Ltd to undertake the Research Project from 2019 and 2020 to deliver four research products: a literature scan, six case studies, a rubric and a synthesis report.

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Acknowledgements

The research team wish to acknowledge the support of Te Puni Kōkiri in providing the initial literature scan from which provided a foundation for this review. This integrative literature review is part of a wider research project investigating whānau centered, Māori and Pacific led, primary health care in Aotearoa. The wider research was undertaken by three research teams, Ihi Research, Moana Research and FEM. This literature review was completed by two of the research teams, Ihi and Moana with support from FEM.

Executive summary

Te tōia, tē haumatia

“Nothing can be achieved without a plan, workforce and way of doing things”

This integrative literature review sought to understand the evidence for whānau-centred primary health provision towards improved Māori and Pacific health outcomes. A focus was to gain insights regarding the enablers, inhibitors, and challenges in delivering effective primary health care services and support for Māori and Pacific communities across Aotearoa. A key aim was to identify components (critical success factors) required to give effect to such approaches that were cognisant of communities' diverse characteristics, needs, and aspirations, and agencies' public accountability obligations.

In total 345 articles, reports and other literature were screened, with 110 being included for this literature review. Literature was included if a publication (i.e. journal article, book chapter, report/resource or thesis) provided theoretical or empirical evidence on delivery of whānau-centred primary health care (health provision/ health service) for Māori and Pacific communities.

The publications were further assessed and selected on the basis of whether information was available to identify:

a) key enablers and barriers to community-led whānau centred primary health provision, or

b) key components (critical success factors) required to give effect to this type of primary health provision (including information about communities' diverse characteristics, needs, and aspirations, and agencies' public accountability obligations). Thematic analysis was employed with all included articles.

Key results

Overall results indicated that enablers and barriers of whānau-centred primary health care are best understood through an ecological framework, that highlights the impact and influence of three different interacting environments or contextual layers. These layers emerged at the individual whānau level, at the provider level and at the government policy and practice level.

These different environments, or layers, overlapped and interacted in ways that impacted the development and strengthening of whānau-centred primary health care provision and ultimately on hauora outcomes for Māori and Pacific communities. Three major interconnected patterns emerged from analysis.

- Layer One: Enablers and barriers associated with individual whānau circumstances that influence engagement within whānau-centred primary health contexts
- Layer Two: Enablers and barriers associated with the provision and process of whānau centred primary health care service
- Layer Three: Enablers and barriers associated with government policies, funding, and systems arrangements.

These three layers all influence whānau-led capability development and improved health outcomes for Māori and Pacific communities. The following diagram illustrates this interaction.

Figure 1: Various layers affecting whānau-centred primary health care

Layer One: Enablers and barriers associated with individual whānau circumstances that influence engagement within whānau-centred primary health contexts

The diversity of Māori whānau and Pacific families (in particular differences in culture/ethnicity, gender, sexuality, disability, age, health status and socio-economic circumstances) influenced family engagement in primary health care, whether whānau-centred or not. Māori whānau and Pacific families are diverse and have different strengths/cultural capital, aspirations and needs, as well as different experiences of primary health care when compared with New Zealand Europeans. This means whānau-centred primary health care needs to cater for cultural diversity, acknowledging different forms of expertise, utilising family strengths and needs with a variety of engagement and access points.

There are gender differences in terms of how tāne and wāhine engage in primary health care. This means whānau-centred programmes need to address and be inclusive of gender and sexuality differences. Wāhine, tāne and takatāpui can be influential change agents, therefore whānau-centred programmes need to utilise their knowledge and expertise. Further research needs to examine the role of tāne and takatāpui in whānau-centred programmes, to address whakamā and fear. The area or rohe (rural or urban) that Māori and Pacific families live makes a difference in terms of access to cultural, social, and economic resources.

The cost of health care is a barrier for many Māori and Pacific families, so this means whānau-centred primary health care needs to be low or no cost. Family members who are caregivers are challenged to meet the needs of their loved ones with long-term or terminal health issues. Whānau-centred primary health care needs to include caregiver support. Local environments make a difference and whānau in deprived areas often have multiple and complex health needs. The high cost of housing and transport in large urban areas is a significant barrier to improving primary health for Māori and Pacific families. Whānau-centred providers in these areas need additional time and resourcing, to combat the legacy of intergenerational harm and work with other stakeholder groups to ensure better access to primary health care and safe, healthy home environments. Māori and Pacific groups who have disabilities are poorly served by the primary health care system. Whānau-centred primary health care needs to be inclusive of specific disability services and ensure a strengths-based, and not deficit, approach.

Whakawhanaungatanga and 'va' are key enablers of change highlighting the importance of relationships. Whānau support can come from relatives, friends, colleagues, church members and primary health care workers. Whānau-centred programmes need to be inclusive of those who can best support families to meet their health goals and aspirations.

> **Whakawhanaungatanga and 'va' are key enablers of change highlighting the importance of relationships.**

It is important to acknowledge health equity issues and the health debt owed to Māori and Pacific groups caused by colonisation, institutional racism and decades of economic deprivation that have influenced their primary health outcomes. Healing is an essential part of whānau transformation, particularly for those experiencing physical, spiritual, and emotional trauma. Acknowledging the impact of colonisation, discrimination and institutional racism is an important part of collective healing for Māori.

Layer Two: Enablers and barriers associated with the provision and process of whānau-centred primary health care

Whānau-centred services and programmes in the primary health context are critical to improved primary health outcomes for diverse Māori and Pacific families. Several key interconnected enablers and barriers were highlighted. Enablers at service provision included a clear model of practice. This needed to be underpinned by quality relationships and partnerships that ensured whānau ownership and participation. The model of practice also needs to fuse together cultural and clinical approaches. This emphasises the need for a shared vision, core values and relational trust to guide whānau-centred primary health care, underpinning the model of practice. Given the diversity of whānau and their strengths, aspirations and needs, it is imperative that whānau-centred primary health care is flexible and localised. Whānau-centred tools, resources and processes support strengths-based approaches and holistic capability development.

The employment of a culturally safe, competent, and capable workforce that can work effectively with Māori and Pacific families is a key enabler. In addition, service provision must support worker's professional development. Whānau-centred primary health care providers need to ensure reflective-culturally safe, relational, and evidence-based workplace practices. It is critical that providers working with whānau are able to critically reflect on their relationships with whānau and the degree to which efforts strengthen self-determination and improve hauora. Ongoing workforce development, regular training and supervision are key enablers to this, as are 'fit for purpose' information systems and systematic record keeping for monitoring and evaluation purposes. To ensure accountability and transparency, clear governance structures and effective leadership are also needed.

Barriers to whānau-centred primary health care are the absence of key enablers. Major barriers included the lack of a clear definition/model of whānau-centred primary health care. Interestingly, analysis revealed a plethora of terms used to describe different approaches such as whānau led, whānau centred, community centred, Treaty of Waitangi based primary health care provision, culturally safe health care provision, culturally responsive health care provision, culturally appropriate and culturally aligned health care provision. The lack of a clear definition (and model) of whānau-centred primary health care with obvious indicators of practice remains a barrier to strengthening primary health care provision and health outcomes. Related to this were issues of power and the degree to which power imbalances were evident within primary health care provision. This was noticeable when health care provision did not recognise whānau expertise, aspirations and strengths and/or positively respond to difference. These imbalances negatively impact on whānau rangatiratanga, capability development and hauora.

> **Barriers to whānau-centred primary health care are the absence of key enablers.**

Power imbalances were most noticeable at the clinician level, indicating a lack of a shared vision, core values and relational trust to underpin whānau centred primary health care provision. Another significant barrier was with the present funding, contracting, and reporting requirements that negatively impact on whānau-centred primary health care provision. This lack of funding meant significant challenges in sustaining and/or further developing a culturally safe, competent and capable workforce, so necessary for whānau-centred primary health care provision.

Greater alignment is needed across different levels, if effective whānau-centred practice is to be sustained. These levels include the wider primary health and policy sector, whānau-centred primary health providers, funders, regional health and social services, iwi, community, and church organisations. Findings emphasised the interconnectedness between enablers and barriers at the provider level and those related to government policies, funding, and systems arrangements.

Layer Three: Enablers and barriers associated with government policies, funding, and systems arrangements

Barriers and enablers that emerged at the first two layers (individual whānau circumstance and whānau-centred primary health provision) were also connected to the third and final layer of the eco-system. These were associated with government policies, funding, and accountability mechanisms.

A 'whole systems approach' to strengthen and sustain whānau-centred primary health care across Aotearoa is required. In Aotearoa, Te Tiriti o Waitangi protects Māori rights to self-determination and obliges the state to ensure that public policy is as effective for Māori as it is for everybody else. There needs to be greater alignment between Te Tiriti and the degree to which government policies, practices and systems arrangements support and further strengthen whānau-centred primary health care, to address health inequities for Māori.

The power and impact of Whānau Ora as a government policy to improve whānau capability development and health outcomes for Māori and Pacific groups was noted as a key enabler. Whānau Ora as a government policy has contributed to family-centred primary health care provision and improved health outcomes for Māori and Pacific communities. Whānau-centred primary health care provision requires stability and government commitment over time. The need to improve and act on a valid and reliable evidence base to strengthen whānau-centred primary health care policy and achieve greater adherence to Te Tiriti o Waitangi and Whānau Ora was noted.

If whānau-centred primary health care is going to be strengthened a more localised/community based, or regional approach is needed. A key enabler is the development of community advocacy to improve social and/or economic determinants of health. It is imperative that the wider policy environment for primary health care is developed in collaboration with Māori and Pacific stakeholder groups, including whānau, hapū, iwi and community-based groups, churches, and faith-based institutions. Such an approach calls for a shared and localised vision of whānau-centred primary health provision across government agencies, as well as valid evaluation and monitoring processes that take a holistic view of whānau capability development and health outcomes.

Locally defined performance measures are imperative to address localised health and wellbeing priorities, particularly in deprived areas. These measures need to be open to review to reflect changes in the local environment, regularly revisited, rather than established as fixed measures set at the outset of a contract. This can present a significant challenge to public policy, as the performance monitoring and accountability arrangements must also be responsive, flexible, and adaptable based on localised needs. A regional and localised approach enables whānau-centred primary health care providers, iwi, faith-based groups, and other social service providers to work in interconnected ways, across employment, housing, education and drug and alcohol addiction services. The capability of whānau and whānau-centred provision to achieve collective hauora in deprived and high costs areas, is severely constrained by limited employment options, lower wages, and the wider regional economic context. This suggests more needs to be done to ensure current regional development work across Aotearoa supports intersectoral development that strengthens and addresses whānau wellbeing in a range of areas (primary health care, safe housing, financial literacy, and education).

A significant barrier to achieving whānau-centred primary health care and improved hauora outcomes for Māori has been the failure of Crown agencies to adhere to Te Tiriti o Waitangi; and collect and use sufficient and valid data to strengthen whānau centred primary health care provision and improve health outcomes for all. The recent release of the Waitangi Tribunal findings from the first phase of 'Wai 2575 - the Health Services and Outcomes Inquiry' has emphasised this failure (Waitangi Tribunal, 2019). Clearly more needs to be done across government departments and agencies to ensure the Crown meets its Treaty of Waitangi obligations and strengthens its commitment to whānau-centred primary health care provision.

> **A significant barrier to achieving whānau-centred primary health care and improved hauora outcomes for Māori has been the failure of Crown agencies to adhere to Te Tiriti o Waitangi.**

Specific recommendations

Recommendations emerged to strengthen whānau-centred primary health care provision and whānau capability development. These included:

- Recognising that each layer of the wider eco-system interacts in ways that either enables or inhibits whānau capability development and ultimately hauora outcomes.
- Ensuring whānau-centred primary health provision and government policies and funding arrangements recognise and respond to the aspirations and needs of whānau across intersections of gender, sexuality, ethnicity, age, health status, socio-economic status, and dis/ability.
- The need for sustained, adequate funding for whānau-centred primary health provision, particularly across high needs areas and rohe.
- Ensuring whānau engage in collaborative processes that strengthen their self-determination and that whānau rangatiratanga informs policy development across various levels of the health system as well as other government agencies (whānau and community/regional development, housing, education, social services, financial literacy, drug and alcohol programmes etc).

- Ensuring wider government policy environments, funding and monitoring arrangements for primary health care are aligned to Te Tiriti o Waitangi obligations and developed in collaboration with whānau, hapū, iwi and whānau-centred primary health care providers.

- Recognising that Whānau Ora alone may not improve the overall health and wellbeing of all Māori and Pacific families in Aotearoa, New Zealand. Rather a whole of government inter-sectorial approach that encourages and advocates for whānau and community partnership and collaboration is vital for any real improvements to be seen in the overall health and wellbeing of all families.

- Ensuring greater collaboration and partnerships between government agencies, whānau, hapū, iwi and whānau-centred primary health care providers to identify locally defined performance measures for evaluation purposes.

- Ensuring that such performance measures are adaptable and updated regularly, rather than established at the outset of a contract and never reviewed.

It is important to acknowledge health equity issues and the health debt owed to Māori whānau and Pacific families, caused by colonisation, institutional racism and decades of economic deprivation that have influenced whānau health. Healing is an essential part of transformation, particularly for those experiencing physical, spiritual, and emotional trauma. This means whānau -centred primary health needs to be holistic, healing and strengths-based for diverse groups and further strengthened and sustained through government policies and funding arrangements that adhere to Te Tiriti o Waitangi obligations and the policy of Whānau Ora.

Chapter 1

Methodology

This integrative literature review sought to understand the evidence for whānau-centred primary health provision towards improved Māori and Pacific health outcomes versus mainstream approaches. An integrative literature review “summarizes past empirical or theoretical literature to provide a more comprehensive understanding of a particular phenomenon or healthcare problem” (Broome 1993, cited in Whittemore & Knaf, 2005). It is a method that permits the presence of diverse methodologies (including experimental and non-experimental research) and has the potential to contribute significantly in evidence-based practices. Integrative reviews can clarify concepts and review theories by presenting an overview of the present state of a phenomenon. In this way an integrative literature review contributes to theory development. This is done by analysing and highlighting methodological issues and debates, whilst pointing out gaps in current understandings. It provides evidence that has direct applicability to practice and policy (Whittemore & Knaf, 2005).

The focus of the literature review

A focus of this integrative literature review was to gain insights about the enablers, inhibitors, and challenges in delivering effective whānau-centred, primary health care services and support. Another aim was to identify key components (critical success factors) required to give effect to a whānau-centred approach that was cognisant of communities' diverse characteristics, needs, and aspirations, and agencies' public accountability obligations.

> A focus of this integrative literature review was to gain insights about the enablers, inhibitors, and challenges in delivering effective whānau-centred, primary health care services and support.

Whānau-centred primary health care (for Māori)

The following section describes the process of analysing literature to better understand effective whānau-centred, primary health care services and support for Māori. Definitions of 'whānau' are many and varied, however family and whānau are not the same. The western definition of family is often based on a nuclear family model. Whakapapa forms the basis of whānau, these relationships are intergenerational, shaped by context, and given meaning through roles, responsibilities, and relationships of mutual obligation. Key characteristics of whānau are collective identity, interdependence, mutuality, reciprocity and shared responsibility, and cultural practice and transference within a Māori context (Wehipeihana, 2019).

We have used the definition of 'whānau-centred' provided by Te Puni Kōkiri (2015) 'Understanding whānau-centred approaches: Analysis of Phase One Whānau Ora research and monitoring results'. According to this report a 'whānau-centred approach' refers to a culturally grounded, holistic approach focused on improving the wellbeing of whānau and addressing individual needs within a whānau context (Te Puni Kōkiri, 2015, p. 6).

Whānau-centred Initiatives (and subsequently the Whānau Ora Initiative) address:

- Delivery of services to whānau that are integrated and coordinated across agencies and social service providers, instead of being fragmented
- Complexities where several problems coexist
- Place whānau at the centre of service design and delivery and empower whānau as a whole (Te Pūni Kōkiri, 2015, p. 6).

Essential components of whānau-centred practices have been emphasised. These include:

- Establish relationships that benefit whānau
- Build whānau rangatiratanga (whānau capability to support whānau self-management, independence, and autonomy)
- Build a capable workforce – grow a culturally competent and technically skilled workforce able to adopt a holistic approach to supporting whānau aspirations
- Ensure whānau-centred services and programmes – whānau needs and aspirations at the centre, with services that are integrated and accessible
- Ensure supportive environments – funding, contracting and policy arrangements, as well as effective leadership from government and iwi (tribes) to support whānau aspirations.

Two fundamental aspects of whānau engagement were also identified:

- Culturally anchored practices (for Māori this would be in te ao Māori) and;
- use of whanaungatanga/relationships as a tool to connect and build whānau capability.

To assist the literature analysis, a template was created highlighting these components of whānau-centred practices (refer to Appendix 1). The template was used to determine the inclusion/exclusion process.

In terms of a definition of primary health care, we referred to the New Zealand Ministry of Health and the World Health Organisation. The Ministry of Health defines primary health as "the professional health care provided in the community, usually from a general practitioner (GP), practice nurse, nurse practitioner, pharmacist or other health professional working within a general practice" (Ministry of Health, 2009).

The World Health Organisation defines primary health care "as a whole-of-society approach to health and well-being centred on the needs and preferences of individuals, families and communities. It addresses the broader determinants of health and focuses on the comprehensive and interrelated aspects of physical, mental, and social health and wellbeing.

WHO has developed a cohesive definition based on three components:

- Meeting people's health needs through comprehensive promotive, protective, preventive, curative, rehabilitative, and palliative care throughout the life course, strategically prioritizing key health care services aimed at individuals and families through primary care and the population through public health functions as the central elements of integrated health services;
- Systematically addressing the broader determinants of health (including social, economic, environmental, as well as people's characteristics and behaviours)

through evidence-informed public policies and actions across all sectors; and

- Empowering individuals, families, and communities to optimize their health, as advocates for policies that promote and protect health and well-being, as co-developers of health and social services, and as self-carers and care-givers to others." (World Health Organisation, 2019)

Primary health care is rooted in a commitment to social justice and equity and in the recognition of the fundamental right to the highest attainable standard of health, as echoed in Article 25 of the Universal Declaration on Human Rights: "Everyone has the right to a standard of living adequate for the health and wellbeing of himself and of his family, including food, clothing, housing and medical care and necessary social services [...]".

Search strategy

An initial scan was undertaken by staff at Te Puni Kōkiri (Gregor, 2019). This broad search included:

- Terms such as 'community-based' and 'community-led' primary health care
- A search for literature within PubMed/ Medline database
- Unpublished literature and reports; and
- Masters/PhD theses relevant to the review

Variations on the following search statements were also used:

1. (Family OR whānau) AND centred) AND (health AND (service OR care)
2. (Family OR whānau) AND (focused OR centered OR centred)

This search was narrowed by focusing on articles and reports related to primary health and further search statements included:

3. (primary health) AND (care OR service OR initiative OR programme OR program) OR "Primary healthcare"

These phrases were searched in:

4. Google scholar
5. INNZ (an online index of New Zealand journal articles)
6. Australia/New Zealand Reference Centre & MasterFILE Premier (EBSCO databases)
7. AlterNative
8. Mai Journal

The results were manually scanned and selected for relevance to Māori or Pacific or indigenous peoples. Studies on indigenous populations included in this literature review, refer to communities from the USA, Canada, Australia and New Zealand and included Aboriginal and Torres Strait Islander Australians, Māori and Samoans, Canadian First Nations (including Cree, Saulteaux/Anishinaabe, and Lakota/Dakota), Métis, Alaska Natives (including Tlingit/Haida, Yup'ik Eskimo, Inupiaq, Athabascan, Aleut and Alutiiq/Sugpiaq), Native Americans (including Pueblo, Navajo, Hopi and Zuni), and Native Hawaiians.

Additional searches were undertaken and included: • Webpages searched: Ministry of Health, Health Promotion Agency, TPK, and Waitangi Tribunal.

Databases:

- ProQuest
- Kiwi Research Information Service (https://nzresearch.org.nz/)

- Matapihi/ DigitalNZ (https://digitalnz.org)
- Gale Health and Wellness database
- Gale Onefile Health and Medicine
- Gale Onefile Nursing and Allied Health

The reference lists of identified publications were hand searched to identify additional relevant publications. Finally, other researchers who had expertise in the field of whānau-centred primary health care were consulted for publications not found by the electronic database search.

Data analysis

Literature was included if a publication (i.e. journal article, book chapter, report or thesis) provided theoretical or empirical evidence on delivery of community-led (community-based) whānau-centred primary health care (health provision/health service). The publications were further assessed and selected on the basis of whether information was available to identify: a) key enablers and barriers to community-led whānau-centred primary health provision, or b) key components (critical success factors) required to give effect to community-led whānau-centred primary health provision (including information about communities' diverse characteristics, needs, and aspirations, and agencies' public accountability obligations).

All included literature material was analysed using the template based on the Te Puni Kōkiri (2015) report (refer to Appendix 1). The title of each article, report, thesis, and/or other literature material was recorded, along with author(s), year of publication, location, and stated purpose.

Where possible components of whānau-led as determined by the template were recorded, including characteristics and accounts of participant experiences, findings and outcomes, enablers and barriers identified and recommendations arising. Information on the total number of articles identified and screened are included in Table 1. This table also includes information on the number of included articles and competed templates for analysis. Thematic analysis was employed with all articles included.

Total articles identified & screened	**181**
Included (literature about Māori & other overseas indigenous communities)	**65**
Completed templates	**59**

Table 1. Information on total number of articles Māori

Total articles identified and screened	**164**
Included (literature about Pacific and other overseas indigenous communities)	**45**

Table 2: Information on total number of article Pacific

Thematic analysis

The development of themes included both descriptive and analytic analysis. As Thomas and Harden (2008) note the construction of descriptive themes remains 'close' to the primary sources, however the analytical themes represent a stage of interpretation whereby the reviewers "go beyond' the primary sources and generate new interpretive constructs, explanations or hypotheses" (p.2).

The extracted data from templates underwent two cycles of coding. During the first cycle of coding, descriptive coding was used to identify the basic focus for each component of reported data, with a focus on reported enablers and barriers to whānau-led primary health care. In the second cycle of coding, themes related to context and environments were identified.

The literature review is divided into two chapters, whānau centred primary health care for Māori, and whānau centred primary health care for Pacific families. These chapters were written by Ihi Research and Moana Research respectively, each of the teams bringing a cultural lens to their analysis.

Limitations

This literature review was completed within a short time frame so is limited in terms of its size and scope. All literature material that was reviewed was written in English and consequently does not include studies or publications written in reo Māori and/or other Pacific languages. A variety of literature comprising peer reviewed journal articles, theses, evaluation documents and reports were included. However, most texts were from peer reviewed journals. Included journal articles were confined to word limits. This may have meant the authors chose not to identify components of whānau and/or family-centred provision, and/or enablers/barriers and critical success factors.

Another limitation of this literature review is the lack of evidence of solely family-led models of primary health care models for Pacific communities, where families/family groups are funded directly to self-service their own families through the entire process of PHC. There are no known models that fit this approach, which presents opportunities for piloting these models in future.

Finally, it is important to note that Māori and Pacific communities within New Zealand are diverse. Anae, Anderson, Benseman and Coxon (2002) warn the terms ‘Pacific peoples’ or ‘Pacific communities’ within Aotearoa encompass “considerable cultural and historical diversity” (p. 2). There were many instances within the reviewed literature that the term ‘Pacific’ or ‘Māori’ communities was used, and it was not always clear how such diversity was addressed by whānau/family-centred’/family-led primary health care providers. The issue on poorly reported ethnic data has been identified as a major barrier to health equity for diverse Māori and Pacific communities (King, 2019; Ryan, Grey & Mischewski, 2019; Waitangi Tribunal, 2019).

Chapter 2

Whānau-centred primary health care for Māori

The results are presented in the following sections highlighting major themes that emerged from an analysis of literature related to enablers and barriers that affect whānau-centred primary health care provision for Māori. Research and literature that examined indigenous communities' experiences of community and/or family-centred health care provision was also included. The majority of this literature included the perspectives and experiences of Aboriginal and Torres Straits peoples in Australia, First Nations peoples in Canada and Native Americans in the USA.

The enablers and barriers of whānau-centred primary health care are best understood through an ecological framework, that highlights the impact and influence of different environments or contextual layers (at an individual whānau level, at the provider level and at the government policy and practice level).

The different environments, or layers, overlapped and interrelated in ways that impact on the development and strengthening of whānau-centred primary health care provision and ultimately on hauora health outcomes. Three major interconnected themes emerged from analysis.

- Layer One: Enablers and barriers associated with individual whānau circumstances that influence engagement within whānau-centred primary health contexts
- Layer Two: Enablers and barriers associated with the provision and process of whānau-centred primary health care service
- Layer Three: Enablers and barriers associated with government policies, funding and systems arrangements needed to further support whānau-centred primary health provision

These layers influence whānau rangatiratanga within primary health contexts and ultimately, whānau-led capability development. Primary health care provision in Aotearoa must create coherent and aligned spaces that enable whānau to self-define their own health needs. This means ensuring whānau engage in collaborative processes that strengthen their development for self-determination. Whānau rangatiratanga must inform policy development across various levels of the health system (whānau and community development, service provision and programmes as well as government policies and funding arrangements).

> **Different environments, or layers, overlapped and interrelated in ways that impact on the development and strengthening of whānau-centred primary health care provision.**

The importance and influence of these various layers, or contexts, was emphasised in findings. For example, the diversity and personal circumstances of individual whānau, as well as other contextual influences such as access to cultural and financial resources to strengthen whānau rangatiratanga within primary health care settings. Poverty and financial hardship were a considerable barrier, particularly for whānau in 'deprived' settings. Service provision and programmes that supported whānau rangatiratanga and strengths-based approaches were considered critical to strengthening whānau rangatiratanga. However, such programmes depended on a culturally competent and capable workforce. The ability of organisations to sustain and further develop their workforce is severely constrained by current government contracting and funding arrangements. Each layer (individual whānau circumstances, service provision to support whānau rangatiratanga and government policy and funding arrangements) interact in ways that either enable or inhibit the strengthening of whānau rangatiratanga in primary health care settings.

> **Poverty and financial hardship were a considerable barrier.**

The following figure highlights the interrelationship between these major themes (refer figure 1). Whānau-centred health and wellbeing will only be achieved when whānau actively participate in developing and evaluating practice, policy, and research work across the primary health care system. This means actively involving whānau to address the consequences of colonisation and institutional racism that constrain whānau rangatiratanga and capability development at all levels of the primary health care system.

Figure 1: Various layers affecting whānau-centred primary health care

Key enablers and barriers emerged at three different layers of a larger eco-system that all influenced the provision and process of whānau-centred primary health care.

The following table outlines the enablers and barriers that emerged at the very first layer of the eco-system; that is for individual whānau.

Enablers	Barriers
1 The importance and value of whānau diversity - gender, sexuality, ethnicity, age, socio-economic and disability differences	**1** Intergenerational exposure to health compromising conditions, causing 'vulnerable' or 'victim' whānau
2 Whānau mātauranga and expertise	**2** Whakamā and fear
3 Whānau rangatiratanga	**3** Whānau experiences of poverty
4 Ability of whānau to be 'resilient' and access cultural, social, and financial resources Whakawhanaungatanga and community support for whānau	**4** The physical location of whānau in 'deprived' areas
5 Wāhine and tāne as change agents	**5** Limited options for whānau with lived experience of disability
6 The importance of decolonising, collective, healing, and holistic health experiences	

Table 2: Layer One: Enablers and barriers associated with individual whānau and their circumstances that can influence their engagement in whānau-centred primary health

The table below (Table 3) outlines that enablers and barriers that emerged related to the second layer of the eco-system; that is the provision and process of whānau-centred primary health care needed to strengthen whānau rangatiratanga and hauora.

Enablers

1. A clear definition/model of practice of whānau-centred primary health care
2. Whanaungatanga: quality relationships and strengths-based partnerships
3. Fusion of mātauranga Māori and clinical approaches
4. Flexibility of approach
5. Whānau-centred tools, resources, and processes to support rangatiratanga, a strengths-based approach and holistic whānau capability development
6. The importance of a shared vision, core values and relational trust
7. Culturally safe, competent, capable workforce and service provision
8. Reflective, relational, and evidence-based practices
9. Ongoing workforce development, regular training, and supervision
10. Fit for purpose information systems, systemic and secure record keeping for monitoring and evaluation processes Clear governance structures and effective leadership

Barriers

1. A lack of a clear definition/model of whānau-centred primary health care
2. Power imbalances - approaches that do not recognise whānau expertise and/or positively respond to whānau diversity (Gender, sexuality, ethnicity, age, socio-economic, experience of disability) negatively impacting on whānau rangatiratanga.
3. Power imbalances – Clinician versus whānau
4. Difficulties with funding, contracting, and reporting requirements
5. Funding that does not sustain or further develop a culturally competent and capable workforce

Table 3. Layer Two: Enablers and barriers associated with the provision and process of whānau-centred primary health care service provision

Finally, analysis highlighted that barriers and enablers that emerged at the first two layers (individual whānau circumstance and whānau-centred primary health provision) were also connected to the third and final layer of the eco-system. These were associated with government policies, funding, and accountability mechanisms. Table 4 highlights the major enablers and barriers that emerged at this third layer.

Enablers	Barriers
1 A whole of system approach: Adherence to Te Tiriti o Waitangi and policies such as Whānau Ora (at national and regional levels)	**1** Failure of Crown agencies to adhere to Te Tiriti o Waitangi obligations; support Māori health provision; and collect and use sufficient data to improve Māori health outcomes
2 Improving and acting on the evidence-base to better inform policy decisions (to ensure adherence)	

Table 4. Layer Three: Enablers and barriers associated with government policies, funding, and accountability mechanisms

Enablers and barriers

Associated with individual whānau

Differences in gender, sexuality, ethnicity, disability, age, health status and socio-economic circumstances influence whānau engagement in primary health care. Whānau diversity is a strength, and a 'one-size fits all approach' to whānau-centred service provision will not work.

Enablers

This following section highlights the major enablers that influenced whānau starting points as they engaged within whānau-centred primary health care.

The importance and value of whānau diversity

A number of studies highlighted important age, gender and sexuality differences and the critical need for whānau-centred primary health care providers to recognise this (Baker & Pipi, 2014; Canuto, Brown, Wittert, & Harfield, 2018; Kidd et al., 2013, McCalman et al., 2017; Rainbow Youth Inc & Tīwhanawhana Trust, 2017; Lakhotia, 2017). For example, gender differences were emphasised in a study involving tāne who had chronic disease or cancer (Kidd et al., 2013). Some male respondents explained they were reluctant to access services, regardless of whether they were Māori-led. Tāne could experience feelings of shame and fear of being a burden to others which impacted on their engagement in primary health care programmes (Kidd et al., 2013). The beliefs, attitudes, and knowledge of males is an important influencing factor in their engagement in primary health care services (Canuto et al., 2018; Kidd et al., 2013).

Reclaiming and affirming the mana of takatāpui, is an essential part of achieving hauora for whānau with diverse gender and sexual identities (Rainbow Youth Inc & Tīwhanawhana Trust, 2017). Takatāpui refers to 'intimate companion of the same sex' and used by individuals who are transgender, gay, lesbian, bisexual, intersex or view themselves as part of the rainbow community (Rainbow Youth Inc & Tīwhanawhana Trust, 2017). It is imperative that whānau-centred primary health programmes are inclusive and supportive of diverse whānau members, and this is particularly important for takatāpui rangatahi (Rainbow Youth Inc & Tīwhanawhana Trust, 2017).

It is imperative that whānau-centred primary health programmes are inclusive and supportive of diverse whānau members.

Results from a Whānau Ora outcomes report by Te Pou Matakana (TPM), also highlighted gender, ethnicity, and age differences in terms of whānau engagement (2018). "In 2016/17 fiscal year, 5,420 whānau were engaged with the TPM Kaiārahi programme across all TPM Partners. Among these whānau, 4,618 (85%) developed a plan and set goals for themselves. These 4,618 whānau, included 11,068 whānau members, of which, more than half (55%) were under 25-years of age. The majority (55%) of whānau members were female, and more than eight out of ten (85%) whānau members identified themselves as Māori with a further 6% as Pacific (2018, p. 3) (and later) …. Only 4% of all whānau members engaged across the regions were aged 65-years and above (2018, p. 14).

For many whānau their definition of health and wellbeing was tied to their socio-economic realities and their ability to have their basic needs met. Financial situations included whānau access to healthy food and nutrition; warm, safe, and secure housing; reliable transport, sustained employment, quality education etc (Brown, 2010; King, 2019; Ministry of Health, 2002).

Gott et al.'s (2015) study of whānau caregivers who were caring for someone with a life-limiting illness found that Māori caregiving was informed by cultural values steeped in aroha and manaakitanga, which were prioritised over care costs. However, whānau ability to provide caregiving was highly dependent on their own financial circumstances. In Gott et al.'s study, whānau who stated the highest levels of financial resource believed themselves to be 'lucky'. These whānau described only having to cut back on planned expenses, such as an overseas holiday to visit a new moko, to meet their direct and indirect caring costs.

The importance of recognising the diversity and distinctiveness of whānau; their beliefs and values as well as their resilience, role, experiences and needs was emphasised (Baker & Pipi, 2014; Te Puni Kōkiri. 2010; Te Pūtahitanga o te Waipounamu, 2016; Rainbow Youth Inc & Tīwhanawhana Trust, 2017). As Wehipeihana et al. (2016) note, "each whānau is unique" and this influences their goals, pathways and their hauora journey. The health priorities and circumstances of individual whānau are diverse (Ball, 2010; Elder, 2017; Rainbow Youth Inc & Tīwhanawhana Trust, 2017; Snijder et al., 2015) and can change suddenly (Baker, Pipi, & Cassidy, 2015; Shahid et al., 2018).

Concepts such as hauora, Whānau Ora and whānau-centred health care were varied and place-based and are open to many different interpretations (Boulton, Tamehana, & Brannelly, 2013; Rainbow Youth Inc & Tīwhanawhana Trust, 2017). How individual whānau consider their cultural needs in the context of achieving hauora, may be something they feel very familiar with or something that is very new to them (Elder, 2017).

Concepts such as hauora, Whānau Ora and whānau-centred health care were varied and place-based and are open to many different interpretations.

The concept of time could be interlinked with whānau interpretations of hauora and mauri ora with whānau members being physically or spirituality present in health contexts (Elder, 2017). Whānau capability to engage in self-determining health care was shaped by life factors; such as a person's growth and development, access to education and other environmental influences (political, economic, and social), as well as by that person's whānau, hapū, and iwi (Baker & Pipi, 2014; Baker, Pipi, & Cassidy, 2015; Gott et al., 2015; Shahid et al., 2018; Te Puni Kōkiri, 2010). There were differences for whānau living in rural and urban settings in terms of cultural identities 'as Māori' and how they accessed support (Allport et al., 2017).

Whānau rangatiratanga

Analysis of literature indicated that whānau must be at the centre of primary care health transformation. The recognition of whānau as experts in achieving whānau health and wellbeing was emphasised (Ball, 2010; Baker & Pipi, 2014; Baker et al., 2015; Crengle, 1999; Elder, 2017; Kidd et al., 2013; Moss & Pipi, 2014; Pipi, 2014; Pipi et al., 2003; Te Pou Matakana, 2018; Te Pūtahitanga o te Waipounamu, 2016; Wehipeihana et al., 2016). Acknowledging, utilising and strengthening whānau rangatiratanga was considered essential to hauora and wellbeing for Māori, as well as other indigenous communities within Australia, USA and Canada (Allport et al., 2017; Anderson, Mills & Eggleton, 2017; Brown, 2010; Boulton & Gifford, 2014; Boulton et al., 2013; Chant, 2011; Gibson et al., 2015; Harfield et al., 2018; Harwood et al., 2018; McCalman et al., 2017; Ministry of Health, 2010; O'Sullivan, 2019; Shahid et al., 2018).

Whānau mātauranga and expertise

The importance and value of whānau mātauranga and expertise within primary health contexts was emphasised (Baker & Pipi, 2014; Chant, 2011; Elder, 2017; Kidd et al., 2013; Shahid et al., 2018). Whānau mātauranga (knowledge systems) are a potent resource for enhancing hauora (Elder, 2017). This stresses the importance of intergenerational health and wellbeing for whānau (Brown, 2010). Therefore, it is important to note that the hauora values, needs and preferences of whānau are culturally and locally defined.

> **Hauora values, needs and preferences of whānau are culturally and locally defined.**

Whānau resilience and access to cultural, social, and financial resources

Whānau resilience and support is an important protective factor in primary health contexts (Te Puni Kōkiri, 2010; Rainbow Youth Inc & Tīwhanawhana Trust, 2017). However, several studies highlighted that whānau capability to be self-determining and resilient was often linked to their personal circumstances or physical location (Allport et al., 2017; Baker & Pipi, 2014; Boulton & Gifford, 2014; Crengle, 1999; Gott et al., 2015). For example, Māori participants in one study explained that some whānau could be more 'resilient' than others (Boulton & Gifford, 2014). More resilient whānau were reported as having greater access to natural resources. These resources included whānau, friends, links to their marae and other cultural institutions, including places of significance (such as wāhi tapu, māhinga kai, awa and maunga). More resilient whānau often had a greater knowledge of their rights as consumers of health care services (Boulton & Gifford, 2014) and therefore had higher expectations regarding the quality of primary health care services provided. In contrast, a portion of whānau were described as 'victim whānau' (Boulton & Gifford, 2014) who were viewed as having less motivation and/or had developed a learned helplessness that inhibited their ability to be self-determining. Other authors highlighted that there was a portion of whānau who were 'hard to reach' (Ball, 2010).

Takatāpui rangatahi with diverse bodies and gender identities often faced discrimination, rejection, and isolation within their own whānau as well as wider society leading to high rates of isolation, depression, self-harm and suicide (Rainbow Youth Inc & Tīwhanawhana Trust, 2017). Supportive whānau make certain takatāpui rangatahi receive competent and affirming healthcare that ensures their privacy and sensitivity (Rainbow Youth Inc & Tīwhanawhana Trust, 2017).

A literature review published by Te Puni Kōkiri (2010) on whānau resilience identified a number of 'general protective factors' or 'characteristics of whānau resilience' (p. 5). These included:

- Experiential learning: People learn from their culmination of experiences in life;
- Support networks: Access to agents of positive change that provide effective coping processes;
- Good communication: The attributes and outcomes of good communication within the whānau was an integral protective factor" (p. 5).

In addition, whānau were more able to cope with adverse situations when they had access to multiple financial, educational, and cultural resources (Te Puni Kōkiri, 2010).

Whakawhanaungatanga, manaakitanga and community support for whānau

The diversity of circumstances and location for whānau (rural or urban) impact on whanaungatanga as a catalyst for resilience, hauora and wellbeing (Allport et al., 2017). For many Māori living in their traditional tribal areas, concepts such as whanaungatanga or the assistance afforded by the extended family was an important source of ongoing support. Within urban settings, these tribal support systems may not be typically available, but could emerge as part of community or social engagement initiatives.

> **Whanaungatanga or the assistance afforded by the extended family was an important source of ongoing support.**

For the whānau interviewed as part of Allport et al.'s (2017) study, 'community' in urban settings served as a proxy for whanaungatanga for groups of urban Māori. These whānau came from various tribal areas. However, in urban environments they pooled their resources, developed new relationships, and provided support for each other. Therefore, whānau members could include Māori and non-Māori members and be 'kaupapa whānau' (friends or colleagues who were not related by whakapapa). Other studies on Māori rural whānau and their engagement in primary health care have noted that strong whānau ties were an important health resource support for rural whānau, as well as the support provided by friends (Henry, 2001).

The literature review on whānau resilience published by Te Puni Kōkiri has noted the importance of collective responsibility for healing (2010). "Whanaungatanga, manaakitanga and whānau are central concepts to a Maori worldview and are a principal source of strength for the recovery process" (p. 5).

Findings from the Te Puni Kōkiri published review included the importance of strengthening cultural identity and whānau connectedness. Findings emphasised that whānau who have "positive relationships are able to learn to cope more effectively" with health-damaging contexts, such as dealing with drug and alcohol addictions (2010, p.5).

Whānau, wāhine and tāne as change agents

Role models and change agents within whānau are important resources that promote and protect whānau resilience (Te Puni Kōkiri, 2010). They are "protective factors because they provide motivation, hope and a positive attitude and example to others" (Te Puni Kōkiri, 2010; p. 5).

The importance of wāhine and tāne as change agents was highlighted in the analysis (Baker and Pipi (2014; Henry, 2001; Kidd et al., 2013; Rainbow Youth Inc & Tīwhanawhana Trust, 2017) although gender could influence the championing of hauora. For example, a study by Baker and Pipi (2014) noted the importance of wāhine and particularly the role of mothers, grandmothers, and kuia as change agents in whānau-led primary health care. They found wāhine (women) were more likely to directly seek assistance from services for themselves and whānau, while men were more likely to gain help indirectly through women, whānau or community forums. Other studies involving rural Māori whānau in primary health care initiatives have also highlighted the critical role that wāhine play in prioritising whānau health needs and ensuring these are met (Henry, 2001). In contrast Kidd et al.'s (2013) research noted the importance of and need for male support and Māori male change agents in the lives of tāne living with a chronic health condition (cancer, diabetes or heart-related conditions). Interestingly, some authors argued that further research pertaining to the role of tāne (fathers, grandfathers, kaumatua) as change agents in the provision of whānau-centred care was needed (Canuto et al., 2018; Elder, 2017; McCalman et al., 2017).

Support from whānau is essential to ensuring takatāpui rangatahi hauora. Access to positive role models as well as support from immediate and kaupapa whānau, especially kuia and kaumātua assists takatāpui rangatahi to 'stand in their own mana' (Rainbow Youth Inc & Tīwhanawhana Trust, 2017).

> **Wāhine were more likely to directly seek assistance from services for themselves and whānau, while men were more likely to gain help indirectly through women, whānau or community forums.**

The importance of decolonising, collective, healing, holistic health experiences

Healing is an essential part of whānau transformation, particularly for whānau experiencing physical, spiritual, and emotional trauma (Baker & Pipi, 2014; Allport et al., 2017; Moss & Pipi, 2014; Te Puni Kōkiri, 2010; Rainbow Youth Inc & Tīwhanawhana Trust, 2017). De-colonisation is important for whānau hauora as there is a need to acknowledge that widespread physical and mental ill health was not normal before the arrival of Europeans (King, 2019; Rainbow Youth Inc & Tīwhanawhana Trust, 2017).

> **Healing is an essential part of whānau transformation.**

Health and wellbeing for whānau should be collective, holistic, and tied to important cultural values (Te Puni Kōkiri, 2010). Allport et al. (2017) found that health and hauora for whānau 'was about the body, the mind and the spirit all working in accord' as well as addressing basic whānau needs. Whānau could become engaged in primary health care through crisis and this was a starting point towards whānau transformation (Baker & Pipi, 2014). Whānau sharing of personal stories has been highlighted as an important part of the healing process (Baker & Pipi, 2014; Rainbow Youth Inc & Tīwhanawhana Trust, 2017).

A key finding from the literature review on whānau resilience, published by Te Puni Kōkiri, was the importance of collective healing particularly when the behaviour of individual members negatively impacts on others (2010).

Barriers

The following section highlights major barriers associated with the first layer of the eco-system; those associated with the circumstances of individual whānau that influence engagement in whānau-centred primary health care.

Intergenerational exposure to health compromising conditions, causing vulnerable whānau, whakamā, anger and fear

The current circumstances, location and health needs of whānau cannot be separated from the socio-political and historical contexts of Aotearoa and the legacy of colonisation (King, 2019; O'Sullivan, 2019; Te Puni Kōkiri, 2008; Te Puni Kōkiri, 2010; Rainbow Youth Inc & Tīwhanawhana Trust, 2017). Poor health statistics for Māori have been caused through land, identity, language and cultural loss, oppression, and injustice (Margeson & Gray, 2017; Rainbow Youth Inc & Tīwhanawhana Trust, 2017).

Colonisation was inherently violent and as a result Māori whānau suffer violence daily (Te Puni Kōkiri, 2008). In addition, colonisation and assimilationist policies have undermined traditional whānau structures and relationships, including gender relationships (Te Puni Kōkiri, 2008). Successive governments have failed to meet their obligations to te Tiriti o Waitangi and this has severely impacted Māori health and wellbeing (Health Quality & Safety Commission, 2019). Institutional racism and mono-cultural practices within the health system, has established and maintained advantage for most non-Māori as opposed to Māori (Berghan, Came, Coupe, Doole, Fay, McCreanor, & Simpson, 2017; Curtis, Jones, Tipene-Leach, Walker, Loring, Paine & Reid, 2019; Health Quality & Safety Commission, 2019).

Colonisation and assimilationist policies have undermined traditional whānau structures and relationships.

Increased intergenerational exposure to health compromising conditions, created through decades of persistent and marked inequities, negatively impacts whānau health (Baker & Pipi, 2014; O'Sullivan, 2019). Whānau members are more vulnerable to having a chronic health condition (cancer, diabetes, or heart-related conditions) if their whānau have a history of such conditions (Kidd et al., 2013). Whakamā and fear can seriously inhibit whānau ability to access services, regardless of whether they are Māori-led (Kidd et al., 2013). For example, Māori men could feel shame and fear of being a burden. In Kidd et al.'s study, some male respondents reported being reluctant to use whānau support for fear of being 'a burden'. Kidd et al. emphasise that whakamā can result in withdrawal from primary health care settings as well as anger due to the loss of mana. Such feelings can reduce hope, personal power and agency that inhibit rangatiratanga.

Baker and Pipi (2014) note that while the location of primary health care whānau-centred services provides considerable opportunities for whānau, particularly in the context of domestic violence, it also provides specific challenges. Takatāpui rangatahi are likely to face violence and abuse in their lives because of their diverse sexes, genders, or sexualities (Rainbow Youth Inc & Tīwhanawhana Trust, 2017). Some whānau members can be hesitant about engaging with primary health services, as this means kaimahi become more aware of their circumstances. Fear of partner or whānau reprisals; fear of whānau rejection; concern that kaimahi may report incidents to police and/or social service agencies may mean some whānau refuse to engage in primary health care, whether they are whānau-centred or not (Baker & Pipi, 2014).

Similar findings were noted in a 2018 study undertaken in Australia, with Torres Strait and Aboriginal communities. Canuto et al. (2018) found fear was a considerable barrier to community members accessing primary health care, regardless of whether they were offered through Torres Strait or Aboriginal providers. Negative past experiences with primary health professionals, fear of hospitals, procedures, receiving bad health news, fear of being labelled by others, or fear that children could be removed from home could all act as barriers to family members accessing primary health care.

Whānau experiences of poverty and financial hardship

Poverty was cited as a prominent barrier to Māori and other indigenous communities (such as Aboriginal communities across Australia, Native Americans in the USA and First Nations tribes in Canada) to accessing primary health care (Allport et al., 2017; Anderson, Mills & Eggleton, 2017; Baker & Pipi, 2014; Brown, 2010; Davy et al., 2016, Gott et al., 2015). It's acknowledged that a proportion of Māori are tightly constrained by their socio-economic situation and without adequate resources to make 'free choices' (Te Puni Kōkiri, 2010).

For example, although Gott et al.'s (2015) study of whānau caregivers (who cared for someone with a life-limiting illness) found that Māori caregiving was underpinned by cultural values, they noted considerable variability in the financial situations of whānau that limited their caregiving ability. This study found that whānau in a caregiving capacity faced direct and indirect costs. Direct costs involved straight outlays of money, typically related to providing care at home and ensuring whānau members got to doctor or hospital appointments. These costs were typically incurred in the process of caregiving. For example, whānau had parking and transport costs, admissions to hospital, cost of food, clothing, and bed linen etc. Gott et al. noted that whānau with life limiting illnesses, may need new clothes because of weight loss and/or new bed linen due to laundry demands. Indirect costs were those incurred by whānau members because of their caregiving role. These costs were typically incurred due to the need to change or reduce employment obligations and/or related to lost employment opportunities. Whānau who were in paid work were often forced to fit in caring tasks around work. This could mean using annual leave and sick leave entitlements and/or taking unpaid leave. Some whānau in Gott et al.'s study had to give up paid work altogether to care for whānau members. Others were unable to look for work because of their caring responsibilities and faced the consequences of having their benefits cut. Some whānau reported that caring had negatively affected their own health and wellbeing. Physical harm could be caused by lifting whānau members. They noted considerable serious impacts for whānau, including developing significant debt and the need to move to a smaller house or less expensive accommodation. In extreme cases, whānau reported going without food because they could not afford to buy enough for everyone in their care (Gott et al., 2015). Anxiety, depression, and insomnia associated with caregiving could also incur financial costs. This could be related to additional doctor visits and prescriptions for medication, both when caregiving whānau are looking after a whānau member and after their passing. The grief of losing a loved one could compound anxiety for caregiving whānau (Gott et al., 2015).

> **Whānau in a caregiving capacity faced direct and indirect costs.**

The authors also noted the cultural needs of whānau as they neared the end of their lives, that incurred costs for caregiving whānau. This included the desire to return to tribal areas before death. There were also additional costs for tangihanga. The study found that for whānau with limited financial resources, in many cases customary funeral traditions could not be completed despite whānau desires (Gott et al., 2015). The grief of losing a loved one, as well as not being able to fulfil customary traditions, could compound anxiety for caregiving whānau (Gott et al., 2015).

Other literature highlighted the high costs of treatments for diverse whānau members. For example, takatāpui rangatahi may need to transition from the gender they were assigned at birth. Transitioning is an essential part of the journey to align their tinana with their wairua. However, the treatments and surgeries necessary for this are both extremely costly and not readily available (Rainbow Youth Inc & Tīwhanawhana Trust, 2017). This lack of access to life-changing treatments is a serious barrier to the physical and mental health of takatāpui rangatahi.

The physical location of whānau

The physical location of whānau in various rohe could severely limit whānau access to primary health care settings and impact on their resilience (Allport et al., 2017; Anderson, Mills, & Eggleton, 2017; Baker and Pipi, 2014; Crengle, 1999; Te Puni Kōkiri, 2010). Whānau living in isolated, rural areas face specific challenges in accessing primary health care, whether it is whānau-centred or not (Anderson, Mills, & Eggleton, 2017; Crengle, 1999).

Different rohe across Aotearoa are described as 'deprived' (Te Puni Kōkiri, 2018). In these areas whānau often have multiple and complex hauora needs. For example, cannabis culture and accompanying addiction rates were particularly noted in Māori communities within Northland; "borne from the absence of adequate resources" (Te Puni Kōkiri, 2010, p. 36). Anderson, Mills, & Eggleton (2017) studied whānau experiences of acute rheumatic fever (ARF) in Northland. This included investigating barriers and facilitators for diagnosis of ARF. The authors note that the majority of ARF cases are diagnosed within the most 'deprived regions' with the highest rates most noticeable in Northland, the Bay of Plenty, Gisborne and South Auckland. The authors state that Māori children aged between 5-15-years living in Northland have some of the highest ARF rates nationally. This is related to socio-economic deprivation and household crowding, which are both known to be related to ARF within Aotearoa. In addition, Baker and Pipi (2014) also noted the high rates of domestic violence amongst whānau living within Whangarei and surrounding areas. Anecdotal reports from whānau-centred hauora providers connected to Maori communities in these areas, linked these high incident rates to intergenerational abuse caused through decades of deprivation. These authors argue that the capability of whānau and whānau-centred providers to achieve collective hauora in such areas, is severely constrained by limited employment options and the wider regional economic context (Baker & Pipi, 2014).

> **While an area maybe economically deprived, they can also be culturally rich in terms of cultural capital.**

Other authors have highlighted the difference that context and environment make to both hauora outcomes and whānau engagement in whānau-centred primary health care. For example, Allport et al., (2017) note specific, multiple challenges that some urban whānau face, particularly in Auckland. They cite rising housing and transport costs as well as various expenses associated with the health and nutrition needs of whānau living within Auckland. However, Paipa and Smith (2014) note that while an area maybe economically deprived, they can also be culturally rich in terms of cultural capital, with easy access to local marae and in terms of numbers of Māori speakers.

Limited options for whānau with lived experience of disability

Whilst many authors noted the importance of recognising and responding to whānau diversity, we found only two reports that specifically addressed the issue of disability (Elder, 2017); King, 2019). Elder's (2017) study examined the experiences of whānau with traumatic brain inquiry, whilst King's report examined evidence related to whānau lived experiences of disability. Both authors note that Māori are over-represented both in instances of brain inquiry and in general disability.

"According to Crown data submitted to the Tribunal, there are 176,000 Māori with lived experience of disability compared with 885,000 non-Māori in Aotearoa/New Zealand. Additionally, the prevalence of disability is higher for Māori than non-Māori. The proportion of Māori with lived experience of disability in 2013 was 23.9% compared with 15.6% for non-Māori. For Māori males it was 25.7% compared with 16% for non-Māori, and for Māori females it was 22.1% compared with 15% for non-Māori. Māori have higher proportions of disability across all age groups." (King 2019, p. 20)

Ableism is defined as discrimination or prejudice against people with lived experience of disability and this is particularly true for tāngata whaikaha (King, 2019). Currently there is a significant lack of data on Māori disability provider support services and up-to-date information suggests there are only a small number operating.

King (2019, p. 291) notes that, “The Ministry of Health (MoH) does not routinely identify or monitor the number of Māori-owned and Māori governed disability support service (DSS) providers and cannot provide information on MoH audits of Māori DSS providers. However, in response to the information request under the Official Information Act, the MoH undertook a manual review of providers contracted to deliver Disability Support Services (DSS) and those who have received Māori Provider Development Scheme funding. Although there are caveats around the quality of the information, it does indicate that there are only a small number of Māori Disability Support Services providers (the review identified 33) operating in a large disability support service sector (total of 980 providers).”

> **Māori with lived experience of disability have few options when it comes to accessing disability support services provided by Māori."**

Māori with lived experience of disability have few options when it comes to accessing disability support services provided by Māori. “There are potentially only 33 providers nationwide, and geographically there are a number of areas where they are not available” (King, 2019, p. 356). These limited options for whānau with lived experiences of disability severely constrain their ability to be self-determining within primary health care settings.

Section summary

Whānau are at the very heart of whānau-centred primary health provision. However, whānau rangatiratanga and capability development is influenced by different layers of a much larger eco-system of primary health care, that has poorly served whānau aspirations and needs. Whānau are diverse and have different strengths, needs and experiences of primary health care. This means primary health care needs to cater for diverse whānau, acknowledge their expertise, utilise their strengths and have a variety of engagement and access points. There are gender differences in terms of how tāne and wāhine engage in primary health care – this means whānau-centred programmes need to address and be inclusive of gender and sexuality differences. Wāhine, tāne and takatāpui can be influential change agents, therefore whānau-centred programmes need to utilise their knowledge and expertise. Further research needs to examine the role of tāne and takatāpui in whānau-centred programmes, to address whakamā and fear for others.

The area or rohe (rural or urban) that whānau live in makes a difference in terms of access to cultural, social, and economic resources. Environments make a difference and whānau in deprived areas can have multiple and complex health needs. Whānau-centred providers in these rohe need additional time and resourcing, to combat the legacy of intergenerational harm.

Whakawhanaungatanga is a key enabler and whānau support can come from relatives, friends and/or colleagues. Whānau-centred programmes need to be inclusive of kaupapa whānau, who may or may not be Māori. The cost of health care is a barrier for many whānau, suggesting whānau-centred primary health care needs to be low, or no, cost. Whānau who are caregivers are challenged to meet the needs of whānau with long-term or terminal health issues – this means whānau-centred primary health care needs to include caregiver support.

Māori whānau who have lived experience of disabilities are poorly served by the primary health care system. Whānau-centred primary health care needs to be inclusive of Māori specific disability services with a strengths-based, not deficit, approach.

Addressing the impact of colonisation on whānau and acknowledging that ill-health was not normal for Māori prior to Europeans arriving, is an important part of collective healing, and requires a de-colonising approach. The health debt owed to whānau, caused by colonisation, racism and decades of economic deprivation that have influenced whānau hauora is noted in the literature. Healing is an essential part of whānau transformation, particularly for whānau experiencing physical, spiritual, and emotional trauma.

> **Whakawhanaungatanga is a key enabler and whānau support can come from relatives, friends and/or colleagues."**

Enablers and barriers

Associated with provision of whānau-centred primary health care

The following section highlights findings related to the factors associated with whānau-centred services and programmes, that enable or act as barriers to whānau rangatiratanga and strengths-based approaches. Often analysis indicated the absence of an enabler was itself a barrier, so these themes are interconnected and interdependent. An important enabler that emerged was a clear model of whānau-centred primary health care provision. This section starts with the acknowledgement of this.

Enablers

A clear model of practice

Many authors highlighted the need for a clear model of practice (or framework of practice, theory of change, or logic model) that defined whānau-centred primary health care provision within specific communities. The model of practice needed to be linked to core provider values (Abel et al., 2012; Alcorn, 2011; Baker, Pipi & Cassidy, 2015; Berghan et al., 2017; Chant, 2011; Cram, 2014b; Elder, 2017; Harwood et al., 2018; McClintock & McClintock, 2018; Paipa & Smith, 2014; Lakhotia, 2017; Te Pūtahitanga o Te Waipounamu, 2016).

As indicated in earlier sections of this literature review, Te Puni Kōkiri (2015) has published a report ‘Understanding whānau-centred approaches: Analysis of Phase One Whānau Ora research and monitoring results.’ The analysis provided in this 2015 report emphasised essential components of whānau-centred practices. These are:

- Establish relationships that benefit whānau
- Build whānau rangatiratanga (whānau capability to support whānau self-management, independence, and autonomy)
- Build a capable workforce – grow a culturally competent and technically skilled workforce able to adopt a holistic approach to supporting whānau aspirations
- Ensure whānau-centred services and programmes – whānau needs and aspirations at the centre, with services that are integrated and accessible
- Ensure supportive environments – funding, contracting and policy arrangements, as well as effective leadership from government and iwi (tribes) to support whānau aspirations

Two fundamental aspects of whānau engagement were also identified:

- Culturally anchored practices (for Māori this would be in te ao Māori) and;
- use of whanaungatanga/relationships as a tool to connect and build whānau capability (Te Puni Kōkiri, 2015).

Other authors have called for 'Tiriti-based' health practice (Berghan et al., 2017). Tiriti-based health practices aligns strongly to values and concepts such as "kāwanatanga, tino rangatiratanga, ōritetanga and wairuatanga" (Berghan et al., 2017, p. 8). Berghan et al. (2017) state that "whanaungatanga, is the active process of building relationships though shared experiences and connections, critical to Tiriti-based practice and a prerequisite of authentic engagement. It sets the tone for all relationships with Māori" (p. 19). Importantly, these authors argue that, "within these Tiriti-based relationships, the ability of Tauiwi to listen and act on advice and input from Māori is central at all levels. It is not simply about building any relationship, it is about the pursuit of the "right relationship" (Huygens 2006, p. 370).

Such a relationship recognises each party's sphere of influence, and each party works towards learning about the practice of relating to each other" (p. 19). Developing cultural safety is an essential part of Tiriti-based practice (Berghan et al, 2017). Citing the work of Crengle, and McCreanor (2006) Berghan et al. (2017) identify several principles including: mana, tapu, he kanohi kitea, whanaungatanga, manaakitanga, koha, and aroha ki te tangata. "Collectively understanding and valuing these principles can guide an endeavour to work safely, with Māori communities and maintain cultural safety. By cultural safety we mean:

1. Reflecting on one's behaviour and understanding oneself as cultural bearer
2. Understanding the socio-political context and the impact of inter-generational trauma and colonisation
3. Working to develop trust
4. Implementing te Tiriti in practice" (Berghan et al, 2017, p. 40).

In addition, it is important that models of whānau-centred primary health care provision provide explicit criteria for evaluation purposes. This is essential for kaimahi reflective practices, tracking whānau progress over time and organisational learning (Baker, Pipi & Cassidy, 2015; Berghan et al, 2017; Elder, 2017; Moss & Pipi, 2014; Savage et al., 2017; Te Pūtahitanga o te Waipounamu, 2016). Cram (2014b) in her discussion on what is needed to effectively measure Māori wellbeing, cites the work undertaken by Pitama et al. (2007) and the Meihana Model that was based on Durie's paradigm of Te Whare Tapa Whā. She notes that, "The Meihana Model is a framework to guide mental health clinical assessment and

Tiriti-based health practices aligns strongly to values and concepts such as kāwanatanga, tino rangatiratanga, ōritetanga and wairuatanga

intervention with Māori clients and whānau (Pitama et al., 2007). The development of the model was initially informed by a literature review and key informant interviews with 25 health clinicians focusing on how they were implementing Te Whare Tapa Whā within their practice. The effectiveness of the framework that emerged from this initial investigation was then tested with clients and their whānau. The resulting six- dimension framework (Te Whare Tapa Whā, plus taiao and iwi katoa) was then "tested to see if it helped clinicians to engage with Māori patients" (Pitama et al., 2007, p. 119). It was then recommended that the use of the model occur within a multilayered, systemic approach to Māori mental health" (Cram, 2014b, p. 24).

Whanaungatanga: quality relationships and strengths-based partnerships

As indicated in the previous section, whānau rangatiratanga is critical to the development and success of whānau-centred primary health care. Local ownership Is considered a major strength of Māori-centred primary health care (Allport et al., 2017; Baker & Pipi, 2014; Paipa & Smith, 2014; Pipi et al., 2003) as regional communities are best positioned to identify and control their own health aspirations and needs. Tribal involvement is critical to the design and ownership of primary care intervention (Shahid et al., 2018; Te Puni Kōkiri, 2015; Pipi et al., 2003).

Local ownership is considered a major strength of Māori-centred primary health care.

The success of primary health care for Māori, Aboriginal, Torres Straits Islanders, Native Americans and First Nations people is their participation in the design, implementation and/ or evaluation of primary care health initiatives (Allport et al., 2017; Ball, 2010; Brown, 2010; Chant, 2011; Davy et al., 2016; Gibson et al., 2015; Harfield et al., 2018; Margeson & Gray, 2017; McCalman et al., 2017; Pipi et al., 2003).

Representation of whānau with diverse abilities in whānau-centred health provision is essential for ensuring equitable health outcomes (King, 2019). Therefore, whānau-centred programmes must align to the various strengths and needs of whānau members. For example, Tan, Carr & Reidy (2012) investigated the link between investment in primary health care and increased access to primary care for high need populations resulting in improved health outcomes within Aotearoa. The authors cited a range of 'youth-friendly service developments' for rangatahi. These included school clinics in Porirua, two youth-centred health services in Wellington and Kāpiti, subsidised sexual health services, rangatahi-led health promotion initiatives and rangatahi engagement activities that improved primary care utilisation for young people. The authors reported increased youth engagement and a decrease in avoidable admissions. Tan et al. (2012) noted that Māori provision in primary health care settings improved other families' engagement in primary health care across all ethnicities. The elements of the approach to service delivery from Māori providers worked for other ethnic groups, not just Māori (ibid).

Quality relationships underpin whānau-centred approaches to primary health care

It is essential that primary health care is planned and implemented around the whole whānau, recognising, and supporting whānau functioning; through communication, maintenance of relationships in healthy ways, decision making and problem solving (Allport et al., 2017; Harfield et al., 2018). Regardless of the kaupapa, whānau-centred service provision health promotions and interventions needed to be credible for the Māori communities they seek to serve, and relevant to their needs (Berghan et al, 2017; Moss & Pipi, 2014).

Quality relationships underpin whānau-centred approaches to primary health care (Baker & Pipi, 2014; Cram, 2014a; Cram, 2014b; Moss & Pipi, 2014; Paipa & Smith, 2014; Savage et al., 2017; Smith & Emery, 2015). Whanaungatanga fortifies "everything" in whānau-centred primary health care (Moss & Pipi, 2014, p. 2). Trusting, respectful and reciprocal relationships are essential to whānau-centred provision, but developing such relationships takes time (ibid). The focus on the whole whānau as part of their work practices, places additional demands on providers as they must extend whanaungatanga and gain the trust of others. Moss and Pipi note that features of quality relationships underpinning whānau-centred service provision include:

- Genuineness: real; sincere
- Reciprocity: there is a mutual or cooperative interchange of favours or privileges
- Tika: following tikanga in Māori and professional terms; right according to nature and purpose of the engagement
- Pono: integrity; honour; truthfulness; mana enhancing (on the premise of valuing culture)
- Aroha: compassionate; non-judgmental; congruent thoughts, feelings, and actions; respectful
- Empathy: ability to feel and share another person's emotions
- Openness and honesty (2014, p. 4).

It is the quality of relationships in whānau-centred primary health provision that determine outcomes, (Moss & Pipi, 2014, p. 2). Local knowledge, trustworthiness and credibility is important for networking and connecting whānau and providers (Savage et al., 2017). Community leaders, community champions and involvement of local gatekeepers encourage whānau engagement (Brown, 2010; Cram, 2014a). Examples of whānau capability building initiatives can be seen in the Whānau Ora Commissioning Agencies as they are networked and connected to their Māori communities (Savage, Dallas-Katoa, Leonard, Goldsmith, & Fraser, 2017; Wehipeihana et al., 2016).

> **Whānau Ora Commissioning Agencies are networked and connected to their Māori communities**

Savage et al. (2017) note that the Whānau Ora Navigator approach has been identified by the Productivity Commission (2015) "as a key example of an integrated whānau-centred approach supporting seamless access to health and social services" (p 5). They interviewed 27 Navigators, seven chief executives or managers from Navigator host agencies and two whānau who had worked alongside a Navigator. Findings emphasised the importance and impact of whanaungatanga. "Navigators describe their role as 'walking alongside whānau', the work is led by whānau with their dreams and aspirations leading the way. The freedom to respond to whānau in a way that is not constrained by Western constructs of support allows the Navigators to work in more naturalistic ways. .... Whanaungatanga is the foundation of the approach" (Savage et al., 2017, p. 5). Four recommendations emerged from their research. These included the need to continually improve the Navigator network; create a foundation of reflective learning, introduce an induction process, investigate qualifications and recognition, develop a whānau outcome progression framework and strengthen relationships with host agencies (Savage et al., 2017, p. 5).

Acknowledging the importance of the quality of relationships, several authors have stated that this requires doctors and others working in the health profession to enact cultural safety (Curtis et al, 2019). "Cultural competency, cultural safety and related terms have been variably defined and applied. Unfortunately, regulatory, and educational health organisations have tended to frame their understanding of cultural competency towards individualised rather than organisational/systemic processes, and on the acquisition of cultural-knowledge rather than reflective self-assessment of power, privilege, and biases. This positioning has limited the impact on improving health inequities. A shift is required to an approach based on a transformative concept of cultural safety, which involves a critique of power imbalances and critical self-reflection. Health practitioners, healthcare organisations and health systems need to be engaged in working towards cultural safety and critical consciousness. To do this, they must be prepared to critique the 'taken for granted' power structures and be prepared to challenge their own culture and cultural systems rather than prioritise becoming 'competent' in the cultures of others. The objective of cultural safety activities also needs to be clearly linked to achieving health equity. Healthcare organisations and authorities need to be held accountable for providing culturally safe care, as defined by patients and their communities, and as measured through progress towards achieving health equity" (p. 15).

Fusion of mātauranga Māori and clinical approaches

The fusion of mātauranga Māori and clinical approaches is considered vital (Allport, 2017; Ball, 2010; Chant, 2011; Cram, 2014a; Elder, 2017; Harwood et al., 2018; Gibson et al., 2015; Lewis

& Myhra, 2017; Medical Council of New Zealand, 2019b). Holistic approaches to whānau-centred approaches require whānau-centred service providers to collaborate with others. Lakhotia stresses that “in order to support whānau success, solutions must go beyond a single programme or provider” (2017, p. 1).

However, this can only be achieved through effective partnerships and quality relationships that build trust between whānau, clinicians and local Māori community stakeholders. The combination of mātauranga Maori and clinical approaches enables flexibility and a holistic approach in terms of whānau-centred service provision (Boulton et al., 2013; Harwood et al., 2018; Lewis & Myhra, 2017). It is imperative to address the cultural, spiritual, and environmental needs of whānau as well as those associated with clinical aspects (Ball, 2010; Harwood et al., 2018; Margeson & Gray, 2017). Consideration of the whole person and the context in which they live is essential (Elder, 2017; Lewis & Myhra, 2017). The role and use of nursing staff working in the community has been highlighted as effective, particularly when they can take the lead in working with whānau (Cram, 2014a). However, this also requires nurse practitioners to enact cultural safety, and be responsive and respectful.

In their description of whānau-centred practice, Boulton et al. (2013) note the need to work across such boundaries. They argue that integration of services must emerge from a cultural understanding of the wellbeing of the whole whānau and be underpinned by an approach that works with whānau to attain and sustain hauora and wellbeing. For example, Kidd et al.’s (2013) study of tāne with chronic illnesses and disease emphasised that clinicians who enabled participants to “be Māori” were viewed as more caring. In those instances, tāne reported feeling valued and more hopeful about their situations. They also engaged in discussions about approaches to treatment and demonstrated improved levels of health literacy. This means clinicians and other health professionals need to value, and be respectful of mātauranga Māori as well as believe in, and encourage whānau expertise.

> **Services must emerge from a cultural understanding of the wellbeing of the whole whānau**

In a study of urban Māori in West Auckland, Allport et al. (2017) reported that whānau aspirations related to health and wellbeing were related to ‘their desire to become more culturally aware’. This meant developing their knowledge and expertise in te ao Māori and to express their health and wellbeing in ways which were important to them. A positive cultural identity is critical to Māori health and wellbeing (Durie, 1999; Te Puni Kōkiri, 2010).

Flexibility of approach

Flexibility of whānau-centred primary health care is essential (Allport, 2017; Abel, Marshall, Riki & Luscombe, 2012; Baker & Pipi, 2014; Harwood et al., 2018; Gibson et al., 2015; McCalman et al., 2017; Shahid et al., 2018; Smith & Emery, 2015). Examples include the provision of home-based care, use of local culturally based institutions for education/training and the provision of transport. Flexibility of approach also enables the employment of local whānau (kaumātua and kuia), who may not have certified qualifications but have expertise in mātauranga Māori and tikanga (Allport, 2017). Successful programmes are flexible in nature and embrace co-ownership and partnership (Baker & Pipi, 2014; Harwood et al., 2018; Lakhotia, 2017; Savage et al., 2017; Shahid et al., 2018).

Baker and Pipi (2014) undertook action research to better understand the impact of 'Te Hau whiowhio o Otangarei' in Otangarei (Northland). Te Hau whiowhio o Otangarei is a collective of six non-government organisations, as part of the Whānau Ora kaupapa. One of the objectives of the research was to evaluate the effectiveness of whānau-centred service delivery to assist whānau to achieve Whānau Ora. The authors noted many strengths and outcomes associated with this whānau-centred provision, and that achieving whānau rangatiratanga was complex and took time.

For example, to meet the hauora needs of whānau experiencing domestic violence in Northland, whānau were able to access a range of supports, including interpersonal counselling, partner and whānau support, and skills training. Skills training included anger management, parenting and communication skills and strengthening relationships (Baker & Pipi, 2014). Whānau outcomes included feeling accepted and safe, addressing domestic violence and improved physical and emotional safety for tamariki and wāhine. Flexibility of approach was a key enabler in that wāhine and tāne had different pathways for accessing services and support. Wāhine often sought assistance directly, while tāne were more likely to access services indirectly through women, whānau or community forums. Whānau-centred services need to be flexible and are designed to meet the needs of wāhine and tāne. The process of transformation was connected to the healing process, and a flexible approach to co-ordination of support. It also took considerable time (ibid).

In another study, Harwood et al. (2018) describe a case study of Mana Tū, a partnership approach in primary health care. Although it works with people from a range of ethnicities it is described as a 'uniquely Māori-led' programme, developed and facilitated by the National Hauora Coalition. It aims to support whānau to better control type 2 diabetes through self-management of their condition and holistic approaches. Another goal is to address the health and social barriers that inhibit whānau from living well with their condition. The programme was developed collaboratively by clinicians and whānau who had experience of living with type 2 diabetes. Identified health issues included a lack of knowledge of healthy eating and medications, and the need for more physical activity. Social barriers were financial constraints, housing, and transport issues. Harwood et al. (2018) note that Mana Tū has three major components: a Network Hub, Kai Manaaki (skilled case managers who work with whānau) and a cross-sector network of services to enable whānau to address the wider determinants of their hauora needs. It is important to note that the evaluation of Mana Tū has not yet been completed.

A strengths-based approach and holistic whānau capability development

A number of studies highlighted the importance of tools, resources and processes that enabled whānau to take charge of their health situations, utilised whānau strengths, were holistic and supported collective capability development (Allport, 2017; Boulton, & Gifford, 2014; Baker & Pipi, 2014; Cram, 2014a; Elder, 2017; Harwood et al., 2018; Gibson et al., 2015; Smith & Emery, 2015). 'Being healthy' meant that you and not others were in control of hauora decisions (Allport et al., 2017). Therefore, 'Doing things our own way' becomes the basis of whānau-centred approaches to hauora (ibid). Constructing whānau as 'at risk' or 'dysfunctional', rather than experiencing challenges, can negatively influence the way that providers respond to whānau and vice versa (Te Puni Kōkiri, 2010). Therefore, a strengths-based approach that fosters whānau resilience and capability development is essential (Te Puni Kōkiri, 2010).

A strengths-based approach that fosters whānau resilience and capability development is essential

Several approaches were commonly described, these included goal setting processes associated with whānau aspirations, such as pathway plans and processes for monitoring and celebrating progress (Allport, 2017; Boulton & Gifford, 2014; Smith & Emery, 2015). Appropriate needs assessments were also considered essential for creating a baseline to track progress over time (Elder, 2017; Boulton, Tamehana, & Brannelly, 2013; Harwood et al., 2018). One example noted by Elder (2017) is 'Te Waka Kuaka', a bilingual cultural needs assessment tool for whānau with traumatic head injuries. It was developed using theory building, whakawhiti kōrero, and Rasch analysis (psychometric testing). It is argued that this tool forms a baseline assessment of cultural and clinical needs and monitoring of these needs as part of a collaborative way of working with whānau called 'Te Waka Oranga'.

Other authors noted the importance of fit for purpose assessment tools, that enabled whānau to work with clinicians, community health workers and other practitioners to identify their health aspirations and needs; set achievable wellbeing goals; develop appropriate care and management plans; and chart progress in health and wellbeing over time (Boulton et al., 2013; Savage et al., 2017). Tools, resources, and processes needed to take a holistic approach and be strengths-based. Effectiveness in a Māori context is associated with an overall kaupapa that reflects localised Māori values and aspirations, using culturally appropriate models and methods and incorporating clinical approaches (Allport et al., 2017; Baker, Pipi & Cassidy, 2015; Ball, 2010; Chant, 2011; Margeson & Gray, 2017, Te Puni Kōkiri, 2010). Cram (2014a) notes the critical importance of whānau based, holistic health literacy programmes, tailored around whānau hauora aspirations and needs. However, she also notes that "The close involvement of Māori in the development of any wellbeing measure is essential for that measure to be culturally responsive and valid" (Cram, 2014b, p. 18).

Therefore, it is important that whānau-centred providers document how they engage with whānau to construct a clear model of practice, develop, and drive solutions, and determine their own outcome measures across different rohe.

The importance of a shared vision, core values and relational trust

The importance of a shared vision and core values underpinning whānau-led service provision was emphasised (Ball, 2010; Baker & Pipi, 2014; Baker, Pipi & Cassidy, 2015; Paipa & Smith, 2014). Achieving health equity goals and reducing disparities underpin the shared vision (Cram, 2014a).

Core values underpinning the components of one whānau-centred primary health care collective effective were tika, pono and aroha

Whanaungatanga and kotahitanga were often cited as enablers for successful whānau engagement, effective whānau-centred practice, and collaborative approaches to service delivery (Allport et al., 2017; Baker & Pipi, 2014; Baker, Pipi & Cassidy, 2015; Ball, 2010; Chant, 2011;

Margeson & Gray, 2017, Moss & Pipi, 2014; Te Puni Kōkiri, 2010). Such concepts are central to a Māori worldview and are a principle source of strength (Te Puni Kōkiri, 2010). Core values underpinning the components of one whānau-centred primary health care collective effective were tika, pono and aroha (Baker, Pipi & Cassidy, 2015). Associated values included reciprocity, rapport, consideration, and empathy (Baker, Pipi & Cassidy, 2015). Adherence to core values was essential for developing relational trust across the collective (Baker, Pipi & Cassidy, 2015).

A systematic literature review, synthesized findings from studies involving different indigenous communities including Māori, Native Americans, First Nations, Aboriginal and Torres Strait Islanders (Gibson et al., 2015). The analysis focused on identifying factors that enabled or inhibited the implementation of primary care interventions aimed at improving chronic disease care within these communities. Results indicated that health care providers needed to understand health from the perspective of the patient, and this could only be achieved through long-term, quality relationships. Effective programmes were developed through relational trust between clinicians, whānau and communities. In addition, successful programmes provided an 'indigenous space' underpinned by core community values. Findings from this systematic literature review highlighted the importance of clinicians' respect for the strong ties that indigenous communities have to family and their land (ibid).

Culturally safe, competent, capable workforce and service provision

A key enabler was the critical importance and impact of a culturally safe, competent, capable workforce (Allport, 2017; Abel, Marshall, Riki & Luscombe, 2012; Baker & Pipi, 2014; Baker, Pipi & Cassidy, 2015; Ball, 2010; Cram, 2014a; Crengle, 1999; Curtis et al, 2019; Harfield et al., 2018; Gibson et al., 2015; Kidd et al., 2013; Margeson & Gray, 2017; McCalman et al., 2017; Shahid et al., 2018; Smith & Emery, 2015; Te Puni Kōkiri, 2015). As noted earlier, a number of authors have argued that cultural responsiveness is not enough to achieve health equity for Māori (Curtis et al, 2019). Adherence to cultural safety, "requires individual health care professionals and health care organisations to acknowledge and address their own biases, attitudes, assumptions, stereotypes, prejudices, structures and characteristics that may affect the quality of care provided. Heightened critical consciousness and self-reflection in health care providers is required, and action on the basis of that self-reflection" (Curtis et al., 2019). It was noted that the term 'cultural safety' was first used by Dr. Irihapeti Ramsden and Māori nurses in the 1990s. Then in 1992, the Nursing Council of New Zealand made "cultural safety" a core component of midwifery and nursing education. Cultural safety is described as providing "a focus for the delivery of quality care through changes in thinking about power relationships and patients' rights" (Curtis, 2019, p. 12).

"Cultural safety is about acknowledging the barriers to clinical effectiveness arising from the inherent power imbalance between provider and patient. This concept rejects the notion that health providers should focus on learning cultural customs of different ethnic groups. Instead, cultural safety seeks to achieve better care through being aware of difference, decolonising, considering power relationships, implementing reflective practice, and by allowing the patient to determine whether a clinical encounter is safe." (Curtis et al., 2019, p. 13). The Medical Council of New Zealand (2019a) also states that "cultural safety in the healthcare environment has an important role to play towards achieving health equity for Māori" (p. 1).

Parity of participation and representation is also important in whānau-centred health provision. Employing local Māori staff enables a community's cultural values, beliefs, and customs to be infused into primary health service delivery (Allport, 2017; Harfield et al., 2018; Margeson & Gray, 2017). This contributes to other benefits including local employment and training for whānau and enabling kaumātua and kuia oversight. Whānau-centred providers embody an understanding of "being Māori" and the positive impacts this has for whānau in terms of engagement and health-related outcomes (Baker & Pipi, 2014).

> **Whānau-centred providers embody an understanding of 'being Māori'**

A literature review carried out by McCalman et al. (2017), found that Aboriginal and Torres Strait Islander families' views about family-centred primary health programmes in Australia could not be separated from their appreciation of the qualities and abilities of the staff they engaged with. These individual qualities were considered more important than the staff member's ethnicity. Culturally competent and capable staff have effective inter-personal, communication and problem-solving skills; show compassion and are non-judgmental (McCalman et al., 2017; Ball, 2010). They also follow through on promises made to whānau, believe in their expertise, and motivate them (Baker & Pipi, 2014; Baker, Pipi & Cassidy, 2015; Savage et al., 2017).

Effective primary health service providers for Māori communities are committed to spending extra time and resources to gain the confidence and trust of whānau (Ball, 2010; Baker & Pipi, 2014; Shahid et al., 2018). Kaimahi working with whānau enable them to share their own stories. This is extremely important so that kaimahi can clarify and address the real issues impacting whānau (Baker & Pipi, 2014). It is important that such relationships are reciprocal; whānau are responsive to staff, and vice versa. The relationship needs to be conducive to whānau driving their own self-actualisation and supportive of whānau maintaining their own health and wellbeing (Baker & Pipi, 2014; Baker, Pipi & Cassidy, 2015; Moss & Pipi, 2014).

Reflective, relational, and evidence-based practices

Whānau strengthen their capacity through relevant and appropriate support, education, tools, and resources. However, Boulton and Gifford's (2014) noted the fine balance between "doing for" whānau (that encourages dependence on the services provided) and "empowering" whānau members to develop resilience and take responsibility for making the necessary changes within their own lives. Therefore, a strengths-based, collaborative, and reflective approach is vital (Moss & Pipi, 2014). However, this can only be achieved when kaimahi, whānau and other stakeholders (such as programme leaders) engage in a reciprocal process of reflecting on progress against a clear outcomes framework (Moss & Pipi, 2014).

> **A strengths-based, collaborative, and reflective approach is vital**

However, Curtis et al., (2019) argue that effective, reflective practice must include "an assessment of power, privilege and biases" not just of the individual health care worker but also of the organisation (p. 13). They state that, "health practitioners, healthcare organisations and health systems need to be engaged in working towards cultural safety and critical consciousness. To do this, they must be prepared to critique the 'taken for granted' power structures and be prepared to challenge their own culture and cultural systems rather than prioritise becoming 'competent' in the cultures of others. The objective of cultural safety activities also needs to be clearly linked to achieving health equity. Healthcare organisations and authorities need to be held accountable for providing culturally safe care, as defined by patients and their communities, and as measured through progress towards achieving health equity" (p. 1).

In addition, the authors argue that "Unfortunately, regulatory and educational health organisations have tended to frame their understanding of cultural competency towards individualised rather than organisational/systemic processes, and on the acquisition of cultural-knowledge rather than reflective self-assessment of power, privilege and biases" (p. 13).

Other authors have noted improvement tools such as the Health Equity Assessment Tool (Berghan et al., 2017). These authors note that the Ministry of Health commissioned the development of this tool to assist health workers and decision-makers decide whether practices and/or policies were increasing or decreasing health disparities. They argue that "It is most useful in planning, and works at both strategic and operational levels, but users need a level of political and cultural competence to ensure that analysis is robust" (Berghan et al., 2017 p. 33). This highlights the need to invest in and further support the ongoing development of whānau-centred primary health care providers.

Ongoing workforce development, regular training, and supervision

Ongoing professional development, training and supervision is critical in achieving effective, whānau -centred primary health care (Baker & Pipi, 2014; Harwood et al., 2018). In the 'Mana Tū' programme six kaimanaaki represent a variety of diabetes-related backgrounds including nursing, social work, education, and community workers. In addition to the usual training regarding diabetes and its management, kaimanaaki are trained in cultural safety, motivational interviewing, and health literacy. Kaimanaaki live and contribute in the local communities across metro-Auckland and in Whangaroa in Te Tai Tokerau. They meet regularly for peer support and review, and quality improvement activities and mentorship with qualified health professionals and are provided with other capacity building opportunities (i.e. workshops, conferences, report writing).

Kaimahi and Navigators need to be 'doubly qualified' (Smith & Emery, 2015) both culturally and professionally. They need to be flexible and open to learning as they work with whānau to address their needs and aspirations (Smith & Emery, 2015). They need to work collaboratively with other agencies to address goals for whānau and often this can mean working with marae, trusts and economic authorities to support better outcomes for whānau (Smith & Emery, 2015). It is important that they are known and credible to the communities they serve (Smith & Emery, 2015). They need to identify and gather data that is a priority for tracking, monitoring, and reporting outcomes (ibid). Analysis of literature demonstrates that working in a whānau -centred way is essential yet complex work and resourcing is needed to support front-line staff for on-going development.

> **Kaimahi and Navigators need to be 'doubly qualified'**

The importance of tuākana-tēina relationships that ensure all staff members (including leaders and those at the governance level) are mentored appropriately has been noted (Moss & Pipi, 2014). Findings from the Takitini Whānau Ora Action Research Collective emphasised the importance of adhering to the principles of a tuakana-teina relationship. These authors note that such a relationship is integral to Māori society. It 'provides a model', whereby a more experienced tuakana can provide mentoring support to a less experienced teina. Such roles can be reversed through ako (reciprocal teaching and learning) so that the tuakana becomes the teina in a different situation and vice versa (Moss & Pipi, 2014).

Fit for purpose information systems, systemic monitoring, and evaluation

The importance of 'fit for purpose' information systems (data-bases) and/or systematic record keeping necessary for tracking whānau progress, ensuring service provision and enhancing organisational learning was highlighted as important in several studies (Cram, 2014a; Pipi, 2014;

Harwood et al., 2018; Shahid et al., 2018). A clear outcomes framework enables providers to define and measure improved outcomes/wellbeing for whānau and ensures accountability to whānau, hapū, iwi and the government (Savage et al., 2017; Te Pūtahitanga o te Waipounamu, 2016). Baker and Pipi (2014) highlighted the importance and impact of community-based, grass-roots research teams and partnerships that enabled whānau-centred providers to improve their services. Harwood et al. (2018) note that information systems need to 'allow innovative data capture' during whānau home visits and clinical practice. Mobile tablet devices enable whānau progress to be recorded in real time. In addition to recording whānau progress over time, systemic record keeping involved claims, referrals, compliance reporting, budget management and clinical decision support and analysis (Savage et al., 2019). It is imperative that whānau data is stored in secure ways and providers adhere to the 1993 Privacy Act.

However, Durie (2006) has argued that measuring health related outcomes for whanau must be tied to six essential whānau capacities. These include:

- **Manaakitanga** – Whānau care
- **Pupuri taonga** – Guardianship
- **Whakamana** – Empowerment
- **Whakatakato tikanga** – Planning
- **Whakapūmau tikanga** – Cultural endorsement
- **Whakawhanaungatanga** – Whānau consensus

Durie (2006) notes that the development and strengthening of these six whānau capacities should be reflected in the whānau health plans, and monitoring processes. Therefore, multiple sources of data are needed to determine the achievement of the following related outcomes. Consequently, evidence needs to be centred on:

- **Manaakitanga** – That whānau achieve a strong sense of identity, are well cared for, enjoy a quality lifestyle, a sense of independence, share concern for wellbeing of other whānau members
- **Pupuri taonga** – That whānau are actively involved in decision- making about whānau estate, there is an increase in value of whānau assets
- **Whakamana** – That whānau participate as Māori in te ao Māori and te ao whānui
- **Whakatakato tikanga** – That consensus is reached about strategies for whānau development, and protection of interests for future generations
- **Whakapūmau tikanga** – That whānau ensure access to whānau cultural heritage, including fluency in te reo Māori
- **Whakawhanaungatanga** – That whānau decision- making processes strengthen

whānau inter- connectedness and collective action (Durie, 2006)

Clear governance structures and effective leadership

Effective leadership and clear governance structures are critical to whānau-centred approaches (Allport et al., 2017; Ball, 2010; Boulton et al., 2013; Cram, 2014a; Crengle, 1999; Harwood et al., 2018; McCalman et al., 2017; Pipi et al., 2003; Pipi; 2014). This requires Māori representation and ownership at a governance level if whānau-centred primary health care provision is going to address local needs (Crengle, 1999). Hapū and iwi representation is necessary given the differences in regional and community needs across Aotearoa (Boulton et al., 2013). Strategic plans, business plans and Memorandums of Understanding with iwi are essential for organisational management (Pipi et al., 2003).

> **Effective leadership and clear governance structures are critical to whānau-centred approaches**

Berghan et al, (2017) note that “many community sector organisations use a two house or waka hourua (double-hulled) power sharing approach to governance” (p. 24). These authors argue that values and concepts such as “kāwanatanga, tino rangatiratanga, ōritetanga and wairuatanga” are central to effective governance (p. 8). However, the extent of Māori and whānau expertise available for governance may vary depending on the size of the provider (Crengle, 1999).

Effective whānau-centred leadership is close to the ground and includes incorporation of local Māori community champions (Allport et al., 2017). Leaders are agents of change. They can motivate and enhance the desires and or competencies of whānau (Allport et al., 2017). Leaders in whānau-centred primary health contexts may not always have the ‘formal’ qualifications, but they have acquired the necessary life skills and experiences to promote hauora within whānau and the wider community (ibid).

> **Effective whānau-centred leadership is close to the ground and includes incorporation of local Māori community champions**

Achieving health equity goals and reducing hauora disparities are key for organisational effectiveness, but requires committed leadership (Cram, 2014a). It is equally important that leaders of whānau centred services provide space to develop, trial and evaluate the delivery model and be prepared to learn through failure (Paipa & Smith, 2014).

In addition, effective leadership ensures internal and external accountability through robust and transparent reporting (Pipi et al., 2003). Provider success was associated with completion of contractual requirements and having the capability and capacity to deliver services and/or programmes. Effective leaders communicate high expectations of staff members to work in whānau-centred ways (Pipi et al., 2003). They set health equity goals as a clear expectation and have credibility with staff and community (ibid). Leadership is an essential component of effective partnerships with other services, whānau and the community as it enhances the culture of the organisation and ensures effective partnership approaches (McCalman et al., 2017).

Barriers

The absence of the enablers identified above, often resulted in considerable barriers to the provision of whānau-centred primary health care practice. Key barriers that emerged in this layer are introduced next.

A lack of a clear definition and/or model of whānau-centred primary health care

A plethora of terms are used to describe the relationship between Māori and primary health care. It was very difficult to identity what defined or differentiated 'whānau-led, or whānau-centred' as these terms appeared to be used interchangeably with 'Māori-led, 'iwi-led', 'family-centred' and/or 'community-centred' (as reported by overseas studies involving Aboriginal and Torres Strait Islander communities in Australia, First Nations peoples in Canada, and Native American communities in the USA). In addition, the make-up of service provision was often not reported. The size of the provider may also be an issue in terms of enablers and barriers, as it was difficult to ascertain how large organisations/service providers were and the degree to which this impacted their ability to provide whānau-centred primary health care. Alcorn (2011) argues that little is known about differences in models of care and how these are related to whānau health and wellbeing across service providers in various rohe. In addition, little is known about how these are constructed between whānau and providers.

Power Imbalances – distrust and negative past experiences

Whānau-centred care is based on the principle that whānau bring expertise at both the individual care-giving level and the systems level (Moss & Pipi, 2014; McCalman et al., 2017; Shahid et al., 2018). However, there is a considerable lack of studies that report the extent to which diverse groups of whānau actively contribute to primary health care service provision and policy development (King, 2019; McCalman et al., 2017; Palmer et al., 2019; Rainbow Youth Inc & Tīwhanawhana Trust, 2017; Snijder et al., 2015). Whānau can be suspicious of 'new' initiatives, including those associated with Whānau Ora as they have seen many such initiatives come and go, with no meaningful change (Smith & Emery, 2015). Due to distrust and negative past experiences whānau can be reluctant to participate in governance, despite providers being 'whānau -centred'. Smith and Emery (2015) report that this can create a "chicken and egg" scenario whereby whānau-centred providers intend to engage whānau in contributing directly to their vision and strategic planning, however whānau may be reluctant to engage until providers make clear their priorities and processes. Building trusting relationships takes time and a process of establishing credibility with whānau (Smith & Emery, 2015). This includes a willingness to go above and beyond, particularly in rohe that are underserved.

> **Whānau-centred primary health provision needs to affirm takatāpui mana and identity**

Colonisation has erased the histories and stories of takatāpui across different rohe, so takatāpui rangatahi often face considerable discrimination, that negatively impacts their hauora and mana. Homosexuality was illegal in Aotearoa until 1986. With the arrival of the colonisers the only valid sexual identities have been those associated with heterosexual, cisgendered and/or monogamous norms (Rainbow Youth Inc & Tīwhanawhana Trust, 2017). Whānau-centred primary health provision needs to affirm takatāpui mana and identity and ensure primary health programmes are inclusive and effective for their needs.

King (2019) highlights the severe lack of representation and participation by tāngata whaikaha (Māori with lived experiences of disability) in governance related to the health and disability system. "Aspirational statements about Māori participation at all levels of the health and disability system lack follow through generally, and this is amplified when it comes to Māori with lived experience of disability. There are no Māori with lived experience of disability on the boards of any district health board in Aotearoa/New Zealand. Crown organisations do not ensure Māori with lived experience of disability are part of advisory groups, participation in the health and disability workforce by Māori with lived experience of disability is not well documented, and the number of Māori owned and Māori-governed providers involved in disability support service provision is greatly outweighed by their non-Māori counterparts" (King, 2019, p. 349).

> **Community involvement is critical in evaluation as it determines the effectiveness of the project for local tribes.**

A lack of representation of diverse whānau, in developing and strengthening whānau-centred health care provision is a barrier to ensuring whānau-centred programmes (King, 2019; Rainbow Youth Inc & Tīwhanawhana Trust, 2017). Snijder et al. (2018) conducted a systematic literature review to identify the extent of community participation in community development projects aimed at improving primary health care within Australian Aboriginal communities. The extent of community participation was assessed using a participation typology, which described seven-levels of community participation. This ranged from 'no participation' (completely top-down) to 'self-mobilisation' (completely bottom-up). These authors caution that community participation can change during primary health care interventions, so the extent of community participation was evaluated separately across four phases of programme development. The four phases included: diagnosis such as identifying a community's priorities; development such as appropriate processes and strategies to address these priorities); implementation of the processes and strategies); and evaluation. Community involvement is critical in evaluation as it determines the effectiveness of the project for local tribes. Thirty-one evaluation studies of Aboriginal community development projects were analysed. Results indicated that community participation varied between different phases of project development, and were generally high during project implementation, but much lower during the evaluation phase. This unequal participation for local communities to effectively engage in evaluation of programmes that are designed to meet their needs, highlights a significant lack of respect for their knowledge. This lack of representation in evaluation activities highlights significant barriers to whānau rangatiratanga, underpinned by unequal power relationships.

Power imbalances – clinician versus whānau

As identified earlier, local whānau and community governance is seen as critical for Māori hauora, however clinical leadership is also considered vital (Ball, 2010). A considerable barrier to the development of whānau-centred practices emerges when clinicians take an 'expert view' and discount important Māori values and practices (Ball, 2010). Consequently, this in turn creates distrust and a lack of respect for whānau mātauranga. Problems with power imbalances were noted in another study (Farnbach et al., 2017). These authors conducted a systematic literature review on published health care research focused on improving the social and emotional wellbeing for Australian Aboriginal and Torres Strait Islander communities. Results emphasised the importance of a holistic and strengths-based perspective of mental health and wellbeing for these communities. However, the authors noted that 'evidence-based' evaluation and research methods were typically developed within a Western cultural perspective that did not incorporate Aboriginal and Torres Strait Islander communities' social, cultural or historical perspectives. Findings emphasised the inappropriateness of 'traditional' clinically based, or academic measurements and evaluation methods because they discounted community views about what constituted evidence and rigour.

The formation of trusting relationships takes time and cannot be rushed (Ball, 2010; Cram, 2014a; Paipa & Smith, 2014). Partnership approaches that involve different organisations, that mix different cultural and clinical procedures, practices and communities together is challenging work (Paipa & Smith, 2014). Specific barriers to quality partnerships include: a lack of trust and shared vision/values; competitive funding environments; lack of effective governance structures; and vague, irrelevant accountability mechanisms (Ball, 2010).

Others note the considerable barriers to te Tiriti-based health practices can only be addressed by adherence to important values and principles, such as kāwanatanga, tino rangatiratanga, ōritetanga and wairuatanga (Berghan et al., 2017, p. 8). However, these authors note that many organisations have limited scope and mandate to enact kāwanatanga. "While the appointment of Māori operational staff may strengthen the Māori capacity of an organisation and provide benefits, it does not necessarily address the requirements of kāwanatanga. Māori participants in this study argued that kāwanatanga is about Māori input into the highest levels of decision-making, rather than operational participation. This includes representation on governance boards, on steering and advisory committees, and/or being part of senior management teams" (Berghan et al., 2017, p. 23). Others argue that culturally safe practices require acknowledgement and removal of power imbalances, privilege, and racism implicit within the health-care system (Curtis et al., 2019).

> **Culturally safe practices require acknowledgement and removal of power imbalances, privilege, and racism implicit within the health-care system**

Significant difficulties with funding, contracting, and reporting requirements

The most cited barrier was difficulties with funding (Brown, 2010; Boulton et al., 2013; Crengle, 1999; Gibson et al., 2015; Harfield et al., 2018; Margeson & Gray, 2017; Pipi, 2014; Pipi et al., 2003). This was a multi-faceted barrier as it was linked to contracting and reporting requirements, development of appropriate information systems as well as developing and sustaining culturally competent and capable staffing. Whānau-centred primary health care providers experience additional costs that were often not funded by contracts. Resources and services need to be mobilised around the whānau (Boulton et al., 2013). This often requires kaimahi to work in innovative ways with other health care providers but working inter-sectoral and innovatively is not usually recognised in contracting arrangements that have specific outputs-based reporting requirements (Boulton et al., 2013; Baker & Pipi, 2014; Lakhotia, 2017; Savage et al., 2017).

> **Whānau-centred providers need to be non-judgemental and respectful of whānau experiences, whilst at the same time supporting them to progress**

Given the diverse, high and complex health needs of many whānau (particularly in deprived areas), progress is not linear and often requires much more time and investment than traditional contracting arrangements allows (Brown, 2010; Boulton, Tamehana & Brannelly, 2013; Baker & Pipi, 2014; Crengle, 1999; Harfield et al., 2018; Margeson & Gray, 2017; Pipi, 2014; Pipi et al., 2003). The complexity and trajectory of change is not provided for in the contracting and accountability reporting often with, narrow, nationally prescribed, fixed set of indicators or measures. Baker and Pipi emphasise the challenge that whānau-centred providers encounter when attempting to track whānau progress over time. This is due to whānau transformation being complex and not necessarily linear. It can take time for whānau to develop rangatiratanga and achieve improved health and wellbeing outcomes. Dealing positively with inevitable setbacks and challenges that are often encountered, is an important process that strengthens whānau resilience. However, this means that whānau-centred providers need to be non-judgemental and respectful of whānau experiences, whilst at the same time supporting them to progress (Baker & Pipi, 2014).

Funding that does not ensure adequate representation, sustain or further develop the workforce

One of the many challenges faced by whānau-centred primary health care services is their ability to maintain culturally safe, competent and capable staffing, whilst at the same time further developing their workforce (Brown, 2010; Harfield et al., 2018; Margeson & Gray, 2017; Moss & Pipi, 2014; Pipi, 2014). Retention of staff is an issue, as qualified, credible community health workers are highly desirable. However, they can also face issues of burn out and stress (Brown, 2010). This is particularly evident when working with whānau with high and complex needs. Many primary care health workers in Māori communities ‘go the extra mile’; adapting resources in their own time and using their own personal funds to supply food or transport (Brown, 2010; Harfield et al., 2018; Margeson & Gray, 2017). Contracting arrangements do not cover the full scope of what front lines workers do (Lakhotia, 2017). “Terms such as FTE, caseloads and contracts are often redundant in the world of Kaiārahi, (navigators) who work outside of such structures to achieve the best outcomes for whānau" (Lakhotia, 2017, p. 1).

Living in the community means front-line staff are more accountable and are often at the receiving end of whānau frustration over the lack of government accountability. In their evaluation of Whānau Ora Navigator practice, Savage et al. (2017) identified a variety of challenges that Navigators faced in their role. Challenges included employment related concerns and the need to ensure their personal safety, particularly as they worked to support whānau with drug and alcohol addictions and anger issues. In addition, Navigators often experienced racism, frustration and challenges when advocating for whānau with government agencies and schools (Savage et al., 2017).

Māori led primary health care providers may not have sufficient funding to ensure all their workers are able to undertake health promotion courses, regular supervision and/or professional development. In addition, timing of courses may conflict with workloads and there may be limited staff availability to cover for staff attending workshops (Brown, 2010).

Difficulties in funding, short-term contracts and uncertainty often means providers cannot guarantee kaimahi sustained or full employment. This is a major barrier to sustaining and further developing a culturally competent and capable workforce (Pipi, 2014). Such problems with funding have also been noted internationally. As indicated earlier, a systematic literature review synthesised research involving indigenous communities from the US, Canada, Australia, and New Zealand on the factors that inhibit the implementation of interventions aimed at improving chronic disease care for indigenous peoples (Gibson et al., 2015). A major inhibitor was the lack of sustainable funding as indigenous-specific services often needed to rely on a multitude of short-term government funding arrangements which threatened their sustainability and resulted in overwhelming reporting requirements.

> **The scarcity of available Māori, Pacific male primary health care workers, therapists and clinicians is identified as an ongoing issue**

The challenge of ensuring equal representation and participation by employing local community health workers reflective of the families they seek to serve, has been noted as a significant barrier in Australia, Canada, and the USA (Lewis & Myhra, 2017). The scarcity of available Māori, Pacific male primary health care workers, therapists and clinicians is identified as an ongoing issue (Abel et al., 2012; Canuto et al., 2018; Kidd et al., 2013). It is important that primary health care programmes and services do not disproportionately benefit some groups over others (Abel et al., 2012; King, 2019). Therefore, much more needs to be done to ensure adequate representation of whānau-centred primary health care workers across intersections of ethnicity, disability, age, gender, sexuality, socio-economic status, as well as across rural and urban settings.

Section summary

Whānau-centred services and programmes in the primary health context are critical to whānau rangatiratanga and capability development. A number of key interconnected enablers and barriers were highlighted. Enablers at service provision included a clear model of practice. This needed to be underpinned by quality relationships and partnerships that ensured whānau ownership and participation. The model of practice also needed to fuse together mātauranga Māori and clinical approaches. This also emphasised the need for a shared vision, core values and relational trust to guide whānau-centred primary health care practice. Given the diversity of whānau and their strengths, aspirations and needs, it was important that whānau-centred primary health care was flexible and localised. Whānau-centred tools, resources and processes supported whānau rangatiratanga, strengths-based approaches and holistic whānau capability development. The key enabler to all of this was the involvement of a culturally safe, competent, and capable workforce and service provision needed to support their development. Whānau-centred primary health care providers needed to ensure reflective, relational, and evidence-based work-place practices. Critical reflection must acknowledge and redress power imbalances across whānau-centred health provision. It was essential that providers working with whānau are able to reflect on their relationships with whānau and the degree to which efforts resulted in strengthening whānau rangatiratanga and improved hauora. Ongoing workforce development, regular training and supervision were key enablers to this, as were 'fit for purpose' information systems and systematic record keeping for monitoring and evaluation purposes. To ensure culturally safe and effective practices there needs to be clear governance structures and effective leadership that address kāwanatanga and whānau rangatiratanga. Providers needs to be accountable to whānau they seek to serve, this also requires robust accountability systems and transparency.

Barriers to whānau-centred primary health care were the absence of key enablers. Evidence highlighted the major inhibitors included a lack of a clear definition/model of whānau-centred primary health care. Related to this were power imbalances, particularly approaches that did not recognise whānau expertise and/or positively respond to whānau diversity negatively impacting on whānau rangatiratanga and hauora. These power imbalances were most noticeable at the clinician level, indicating a lack of shared vision, core values and relational trust to underpin primary health care provision. However, such power imbalances are infused within the wider health system and have a direct impact on the provision whānau-centred primary health care. For example, associated barriers included difficulties with funding, contracting, and reporting requirements that negatively impacted on whānau-centred primary health care provision. In particular, lack of funding meant significant challenges in sustaining and/or further developing a culturally safe, competent, and capable workforce, necessary for whānau-centred primary health care provision.

Finally, greater alignment is needed across different levels if effective whānau-centred practice is to be sustained (Moss & Pipi, 2014). These levels include the wider primary health and policy sector, whānau-centred primary health providers, funders, regional health & social services, iwi, and other Māori stakeholders (Moss & Pipi, 2014, p. 2). The following section highlights results that emphasise the importance and impact of this third interconnected layer; that is, the enablers and barriers associated with government policies, funding, and systems arrangements.

> **Greater alignment is needed across different levels if effective whānau-centred practice is to be sustained**

Enablers and barriers

Associated with government policy, funding and accountability

This section highlights evidence related to enablers and barriers related to government policy, funding, and accountability mechanisms. Results indicated these worked in ways to either strengthen or inhibit the provision of whānau-centred primary health care provision.

Enablers

A whole of system approach: Adherence to Te Tiriti o Waitangi and Whānau Ora

The importance of a 'whole systems approach' to strengthen and sustain whānau-centred primary health care was a key theme across multiple studies (Boulton et al., 2013; Cram, 2014a; Curtis et al., 2019; Gibson et al., 2015; King, 2019; Ministry of Health, 2002; Palmer et al., 2019; Pipi et al., 2003; Moss & Pipi, 2014; Ministry of Health, 2010; Te Puni Kōkiri, 2018; Wehipeihana, Were, Akroyd & Lanumata, 2016). In Aotearoa, Te Tiriti o Waitangi protects Māori rights to self-determination (Berghan et al., 2017; King, 2019; Palmer et al., 2019; O'Sullivan, 2019; Health Quality & Safety Commission, 2019) and obliges the state to ensure that public policy is as effective for Māori as it is for everybody else. Palmer et al. (2019) note that, "Aotearoa New Zealand has a governance system with the capacity to address health inequity as required by the Treaty of Waitangi. This system includes robust quantitative data collection and reporting on social determinants of health, legislative structures that enable intersectoral action on equity, a governmental framework linked to budget, and a strong public health system" (Palmer et al., p. 13).

Te Tiriti as a system enabler of transformation was highlighted in the analysis. This requires greater adherence to Te Tiriti at all levels to ensure government policies, practices and systems support and strengthen whānau-centred primary health care, and better address health inequities for Māori (Berghan et al., 2017; Health Quality

& Safety Commission, 2019). It was noted that, "Fundamentally, te Tiriti o Waitangi is central to the functioning of our health system, whether there are inequities or not. The Crown must meet its Treaty obligations. Te Tiriti o Waitangi is Aotearoa New Zealand's most important equity tool and framework for monitoring the Crown's performance in meeting its responsibility to ensure Māori rights to health. Te Tiriti o Waitangi is the founding document of Aotearoa New Zealand as it is now and in the future, and it is embedded in the legislation that underpins our health and disability sector through the New Zealand Public Health and Disability Act 2000" (Health Quality & Safety Commission, 2019, p. 49)

> **Fundamentally, te Tiriti o Waitangi is central to the functioning of our health system**

The power and impact of Whānau Ora as a government policy to address health inequities, improve whānau rangatiratanga and capability development has also been noted (Boulton et al., 2013; Ministry of Health, 2010; Te Puni Kōkiri, 2018; Health Quality & Safety Commission, 2019). Boulton et al. (2013) acknowledge the policy and principles of Whānau Ora as imperative to achieving and strengthening whānau-centred primary health care and highlight the collective responsibility of the Crown and Māori to adhere to it. It is argued that "Essentially, Whānau Ora is a systems-change approach that advocates for a whole-of-government response, using its full range of policy levers (across many sectors, not just those specific to health) to reduce inequity and promote whānau wellbeing" (Health Quality & Safety Commission, 2019, p. 52).

He Korowai Oranga is identified as "a strategic tool that the government and the health and disability sector can use to work together with iwi, Māori providers and Māori communities and whānau to ensure Māori have equitable health outcomes through access to high-quality health and disability services. Its key focus is on pae ora as a strategic direction for Māori health for the future. Pae ora brings together three interconnected elements: mauri ora – healthy individuals; whānau ora – healthy families; and wai ora – healthy environments" (Health Quality & Safety Commission, 2019, p. 52).

In addition, much more needs to be done to secure greater alignment of such policies across various government departments that have an impact on whānau rangatiratanga and capability development (Te Puni Kōkiri, 2018). The resilience of whānau "is inextricably linked to the wider imperatives of Māori development and the success and resilience of Māori as distinct collectives" (Te Puni Kōkiri, 2010, p. 14). Cram (2014) argues that the overall health system in Aotearoa must be committed to achieving hauora goals for Māori communities. However, this requires a 'whole of government approach' as there are factors outside the direct control of the health sector that also shape the health of Māori communities (Ministry of Health, 2002; Health Quality & Safety Commission, 2019). These include education, housing, employment, and policies designed and implemented by local and national government. Therefore, interventions to improve Māori health require a partnership approach at different levels; nationally, regionally, and locally (Ministry of Health, 2002).

> **Whānau-centred primary health care provision requires government stability and commitment over time.**

Therefore, it is imperative that the wider policy environment is developed in collaboration with whānau, hapū, iwi and whānau-centred primary health care providers (Pipi et al., 2003; Palmer et al., 2019). Whānau-centred primary health care provision requires government stability and commitment over time. Policies that will best support continued Māori provider success are those designed by whānau, hapū and iwi because they are in touch with their communities; their aspirations and needs (Pipi et al., 2003).

Palmer et al. (2019) emphasise the need to better understand how "socio-economic, political and public policies influence whānau experiences of primary health services and programmes" (p.1). These authors argue that involving whānau in qualitative and participatory research must move beyond micro issues (such as whānau experiences of primary health services and programmes) to a broader "macro-level in ways that can inform a broader range of structural policies to address health inequities" (p. 1).

> **Misunderstandings and a lack of acknowledgement across government agencies and/or adherence to 'what counts' as hauora, whānau rangatiratanga and mana motuhake have been noted.**

Such an approach calls for a shared vision of whānau-centred primary health provision across government agencies, as well as valid evaluation and monitoring processes that take a holistic view of whānau rangatiratanga and hauora outcomes. It is argued that government departments, funders, policy makers and researchers often use 'the right words' in primary health care documents and government policies, particularly around whānau rangatiratanga and community-led development. However, when whānau-centred providers have noted evidence of transformation within Māori communities, often government primary health officials fail and/or refuse to recognise it (Pipi et al., 2003). Misunderstandings and a lack of acknowledgement across government agencies and/or adherence to 'what counts' as hauora, whānau rangatiratanga and mana motuhake have been noted (Boulton et al., 2013; Pipi et al., 2003; Te Puni Kōkiri, 2018; Treaty of Waitangi 2019).

Greater collaboration with whānau, hapū and iwi for localised and regional approaches

The need for a more localised or regional approach if whānau-centred primary health care was going to strengthened was emphasised in a range of literature (Baker & Pipi, 2014; Boulton et al., 2013; Consan Consulting, 2012; Cram, 2014a; Gibson at al., 2015; McCalman et al., 2017; Ministry of Health, 2010; Te Puni Kōkiri, 2018). The involvement of hapū and iwi across different rohe is critical for developing and sustaining whānau-centred health care (Boulton et al., 2013; Pipi et al., 2003). Realising that potential of Whānau Ora requires the policy direction, design, and delivery of government services to be aligned to the localised needs of specific communities and whānau (Ministry of Health, 2010; Te Puni Kōkiri, 2018). Whilst it needs to be acknowledged that community-based development is hard work and time intensive (Department of Internal Affairs, 2016) it must be adaptable, flexible, and responsive (Boulton et al., 2013).

The importance of taking a regional approach to whānau-based primary health care was noted. A key strength of whānau-centred primary health care is the development of community advocacy to improve social and/or economic determinants of health (McCalman et al., 2017). Examples include rallying community support for young children and whānau; working to restrict alcohol sales and availability; providing advocacy and support for child access and protection, as well as advocating for better housing (McCalman et al., 2017). Regional and community differences need to be acknowledged and responded to, if whānau-centred primary health care is to make a difference for all (Baker & Pipi, 2014; Boulton et al., 2013). Locally defined performance measures are imperative to address local whānau health and wellbeing priorities, particularly in deprived areas (Te Puni Kōkiri, 2018). These measures can be changeable and need to be updated regularly, rather than established at the outset of a contract and never reviewed (Boulton et al., 2013). This presents a significant challenge to public policy, as the performance monitoring and accountability arrangements must also be responsive, flexible, and adaptable based on localised needs. A regional and localised approach enables whānau-centred primary health care providers, iwi, and other social service providers to work in interconnected ways; across employment, housing, and budgeting services (Boulton et al., 2013). The capability of whānau and whānau-centred provision to achieve collective hauora in high need areas, such as Northland, is severely constrained by limited employment options and the wider regional economic context (Baker & Pipi, 2014). This suggests more needs to be done to ensure current regional development work across Aotearoa supports intersectoral development that supports and addresses whānau wellbeing in a range of areas (primary health care, housing, financial literacy, education).

An analysis of literature for primary health care for Aboriginal and Torres Strait Islander peoples in Australia found that in geographically remote and rural situations indigenous health care workforce shortages became less of an issue when regional funding, governance, management and leadership, as well as linkages with community agencies and infrastructure were addressed (Gibson at al., 2015). In addition, results from an evaluation of GP Super Clinics involving Aboriginal communities and Torres Strait Islander peoples in Australia, found that a considerable barrier to sustaining exemplary models of community-based primary health care for these communities was the lack of a regional and strategic approach to local community engagement (Consan Consulting, 2012).

> **A regional and localised approach enables whānau-centred primary health care providers, iwi, and other social service providers to work in interconnected ways**

Improving and acting on the evidence base to better inform policy decisions

Improving and acting on a valid and reliable evidence base to strengthen whānau-centred primary health care policy across various rohe was noted by several authors (Cram, 2014a, Margeson & Gray, 2017; Palmer et al., 2019; Wehipeihana et al., 2016). Criticisms that the methodological quality of research for evaluating Australian Aboriginal community development projects argue that the primary health care is 'weak' (Snijder et al., 2015). However, such evaluations in Aoteaora must extend beyond mono-cultural, narrow definitions of health and wellbeing and include mātauranga Māori values and concepts. This has important implications for the trustworthiness of data and what counts as evidence (Health Quality & Safety Commission, 2019). In addition, it is argued that most studies involving indigenous communities consist of small-scale evaluations that have a limited timeframe and longitudinal research is now needed, along with long-term follow-up studies in order to improve the evidence base (Margeson & Gray, 2017).

> **Whānau Ora Commissioning Agencies have developed valuable data bases, related to whānau outcome data and this evidence should inform government policy and decision-making.**

Within Aotearoa Wehipeihana et al. (2016) argue that all three Whānau Ora Commissioning Agencies have developed valuable data bases, related to whānau outcome data and this evidence should inform government policy and decision-making. These authors note that these Commissioning Agencies will increasingly be able to describe 'what works', for whom and under what set of conditions (ibid).

Others caution though that improving the evidence base is not enough to improve Māori health care and outcomes (Palmer et al., 2019, p. 5). These authors argue, "In the last two-decades, there has been an increase in qualitative research to explore patient viewpoints to inform public policy and align health service development with consumer preferences and expectations. Despite this shift toward greater inclusion of patient voices in clinical health research, including with Māori consumers, health outcomes remain inequitable across numerous clinical settings in Aotearoa New Zealand and for indigenous and tribal peoples worldwide" (Palmer et al., 2019, p. 5). These authors contend that transformation will only be achieved when there is greater alignment and adherence across government agencies to Te Tiriti o Waitangi principles. They emphasise the importance of the Treaty of Waitangi, and its place within the health governance system to ensure "robust quantitative data collection and reporting on social determinants of health, legislative structures" that can enable "intersectoral action on equity" (Palmer et al., 2019, p. 13).

Barriers

In many ways the absence of the enablers identified above, create considerable barriers to the provision of whānau-centred primary health care. This next section identifies the major barriers that emerged at this third layer of analysis.

Failure of Crown agencies to adhere to Te Tiriti o Waitangi

The Crown failure to adhere to Te Tiriti o Waitangi has contributed to structural inequities for Māori (Waitangi Tribunal, 2019; Health Quality & Safety Commission, 2019). The recent release of Waitangi Tribunal findings from the first phase of 'Wai 2575 - the Health Services and Outcomes Inquiry' highlights this failure (Waitangi Tribunal, 2019). This inquiry is currently hearing "all claims concerning grievances relating to health services and outcomes and which are of national significance" (Waitangi Tribunal, 2019, p. 1). A key objective is to investigate claims related to the way the primary health care system in New Zealand has been "legislated, administered, funded, and monitored by the Crown since the passing of the New Zealand Public Health and Disability Act 2000 (p. xii)". In addition, the inquiry investigated whether the legislative, strategy, and policy framework that administers the primary health care sector is Treaty compliant. Findings from the first phase of this inquiry have highlighted widespread government failure to adhere to the principles of Te Tiriti o Waitangi; provide adequate funding and support for Māori primary health care provision; and collect and use sufficient data to improve primary health care sector for Māori. Evidence must be used to improve parity of participation for Māori as aligned to the principles of Te Tiriti o Waitangi (Health Quality & Safety Commission, 2019).

The report notes, "Although Māori are 16 percent of the total population, they are significantly under-represented in many key health professions. March 2019 data shows that only in care and support roles does Māori representation reach parity with overall population levels, with the smallest percentages of Māori in DHB workforces being those in senior roles, and junior doctors. (Within the care and support category the roles with the greatest reported percentages of Māori were Māori health assistants, nursing support workers, hospital orderlies and community workers.) Broken down by DHB, the pattern is distinctive: consistently, Māori representation in the health care workforce is approximately half that of the DHB population" (Health Quality & Safety Commission, 2019, p. 55).

According to a number of reports, there is clear evidence of multiple systemic, structural barriers that implicate Crown failure to adequately address Māori health outcomes and meet Treaty of Waitangi obligations (King, 2019; Waitangi Tribunal, 2019; Health Quality & Safety Commission, 2019). These failures have fuelled institutional racism and dominant, monocultural approaches that maintain inequities for Māori. The Waitangi Tribunal (2019) found that the Crown has failed to meet Treaty of Waitangi obligations, provide enough support for Māori health provision, and improve Māori health outcomes.

> **Failures have fuelled institutional racism and dominant, monocultural approaches that maintain inequities for Māori.**

The Crown recognises the importance of Māori health providers within the system change. "Māori primary health organisations and health providers are intrinsic to sustaining Māori health and wellbeing and are expressions of tino rangatiratanga. That the Crown fails to adequately resource these organisations, and further fails to govern the primary health care system in a way that properly supports them to design and deliver primary health care to their communities, is a serious Treaty breach. Overall, we concluded that the primary health care framework does not recognise and properly provide for tino rangatiratanga and mana motuhake of hauora Māori (xiv).

The Tribunal also found that in relation to the New Zealand Public Health and Disability Act 2000: “the framework fails to state consistently a commitment to achieving equity of health outcomes for Māori. We also found that the Treaty clause in the Act is not so much an elaboration as a reductionist effort at a Treaty clause: it simply does not go far enough in ensuring that the whole health system complies with the Treaty and its principles…. (and later) …. On the topic of funding, we found that Māori primary health organisations were underfunded from the outset. We further found that ongoing resourcing was a significant issue too: the funding arrangements for the primary health care system disadvantage primary health organisations and providers that predominately serve high-needs populations, particularly Māori primary health organisations and providers. The Crown has been aware of these failures for well over a decade but has failed to adequately amend or replace the current funding arrangements” (Waitangi Tribunal, 2019, p. xiii).

The Tribunal has made several interim recommendations for “structural reform of the primary health care system” within Aotearoa and one of these is the Crown commits to exploring the concept of a stand-alone Māori Primary Health Authority (xv).

Systemic, wider government failures have also been highlighted in overseas studies. McCalman et al., 2017 argue that indigenous family-centred programmes for Aboriginal Tribes in Australia are vulnerable to ‘lifestyle drift’. This means that government sponsored primary health care programmes often have evidence that emphasises the impact of structural and political causes of health disparities for tribal communities, but only address behavioural lifestyle efforts for these communities. Clearly more needs to be done to remove structural barriers at the government level to strengthen whānau-centred primary health care provision and whānau outcomes.

Section summary

A ‘whole systems approach’ is required to strengthen and sustain whānau-centred primary health care. In Aotearoa, Te Tiriti o Waitangi protects Māori rights to self-determination and obliges the state to ensure that public policy is as effective for Māori as it is for everybody else. The importance of proper adherence to Te Tiriti and ensuring government policies, practices and systems arrangements support and further develop whānau-centred primary health care, to address health inequities for Māori, cannot be understated. The power and impact of Whānau Ora as a government policy to improve whānau rangatiratanga and capability development was noted, alongside high level strategies such as He Korowai Oranga. Whānau-centred primary health care provision requires stability and government commitment over time. Improving and acting on a valid and reliable evidence base to strengthen whānau centred primary health care policy and achieve greater adherence to Te Tiriti o Waitangi was noted. But this can only be developed through more robust policies and funding mechanisms developed in partnership with whānau, hapū, iwi and whānau-centred primary health care providers.

> **A ‘whole systems approach’ is required to strengthen and sustain whānau-centred primary health care.**

There was the need for a more localised or regional approach if whānau-centred primary health care was going to strengthened. A key strength of whānau-centred primary health care is the development of community advocacy to improve social and/or economic determinants of health. A regional response recognises the expertise of whānau, hapū, iwi and whānau-centred primary health care providers across different rohe.

> **A regional response recognises the expertise of whānau, hapū, iwi and whānau-centred primary health care providers across different rohe.**

Locally defined performance measures are imperative to address local whānau health and wellbeing priorities, particularly in deprived areas. These measures can be changeable and need to be updated regularly, rather than established at the outset of a contract and never reviewed. This can present a significant challenge to public policy, as the performance monitoring and accountability arrangements must also be responsive, flexible, and adaptable based on localised needs. A regional and localised approach enables whānau-centred primary health care providers, iwi, and other social service providers to work in interconnected ways, across employment, housing and budgeting services. The capability of whānau and whānau-centred provision to achieve collective hauora in deprived areas, is severely constrained by limited employment options and the wider regional economic context. This suggests more needs to be done to ensure current regional development work across Aotearoa supports intersectoral development that addresses whānau wellbeing in a range of areas (primary health care, housing, financial literacy, education).

Finally, a significant barrier to achieving whānau-centred primary health care and improved hauora outcomes for all whānau has been the failure of Crown agencies to adhere to Te Tiriti o Waitangi; and collect and use sufficient and valid data to improve Māori health outcomes. This means ensuring the inclusion of Māori knowledge and worldviews, including Māori data and analysis approaches. The recent release of the Waitangi Tribunal findings from the first phase of 'Wai 2575 - the Health Services and Outcomes Inquiry' has emphasised this failure (Waitangi Tribunal, 2019). Clearly more needs to be done across government departments and agencies to ensure the Crown meets its Treaty of Waitangi obligations and supports whānau-centred primary health care provision.

> **More needs to be done to ensure current regional development work across Aotearoa supports intersectoral development.**

Discussion and recommendations

Findings demonstrated the interconnected layers that influence the provision of whānau-centred primary health care for all whānau and the development of whānau rangatiratanga. The importance of a 'whole of systems' approach and primary health care provision in Aotearoa that creates coherent and aligned spaces that enable whānau to self-define their own health needs is identified. This means ensuring whānau engage in collaborative processes that strengthen their development for self-determination and that whānau rangatiratanga must inform policy development across various levels of the health system (whānau and community development, service provision and programmes as well as government policies and funding arrangements).

The importance and influence of various layers or contexts was emphasised in findings. For example, the diversity and personal circumstances of individual whānau, as well as other contextual influences such as access to cultural and financial resources to strengthen whānau rangatiratanga within primary health care settings. Poverty and financial hardship are a considerable barrier, particularly for whānau in 'deprived' settings. Whānau-centred primary care service provision and programmes to support whānau rangatiratanga and strengths-based approaches in these areas is considered critical. However, such programmes depend on a culturally competent and capable workforce. The ability of organisations to sustain and further develop their workforce is severely constrained by current government contracting and funding arrangements. Each layer (individual whānau circumstances, service provision to support whānau rangatiratanga and government policy and funding arrangements) interact in ways that either enable or inhibit the strengthening of whānau rangatiratanga and ultimately hauora outcomes.

> **The ability of organisations to sustain and further develop their workforce is severely constrained by current government contracting and funding arrangements.**

It is imperative that the wider policy environment and funding arrangements for primary health care are developed in collaboration with whānau, hapū, iwi and whānau-centred primary health care providers. Such an approach calls for a shared vision of whānau-centred primary health provision across government agencies, as well as valid evaluation and monitoring processes that take a holistic view of whānau rangatiratanga and hauora outcomes. This emphasises the need for a more localised or regional approach if whānau-centred primary health care was going to strengthened. A shared vision of whānau-centred primary health provision across government agencies and stronger partnerships with whānau, hapū and iwi is required. Valid evaluation and monitoring processes that take a holistic view of whānau rangatiratanga and hauora outcomes are needed to support this shift.

> **Locally defined performance measures are imperative to address local whānau health and wellbeing priorities.**

Locally defined performance measures are imperative to address local whānau health and wellbeing priorities, particularly in deprived areas. These measures should be regularly reviewed and updated as needed, rather than fixed at the outset of a contract and never reviewed. This may present a significant challenge to public policy, however evidence from this literature review indicates that whānau-centred performance monitoring and accountability arrangements must be responsive, flexible, and adaptable based on localised needs. A regional and localised approach enables whānau-centred primary health care providers, iwi, and other social service providers to work in interconnected ways, across employment, housing and budgeting services. The capability of whānau and whānau-centred provision to achieve collective hauora in deprived areas, is severely constrained by limited employment options and the wider regional economic context. A key recommendation is that current regional development work across Aotearoa supports intersectoral development that further addresses and strengthens whānau wellbeing in holistic ways (encompassing primary health care, housing, financial literacy, education, and cultural identity).

Recommendations emerged from analysis to strengthen whānau-centred primary health care provision and whānau rangatiratanga. These included:

- Recognising that each layer of the wider eco-system interacts in ways that either enables or inhibits whānau rangatiratanga, whānau capability development and ultimately hauora outcomes across different rohe.
- Ensuring whānau-centred primary health provision and government policies and funding arrangements recognise and respond to the aspirations and needs of whānau across intersections of gender, sexuality, ethnicity, age, health status, socio-economic status, and dis/ability.
- The need for sustained, adequate funding for whānau-centred primary health provision, particularly across high needs areas and rohe.
- Ensuring whānau engage in collaborative processes that strengthen their self-determination and that whānau rangatiratanga informs policy development across various levels of the health system as well as other government agencies (whānau and community/regional development, housing, education, social services, financial literacy, drug and alcohol programmes etc).
- Ensuring wider government policy environments and funding arrangements for primary health care adhere to Te Tiriti o Waitangi obligations and are developed in collaboration with whānau, hapū, iwi

and whānau-centred primary health care providers.

- Ensuring greater collaboration and partnerships between government agencies, whānau, hapū, iwi and whānau-centred primary health care providers to define locally defined performance measures.
- Ensure performance measures include Mātauranga Māori; are adaptable, and updated regularly, rather than established at the outset of a contract and never reviewed.

Finally, it is important to acknowledge health equity issues and the health debt owed to whānau, caused through decades of economic deprivation and racism that have influenced whānau hauora. De-colonisation and healing are an essential part of whānau transformation, particularly for whānau experiencing physical, spiritual, and emotional trauma. This means whānau-centred primary health needs to be holistic, healing and strengths-based for diverse groups of whānau and further strengthened and sustained through government policies and funding arrangements that adhere to Te Tiriti o Waitangi and the policy of Whānau Ora.

Chapter 3

Pacific whānau ora primary health care

Introduction

Primary Health Care has long been viewed as a fundamental entry point to formal healthcare for individuals and families living in New Zealand. Quality primary health care as defined by the Ministry of Health (2001) is "essential health care based on practical, scientifically sound, culturally appropriate and socially acceptable methods that is i) universally accessible to people in their communities; ii) involves community participation; iii) integral to, and a central function of, New Zealand's health system; and iv) the first level of contact with our health system". For Pacific peoples living in New Zealand, primary health care has fallen short of its defined purpose and based on the experiences and outcomes of Pacific families (Ministry of Health, 2008a; Ryan, Southwick, Teevale, & Kenealy, 2011), has often failed to meet their health needs.

Pacific providers were established to help provide quality primary health care that aligned with Pacific models of health and service delivery (Ryan, Beckford, & Fitzsimmons, 2010). Policies and best practice frameworks were also developed to improve the quality of care for Pacific peoples (Ministry of Health, 2008a; Mauri Ora Associates, 2010). The evolution of Pacific primary health care has enabled the provision of holistic, culturally aligned services that are delivered within Pacific communities. Moving towards the delivery of Pacific models of primary health care has also helped to leverage the cultural strengths of Pacific peoples. However, this movement is not without its challenges as described later in this review. Providers have identified strengths and challenges in their attempts to deliver Pacific primary health care that meets the diverse needs of Pacific families within the remits of the health system. The introduction of the Whānau Ora framework and its principles of family self-determination has helped to leverage the ability of providers to deliver Pacific approaches that address their health aspirations and goals and to acknowledge and address broader determinants of health.

> **For Pacific peoples living in New Zealand, primary health care has fallen short of its defined purpose and based on the experiences and outcomes of Pacific families.**

This chapter describes the findings from a review of literature of Pacific family-centred/family-led primary health care. An initial search resulted in a limited number of publications, however upon exploring literature on Pacific primary health care and their enablers and barriers and the Pacific primary health care movement towards more holistic models of health, a greater number of documents were found to be relevant to the discussion on family centred and family led primary health care.

Background

Pacific health outcomes in relation to Primary health care

Research to date highlights the complex circumstances that influence Pacific family health aspirations and needs as well as the enablers and barriers towards their engagement with primary health care services. Notably, the findings by Ryan et al. (2019) indicate that Pacific peoples have high rates of primary care and GP service utilisation, similar to rates of non-Pacific and non-Māori. Nonetheless, Pacific peoples have by far the highest Ambulatory Sensitive Hospitalisation (ASH) rates which coincide with the conditions that are "considered to be reduced through preventative measures (and therapeutic) interviews delivered in primary care" (Ryan, Grey & Mischiewski, 2019). In relation to the ASH rates among Pacific children, Pacific ASH rates for children have increased over the past decade while the ASH rates for Pacific adults have worsened widening the gap between Pacific to non-Pacific and non-Māori ASH rates. The report by Ryan et al. (2019) discusses the issues of mismatches of cultural values between the health system from the cultural values of families. As such the cultural worldviews between the health sector and that of Pacific communities, clash as services are at times discriminatory seen in the way Pacific families experience care influencing their future health seeking behaviour (Ryan, Grey & Mischiewski., 2019).

Issues with poor access to primary care is shown in the high percentage of Pacific peoples utilising Accident & Emergency clinics particularly outside of normal working hours (Davis et al., 2005). The study by Davis and colleagues (2005) indicate the high preventable and avoidable hospitalisation rates for communicable diseases such as respiratory illnesses among Pacific peoples (Davis et al., 2005). The high avoidable hospitalisation rates were coupled with lower rates of follow-up requests and lower levels of rapport with their health care provider. The low follow-up requests may reflect the poor rapport of Pacific patients with their health care providers (Davis et al., 2005). The poor vā with Pacific patients may also mean that Pacific peoples are deprived of the necessary diagnosis and treatment services needed to prevent avoidable hospitalisations.

> **Issues with poor access to primary care is shown in the high percentage of Pacific peoples utilising Accident & Emergency clinics.**

Evidence indicates the discrepancies between Pacific patients attending community-governed non-profit providers versus for-profit non-community-based Pacific practices (Davis et al., 2005). Pacific patients received a much higher level of service within community general practices (non-profit) where referral rates were higher compared to for-profit providers (Davis et al., 2005). The high percentage of Pacific patients utilising community-governed not-for-profit providers may reflect access to lower-fee paying GP services, and the vision of providers to serve disadvantaged communities of whom many are Pacific (Crampton et al., 2004). Such service provider characteristics can be seen as enablers of access to primary care services among Pacific peoples.

On the other hand, the high demand of community based non-profit services lead to other system barriers such as long waiting times (Southwick et al., 2012). Long waiting times has been reported as a barrier to accessing primary care services (Ryan et al., 2011). Southwick et al, (2012) states that practices with good management oversight of appointment systems do not experience delays in access to care. Although improved appointment systems may be necessary, these GP practices are usually under-staffed, and with the staff that are on duty, they are usually over-worked which can contribute to the long waiting times. Coupled with the freedom of doctors who choose when to arrive and when to leave the practice, implementing improved appointment times alone may not be feasible in reducing long waiting times.

A study by Brown (2018) indicates the issues of cultural incompetency held by overseas health care professionals. There seems to be a lack of awareness of Pacific cultural worldviews where members of families were often viewed by medical and nursing staff as an annoyance. Despite the study being undertaken in the hospital setting such views may also be held by primary health care practitioners (Brown, 2018). The families felt that they were unable to make a complaint about the poor care they were receiving from the services out of fear of repercussions made to the quality of care received (Brown, 2018). Racism experienced by Pacific peoples at all levels of the health care system is a common issue (Anderson et al., 2019; Arlidge et al., 2009; Brown, 2018; Pacific). Families from these studies have noted the differential treatment received by families of different ethnicities.

> **Racism experienced by Pacific peoples at all levels of the health care system is a common issue.**

In relation to cultural insensitivity is the issue of poor Pacific ethnic specific data collected that is routinely collected and accessible. Improved data collection that is evidence based is required to identify the extent of effective primary health care service provision for Pacific families. Unpublished findings from Ryan et al (2019) identified the lack of standardised data linked to ethnicity within primary care. They state that there seems "to be no secondary care data governance requirements to support policy on equity for Pacific" (p.2).

> **Family's expectations of secondary health services and professionals were often based on negative healthcare experiences that undermined their confidence.**

The findings from Ryan et al. (2019) point out the racial discrimination families have as families of different ethnic groups are treated differently to them are the language used, resources offered, and assumptions made about them also differ.

The majority of Pacific families have had negative experiences of primary health care which can have long lasting consequences. Such negative experiences are not limited to primary health care. The same report also indicated how family's expectations of secondary health services and professionals were often based on negative healthcare experiences that undermined their confidence and curtailed their ability to challenge hospital processes where necessary (Ryan et al., 2019). This in part may provide some indication on the reason why some Pacific families are less likely to complain about the level of service and care received. The issue however is that the perceived lack of respect of an unresponsive or unsympathetic doctor and system which can discourage future attendance (Ryan et al., 2019).

The provision of Pacific Whānau Ora

Whānau Ora, as a government initiative, began in 2009, with the development of an evidence-based framework to strengthen whānau capabilities and self-determination (Taskforce for Whānau-Centred Initiatives, 2010). In 2014, the government expanded Whānau Ora to include Pacific families, while also devolving the programme to three non-government commissioning agencies. Pasifika Futures, a Pacific owned and led organisation, was appointed as the Whānau Ora Commissioning Agency for Pacific families. Since 2014, Pasifika Futures has commissioned Pacific family wellbeing outcomes, including health outcomes, through a network of 51 partners organisations across New Zealand (Jensen, Sorensen & Jensen, 2019).

Pasifika Futures has utilised a culturally anchored, evidence-based performance framework with commissioned partners, focussed on the achievement of a holistic set of Pacific family wellbeing outcomes (Jensen, Sorensen & Jensen, 2019). The Outcomes Framework (Figure 1) measures and frames Pacific family prosperity and wellbeing. Health is one part of four key aspirational outcomes for Pacific families are; succeeding in education through lifelong learning; healthy Pacific families living longer and better lives; economically independent and resilient families with financial freedom; and leading and caring for families, communities, and country.

> **Pasifika Futures has utilised a culturally anchored, evidence-based performance framework with commissioned partners.**

The success of the Pacific Whānau Ora Programme is reflected in the results reported in 2019 Quarter 4 Report and in a 2018 evaluation report with a wide range of wellbeing outcomes, including improvements in health for Pacific families. Pasifika Futures reports high engagement and reach across the Pacific population in New Zealand with engagement of 15, 556 families or 81,525 individuals (27% of the Pacific Population) and achievement of over 39,000 wellbeing outcomes since 2014 (Pasifika Futures, 2019).

Pasifika Futures reported analysis of family assessment results shows that after one year in Whānau Ora, 61 percent (531/877) of all high need families have reduced their need level and after two years in Whānau Ora, 87 percent (764/877) of high needs families have reduced their needs level (Pasifika Futures, 2019). Since 2014, notable health improvements reported by families engaged in Whānau Ora and having completed at least two assessments include the following (Pasifika Futures, 2019):

Pacific Whānau Ora Outcomes Framework

Prosperous Pacific Families

	Succeeding in education	**Healthy lives**	**Economically independent and resilient**	**Leadership, culture and community**
Long term Achievement (6-10 yrs+)	**Lifelong learning** • Increased achievement across all educational pathways	**Living longer, living better** • Increased quality of life expectancy rate for Pacific families	**Financial freedom** Pacific families will have: • Increased capital wealth • Increase in average income levels • Increase in home ownership	**Leading and caring for our families, communities and country** • Increased leadership in Pacific families, communities and country • Increase number of Pacific people in leadership roles
Medium term Engagement (3-5 yrs)	**Pacific families are:** • Achieving educational success • Supporting and nurturing educational success • Increase in the number of students achieving NCEA level 2 and 3 and Universtiy entrance • Increase in the number of students achieving tertiary studies and training qualifications • Increase in the number of families improving their literacy	**Pacific families are:** • Smoke free • Physically active and making healthy eating choices • Managing their health in partnership with health professionals • Actively participating in national screening programmes • Increase in families engaging in regular physical activity • Increase in families national screening rates • Increase in the number of non-smokers	**Pacific families are:** • Economically independent and resilient • Reducing their indebtedness • Owning and operating their own businesses • Increase in employment rates • Increase in level of savings • Increase in average income levels • Increase in the number of owned businesses	**Pacific families are:** • Living in healthy, safe & violence-free environments • Strong leaders, influential, foster resilience and empower each other to improve their lives • Accept and advocate for the inclusion of our diversity • Involved and influential in their civic duties • Increase in number of parents on school boards • Increase in Pacific people voting in local, regional & government elections • Increase in Pacific people on local, regional, community & national boards • Reduction in incidence of mental illness & addiction • Reduction in incidence of women, children & elders experiencing abuse
Short term Participation (1-2 yrs)	**Pacific families are:** • Well prepared for schooling • Indentifying their educational pathways • Understanding how to support and nurture educational success • Increase in children enrolled in quality early childhood education • Increase in students enrolling in teritary, traders and training qualifications	**Pacific families are:** • Embarking on the journey to live a smoke-free and healthy lifestyle • Partnering with health professionals in the management of their health • Fully immunised • Progressing towards achieving their aspirations for those living with disabilities • Enrolled with a primary carer practice and have a family health plan • Increase in families participating in smoking cessation support services • Increase in families recieving the full set of vaccinations as per the National Immunisation Schedule • Accessing services for long-term conditions and to support those with disabilities	**Pacific families are:** • Becoming economically independent • Engaging with support to reduce their debt • Engaged in a range of pathways that provide successful employment and business opportunities • Increase in families using banking services and facilities better • Increase in families enrolling in a range of employment and business courses	**Pacific families are:** • Taking leadership in providing healthy and safe environments for their families • Strong in their cultural captital and sense of belonging • Understanding the diversity of our communities • Actively participating in their communities • Increase in participation in culture and language programmes • Increase in the profile and participation of families in community and national events for our diverse Pacific communities • Increase in participation in parenting and relationship programmes that support healthy and safe environments • Participating in local, regional, national and Government events

Figure 2: Pacific Whānau Ora Outcomes Framework

Critical success factors

For Pacific family-led primary health care

The following section outlines critical success factors that influence Pacific family engagement in primary health care and the provision of family-centred primary health care for Pacific peoples. Analysis of literature highlighted the following themes:

- The importance of fostering vā (relationships)
- Self-determination and empowerment of families
- The ability of providers to establish and deliver integrated care models to provide family-led primary health care approaches
- A skilled Pacific workforce that possess language and/or cultural skills

In addition, analysis of literature highlighted how these critical success factors were also influenced by government policy, funding, and accountability mechanisms. The following section explores these results.

Fostering vā (relationships)

Pocknall (2009) describes the importance of health care providers establishing ongoing positive relationships with their patients. She informs that the relationship developed between health care professionals and their communities can influence future access to health care services among their children, as a form of continuity of care becomes established where rapport, trust and reciprocity is formed between the health care professionals and the community. Continuity of care was an important factor that aids the trust between provider and patients as patients increase their confidence in the providers ability to provide meaningful health advice and medication (Pocknall, 2009).

Continuity of care was an important factor that aids the trust between provider.

Congruently, the feeling of being connected to ones' health provider was a key finding from the study by Pocknall (2009) which aided the positive relationship between health care professionals and patients. The quality of care received by the Pacific participants was based on their sense of vā with the health care professionals (Southwick et al., 2012). If vā was based on mutual respect and cultural competency, it was likely that a positive relationship was established enabling ongoing continuity of care as trust is nurtured (Pocknall, 2009). Therefore, vā that is harmonious is intrinsically linked to cultural competency enabling continuity of care, which ought to be practiced by PHOs and GP practices. Contradictorily, poor relationships with practitioners were indicated when practitioners were seen as disinterested in the child during consultations, which led to participants becoming reluctant to see that practitioner again, indicating that the attitude of practitioners and racial discrimination which is a barrier in accessing primary health care services.

Self-determination and empowerment of families

The report by Molineux and Pandi (2019) supports the need for more community advocacy and in particular that there needs to be "strong, confident local provision that shapes the direction of policy rather than respond to it" in order to shift the power to communities (p.8). Outcomes-focused approaches that equip families with the right support and reorients power to the families enable self-empowerment and self-determination of their own overall health and wellbeing (Molineux & Pandi, 2019; Jensen et al., 2019). Solutions should be co-created by families and not forced by providers as families know best what will work for them and will not. However, what may work for individual families may not necessarily work for communities at large. Hence, the need for Whānau Ora programmes to bring about a balance between family and community voice, that advocate issues that are shared between Pacific families and can have a wider impact across different Pacific families and communities.

The ability of service providers to establish and deliver integrated care models

A cross-disciplinary Pacific team (Mulder, Sorensen, Kautoke, & Jensen, 2019) in their article Part II: using an integrated case model for delivering mental health services in general practice for Pacific people describe an alternative model of mental health care in primary care, which is being introduced at Etu Pasifika General Practice in Christchurch, New Zealand. This integrated, collaborative, and relationship-based model of primary care model aims to integrate physical and behavioural health and focuses on the strengths of Pacific people. The authors highlight the international movement towards an integrated model (Dale & Lee, 2016) and discuss the difference of an integrated model. Such models integrate a multi-professional group designed to incorporate social and psychological/behavioural expertise as part of a collaborative primary healthcare team. The integrated primary care team prioritizes interactions with patients that are relationship based, empathic and collaborative. A proportion of patients may require targeted, psychological interventions to help them with behavioural changes to improve management of long-term conditions, enhance wellbeing, and reduce the risk of developing preventable health conditions.

The Etu Pasifika model is based on the Nuka system of care in Alaska, one of the few integrated models which has been successfully implemented. Pioneered by the South-Central Foundation (SCF) in Alaska for Native Americans, the Nuka model is based on the premise that patients control their health, with relationship-based, continuity of care central to the model (Gottlieb, 2013; Graves, 2013). The Nuka model has impressive results. Since the introduction of the SCF model of care hospital emergency room visits have reduced by 42%, hospital days by 36%, specialty care by 58% and routine doctor visits by 30%. In addition, binge drinking declined by 30% and suicides fell by 66%

Mulder et al (2019) discuss the potential benefits of an integrated approach for Pacific patients in primary care services, with the main benefit being that an integrated collaborative primary healthcare team may enhance the effectiveness of interventions, partly through greater reach of access to patients and delivery of early behavioural interventions.

Other holistic wrap around services include those being provided by the Fono and their approach to providing pastoral care for their families and patients. The Fono's relationship with the Oceania Career Academy (OCA) is focussed on supporting the education and career progression of Pacific youth interested in trades (Ministry for Pacific Peoples, 2018). The OCA provides mentorship for Pacific youth in light of the barriers that Pacific youth encounter. A key principle of the academy is working together with the families to develop solutions to barriers Pacific youth encounter during trades education (Ministry of Pacific Peoples, 2018). The approach has benefited many Pacific youth who have taken part in the academy, with supporting all learners into employment, apprenticeships, or further study (Ministry of Pacific Peoples, n.d.). The completion and placement rates of the OCA are over 80 per cent. Many Pacific parents aspire for their children to be well educated and are well and healthy (Koloto & Misa, 2018), the OCA approach to improving Pacific youth education in the field of trades is only one example of how Pacific parent's aspirations for their families are being met.

> **Integrated collaborative primary healthcare team may enhance the effectiveness of interventions.**

The Pasifika Futures Commissioning Agency identifies suitable organisations that must demonstrate the ability to provide a navigation service where they support families to develop a plan and to work towards achieving their family aspirations (Te Puni Kokiri, 2016). For many organisations, such a response would require working collaboratively with other service providers and leveraging off existing government funding and programmes to ensure access to the required support and services. It is a requirement that 60 per cent of the funding per family is to be provided in direct services to support families.

A skilled Pacific workforce that possess language and/or cultural skills

A few studies acknowledge the importance of having the right people involved in the provision of care for the community (Keating & Jaine, 2016; Counties Manukau Health, 2018). As well as having partnerships with local Māori and Pacific communities and providers. Other studies support this finding indicating the importance of providing services for Pacific by Pacific (Ludeke et al., 2012). The presence of Pacific workers within general practice was viewed as particularly inviting which prompts the need for Pacific workforce development (Ludeke et al., 2012). Southwick et al (2012) describe the important role of the Pacific health workforce: “Pacific people in frontline services offer obvious language and cultural skills. Perhaps less obvious is the role of Pacific people at every level of the system who are able to observe and articulate a combined understanding of both the realities of the health services and the reality of living as a Pacific person” (p. 8)

> **The presence of Pacific workers within general practice was viewed as particularly inviting.**

Despite the benefits of a growing Pacific health workforce, there are still shortages within the health workforce. This is particularly true for certain health care roles across different ages, genders, and Pacific specific ethnicities. For example, the shortage of gender specific Pacific health workers, such as Pacific male therapists and counsellors (Abel et al., 2012).

> **The shortage of gender specific Pacific health workers, such as Pacific male therapists and counsellors.**

Pacific care providers, or Pacific Primary Health Organisations (PHOs) in Aotearoa indicate effective reach of the Pacific population. In 2010, Pacific providers had an estimated 15% of Pacific population enrolled with a Pacific PHO and are more likely to reach the most vulnerable Pacific population groups (Ministry of Health, 2010a). For example, almost 90% of TaPasefika’s enrolled population were from high deprivation areas, NZDep 8, 9 or 10 (Ministry of Health, 2010a).

Positive outcomes from these Pacific PHOS was the impressive reach of Pacific peoples and the improvement measures in performance in relation to immunisation rates. The immunisation rates of 2-year olds within Langimalie exceeded the rates across all DHBs nationally in 2009 (Ministry of Health, 2010a). There was also a high detection rate of high-needs diabetes detection surpassing the DHB and national averages in 2009 (Ministry of Health, 2010a).

Other performance measures indicate the extension of practice beyond the PHO realm to other forms of public health promotion activities that target Pacific engagement. For example, numerous accounts have been made by nurses who go above and beyond their contracts filling in the gaps of social service provision such as housing and social welfare services. Some nurses stated that their existing relationship with local social services meant food parcels from a local food bank were organised with the patient who had not been eating an adequate diet due to lack of money to spend on grocery items (Pack, 2018).

Enablers of Pacific family-led primary health care

This next section identifies enablers important for the provision of family centred primary health care provision for Pacific peoples. Literature analysis has highlighted how Whānau Ora as a government policy has contributed to family-centred primary health care provision for Pacific peoples. In particular several enabling factors were noted. These were:

- Equitable Funding and Infrastructure Support
- Pacific cultural frameworks for Whānau Ora
- Acknowledging holistic understanding of health and wellbeing
- The ability to acknowledge and address broader determinants of health through holistic models of care
- Culturally competent, Compassionate & Caring Navigator Workforce
- Sustainable workforce development embedded in Whānau Ora cultural models of reciprocal engagement
- Strengthening Partnerships with Organisations and the importance of vā between health care providers
- Flexibility in service structure.

The following section describes these enablers in more depth.

Equitable Funding and Infrastructure Support

Pacific Commission Agency, Pasifika Futures is the Whānau Ora commissioning agency for Pacific families. The agency is based on Pacific values and culture. The Pasifika Futures (2017) report provides the third year of operation presenting the progress in family outcomes and progress in implementing Whānau Ora services for Pacific families.

Pacific cultural frameworks for Whānau Ora

A key framework and methodology that is used by the commissioning agency to inform their activities and processes is the Talanoa methodology (Jensen et al., 2019). Talanoa provides the agency with a culturally embedded and congruent approach to Whānau Ora Commissioning, generating knowledge of its use by the agency. Talanoa is a term shared by different Pacific ethnicities (Tongans, Samoans, and Fijians) and is a concept that is familiar to other Pacific nations. Vaioleti (2006) describes talanoa as a "personal encounter where people story their issues, their realities and aspirations" (p.1). Jensen et al. (2019) further describe the methodology and its practical application within Pasifika Futures as more than just a method of "good empathetic conversation" whereby talanoa creates a transformative space that enables "self-determination for Pacific families and communities" where Pacific social-cultural contexts for it to be valid, whereby without Pacific cultural knowledge, relationships, skills and understanding it is not Talanoa. The methodology engages and enables Pacific families, Pacific staff, and Pacific organisations to identify issues and co-create knowledge, solutions, and relationships to support achievement of outcomes. Based on the Talanoa methodology, a framework was developed by the agency called the Knowledge, Engagement, Enablement and Performance (KEEP) Framework that ensures the agency's processes are evidence, dialogue and actions focussed, and accountable to improve family outcomes (Jensen et al., 2019). In this sense the utilisation of the Talanoa methodology by Whānau Ora programmes has "created a strengths-based culture that is culturally grounded and supports the capability and capacity of Pacific staff and organisations to achieve results with families and communities" (Jensen et al., 2019, p. 179).

Acknowledging holistic understanding of health and wellbeing

Research with Pacific peoples to identify their understanding of health and wellbeing often results in a broad range of responses that extend beyond the state of physical health (Ryan, Southwick, Teevale, & Kenealy, 2011). Many participants reflected that, for them, being healthy was an indication that one was leading a balanced life. "Have a balanced life. Not too much on materialistic side but should also have a good spiritual life. It should be balanced. ...if you have a happy soul and mind then you find wellness."

In discussions with Pacific peoples, there appeared to be an understanding of health and wellness that was more than the mere absence of disease. In some cases, there was explicit reference to a spiritual element and in other cases there was strong reference to the significance of relationships as a critical element of how one understands health.

Pacific peoples' definition of health and wellbeing are complex and involve multiple factors that influence individuals, families and communities' perception of health and health seeking behaviour. Some of the literature pointed towards the important incorporation of spiritual values in the provision of care. The successful establishment of processes and protocols for making decisions and acknowledging shared values and beliefs with their Pacific population aided the success of certain Pacific PHOs (Pack, 2018). Stated by one of the PHO CEO's: "We're bound by a common philosophy… I think fundamentally in essence we are a Christian organisation bound by a set of Christian values that hold us together in quite hard times and they are around all of those things, you know like…, integrity, respect… we do have hard times and we have our difficulties and battle but we try to work through them and there is a lot of passion. It's still trying to work through that respect and

Pacific peoples' definition of health and wellbeing are complex and involve multiple factors that influence individuals, families and communities' perception of health.

just wanting the best for our community" (CEO/Manager) (Pack, 2018, p. 64).

Studies describe the incorporation of culturally appropriate models of well-being as a form of advocacy on behalf of Pacific patients (Pack, 2018; Pocknall, 2009). The study by Pack (2018) indicated that some Pacific health care providers advocated for income support agencies on behalf of Pacific people who were on the sickness and invalid beneficiaries who could not afford to see a GP. Patients who have long-term conditions and were unable to pay consultation visits were encouraged to visit the GP despite the lack of means to pay for unpaid fees (Pack, 2018). Similar forms of advocacy have been described in the past (Agnew, 2004) indicating that despite the lowered costs of doctor consultations, Pacific families still face financial barriers in accessing primary health care services.

Holistic models of care have also been described by Hogg and colleagues (2008) as involving four facets of primary care service delivery that is prefaced on the importance of the patient, treatment provider relationship, awareness of the whole person, gender, culture and family (Pack, 2018). For example, Pacific led PHOs offer a broad range of services including health promotion, advocacy, education programmes and referral to social services such as housing (HNZ) and Work and Income New Zealand.

Design factors to help reduce barriers to accessing primary care services were suggested by Ryan and colleagues (2011). These include overcoming barriers (in particular cost, transport, and language), flexibility, mobile primary care services, nurse-led programmes, strengths-based approach, collaboration. Implementation factors that were deemed important were suggested by Ryan et al. (2011) to help improve access to primary health care. This included ownership and commitment, personal engagement, communication, family-focused, role models.

The Whānau Ora services that are offered by Pasifika Futures Limited are based on addressing the social economic hardships that Pacific families face. These programmes included financial literacy programmes, financial support and navigating support.

Addressing the social determinants of health such as income, education and housing are important factors in a Whānau Ora approach to primary health care. The Whānau Ora programmes provided or funded by Pasifika Futures Limited provided useful financial, education and housing social support services for Pacific families enrolled in their programmes. Koloto and Misa (2018) indicated how the financial support provides Pacific parents with the capacity to fulfil their responsibilities as parents. For many of the families who took part in the programme, the main focus of their aspirations and plans were to improve and meet their children's education and health needs. Parents were grateful for the financial help which enabled them to provide for the needs of their children. The financial support by the Whānau Ora programmes provided families with a 'peace of mind', which reduced stress, further enhancing their sense of health and wellbeing (Koloto & Misa, 2018).

> **Addressing the social determinants of health such as income, education and housing are important factors in a Whānau Ora approach to primary health care.**

Paipa and Sauni's (2013) study indicate the effectiveness of utilising Pacific approaches to inform the Pacific Island Safety and Prevention Project (the Project). The Project is a Whānau Ora provider that was funded in 2010 (Paipa & Sauni, 2013). The Project's area of focus is family violence prevention among Pacific families. A range of support services that the Project provides include family violence programmes, counselling, relationship counselling and community education programmes (Paipa & Sauni, 2013). The findings from their study indicate the effective use of Pacific models in service delivery that led to the important gains in the prevention of family violence among the families who took part in the program. The Fa'afaletui programme provided by the Project, encompassed key Pacific values and culturally appropriate practices led to the improvement of family relationships, re-engaging Pacific parents with their children and improving overall family dynamics. Families became healthier and happier during and after the programme. Children and partners describe the positive changes they have experienced in their family dynamics that transitioned from a "dysfunctional and desperate environment" to one that was "higher functioning and vibrant" where parents have re-engaged back into the family at a higher level (Paipa & Sauni, 2013, p.7). The overall findings from the Fa'afaletui programme indicated that "when Pacific practices are validated, are resourced and encouraged, families are enabled to process life-changing events, motivated to improve their behaviour and relationships and become employed and reconnected within their communities" (Paipa & Sauini, 2013, p.7).

A culturally competent, compassionate & caring Navigator workforce

Navigators play a valuable and important role in ensuring Whānau Ora is effective in improving the overall health and wellbeing of Pacific families. The report by Koloto and Misa (2018) indicate the success of strengthening the role of navigators in Whānau Ora programmes as they play an important role as family advisors, mentors, encouragers, guide, advocates, communication officers, brokers, trainers and much more" (p.8). The skills, qualities and characteristics that are possessed by navigators include (Koloto & Misa, 2018):

- Empathy towards families
- Knowledge of the New Zealand system and support services which are available to individuals and families in the arena of health, education, housing, and social services
- Good problem solver

- Skilled facilitator
- Culturally competent with an understanding of core cultural values of faka'apa'apa (respect), mamahi'ime'a, lototō, and tauhi vā (maintaining reciprocal relationships).

Unlike traditional forms of primary care, the Whānau Ora centred approach to health care provides a greater sense of support. The navigators provide support that is based on the needs of families as they gain a better understanding of the family's contexts through frequent home visits and opportunities that allows for a co-creation and implementation of plans with the families. The navigators experience of working with families further enhance their skill sets and capacities to serve other Tongan and Pacific families" (Koloto & Misa, 2018). The adoption of and commitment to the Tongan values (mentioned above) by the navigators in their approach of serving the families enabled the success and achievement of the family's plans towards prosperity and overall family wellbeing (Koloto & Misa, 2018).

> **Unlike traditional forms of primary care, the Whānau Ora centred approach to health care provides a greater sense of support.**

Formal interpreters and navigating services have been developed to help overcome language barriers and issues navigating the health system in New Zealand (Gray et al., 2017). Gray et al. (2017) investigate the interface between health navigators and interpreters in overcoming barriers to health care for patients with Limited English Proficiency (LEP) in the Wellington region. The role of navigators is to help assist patients within the health system. Some navigation services have been developed in specialised areas of health care such as cancer and mental health as an ad hoc initiative (Gray et al., 2017). The lack of interpreter resources is partly the problem. More than often communication barriers are due to cultural insensitivity and implicit bias held by health care providers (Southwick et al., 2012; Brown, 2018).

Sustainable workforce development embedded in Whānau Ora cultural models of reciprocal engagement

The integration of cultural models and practices at all levels of workforce development have been effective in improving the overall wellbeing of Pacific families and their communities. The effective implementation of culturally safe training of staff that directly feeds into improved engagement with families has been a strong force behind improvements in various Whānau Ora programmes. The study by Paipa and Sauini (2013) indicated the benefits of using a culturally embedded Whānau Ora approach to workforce development. The Project initiative was staffed with people from Pacific Island nations who live and grow with their families within the communities they serve (Sauini & Paipa, 2013). Reciprocal relationships were fostered with the families and were based on cultural models of engagement which allowed staff members to understand the needs of Pacific families at a deeper level. Such models of engagement were utilised by programmes including the Fonotaga A Le Aiga Nu'u A Le Project which led to improved engagement with Pacific families. The Nga Vaka o Kāiga Tapu framework is another culturally appropriate framework that supported staff interaction with families which have been used to inform improved engagement within family dynamics (Paipa & Sauini, 2013). To ensure that Whānau Ora approaches to workforce development is maintained and sustainable, ongoing improvements in the delivery of services were based on the feedback provided by the families and staff which was directly incorporated into the training of staff members, as seen in the Nu'u A Le Project and Nga Vaka Kaiga (Paipa & Sauini, 2013).

Strengthening partnerships with organisations

The success of Whānau Ora programmes also depends on the relationship and collaboration providers have with each other service providers. Pasifika Futures has a network of 51 partner organisations that are commissioned to deliver Whānau Ora to Pacific families (Jensen et al., 2019). The findings from the report by Koloto and Misa (2018) indicate the importance of strengthened partnership between organisations in their capacity to serve Pacific families. The example from the Innovation and Small Grant Case Study illustrates the benefits of incorporating the church in the delivery of Whānau Ora activities that enhance the capacity of the projects in addressing physical, social, and spiritual needs of Pacific families.

Community-based initiatives have indicated the benefits of nurturing good relationships between service providers (Abel et al., 2012; Pack, 2018) and acknowledging the 'va' between health organisations. Abel and colleagues (2012) describe how health care professionals who referred their patients to a community-based programme the Wairua Tangata Program (WTP) showed strong confidence in the programme by service users. Such confidence and trust in the programme indicated a subsequent increase and willingness of the team to probe and ask further questions about the mental health program (Abel et al., 2012). In turn, more primary health care providers referred their patients to the WTP increasing the utilisation of the service (Abel et al., 2012). This led to the significant reduction in the prescribing of medication where therapy through the WTP was most accepted and popular (Abel et al., 2012). GPs reported important and significant health outcomes in many of their referred patients, such as reductions in anxiety, distress and in some cases major lifestyle changes (Abel et al., 2012).

Flexibility in service structure

Described by Ryan et al. (2011) is the degree of flexibility within primary care that contributes toward effective primary care delivery. For example, appointment scheduling being open and flexible to accommodate timing restrictions outside of normal opening hours to help with access to primary care (Kool et al., 2008; Pacific Perspectives, 2011).

> **Community-based health care initiatives demonstrate the concept of 'going beyond' the standard level of care in order to address the complex health and social needs.**

Within Pacific PHOs, community-based health care initiatives demonstrate the concept of 'going beyond' the standard level of care in order to address the complex health and social needs of Māori and Pacific population (Abel et al., 2012). This often meant the need to seek alternative funding sources, such as Work and Income New Zealand (WINZ), Ministry of Social Development (MSD) and Accident Compensation Corporation (ACC) (Abel et al., 2012). Another Pacific PHO such as West Fono had other projects outside of the clinic that promoted healthy living among the Pacific community, such as the gardening project (Ministry of Health, 2010a). The project had been running for over a decade and involved vegetable seedlings being provided to families, where healthy competition was fostered between families with rewards at the end of three months. In 2008 more than 200 people took part in the gardening program (Ministry of Health, 2010a).

Langimalie, a Tongan community owned PHO offers flexibility with longer appointments and walk in appointments. Langimalie's philosophy is to provide services that 'go to the people' (Ryan et al., 2010, p.14). Such models of care delivery have shown positive results. For example, Langimalie met the 2009 target for vaccination coverage for 2-year olds and exceeded the detection of high-needs diabetes ahead of ADHB and national levels for the same measures (Ryan et al., 2011). Other Pacific providers also show promising results, with the TaPasefika and Bader Drive reporting improvements in chronic care management for HbA1c, statin use and blood pressure exceeding the overall indicators within CMDHB (Ryan et al., 2010).

The vast majority of Pacific ethnic groups are affiliated with a religion and hence a church denomination (Statistics New Zealand, 2014). The church setting has been used and recommended as a key community-based venue for health promotion activities and health care initiatives (Dewes, Scragg & Elley, 2013). Pacific peoples are also more socially connected with a church compared to other population groups in Aotearoa (Ministry of Health, 2014; Tait, 2009). As such, many Pacific families who are strong participants in church and community activities, "create and reinforce strong social connections and therefore resilience" (Tait, 2009). The demand in health initiatives to be undertaken within the church has been highlighted in previous literature (Dewes et al., 2013). An example of an effective church-based initiative was the Enua Ola program which was implemented with West Fono and West Auckland Pacific churches to improve physical activity and nutritional practices of Pacific peoples (Ministry of Health, 2010a).

Health promotion activities in Wellington, such as the Pacific kilikiti community sports event was supported by Wellington Pacific health providers, reached an estimated 2,000 people per week over a four-week period (Ministry of Health, 2010a). Another, the Health Star Pacific community cultural seminar also attracted 2,000 people (Ministry of Health, 2010a).

> **Many Pacific families who are strong participants in church and community activities, create and reinforce strong social connections and therefore resilience**

Such community initiatives help to improve the acceptability and reach of intervention which is linked to overall improved health outcomes (Ryan et al., 2010). An unpublished report by Pacific Perspectives (2011) indicates the important role of community health initiatives that are characterised by family focus, shared community leadership and a pass it on style of the delivery of health promotion messages to encourage healthy behaviour change (Pacific Perspectives, 2011).

An effective community-based initiative for Pacific people has been indicated in the midwifery services delivery model (Priday & McAra-Couper, 2016). The positive outcome from the community-based initiative was the early access and engagement with maternity care by Pacific women. Paterson et al. (2012) states that early engagement and access to maternity care is a priority recommendation that can improve maternity outcomes to avert avoidable morbidity and mortality. Factors that contributed towards the success of the delivery care model was the focus on continuity of care and establishing a grounded relationship with the midwives early on in pregnancy (Priday & McAra-Couper, 2016). The findings discussed the important development of a 'one-stop shop' where the maternity clinic was co-located with two family health practices in a high deprivation area, which allowed for easy access for the Pacific mothers. The provision of midwifery care within one facility enabled contact with pregnant women providing a strong foundation from which trust could be formed in midwifery care (Priday & McAra-Couper, 2016). The resulting outcome of these positive relationships was that subsequent extended family members were more likely to access midwifery services early on in their pregnancy, promoted and supported by their family members who had previously established positive relationships with the midwives within the facility.

Another study by Tan et al. (2015) indicate the importance of community-based programmes in the management of chronic illness such as kidney failure. Their findings showed that there were fewer inpatient days in the intervention group, associated with lower hospitalisations among the community-based participants (Tan et al., 2015). The intense education that was received by the community group was thought to have contributed towards an increase in health literacy, leading to the improvement of overall personal care and timely access to primary healthcare (Tan et al., 2015). As such the study indicates the benefit of community-based programmes in the management of kidney failure which can benefit Pacific people who have other chronic illnesses that require ongoing access to primary care.

> **Intense education that was received by the community group was thought to have contributed towards an increase in health literacy.**

Barriers to the delivery of Pacific family-led primary health care

This next section highlights interrelated themes associated with the wider ecological system that influences not only the delivery of Pacific Family-led primary health care provision but ultimately improved health outcomes for diverse Pacific families. Literature analysis highlighted key systemic barriers that influenced the personal circumstances of diverse Pacific families, such as poverty and low socio-economic status that negatively impacts their health. Analysis of literature also indicated that barriers to primary care services differed by ethnicity, age, gender, and language proficiency (Abel et al., 2012; Ryan et al., 2011). This means that a 'one-size' fits all approach will not work.

In addition, analysis revealed the 'ad hoc' nature of initiatives and ostensible evaluation measures that prevented the ongoing development of Pacific family-led primary health care. Other key barriers included insufficient funding and problems with contracting. The socio-political, economic environment influences Pacific people's health and well-being. For example, issues associated with the impact of Auckland's housing crisis, housing shortages, and increasing housing stress on Pacific families influence high mobility as families are forced to move location. This leads to a disruption in Pacific children's education, moving further away from employment and disconnecting families from their social support systems, including social and health care services. A key barrier to the delivery of Pacific family-led primary health care and ultimately improved health outcomes is the lack of a whole of government, intersectoral approach. Evidence indicates that Whānau Ora by itself will not be enough to transform health and wellbeing for diverse Pacific groups, as a whole of government approach is needed. The following section explores these findings.

> **Whānau Ora by itself will not be enough to transform health and wellbeing for diverse Pacific groups, as a whole of government approach is needed.**

Poverty and financial barriers

A key determinant of health is poverty, which is intrinsically linked to poor employment and income. Despite some effective Whānau Ora programmes being implemented to help improve and support the finances of Pacific families (Jensen et al., 2019), poor economic policies, employment opportunities and working conditions can stifle the efforts made by Whānau Ora financial support programmes. The lack of effective Pacific advocacy groups that advocate for improved financial and employment opportunities at the higher levels of policy making is long overdue. In-line with the suggestion to develop advocacy groups is the necessary environment that is required to be conducive to developing policy decisions that support the social, economic and health care needs of Pacific families in New Zealand. The New Zealand health system dictates a fee for service in primary care where GPs play a role as gatekeepers to secondary health care (Widodo, 2007). However, Pacific peoples are significantly more likely (33.4%) to report that the cost of primary care is the main reason for unmet GP need (Ministry of Health, 2008). The study by Jatrana, Crampton and Norris (2011) indicated that Pacific reported the same cost barrier in relation to the collection of prescribed medication from the pharmacy. Despite the government increase in subsidies for health care and prescriptions, evidence indicates that cost remains a key barrier for Pacific peoples.

> **Despite the government increase in subsidies for health care and prescriptions, evidence indicates that cost remains a key barrier for Pacific peoples.**

Current and past community-based initiatives outside of the health sector have supported new Pacific migrants to New Zealand (Tamasese et al., 2010). Although these services are not primarily responsible for ensuring new Pacific migrants have access to primary health care, it comes as no surprise that the cost of health care for settling Pacific migrants is costly indicating a barrier for Pacific communities and families that host Pacific migrants whilst their stay in New Zealand. For Pacific migrant families who do not share the same entitlements as Pacific New Zealand citizens and permanent residents their health and their access to health care is limited and the stresses that host families experience can take a toll on the entire family (Tamasese et al. 2010).

Ad hoc nature of initiatives

Southwick et al. (2012) argues that there are many innovative and effective services currently being provided for Pacific peoples, though the issue is the seemingly the ad hoc nature of these services where the services are not "built into" the health system (p. 8). The lack of socio-political will for flexibility in the health system fails to cater to the health needs of Pacific peoples at all levels of care at a national scale. As such, the existence of few Pacific focused health practices relies heavily on the energy and goodwill of individuals-who are more than often Pacific staff-who are overworked, overused, exhausted and in demand as Pacific communities, families and patients require health care services at the primary level.

Ostensible evaluation measures

Widodo (2007) recommends the need to measure the effectiveness of primary care organisations such as cost, quality and health outcomes of services that serve marginalised groups such as Māori and Pacific. However, in doing so questions the very existence of Pacific PHOs and general practices that seek to improve access and health outcomes of Pacific peoples. Government health policies need to be responsive to the health care needs of Pacific peoples. Evaluation measures of quality and access to health care need to take into consideration the health care preferences of Pacific peoples in relation to service availability, service delivery and overall models of care.

Insufficient Funding and problems with Contracting

Insufficient government funding can be a barrier in delivering Whānau Ora services for Pacific families. Often, the financial barriers experienced by Pacific families requires financial support (Ryan et al., 2019), and a lack of funding provided to overcome these issues, makes it difficult to provide holistic forms of support for Pacific families.

> **Contracting is seen as a barrier in the delivery of family centred care.**

Contracting is seen as a barrier in the delivery of family centred care. This is related to the high demand of services, where services providers go above and beyond their contracted roles in order to provide services for Pacific families. Unfortunately, these activities are not acknowledged by funding or commissioning authorities which can be a challenge in the provision and maintenance of services and staff. Staff become overworked and often lead to high turnover rates.

On the other hand, the report by Koloto & Misa (2018) indicates the effective implementation of Whānau Ora services contracted by a single organisation the Pasifika Futures Limited that contract organisations to deliver financial literacy programmes for Pacific families for instance. The success of these services may perhaps lie in the acknowledgement of the commissioning agencies of the sacrifices the partner organisations and staff members make in the delivery of services for Pacific families.

Nearly a decade ago the Ministry of Health (2010b) provided information on the existing Pacific Health providers that were funded by the Pacific Provider Development Fund (PPDF) established by the Ministry of Health in 1998. In 2009, there were 39 providers that received PPDF funding. During this time Pacific health providers delivered service contracts that totalled nearly $50 million per annum and overall, the PHOs own significant assets. “Most providers are community owned or not-for-profit trusts of which the governance boards are almost entirely Pacific, profiting valuable governance experience for community members” (Ministry of Health, 2010a, p.3). However, despite these benefits for Pacific peoples, the extent in which these programmes are bounded by these funding contracts and unable to be fully responsive to the Pacific community is questionable. Furthermore, these findings are nearly a decade old, which questions the consistency of government funding and whether these health care organisations are still operating under government funding.

The lack of funding to support the delivery of equitable primary care services was a key barrier for GP services (Keating & Jaine, 2016; Ludeke et al, 2012). Some of the findings indicated the demand, and the willingness of Pacific PHOs to do more, but the lack of funding stands as a barrier to providing certain services (Pack, 2018; Ludeke et al., 2012). For example, the study by Pack (2018) indicated the high number of Did Not Attend’s (DNAs) especially when attending primary health care appointments or treatment services where the PHO was unable to provide transport to and from the facility. The lack of funding to provide transport for patients was a barrier for most patients.

Socio-political economic environments and the lack of a whole of government, intersectoral approach

The socio-political economic environment that determine the types of policies that are being developed and implemented have a direct and indirect effect on who has access to the social determinants of health and who does not. Such factors can pose as barriers for Pacific families even if funding is provided for Whānau Ora programmes to be implemented. For example, the impact of Auckland's housing crisis, housing shortages, and increasing housing stress on Pacific families can influence high mobility as families become forced to move location. This leads to a disruption in Pacific children's education, moving further away from employment and disconnecting families from their social support systems, and social and health care services (Malungahu, 2019; Anderson et al., 2019).

Whānau Ora alone may not improve the overall health and wellbeing of all Pacific families in Aotearoa, New Zealand. Rather a whole of government inter-sectorial approach that encourages and advocates for family and community partnership and collaboration is vital in order for any real improvements to be seen in the overall health and wellbeing of Pacific families.

> **The impact of Auckland's housing crisis, housing shortages, and increasing housing stress on Pacific families can influence high mobility as families become forced to move location.**

Summary

The findings from this review identified numerous success factors of Pacific Whānau Ora primary health care. These included fostering vā (relationships), self-determination and empowerment of families, the ability of service providers to establish and deliver integrated care, enabling self-determination and empowerment of families and skilled Pacific workforce. The enablers of Pacific Whānau Ora primary health care were overall based on the incorporation of Pacific approaches at the service level and or systems level that inform the functions and operational activities of Whānau Ora providers, their policies, service delivery, engagement with families and workforce development. Holistic models of care and the ability of providers to address the wider social determinants of health such as income, education and housing was found to be a significant element of family-led primary health care. Pacific peoples and health professionals have long understood the importance of looking beyond people's immediate and physical health needs. At the service level, the ability of providers to be flexible in their processes of service delivery has improved access to services delivered by Whānau Ora providers. Improved funding, accountability and infrastructure at the systems level have also indicated promising benefits for many Pacific families for example, Pasifika Futures Limited. The barriers and challenges in the delivery of Pacific family-led primary health care that were identified included the increasingly diverse nature of Pacific families, increasing poverty and financial barriers. At the systems level the ad hoc nature of initiatives, ostensible evaluation measures and insufficient government funding that can restrict contracting opportunities posed as key barriers in the delivery of Whānau Ora services. These barriers led to poor service delivery failed to comprehensively address the needs of Pacific families ultimately stifling the Whānau Ora approach. The poor social-political economic environment in which Whānau Ora initiatives are provided was also identified as a key barrier in the success of any initiative that is informed by the Whānau Ora approach. For any real improvements to be seen in the overall health and wellbeing of Pacific families it is vital that the social-political economic environment is conducive in meeting the needs of Pacific families at all levels of care.

With the extensive number of factors associated with the successful and sustainable delivery of family-led primary health care with Pacific peoples, it becomes apparent that there is no one solution. The fundamental values and principles that motivate and mobilise Pacific families and communities must be understood at all levels of primary health care from commissioning through to family and individual level activities. The integration of the Whanau Ora Programme into existing Pacific primary health care services by some Pacific providers has helped to progress the delivery of Pacific family-centred and/or led services. However, normalising these approaches within all primary health care funding and systems would significantly improve the primary health care landscape and thus health outcomes for Pacific peoples.

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Appendix 1: Initial working template

To guide preliminary analysis and synthesis

Context & Issue

What is the central issue, problem or question?

What aspects of primary health care are at the centre of this?

To what extent is a holistic approach taken to meet the needs of whānau?

Relationships & engagement

What type of relationships have been established with whānau/families?

How are whānau engaged in the work?

How are relationships used to connect and build whānau, community capability?

Characteristics of Participants (age, gender, cultural identity, dis/ability, socio-economic status)	
Self-determination How is whānau capability developed/strengthened?	
Culturally competent, capable workforce In what ways is the workforce able to adopt a holistic approach to supporting whānau aspirations? What evidence is there of culturally anchored practices?	
Ensure whānau/community -centred services & programmes To what extent are whānau/community needs and aspirations at the centre of services?	
Ensure supportive environments How are practices assessed and evaluated (in terms of outcomes/benefits for whānau)? To what extent are funding, contracting and policy arrangements, supporting whānau community aspirations?	

Findings/ Outcomes What are the outcomes and benefits for whānau? How are these related to wellbeing?	
Other enablers & critical success factors	
Barriers & Inhibitors	
Reviewer reflections, questions etc	