Creating a Healthier
NORTHLAND
Kia Hangahia He Hauora Mo Te Tai Tokerau

Te Tai Tokerau

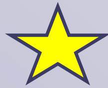
Strategic Public Health Plan

2008 - 2011

NORTHLAND DISTRICT HEALTH BOARD
Te Poari Hauora Ā Rohe O Te Tai Tokerau

Mauri Ora
Access to Te Ao Maori

Waiora
Environmental
Protection

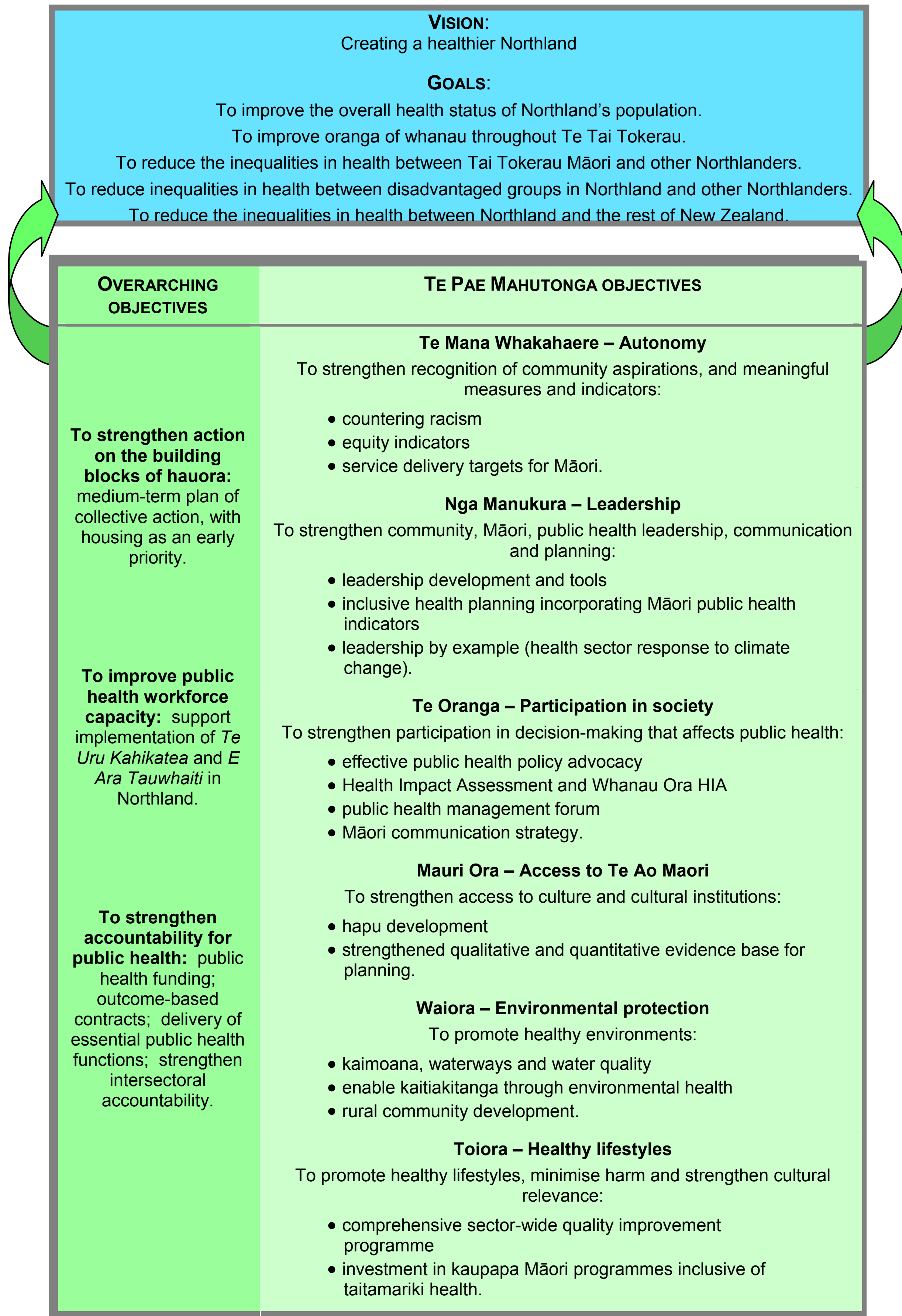

Te Oranga
Participation in Society

Toiora
Healthy LIfestyles

Nga Manukura
Leadership

Mana Whakahaere
Autonomy

Te Tai Tokerau Framework for Public Health Action



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1 Background and methodology

This plan provides a strategic framework to guide public health action in Northland. The impetus for the plan came from joint discussions between the Northland District Health Board (Northland DHB), Te Tai Tokerau MAPO Trust (TTMT) and the Ministry of Health. This plan begins to assess where public health in Northland is at, how it can be strengthened and re-orientated to maximise the likelihood of public health action improving the health status of the people of Te Tai Tokerau. This plan provides a collective public health pathway to shape and influence Northland's approach to planning, funding and delivery across the sector and with intersectoral partners.

The primary audience for this plan is the public health sector, that is the planners, funders, and providers of public health services in Northland. A predominantly internal focus is appropriate at this time to allow the public health sector to get its own house in order as a platform for effective intersectoral action in the next planning period. The plan recognises, however, the critical importance of working intersectorally with the key partners identified for each objective. Whereas there are around seven funders of public health services in Northland[1], the Ministry of Health predominates.

1.1 Policy context

The Government's *New Zealand Health Strategy* (NZHS)[1] and the *New Zealand Disability Strategy* (NZDS)[2], alongside *He Korowai Oranga: Māori Health Strategy*[3] and the *Primary Health Care Strategy*[4], signal the directions in which the Government wishes to proceed.[2] Within this context, the Minister of Health annually signals priorities. Planning for implementation of these priorities, the Northland DHB's strategies, and other relevant plans (such as *Te Tai Tokerau Māori Health Plan* (draft))[5] is laid out in the Board's district annual plan. The performance of the health sector is monitored through ten health targets, indicators of DHB performance and performance measures in contracts.

These accountability arrangements establish direction on the scope of public health action that is funded in Northland. Public health action needs to be aligned to national priorities while remaining responsive to local health needs.

This plan has a focus on strengthening Māori public health action to improve Māori health outcomes and on reducing inequalities. This focus is based on overwhelming need, as laid out in section 2.0 Tai Tokerau Specific Analysis. This focus upholds the commitments made to tangata whenua under Te Tiriti o Waitangi.

While emphasising Māori health needs and ways of working, the plan in no way suggests that this emphasis should be to the exclusion of other Northlanders. The plan establishes a platform of action to discover new ways to deal with long standing inequitable issues: between Māori and

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a The Ministry of Health, Northland District Health Board (Northland DHB), ACC, territorial local authorities, the New Zealand Food Safety Authority, ALAC, commercial shellfish operators. Most of these agencies participate in a range of public health activities in Te Tai Tokerau of which funding is just one.

b There are a number of other relevant and important government strategies which have a bearing on this plan, such as the *New Zealand Injury Prevention Strategy.*

non-Māori; between other disadvantaged groups and other Northlanders; and between Northland and the rest of New Zealand. These inequities are reflected in the goals of the plan.

1.2 Te Tiriti o Waitangi and its impact on the plan

Te Tiriti holds particular meaning in the North as Sir James Henare declared; "It is the burden of Tai Tokerau to argue the Treaty". It was at Waitangi in 1840 that the Treaty was first signed. As one submission reminds us[3] "Sir James Henare took an ongoing position for recognition of the Treaty of Waitangi in his time… He grew up with the Treaty in mind and saw the carvings that now adorn the Whare Runanga at the Waitangi Treaty Grounds and as a boy in his own Marae in Motatau. He had been a member of Te Runanga o te Tiriti o Waitangi, a committee of descendants of the chiefs who signed the Treaty, from 1928. He had known sons of men who had signed the Treaty and believed the mana of the Treaty and all this infused in him a sense of responsibility for ensuring that the integrity of the Treaty was maintained. Sir James Henare took on himself at the request of other local elders, the responsibility of ensuring that the Treaty was kept in the forefront of debate in the country, let alone Te Tai Tokerau."

As discussed in *Te Tai Tokerau Māori Health Plan,* many people have a strong sense of responsibility to ensure that the spirit and the intent of Te Tiriti is honoured. Te Tiriti forms the basis of the unique and special relationship between Māori and the Crown and provides non-Māori with the right to become New Zealand citizens.

Northland DHB's stated accountabilities for Te Tiriti O Waitangi are that it forms the basis of the unique and special relationship between Māori and the Crown based on equity. Māori participate in public health funding, planning and decision making through an active Treaty partnership at all levels of the health sector – in governance, operational management and workforce development, in supporting Māori public health provider development, including kaupapa Māori models of public health service delivery, and in acting to improve the health and wellbeing of Māori while safeguarding Māori cultural concepts and values.

Primary health organisations (PHOs) in Northland address their Treaty obligations through a range of mechanisms, one of which is their Treaty-based governance structure with 50% Māori representation on their boards.

Māori health providers across Te Tai Tokerau are generally hapu and iwi based and aim to provide public health services directly to mana whenua across their rohe.

Addressing Māori health means working with Māori world views around hauora. Hauora is broader than physical wellbeing and takes into account wairua, whanau and hinengaro as well as cultural elements such as land, environment and language.[6] Hauora must be understood in the context of the social, cultural and economic position of Māori in the present day, whilst acknowledging the legacies and consequences of the past.

Addressing Māori health also means acknowledging the critical importance of Te Reo Māori. As a result, in this plan Te Reo Māori phrases, terms and words are used throughout, sometimes interchangeably with and sometimes alongside English, and sometimes exclusively. Inconsistency in the use of Te Reo Māori and English has been used deliberately in this plan to reinforce the inclusion of multiple world views that are essential to any regional public health plan for Te Tai Tokerau that is inclusive of the whole population.

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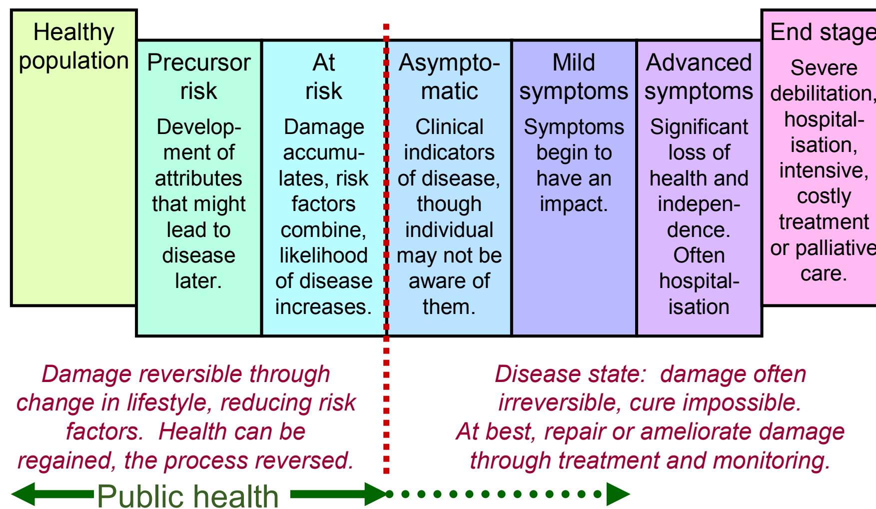
c Submission MHP 2.

1.3 An integrated Te Tai Tokerau public health approach

Public health has been defined as "the science and art of promoting health, preventing disease and prolonging healthy life through organised efforts of society".[7] Public health operates at the beginning of the continuum shown in Figure One. It uses a mix of tools at different levels, from healthy public policy on the wider determinants of health to advocacy for healthy environments to social marketing targeting health behaviours. Public health action is essential to addressing many of the challenges we face, as outlined in section 2.0 and throughout this plan.

Figure One: Contiuum from healthy populations to end-stage disease



This plan recognises that public health action needs to be re-orientated from issue and disease based approaches to the primary business of improving health status in its broadest sense so that inequities are reduced. This plan provides a pathway forward that integrates several public health approaches working from the realities of the circumstances facing the people of Te Tai Tokerau. Integrating these approaches will require a reorientation of how health services are planned, funded and delivered.

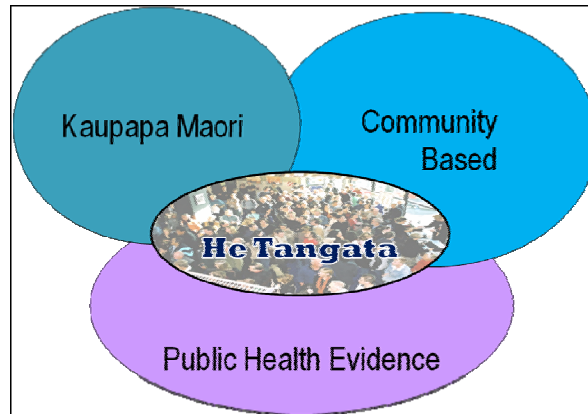
This plan draws on Māori public health practice, the longest standing public health tradition in Aotearoa and affirms Māori understandings of hauora. Traditionally Māori maintained hauora through concepts and practices such as tapu and noa and rahui that protect(ed) water supplies, food sources, and safety of whanau. Contemporary Māori public health is driven by both health need and by a rights based discourse recognising Māori as both indigenous peoples and Treaty partners.[8] Whanau Ora is central to current Māori health policy. *He Korowai Oranga*[9] recognises the desire of tangata whenua to have control over their future direction and this is a strong motivation for Māori to seek their own solutions and to manage their own services.

This plan also emphasises the importance of community based approaches inclusive of primary health care, where communities can have a strong voice in determining what and how health services will be provided to them, by them, and with them. Community development emphasises the expertise and knowledge held within communities (both urban and rural) and ensures this is utilised across the primary and public health interface. Community development is a people-centered practice and way of thinking about public health that has been championed through the Ottawa Charter for Health Promotion[10] and succeeding charters and declarations. Community based approaches work with populations from the circumstances in which they are living. Concepts such as empowerment, enablement, and equity lie at the heart of this approach.

Robust public health intelligence is critical to all public health action. It involves sourcing quantitative and qualitative data to monitor the health status of communities and address health needs through evidence based planning and evaluation. Evidence based approaches are the cornerstone of continuous quality improvement in public health practice. Evidence is both quantitative (eg, hospital admissions data) and qualitative (eg, key stakeholder interviews).

Together these approaches, with he tangata – people at the heart, reflect a uniquely integrated Te Tai Tokerau approach to public health, to maximise healthful outcomes for all Northlanders (see Figure Two).

Figure Two: Approaches to Public Health



Common to all these public health approaches is a commitment to prioritise "working with those whose circumstances place their health at greatest risk"[11]. Generic and universal approaches can have the effect of increasing rather than reducing health inequities. Alongside tangata whenua, unique communities that need localised and tailored responses include geographic communities (including those of low socio-economic status), Pacific peoples, people living with disabilities, migrant communities, and the wider lesbian, gay and bisexual communities.

This integrated approach incorporates the need to maintain core public health services, such as regulatory health protection services, and disease and injury prevention services. Essential public health functions have not been clearly articulated for New Zealand but the Western Pacific Region of the World Health Organization has defined nine essential functions, each with outcomes and a set of tasks.[12] These functions are:

- Health situation monitoring and analysis.
- Epidemiological surveillance/disease prevention and control.
- Development of policies and planning in public health.
- Strategic management of health systems and services for population health gain.
- Regulation and enforcement to protect public health.
- Health resources development and planning in public health.
- Health promotion, social participation and empowerment.
- Ensuring the quality of personal and population-based health services.
- Research, development, and implementation of innovative public health solutions.

Later in the plan (see 3.3.3), it is proposed that the relevance of developing a set of essential public health functions to underpin public health in Tai Tokerau should be considered.

It is important to strengthen the inequalities focus in all public health actions to reduce the inequities analysed in section 2.0. As outlined later in the plan, emphasis and resources need to be shifted so there is a new balance between tackling the upstream building blocks of hauora and minimising symptoms e.g. alcohol misuse, obesity prevention. This shift will present a range of challenges for the existing issues-based public health services, contracting processes, practitioners and managers, and will require innovative transitional processes.

Collaboration and co-operation within the public health sector, the wider health sector, and across sectors remain key to this integrated approach. For example, this plan has been developed concurrently with the second Tai Tokerau Maori Health Strategic plan[4] ensuring close alignment and support from Northland health sector stakeholders. In addition, public health action is embedded in the strategic framework of other intersectoral partners in their individual and collective work.

1.4 Method of developing the plan

The method used to develop this plan included engagement across the public health sector with Māori and non-Māori stakeholders, including the Te Tai Tokerau Māori Health Strategic Alliance[5], the Public Health Unit, PHOs, national public health providers, non-government organisations, intersectoral partners (eg, territorial local authorities (TLAs), Sport Northland, Ministry of Social Development, Housing New Zealand), and colleagues from the wider health sector (see Appendix for list of contributors).

Most Māori health providers were invited to host focus groups to explore what the local issues were for Māori public health as part of this process. These contributors included practitioners, managers, kaimahi, kaumatua, and kuia. Structured key stakeholder interviews were also conducted with several key Māori stakeholders.

This engagement was supported by analysis of quantitative information and focused reviews of the literature. The reducing inequalities framework was used to provide context for much of this analysis.[13] Part of the analysis involved a review of a small number of accessible public health contracts for: scope and coverage, compliance load, specification of outputs, and incentive structure. A representative public health steering group was also formed to support the plan development (see Appendix). A working draft of the plan was distributed for comment. Seventeen submissions were received (see Appendix for list of submissions).

Sectoral and intersectoral collaboration is fundamental to successful public health action at the strategic, planning, and operational levels. The key partners to achieve the goals of this plan are; communities, whanau, hapu, iwi, central and local government, public health providers, PHOs, non-government organisations (NGOs), Māori health providers, MAPOs, other health service providers, Northland DHB and the Ministry of Health. Key initial partners for each objective are listed in the plan. As the approach in this plan is inclusive, it is anticipated that other partners will come on board as we progress down the implementation path.

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d The Tai Tokerau Maori Health Strategic Plan 2008-2013 is a collaboration between the Te Tai Tokerau Maori Health Strategic Alliance and the PHO Managers networks.

e An inter-organisational network of nine Māori and community health providers, the Northland DHB, Tihi Ora MAPO and Te Tai Tokerau MAPO

Professor Mason Durie's Te Pae Mahutonga (see Table One and cover) is the key organising framework for this plan.[14] Te Pae Mahutonga offers a comprehensive approach to the fundamentals of good health for tangata whenua and non-Māori alike. Consistent with Māori world views, Te Pae Mahutonga is not linear. The components of the model are overlapping and have dynamic internal relationships.

Using a Māori framework for the plan is appropriate. As one submitter reminded us "…this should be welcomed because this brings its own integrity to stand alongside the generic public health modeling which services the population in general. These two intellectual reflections of how to deal with public health problems have been combined into this document to achieve a result which is beneficial to the whole of the Northland population"[6]

Table One: Te Pae Mahutonga

Te Pae Mahutonga	
Mauri Ora	Access to Te Ao Māori
Waiora	Environmental Protection
Te Oranga	Participation in Society
Toiora	Healthy Lifestyles
Nga Manukura	Leadership
Te Mana Whakahaere	Autonomy

Reducing inequities in health between socio-economic and ethnic groups is a key policy goal in New Zealand driven by a concern for social justice, human rights, and an overarching aim of the health sector - to improve Māori health outcomes. Reducing inequities is one of the most effective pathways available within public health and primary health care to improve the overall health status of the New Zealand population.[15] Into the future it is crucial that all health interventions in Northland include inequalities analysis in their planning.

1.5 Implementing Te Tai Tokerau Strategic Public Health Plan

This strategic public health plan is part of a hierarchy of planning to achieve improved health outcomes within the context laid out above. It is supported by an implementation plan (under development) and issue-specific plans (see for example, Tupeka Kore Te Tai Tokerau: Tobacco Free Northland 2008 to 2011[16]). The implementation plan provides more detail on which agency is responsible for what action, with more detail on performance measures and timeframes. Northland DHB in partnership with Te Tai Tokerau MAPO Trust are the lead for implementation of the majority of the key actions.

There are many issues that affect health. The building blocks of health are discussed in 3.1, and are a key focus of this plan. Lifestyle and related issues include tobacco, drugs and alcohol, healthy eating, healthy action, sexual behaviour, problem gambling, violence (including family violence), risk taking behaviours leading to injury, oral health, mental illness (including suicide and attempted suicide), and so on. The challenge for a relatively small workforce distributed

f Submission MHP 2.

thinly across Northland is to focus action to achieve the best health outcomes for Northlanders. The implementation plan sets priorities for the development of issue-specific plans.

Within issue-specific plans, prioritisation of actions has occurred (or will occur) and funding is allocated, although still at a relatively high level. The programmes and projects that emanate from this funding are then subjected to more detailed planning at the provider level, using a range of models.[17]

Planning is essentially collaborative and co-operative. At all levels, engagement with partners occurs with varying degrees of success depending on timing, resources, and competing priorities. Evidence clearly supports ongoing, robust engagement with tangata whenua as being critical to this process. Planning is an iterative process and so over time engagement becomes more effective.

Implementation of this plan will occur alongside other plans and strategies, such as the *Te Tai Tokerau Māori Health Plan,* and Northland DHB plans and strategies related to population groups (eg. *Child and Youth Strategy Implementation Plan* and the *Health of Older People Strategic Action Plan* (under development), diseases (eg, *Northland Cancer Control Strategic Action Plan)*, and services.

Implementation of the plan will be informed by sub-regional analysis of health status that is anticipated to occur as part of the revised Northland DHB *Health Needs Analysis*, due for completion in 2009.

2 Tai Tokerau-specific analysis

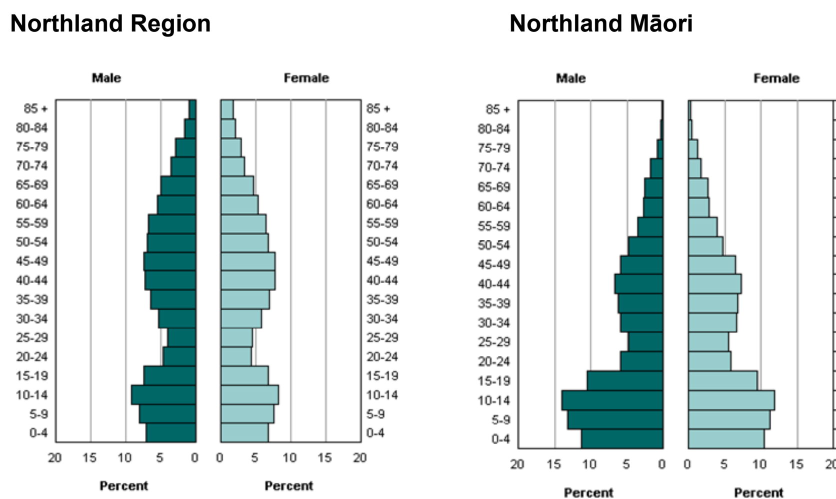
Northland has a unique socio-economic, cultural, environmental, and historical landscape that shapes the health status of the people of Te Tai Tokerau. The Northern Tribes are: Ngāti Whatua, Ngāti Wai, Ngāpuhi, Ngāti Hine, Ngāti Kahu, Whaingaroa, Ngāi Takoto, Ngāti Kurī, Te Rarawa, and Te Aupōuri.

Much health planning is centrally driven and does not capture the unique dynamics of Northland. The Northland DHB *Health Needs Analysis*[18] goes some way to quantify the patterns of disease and injury within Te Tai Tokerau but it does not yet encompass the world views of the integrated Te Tai Tokerau public health approach. This analysis will be updated in the next 12 months.

This section is a preliminary analysis of health status locally using available Northland and ethnic specific data. This analysis is not exhaustive and is not intended to duplicate the *Health Needs Analysis.* Action points 4.2.2 and 4.4.2 both address the need to strengthen Northland public health planning through improved engagement with communities, tangata whenua and improved access to both qualitative and quantitative data.

At the 2006 Census, the Northland population was 148,470 of whom 29% were Māori (43,527). The Northland Māori population was younger than the total population in Northland with a median age of 22.9 years and 38.1 years respectively. It is important to focus on the youthfulness of the Māori population for successful long-term improvement in health. The Māori population is not distributed evenly across the region with the area covered by the Far North District Council having the highest proportion of Māori of the three council areas in the region.

Figure Three: Total population (age group and sex) for Northland

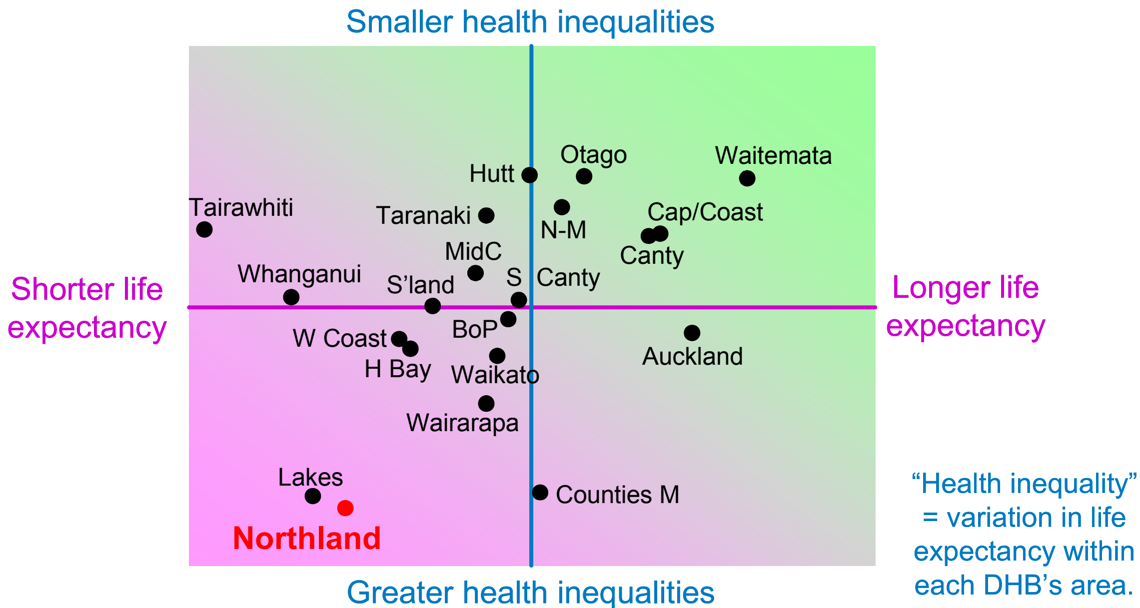


Source: Statistics NZ 2007

Health inequality is distributed unevenly throughout New Zealand. Using the 2001 Census and mortality data for the same year, analysis conducted by the Ministry of Health has found that the range of life expectancy at birth was approximately 5.0 years across DHBs' usually resident populations, but approximately 28.5 years across neighbourhoods (from 64.4 to 93.0 years). [19] The results for Northland placed it in the least preferred quadrant in that the Northland

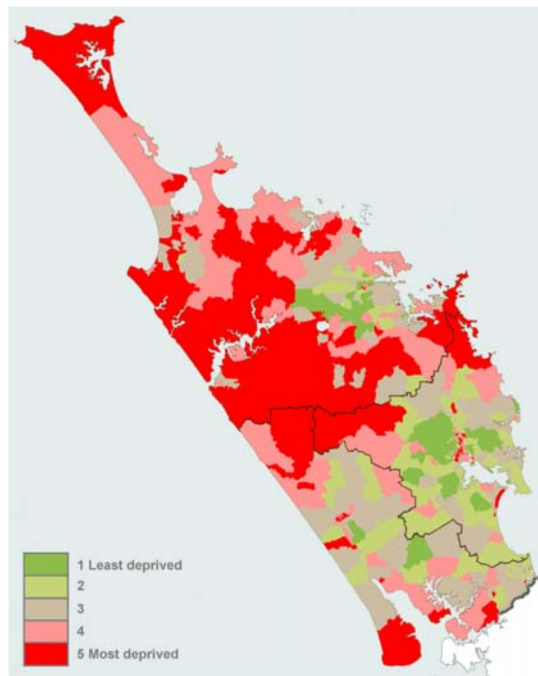
population has both a low overall (average) level of health and a high degree of inequality in life expectancy between Census Area Units within the district (see Figure Four).

Figure Four: DHB life expectancy at birth versus health inequality 1999-2003



Inequalities also occur within Northland as shown in Figure Five, derived from socio-economic position in the 2006 Census. This deprivation manifests itself in negative social and health statistics and restricted access to the building blocks of hauora. It is important to note that this hardship for many is long-standing and inter-generational. Importantly this hardship is resisted and challenged individually and collectively by resourceful and capable paid and unpaid workers, whanau, and hapu across Te Tai Tokerau. This burden of deprivation is disproportionately carried by Māori, as shown below.

Figure Five: Deprivation in Northland 2006



The red areas are deprived in terms of housing, drinking water quality, educational achievement, income level, employment, educational achievement,[20] and transport difficulties with poor quality roads, and lack of public transport. Transport difficulties are compounded by Northland's population being spread across a long (343 km by road), narrow land mass of nearly 14,000 km^2. Northland's high rate of road casualties illustrate these problems with the 4th highest rate of road casualty injuries (479.9 per 100,000) and the highest rate of road casualty deaths (19.4 per 100,000), in the country.[21]

Northland for example has:

- Around 500 households waiting for homes. This list is long compared with other regions, and those waiting for social housing have been shown to have the poorest health. [22] There are an estimated 16,000 pre-1978 poorly insulated homes in Northland that would benefit from retro-fitting insulation with consequent health benefits.[23] In addition, there are around 6000 sub-standard houses.[24] Poor housing quality is associated with infectious diseases, chronic disease, injuries, poor nutrition, and mental disorders.[25]
- The 2nd poorest drinking water quality in terms of the proportion of the total population whose drinking water complies with the 2000 Drinking Water Standards of New Zealand relating to *E Coli* and the 4th poorest compliance with *Cryptosporidium,* in the country. [26]
- The 2nd lowest participation in early childhood education (90.1%), the 3rd lowest proportion of school leavers with higher qualifications (52.2%), and the lowest educational attainment of the adult population in the country (71.5%).[27]
- The 2nd highest rate of unemployment (4.7%), the lowest median hourly earnings ($15 per hour), and the highest proportion of people living in households with low income,[7] in the country (25.2% of total population, 33.9% of Māori population).[28]

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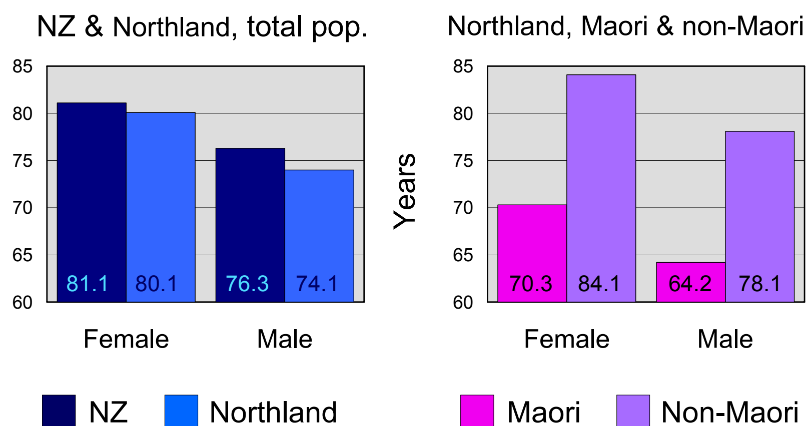
g The income measure used is equivalised disposable household income after deducting housing costs. The adjustment for household size and composition is based on the 1988 Revised Jensen Equivalence Scale.

Underpinning this restricted access to the building blocks of hauora are a range of negative statistics that speak to the struggle of many Northland residents to participate fully and safely in society. Households stretched by debt, food security issues, transport challenges make survival-based decisions that may be hard to understand from the perspective of relative privilege.

The *Te Tai Tokerau Māori Health Plan* provides a careful analysis of the disproportionate deprivation experienced by Māori in Northland and the impact of this deprivation on Māori health.[29] Both plans put gaining access to the building blocks of hauora at the centre of the planned actions.

As a result, inequalities in health between Māori and non-Māori are of particular concern, as shown in Figure Six for life expectancy at birth, using the most recent complete New Zealand period life tables. [8,30]

Figure Six: Life expectancy by ethnicity



Source: Statistics NZ. 2004. *NZ Life Tables 2000-02.*

The findings of the New Zealand Census-Mortality Study has found that approximately one third to one half of the Māori: European/Other disparity in mortality can be explained by socio-economic position. Other factors operating independently (at least in part), such as racism, disparities in access to and quality of health care, and lifestyle factors explain the other half to two thirds of the inequalities in mortality.[31] Therefore those living in similar circumstances do not necessarily have similar health outcomes.

Inequalities between Māori and non-Māori exist for the Northland District Health Board's priorities,[32] as follows:

Diabetes	While Māori are 30% of Northland's population, 43% of people known to have diabetes are Māori.
Cardiovascular disease	In Northland Māori death rates are 4 times higher for ischaemic heart disease and twice as high for stroke (after figures are adjusted for the different age structures) than non-Māori death rates.

h In the years between construction of complete period life tables, abridged period life tables for the total New Zealand male and female populations, providing an indication of the trends in life expectancy, are all that are available. For the purposes of this analysis, the most recent complete period life tables have been used.

Cancer	Māori deaths from cancer are 69% higher than non-Māori deaths.
Oral health	Northland has repeatedly had the worst oral health for 5 year-olds in the country. The figures for Māori are worse than for non-Māori. In 2004, only 19% of Northland Māori 5 year-olds had no tooth decay compared with 33% of all Northland 5 year-olds (NZ non-fluoridated areas 41%).
Mental health	the proportion of Māori admissions for acute mental illness to inpatient mental health services in Northland is high relative to the Northland Māori population. Māori make up 46% of admissions from 29% of the population compared with 54% of admissions being non-Māori from 71% of the Northland population.[33]

The consequences of all of these – diabetes, cardiovascular disease, cancer, poor oral health, and poor mental health, are misery in family life.

Inequities between Northland and the rest of New Zealand and within Northland also exist for key lifestyle risk factors such as tobacco smoking and healthy eating. For example:

Tobacco	The prevalence of regular smokers in Northland (15+ years) is 25.7% (compared with 20.7% for NZ) with particularly high rates among 20-24 year olds (40.1%). Māori (43.5%) and Pacific peoples (39.5%) have higher smoking rate than other ethnicities. Northland has a higher prevalence of ex-smokers (25.6%) and a lower proportion of never smokers (48.7%) than the rest of NZ (22.1% and 57.2% respectively). [34] Smoking in Northland is related to 25% of all deaths (47% of all Māori deaths, and 18% of non-Māori deaths), 1.4 times higher than the national proportion. Smoking related hospitalisations in Northland (1161 per 100,000 hospitalisations) are 1.5 times higher than the national rate. [35]
Healthy Eating, Healthy Action (HEHA)	Overall 60% of Northland's population is overweight or obese (26% are obese compared with 20% nationally; 35% are overweight compared with 34% nationally). Māori have a higher prevalence of obesity (31%) than non-Māori (24%). Northlanders participate in physical activity at comparable rates to New Zealanders as a whole across all ethnic groups. [36]
Alcohol and drugs	In 2006/07, the Northland Police recorded 2168 alcohol related crimes. Drug misuse crimes in the same period were 355. Last drink surveys in Northland indicate that home/private residence is the most frequent source of alcohol (44%), 6% more than the national average. Nationally 75 – 90% of weekend crime, 70% of admissions to A&E departments, over 1000 deaths per annum and $1.17b in lost productivity are attributed to alcohol. [37]

The impact of inequalities between Māori and non-Māori on whanau ora are considerable and unacceptable. The inequalities mean loss of kaumatua and kuia and their cultural and social knowledge and contribution to whanau and hapu. The inequalities mean that whanau have to deal with grief on a frequent and ongoing basis with consequent impact on mental health. The inequalities mean the loss of whanau members during their working lives with the subsequent loss of their contribution to the economic security of whanau.

To be clear, tangata whenua in Northland experience a disproportionate level of disease, injury, and premature death, hence the strong Māori focus of this plan. In this plan, it is intended to work upstream on the building blocks of hauora alongside a re-orientated inequities focus on lifestyle issues.

3 Actions to improve Hauora

This section of the plan outlines the vision and goals of the public health plan and introduces the objectives, action areas, and outcomes. As introduced earlier the major focus of the public health sector in Northland is on improving health status and reducing inequities; this by necessity involves a significant focus on Māori health gain.

Figure Seven: Te Tai Tokerau Public Health Vision and Goals

Table three summarises the integration of public health action to improve hauora in Tai Tokerau. The table is organised around Te Pae Mahutonga (4.1 – 4.6) with three overarching objectives: addressing the building blocks of hauora (3.1); public health workforce development (3.2); and strengthened accountability for public health (3.3). These action areas are interlinked and interdependent and recognise that healthy lifestyles are most likely to be promoted in a context where action is being taken on the building blocks of health, a competent public health workforce is in place to lead the promotion of healthy lifestyles in partnership with community leadership, and for Māori, access to Te Ao Māori is strengthened.

Table Three – The Integration of Public Health Action to Improve Hauora

OVERARCHING OBJECTIVES	TE PAE MAHUTONGA OBJECTIVES
To strengthen action on the building blocks of hauora: medium-term plan of collective action, with housing as an early priority. **To improve public health workforce capacity:** support implementation of *Te Uru Kahikatea* and *E Ara Tauwhaiti* in Northland. **To strengthen accountability for public health:** public health funding; outcome-based contracts; delivery of essential public health functions; strengthen intersectoral accountability.	**Te Mana Whakahaere – Autonomy** To strengthen recognition of community aspirations, and meaningful measures and indicators: • countering racism • equity indicators • service delivery targets for Māori. **Nga Manukura – Leadership** To strengthen community, Māori, public health leadership, communication and planning: • leadership development and tools • inclusive health planning incorporating Māori public health indicators • leadership by example (health sector response to climate change). **Te Oranga – Participation in society** To strengthen participation in decision-making that affects public health: • effective public health policy advocacy • Health Impact Assessment and Whanau Ora HIA • public health management forum • Māori communication strategy. **Mauri Ora – Access to Te Ao Maori** To strengthen access to culture and cultural institutions: • hapu development • strengthened qualitative and quantitative evidence base for planning. **Waiora – Environmental protection** To promote healthy environments: • kaimoana, waterways and water quality • enable kaitiakitanga through environmental health • rural community development. **Toiora – Healthy lifestyles** To promote healthy lifestyles, minimise harm and strengthen cultural relevance: • comprehensive sector-wide quality improvement programme • investment in kaupapa Māori programmes inclusive of taitamariki health.

3.1 Urgent action on building blocks of Hauora

In order to be healthy it is widely accepted that certain building blocks / necessities of life need to be in place. They have been defined as "peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity".[38] Improvement in health requires a secure foundation in these necessities. Many living in Northland do not enjoy reasonable access to these minimum requirements. From a Māori world view all of the above fundamentals are necessary for health but there are additional cultural building blocks that need to be in place for hauora to be achieved.

Access to land, has long been identified by Māori as a core component of hauora. Whenua is a tangible connection to the past, a turangawaewae - a place to feel secure, confident and supported. About 1.3 million hectares in New Zealand are still designated as Māori freehold land, just under five percent of the total 26.4 million hectares in the country.[39] A significant number of Māori whanau continue to live in health risking (and enhancing) conditions on Māori freehold land, forming stand-alone papakainga.

Ko te reo te mauri o te mana Māori. Te Reo Rangatira is another cornerstone of Māori health.[40] Te Hoe Nuku Roa, a longitudinal study of Māori whanau, confirms that a secure and positive cultural identity appears to offer Māori some protection against ill health.[41] Language is central to the cultural identity of both individuals and the community to which they belong. Te Reo has been a site of struggle since the beginning of state education and government policies of assimilation.[42] Much progress has been made in recent years in advancing knowledge of Te Reo Māori, however fluency in Māori remains the province of a minority with 27.9% of Tai Tokerau Māori being able to hold a conversation in Te Reo Māori.[43]

Action on the building blocks of hauora is a central component of this plan, as it is for the *Te Tai Tokerau Māori Health Plan*. Contributors to the plan consistently spoke of the challenge of working with under-resourced communities “living in third world conditions”. They experienced a lack of accountability of government agencies to their clients with those working in offices sometimes misunderstanding the impact of the conditions in which people live. Promoting healthy lifestyles messages in this context is problematic when housing and income (including terms and conditions of employment) are inadequate. It is clear that a considered, resourceful, flexible and creative response by the public health sector and our partners is urgently required.

To advance action on the building blocks of hauora in a systematic and co-ordinated way requires a detailed medium and long term strategy that is resourced to pro-actively deal with the healthy public policy dimension of this public health challenge.[44] Such a strategy would contribute to advocacy for Northland with central government. A mechanism for dealing systematically with policy dimensions of public health and intersectoral collaboration is outlined under 4.3.2. Actions to advance hapu development, rural community development, and workforce development are outlined under 4.4.1, 4.5.2 and 3.2 respectively.

Achieving collective agreement on the pathway forward should not prevent the continuation of important existing programmes dealing with the broad determinants of health and healthy public policy generally. Tangata whenua as the most affected by absent building blocks, need to be at the heart of identifying solutions and pathways forwards.

The analysis in 2.0 makes the case for improved housing being identified as a priority building block of hauora that can be strongly linked to health outcomes, such as reduction in housing-sensitive hospital admissions including those from falls. Specific action on housing is likely to

involve supporting the implementation of Te Au Roa – Māori Strategic Plan and may focus on retro-fitting, substandard housing and advocacy for affordable housing.[45]

3.1 Objective: To strengthen action on the building blocks of hauora			
Key actions			**3 – 5 year outcomes**
Co-ordinate a series of intersectoral forums, with representative input, to agree key policy objectives and actions around individual building blocks of hauora.	Workshop series inclusive of housing, food security, whenua, Te Reo Māori, adequate income, education, family violence, etc.	Develop medium-term plan of collective action to address access to the building blocks of hauora.	Increased focus on the building blocks in key strategic and operational policies and plans in Northland, and nationally as they impact on Northland. Strengthened access to the building blocks of hauora in Northland.

The key initial partners to achieve progress on this objective are: PHOs, Te Tai Tokerau Māori Health Strategic Alliance, central and local government and other non-government organisations.

3.2 Public health workforce capacity

A major review and planning process for the public health workforce is underway.[9] The review found that the entire sector needs to equip itself better to adapt to; changing models of care, changing community and societal structures, population demographics, and public health issues. The major goals in the new strategic framework are; develop an effective and sustainable public health workforce and support public health environments to grow and develop the public health workforce.

The implementation of *Te Uru Kahikatea: The Public Health Workforce Development Plan* needs to be a major focus of attention over the years to come.[46] It is important that the limited workforce development resources in Northland are co-ordinated and planned to achieve maximum sustainable impact. A crucial first step is to gather baseline data for Northland on workforce capacity to gain a clearer understanding of where we are starting from. The pooling of collective resources, inclusive of primary health care, could prove a beneficial way forward to maximise the usefulness and reach of this resource. A collective multi-agency approach to workforce development could be driven through the proposed public health management forum outlined under 4.3.1.

The major Māori themes from the review undertaken for *E Ara Tauwhaiti Whakarae*[47] are; workforce navigation, workforce expansion, workforce extension and workforce excellence. To strengthen the Māori workforce, pathways need to be established for practitioners to secure both pre- and post-entry training opportunities to strengthen their effectiveness. In order to achieve a robust and vibrant Māori health workforce there needs to be dual cultural and public health competency-based workforce development strategies.[48] Securing Māori involvement in senior public health, management, and decision-making roles was also identified through this consultation and the work undertaken by the Ministry.

i This research undertaken by the Ministry of Health focused only on providers with contracts with the Public Health Directorate.

An effective model of Māori workforce development that is working locally is the Oranga Kai project.[49] This project centers on a nutrition professional working specifically with the Māori health workforce to identify development needs and source relevant training to strengthen practice, including mentoring. This collaborative kaupapa Māori framework and approach has allowed a relevant and individualised approach for providers.

<table>
<tr><td colspan="4">3.2 Objective: To improve public health workforce capacity</td></tr>
<tr><th colspan="3">Key actions</th><th>3 – 5 year outcomes</th></tr>
<tr><td rowspan="2">Establishing baseline information on public health practitioners in Northland.</td><td>Support the implementation of Te Uru Kahikatea in Northland.</td><td>Inclusive implementation of generic public health competencies, developing career pathways, improve non-Māori capacity to reduce inequalities.</td><td>Increase in the number of public health workers who have recognised public health qualifications and training.</td></tr>
<tr><td>Support implementation of E Ara Tauwhaiti Whakarae in Northland.</td><td>Inclusive Māori recruitment strategy, dual technical / cultural training options, mentoring.</td><td>Expanded Māori public health workforce.

Increase technical and cultural competencies of Māori public health workforce.</td></tr>
</table>

The key initial partners to achieve progress on this objective are: Ministry of Health, Northland DHB provider arm, PHOs, Te Tai Tokerau Māori Health Strategic Alliance, territorial local authorities (TLAs), training organisations, and tertiary education institutions.

3.3 Accountability for Public Health

3.3.1 Public Health funding

A key concern that emerged through the development of the plan was the lack of transparency on public health expenditure in Northland. The Ministry of Health's national public health ring fence for 2007/08 is about $400m.[10] There is a lack of clarity on the proportion of this funding that is allocated to public health service delivery in Northland. Getting to the bottom-line in terms of Northland's share of public health expenditure from local and national providers is a key advocacy opportunity that was overwhelmingly supported through the development of the plan. Greater transparency is needed throughout the public health system in Northland in order to ensure a fair and equitable distribution of resources across Northland.

3.3.2 Outcome-based contracts

It is widely recognised that output based contracts lack flexibility and to some extent have become something of a "ticking the box" exercise in terms of public health interventions. Certainly issue-based contracting has been challenging for organisations wishing to integrate whanau ora into their practice.[50] Contract reporting has demanded the recording of 'widgets',

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j Excluding the meningococcal vaccine programme and scientific advice to support pest management strategies. Ministry of Health. 2007. *Statement of Intent 2007 – 2010.* Wellington: Ministry of Health, p 91.

such as number of meetings attended and events held, rather than demonstrating health outcomes. It is timely for an overhaul of public health contracting, monitoring, and reporting to accommodate kaupapa Māori approaches and managing for outcomes thinking coming from central government.[51] In this process, it is important to ensure that providers are sustainable. The contract price needs to adequately recognise the cost of providing services.

A review of a small number of local public health contracts found weak intervention logic between the service description and the intended objectives, and weak incentives to achieve outcomes, reduce inequalities, and/or implement the Treaty of Waitangi. There appear to be similar problems with national contracts. These difficulties are supported by the findings of the Health Reforms 2001 Research Project.[52] These findings support the realignment of contracting and reporting to focus on outcomes.

3.3.3 Delivery of essential public health functions

In section 1.3, essential public health functions, identified by the World Health Organization, are listed. Assessing the relevance of essential or core functions to underpin public health in Northland, and then strengthening accountability for delivery of the agreed functions, could strengthen capacity and capability to deal with the realities of Northland and emerging public health issues. This action could be particularly important in light of the Public Health Bill, the revision of the Health Act 1956, that is currently before parliament.

3.3.4 Strengthening intersectoral accountability

The Local Government Act 2002 provides a process for the health sector to be engaged in the identification and promotion of community outcomes in partnership with local government. The Act requires councils to address four key areas: cultural, social, environmental, and economic wellbeing. There could be significant gains through collective health sector engagement with local government planning processes that build on local relationships and expertise.

The health sector also has a responsibility to contribute to the reporting of community outcomes. These community responsibilities for accountability for public health are complementary to contributing to progress on measures of wellbeing and quality of life as reported in *The Social Report 2007*.[53] These intersectoral accountability arrangements are also relatively new. There are significant opportunities to strengthen the reducing inequities and health focus of intersectoral approaches.

Other mechanisms to strengthen intersectoral accountability include shared outcomes achieved through co-location and coordination of services, using multidisciplinary teams made up of health, social development, housing, education, justice, and iwi partners, for example.

3.3 Objective: To enhance accountability for public health		
Key actions		**3 – 5 year outcomes**
Continue to work with the MoH and other funders to 'open the books' on public health funding to ensure equitable allocation of public health funds to Northland (compared with other districts) and equitable distribution across	Advocate for Northland's fair share of service delivery and/or financial investment.	Increase transparency of investment in public health in Northland. Reduced inequalities between Northland and the rest of New Zealand.

Northland.		Reduced inequalities within Northland.
Systematically realign all PH contracts within Northland to ensure they are outcome based and inclusive of Māori world views.		Contracting processes are inclusive of Māori world views, are outcome based, and community focused.
Assess relevance of core or essential functions for underpinning public health in Northland, then strengthen accountability for the functions.		Improved delivery of the core business of public health.
Strengthen intersectoral accountability by engaging in joint work to achieve shared outcomes, inclusive of health indicators.		Improvements in desired health outcomes. Improved performance on shared outcomes and community outcomes.

The key initial partners to achieve progress on this objective are: Ministry of Health, other public health funders, PHOs, Northland DHB provider arm, Te Tai Tokerau Māori Health Strategic Alliance and other health sector non-government organizations (NGOs).

4 Te Pae Mahutonga

This section is based on evidence of public health actions from Māori and non-Māori contributors to the development of the plan, and from relevant literature. The actions are designed to build and consolidate the existing strengths in the sector and lay out a more strategic pathway for public health action for the whole population of Northland.

4.1 Te Mana Whakahaere – Autonomy

Autonomy or self governance is central to notions of good health and positive wellbeing, at all levels. This concept is related to empowerment in the 'reducing inequalities' framework. To the extent that self governance is only occasionally realised, then opportunities for good health are correspondingly limited. Little health gain can be achieved within a legislative and policy environment which is the antithesis of health, or if public health programmes are imposed with little sense of community ownership or control.

> "Good health cannot be prescribed. Communities must ultimately be able to demonstrate a level of autonomy …in promoting their own health" [54]

Autonomy can be considered in the way in which public health actions are planned, delivered and evaluated.

4.1.1 Countering racism

Several contributors to the plan disclosed experiences of personal and institutional racism within and outside of the sector. There is a growing body of evidence on the impact of racism on health.[11]12 Despite the profile of Māori as a priority population in key strategic health policy documents, there is a considerable gap between policy and action.[55] In Northland, work is already underway, such as in PHOs, to address these issues.

Through the development of the plan there were calls from contributors to see greater auditing to ensure the appropriateness and accessibility of service delivery to Māori. There are a range of existing models which could easily be utilised for auditing purposes; He Taura Tieke[56], the CHI Model[57] and TUHA-NZ[58] and He Ritenga[59].

As discussed in 2.0, the New Zealand Census-Mortality Study has found that factors operating independently of socio-economic position, such as racism, disparities in access to and quality of health care, and lifestyle factors, explain half to two thirds of the inequalities in mortality between Māori and non-Māori.[60]

It is essential that non-Māori continue to take responsibility for addressing these discrepancies in a positive and systematic way while working in partnership with tangata whenua.

4.1.2 Equity indicators

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k See for example Coker N. 2001. *Racism in Medicine: An agenda for change*. London: King's Fund. Karlsen S, Nazroo J Y. Fear of racism and health. *J Epidemiology and Community Health 2004; 58: 1017 – 18.*

l Larsen A, Gillies M, Howard PJ, Coffin J. It's enough to make you sick: the impact of racism on the health of Aboriginal Australians. *Aust NZ J Public Health 2007; 31: 322 – 9.*

It is estimated that funding specifically for Māori health providers accounts for only about three percent of health and disability expenditure. The estimated total health expenditure for Māori in 2004/05 was 14.5%, less than the proportion of Māori in the population at that time.[61] These data raise the issue of whether sufficient expenditure is being directed to Māori.

Through the development of the plan, many contributors were interested in oritetanga and more specifically article three of Te Tiriti o Waitangi. Contributors called for the establishment of equity indicators, or a similar mechanism, to facilitate momentum around enhancing mana whakahaere. Likewise contributors called for clarity on Māori public health expenditure in Northland whether it be through the establishment of a Māori public health ringfence or expenditure targets. It was felt this would enhance transparency and accountability for the investment and outcomes from both generic and dedicated Māori health resource.

Further dialogue and investigation is required to define a robust mechanism for oritetanga. This action sits alongside:

- 3.3 which examines accountability of funders for the investment in public health
- 4.2.2 which establishes hauora measures to be used within health planning; and
- the implementation of the Māori Health Index in the *Te Tai Tokerau Māori Health Plan.*

4.1 Te Mana Whakahaere - Autonomy: To strengthen recognition of community aspirations, and meaningful measures and indicators		
Key actions		**3-5 year outcomes**
Build on existing work to develop a comprehensive programme to address institutional and personally mediated racism within the health sector.	This work will be supported through an expert advisory committee.	Reduction in indicators of personally mediated and institutional racism.
Develop Northland specific equity Indicators in partnership with tangata whenua.	Indicators inclusive of financial investment, delivery, FTEs and health outcomes.	Equity targets achieved. Increased % of public health funds allocated to Māori public health.
Demonstrate consistent use of Treaty/Māori responsiveness tools in population-wide public health service planning and review.	Monitored through internal and external review with findings embedded into ongoing practice.	Increased transparency of organisational competence to deliver effective and culturally competent public health action. Achievement of service delivery targets for Māori.

The key initial partners to achieve progress on this objective are: tangata whenua, Northland DHB provider arm, PHOs, Te Tai Tokerau Māori Health Strategic Alliance, and other health sector NGOs.

4.2 Nga Manukura – Leadership

Health professionals have an important leadership role but they should not undermine or replace existing community leadership. Moreover public health practitioners must be able to relate to communities in terms which make sense to those communities.

> "Public health leadership will be more effective if a relational approach is fostered and alliances are established between groups who are able to bring diverse contributions to a programme. No single group has sufficient expertise to encompass the range of skills and linkages necessary for effecting change." [62]

Māori and non-Māori concepts of leadership are different.[63] In order to strengthen Māori public health leadership in the first instance it is necessary to expand and nurture the Māori public health sector workforce. Māori public health leadership needs to complement tangata whenua leadership in other domains (community, tribal, academic, and political) which are all collectively critical for effective Māori public health action.

In Northland it is important to acknowledge the existing leadership of the Te Tai Tokerau Māori Health Strategic Alliance, the Primary Health Organisation Managers network, Te Roopu Kai Hapai o te Tai Tokerau, and the many leaders in communities. These groups have made a significant contribution to enhancing collaboration and a collective voice for Northland on the national stage. The ongoing collaboration of these groups holds much promise for the public health sector.

4.2.1 Leadership development

Leadership development opportunities were reiterated as important in several recent key documents and from contributors to this plan.[64] The mobilisation of community and professional leadership was seen as essential for any successful public health intervention. Local leaders are the change agents, the movers and shakers that make things happen within communities. Leadership development needs to include training opportunities and tools that can assist organisations to assess and strengthen their own leadership capability.

4.2.2 Health planning

Through the development of the plan, contributors called for a different type of engagement with public health decision-makers. Some wanted formal processes established for ongoing identification of public health needs and local indicators of success. These indicators would focus on hauora and set a clear alternative to traditional disease prevention measures. These local indicators will be developed with, and reviewed and reported back, to communities. This action will also support the overarching objective of enhancing accountability for public health (section 3.3).

Contributors to the plan also called for greater effort to be made to ensure public health surveillance information was fed back directly to communities so they could participate in ongoing decision-making from an informed position. Ratima et al[65] argue that:

> "Māori health indicator sets that are relevant and meaningful at national, regional, and local levels are a necessary foundation for the most effective planning, policy development, purchasing, service delivery, and monitoring for improved Māori health outcomes".

4.2.3 Leadership by example: climate change

Northland is vulnerable to climate change. Sea levels are projected to rise with increased coastal erosion, flooding from storms, salinisation of freshwater, and problems with drainage.[66] Two events of severe flooding requiring civil emergency response by authorities have recently hit Northland. Many communities were severely affected by flooding. Such seasonal weather is here to stay, so it is important that Marae have all structures in good condition for the future as these are an obvious alternative accommodation for affected communities during civil emergencies. Northland DHB can contribute to addressing these challenges by leading by example and working collaboratively with others in the health sector to develop a health sector response to climate change.

<table>
<tr><td colspan="4">4.2 Nga Manukura - Leadership: To strengthen community, Māori, public health leadership, communication and planning</td></tr>
<tr><th colspan="3">Key actions</th><th>3-5 year outcomes</th></tr>
<tr><td colspan="2">Concept test the applicability of a Northland Māori PH leadership course.</td><td rowspan="2">If viable source funding, implement, and evaluate respective leadership programme(s) and tools.</td><td rowspan="2">Māori public health leadership capacity is increased.

Public health leadership capacity is increased.</td></tr>
<tr><td colspan="2">Develop pathways with respect to generic public health leadership programmes and tools for Northland.</td></tr>
<tr><td rowspan="2">Ensure communities have access to data to enable meaningful planning.</td><td>Establish a transparent mechanism for feeding forward and feeding back PH issues.</td><td>Regularly enact mechanisms to enable community participation in planning.</td><td rowspan="2">Public health planning in Northland is inclusive of informed community and Māori perspectives.</td></tr>
<tr><td>Establish local Māori public health indicators.</td><td>Indicators used in PH planning and reporting.</td></tr>
<tr><td colspan="2">Northland DHB leads by example by working collaboratively to develop a health sector response to climate change.</td><td>Advocate to include in Northland DHB DAP.</td><td>Reduce the impact of climate change.</td></tr>
</table>

The key initial partners to achieve progress on this objective are: Northland DHB provider arm, PHOs, Te Tai Tokerau Māori Health Strategic Alliance, other health sector NGOs, community leaders.

4.3 Te Oranga – participation in society

This element is about participation in society. It is well recognised that public health cannot be separated from socioeconomic circumstances. Part of wellbeing is about access to services which people can count on, input into decision making, and a sense of ownership over these services.

There is evidence that participation is low across a number of areas, and disproportionately so for Māori. Low participation can partly be explained by barriers, such as mental illness or disability. Electoral engagement is one example of low participation on which significant research has been undertaken.[67]

Participation in society is at the heart of public health activity in community development and public health advocacy efforts across the wider sector. Advocating for healthy public policy is a long-standing and core element of public health practice.

4.3.1 Public Health Management Forum

A collective approach is necessary to facilitate the effective development of Northland's public health infrastructure. As identified in this plan, there are various areas needing attention and investment that require input beyond that of a single organisation. A public health management forum, inclusive of representation from the sector, holds promise to enable specific public health infrastructure development and greater collaboration on planning and delivery into the future. The forum could, for example, develop approaches to enable health workers focused on issues to collaborate better with those working holistically. The forum could also be a hub of communication on the implementation of much of this plan.

4.3.2 Enhanced healthy public policy

Many public health issues in Northland have solutions outside of the health sector. Engagement with central and local government is essential to ensure positive health outcomes and healthful policy for Northland. There are a number of existing forums that have an intersectoral focus, such as the Sport and Physical Activity Steering Group.

Ongoing health sector representation/ engagement and participation at intersectoral forums are important for sharing inclusive public health analysis and advancing health outcomes.

Existing healthy public policy work is occurring in an ad hoc fashion across a range of public health issue areas. This work could be strengthened through a co-ordinated approach and a deliberate programme of capacity building to engage communities in submission processes and advocacy. A multi-cultural, inter-agency (potentially inter-sectoral) pool of practitioners, with growing expertise in supporting submission writing and policy analysis, could respond effectively to policy initiatives that impact on hauora including transport, problem gambling, housing developments etc. The same approach could be taken to Health Impact Assessment (HIA)[68] and Whanau Ora HIA[69].

4.3.3 Māori communication strategy

A core function of public health is the delivery of health messages to specific populations. In Northland, Māori are a priority population whom health professionals need to reach. Communication pathways between the public health sector and Māori are unclear locally. This is a public health risk particularly in the context of pandemics and natural disasters such as

Northland's recent floods. A comprehensive communication strategy that utilises Māori networks, inclusive of Māori media would greatly strengthen public health action. Once established, it could support advocacy and community engagement processes. As part of this strategy relevant Te Reo Māori health education resources could be developed to reinforce key public health messages.

<table>
<tr><td colspan="5">4.3 Te Oranga – Participation in Society: To strengthen participation in decision making that affects public health</td></tr>
<tr><th colspan="4">Key actions</th><th>3-5 year outcomes</th></tr>
<tr><td>Develop a robust collective approach to central and local government policy and legislative developments.</td><td colspan="2">Develop a multi-cultural, interagency pool of Northland practitioners to support submission writing, policy analysis, and advocacy.</td><td rowspan="2">Focus on building community and collective workforce capacity through shared training opportunities.</td><td rowspan="2">Strengthened policy outcomes for Northland.

Strengthened policy analysis and impact assessment capacity and competency across Northland.</td></tr>
<tr><td colspan="3">Establish a regional strategy for the consolidation of HIA and Whanau Ora HIA.</td></tr>
<tr><td colspan="2">Strengthen relationships at the management level of the public health sector in Northland through the establishment of a PH Management Forum.</td><td colspan="2">Terms of reference inclusive of infrastructure development, workforce development, strategic planning, PH surveillance, collaboration, and Northland advocacy.</td><td>Strengthened collaboration and co-ordination of public health action with reduced gaps and overlaps.</td></tr>
<tr><td colspan="2">Establish a regional PH Māori media and communication strategy.</td><td colspan="2">Source relevant health education resources to support this process.</td><td>Relevant health messages delivered to tangata whenua.</td></tr>
</table>

The key initial partners to achieve progress on this objective are: Northland DHB provider arm, PHOs, Te Tai Tokerau Māori Health Strategic Alliance, other health sector NGOs and community leaders.

4.4 Mauri Ora – access to Te Ao Māori

This element refers to Māori gaining and maintaining access to Te Ao Māori and encompasses the inner strength and vitality resulting from this. A secure cultural identity is recognised as a building block of hauora while deculturation is linked to poor health. [70] This sense of identity needs to be linked to sharing the group's collective cultural, social, and economic resources. In contemporary society being Māori for some is under threat. Mauri Ora is central to many kaupapa Māori public health programmes, including aukati kai paipa and auahi kore Marae.

4.4.1 Hapu development

As Treaty signatories alongside the British Crown, hapu have a unique status within Aotearoa New Zealand. Hapu are the centre of localised decision making and frequently have strong leadership structures. Enabling hapu development was recognised by contributors to the plan as a core component of effective Māori public health action and a means to fulfill Treaty obligations. See also 5.4.3.

4.4.2 Evidence base

In developing this plan it has become clear that there is not a comprehensive picture of the public health status of Northland; certainly not one that is inclusive of Māori world views. There are a number of gaps and omissions in quantitative data for Northland and in ethnic specific material. Surveillance data is steadily improving but is not being used consistently in public health planning.

There is also limited availability of qualitative data in Northland. There are a number of informal, unpublished evaluation reports of variable quality and some external evaluations. These are not centrally held, nor easily accessible for practitioners engaging in public health planning. In addition there is little peer-reviewed and formally published material.

This lack of evidence poses risks that need to be addressed through workforce development in the sector and increased investment in research. It seems timely to develop a research agenda to fill identified evidence gaps and broker research projects into Te Tai Tokerau. Evidence gathering needs to incorporate indigenous world views about hauora and build local capacity in this area.

4.4 Mauri Ora – Access to Te Ao Māori: To strengthen access to culture and cultural institutions		
Key actions		**3-5 year outcomes**
Enable hapu development as a core component of effective Māori public health action.	Method developed through engagement with tangata whenua.	Strengthened hapu engagement in hauora.
Develop a Northland public health research agenda inclusive of qualitative and quantitative approaches and kaupapa Māori methodologies.	Source funds to advance research priorities and disseminate information.	Strengthened evidence base inclusive of Māori world views and improved health planning.

The key initial partners to achieve progress on this objective are: hapu, Northland DHB provider arm, PHOs, Te Tai Tokerau Māori Health Strategic Alliance, community leaders, research funders and providers.

4.5 Waiora – environmental protection

This element is about balance, harmonising people with their environment and subsequently protecting the environment. It recognises the mauri and the interconnectedness of all things, and that the human condition is intimately connected to the wider domains of Rangi and Papa. It is difficult to achieve hauora…

> "…if there is environmental pollution; or contaminated water supplies, or smog which blocks out the sun's rays, or a night sky distorted by neon lighting, or earth which is hidden by concrete slabs, or the jangle of steel which obliterates the sound of birds." [71]

Urgent action on the building blocks of hauora (3.1) will lay the foundation for strengthening the social environment that is complementary to key actions on the physical environment and community development, outlined below.

4.5.1 Kaimoana, waterways and water quality

Water is considered a taonga by tangata whenua. This has been recognised as such by the Crown through The Waitangi Tribunal Whanganui, Manukau and Mohaka River Reports.[72] Within hapu, individuals traditionally taught people to be kaitiaki or guardians of the waterways and other taonga for current and future generations. This was enabled by an intricate system of tikanga around water, based on the principles of tapu and noa and the imperative of sustainability.

Access to clean water and waterways were identified as strong themes throughout the consultation that needed to be addressed. Māori reported feeling marginalised from their traditional kaitiaki function.

A significant number of people in Northland do not enjoy easy access to safe water; rather their access to a water supply has been limited and at times contaminated. Northland has 277 drinking water supplies that are registered with the Ministry of Health (35 local authority, 76 school supplies and 166 other supplies). At the last review in 2005, there was no bacteriological compliance in 40% of TLA supplies, in 82.9% of school supplies and 99.4% of other supplies.

The Drinking Water Assistance Programme, comprising technical and capital assistance (TAPS and CAPS respectively), is a response to this problem but is currently inadequate. The Programme prioritises neighbourhood and small drinking water supplies that supply no more than the equivalent of 100 or 500 people respectively for at least 60 days per year.[13]

Analysis of the recent round of capital funding allocations from the Drinking Water Assistance Programme shows that on a crude population basis, with no adjustment for the need described above, at the 2006 Census Northland had 3.69% of New Zealand's usually resident population (or 3.73% of the total population count) but received only 3.54% of the capital funding allocated. In this funding round, district councils captured 65% of the funds. This inequity is in part due to the current policy of the programme. In the meantime, small communities continue to suffer because their water supply is insufficient in quantity and quality.

People in Northland collect shellfish which are at times contaminated by disease-causing organisms. This results in adverse health impacts not only for those people who live in the area and collect and eat kaimoana but also for those people in the surrounding areas who rely on the same food baskets that have sustained them for hundreds of years. A joint project between ESR

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m As defined in the Health (Drinking Water) Amendment Act 2007

and Ngapuhi found the presence of human enteric viruses in 19 of 49 shellfish (38.8%) collected from two traditional shellfish harvesting beds (Waitangi and Te Haumi beds).[73]

4.5.2 Rural community development

A significant proportion of Northland's residents are rurally located. Each community has their own set of health (and infrastructure) priorities. This is challenging in the Northland context due to the geographic spread of the population. Community development is seen as an appropriate vehicle for dealing with public health issues in this context, as this approach ensures communities are in the driving seat. [74]

4.5.3 Enabling kaitiakitanga

Acknowledging the work that has already been done in this area, plan contributors called for increased efforts to enhance Māori traditional kaitiakitanga function within the broad realm of environmental health.[75] Given this kaitiaki function, questions were asked on what services could be devolved or delivered in partnership with Māori organisations.

A successful local kaitiaki based model is the work Hauora Hokianga did (and continues to do) on marae water supplies and community-based sewage treatment and disposal after the devastating 1999 floods.[14] After considerable community consultation, water treatment or tank systems have been installed in all thirty six marae in the district. The flow on in terms of positive engagement with other health initiatives has been built on the success of the water project.

A number of communities in Northland have major sewage management issues. These result from faulty or poorly maintained septic tanks causing direct impact on residents by way of; risk of disease through physical contact with faecally contaminated wastewater, children unable to attend school due to being sick, and subsequent financial burden on the household. These problems were only partially solved by the Sanitary Works Subsidy Scheme. Marae have particular difficulties because septic tanks systems do not work effectively when the sewage load is highly variable.

<table>
<tr><td colspan="3">4.5 Waiora – Environmental Protection: To promote healthy environments</td></tr>
<tr><th colspan="2">Key actions</th><th>3-5 year outcomes</th></tr>
<tr><td>Conduct monitoring of the safety of kai moana comparable to the systems in place for commercial shellfish.</td><td rowspan="3">Ensure work is consistent with tikanga and inclusive of input of community leadership, including kaumatua and kuia.</td><td rowspan="3">Healthy water and kaimoana.
Enhanced kaitiakitanga.
Reduced enteric disease attributable to kai moana and inadequate sewage treatment.
Reduced waterborne disease.
Improved performance on community outcomes.</td></tr>
<tr><td>Maintain acceleration of the Drinking Water Assistance Programme for small drinking-water supplies and ensure that the policy settings are appropriate to meet the need.</td></tr>
<tr><td>Investigate rolling out the kaitiaki based environmental health approach developed in the Hokianga.</td></tr>
</table>

n Foote J, Ahuriri-Driscoll A, Hepi M. Personal communication, 25 September 2007.

Use community development models with interested rural communities.	Resource communities to enable this process utilising community development principles.	Increased community resilience and engagement in hauora.

The key initial partners to achieve progress on this objective are: Ministry of Health, Food Safety Authority of New Zealand, Territorial Local Authorities, hapu, Northland DHB provider arm, Te Tai Tokerau Māori Health Strategic Alliance, and community leaders.

4.6 Toiora – healthy lifestyles

Toiora is about minimising threats to health by adopting healthy lifestyles. Preventable injury, self-harm and illness are obstacles to many living a long and healthy life. The subsequent loss to whanau, communities, and New Zealand from premature and preventable death is significant. Targeted interventions at individual and community levels need to stand alongside macro policy solutions that address the poverty traps and deculturation that feed these lifestyle choices. It is important to note:

> "…it would be an over simplification to suggest that everyone had the same degree of choice regarding the avoidance of risks. Risks are highest where poverty is greatest." [76]

The adoption of healthy lifestyles through behaviour change lies at the heart of much public health action. Central to successful behaviour change is an understanding of the theory and practice of behaviour change. Public health action needs to recognise the risk conditions in which people are living and their psycho-social and psycho-cultural circumstances. Healthy lifestyle choices are most likely to be made and sustained in an engaged community with a supportive policy, social and whanau environment.

4.6.1 Comprehensive sector quality improvement

Northland's current delivery of lifestyle-based public health actions appears decidedly "organic" with the absence of both a regional approach and a medium to long term strategic view. Some contracts appear to have been rolled over without substantive review and programmes have been maintained for historical rather then evidence based reasons. Northland's statistics related to healthy lifestyle (see section 2) illustrate that the status quo approaches are not all achieving the desired health outcomes. This is particularly true for tangata whenua (see 4.6.2).

At the heart of public health practice are robust quality improvement processes and systems; in particular good planning and evaluation. Across the sector various quality improvement programmes are in place in public health providers and various internal and external auditing processes exist. There needs to be a strategic focus on quality improvement.

Under 3.3.2 work will be done to re-align contracts to be outcome based which will alleviate some of these issues. To advance lifestyle work it seems useful to stocktake what is going on regionally both within the sector and intersectorally, review relevant literature and evidence, and facilitate a process to determine a 3-5 year pathway for each issue. This work would be informed by the local service mapping being undertaken by the Ministry of Social Development and by previous stocktakes[77]. It would ensure delivery was aligned to relevant strategic documents and localised knowledge and could help focus workforce development (3.2) and research agendas (4.4.2). A systematic approach needs to be taken that is future-focused, strengths-based, enabling for public health practitioners, and recognises the importance of social capital to support healthy lifestyle choices.

Nutrition and physical activity is one area where work has already started to pull the sector together to develop evidence-based approaches and jointly plan with intersectoral partners. Priority action areas have also been identified to focus public health action, including breastfeeding, a nutrition fund for schools and early childhood education services, communications, evaluation, and workforce support. This process could provide some valuable lessons for other issues.

This mapping/ audit/ review process would also need to occur across the geographic reach of Northland to ensure appropriate coverage of public health service provision and with sub-populations.

4.6.2 Investment in kaupapa Māori approaches

The urgency of addressing major chronic preventable diseases such as cardio-vascular disease and cancer that are decimating whanau was echoed through the development of this plan. Many contributors wanted to see greater investment in Māori-led programmes to address these chronic health statistics. While acknowledging the role of population-wide services that specifically address Māori health needs, kaupapa Māori approaches to these issues were seen as very effective in motivating and reaching tangata whenua.[78] This prioritisation is heightened by limited evidence to support claims that "generic" services and universal approaches were getting traction within local Māori communities. [79]

Māori identified Korikori a Iwi as a positive example of a Māori-led regional approach.[80] Auahi kore, aukati kai paipa, and physical activity initiatives were seen as particular priorities to be delivered through a whanau ora approach. Given the youth of the Māori population, Northland tamariki and taitamariki also need to be a key focus to this increased investment in kaupapa Māori approaches.

4.6 Toiora – Healthy Lifestyles: To promote healthy lifestyles, minimise harm, and strengthen cultural relevance			
Key actions			**3 – 5 year outcomes**
Within a quality improvement framework, stocktake public health action on individual PH issues throughout Northland.	Review relevant literature and evidence and facilitate a process to determine a 3-5 year pathway for each issue.	Ensure pathways have a strong reducing inequalities and Māori health gain focus.	Improvements in desired health outcomes.
Map existing kaupapa Māori programmes to ensure coverage of priority sub-populations across the geographic spread of Northland, with particular attention to taitamariki.	Identify gaps and advocate for investment in kaupapa Māori approaches to bridge these gaps.		Improved health outcomes for tangata whenua. Strengthen taitamariki engagement with hauora.

The key initial partners to achieve progress on this objective are: Ministry of Health, Northland DHB provider arm, Te Tai Tokerau Māori Health Strategic Alliance, PHOs, and other health sector NGOs.

5 Appendix

5.1 Public Health Steering Group

Member	Position	Organisation
Cayti Whitton (Chair) Kim Tito (Chair) in CW's absence	Population Health Strategist General Manager, Service Development & Funding and Māori Health	Northland DHB Northland DHB
Louise Kuraia	Strategic Projects Manager/ Senior Policy Analyst	Te Tai Tokerau MAPO Trust
Anna Redican or Jo Wall (delegate)	Northern Regional Manager, Public Health Operations Public Health Medicine Specialist	Ministry of Health Ministry of Health
Jeanette Wedding	GM Child, Youth, Maternal, Public and Dental Health	Northland DHB
Jonathan Jarman/Loek Henneveld	Medical Officer of Health	Northland DHB
Maxine Shortland	General Manager Matauranga Whanui	Ngati Hine Health Trust
Lisa McNab	Te Roopu Whakahirahira Manager	Te Hauora O Te Hiku o Te Ika
Chris Farrelly	CEO, Manaia PHO	Northland PHOs
Marama Wiki	Regional Commissioner, Ministry of Social Development	Northland Intersectoral Forum
Heather Came	Public Health Planner	Te Tai Tokerau MAPO Trust
Gillian Durham	Public Health Planner	Northland DHB

5.2 Contributing organisations

Accident Compensation Corporation

Alcohol Advisory Council of New Zealand

Action on Smoking and Health

Cancer Society

Environmental Science & Research Ltd

Far North District Council

Hapai Te Hauora Tapui

Hauora.com

Hauora Hokianga

Health Research Council

He Iwi Kotahi Tatou Trust

Housing New Zealand

Kaipara Care

Kaipara District Council

Kaipara District Council open forums at Dargaville and Maungaturoto

Ki A Ora Ngati Wai

Manaia Primary Health Organisation

Mental Health Foundation

Ministry of Health

National Heart Foundation

Ngati Hine Health Trust

Northland District Health Board funder and provider arms

Northland Regional Council

NZ AIDS Foundation

New Zealand Food Safety Authority

Pacific Islands Charitable Trust (Northland)

PHO Managers as a group

Public Health Association

School of Population Health, University of Auckland

Sport Northland

Te Ha O te Oranga o Ngati Whatua

Te Hauora O Te Hiku o Te Ika

Te Puni Kokiri

Te Runanga o Te Rarawa

Te Tai Tokerau Māori Health Strategic Alliance

Te Tai Tokerau Primary Health Organisation

Te Tai Tokerau MAPO Trust

The Quit Group

Tihewa Mauriora Primary Health Organisation

Tihi Ora MAPO Trust

Whakawhiti Ora Pai

Whangarei District Council

Whangaroa Health Services

5.3 Submissions received on working draft of the plan

Public and Population Health Unit, Northland DHB

Public Health Nurse team, Northland DHB

Director of Medical Services, Northland DHB

Manaia PHO

Northland PHOs

Te Ha o Te Oranga o Ngati Whatua

Ngati Hine Health Trust

Ministry of Health (x2) and Health Impact Assessment Support Unit.

Ministry of Social Development

Northland Intersectoral Forum

Action on Smoking and Health

New Zealand AIDS Foundation

Accident Compensation Corporation

Alcohol Advisory Council

Public Health Association

Glossary[15]

access	The ability of people to reach or use health services. Barriers to access may be influenced by: • a person's locality, income or knowledge of services available • the availability or acceptability of existing services.
community	A collective of people identified by their common values and mutual concern for the development and wellbeing of their group or geographical area.
effectiveness	The extent to which a specific intervention, procedure, regimen or service, when implemented, does what it is intended to do for a defined population.
epidemiology	The study of the distribution and determinants of health related states or events in specific populations.
equity	Fairness.
evaluation	Assessment of a service or programme against a standard. Evaluations can be: • formative (informs the development and improvement of a programme) • an assessment of the process (describes the programme and helps to explain why it produces the results it does) • an outcome evaluation (an assessment of the ultimate effects of a programme).
evidence-based practice	Practice that is based on scientific evidence that demonstrates effectiveness.
goal	A high-level strategic statement.
hapu	Clan, tribe, subtribe; section of a large tribe.
hauora	Wellness of body and mind.
health equity	The absence of systematic disparities in health (or in the determinants of health) between different social groups who have different levels of underlying social advantage/disadvantage – that is, different positions in a social hierarchy. [16]
health promotion	The process of enabling people to increase control over and improve their health status, as described in the Ottawa Charter.
health status	A description and/or measurement of the health of an individual or population.
he tangata	The people.
hinengaro	Mind, thought, intellect, consciousness, awareness.
intersectoral	Joint projects involving various sectors of society including central and

o Sourced from Ministry of Health (eg, the New Zealand Cancer Control Strategy, the Public Health Workforce Plan), Northland District Health Board glossaries and from the online Māori dictionary – www.maoridictionary.co.nz.

p Braveman P, Gruskin S. 2003. Defining equity in health. *J Epidem Comm Health* 57: 254 – 8.

collaboration	local government agencies (health, education, welfare and so on), community organisations and the private sector.
iwi	Tribe or nation.
kaimahi	Worker, employee.
kaimoana	Seafood, shellfish.
kaitiakitanga	Guardianship.
kaumatua	Adult, elder, elderly man, elderly woman.
kaupapa Māori	Māori ideology. 'Being Māori; Māori values and principles; takes for granted the value and legitimacy of Māori, the importance of language and culture and is concerned with the struggle for autonomy over their own culture and well-being."[17]
kotahitanga	Unity.
ko te reo to mauri o te mana Māori	Language is the essence of all that is Māori.
kuia	Elderly woman, grandmother, female elder.
mana whakahaere	Autonomy.
mauri ora	Access to Te Ao Māori – the Māori world.
nga manukura	Leadership.
NIF	Northland Intersectoral Forum - a network of senior local and central government decision-makers.
noa	Be free from the extensions, ordinary, unrestricted.
objective	A statement of what is to be achieved and the range of desired outcomes to achieve a goal.
outcome	The result of an action. As distinct from an output, which is a measure of an activity rather than the result it has. An operation to mend a broken leg is an output, while the return to full function of the leg is the outcome. In a bigger sense, a focus on outcomes aims to analyse how effectively health services are provided and how well they work together.
papakainga	Original home, home base, village.
population health	The health of groups, families and communities. Populations may be defined by locality, biological criteria such as age or gender, social criteria such as socioeconomic status, or cultural criteria such as whānau. A population health approach aims to maintain and improve the overall health of populations and reduce inequalities in health between different groups.
primary health care	Health services provided in the community which people can access themselves. The most well known are those provided by general practitioners, though they also include pharmacy services, private physiotherapists and, increasingly, nurse practitioners.
primary health	A group of providers of *primary health care services* whose responsibility

q Submission MoH 2.

organisation (PHO)	is to look after the people who enroll with them (those who are 'on the register'). PHOs include GPs as well as a whole range of primary health care providers and practitioners (Māori and community health service providers, nurses, pharmacists, dietitians, community workers, and others). As well as providing traditional primary health care services, PHOs must improve access to services for those with higher needs (such as Māori or those with chronic health conditions), have a focus on preventing ill health (rather than waiting till they are visited by sick people) and improve the way services work together.
programme	A planned group of activities directed towards achieving defined objectives and targets.
quality	The degree to which the services for individuals or populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.[81]
rahui	To put in place a temporary prohibition, closed season, ban, reserve – traditionally a rāhui was placed on an area, resource or stretch of water as a conservation or health measure. After an agreed lapse of time, the rāhui is lifted.
strategy	A course of action to achieve health targets.
taiao	World, Earth, environment, nature, country.
tai tamariki	Children and adolescents.
tangata whenua	Indigenous people of the land – people born of the whenua, ie of the placenta and of the land where the people's ancestors have lived and where their placenta are buried.
tapu	Special, elevated, sacred.
te ao Māori	The Māori world.
Te Au Roa	Housing New Zealand's Māori Housing Strategy.
te hoe nuku roa	A longitudinal study of Massey University focusing on Māori whanau.
te mana whakahaere	Autonomy.
te oranga	Participation in society.
te reo rangatira	The noble and chiefly language of Māori.
TLA	Territorial local authority.
toiora	Healthy lifestyles.
total health expenditure	This includes expenditure on institutional care in public and private institutions, community care (general practice, specialist medical services, referred services, medicaments and dental services), public health, and teaching and research.[82]
turangawaewae	Place where one has rights of residence, belongs too.
waiora	Environmental protection.
wairua	Spirit, soul, quintessence - spirit of a person which exists beyond death.
whanau	Extended family, family group, a familiar term of address to a number of

people.

whanau ora	A Ministry of Health-driven process aimed at supporting healthy Māori families which emanates from *He Korowai Oranga*. It aims to identify and extend whanau strengths and build them into initiatives throughout the health sector.
whenua	Land, country, ground, placenta.
workforce excellence	Promoting excellence and best practice in the public health workforce development through the strengthening of both cultural and technical/clinical expertise, models of practice, training opportunities, competency-development, and the valuing of both bodies of knowledge to achieve Māori public health gains.
workforce expansion	Increasing capacity of the public health workforce to respond to Māori public health through dual cultural and technical/clinical-based recruitment and retention strategies across all disciplines, professions and occupations.
workforce extension	Enhancing the capability of the public health workforce to respond to Māori public health needs by strengthening the expertise of workers in related fields and recognizing public health gains via other sectors and individuals contributing to health protection and promotion.
workforce navigation	A coordinated approach to workforce development at national and regional levels in the health sector and also more widely across the broader arena of Māori development. This is supported by informed workforce planning, research, evaluation and planning.

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