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DISCUSSION DOCUMENT - JUNE 2007

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# Introduction

The *Niu* Pacific Health Plan is MidCentral District Health Board's (MDHB) plan for advancing Pacific peoples' health for the period 2007-2009.

The plan builds on the *niu* approach to health developed by the health plan writers and the MidCentral Pasifika Health Development Group. There are two parts to the plan. The first part outlines the context and background for the priorities and goals presented in the second part. The priority areas are:

1. Pacific provider and workforce development
2. Improving and protecting Pacific child and maternal health
3. Improving and protecting the health of Pacific youth
4. Improving and protecting the health of Pacific people with long-term chronic conditions
5. Promoting healthy lifestyles and wellbeing for all Pacific peoples
6. Pacific health information, research and communication

This *Niu* Pacific Health Plan intersects with and builds on the following Ministry of Health (MoH) and MDHB policy documents (Appendix One):

- New Zealand Health Strategy, MoH, 2000
- Pacific Health and Disability Action Plan, MoH, 2002
- Well Child Framework, MoH, March, 2002
- Pacific Health and Disability Workforce Development Plan, MoH, 2004
- Primary Health Care Strategy, MDHB, April 2004
- Ageing in MidCentral: Health of Older People Strategy, MDHB, September 2004
- Diabetes Service Plan, MDHB, July 2005
- Cancer Service Plan, MDHB, August 2005
- Maternity Services Strategy, MDHB, August 2005
- Child Health Strategy, MDHB, September 2005
- Cardiovascular Service Plan, MDHB, September 2005
- Secondary Care Services Strategy, MDHB, September 2005
- Oral Health Service Plan, MDHB, October 2005
- Respiratory Service Plan, MDHB, November 2005
- Depression Service Plan, MDHB, December 2005
- Health Needs Assessment, MDHB, 2005
- District Annual Plan, MDHB, 2006/7

## Reasons for the *Niu* Pacific Health Plan

The *Niu* Pacific Health Plan is a comprehensive, Pacific focused action plan, which moves MidCentral further towards the accomplishment of positive health outcomes for Pacific peoples in MidCentral. Many existing MidCentral strategies and plans include Pacific related initiatives, sometimes conflated as 'Maori and Pacific' initiatives (Appendix One). Maori-centred planning and development is necessary, given tangata whenua status and the Treaty of Waitangi, and this has been achieved in part with the development of *Oranga Pumau: Maori Health Strategy* (MDHB, 2005) and the *Maori Health Workforce Strategy* (MDHB, 2005). The conflation of Maori and Pacific peoples' health, however, will not necessarily lead to change in

Pacific health status. While health issues may be similar between Maori and Pacific peoples, improvement in health status for Pacific peoples will most likely be realised when their distinctive characteristics are taken into account. Issues related to migration, accelerated cultural change, language and access underline the importance of tailoring culturally relevant policies and services. Positive health outcomes for Pacific peoples can occur when their particular needs, cultures and aspirations are given due consideration in policy making and service planning. The *Niu Pacific Health Plan* sets the platform for such development in MidCentral.

## **Process for Developing the *Niu Pacific Health Plan***

A Pacific Island Community Awareness Raising Group was set up at the end of 2004 in the MidCentral region to assist with the implementation of an immunisation schedule, known as the MeNZB programme. Over a three month period, several Pacific fono were held in Palmerston North and Horowhenua. The programme was notably successful and this was attributed to the following factors:

- **Pacific networks:** in-person contacts, including community fono, were utilised to inform communities.
- **Ethnic specific:** wide community engagement was achieved through ethnic specific fono. For example, the first pan-Pacific fono in Horowhenua did not have any Tongans in attendance. However, when a Tongan community leader was engaged to assist and there was a Tongan specific fono, there were 200 who attended the Tongan community fono. One in four Pacific peoples in the MidCentral region was accessed via ethnic specific fono.
- **Community leaders:** community leaders were engaged, acknowledging that it matters who the messenger is.
- **Resourcing:** community representatives were adequately remunerated for their cultural knowledge, skills and coordination role.
- **Pacific nurses:** Pacific nurses working in the MidCentral region took on extra duties and worked after hours to administer the immunisation service. They were able to offer the service using Pacific languages.
- **Mobility:** in many cases, the immunisation service was taken to families in their homes.

The Pacific Island Community Awareness Raising Group continued to meet, but now has a broader focus on Pacific health and is known as the MidCentral Pasifika Health Development Group. There are around 30 members, including Pacific professionals in health and related fields in the MidCentral region.

A series of community fono were held in Palmerston North and Levin as part of the process of developing this *Niu Pacific Health Plan*. The first fono held in July 2006 engaged community members to identify what their ideal Pacific health service would entail. The subsequent fono in November 2006 and the Pacific community leaders' fono in March 2007 involved reporting back and consulting on the plan's progress.

# The *Niu* Pacific Health Approach

The *Niu* Pacific Health Plan employs the metaphor of the *niu* (coconut plant) to depict a vision and philosophy of Pacific health and development<sup>1</sup>. There are a number of Pacific language proverbial sayings which refer to the *niu* and which reflect Pacific values and perceptions of health, wellbeing and development:

## ***Samoa***

"Ole pa'u a le popouli (niu)"

Explanation: When a mature/ripe coconut falls to the ground, it becomes rooted and produces new growth. This is unlike an immature or unripe coconut, which will rot on the ground. This can be applied to a strong and clever person or to a strong community not easily overcome (Pratt, 1911).

## ***Cook Island***

"Kapuaanga mei te uto, riro mai ei pu nu tupu ruperupe e te uua; ei utuutu e ei marumaru, no te au uki ki mua"

Explanation: The budding coconut begins life seeking and settling for a safe and suitable environment. It flourishes to maturity, providing shelter and sustenance to protect and nurture future generations (personal communication, Elizabeth Leahy and Raetea Ngatama, April 2007).

## ***Tonga***

"Potopoto a niiumui"

Explanation: The 'cleverness' of a young coconut tree This can be applied to someone who is young and inexperienced (Mahina, 2004). In relation to the implementation of the *Niu* Pacific health plan, it is understood that time and experience can lead to greater maturity and wisdom.

## ***Fiji***

"Tea nikua me baleta na nomu mataka" (Meo, Dale, & Dale, 1985)

Explanation: Plant today for your tomorrow. Planting the seed today, or the inception of the health plan, will benefit our children and our future as Pacific peoples in Aotearoa. The wisdom to know how and what to do now will have an impact on the future of our children – so it is important to plan for the future. The verb 'plant' implies the need to make a difference through some form of action. The inception of the *Niu* Pacific Health Plan today, with the concerted efforts of Pacific communities will have positive health outcomes realised for generations to come.

## ***Indo-Fijian***

"Naariyal"

Explanation: The coconut (naariyal) has significance for the Hindu religion practiced within Indo-Fijian communities. The coconut is used in 'pooja' (prayers) where it is put on a fire, representing a cleansing of negative thoughts thus enabling one to be in a clean, pure, peaceful and loving state. This is understood to ultimately align mind, body and soul, thereby creating a feeling of health and wellbeing (personal communication, Nirmala Nand, 1 March, 2007).

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<sup>1</sup> It has been shown elsewhere that metaphors are an appropriate way to present Pacific knowledge and values and to represent models for social and community practice in contemporary contexts (Mafale'o, 2005b; The Community Employment Group, 2004).

### **Rotuma**

“Niu asoa; Niu he rua”

Explanation: “Coconut Helper, Two coconuts”. This refers to the custom of presenting coconuts in pairs at feasts (Inia, 1998). As the saying implies, one is given and the other is a helper. When coconuts are presented with a basket of food they are carried on a pole to balance the basket; in order to be carried on a pole they must be tied together in two pairs (*niu asoa rua*). Odd-numbered things are regarded as incomplete; wholeness is associated with even numbers. This proverb demonstrates the need for balance in health and life.

### **Tokelau**

“Ke ola lelei te niu”

Explanation: This proverb states, “let the coconut live” (personal communication, Oneone Sini, March 2007). The *Niu Pacific Health* plan facilitates quality of life and wellbeing.

### **Niue**

“Ka gahua a koe he tafagafaga moua ni a koe he pona huli”

Explanation: If you work on shrub land you reap a poor harvest. Similarly, if we want good social, education and health outcomes, we need to have high aspirations (personal communication, Sonny Freddie Liuvaie, March 2007).

The *niu* has some shared meaning across the Pacific and, for the purposes of this plan, distinguishes Pacific peoples’ cultures from that of *iwi* Maori as the *tangata whenua* of Aotearoa. The *niu* represents life, wellbeing, resource, usefulness and regeneration. Starting life as a seed, when nourished with soil, sun and water, the *niu* establishes roots and grows in strength to bear fruit.

The *niu* invokes several layers of meaning in regard to Pacific health in MidCentral. There is acknowledgement that this plan is a small beginning and, like a seed, requires appropriate nurture and input from a variety of sources, to bring the vision to fruition. These sources include clinicians, funders, community and Pacific churches.

From another point of view, positive Pacific health arises from strong Pacific cultural roots. Collaborative efforts between community and mainstream are warranted, to assist the growing majority of New Zealand–born Pacific peoples to access Pacific cultures and, further, to positively contribute to innovations in Pacific knowledge, wellbeing, and leadership and so on.

This leads onto a generational understanding of Pacific health drawn from the *niu* approach; when a *niu* plant matures, the fruit drops to the ground with potential to grow into another plant and to nourish others. The health development initiated for Pacific children, for example, will have benefits for future generations of Pacific and other New Zealanders as they grow to make a positive contribution to their families and communities.

The *niu* health metaphor then is holistic. It integrates the past, present and the future. It also resonates with the *fonofale* model (Pulotu-Endemann, 2002) widely used within Pacific health throughout New Zealand (Appendix Two). The *fonofale* model rests on family as a foundation – both nuclear and extended. The pillars represent spiritual, physical, mental and other dimensions of health, while culture serves as an umbrella encompassing the various components. Environment, time and context surround the *fale*, impacting on Pacific health and wellbeing.

From the *Niu* and *Fonofale* perspectives, health transcends beyond the absence of disease for an individual; health manifests and is experienced collectively. Community development, therefore, is central to the transformation of Pacific peoples' health.

## **Community Development**

Harnessing the resource inherent within Pacific communities is pivotal to achieving desired health outcomes for Pacific peoples. Pacific communities are defined as "groups of individuals, their families and associates who may share common characteristics, cultures, values, interest, visions and/or goals; and who collaborate to fulfil shared purposes and aspirations" (The Community Employment Group, 2004, p.14). Pacific communities may be ethnic specific or pan-Pacific and may include churches, youth groups, and women's groups and so on.

A community development approach engages with communities in order that they understand the causes of disparity, identify their needs and aspirations and develop strategies to achieve sustainable social transformation (Elliot, 1978; Ife, 2002; Munford & Walsh-Tapiata, 2000).

The community approach is the best strategy for achieving change in Pacific communities and therefore, for improving the health of Pacific peoples (Mafale'o, 2005a; The Community Employment Group, 2004; Tiimalu-Faleseuga, 1993). Such an approach is in line with the 2004 *New Zealand Health Strategy* and the *Pacific Health and Disability Action Plan*, both of which support culturally appropriate strategies and initiatives.

## **Community Settings**

A method that has been used internationally and within some DHBs here in New Zealand is the 'settings approach to health promotion' (World Health Organisation, 1986). This approach focuses on places where people live, work or play with emphasis on the environment rather than the behaviour that is to be changed. It shifts away from disease focused vertical programmes and requires community participation; in contrast to the disease approach it addresses the needs within the chosen setting. While literature argues that this approach is time consuming and requires a lot of networking within communities, established networks within Pacific communities make this approach an appropriate one. Moreover the initiatives focus on a system that not only treats illness but also promotes good health and wellbeing. The Ottawa Charter for Health Promotion (World Health Organisation, 1986) clearly defines these strategies (Appendix Three). It looks beyond health education and considers other aspects that can allow a person to increase control over the factors that improve his/her health. For Pacific peoples this is best achieved through group initiatives and the concerted effort of the community to bring about the desired change. Initiating changes through existing social structures, such as churches and women's groups, will improve health amongst Pacific peoples.

While there are established mainstream and non-Pacific services available for Pacific peoples, access to health services remains a primary barrier to Pacific peoples' wellbeing (Huakau & Bray, 2000; Moata'ane, Muimui-Heata, & Guthrie, 1996; Young, 1997). Barriers include communication, the stigma associated with particular health issues, location and physical environment. Via community development processes, and the settings approach in particular, partnerships will be formed between MDHB and Pacific communities to improve health access.

## **Vision**

The *Niu* Pacific Health Plan, in line with the Pacific Health and Disability Action Plan (Ministry of Health, 2002), has the following vision:

*Healthy Pacific peoples supported by healthy families and communities, achieving their full potential throughout their lives.*

This vision requires that access issues and inequalities are addressed, and that services are culturally appropriate for Pacific peoples in the MidCentral. The *Niu* Pacific Health Plan sets the premise for the establishment of a Pacific health service in the MidCentral region to help achieve this vision.

## **Values and Principles**

Emerging from the *niu* health approach there are several identifiable values and principles underpinning the *Niu* Pacific Health Plan:

1. Cultural diversity – valuing cultural diversity and acknowledging both shared and distinctive cultural factors related to nation, language, New Zealand-born and Island-born, gender and age (Macpherson, 2001; Tiatia, 1998);
2. Pacific knowledge and frameworks for health practice (Agnew et al., 2004; Pulotu-Endemann, 2002);
3. Community development – culturally relevant and effective change processes (Mafile’o, 2005; Tiumalu-Faleseuga, 1993).

## **Background Information**

### **Pacific Peoples**

Pacific peoples are “linguistically, culturally, and geographically distinctive from each other” (Health Research Council of New Zealand, 2003, p.4). There are several major Pacific nation groups in New Zealand: Samoa, Cook Islands, Tonga, Fiji, Tokelau, Niue and Tuvalu. However, Pacific peoples include many other Pacific nation communities, for example Kiribati, Solomon Islands, Papua New Guinea or Tahiti. Samoans account for around half of the Pacific population, and Cook Islanders and Tongans are respectively the next largest groups. Cook Islanders, Niueans and Tokelauans are New Zealand citizens by birth. The growing New Zealand-born Pacific population (58% at the 2001 Census) adds to the diversity within Pacific communities. The Pacific population is projected to rise in all regions of New Zealand. By 2021, it is expected that the Pacific population will constitute 9.1% or 420,000 of the New Zealand population. This is a 59 percent increase over the 2001 figure of 260,000 (Statistics\_New\_Zealand, 2005).

The MidCentral region’s Pacific peoples’ population has steadily increased, with 5,892 or 2.7% being Pacific peoples amongst a total of 220,000 (Statistics New Zealand, 2006). This an increase from the 2001 Census where Pacific peoples constituted 2.0% of the MidCentral population (Statistics New Zealand, 2006).

MidCentral region covers four whole territorial authorities and part of a fifth, Kapiti Coast. These territories are Palmerston North, Manawatu, Horowhenua, and Tararua. Palmerston North and Horowhenua have the most number of Pacific peoples (2,754 and 1,014 respectively) (Statistics New Zealand, 2006). However, because Horowhenua is more rural, there is less access to health care. The *Niu* Pacific Health Plan outlines initiatives which will increase accessibility and reduce inequality (MDHB, 2005b).

The Pacific people's population has a relatively young age structure, with the majority being between 15-44 years old. This population will age and health programmes will need to be in place to cater for their needs.

## Pacific population profile in MidCentral

- *MidCentral's Pacific peoples population has a younger age balance compared to MidCentral overall.*
- *Roughly 56% of MidCentral Pacific Peoples are aged under 25, compared to 37% of MidCentral's overall population.*
- *The proportion of MidCentral's Pacific Peoples population aged 65 or over is less than for MidCentral's overall-3% compared to 13.5%.*
- *By 2021, 48.3% of Pacific Peoples will be under 25 and 6% aged 65 and over.*

*(MDHB, 2005)*

The youthful profile of the Pacific population in MidCentral is the basis of the particular emphasis on children and youth in the *Niu Pacific Health Plan* priorities.

### **Pacific Peoples' Health**

Nationally, Pacific peoples generally suffer from a number of communicable and lifestyle diseases. These diseases are compounded by the fact that a disproportionate number of Pacific peoples are socio-economically disadvantaged and are therefore affected by other factors that determine health (Poutasi, 2001).

Following the settings approach to health promotion', prevalent diseases amongst Pacific peoples can be addressed more effectively by identifying contributing risk factors as follows:

**Physical Activity:** Studies indicate that 73.5% of Pacific peoples are obese (MDHB, 2005b). Even though Pacific peoples are more likely than non Pacific New Zealanders to engage in some form of physical activity, rates of obesity continue to increase especially among Pacific females (82.2%) (MDHB, 2005b). The National Children's Nutrition Survey found that 62% of Pacific children in New Zealand were overweight or obese, compared to 31% of New Zealand children overall (Parnell, Scragg, Wilson, Schaaf, & Fitzgerald, 2003).

**Nutrition:** Pacific peoples are known as feasting people. Food choices at these feasts often lack good nutritional value. This in turn contributes to the high incidence of obesity, diabetes, cardiovascular diseases and other such lifestyle diseases. Initiatives encouraging healthy food choices within settings where most of the feasting occurs is a major part of the *Niu Pacific Health Plan*.

**Tobacco:** A total of 36.4% Pacific peoples are smokers within the MidCentral region. Specifically, 44.4% of Pacific men and 28.7% of Pacific females smoke. There are almost twice as many Pacific males who smoke compared to European/Other ethnic groups whereby 24.8% of males are smokers (MDHB, 2005b). Infectious and respiratory diseases affecting children - such as asthma, and bronchitis - and non-communicable or lifestyle diseases such as cancer/stroke/cardiovascular diseases affecting adults, are also addressed in this *Niu* Pacific Health Plan.

**Alcohol:** Although alcohol consumption among the Pacific population is similar to that of the national population, consumption among Pacific males is slightly higher (30.8%) than Europeans (27.3%). In addition to avoidable accidents and injuries resulting from excessive drinking there are other health issues such as sexually transmitted infections (STI) and teenage pregnancies. The *Niu* Pacific Health Plan includes initiatives which aim to reduce the negative health effects of excessive drinking or alcohol abuse among Pacific peoples specifically the Pacific youth.

### **Other contributing factors**

**Screening Services** (breast/cervical/mental): Another major contributing factor to the poor health status of Pacific peoples is the lack of accessibility to and awareness of screening services.

**Dental and Oral Health:** Poor dental health is also a concern for Pacific peoples. The *Niu* Pacific Health Plan contains initiatives that aim to reduce the rates of dental caries, especially amongst young Pacific children.

**Immunisation:** To improve immunisation rates the *Niu* Pacific Health Plan sets out to duplicate the successful approach taken with the MeNZB community initiative which led to the immunisation of more than 90% of Pacific children and youth.

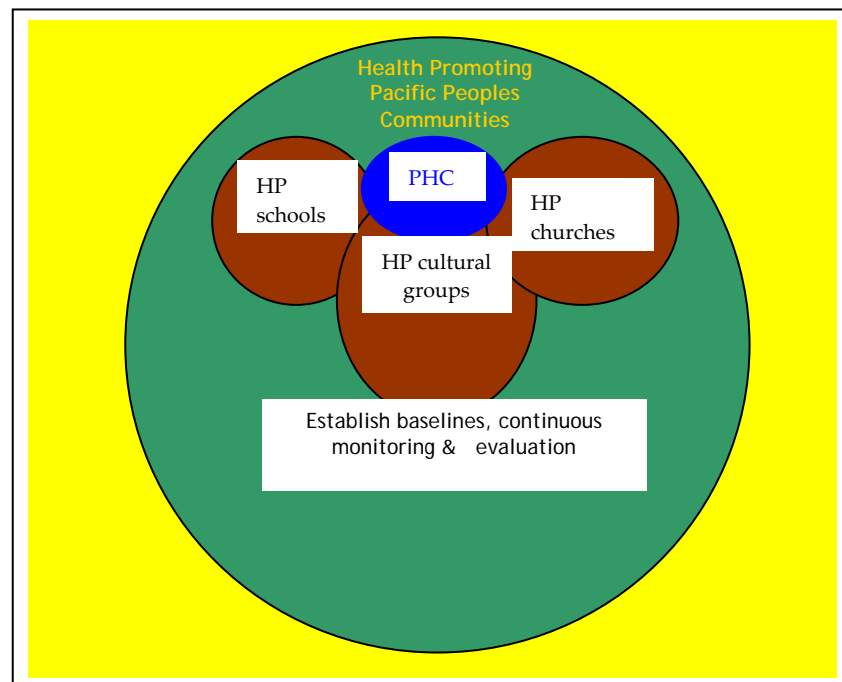
### **Pacific Health Services**

In recent years, there have been groundswell developments in particular regions, whereby Pacific groups and communities have established 'by Pacific for Pacific' services (Ministry of Health, 2004). Such services have been set up to counter the low utilisation of mainstream services by Pacific peoples and concerns around cultural sensitivity in the way services are delivered. The *Niu* Pacific Health Plan therefore includes initiatives that will increase accessibility and address cultural competencies amongst health care providers, primarily through the establishment of a Pacific health service.

## **Health Promotion**

Health promotion is the process of enabling people to increase control over, and to improve, their health (World Health Organisation, 1986). The Ottawa Charter for Health Promotion consists of five action areas that will achieve equity in health and enable all people to achieve their health potential (World Health Organisation, 1986). The vision, values, priorities and initiatives within the *Niu* Pacific Health Plan reflect the essence of the Ottawa Charter and reinforce the need for a community approach. Notably, such an approach was proven successful with the MeNZB project. The 'settings approach' allow Pacific communities to improve health within their community settings. The establishment of health promoting churches, health promoting schools or early childhood centres, women and men cultural groups makes provision for health to be placed on the agendas of these established groups and networks. The Primary Health Care systems is the machinery that will establish baselines within each setting allowing continuous monitoring and evaluation of

health promotion initiatives, resulting in a healthier population group. The approach is illustrated in Figure 1.



**Figure 1: Settings Approach adopted in the *Nui Pacific Health Plan***

The five action areas of the Ottawa Charter, reflected in the *Niu Pacific Health Plan*, are as follows:

***Action Area 1: Building healthy public policy***

Policies must make the 'healthy choice' the 'easy choice'. The *Niu Pacific Health Plan* includes initiatives that advocate for health at regional and community levels. Moreover, community leaders and members with the help of community health workers will have opportunities to develop policies pertinent to their own health, and communities will be empowered to take control of their health.

***Action Area 2: Creating supportive environments***

As a result of the change in policies, environments become more conducive to health. The *Niu Pacific Health Plan* includes initiatives that focus on creating environments conducive to the behaviour that is to be changed. Initiatives address social environments rather than just the behaviour itself.

***Action Area 3: Strengthening community action***

This is the drive of the *Niu Pacific Health Plan*. Community groups are central to the planning and decision making process. The inception of the *Niu Pacific Health Plan* involved such a process. This reinforces ownership of the programme or plan. Pacific peoples community groups are well equipped to mobilise their people into action. The *Niu Pacific Health Plan* imparts a structured approach in strengthening community via the 'settings approach'.

***Action Area 4: Developing personal skills***

Life skills that are conducive to health are developed by providing information, increasing awareness and providing opportunities within a community. The *Niu Pacific Health Plan* facilitates this process through the settings approach in which church groups, cultural groups and other social groups implement skills training on health.

***Action Area 5: Reorient health services***

Reorienting health services means that “the health sector must move increasingly in a health promotion direction, beyond its responsibility in providing clinical and curative services” (World Health Organisation Charter, 1986, p.4). Reinforcing this approach, the MidCentral Primary Health Care Strategy (2004) promotes “a strong focus on health promotion and prevention” (p.7). The *Niu Pacific Health Plan* shifts away from disease focused initiatives, reiterates the need for culturally appropriate initiatives, and encourages health research and the development of a culturally competent workforce to improve the health of Pacific peoples.

## Priority One: Pacific Provider Development and Workforce Development

A key objective of this plan is to lay the foundation for the development of a Pacific health service within MidCentral. This will require development of the Pacific workforce both in terms of numbers and their competency to work with Pacific communities. Secondly, the non-Pacific workforce and services can be assisted to develop their competency to work with Pacific peoples and communities.

Health disparity can partly be attributed to the cultural differences between service providers and service users (Smedley, Stith, & Nelson, 2000). Workforce development will necessarily require health professionals and service providers increasing awareness of their own cultural values, and increasing knowledge of Pacific cultural values. Importantly, increased knowledge will need to translate into actual behaviour, for example, appropriate communication forms or etiquette for undertaking physical examinations.

The need for cultural competency is even more pertinent for mental health practitioners if it is understood that mental health, meaning and perception is more explicitly culturally determined than physical health conditions. Furthermore, the expected impact of health promotion activities in de-stigmatising mental health issues is that there will be an increase in demand for mental health services that are responsive to Pacific peoples' needs.

<b>Objective</b>	<b>Initiative</b>
1.1 Establish a Pacific health service	1. Establish a community-based Pacific health service for Palmerston North and Horowhenua
1.2 Increase the number of Pacific health professionals	2. Prioritise the health related fields where the Pacific workforce is most needed and establish scholarships for Pacific young peoples and second chance learners to gain professional qualifications in those areas  3. Participate in careers expos and the like in order to promote health careers to Pacific peoples  4. Provide opportunities for Pacific health professionals to talk about their career journeys with other Pacific peoples  5. Establish links between high schools, tertiary institutions and MDHB for mentoring Pacific young people through a health qualification  6. Develop Pacific specific positions within the community health sector

<p>1.3 Enhance the competency of the Pacific and non-Pacific workforce to work with Pacific peoples</p>	<ol style="list-style-type: none"> <li>7. Mobilise the existing Pacific workforce in MDHB by coordinating Pacific professional development and networking forums</li> <li>8. Initiate and host an annual Pacific Health Workshop for Pacific community leaders and health practitioners to come together to consult and develop joint initiatives</li> <li>9. Provide cultural competency training and other relevant short courses</li> <li>10. Develop, maintain and make available to health professionals in MidCentral, a database of Pacific peoples available for consultation on cultural and Pacific health matters</li> <li>11. Train a pool of Pacific language translators and develop a Pacific language translation service</li> <li>12. Develop relationships with education providers of health related courses in MidCentral (Massey University, UCOL and Te Wananga o Aotearoa) and liaise on course content related to Pacific peoples' health and Pacific models of practice</li> </ol>
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## Priority Two: Improving and Protecting Pacific Child and Maternal Health

Statistics indicate that Pacific People have a much younger age profile than the total New Zealand population. Thirty nine percent (39%) of the Pacific people's population is under the age of 15 years compare to 23% of the total New Zealand population. The average age of Pacific people's population is 21 years compared to 35 years for the New Zealand total population (MPIA, 2002). In the MidCentral region, the Pacific peoples' population has a younger age structure compared to MidCentral overall. Roughly 56% of MidCentral Pacific peoples are aged under 25, compared to 37% of MidCentral's overall population (MDHB, 2005b).

MidCentral DHB's vision for 2006/2007 is to meet the needs of specific age-related groups such as children and youth. The priority areas therefore are derived from the broader vision and encompass the problems faced by this population group.

Initiatives for this priority are based on *MidCentral's Health Needs Assessment Report* (MDHB, 2005b) and the *Health Status of Children and Young People in the MidCentral Region* report (MDHB, 2005a). The objectives respond to the health needs most relevant to Pacific children.

- ✦ Respiratory infections and their complications such as asthma, bronchiectasis, meningococcal infection and skin infection are all prevalent amongst Pacific children. In the last 10 years prevalence of these diseases and admission rates into hospital in the MidCentral region was highest amongst Pacific children and young people.
- ✦ Dental or Oral health amongst Pacific children is also generally poorer. The use of fluoride at an early age is pertinent if prevalence is to be reduced.
- ✦ Childhood hearing is another major area affecting Pacific children. Almost 14% of Pacific children in MidCentral fail the hearing test; this is higher than Maori (7%) and Pakeha (5%).
- ✦ Child injury and poisoning are lower than average in the MidCentral region among Pacific children. However, there still needs to be a strategy that covers these two issues since national figures indicate that Pacific children have high rates of injury.
- ✦ The immunisation rate amongst Pacific children in MidCentral region close to 90% for the MeNZB programme. This was achieved through the 'door to door' approach led by the Pacific Health workers and Pacific community leaders.
- ✦ Through the consultation process of this plan it has been noted that gastroenteritis among Pacific children is becoming more prevalent.

The implementation of the Well Child/Tamariki Ora National Schedule will help to address some of the health issues outlined as most prevalent amongst Pacific children. The Well Child/Tamariki Ora service is a screening, surveillance, education and support service offered to all New Zealand children and their families and community from birth to five years. It assists families and communities to improve and protect their children's health (MoH, 2002).

### **Maternity Service Strategy**

MidCentral's maternity service's vision is to enable access to a high quality, collaborative and safe maternity service, which is responsive to the needs of women while achieving healthy outcomes for mothers and babies (MDHB, 2005). Maternity care within MidCentral outlines six major goals that the *Niu Pacific Health Plan* aligns with. The goals are increasing access, enabling and maintaining collaboration between primary and secondary care, increasing community participation, ensuring continuity of care through efficient coordination of services, development of infrastructure that will enable implementation of agreed priorities and directions and ensuring that quality maternity service is provided through monitoring of service via a reliable, multidisciplinary and informative process (MDHB, 2005).

Within Pacific communities, increasing awareness on the importance of ante and post natal care is a priority. The provision of best possible, quality and culturally appropriate services for both Pacific mother and babies is part of the *Niu Pacific Health Plan*. There is also need to examine the pressure and mental well being of a Pacific teen faced with pregnancy. Initiatives that allow free flow of information pertinent to their health and wellbeing should be encouraged, hence increasing wellbeing and contributing to the prevention of issues such as suicide.

<b>Objective</b>	<b>Initiatives</b>
2.1 Improve access for Pacific children to primary health care service	<p>13. Work with Horowhenua, Otaki, Tararua and Manawatu PHOs to improve access for all Pacific children to PHC services</p> <p>14. Ensure that the PHC Provider plan makes provisions on how they will improve access for Pacific children, their caregivers and mothers</p>
2.2 Improve uptake of Well Child services/Well Pacific Children	<p>15. Ensure full enrolment and uptake of well child by all Pacific children through the 'Well Child provider and settings' by six weeks and actively monitor</p> <p>16. Work with Plunket and Tamariki Ora services to develop culturally appropriate services to Pacific children and their families</p> <p>17. Monitor and evaluate effectiveness of immunisation services through the well child framework (duplicate initiatives from MeNZB programme)</p> <p>18. Initiate ear checks and monitoring at community level within the Pacific early childhood centres and playgroups and other 'settings' within the Pacific community</p> <p>19. Work with PHC and WCP to ensure initiatives are in place to reduce the rate of serious skin infections</p>

<p>2.4 Reduce the rate of infectious diseases</p>	<p>20. Establish initiatives within existing networks through PHOs, Pacific early childhood centres and schools that focus on meningococcal, rheumatic fever and hepatitis B</p> <p>21. Increase community awareness on infectious diseases via the 'settings' approach</p> <p>22. Initiate smoke free and quit programmes for parents and caregivers</p>
<p>2.5 Improve and protect the oral health of Pacific children</p>	<p>23. Develop Pacific specific programmes to encourage enrolment in the School Dental health Service (to be part of HP schools plan)</p>
<p>2.6 Reduce avoidable injuries</p>	<p>24. Develop and implement a Pacific Child Injury prevention programme (injury from falls, motor accidents, drowning and poisoning) in line with the national programme</p> <p>25. Ensure the safe practice of male cultural procedure</p> <p>26. Increase awareness on safe practices within the homes, schools, churches and community groups on avoidable injuries</p> <p>27. Increase awareness of positive parenting strategies via the 'settings' approach</p>
<p>2.7 Improve and protect maternal health</p>	<p>28. Work with PHO's to ensure that provisions for Pacific mothers are made specifically to increase awareness and access, cultural sensitivity and providing quality care, continuity of care and maternity service options.</p> <p>29. Support teen and marginalised mothers by providing appropriate counselling and referrals (ensuring that depression and de-stigmatisation is part of ante natal and post natal education)</p> <p>30. Increase awareness and compliance on maternity care, ante natal and post natal education and ensure cultural appropriateness</p>

## Priority Three: Improving and Protecting Pacific Youth Health

Pacific youth (15-24 years) make up about 20% of Pacific peoples in the MidCentral region (MDHB, 2005b). Youth focused strategies are often omitted in health plans, because youth is seen as a healthy stage of life when people are most immune to diseases. It is at this time of life, however, that certain behaviours are adopted that determines the health status of an individual. The *Niu* Pacific Health Plan looks at health issues amongst youth such as pregnancies, suicide, injuries and obesity and identifies initiatives that can help improve the health of Pacific youth.

The development of the Pacific youth health programme is in line with the National Youth Health Strategy. In order to meet the needs of Pacific youth, services must assure young people of confidentiality, especially when dealing with sexual health issues. Establishing peer advisors ensures that young people are getting the right information from a less intimidating source. Services must be accessible and provide a safe environment for young people.

A qualitative study by Fonua (2007) on Palmerston North Pacific youth perspectives on health found support for a holistic concept of health amongst Pacific youth. It was concluded that parents and families are role models and key agents to support, facilitate and nurture youth health. Key recommendations from the study include:

- ✦ Encouraging physical activity amongst Pacific youth through their various settings (youth group, schools);
- ✦ Developing youth and cultural groups as a means of supporting social and emotional wellbeing;
- ✦ Encouraging female participation in physical activity through their social groups and settings;
- ✦ Encouraging family support in adopting healthy lifestyles;
- ✦ Encouraging parents and families to be positive role models;
- ✦ Setting up community and public facilities for Pacific youth where youth needs can be addressed;

These recommendations have been incorporated into the initiatives, reinforcing the essence of the *Niu* Pacific Health Plan for community action through the 'settings' approach.

<b>Objective</b>	<b>Initiatives</b>
<p>3.1 Improve young peoples' access to appropriate primary and mental health services</p>	<p>31. Ensure that mainstream providers have culturally specific responses to Pacific youth health needs</p> <p>32. Initiate a high school peer support, peer advisors and mentoring services concerning Pacific youth health and mental health issues</p> <p>33. Ensure youth health and community services promotes mental wellbeing, support and counselling services appropriate to Pacific youth</p> <p>34. Encourage support services that reduce the rate of suicide (free flow of information)</p>
<p>3.2. Minimise the harm caused by alcohol and drugs</p>	<p>35. Increase awareness about substance or drug abuse, including effects of kava</p> <p>36. Utilise existing Pacific forums (for example, churches, youth groups, school groups) to promote awareness and responsible substance use amongst Pacific youth</p>
<p>3.3. Improve access to sexual and reproductive health services</p>	<p>37. Ensure that mainstream services and youth health providers are responsive to the needs of Pacific youth (check Health plans)</p> <p>38. Develop a peer group program that promotes healthy choices and promotes confidentiality (teen pregnancy)</p> <p>39. Establish a confidential system for youth to get information pertinent to their wellbeing (for example risk of STIs).</p>

## Priority Four: Improving and Protecting the Health of Pacific People with Long-term Chronic Conditions

The World Health Organisation has stressed that “chronic conditions are the health care challenge of this century” (National\_Health\_Committee, 2007, p.1). Chronic conditions include diseases such as diabetes, heart disease, and cancer. In New Zealand, the mismanagement of chronic conditions is “the leading cause of hospitalisations” and “accounts for 80% of preventable deaths” (National\_Health\_Committee, 2007, p.1). Furthermore, the prevalence of chronic conditions amongst Pacific peoples is much higher than for the total New Zealand population. For example, the prevalence of diabetes among Pacific women between the ages of 25-44 is 6.2 per 100 Pacific women versus 1.4 New Zealand women; for the age group 45-64 the prevalence is 20.1 per 100 Pacific versus 6.2 per 100 New Zealand women (Ministry of Health, 2004). From middle age onwards, chronic diseases including ischemic heart disease, stroke, lung cancer and COPD are the major causes of avoidable mortality for Pacific peoples.

In the MidCentral region, chronic diseases such as hypertension, cancer, heart disease and diabetes are more prevalent. Diabetes hospital admission rates in amongst Pacific People in the Mid Central region are over twice the rate of all New Zealanders. Hospital admission rates for heart attacks and angina amongst Pacific People are around 20% higher compared to all New Zealanders(MDHB, 2005b). Moreover, diagnoses are often compounded by factors such as obesity and hypertension, whereby there is an increased likelihood that individuals will have multiple chronic conditions. That is, one might suffer with diabetes as well as heart disease.

The New Zealand Mental Health Survey (Browne, Wells, & Scott, 2006) revealed that Pacific peoples with chronic physical conditions experience higher rates of mental disorders, particularly anxiety and mood disorders, than those without physical conditions. The higher rates of chronic disease amongst Pacific peoples, combined with the higher rate of mental disorders associated with having a chronic condition, underlines the need to address Pacific peoples’ mental health as part of the management of chronic conditions. Addressing mental health issues will always need to consider cultural factors, such as the importance of family and community for many Pacific peoples.

It is important that key extended family members are encouraged and enabled to be a part of meetings and specialist appointments regarding the management of the chronic conditions. There will be those who have decision making roles in Pacific contexts and those who have a culturally imbued duty to care (such as older siblings or children of the person with a chronic condition). The involvement of extended family will reduce the likelihood of Pacific peoples with chronic conditions being classified as ‘non-compliant’.

The process of involving extended family in health and medical discussions will also go a some way towards Pacific peoples living with chronic conditions becoming ‘expert patients (Department\_of\_Health., 2001). Within Pacific contexts, the ‘expert patient’ concept extends beyond the individual so that there is an ‘expert network of family members’. Such extended family members take on roles around transport to appointments, collecting prescriptions, food preparation and so on.

The National Health Committee (2007) has promoted a model for chronic care management espoused by the Wagner (Rothman & Wagner, 2003; Wagner, 2000). The themes within the model, outlined below, are reflected in the *Niu Pacific Health Plan*:

1. Services must be *culturally appropriate*, acknowledging that understandings held by health professionals and provider organisations affect the services they design and offer;
2. *Organisational systems* must be clear about what is being provided and who is accountable; and consistent messages need to be given throughout the health sector;
3. People with long-term chronic conditions will benefit from access to a wide range of *community* services outside of the health sector (such as employment, income, education, housing and maintaining social contacts);
4. Those with long term conditions and their families have a vital role in *self-managing* the condition(s);
5. The *delivery system* must be well integrated in order to provide a continuum of care;
6. People with long term conditions should be *supported* to make *decisions* about their treatment, based on the best available evidence; and
7. *Information systems* need to be in place to allow effective monitoring amongst a range of health providers.

<b>Objective</b>	<b>Initiative</b>
4.1 Increase awareness on the management of these diseases	40. Develop a health promotion plan on the management of long term chronic conditions  41. Provide a mobile primary health care service  42. Set up culturally appropriate (and ethnic specific) education and support groups to assist Pacific peoples with chronic long-term conditions and their families to deal with physical and mental health implications associated with managing such conditions
4.2 For those with chronic conditions to become 'expert patients' and their families to become 'expert family networks'	43. Enable extended family members to be involved in health and medical discussions related to the management of chronic diseases  44. Ensure a continuum of care is provided via integrated health services

## Priority Five: Promoting Healthy Lifestyles and Wellbeing for all Pacific peoples

This priority includes initiatives that promote healthy lifestyles from infancy through to older age. Culturally, Pacific children and young people are still part of extended families, therefore these initiatives involve and community groups.

### ***Elderly Care***

As part of government's mandate to implement the *Health for Older People Strategy* by 2010, MDHB has adopted the *AIM* (Ageing in MidCentral) strategy, which has four components:

1. Improve and support independence and choices;
2. Improve older people's ability to live at home, or in their place of choice, longer;
3. Support older people, their carer/community and networks to live in their community ensuring their lives are healthier and meaningful to them; and
4. Be proactive and reduce the number of admissions to hospital, especially where this can be prevented with, for example, better information and earlier care.

The care of older people within the Pacific community is premised on respect and acknowledgement of the key leadership role they continue to play in Pacific families and communities.

<b>Objective</b>	<b>Initiatives</b>
5.1 Encourage and promote healthy nutrition practices	45. Develop and implement healthy lifestyle programmes  46. Plan and implement health promoting settings approach to encourage healthy lifestyle (pilot) <ul style="list-style-type: none"> <li>* To include small grants</li> <li>* Training initiatives within the settings</li> <li>* Arrange for constant engagements and communication with community groups promoting this lifestyle (showcasing projects)</li> </ul>
5.2. Increase levels of physical activity	47. Plan and implement health promoting settings with Pacific communities that encourage physical activity
5.3. Minimise the harm caused by alcohol, tobacco and drugs	48. Establish smoke free and safe environments within Pacific community settings  49. Establish HP services in districts that can address key risk factors
5.4. Increase the uptake of women's screening services (breast and cervical)	50. Review current screening programmes to ensure cultural suitability for Pacific women  51. Ensure screening services include screening for mental wellbeing for all Pacific-women  52. Establish health promotion programmes targeted to Pacific women to facilitate uptake in women's screening services

<p>5.5. Men to take responsibility of their wellbeing</p>	<p>53. Develop a health promotion programme for Pacific men within PHOs</p>
<p>5.6 Improve and protect the health of the elderly within the Pacific Community</p>	<p>54. Ensure that family and extended family members have full information about the care options available to older people</p> <p>55. Ensure accessibility through the implementation of mobile primary care services and collated services</p> <p>56. Plan and implement a culturally appropriate health promotion strategy for older people</p>

## Priority Six: Pacific Health Information, Research and Communication

Continued quality improvement of health services is contingent on the availability of good information. Information about Pacific peoples' health status, the nature and degree of access to health and wellbeing services, best practice, and programme evaluations are all important. Furthermore, it is important that methodologies and ethics appropriate to Pacific peoples are employed in research and evaluation activities (Health Research Council of New Zealand, 2003). It is also important to develop Pacific research capacity to inform Pacific policy, planning and service development. Further, research related to Pacific peoples' health must be well disseminated and readily available. A newsletter on Pacific health in MidCentral will be one means for achieving this.

It is important that research include an ethnic specific focus, so that the implications or the particularities to specific Pacific ethnic groups are factored into research questions, methods, and recommendations. For example, the Pacific Islands Families Study, a longitudinal study following a cohort of children from birth through to six years has found that post natal depression is highest amongst Tongans – a factor that is fudged in pan-Pacific analysis of research data (Abbott & Williams, 2006).

<b>Objective</b>	<b>Initiative</b>
6.1 Collect, collate and analyse ethnic-specific health information related to Pacific peoples in MidCentral	57. Undertake a review of categories of health information collected in MidCentral on Pacific peoples and identify areas where information collection can be improved, especially in regard to ethnic specific information  58. Establish baselines for Pacific health priorities and objectives
6.2 Undertake relevant research and evaluation	59. Foster inter-regional collaborations to work on Pacific health research projects, particularly projects related to rural and provincial areas similar to the MidCentral region  60. Develop a monitoring framework  61. Undertake evaluation studies on the impact of health initiatives in MidCentral  62. Advocate for the appointment of an appropriate Pacific person to the Central Regional Ethics Committee.
6.3 Effectively communicate health information to Pacific peoples	63. Support the development of networks between health organisations and Pacific communities for two way transmission of health information  64. Utilise Pacific media, where necessary in collaboration with other DHBs, to communicate health information to MidCentral Pacific peoples
6.4 Respond to the needs of consumer groups	65. Set up a support, advocacy and liaison group for Pacific mental health consumers to enable information rich feedback to MDHB on their needs and aspirations.

## References

- Abbott, M. W., & Williams, M. M. (2006). Postnatal depressive symptoms among Pacific mothers in Auckland: Prevalence and risk factors. *Australian and New Zealand Journal of Psychiatry*, 40(3), 230-238.
- Agnew, F., Pulutu-Endemann, F. K., Robinson, G., Suaalii-Sauni, T., Warren, H., Wheeler, A., et al. (2004). *Pacific models of mental health service delivery in New Zealand*. Auckland: Clinical Research and Resource Centre, Waitemata District Health Board and Health Research Council of New Zealand.
- Browne, M. A., Wells, J. E., & Scott, K. M. (2006). *Te Rau Hingengaro: The New Zealand Mental Health Survey*. Wellington: Ministry of Health.
- Department of Health. (2001). *The expert patient: A new approach to chronic disease management for the 21st century*. United Kingdom: Department of Health.
- Elliot, M. (1978). Towards an understanding of the nature of community work. *Ripple Community Volunteers Newsletter*, 14.
- Fonua, A. (2007). *Pacific Youth Health: Perspectives, participation and wellbeing, Unpublished Report on a Pacific Health Research Summer Studentship Project*. Massey University, Palmerston North.
- Health Research Council of New Zealand. (2003). *Guidelines on Pacific health research*. Auckland: Health Research Council of New Zealand.
- Huakau, G., & Bray, A. (2000). *"Talking disabilities" from a Pacific perspective*. Dunedin: Donald Beasley Institute Incorporated.
- Ife, J. (2002). *Community development: Community-based alternatives in an age of globalisation* (2nd ed.). Frenchs Forest: Longman/Pearson Education Australia.
- Inia, E. K. (1998). *Fäeag 'es fūaga – Rotuman Proverbs Suva*, Fiji: Institute of Pacific Studies, University of the South Pacific.
- Macpherson, C. (2001). One trunk sends out many branches: Pacific cultures and cultural identities. In C. Macpherson, P. Spoonley & M. Anae (Eds.), *Tangata o te moana mui: The evolving identities of Pacific peoples in Aotearoa/New Zealand* (pp. 66-80). Palmerston North: Dunmore Press.
- Mafile'o, T. (2005a). Community development: A Tongan perspective. In M. Nash, R. Munford & K. O'Donoghue (Eds.), *Social work theories in action* (pp. 125-139). London: Jessica Kingsley Publishers.
- Mafile'o, T. (2005b). *Tongan Metaphors of Social Work Practice: Hangē ha Pā kuo Fa'u*. Unpublished PhD Thesis, Massey University, Palmerston North.
- Mahina, O. (2004). *Reed book of Tongan proverbs*. Auckland: Reed Publishing.
- MDHB. (2005a). *Health Status of Children and Young People in the MidCentral Region*. Palmerston North: MDHB.
- MDHB. (2005b). *MidCentral's Health Needs Assessment Report*. Palmerston North.
- MDHB. (2004). *Primary Health Care Strategy: 20<sup>th</sup> April 2004*. Palmerston North: MDHB
- Medterms. (2007). Online Medical Dictionary. Retrieved 5 April, 2007, from [www.medterms.com/script/main/ph.asp](http://www.medterms.com/script/main/ph.asp)
- Meo, I. J., Dale, A., & Dale, D. (1985). *Plant today for tomorrow*. Suva: Methodist Church, Fiji Press, Epworth House.
- Ministry of Health. (2002). *Pacific Health and Disability Action Plan*. Wellington: Author.
- Ministry of Health. (2004). *Tupu ola moui: Pacific health chart book 2004*. Wellington: Ministry of Health.

- Ministry of Pacific Island Affairs (2002). Fact File: Pacific Peoples Progress Report. Statistics New Zealand & MinPac. Retrieved 5 April, 2007, from [http://www.minpac.govt.nz/regional\\_alafou\\_youngpacificarchivers.htm](http://www.minpac.govt.nz/regional_alafou_youngpacificarchivers.htm)
- Moata'ane, L. M., Muimui-Heata, S., & Guthrie, B. E. (1996). Tongan perceptions of diet and diabetes mellitus. *Journal of the New Zealand Dietetic Association*, 50(2), 52-56.
- Munford, R., & Walsh-Tapiata, W. (2000). *Strategies for change*. Palmerston North: School of Sociology, Social Policy and Social Work, Massey University.
- National\_Health\_Committee. (2007). *Meeting the needs of peoples with chronic conditions: Hapai te whanau mo akeake tonu*. Wellington: National Health Committee.
- Parnell, W., Scragg, R., Wilson, N., Schaaf, D., & Fitzgerald, E. (2003). *NZ Food NZ Children: Key results of the 2002 National Children's Nutrition Survey*. Wellington: Ministry of Health.
- Poutasi, K. (2001). Pacific Vision International Conference—Society Issues Retrieved 17 November, 2006, from [www.minpac.govt.nz/resources/reference/pvdocs/society/poutasi.php](http://www.minpac.govt.nz/resources/reference/pvdocs/society/poutasi.php)
- Pratt, Rev G. (1911)  
*Pratts Grammar & Dictionary of the Samoan Language*.
- Pulotu-Endemann, K. F. (2002). Consequences of alcohol and other drug use: Fonofale. Retrieved 26 April, 2004, from [www.alcohol.org.nz/resources/publications/ALAC\\_drug\\_Manual\\_Chapter\\_4.pdf](http://www.alcohol.org.nz/resources/publications/ALAC_drug_Manual_Chapter_4.pdf)
- Rothman, A., & Wagner, E. (2003). Chronic illness management: What is the role of primary care? *Annals of Internal Medicine*, 138(3), 256-261.
- Smedley, B. D., Stith, A. Y., & Nelson, A. R. (2000). *Unequal treatment: Confronting racial and ethnic disparities in health care*. Washington, D.C.: The National Academies Press.
- Statistics New Zealand. (2006). 2006 Census: Regional Summary Tables. Retrieved 5 December, 2006, from [www.statsnz.govt.nz](http://www.statsnz.govt.nz)
- Statistics New Zealand. (2005). Statistics New Zealand National Ethnic Population Projections 2001(base) – 2021 update. Wellington: Statistics New Zealand.
- The Community Employment Group. (2004). *Seeing with Pacific eyes: Metaphors for Pacific community development*. Wellington: The Community Employment Group (Department of Labour).
- Tiatia, J. (1998). *Caught between cultures: A New Zealand-born Pacific island perspective*. Auckland: Christian Research Association.
- Tiumalu-Faleseuga, K. (1993). Pacific island development in New Zealand. In A. C. Walsh (Ed.), *Development that works! Lessons from Asia-Pacific* (pp. D4.1-D4.4). Palmerston North: Amokura Publications, Massey University.
- Wagner, E. (2000). The role of patient care teams in chronic disease management. *British Medical Journal*, 320(7234), 569-572.
- World Health Organisation. (1998). Glossary for Health Promotion. Geneva: WHO. Retrieved 2 April, 2007 from [www.who.int/hq/1998/WHO\\_HPR\\_HEP\\_98.1.pdf](http://www.who.int/hq/1998/WHO_HPR_HEP_98.1.pdf)
- World Health Organisation. (1986). Ottawa Charter for Health Promotion. Geneva: WHO. Retrieved 2 April, 2007 from [www.who.int/hpr/NPH/docs/ottawa\\_charter.pdf](http://www.who.int/hpr/NPH/docs/ottawa_charter.pdf)
- Young, N. (1997). Pacificans' access to primary health care in New Zealand: A review. *Pacific Health Dialog*, 4(2), 68-74.

## Table of Abbreviations

COPD	Chronic Obstructive Pulmonary Disease
MDHB	MidCentral District Health Board
MoH	Ministry of Health
MPHDG	MidCentral Pasifika Health Development Group
PHC	Primary Health Care
PHO	Primary Health Organisation
WCP	Well Child Provider
WHO	World Health Organisation

# Glossary

**Health Promotion:** The process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realise aspirations, to satisfy needs, and to change or cope with the environment (World Health Organisation, 1986)

**Prevalence:** The proportion of individuals in a population having a disease. Prevalence is a statistical concept referring to the number of cases of a disease that are present in a particular population at a given time (Medterms, 2007)

**Incidence:** The frequency with which something, such as a disease, appears in a particular population or area. In disease epidemiology, the incidence is the number of newly diagnosed cases during a specific time period. The incidence is distinct from prevalence which refers to the number of cases alive on a certain date (Medterms, 2007)

**Communicable disease:** Any disease that is transmissible by infection or contagion directly or through the agency of a vector (Medterms, 2007)

**Non communicable disease:** Diseases that are not transmissible or contagious, commonly known as lifestyle diseases.

**Infectious disease:** A disease resulting from the presence of a microbial agent (Medterms, 2007)

**Sexually transmitted infections (STI):** Infections or diseases due to or propagated by sexual contact (Medterms, 2007)

**MeNZB:** Vaccination for meningococcal disease. Within this plan it refers to the programme that vaccinated over 90% of Pacific children within the Mid Central region.

**Risk factor:** A clearly defined occurrence or characteristic that has been associated with the increased rate of a subsequently occurring disease. (Medterms, 2007)

**Settings Approach to Health Promotion:** The place or social context in which people engage in daily activities in which environmental, organizational and personal factors interact to affect health and wellbeing. (WHO, 1998)

**Reference: new definition**

A setting is also where people actively use and shape the environment and thus create or solve problems relating to *health*. Settings can normally be identified as having physical boundaries, a range of people with defined roles, and an organizational structure. Action to promote health through different settings can take many different forms, often through some form of organizational development, including change to the physical environment, to the organizational structure, administration and management. Settings can also be used to promote *health* by reaching people who work in them, or using them to gain access to services, and through the interaction of different settings with the wider *community*. Examples of settings include schools, work sites, hospitals, villages and cities (WHO, 1998).

**Ottawa Charter:** A Charter for action to achieve Health for All by the year 2000 and beyond. This conference was primarily a response to growing expectations for a new public health movement around the world. The Conference called on WHO and other international organizations to advocate the promotion of health in all appropriate forums and to support countries in setting up strategies and programmes for health promotion (World Health Organisation, 1986).

**Well Child:** The Well Child/Tamariki Ora service is a screening, surveillance, education and support service offered to all New Zealand children and their families and community from birth to five years. It assists families and communities to improve and protect their children's health (MoH, 2002).

**Smoke free environment:** An environment, place or area that promotes no smoking or does not allow cigarette smoking.

## Appendix One

### Pacific Specific Initiatives in MidCentral District Health Board Plans and Strategies

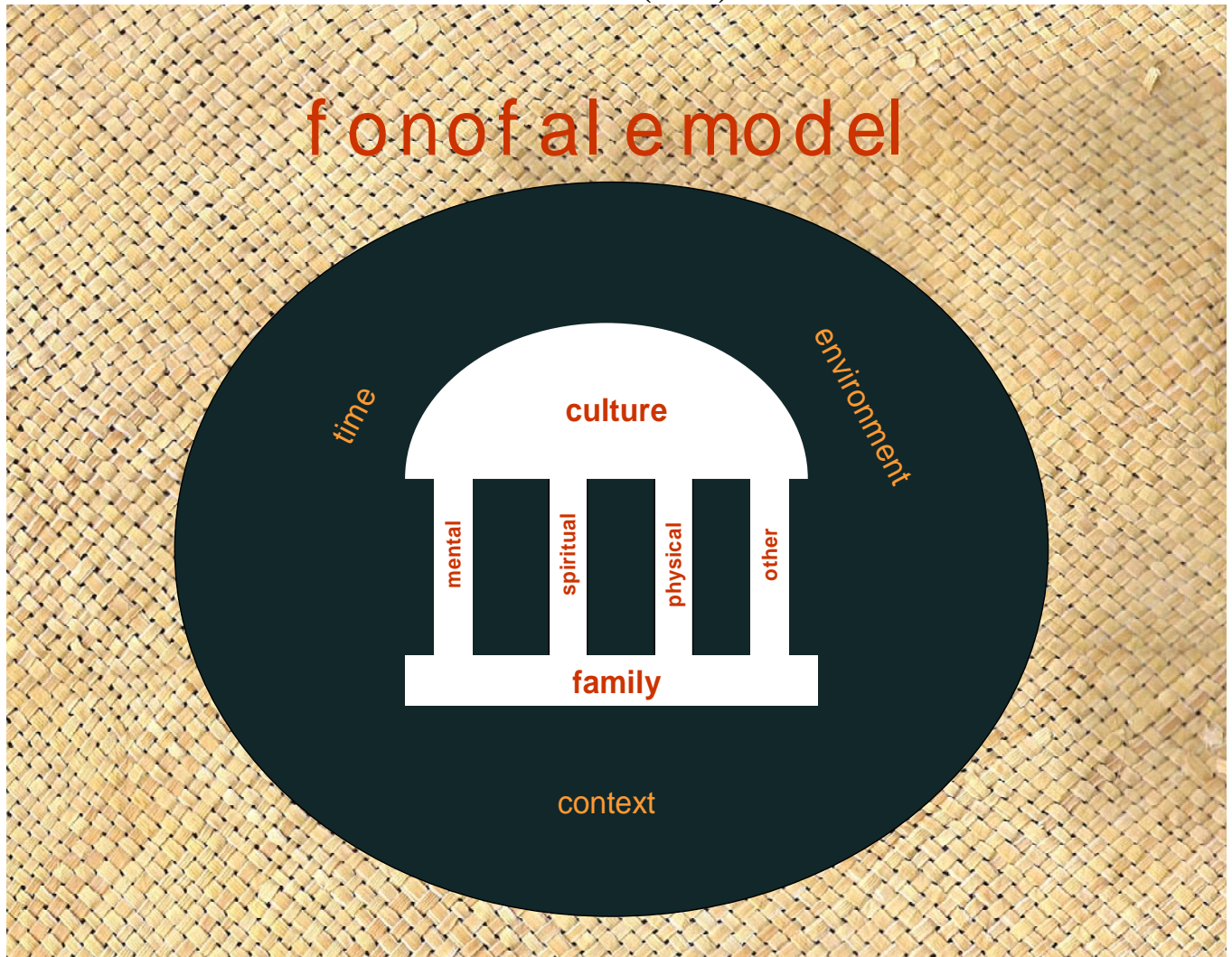
Plan or Strategy	Date	Pacific specific/related initiatives
Ageing in MidCentral: Health of Older People Strategy	September 2004	"Promote the development of culturally appropriate supported living options for older peoples" (p.24).
Diabetes Service Plan	July 2005	"Provide Pacific peoples with a range of health promotion programmes and activities. Such education should: incorporate Pacific knowledge and follow appropriate cultural processes; be based on Pacific health frameworks and models guided by Pacific principles; be delivered through closer co-ordination with Pacific health providers and local elders" (p.34).
Cancer Service Plan	August 2005	No Pacific specific discussion, goals, objectives, initiatives or actions.
Maternity Services Strategy	August 2005	No Pacific specific goals or initiatives. The Pacific birth rate was noted to be "three times lower than the national average" (p.3) although this compares to the national picture where the Pacific peoples' fertility rate is 3.2 compared to 2 for the total population.
Child Health Strategy	September 2005	<i>Objective 3: Reduce inequalities in health outcomes for children/tamariki.</i> Initiative 19: "Provide specific programmes targeted to Maori and Pacific peoples, rural and isolated communities and other high needs, high risk groups to address their top health concerns" (p.30).
Cardiovascular Service Plan	September 2005	<i>Objective 1: Promotion and prevention of cardiovascular disease</i> Initiative 9: "Support and partner with Pacific providers and Pacific communities to promote cardiovascular health for Pacific peoples including education on nutrition, physical activity, smoking cessation and healthy lifestyles. Such education should: <ul style="list-style-type: none"> <li>- incorporate Pacific knowledge and follow appropriate cultural processes</li> <li>- be based on Pacific health frameworks and models guided by Pacific principles; be delivered through closer coordination with Pacific health providers and local elders" (p.57).</li> </ul> <i>Objective 2: Early detection and intervention</i> Initiative 12: "Work with PHOs and stakeholders to develop systematic screening for cardiovascular risk at the following recommended ages... Pacific peoples (men = 35 years; women = 45 yrs)" (p.59). Initiative 14: "Provide opportunistic screening to target population groups such as Maori and Pacific peoples using appropriate providers and in appropriate settings..." (p.59). Initiative 18: "Provide cardiovascular resource material in appropriate languages including Maori and major Pacific and Asian languages" (p.60). <i>Objective 3: Manage cardiovascular disease through treatment, rehabilitation and palliative care</i> Initiative 42: "Ensure the Phase II and Phase III rehabilitation programmes are accessible, appropriate and meet the needs of Maori and Pacific peoples. Programmes are to be run collaboratively in the community with Maori and Pacific providers wherever possible" (p.65). Initiative 43: "Ensure appropriate referrals are made and family/whanau are informed of all their choices so there is

		<p>support during hospital appointments. In particular, ensure Maori and Pacific clients are offered the opportunity of involving Maori or Pacific providers in their care” (p.65).</p> <p><i>Objective 4: Improve cardiovascular services through a responsive workforce</i></p> <p>Initiative 50: “Provide opportunities for health professionals and support staff to create a more culturally aware and skilled workforce that is responsive to Maori and Pacific cultures” (p.66).</p> <p>Initiative 51: “Continue to work with... Pacific communities in planning, purchasing, delivering and monitoring culturally appropriate services for Maori and Pacific peoples who have cardiovascular disease and their family/whanau” (p.66).</p> <p>Initiative 52: “Develop a Pacific health workforce to help identify and address issues specific to Pacific peoples” (p.67).</p>
Secondary Care Services Strategy	September 2005	<p>No Pacific specific options or steps. Contained within the plan to develop and implement patient/clinical pathways across the continuum of care, however, is the intention of developing “culturally appropriate pathways” (p29). This is in recognition of the point made by Dr Paparangi Reid, that services should be designed for the minority rather than the majority as a way to ensure services reach those groups who most need them (p.30).</p>
Oral Health Service Plan	October 2005	<p>“Promote healthy living... with emphasis on Maori and Pacific peoples” and “develop and implement health promotion and education programmes for parents and family/whanau of Maori and Pacific children to create awareness of oral disease and prevention practices. Deliver these programmes in culturally appropriate settings...” (p.43);</p> <p>“Encourage oral health services provided to Maori and Pacific peoples to encompass a holistic, integrated and culturally competent approach in an appropriate setting” (p.43);</p> <p>“Ensure Maori and Pacific peoples continue to have the opportunity to access health care through Maori and Pacific health providers” (p.45);</p> <p>“Commission surveys to provide feedback... and more reliable data on ethnic groups... with a view to service improvement” (p.48).</p>
Respiratory Service Plan	November 2005	<p><i>Smoking cessation</i></p> <p>Initiative 13: “Implement the Pacific Peoples Tobacco Control Plan” (p.44)</p> <p>Initiative 14: “Include a focus on respiratory health in health promotion programmes for Maori, Pacific peoples and other high risk groups. Such programmes should be culturally sensitive and delivered in appropriate settings (p.44).</p> <p>Initiative 15: “Support community based/church based groups to enhance healthy wellbeing” (p.44).</p> <p><i>Objective 2: Improve screening and early detection</i></p> <p>Initiative 22: “Offer church based/community based screening programmes for at risk Pacific peoples. This could be integrated with other health programmes based in these settings” (p.46).</p> <p><i>Objective 3: Support, treatment, rehabilitation and palliative care</i></p> <p>Initiative 38: Review “disease state management (focused health) nursing services to ensure equitable distribution of services across the District and identify any gaps in services” (p.50).</p> <p>Initiative 39 “Continue to support Maori and Pacific paediatric services in the community” (p.50).</p> <p>Initiative 40 “Review service agreements for providers of disease state management (focused health) nursing services so</p>

		<p>that discharge of patients from the disease state management register is determined by assessment of health status and compliance with treatment regimes rather than by timeframes specified in the service agreement” (p.50 ).</p> <p><i>Objective 4: Improve respiratory services through a responsive workforce</i></p> <p>Initiative 45: “In conjunction with other Service Plans, actively recruit Maori and Pacific health professionals in disciplines such as physiotherapy – investigate the feasibility of funded scholarships or sponsorship to attract staff” (p.52).</p>
Depression Service Plan	December 2005	<p>“Develop and implement mental health promotion and education programmes for parents and family/whanau of Maori and Pacific children/youth to create awareness of depressions and prevention practices” and “encourage mental health services provided to Maori and Pacific peoples to encompass a holistic, integrated and culturally competent approach in an appropriate setting” (p.32).</p> <p>“Provide supplementation resources to support general practice screening of depression in Maori and Pacific peoples” (p.34).</p> <p>“Ensure Maori and Pacific peoples continue to have the opportunity to access health care through Maori and Pacific providers” and “target resources specifically for Maori and Pacific peoples to ensure more responsive and culturally appropriate suicide prevention services” (p.36).</p> <p>“Build the capacity of the workforce to understand the needs of Maori and Pacific peoples experiencing depression” (p.37).</p> <p>“Continue to work with... Maori/Pacific communities in planning, purchasing, delivering and monitoring culturally appropriate services for Maori and Pacific peoples who have depression and their family/whanau” (p.38).</p>
The New Zealand Health Strategy	2004	<p>“Improved primary health care services are essential to meet the needs of Pacific Peoples. Pacific Providers will need support to grow and develop further. It is also important that mainstream providers of services deliver their services in a culturally appropriate way to Maori and Pacific peoples” (p.20).</p> <p>“Increasing the number and the range of Pacific people services for youth” (p.39).</p>

## Appendix Two

Source: Fuimaono Karl Pulotu-Endeman (2002)



# Appendix Three

## Ottawa Charter's Health Promotion Action Means<sup>2</sup>:

**Build Healthy Public Policy:** Health promotion goes beyond health care. It puts health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health. Health promotion policy combines diverse but complementary approaches including legislation, fiscal measures, taxation and organizational change. It is coordinated action that leads to health, income and social policies that foster greater equity. Joint action contributes to ensuring safer and healthier goods and services, healthier public services, and cleaner, more enjoyable environments. Health promotion policy requires the identification of obstacles to the adoption of healthy public policies in non-health sectors, and ways of removing them. The aim must be to make the healthier choice the easier choice for policy makers as well.

**Create Supportive Environments:** Our societies are complex and interrelated. Health cannot be separated from other goals. The inextricable links between people and their environment constitutes the basis for a socioecological approach to health. The overall guiding principle for the world, nations, regions and communities alike, is the need to encourage reciprocal maintenance - to take care of each other, our communities and our natural environment. The conservation of natural resources throughout the world should be emphasized as a global responsibility. Changing patterns of life, work and leisure have a significant impact on health. Work and leisure should be a source of health for people. The way society organizes work should help create a healthy society. Health promotion generates living and working conditions that are safe, stimulating, satisfying and enjoyable. Systematic assessment of the health impact of a rapidly changing environment - particularly in areas of technology, work, energy production and urbanization - is essential and must be followed by action to ensure positive benefit to the health of the public. The protection of the natural and built environments and the conservation of natural resources must be addressed in any health promotion strategy.

**Strengthen Community Actions:** Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities - their ownership and control of their own endeavours and destinies. Community development draws on existing human and material resources in the community to enhance self-help and social support, and to develop flexible systems for strengthening public participation in and direction of health matters. This requires full and continuous access to information, learning opportunities for health, as well as funding support.

**Develop Personal Skills:** Health promotion supports personal and social development through providing information, education for health, and enhancing life skills. By so doing, it increases the options available to people to exercise more control over their own health and over their environments, and to make choices conducive to health. Enabling people to learn, throughout life, to prepare themselves for all of its stages and to cope with chronic illness and injuries is essential. This has to be facilitated in school, home, work and community settings. Action is required through educational, professional, commercial and voluntary bodies, and within the institutions themselves.

**Reorient Health Services:** The responsibility for health promotion in health services is shared among individuals, community groups, health professionals, health service institutions and governments. They must work together towards a health care system which contributes to the pursuit of health. The role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services. Health services need to embrace an expanded mandate which is sensitive and respects cultural needs. This mandate should support the needs of individuals and communities for a healthier life, and open channels between the health sector and broader social, political, economic and physical environmental components. Reorienting health services also requires stronger attention to health research as well as changes in professional education and training. This must lead to a change of attitude and organization of health services which refocuses on the total needs of the individual as a whole person.

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<sup>2</sup> WHO (1986). Ottawa Charter for Health Promotion. WHO, Geneva. <http://www.who.int/healthpromotion/conferences/previous/Ottawa/en/index.htm>.

## Appendix Four

### - Pacific Peoples–Society Issues<sup>3</sup>

<b>Pacific peoples</b>	
<b>The People</b>	<ul style="list-style-type: none"> <li>• Samoan, Cook Island, Tongan, Niuean, Fijian, Tokelauan</li> <li>• 58% New Zealand born</li> <li>• 89% speak English</li> <li>• 2% of MidCentral District's population (approx 3 000 people)</li> </ul>
<b>Pacific Children</b>	<ul style="list-style-type: none"> <li>• There are approx 61 000 Pacific children under 15 years in NZ</li> <li>• 53% live in houses with 6 or more people</li> <li>• 34% live in households shared by relatives</li> <li>• An average of 3 dependant children live in 2 parent families</li> <li>• 62% of Pacific children aged between 5-14 years are obese</li> </ul>
<b>Pacific Women</b>	<ul style="list-style-type: none"> <li>• There are approx 64 000 Pacific women aged 15 and over in NZ</li> <li>• 24% have given birth to 4 or more children</li> <li>• 12% receive the Domestic Purposes Benefit</li> <li>• 48% women are obese (high risk factors for diabetes, coronary heart disease, high blood pressure, osteoarthritis and some cancers) [Note: only 27 % of Pacific men are obese]</li> </ul>
<b>Housing</b>	<ul style="list-style-type: none"> <li>• 20% do not have access to a telephone compared to 7.7% of all of NZ</li> <li>• 56% live in rental accommodation</li> <li>• 32.8% own their own home or are rent free (all ethnicities in NZ 67.5%)</li> </ul>
<b>Work and Education</b>	<ul style="list-style-type: none"> <li>• 33% have a school qualification</li> <li>• 19% have a tertiary qualification</li> <li>• Pacific youth aged between 15 and 19 experience higher unemployment rates (33%) than other ethnicities</li> <li>• Overall unemployment rate 17%</li> <li>• Most common occupations are service workers and plant and machine operators</li> </ul>
<b>Income</b>	<ul style="list-style-type: none"> <li>• Average income for all Pacific people 15 years and over is \$12 400</li> <li>• Average household income is \$30 000</li> <li>• 32% of Pacific peoples main source of income was a government benefit</li> <li>• Only 50% of Pacific people eligible for a community services card actually hold one</li> </ul>
<b>Health Issues</b>	<ul style="list-style-type: none"> <li>• Poor dental health</li> <li>• Women have higher death rates than non Pacific women from asthma and diabetes</li> <li>• Higher rates of stroke and heart disease than non Pacific</li> <li>• Twice as likely to be diagnosed with diabetes as non Pacific</li> <li>• Highest incidence of rheumatic fever and rheumatic heart disease</li> <li>• Highest rates of Hepatitis B</li> <li>• Higher smoking rates (1 in 3 Pacific people smoke)</li> <li>• Low uptake of screening services</li> </ul>

<sup>3</sup> Dr Karen Poutasi (2001) Pacific Vision International Conference–Society Issues  
[www.minpac.govt.nz/resources/reference/pvdocs/society/poutasi.php](http://www.minpac.govt.nz/resources/reference/pvdocs/society/poutasi.php)

## Niu Pacific Health Plan Overview

**Vision: Healthy Pacific peoples supported by healthy families and communities, achieving their full potential throughout their lives**

