Runanga Whakapiki ake i te Hauora o Aotearoa
Health Promotion Forum of New Zealand

# newsletter

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*Megan Tunks (Te Whanau-a-Apanui, Whakatohea), Manager of Maori Services, Auckland Public Health Services, with Ani Waaka (Te Arawa, Ngati Raukawa), CEO of Maori TV, at the Gateway Hui*

# Maori Health Promotion and the IUHPE World Conference

In April a hui showcasing Maori Health Promotion - *Mana Hauora, Mana Tangata – Healthy Wellbeing, Healthy Community* - was held at Waipapa Marae in Auckland. The hui was a Gateway Conference and Associated Event of *Health 2004 – the 18th World Conference on Health Promotion & Health Education* held in Melbourne.

The main theme of this Gateway Conference was *Indigenous Health Promotion in Aotearoa* and included: Maori specific models of health promotion; Giving effect to the Treaty of Waitangi – partnerships in health promotion; Indigenous health promotion research – appropriate evidence.

A team from the Organising Committee of the Gateway Hui successfully presented recommendations from the hui to both the Indigenous Caucus and the World Assembly at the main Melbourne Conference.

# MAORI HEALTH PROMOTION GATEWAY HUI
## *Mana Hauora, Mana Tangata*

*Taking a break in the sunshine at the gateway hui*

The Gateway Hui held at Waipapa Marae on the 19th and 20th of April, was the only official Indigenous Gateway Event to the World International Union of Health Promotion and Health Education (IUHPE) Conference in Melbourne.

The hui, attended by 130 participants, showcased a range of models of Maori Health Promotion. Twenty Providers from across the country presented information on their respective models of health promotion.

Keynote speakers included:

Naida Glavish - Partnerships in Health Promotion; Marty Rogers – Maori Models of Health Promotion; Paratene Ngata - an Iwi Model of Health Promotion from Tai Rawhiti; Mihi Ratima – Evidence & Effectiveness in Maori Health Promotion; and Moana Maniapoto - It's About Whanau.

A panel held on the Tuesday morning discussed evidence and effectiveness in Maori health promotion in which a range of views and ideas were shared by Mihi Ratima, Paul Stanley, Sue Crengle and Riripeti Haretuku.

The debate held on the second day in which a panel of Wahine working in Health Promotion (Moe Milne, Delarayne Armstrong and Chris Maxwell) teamed against a team of Tane (Scotty Morrison, Wiremu Manaia and Julian Wilcox) also provided a light hearted view to the topic *"Wahine are on top in health promotion: Fact, Fiction or Fantasy"*

Key Themes from the Maori Health Promotion Gateway Hui included:

- By Maori for Maori
- Maori self-determination and control, therefore Maori driven and led
- Maori health promotion models, frameworks and concepts are valid
- Maori health promotion is centred on Maori people, values and Maori collectives
- Recognise the value of contemporary tools and methods
- Determinants of health, including political and cultural determinants
- Opportunities to learn from Maori health promotion approaches
- Mutually beneficial partnerships
- Acknowledge barriers, including institutional racism
- Support for workforce capacity building
- Recognition of diversity
- Value in an evidence-based approach
- Maori define criteria for evidence and approach connected to communities

The final session for the Gateway Hui discussed recommendations from the hui that could then be presented at a session at the IUHPE World Conference in Melbourne. These were summarised from keynote and provider presentations and presented back to hui participants. These messages and recommendations also formed the basis of the resolutions presented to the Indigenous Caucus session at the Melbourne Conference for feedback, and subsequently the World meeting of the IUHPE General Assembly.

Recommendations and messages from the hui that were taken to the IUHPE World Conference were:

- Expectation that health promotion for indigenous peoples will be led and controlled by indigenous peoples
- That this approach should be reflected in the structures and processes of the IUHPE
- That the IUHPE recognises (and therefore advocates for) the recognition of the validity of indigenous health promotion frameworks, models and concepts
- That the IUHPE gives priority to indigenous peoples' health promotion
- That the IUHPE pays particular attention to supporting capacity building for indigenous health promoters and that these initiatives are indigenous-led

These were accepted and passed, which was a great achievement for all involved!

*Megan Tunks*

# IUHPE WORLD CONFERENCE IN MELBOURNE APRIL 2004

***What was it like?***

There was a high security presence and with over 3000 people representing a range of nationalities some participants found the conference overwhelmingly large. There was a huge number of poster presentations and also an enormous choice of workshops - but this could be frustrating when people found the workshops they wanted to attend became quickly oversubscribed.

The conference highlighted the global context of some of the public health issues we face here. One such context is the impact of very large trade interests on health – for example, some economies depend almost entirely on sugar exports and this has led the countries involved to lobby against the WHO Global Action on Obesity plans.

Presentations about other public health global issues included slave trafficking, the reality of life for many of the world's women, oppressive regimes, human rights abuses and the effects of some religious beliefs and practices.

***Key themes included***

- Obesity and Gambling as emerging global public health issues
- The impact of urbanisation, including transport and community development
- Capacity building and workforce development
- Partnerships and collaboration in public health

***What was missing?***

- Overall a lack of indigenous presenters
- Very few Pacific people attended the conference or gave presentations
- Community voices were few – a number of presentations were very academic and far removed from the reality of service delivery
- There were disappointingly few presentations on public policy and politics

In terms of indigenous health most participants agree that New Zealand is leading the way. For one participant " The conference confirmed for me how well we are doing here in New Zealand, and the strength we have in indigenous health promotion models and practice."

Our warmest congratulations therefore go to those who took the key messages and recommendations from the Maori Gateway Hui to the World Board level of the IUHPE at the Conference, and succeeded in getting a draft resolution for indigenous people accepted. We can now hope that the momentum to improve indigenous health and involvement will continue on the world stage, especially as the next IUHPE World Conference will be in Canada and is expected to have a strong indigenous focus.

## One Health Promotion Practitioner's View

From my perspective my overwhelming impression was the sorry state of affairs for aboriginal Australians and the institutional and personal racism they experience from other Australians. This was most noticeable in the official opening when a senior government official told the story of the health status of "all Australians" without recognising the health status of indigenous Australians. I will never forget the behaviour of some white participants at the indigenous welcome, getting drunk alongside an exhibition telling the colonisation story of Australia. Given all that was happening in New Zealand at this time with the hikoi it was a strange time to be away from home and to be confronted by this full-on racism.

Highlights for me were Dr Paparangi Reid kicking some serious butt re putting Maori health in context with a wonderful acknowledgement of the health impact of colonisation. Clearly NZ work on reducing inequalities is amongst the cutting edge around the world and we start with a more robust analysis of power than many others are up to. We are definitely the best singers by the way, but not the best dancers...

Frustratingly for me the programme was dominated with academics and policy makers, who may or may not have ever done any grass-roots health promotion work. I felt again and again the validation of a particular type of knowledge, rather than hearing voices from different parts of the sector. With participants from 88 countries many interesting informal discussion took place, but crowded workshops made genuine debate within the formal session time difficult to achieve.

So much was happening it is hard to unpack a clear message for NZ practitioners at this time. But the good news is some of our work is cutting edge and the bad news is that inequalities and the impacts of colonisation are global and rather complex. The conference was rich in outlining some of the troubles in the world but less forthcoming with the solutions. Looks like we will have to grow our own...

*Heather Came*

*Heather Came (on right) with Lyn King – just before going to Melbourne*

# HEALTH PROMOTION PERSPECTIVE

## Greg Hamilton asks - How do we know our health promotion interventions work?

### Introduction

*Greg Hamilton*

The aim of this article is to provide *one perspective* on the 'level of evidence' required to evaluate health promotion initiatives conducted by Public Health Units and equivalent organisations. To do this, I need to outline my work. In January I returned to New Zealand in an innovative shared position at Community and Public Health (CPH), the Public Health Unit of the Canterbury District Health Board and the Christchurch School of Medicine and Health Sciences in a health promotion role. At CPH I have reviewed project plans and consulted with practitioner colleagues with the aim of improving the evidence-base for interventions and evaluation of these interventions. This has allowed me to contemplate what level of evaluation is appropriate for Public Health Units to conduct.

### Evidence-based practice or practice-based evidence?

Keynote speakers (e.g. Prof Jeff Koplan) at the recent World Conference for Health Promotion and Health Education in Melbourne proposed transferring some emphasis in health promotion from '*evidence-based practice*' to '*practice-based evidence*'. This shift is in response to two phenomena: firstly, there are problems translating intervention research outcomes to population outcomes; and secondly, that community-based practice may be delivering positive outcomes, but these are frequently poorly measured. The need to better evaluate community-based interventions is apparent (this doesn't absolve community-based projects from being based on the best epidemiological, empirical and theoretical evidence available).

The terms process, impact and outcome evaluation have commonly been used and matched to evaluation of strategies, objectives and goals respectively. While Hawe et al[1] eloquently illustrate this relationship with realistic examples, what is less clear is how Public Health Unit projects fit this model, where the contribution of these projects is a subset of the activity addressing an issue (e.g. national, NGO, possibly PHO and other sectors contribute to physical activity promotion). This challenge of describing what level of evidence could be used is not a new one, for example, Nutbeam[2] expanded on Green and Krueter's[3] Precede-Proceed model for health promotion.

### What level of evidence is realistic?

The level of evaluation will depend on the type of project being evaluated and the evidence supporting its effectiveness. For example, if a project has already been empirically proven effective, further impact evaluation is less warranted and evaluation should focus on process measures to ensure project components are delivered, and adapted and adopted by target communities. More rigorous impact evaluation designs are required to examine the effectiveness of innovative projects. These projects also require strong process evaluation to ensure implementation does occur (avoiding Type III error).

The table below provides an example of how 'level of evaluation' could be interpreted by Public Health Units and other organisations that deliver community-based health promotion interventions.

Measures of impact

| Level of evidence | **MEASURE** | Examples | How measured |
|---|---|---|---|
| High | **Outcome (populations)** | Health measures | MOH, nationally |
| ↑ | **Individual impact** | Change in (knowledge) attitude, behaviours | Pre-post designs |
| | **Community impact** | Policy developed, environmental modification, community committee formed (capacity) | Audit, minutes |
| | **Individual process** | Satisfaction, knowledge development | Post-only designs |
| | **Community process** | Numbers attended | Audit |
| Low | **Inputs** | Number of workshops conducted | Work plans |

*Continued from page 4*

Monitoring of national data (e.g. Census data, Statistics New Zealand, Ministry of Health) will occur as this information becomes available and could be considered as *outcome* evaluation. The division of *impact* evaluation into *individual* and *community* recognises that environmental changes (social and physical) are important outcomes of interventions, but success in these does not necessarily impact on individuals' behaviours (hence why individual impact is considered a higher level of evidence). Similarly, *process* evaluation is divided into *individual* and *community*. Again, *individual process* measures represent a higher level of evaluation than *community process*.

If health promotion is to move towards '*practice-based evidence*', the challenge is to appropriately measure success. To this end, increasing the quality of evaluation of health promotion initiatives relies on health promotion practitioners aiming for the highest practical 'level of evidence' when designing projects. In the long-term, providing greater evidence of the work we are doing in health promotion is vital to the well being of our discipline.

*Greg Hamilton*
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## References

1. Hawe P, Degeling D, Hall J, 1990. *Evaluating Health Promotion: A Health Workers Guide*. Sydney: MacLennan & Petty.
2. Nutbeam D, 1999. The challenge to provide 'evidence' in health promotion. *Health Promotion International 14*: 99-101.
3. Green LW, Kreuter M, 1991. *Health Promotion Planning: An Educational and Environmental Approach*. Mountain View, USA: Mayfield Publishing Company.

# LATEST UPDATE ON ADVOCACY AND PUBLIC HEALTH CONTRACTS ISSUE

You will all be aware of the ongoing debate and uncertainty around NGO's who are funded by the Ministry of Health undertaking advocacy. This issue also potentially affects the delivery of DHB public health services.

The Forum is firmly convinced that advocacy is an essential integral component in effective health promotion and should be funded and supported fully. We also hope that this issue is resolved and clarified as soon as possible.

The Ministry of Health has drafted a discussion/consultation document in response to the recommendations in the Hunn-Brazier *'Report on Contracts with NGOs - Compliance with Public Service Standards'*. This discussion document has still yet to be released, after which there will be a three-month consultation period with the workforce.

We encourage our members and other health promoters to give the Ministry feedback on the document.

You may find the following useful when preparing your feedback to the Ministry:

• The *Topical issues* section of Health Promotion Forum's website - www.hpforum.org.nz - for a full history of the debate so far, including references to key documents and background details of the role of Advocacy in Public Health.

• A Position Paper is also available on the Health Promotion Forum website, that was developed in response to discussions, meetings and communications with many public health people throughout Aotearoa/New Zealand. This Paper argues for ongoing support for advocacy as a legitimate tool, activity and process.

• A report released on May 14th, responding to the *Hunn-Brazier Report* was commissioned by the NZ Drug Foundation and the Cancer Society of NZ with financial assistance from the JR MacKenzie Trust. This report does not represent the views of any one person or NGO but seeks to provide an independent analysis of the appropriateness of the approach proposed by Hunn and Brazier. The commissioning agencies hope that the report will be useful to NGOs considering issues around advocacy. The report is also available on the Health Promotion Forum website, *Topical Issues* section.

In the meantime the Forum is collecting signed copies of the Consensus Statement enclosed with this newsletter that was developed by people working in public health. Signed copies of this Statement will be presented to the Ministry of Health to demonstrate the commitment of the workforce to maintain our ability and our right to continue to use advocacy to further the aims of public health. So please sign the Statement and return it by mail or fax to:

Health Promotion Forum
PO Box 99064, Newmarket Auckland
Fax 09 520 4152

# LOOKING THROUGH OUR CULTURAL SUNGLASSES

The *Asian Cultural Competency Workshop* held in Auckland in May provided a unique opportunity to learn about and discuss Asian cultures and values in Public Health Service delivery. This Workshop was organised by The Asian Network Incorporated (TANI) and Auckland Regional Public Health Service and was a first for public health service providers.

Keynote speaker Vivian Cheung, who is both the Chairperson of TANI and the co-ordinator of the Centre for Asian and Migrant Health Research, AUT, suggested that culture is like a pair of sunglasses. The way we think and how we behave are influenced by how we see the world - and how we see the world depends on how we were socialised as children and on the experiences we have had.

" 'Cultural competency' is not asking people to take off their sunglasses and forcing them to conform to what you see through your own sunglasses. It is, instead, acknowledging and respecting that people have their own beliefs and values and working with, rather than against them. We need to develop a right combination of attitudes, knowledge and skills. Cultural competency is a journey that includes exploring our own values and beliefs, learning about other people's values and beliefs and fully appreciating that different people have different perspectives."

"There is a demand from service providers who want to involve Asian communities and are trying to find the best ways to promote health in these communities. The main purpose of this workshop was to respond to that need", says Janet Chen, the Asian Public Health Co-ordinator of the Auckland Regional Public Health Service.

The main objective of the workshop was to raise awareness on Asian culture, values and world views and how these influence health behaviour and health. People from different Asian cultures worked together to share their knowledge and enthusiasm and to give participants the beginning of an overview of the various cultures that make up the Asian population in Aotearoa. There were presentations and group discussions on Chinese culture, Korean culture, South Asian cultures and South East Asian cultures. Each of these four major divisions includes many diverse cultures, languages, religions and sub-groups.

Presentations covered a range of topics, such as family structures, food, attitudes and beliefs about health and illness, gender roles, education, religion, traditional health practices and post-migration issues.

Group discussions examined scenarios that migrants and refugees from Asia may be facing here in Aotearoa-New Zealand. The scenarios demonstrated how a lack of English language skills plus cultural factors can combine to disempower and prevent people accessing or finding useful the healthcare and public health services offered in this country. Also the scenarios also showed how providers need to develop appropriate strategies to reach Asian individuals and communities.

Other stressors for migrants may include changes in physical and social environments, discrimination, post traumatic stress syndrome, isolation and changes in family dynamics and roles. Different cultural values and beliefs around, for example, childbirth, the place of women, sexuality, smoking, work, study and family decision-making are all significant factors for health providers and health promoters to consider.

Despite the huge diversity of language and ethnicity amongst the Asian communities living in Aotearoa-New Zealand, the workshop presenters identified some common themes across most Asian cultures. These include

- the importance of the extended family
- traditionally most people live in three-generation households
- collectivism as opposed to individualism
- family units are mainly male-dominated, with men making the major decisions.

There was a lot to think about, question and discuss. The eager-to-learn participants came from a wide range of backgrounds and included health promoters, primary care providers, mental and sexual health providers, and people working in education who are concerned with the health and well-being of their students. The workshop presented many challenges and provided a rich mixture of information about our Asian citizens – who currently make up 6.1% of our total population.

At the end of the workshop one health promoter said, "I've learned such a lot that I didn't realise before about what it must be like to be from Asia and adjusting to life in New Zealand. And also how much more there is to learn and understand about this fascinating and diverse community."

*Isabel Bird*

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