

## ORIGINAL RESEARCH PAPER

# Realising Whānau Ora Through Community Action: The Role of Māori Community Health Workers

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## ABSTRACT

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**Context:** In New Zealand, the government's key strategy to improve the health of the indigenous population is advanced through a policy where families are supported to achieve their maximum health and well-being: "whānau ora" (for a glossary of Māori words and phrases, see appendix).

**Objectives:** This paper outlines the role Māori community health workers (CHWs) play in the delivery of whānau ora services and explores the tensions and challenges faced by these workers in carrying out their role.

**Methods:** Recent literature, existing qualitative research data and local level verification from a practising community health worker with 12 years experience.

**Findings:** Roles were complex, varied and generally executed in high need communities. Differing expectations between the contractual requirements, the community and the CHW's own expectations meant CHWs continually managed competing demands. CHWs describe training opportunities as being short-term and ad hoc, specific to a particular health provider's needs and offering only limited options for career advancement.

**Conclusion:** CHWs form an integral part of the New Zealand health workforce acting as the interface between the health sector and Māori communities. By working in a culturally distinctive manner, they help give effect to Māori health development aspirations. Increasingly this work is carried out in complex and demanding environments. Key challenges that need to be resolved to further advance the position of CHWs in New Zealand include greater recognition of the unique role they play in the delivery of



public health and primary healthcare services, linking this recognition to appropriate remuneration and ensuring ongoing role development is met within a Māori worldview.

**Keywords:** Māori health, indigenous health, community health workers, workforce development, strategic policy, health services provision, whānau ora

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## Background

Māori are the indigenous peoples of New Zealand. We claim a separate identity from others residing in the same country, one grounded in our indigeneity, our experience of colonisation and our entitlement to distinctive rights, including the right to self-determination (Robson & Reid, 2001). New Zealand has a history of recognising indigeneity as evidenced by the 1835 Declaration of Independence and the 1840 Treaty of Waitangi. The Treaty acknowledged distinctive rights that flowed from notions of aboriginal title (Durie, 1994) and, to this day, is regarded as the founding document of New Zealand. The so-called “principles” of the Treaty - partnership, participation and protection - guide much of the Crown’s public policy in relation to Māori and underpin the most recent Māori health policy statement, *He Korowai Oranga* (Boulton et al., 2004).

Prior to colonisation, Māori operated a system of public health that ensured the well-being of communities. However, the values on which this system was based were largely broken down through colonisation, resulting in a major decline in Māori health status in the late nineteenth century (Durie, 1994). Since the late 1800s, Māori have initiated a number of community-led health reforms based on Māori concepts of health (Durie, 1994) in an attempt to redress this steady decline.

A series of socio-political changes from the 1960s to the present have highlighted the differences between western and Māori concepts of health. These include: rising Māori political activism; a series of national Māori health hui (meetings) that articulated Māori health concepts; increasing acknowledgement of the Treaty of Waitangi; and a series of major reforms of the New Zealand health system. All have contributed to a growing call for greater incorporation of Māori values, philosophies and ideals in health service provision and for the creation of specific “by Māori for Māori” health services.

The call by Māori for advances in Māori health purchasing and delivery coincided with the central government’s efforts to restructure the health sector, including splitting health service provision and purchasing functions (Durie, 1992; Howden-Chapman & Ashton, 2000). The sector was encouraged to recognise Māori aspirations and structures (such as those based around whānau, hapū and iwi) and the desire of Māori to take responsibility for their own healthcare (Public Health Commission, 1995). Under these policies, the government’s funding agencies were mandated to purchase Māori health services at a regional level. It was within this purchasing environment that “whānau ora” service specifications were established.

The government’s most recent Māori policy document, *He Korowai Oranga: the Māori Health Strategy*, acknowledges the principles of the Treaty of Waitangi, reinforcing earlier policy directions aimed at reducing health inequalities and increasing Māori control over the direction and shape of Māori institutions and development (Ministry of Health, 2002a). Whānau ora, meaning “Māori families supported to achieve their maximum health and well-being”, is the primary objective of the policy. The policy, the service specifications and the contracts for service stress the importance of Māori involvement in the planning, management and delivery of health services. Factors such as socioeconomic status, ability to self-determine, cultural



connectedness, spirituality and access to traditional language are now regarded as fundamental components of Māori well-being (H.W. & Associates, 2005).

Whānau ora contracts aim to provide community-based holistic health services to whānau, hapū and iwi of all age groups. Most services are delivered in primary care settings, varying from marae-based health centres<sup>1</sup>, particularly in more rural communities, to stand alone clinics. Programmes may be offered by iwi (tribal) providers, hapū (sub-tribal) providers or urban providers with no specific tribal affiliations (H.W. & Associates, 2005). The providers rely heavily on Māori community health workers (CHWs) to give effect not only to the contracts but to the overall intent of the Māori health policy.

## Objectives

In this paper, we outline the roles and responsibilities of these CHWs, the multiplicity of tasks expected of them and issues they face in accessing appropriate education and training. Particular attention is paid to the tensions and challenges faced by Māori CHWs as they deliver health services within a dual and often competing framework, one which attempts to reconcile indigenous community expectations and the government's expectations as outlined in formal contracts for service. Community health workers are used extensively throughout New Zealand to deliver whānau ora services to Māori communities and comprise a significant component of the Māori health workforce (Ministry of Health, 2005). While there may be no one single accepted definition of the term community health worker (Berman et al., 1987; Giblin, 1989; Witmer et al., 1995; Love et al., 1997), we define CHWs as those voluntary or salaried health workers who, alongside their communities, work to translate western medical ideas of health promotion and education into activities and tasks relevant to Māori community health and well-being (Laing, 1988). In essence they are community advocates, bridging the health sector and Māori communities (Haretuku, 2000). We focus specifically on those health workers employed under whānau ora contracts.

## Methods

We draw upon three separate pieces of work: previously unpublished qualitative data from 1999 (Gifford, 1999); qualitative data from a current research project; and concept validation through co-authorship by a current practicing community health worker with over 12 years experience working in this role. We briefly summarise the methods of data collection for each component of our work below.

In 1999, Gifford conducted research examining how whānau ora purchasing frameworks were developed and enacted in the field of health promotion activity. The study employed a case study methodology which focused on obtaining rich and thick descriptive data from one Māori community-based health provider (Service A). Data collection methods included: an extensive literature review covering indigenous health promotion concepts and models; open-ended focus groups and in-depth interviews with key informants; researcher field notes and participant observation; and a review of the documentation surrounding the whānau ora contract. Key informants included current CHWs, past employees of the service, service managers and members of the Trust Board responsible for the governance of the service. In total, 35 people participated in key informant interviews and focus groups. Their purpose was to determine how CHWs carried out their work; the actual tasks involved, why their work was undertaken in particular ways, the values they brought to their roles and how the organisation was structured to enable them to work effectively. As a consequence of seeking this information, a rich description of CHW roles was produced.



In 2007, research was conducted with CHWs, clinicians and service managers as part of a study to determine organisational prerequisites to fund and implement a Māori health promotion model in a primary care setting (Service B). Participants were asked about the role of CHWs, the way they conducted their work and what qualifications and training CHWs had. As the focus of the 2007 study was broader than simply understanding the role of CHWs, a range of additional data were collected; however, it is only the material directly relating to the role of CHWs that we present here<sup>2</sup>. The data presented come from 15 interviews and four focus groups (consisting of between five to eight people each). A consequence of carrying out the 2007 work has been that the literature in the area of health promotion and primary healthcare as it relates to Māori health and Māori community health service provision has been updated. Whereas in the 1999 study, Dr. Gifford led all aspects of the research (from conducting the interviews and focus groups, making the field notes, transcribing the data, analysing and synthesising data, and writing up and disseminating the research), in the 2007 study, Dr. Gifford's role was one of oversight and management. A research assistant collected the raw data, transcribed interviews and contributed to the analysis.

Themes for this article were determined in conjunction with the CHW co-author. Ms. Potaka-Osborne participated in the original 1999 research having been employed by Service A for the last 10 years. In total, she has 12 years experience in the field and actively participates in relevant forums and networking opportunities with her colleagues. As part of her co-authorship role, she validated the findings from the two research projects, confirming the relevancy of these themes to New Zealand's contemporary Māori CHW workforce.

*Whānau ora: Māori community health service – A definition:* Community-based health services that contract to deliver whānau ora services are explicitly required to provide a range of general health education, health promotion, advisory, liaison and coordination activities. A key objective is to ensure that the activities of existing health professionals are coordinated and effectively targeted for Māori, and that Māori are assisted to better utilise those services (Ministry of Health, 2002b). According to the service specification, CHWs work with all family members from children to the elderly with a view to making improvements in the following areas: overall health status; whānau ability to make decisions about health; the ability to formulate health plans; individual and whānau self-esteem; and the confidence to self-manage healthcare.

Health service providers undertaking whānau ora contracts are expected to provide health education and promotion programmes that target: specific diseases and conditions; sexual health issues, tobacco, alcohol and drug use; and health screening. In addition, the health service is required to demonstrate good relationships with Māori providers and organisations, local general practitioners, practice nurses and their staff, other local healthcare providers including ambulance services, community nurses, public health and district nurses and midwives, hospital services and local providers of social and community services such as schools and kōhanga reo.

## Findings

### *The roles and responsibilities of CHWs in delivering whānau ora services:*

Given the range of work outlined in the service specifications, it is not surprising that the Māori CHWs interviewed described their work as comprising a number of different roles and activities. These ranged from tasks which might be best described as “culturally-based”, requiring a deep understanding of Māori values and philosophies, to specifically medical tasks, health promotion activities, advocacy and liaison.



*The caseworker is the pivotal point in the implementation of whānau ora. The caseworker... needs to be an iwi [or] hapū-based person, they need to be familiar with the whānau. The caseworker is the referral point, educator and delivers a cultural message, she works in tandem with the clinician if there are medical problems....We need to recognise people's skills and knowledge, it's a team approach (CEO Service A, 1999).*

CHWs have identified that while culturally-based activities such as supporting tribal development, assisting whānau with land issues and working alongside traditional healers are not explicitly identified in the service specifications, such activities comprise a critical component of effective service delivery to Māori. CHWs feel obliged to engage in such activities, in part as a result of community expectation, but also because of their own beliefs in the benefits of such participation.

*We were going up to help prepare the marae for a gifting ceremony. [The tribal leader] had asked us to help out. It's really important to be seen and tautoko all the iwi events. We ended up digging out the ground where the manuhiri sit, putting some boxing round and filling it with gravel. It took all day (CHW Service A, 1999).*

Māori CHWs noted that not only was being Māori crucial to their effectiveness as health workers in their community, it also was to the successful delivery and implementation of whānau ora. In particular, CHWs spoke of the importance of culture, upbringing, personal experience and intuition in their work.

*One of the caseworkers and I went up to the hospital last week, we felt proud that we had achieved a lot of stuff in one afternoon, we don't stop and think what we do we just do it. I feel personally it's about being Māori. We weren't taught, we learnt by example, it's about knowing values, about being brought up Māori (CHW, Service A, 1999).*

*There is no way whānau ora can work if you're not Māori (CHW, Service A, 1999).*

Māori CHWs identified that they typically work with the most difficult and most marginalised families in society - families that other health professionals find difficult to contact, let alone commit to receiving ongoing healthcare or education. Working within a whānau ora paradigm allowed Māori CHWs to "address the hard stuff happening in families" (CHW, Service A, 1999).

*[It's] about advocating for the weakest, for the poorest, for the ugliest, for the least likely to earn some bread. And sometimes when you're working with that...you're working from the bottom of the barrel. People don't want to work with these people because they've tried to and [it's] too hard. For us, that's our bread and butter...it's about "we know you, we probably know your uncles and aunties, and we're interested in how they are and you and we're interested in how the rest of your whānau is working and how we can get in there and help support that" (Manager, Service B, 2007).*

The values and principles behind the concept of whānau ora compel Māori CHWs to work across a range of health and social service sectors including education, housing and social welfare. Working with a largely Māori clientele requires CHWs to conduct their work in a variety of health settings (hospitals and primary care clinics) as well as marae, schools and in the home.

*We have two family support workers. One is trying to find hard-to-reach mums, hard-to-reach babies that have got a lot of medical problems, issues and supporting mum and the whānau with that...Most of them and a lot of women don't always*





*know the health risks, so it's a matter of trying to get them and actually visit them out in their homes (Manager, Service B, 2007).*

When considering the recognition they receive for their work, CHWs indicated that medically-trained health professionals may be reluctant to recognise or take advantage of the skills and knowledge of CHWs. Despite the complexity of the role and the skills and knowledge required to do this work, CHWs are paid poorly when compared with the average New Zealand weekly wage (Statistics New Zealand, 2007).

### ***Managing a multiplicity of complex tasks and accountabilities:***

While Māori CHWs are employed by community health service providers to deliver a range of health promotion activities, these workers are often members of the very communities in which they practice. It is for this reason that CHWs find themselves in a position where they must manage dual, and, often, competing accountabilities. In the first instance they are accountable to the funder, through the contract for services, and also to the community of which they are a member.

*I think it's hell for them really trying to balance all those competing demands and I think they do a truly amazing job most of the time in balancing that...we've got a number of competing demands that create a tension but at the end of the day we are here to make it better for our [clients] and their whānau who are members of our Māori community and the wider community. It's not easy (Trust Board Member, Service A, 1999).*

While the position of a whānau ora CHW may require specific cultural competencies, not all CHWs may be proficient in karanga or whaikorero - important skills for cultural facilitation. Expectations with regard to performing competently in a variety of cultural settings are both self-imposed and community-imposed. This level of additional expectation raises anxiety for some CHWs and is especially heightened when working with kaumatua (esteemed elders).

*Sometimes because we have Māori workers, there's an assumption that they will come on board with tikanga Māori and what we know is that that is becoming more and more a rarity (Manager, Service B, 2007).*

One of the greatest tensions Māori CHWs manage is operating in a manner that delivers on "whānau ora" concepts yet at the same time delivering healthcare services in accordance with a contract that focuses on western concepts of disease.

*Whānau ora is about the health of families, individuals in families and groups of people within families. Families can be a nuclear family, an extended family, families in one household or groups of households together. We need to work in a holistic way, including not only all the domains like the spiritual and mental parts, but also the environment, things such as housing and unemployment. Whānau ora isn't a new concept, we have always organised activities around the whānau to keep ourselves well and ensured we stayed alive...what is new is how we organise the contracting and delivery of services (CHW, Service A, 1999).*

Many CHWs do not have any formal training in health promotion, however local-level contracts may require CHWs to deliver services targeted towards improving population health outcomes through health promotion and improving access to services. In such situations, CHWs become the interface between health professionals and the community.



*Sometimes for new mums, we don't get a referral from the midwife until six weeks and then the midwives have been in and done all the early checks...so if we get a new mum we'll go in, we'll follow the referral up. Some new mums are really competent, happy, some mums are not that competent, so our health workers gauge the competence of our mums (Manager, Service B, 2007).*

Many CHWs work long hours and work outside of their job descriptions to meet community expectations. The competing demands faced by CHWs, the complex roles they assume and the fact CHWs may not have formal health qualifications when they take on the position create some real challenges when considering issues of training and development.

### ***Accessing appropriate education and training:***

Currently, there are a variety of courses offered to CHWs by a range of Māori and non-Māori tertiary education institutions, Māori Charitable Trusts with training provider status and Industry Training Organisations that offer on-the-job training. Courses cover topics as diverse as te reo Māori, the Treaty of Waitangi and health, tikanga and kaupapa hauora, report-writing, communication skills, advocacy skills, working with mental health consumers and their whānau, Māori models of health, assessment and liaison and referral systems in health. Some of the qualifications build on previous courses of learning, advancing through levels to achieve higher qualifications.

CHWs have identified a clear need for ongoing training and development; however, training opportunities are described as being short-term and ad hoc in nature, specific to a particular health provider's needs and offering only limited options for career advancement. CHWs emphasised that practical experience is as important as formal training, yet formal training programmes may not recognise prior or experiential learning.

*There's gaps within the workforce and in terms of academic qualifications and I think this is going to continue to be a problem for Māori health. At what stage do we say the academic qualification needs to end and the humanistic qualification needs to begin? Because what my team lack in the academic, they certainly make up with the humanistic, and really if you're talking about good health outputs, you really need a good mixture of both (Manager, Service B, 2007).*

Compounding the difficulties associated with training opportunities is the very real suspicion with which some CHWs regard tertiary institutions and academic qualifications.

*There's a fear also I think with Māori health workers of academia and learning...I think they're worried that if they become academics they'll lose touch with their grass roots and I think the only reason for that is because there are so few out there [who are] good role models (Manager, Service B, 2007).*

## **Discussion**

The role of the Māori CHWs is a complex and multifaceted one (Laing, 1988; Penney, 1996; Crengle, 1997; Gifford, 1999; Haretuku, 2000). CHWs often act as the interface between western medical science and traditional knowledge. They are expected to understand and advocate for evidence-based medicine, yet impart this knowledge in a manner which is palatable to local communities. They require a unique and broad set of skills over and above those associated with advocacy, assessment and referral - including proficiency in Māori language and tikanga; the ability to synthesise and articulate complex medical information in lay terms; and an in-depth understanding of public health, health promotion and health education.



As in other western countries (Witmer et al., 1995, Love et al., 1997), New Zealand relies heavily on CHWs to facilitate primary and public health interventions in the community. Increasingly, their work is becoming more sophisticated as they are called upon to absorb new knowledge, skills and expertise (Haretuku, 2000), apply these in multiple sites of intervention (such as marae, homes and kōhanga reo) and work competently across a range of different social service sectors.

While the work of Māori CHWs is becoming increasingly complex, they undertake this work in an environment where their roles and responsibilities are often not understood by other health workers and medical professionals (Haretuku, 2000), their competencies are not formally nor routinely assessed and remuneration is poor when compared with the level of complexity in their work. Māori CHWs occupy an extremely vulnerable position in the health sector. They do not belong to an identifiable discipline (Haretuku, 2000), nor can they call upon a professional body to protect them when government priorities shift and change.

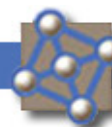
The lack of clarity or flexibility in the role of the CHW may, in part, be explained by the nature of the service specification document which outlines the activities comprising a whānau ora service. Sections of the service specification may be open to liberal interpretation which could impact upon how Māori CHWs define their roles and responsibilities in relation to improving whānau well-being. For example, “assisting whānau and individuals to strengthening whānau, hapū and iwi links” may for one CHW involve running a course on tribal history, while another CHW may instead become directly involved in supporting local efforts in language and cultural revitalisation.

In combination, the scope of the service specification and the inherent flexibility in the CHW’s role may produce some beneficial effects for the community. For instance, Māori CHWs are able to respond relatively quickly to whānau, community and tribal needs, harness innovation and engage in creative problem-solving. However, countering these beneficial effects, this same flexibility and breadth of practice potentially exposes the CHWs to professional “burn-out” or engaging in unfocussed intervention activities which do not deliver measureable health impacts. The latter of these two scenarios has even greater implications for the service as a whole as the funding environment comes to rely increasingly on evidence-based decision-making.

Like their indigenous counterparts in other nations, Māori CHWs contribute to improving the health of communities *and* to nurturing community empowerment (Witmer et al., 1995). Māori CHWs enjoy a very close link with their communities, oftentimes one of whakapapa or genealogy. As a result, CHWs find it difficult to distance themselves from requests for assistance or to turn away those in need. The obligations towards, and responsibility to, the wider community that Māori CHWs feel is not necessarily an obligation or responsibility shared by other health practitioners.

The complexity of the job, the difference in experience and qualifications that CHWs bring to the position and the varying needs and demands from specific communities makes tailoring training and development packages for individual CHWs problematic. Efforts have been made to identify the key areas that should be included in Māori CHW training (Penny, 1996), and while there is general support amongst the Māori CHW workforce for ongoing development and training and indeed the development of a set of core competencies (Te Whiringa Trust, 2003), no agreement has yet been reached on the shape, design or configuration of a training and development package which will meet the needs of all Māori CHWs in New Zealand. CHWs will also be mindful of the risk of losing their effectiveness in the quest for greater professionalisation (Love et al., 1997). However, what Māori CHWs have been able to agree upon is that whatever is developed should be done so from within a Māori worldview.





## Conclusion

Community health workers form an integral part of the New Zealand health workforce acting as the interface between the health sector and Māori communities. By working in a culturally distinctive manner, they help to give effect to Māori health development aspirations. Increasingly this work is carried out in complex and demanding environments. Key challenges that need to be resolved to further advance the position of CHWs in New Zealand include greater recognition of the unique role they play in the delivery of public health and primary healthcare services, linking this recognition to appropriate remuneration and ensuring that ongoing role development is met within a Māori worldview.

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## Notes

- 1: Health services located and operating on a tribes' traditional land.
- 2: Findings related to the implementation of a Māori health promotion model in a primary care setting will be reported elsewhere.

### Appendix - Glossary of MĀORI words and phrases

<b>hapū</b>	<b>a sub-tribe</b>
He Korowai Oranga	the name of the New Zealand government's Māori Health policy document; literally "the cloak of well-being"
hui	usually translated to mean meeting, however it is one which is very formal involving a range of Māori protocols, rituals and procedures
iwi	tribe
karanga	a call made by a woman at the start of a formal meeting (hui) which begins proceedings
kaupapa hauora	Māori health from within a Māori paradigm
kaumātua	esteemed elders
kōhanga reo	a Māori language immersion preschool; literally a "language nest"
manuhiri	guests, visitors of a marae or other Māori facility
Māori	the indigenous people of New Zealand
marae	the meeting area of a village or settlement, including its building and courtyard; also used to refer to the whole complex which may include the meeting house, dining hall and offices
tautoko	support
te	the
te reo Māori	the Māori language
tikanga	Māori protocols, practices and customs
whaikorero	a formal speech or oration
whakapapa	genealogy
whānau	a family (may be nuclear or extended)
whānau ora	family well-being



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