

**What is a Hauora.com Solutions Paper?**  
This paper is the first in a series of papers which focus on promulgating solutions to key health and intersectoral issues affecting Maori development.

Hauora.com plan to release a series of Solutions Papers to stimulate sector discussion around transformative approaches to transformative models of care that achieve equity for Maori.

**Audience**  
This paper has two key audiences. First, Government, Maori and Non-Government policy and funding decision-makers who have the authority to make investment decisions which would implement the solutions outlined in this paper. Second, Maori stakeholders and in particular the Maori Community Health Worker workforce.

**Citation**  
Authors: Haretuku, R; Thompson, L.; Stewart, L. and Shea, S. (2011) Advancing the Smart and Efficient Use of New Zealand's Maori Community Health Workforce (Hauora.com: Auckland)

# Transformative Approaches to Transformative Models of Care

## Advancing the Smart and Efficient Use of New Zealand's Māori Community Health Workforce

---

### EXECUTIVE SUMMARY

The purpose of this solutions paper is to inform and generate sector discussion about the urgent need to advance the smart and efficient use of the Māori Community Health Workforce<sup>1</sup>. Hauora.com<sup>2</sup> suggests that at present, this unique Workforce is not universally recognised and therefore its potential is underutilized. We also posit that the future of the Māori Community Health Workforce is unclear due to the lack of a cohesive and resourced approach for development and advancement.

This situation needs to change in order to effectively mobilise what is effectively New Zealand's largest Māori health workforce. The opportunity to effect change is now because emphasis is being placed on new sector configuration and funding opportunities linked to "transformational" change, for example, Minister Turia's Whānau Ora Strategy (Durie et al, 2010), Minister Ryall's Better Sooner More Convenient Policy (Ryall, 2009) and Minister Bennett's Community Response Forums (MSD, 2010).

Accordingly, this paper outlines the context and rationale for change by analyzing the role of a Community Health Worker, and in particular, a Māori Community Health Worker; why it is important to recognize the value and impact of this workforce; the current state of this workforce and ; the potential of transformational sector opportunities and Māori CHWs. We then summarise the five key barriers, that in our opinion, currently impede Māori CHW development and we present five POU or Solutions to mitigate these barriers.

---

<sup>1</sup> Although this paper focuses on the Māori Community Health Worker advancement it builds upon generic Community Health Worker (CHW) issues and as such, solutions in this paper may also be applicable or adapted to suit non-Māori CHWs.

<sup>2</sup> Hauora.com is a Māori Workforce Development Agency, see: [www.hauora.com](http://www.hauora.com).

The Barriers outlined in this paper are summarized as follows:

**Barrier 1: Lack of a cohesive national approach leading to inconsistent recognition of the value and impact of Māori CHWs**

**Key Point** there is no cohesive national approach to Māori CHW development and this has contributed to inconsistent recognition of the value and impact of Māori CHWs.

**Barrier 2: Resource poor representational infrastructure**

**Key Point:** the representational infrastructure for Māori CHWs is limited in terms of financial, legal, human and technological resources.

**Barrier 3: Poor recruitment, role definition, retention and reward frameworks**

**Key Point:** poor recruitment, role definition, retention and reward frameworks combine to affect the recognition of Māori CHWs and also creates powerful disincentives for Māori to enter into this high value career.

**Barrier 4: A dearth of research and evaluation material.**

**Key Point:** there is still a dearth of readily available published research and evaluation on Māori CHWs.

**Barrier 5: Failure to recognise the extra duties and pressures linked to being a Māori CHW**

**Key point:** Māori CHWs face unique expectations linked to their ethnicity and cultural beliefs. These 'extra' duties and pressures should be recognized as part of their dual mainstream and Māori expertise, skill base and commitment.

The 5 POU (Solutions) are summarized as follows:

**POU 1: Recognition**

**Key Point:** consistent and universal recognition of the value and impact of Māori CHWs is one of the key POU for advancing the smart and effective use of the Māori CHW.

**POU 2: Representation**

**Key Point:** a fully resourced and Māori CHW endorsed representational infrastructure is critical to ensuring Māori CHWs have the capacity to demonstrate leadership in terms of sector reform and to influence system design for the smarter use of Māori CHWs.

### **POU 3: Recruitment & Retention**

**Key Point:** recruitment and retention are two key parts of the gateway and pathway for the long term growth and sustainability of the Māori CHW workforce. Active investment in a cohesive and multi-sector stakeholder response, that connects activity and investment across a new and dedicated Te Ara Mahi (Work Pathway) for Māori CHWs will create more transparent options and choices for potential, new and existing Māori CHWs. The tension between the dual Academic and Maturanga Māori paradigms will be minimized leading to greater workforce satisfaction and CHW impact on outcomes.

### **POU 4: Role**

**Key Point:** clear definition of the role of a Māori CHW will assist with recognition, recruitment, retention and smarter deployment.

### **POU 5: Research & Evaluation**

**Key Point:** a targeted research and evaluation approach is needed for Māori CHWs. This can be linked into other developments but must have sufficient specificity to provide the evidence to support recognition, recruitment, retention and effective relationships.

Hauora.com suggest that if these POU are implemented in a cohesive manner, and if these solutions are endorsed and facilitated by Māori Community Health Worker leadership, this will create a comprehensive platform to rapidly advance this workforce and achieve unparalleled positive outcomes for families/whānau, communities and systems. Finally we note that this paper has been endorsed by Te Whiringa Trust which represents Māori CHWs nationally.

## TABLE OF CONTENTS

<b>EXECUTIVE SUMMARY</b> .....	<b>1</b>
<b>TABLE OF CONTENTS</b> .....	<b>4</b>
<b>INTRODUCTION</b> .....	<b>5</b>
WHAT IS A COMMUNITY HEALTH WORKER AND WHAT DO THEY DO? .....	5
WHAT IS A MĀORI COMMUNITY HEALTH WORKER AND WHAT DO THEY DO? .....	6
RECOGNISING THE IMPORTANCE OF CHWS .....	7
<i>CHWs are recognized as integral members of the health workforce</i> .....	7
<i>A well deployed CHW workforce is able to mitigate key global and domestic health sector drivers such as health workforce shortages; increasing demand and fiscal constraints</i> .....	8
UNDERSTANDING THE IMPACT OF CHWS .....	8
<i>On Individuals and Whānau/Family</i> .....	9
<i>On Communities</i> .....	10
<i>On Systems</i> .....	10
CURRENT STATE OF THE MĀORI COMMUNITY HEALTH WORKFORCE .....	11
CURRENT SECTOR OPPORTUNITIES FOR MĀORI CHWS .....	12
<b>BARRIERS IMPEDING ADVANCEMENT OF THE MĀORI CHW WORKFORCE</b> .....	<b>13</b>
BARRIER 1: LACK OF A COHESIVE NATIONAL APPROACH LEADING TO INCONSISTENT RECOGNITION OF THE VALUE AND IMPACT OF MĀORI CHWS .....	13
BARRIER 2: RESOURCE POOR REPRESENTATIONAL INFRASTRUCTURE .....	14
<i>Te Whiringa Trust</i> .....	15
<i>Legislation</i> .....	15
<i>Data</i> .....	15
<i>Technology</i> .....	15
<i>Finance</i> .....	16
BARRIER 3: POOR RECRUITMENT, ROLE DEFINITION, RETENTION AND REWARD FRAMEWORKS .....	16
<i>Recruitment Barriers</i> .....	16
<i>Retention Barriers</i> .....	18
<i>Role Definition</i> .....	18
BARRIER 4: A DEARTH OF RESEARCH AND EVALUATION MATERIAL .....	19
BARRIER 5: FAILURE TO RECOGNISE THE EXTRA DUTIES AND PRESSURES LINKED TO BEING A MĀORI CHW .....	19
<b>5 POU OR SOLUTIONS TO ADVANCE THE MĀORI CHW WORKFORCE</b> .....	<b>20</b>
POU 1: RECOGNITION .....	20
POU 2: REPRESENTATION .....	21
POU 3: RECRUITMENT & RETENTION .....	22
POU 4: ROLE .....	24
POU 5: RESEARCH & EVALUATION .....	24
<b>CONCLUSION</b> .....	<b>25</b>
<b>GLOSSARY OF MĀORI WORDS</b> .....	<b>26</b>
<b>REFERENCES</b> .....	<b>27</b>

## INTRODUCTION

### What is a Community Health Worker and what do they do?

There are a wide variety of definitions and consequently, titles<sup>3</sup> for a Community Health Worker (CHW/s) both internationally (Patrik et al 2009; Lehman and Sanders, 2007; Lewin et al, 2005; Criger et al, 2010; Witmer et al, 1995; and in New Zealand (Boulton et al, 2009; Haretuku, 2000; Penney, 1996; Crengle, 1997; Gifford, 1999; Love et al, 1997). In general, the term CHW acts as an umbrella term (Patrik et al, 2009; Lehman and Sanders, 2007) and it incorporates a range of roles, skills bases, competencies and characteristics.

The World Health Organisation (WHO) defines CHWs as:

*“members of their communities where they work, should be selected by their communities, should be answerable to the communities for their activities, should be supported by the health system but not necessarily a part of its organization, and have shorter training than professional workers” (WHO, 2007).*

Witmer et al (1995) define a CHW as:

*“Community members who work almost exclusively in community settings and who serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked access to adequate care. By identifying community problems, developing innovative solutions, and translating them into practice, community health workers can respond creatively to local needs.” (p.1055).*

A CHW performs a variety of roles. The following generic elements are relevant to the definition of a CHW. A CHW:

- Provides culturally appropriate health education, information and outreach;
- Has the flexibility to provide services in multiple community-based settings (such as homes, schools, clinics, shelters, local businesses, Marae, Kura, Kohanga and community centres);
- Bridges multiple social, health and systemic gaps for the individual and families/Whānau;
- Provides mediation skills between Whānau, individuals, communities and intersectoral services, including actively building individual and community capacity;
- Facilitates access to services that whānau and individuals need;
- Provides a range of direct services, which may comprise one or more of the following: informal counseling, social support, care coordination and health screenings;
- Advocates for individual and community needs;

---

<sup>3</sup> Examples of the range of titles used to describe a community health oriented worker include: Lay Health Worker; Community Advocate; Social Worker; Kaiawhina; Health Promotion Worker; Community Worker; Whānau Advocate; Health Assistant; Youth Worker; Care Support Worker; Carer; Kaimahi Hauora; Linkworker and more recently, Whānau Ora Practitioner..

- Helps individuals and families navigate through systems;
- Can work as part of a multidisciplinary team environment;
- Engages in community development.

A point of difference for all CHWs is that they are non-regulated. The term non-regulated is defined as a health practitioner and/or support worker that is not registered under the Health Practitioners Competency Assurance Act 2003 or any other registration authority (MOH, 2006). The impact of this is highlighted later in this paper.

### **What is a Māori Community Health Worker and what do they do?**

In New Zealand, Boulton et al (2009) defines a Māori Community Health Worker as “those voluntary or paid 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 wellbeing” (p.2).

In addition to the generic roles outlined for a CHW, it is suggested that for Māori CHWs, the following supplementary and specific roles are also relevant:

- Can work with the most marginalized and high needs communities;
- Can be the first point of contact for highly marginalized whānau and as such provides the initial professional and cultural “face” of the health sector;
- Acts at the intersection point between western medical/scientific models and Mātauranga Māori (Māori models of health and traditional knowledge);
- Are involved as translators and knowledge exchange agents between the Western and Māori paradigms;
- Provides the sector with cultural integrity and in turn reminds the sector of its commitment to act with integrity towards Māori;
- Bridges multiple cultural gaps between the individual/whānau and ‘mainstream’;
- Delivers culturally based activities and interventions that reflect Māori Tikanga and Kaupapa;
- Often works in a dual cultural and professional paradigm with diverse expectations and sometimes competing responsibilities g. to meet contract deliverables, to meet cultural expectations of the community;
- Are expected to achieve or contribute to meeting Māori specific aspirations linked to Te Tiriti O Waitangi;
- Due to the needs of the whānau they serve, almost always work intersectorally and across multiple networks;
- Engages in Māori Community Development;
- Has the unique capability to deliver Whānau Ora and Māori-Whānau-centric interventions.

Whatever definition is used, it must coincide with local societal and cultural norms to ensure community ownership and acceptance (Lehman and Sanders, 2007). This is particularly so in the New Zealand context and in terms of recognising and valuing a Kaupapa Māori approach to CHW.

## Recognising the importance of CHWs

### ***CHWs are recognized as integral members of the health workforce***

There is widespread recognition of the important contribution CHWs make to the health sector and to communities. As Witmer et al (1995) states, CHWs are “integral members of the healthcare workforce”.

Over the last 50 years, pivotal documentation and policy has signalled the continued rise in CHW role recognition. For example, in the 1970s, the WHO Alma-Ata stimulated the rapid expansion and use of Lay Health Workers in response to new ways of delivering primary health care (Lewin et al, 2009).

The American Institute of Medicine (2002) in its vital report “Unequal Treatment: Confronting Racial and Ethnic Disparities in Health” found that:

*“Community Health Workers offer promise as a community-based resource to increase racial and ethnic minorities’ access to healthcare and to serve as a liaison between healthcare providers and the communities they serve.”*

More recently, in 2009, the Sixty Second World Health Assembly confirmed that integral to primary healthcare and health system strengthening was the development of a workforce that could work in a multidisciplinary context and could cooperate with community health workers in order to respond effectively to peoples’ needs.

In the USA, CHWs have recently been legislatively recognised in the Patient Protection and Affordable Care Act 2010, as key members of the healthcare workforce who are vital to restructuring efforts within the primary healthcare sector (Rosenthal et al, 2010).

USAID, the United States Agency for International Development, has also recognised that expansion of CHW roles and the workforce is necessary to meet human resource and health needs in the maternal and child health areas. Accordingly, USAID has set an ambitious growth target of increasing the number of CHWs in specific countries by at least 100,000 by 2013 (Crigler and Hill, 2010).

In New Zealand, the Ministry of Health has recognised that CHWs are “used extensively throughout New Zealand to deliver Whānau Ora services to Māori communities and comprise a significant component of the Māori health workforce” (MOH, 2005). Boulton et al (2009) also establishes the importance of CHWs based upon qualitative research:

*“The caseworker is the pivotal point in the implementation of Whānau Ora. The caseworker ... needs to be an iwi [or] hapu-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 (CEO, Service A, 1999)”*

***A well deployed CHW workforce is able to mitigate key global and domestic health sector drivers such as health workforce shortages; increasing demand and fiscal constraints***

Three key global and domestic drivers: health workforce shortage crises, increasing demand for high quality services and fiscal constraints, have stimulated increased recognition of the role CHWs can play in creating more effective health services and health systems (WHO, 2006; JCIE, 2009; Jimba, 2009).

Workforce shortages have been identified by WHO as one of the most critical ‘building blocks’ of strengthened health systems and the more effective use of the lay health workforce or community health workers is a key strategic response to mitigate workforce shortages (Jimba, 2009). In particular, the concept of Task Shifting or the “rational redistribution of tasks among health workforce teams” (WHO, 2008) has been recently prioritised. Task shifting focuses on reorganizing and decentralising health service delivery linked to the available workforce. The objective is to move specific tasks from regulated to non-regulated workers to make more efficient use of the available workforce. The WHO Report provides examples of how Community Health Workers have undertaken extended roles to improve health outcomes and provides guidelines on how countries can introduce formalized task shifting that maintains safety, efficiency, effectiveness and sustainability.

New Zealand is not immune from workforce shortages (MOH, 2006). In 2010, the Government established Health Workforce New Zealand (HWNZ) to maximize value for money linked to workforce development and manage health workforce issues. HWNZ signaled a move to national consolidation of workforce planning, education, training, development and purchasing. Its overall aims are to develop a “fit-for purpose, sustainable, productive, skilled and responsive health workforce” (MOH, 2010a). Notably, HWNZ has a “renewed and important focus on clinical workforce development and engagement and systems design” (MOH, 2010a).

The demand for healthcare is also rising within the context of fiscal constraints globally and domestically. An ageing population coupled with changing patterns of need has contributed to a growth in demand (MOH, 2010; MOH, 2010a). At the same time, fiscal constraints signal desires to increase efficiency and productivity to maximize optimal use of limited human, financial and technological resources. Accordingly, there has been a renewed focus on twin strategies focused on health systems improvement (inclusive workforce development) and health services development. CHWs play an important role in future twin strategies.

## **Understanding the impact of CHWs**

Alongside recognising the importance of CHWs is an associated understanding of the impact a well-deployed CHW workforce can have. The impact of CHWs can be understood across three domains: for Individuals and Whānau/families; for Communities and for Systems.

These domains are used to summarise evidence from readily available international and domestic (published and grey) literature. This is not intended to be an exhaustive list of impacts but this summary provides a useful insight for the purposes of this paper.

### ***On Individuals and Whānau/Family***

There is evidence which states that CHWs contribute to **reducing health inequalities and disparities** (IOM, 2002; Nemcek and Sabatier, 2003; Lehman and Sanders, 2007; Lewin et al, 2009; Viswanathan et al, 2009; Patrick et al, 2009; Rosenthal et al, 2010). Lewin et al (2009) assessed evidence of the effectiveness of Lay Health Worker (LHWs) interventions in primary and community health care on healthcare behaviours, patients' health and wellbeing and patient satisfaction with care. They focused on randomised controlled trials of any intervention delivered by LHWs, paid or voluntary, in primary or community health care. 43 studies were analysed involving more than 210,000 consumers. Lewin et al found that benefits in comparison to usual care were shown for interventions to promote immunisation uptake in children and adults, selected infectious diseases, and breastfeeding promotion.

Viswanathan et al (2009) conducted a systematic review of evidence about characteristics of CHWs, interventions, outcomes, costs and cost effectiveness. 53 studies were reviewed. They found that CHWs can serve as a means of **improving outcomes for underserved populations** for some health conditions. There was good evidence around CHW interventions improving participant knowledge when compared with alternative approaches; there was mixed evidence regarding participant behaviour change and health outcomes. Some studies suggested that CHW interventions resulted in improved behaviour and health outcomes and other studies suggested no statistically significant benefits. It was also found that CHWs had the greatest effectiveness for some disease prevention services, asthma management, cervical cancer screening and mammography screening outcomes.

*“Substantial disparities in life expectancy, health and health care exists. Although many actions ... contribute to these disparities, bias, discrimination and stereotyping during the clinical encounter also explain healthcare disparities ... A core component in recommendations to address healthcare disparities is the involvement of the community: specifically the involvement of Community Health Workers” (Viswanathan et al, 2009)*

Evidence also confirms that CHW led patient navigation and case management has also been shown to have a significant impact on **reducing disparities**, particularly with respect to cancer screening (Patrick et al, 2009; Mock et al, 2007) and mammography (Crump et al, 2008).

An ethnic and bilingual workforce is also an effective strategy to improve services for underserved populations (Barwick, 2000). In the USA, controlled research on the impact of diabetes education led by a bilingual CHW in an inner-city Hispanic population, found improved rates of programme completion, patient knowledge, self-management and glycaemia control (Corkery et al, 1997).

Broughton (1995) described the impact and value of a Māori CHW when evaluating a dental health service at Ratana Pa when it was stated:

*“She was the person who consulted with her community, made the appointments, was present the whole time to ‘awhi’ (provide a caring embrace) and tautoko [support] the patients. They know her and they trust her.”*

### ***On Communities***

CHWs have been acknowledged as furthering community development and empowerment (Witmer et al, 1995; Lehman and Sanders, 2007). Nemcek (2003) states that “CHWs are indigenous, trusted, and respected members of the underserved community. They can serve as a bridge between peers and health professionals” (p.260). The ‘bridging’ function is a vital element of community development alongside providing community members with employment opportunities. Other examples of community development include CHW provision of advice and education to other professional graduates, which in turn prepares those graduates for community engagement (Levine et al, 1992 in Witmer et al, 1995).

Boulton et al (2009) state that because Māori CHWs work in a “culturally distinctive manner” they contribute to implementing Māori health development aspirations. These aspirations are linked intimately to operationalising the Tiriti O Waitangi and therefore recognising issues such as self-determination, Māori whānau, hapu, iwi and community development; Māori innovation and respect for Māori models and concepts of health.

### ***On Systems***

There is evidence to suggest that CHWs **improve system responsiveness** (Witmer et al, 1995; Patrik et al, 2009; Rosenthal et al, 2010; Barwick, 2000). Witmer et al (1995) reviewed evidence about the impact of CHWs and found that CHWs **increase access** to the health sector because they are workers who can translate system information into lay language for the community (Giblin, 1989 in Witmer et al, 1995); and they deliver services flexibly to reach underserved populations e.g. outreach, community-based interventions; and CHWs have improved access to prevention, prenatal and infectious disease services.

CHWs have particular skills to provide services to people who have had limited experience **accessing** services and are highly effective at recruiting and enrolling individuals into the sector. This reflects their unique linguistic, community-based work and cultural expertise (Patrick et al, 2009).

Witmer et al (1995) confirmed that CHWs improve the **quality of care** offered by the system. Witmer states that CHWs facilitate community participation in the health system and engage in provider education and upskilling ranging from community health issues through to cultural competency and how to achieve outcomes. Other aspects of improved quality of care attributed to CHWs include reduction of DNAs (Knobel, 1992; 1992a in Witmer et al); increased compliance with regimens (Knobel, 1992; Knobel 1992a; Levine et al, 1992; McCormick et al, 1989); and improved early detection and utilisation (Perino, 1992; Warrick et al 1992).

CHWs are key enablers for **patient-centric care**, which is care that respects and responds to patient preference, needs and values. This is due to CHWs commitment to delivering four key quality-based care elements: open communication; culturally competent services; a focus on patient satisfaction and support for clients to be self-managing. (Patrick et al, 2009).

There is evidence to suggest that CHWs offer a **cost-effective service** that promotes the appropriate use of healthcare resources. Giblin (1989) suggests that in comparison with other providers, CHWs are relatively inexpensive to train, hire and supervise. As was stated in Barwick (2000) "... it is easier to train a linkworker to carry out nursing duties than to teach a nurse to speak an Asian language" (p.27). Knobel (1992, 1992a) suggests that CHWs, as extensions of the primary care team, can prevent unnecessary use of expensive emergency department and speciality services.

CHWs can also enhance **cost control** by assisting people to use the healthcare system more wisely and more efficiently. Assistance ranges from being part of an integrated care team and providing complementary services to clinical colleagues; connecting patients with a "medical home" for primary care; reducing inappropriate use of secondary care and providing patient navigation support and advice (Patrick et al, 2009). Whitley et al (2006) studied how CHWs could improve primary care utilisation by underserved men in Denver, USA. They found that due to CHW intervention, care shifted from expensive inpatient and urgent care to primary care services which resulted in a ROI of \$2.28 for every \$1.00 spent on the CHW intervention. This resulted in annual savings of 100k. Similar findings were made by Fedder et al (2003), when studying CHW interventions, where savings of up to 80-90k per CHW/per anum could be made through CHW support for improved primary care compared to secondary care utilization.

### **Current state of the Māori Community Health Workforce**

There is no single national database which contains accurate and up to date information on the overall CHW and/or Māori CHW profile in New Zealand. This is a major systems gap which has been recognized several times (Haretuku, 2000 and 2010; Keelan et al, 2007; Hornblow et al, 2002; MOH, 2006; Ratima et al, 2008; Shea, 2010). However, there are pockets of information (albeit in some cases quite old) which provide a qualified profile of the current state of New Zealand's Māori CHW:

- In 2005, Ramage et al found that ethnicity data in the non-government organisation (NGO) workforce showed that the most commonly represented group in non-clinical roles were mental health support workers and that workforce data held by Child, Youth and Family confirmed 37% of Māori employed were in non-clinical roles (67% in clinical roles) and of these half were either cultural advisors or administrators;
- In 2008, DHBNZ, a national body that represents all District Health Boards and consequently, public sector hospitals in New Zealand stated that, around 4,500 FTE care and support workers were employed in hospitals. Care and support workers ranged from Nursing Support Workers through to Kaiawhina, Community Workers, Indigenous Health Workers and Youth Workers (DHBNZ, 2008). This workforce comprised predominantly female workers (74%), was 7% of the total DHB FTEs; had the oldest average age of 48 years and comprised relatively more Māori and Pacific (n=1006, 22%) than the general DHB workforce;
- In 2009, there were more than 300 Māori addiction workers (comprising 20% of all addiction workers (Durie, 2009);

- In 2010, the Ministry of Health (MOH) stated that the total health and disability workforce in New Zealand comprised around 164,000 people (MOH, 2010)<sup>4</sup>. In 2006, MOH estimated that of the total health workforce, around 40% comprised the unregulated workforce and 30% of this workforce were “support workers”. Using 2010 figures, this would equate to approximately 49,200 “support workers”;
- In 2010, Te Whiringa Charitable Trust, a body that represents Māori CHWs, estimated that at least 50% of the Māori health workforce was CHWs (Haretuku, 2010).

## Current sector opportunities for Māori CHWs

Over time, Māori development aspirations have reflected the increased desire for Māori to take greater control and responsibility for their own health (Durie, 1994; MOH, 2002; Public Health Commission, 1995; Haretuku, 2000) and to take the lead in new and innovative service delivery linked to Māori concepts.

Three recent examples of current sector innovation that promote opportunities for furthering Māori aspirations to lead service development and that could create platforms for better deployment and use of the Māori CHW workforce are Minister Turia’s Whānau Ora Strategy (Durie et al, 2010), Minister Ryall’s Better Sooner More Convenient (BSMC) Policy (Ryall, 2009) and Minister Bennett’s Community Response Forums (MSD, 2010):

Minister Turia’s Whānau Ora Policy is focused on trialling new service delivery models which prioritise achieving Whānau Ora outcomes. These outcomes range from Whānau self-management and healthy lifestyles through to confident participation in Te Ao Māori, Whānau cohesion and economic security leading to wealth creation. The potential gains from Whānau Ora for Whānau and other high needs communities are significant, wide-reaching and intergenerational.

Minister Ryall’s BSMC Policy also provides opportunity for CHW/Whānau Ora Practitioner development linked to services delivered “closer to home”. As outlined earlier in this paper, CHWs have key roles to play in regard to improving access to healthcare; reducing inequalities and reducing unnecessary use of secondary care services.

Minister Bennett’s community response forum enables community members, government representatives and iwi to join forces and develop Community Funding Plans for their area. This plan will drive the future allocation of funds and family-centric, outcomes-focused services are a key part of the Ministry of Social Development’s strategic agenda. CHWs have unique insights into the communities they serve and have high levels of day-to-day “frontline” engagement. This information would be invaluable to validate the Community Funding Plans.

Importantly, Māori CHWs are being seen as the core workforce for new Whānau Ora Practitioner and Navigators; and new Whānau/Family-centric models of care (Te Rau Matatini,

---

<sup>4</sup> In 2006, the estimate was 100,000 (MOH, 2006).

2010; personal communication with Hauora.com Board, February 2011; Careerforce, 2010; Social Services ITO). This has contributed to multiple agencies creating new competencies for this emerging Whānau Ora Practitioner workforce (Te Rau Matatini, 2010; Careerforce, 2010; Social Services ITO). It is yet to be seen how this will impact on the future development of Māori CHWs.

All of these issues are reasons why urgent attention must be given to advancing the Māori CHW leadership and workforce to capitalize on these developments.

## **BARRIERS IMPEDING ADVANCEMENT OF THE MĀORI CHW WORKFORCE**

To understand how to advance the Māori CHW workforce, it is necessary to understand the barriers impeding advancement. We have been grouped barriers into five key themes:

1. Lack of a cohesive national approach leading to inconsistent recognition of the value and impact of Māori CHWs
2. Resource poor representational infrastructure;
3. Poor recruitment, role definition, retention and reward frameworks;
4. A dearth of research and evaluation material;
5. Failure to recognise the extra duties and pressures linked to being a Māori CHW

### **Barrier 1: Lack of a cohesive national approach leading to inconsistent recognition of the value and impact of Māori CHWs**

**Key Point: there is still no cohesive national approach to Māori CHW development and this has contributed to inconsistent recognition of the value and impact of Māori CHWs.**

Despite good historical and current intent demonstrated by multiple government agencies and non-government organisations, there remains a diverse and sometimes confusing approach to Māori CHW development. There are multiple stakeholders involved in this area, ranging from the Māori CHWs themselves through to Government Ministries (Health, Social Development, Education); Industry Training Organisations; Education providers; Māori NGOs (e.g. Te Rau Matatini, Te Whiringa Trust) and Māori providers. All stakeholders are undertaking a wide variety of strategies and actions with differing levels of resources, authority and infrastructure (see Shea, 2010 for a summary of some key stakeholders and activities). The prevalence of multiple stakeholders, without clear roles, agreed responsibilities and lack of endorsement by Māori CHW leadership, has led to an ad hoc approach which is compounded by fragmented investment and activities. We suggest this seriously limits the optimal use of Māori CHWs.

Within the last 5-10 years, recent sector strategy led by the Ministry of Health, has attempted to align and co-ordinate investment into Māori workforce development and this is a positive development. Hauora.com supports initiatives that target investment into Māori CHW development and in particular support recent initiatives such as Kiaora Hauora

([www.kiaorahauora.co.nz](http://www.kiaorahauora.co.nz)) and Te Rau Matatini ([www.matatini.co.nz](http://www.matatini.co.nz)). The difficulty however is that multiple investments are not necessarily aligned with self-defined Māori CHW priorities and despite some recent efforts, there still remains a lack of centralized co-ordination and therefore cohesiveness which is directly aligned with Māori CHW aspirations and enabling direct Māori CHW leadership opportunities. This is a systemic issue and is not attributable to one organization or agency.

This sentiment was recently stated by Te Whiringa Trust, the national body representing Māori CHWs at their hui in 2010, where member Māori CHWs stated that they still felt hindered practicing in a Māori way due to non-Māori perceptions of value and unhelpful perceptions from their clinical peers; that there was no 'national authority' for CHWs in New Zealand and that there was limited understanding in the health sector of the developing context for Whānau centric/Māori community-based care and the new skills required to address these complex issues (Haretuku, 2010).

A recent and important example of workforce development that is not aligned with Māori CHW aspirations is the approach adopted by HWNZ, which is to prioritize clinical or regulated workforce leadership and workforce development without a concomitant strategy linked to the non-regulated workforce. This approach mimics what has often occurred internationally where health sector workforce reform tends to focus on the regulated workforce and the non-regulated or CHW is 'largely overlooked' (Witmer et al, 1995; Shea, 2010).

There is no doubt that clinical leadership is a critical element of a high performing health system. However, in our opinion, there is also little doubt that valuing the diverse role that CHWs can play and their potential impact on reducing health inequalities and improving systems functioning requires significant elevation by HWNZ. We suggest that failure to recognize and invest in the dual leadership roles of both the regulated and non-regulated workforce could lead to significant disinvestment and possible disinterest in one of New Zealand's most readily deployable and available workforces. We suggest that this would be a major oversight with negative impacts on access to, the quality and effectiveness of the healthcare and intersectoral system. From Hauora.com's perspective, this gap will contribute to a wide range of barriers that impedes the advancement of CHWs, and in particular, Māori CHWs in New Zealand (Haretuku, 2000 and 2010).

## **Barrier 2: Resource poor representational infrastructure.**

**Key Point: the representational infrastructure for Māori CHWs is limited in terms of financial, legal, human and technological resources.**

The current infrastructure available to represent the self-determined needs and preferences of Māori CHWs is very limited. Examples of infrastructure discussed in this paper include: the role of Te Whiringa Trust; Legislation; Data; Technology and Finance.

### ***Te Whiringa Trust***

There is one national Māori CHW 'owned' body which is called Te Whiringa Trust. There are no substantive regional and/or localized infrastructure set up to meet Māori CHW needs.

Hauora.com originally played a lead role in supporting the development of the Trust and it was established in 2002 as a result of the inaugural national Māori CHW hui in Rotorua ([www.mchw.net](http://www.mchw.net)). The Trust's Vision is Whānau Ora and its Mission is to build confident Māori CHWs to mobilise their communities. The Trust has been resourced by the Ministry of Health to provide a range of membership functions and the investment into establishing and maintaining the Trust to date has been an essential element for Māori CHW owned and led representation. Accordingly, the Ministry of Health investment into the Trust is viewed extremely positively by the Māori CHW sector<sup>5</sup>. However, to move the Māori CHW sector forward, at a rapid pace and to entrench opportunities for national and direct Māori CHW leadership, the Trust believes that additional capacity is required.

Te Whiringa Trust recently confirmed three new objectives at their 2010 annual hui: (1) reposition Māori CHWs in the health sector; (2) cater for learning needs with national consistency and (3) build support for existing and new Māori CHW roles (Haretuku, 2010). All of these objectives will require additional resourcing over and above what the Trust currently receives, particularly as the sector and environment that Māori CHWs operate within is complex and involves multiple stakeholders across sectors.

### ***Legislation***

Unlike recent international developments e.g. the American Patient Protection and Affordable Care Act 2010, there is no legislative recognition of the important role CHWs play. Nor are there any legislatively defined representation positions on government endorsed agencies, committees or boards. This is a gap which requires further investigation.

### ***Data***

There is limited data on the profile<sup>6</sup> of the Māori CHW or the CHW workforce in general (Haretuku, 2010; Ratima et al, 2008). This has been an issue for the workforce for many years and the lack of robust data impedes good planning and the optimal deployment of resources.

### ***Technology***

There is also no agreed approach to technology support strategies for Māori CHWs from a service delivery perspective and therefore Information and Communications Technology support has developed in an ad hoc manner linked to the capacity and support of the organization CHWs are employed by or volunteer with. This lack of a nationally consistent technology-driven plan for Māori CHWs is a major impediment for development.

---

<sup>5</sup> Personal communication with the Te Whiringa Trust Chair, February 2011.

<sup>6</sup> Profiling can include numbers, ethnicity, age, tribal affiliations, employee status, employer type, title, salary, training, education, etc.

### ***Finance***

There is no readily available data to confirm the level of investment into the development of Māori CHWs; let alone comparative analysis of investment into other types of workforce e.g. regulated vs. non-regulated financial investment. This information would be a useful indicator to determine return on investment and as a key input for cross-sector planning. It would also be a useful proxy for CHW recognition and value purposes.

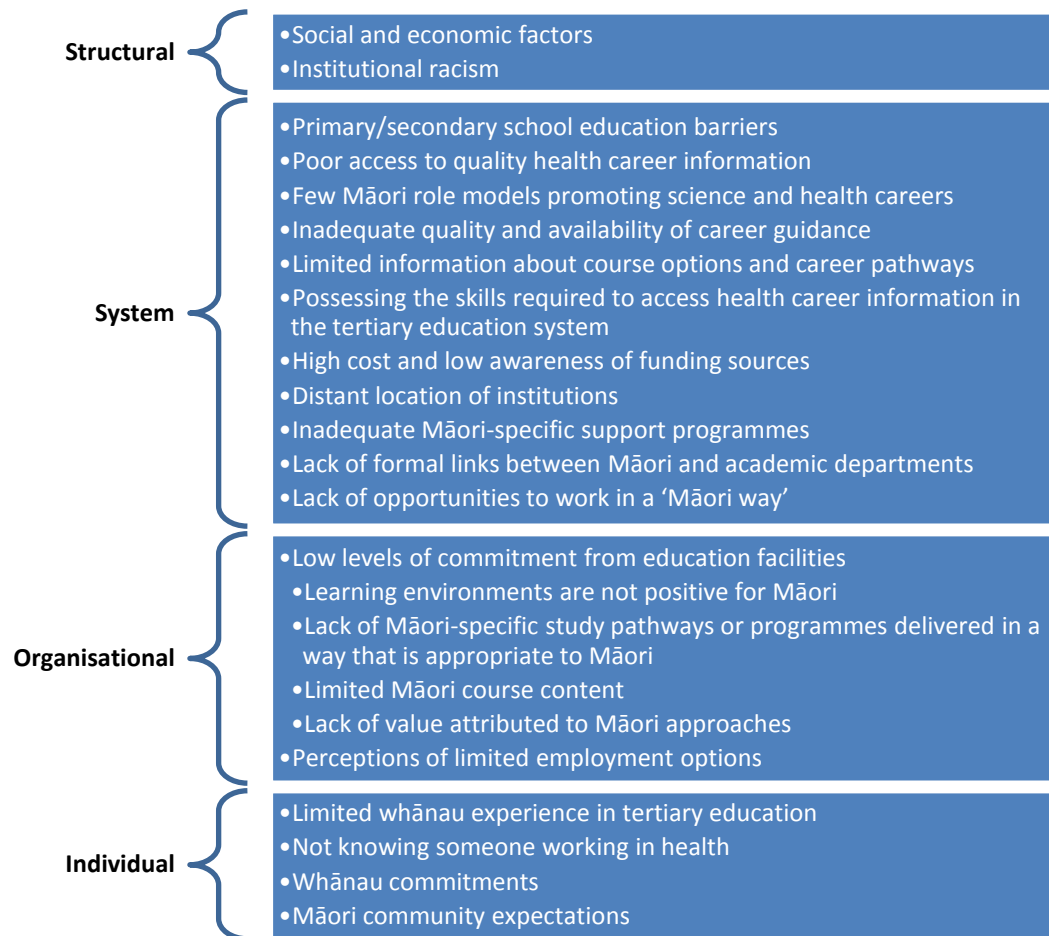
### **Barrier 3: Poor recruitment, role definition, retention and reward frameworks.**

**Key point: poor recruitment, role definition, retention and reward frameworks combine to affect the recognition of Māori CHWs and also creates powerful disincentives for Māori to enter into this high value career.**

There is ample evidence that confirms multiple barriers for Māori exist in terms of recruitment, roles, retention and rewards (Ratima et al, 2008; MOH, 2008 and 2008a).

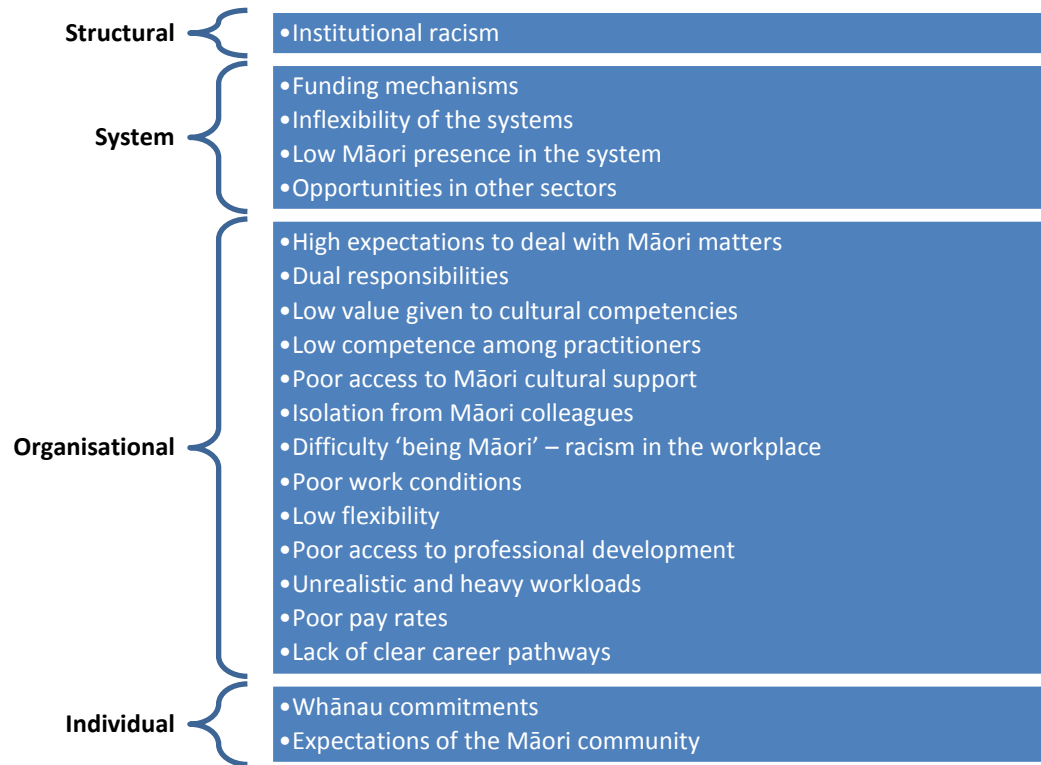
### ***Recruitment Barriers***

Recruitment barriers (MOH, 2008) are summarized as follows:



### **Retention Barriers**

Retention barriers (MOH, 2008a) are summarized as follows:



### **Role Definition**

In addition, role clarification and definition will be a key issue moving forward particularly with the advent of Whānau Ora Practitioner developments, new sector opportunities/models of care and international trends like Task Shifting. The high value impact of Māori CHWs working intersectorally has not yet been fully realized nor has it been fully recognized. From a Whānau-centric perspective, this critical skill to work vertically (within a sector) and horizontally (across sectors) is fundamental to delivering Whānau Ora outcomes for high needs families. The CHW is uniquely positioned to lead this function due to their flexibility, their high level of trust within communities and their mobility. Accordingly, truly valuing and maximising the intersectoral role of Māori CHWs is essential in the new environment.

## **Barrier 4: A dearth of research and evaluation material.**

**Key Point: there is still a dearth of readily available published research and evaluation on Māori CHWs.**

The dearth of research and evaluation is a constant theme for Māori workforce development in general and in this case, Māori CHW development (Haretuku, 2000; MOH, 2002). A background paper commissioned by Hauora.com found that recent and readily available research based on the value and impact of Māori CHWs in New Zealand was infrequent at best (Shea, 2010). It is acknowledged that greater levels of investment are being made into Māori specific research (see [www.hrc.govt.nz](http://www.hrc.govt.nz)). However, there does not seem to be any agreement between key stakeholders around prioritising Māori CHW specific research.

## **Barrier 5: Failure to recognise the extra duties and pressures linked to being a Māori CHW.**

**Key Point: Māori CHWs face unique expectations linked to their ethnicity and cultural beliefs. These extra duties and pressures should be recognized as part of their dual mainstream and Māori expertise, skill base and commitment.**

The unique skill set of Māori CHWs was set out earlier in this paper. Some of the challenges associated with this are briefly summarized below:

- Managing multiple complex tasks and accountabilities – Māori CHWs deliver a range of services to communities and are often community members themselves; sometimes, CHWs find themselves in positions where they have to manage dual and often competing accountabilities

*“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)” (p.190) (Boulton et al, 2008).*

- Māori CHWs are expected to be culturally competent for cultural facilitation purposes therefore Māori need to be able to perform in a variety of cultural settings (Boulton, 2008);
- Sometimes there is a tension between delivering services based on Whānau Ora or tikanga models compared to delivering against contractual outputs (Boulton et al, 2008). Often funders and contractors have been slow to keep contractual arrangements current with Māori CHW innovation; which has for many years focused on intersectoral engagement and Whānau-centric practices;

- There is a tension between the academic professionalization of the CHW workforce and the need to maintain/retain customary and tikanga based knowledge which informs “humanization” of the CHW role (Boulton et al, 2008; Haretuku, 2010). There seems to be suspicion around training that is based within tertiary institutions and linked to academic qualifications (Boulton et al, 2008):

*“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)”*

This issue is compounded by lack of clarity about the bridge between and the consequences of being classified as a regulated and non-regulated workforce. This gap has created a gulf and multiple barriers in terms of entry into and the career progression pathway of many Māori CHWs. Due to this lack of clarity, there seems to be many missed opportunities for Māori CHW growth, expansion and recognition. For Māori CHWs, the dual and equal endorsement of the Māori paradigm (Durie, 2007) and the Academic paradigm is an important but as yet unresolved issue.

## 5 POU OR SOLUTIONS TO ADVANCE THE MĀORI CHW WORKFORCE

In response to the barriers, we outline 5 inter-related POU or Solutions are outlined to advance the Māori CHW workforce in New Zealand:

1. Recognition
2. Representation
3. Recruitment & Retention (includes discussion about Rewards)
4. Role
5. Research & Evaluation

Each of these POU are summarized below noting that further action would be required to finalise an implementation pathway for each solution. Accordingly, the solutions are put forward as high-level ideas for sector consideration.

### POU 1: Recognition

**Key Point: consistent and universal recognition of the value and impact of Māori CHWs is one of the key POU for advancing the smart and effective use of the Māori CHW.**

Universal recognition impacts on the total viability of the 5 POU outlined in this paper. Multi-sector and stakeholder recognition, at all levels, will result in increased financial investment, dedicated policy, strategy and plans to advance the Māori CHW. In our opinion, recognition comprises the following:

### **At a National Level**

- by key stakeholders who hold the decision-making power that influences the 'stage' for Māori CHW development;
- stakeholders may include government agencies; policy makers and funders across sectors, not just health, as the impact Māori CHWs have is intersectoral.

### **By Funders**

- Key Funders are those who fund and/or purchase services and support services that affect Māori CHW development; particularly in health but importantly across other key sectors too e.g. Social Services;
- Funders can be government agencies but also private and philanthropic; the option for using private/public partnerships to invest in the future of Māori CHW development should remain open and explored;
- International funders/investors should also be considered, where appropriate.

### **By the Regulated Workforce**

- This is about regulated professionals recognizing the value and impact of CHWs;
- The advent of multidisciplinary teams and the expert role a Māori CHW can bring to the Team, especially in terms of family-centric/Whānau Ora practice, is yet to be fully realized and recognized.

### **By Providers/Employers**

- Providers act as both employers as well as delivery partners;
- As an employer, recognition is reflected in things like salary, training opportunities, non-financial rewards. These are discussed in more detail later in this section.

### **By Whānau, Hapu and Iwi**

- Whānau, Hapu and Iwi are key delivery partners, particularly in terms of Whānau Ora;
- Regular and available information for Whānau, Hapu and Iwi about the role, value and impact of CHWs would enhance and sustain greater recognition.

## **POU 2: Representation**

**Key Point: a fully resourced and Māori CHW endorsed representational infrastructure is critical to ensuring Māori CHWs have the capacity to demonstrate leadership in terms of sector reform and to influence system design for the smarter use of Māori CHWs.**

### **A nationally endorsed and fully resourced Intermediary**

- A fully resourced and high performing intermediary body is required to bring multiple stakeholders together and facilitate a consistent and cohesive approach to Māori CHW;
- This co-ordination function is critical to ensuring multiple lines of investment, planning and engagement add value as a "package deal";
- Additional functions could include a range of important services ranging from being a dedicated champion for Māori CHW development and co-coordinating a targeted research portfolio and solutions analysis through to , analytical and data warehousing;

ICT support; financial investment strategies, brokering relationships and even budget holding for certain developmental services and back-office support for multiple Māori CHW organisations.

- Other key support services that would assist recognition and representation would include: marketing, branding, training, communications and media management.

### **Regional or Localised Infrastructure(s) or Network(s)**

- To complement the national intermediary body, there could also be small but efficient regional and/or localized representational bodies/centres/networks. The cost and associated infrastructure would be maintained at high efficiency levels whilst the importance of mobilizing localized engagement would be prioritised.

### **Legislative Endorsement**

- As recently demonstrated in the USA, there may be opportunities to investigate legislative recognition of Māori CHW/CHW workforce;
- This is not necessarily linked to regulation but could revolve around recognition of value, impact and dedicated roles on government boards, agencies or committees e.g. a dedicated role in HWNZ or MSD Community Response Fora.

### **Relationships**

- There is a role for the Intermediary body to manage a variety of relationships across a variety of domains: international; with professional colleagues; with Whānau; with Iwi and Hapu; with Providers; with Government agencies and with employers;
- Brokering, facilitation, networking, consultation and engagement are all aspects of prudent relationship development and management.

## **POU 3: Recruitment & Retention**

**Key Point: recruitment and retention are two key parts of the gateway and pathway for the long term growth and sustainability of the Māori CHW workforce. Active investment in a cohesive and multi-sector stakeholder response, that connects activity and investment across a new and dedicated Te Ara Mahi (Work Pathway) for Māori CHWs will create more transparent options and choices for potential, new and existing Māori CHWs. The tension between the dual Academic and Maturanga Māori paradigms will be minimized leading to greater workforce satisfaction and CHW impact on outcomes.**

- A dedicated Te Ara Mahi (The Work Pathway) needs to be developed that is specific to CHWs;
- The pathway should take the role of a 'pipeline' where all necessary entry and exit points from, for example, primary school education through to retirement are mapped to acknowledge the entire journey of a Māori CHW;
- The pathway would incorporate actions and prudent investment to address recruitment and retention barriers and provide options and choices for new, potential or re-entering Māori CHWs;

- Multiple stakeholders (e.g. government, educational, employers, funders, students, Whānau) who have an impact on this pathway should be brought together by the Māori CHW Intermediary body to jointly agree the pathway and to also share resources to ensure the journey is relevant, current and adjusted to meet changing environmental circumstances, whenever necessary;
- Exceptional practice and learning from successful international and domestic programmes should be captured as part of the Te Ara Mahi;
- Work would need to occur to build on new development such as intersectoral interest in Whānau Ora and Whānau Ora practitioner training and development;
- Analysis on the Academic and Maturanga Māori specific education pathways would need to be completed to tease out issues linked to dual accountabilities, graduand understanding of the bridges between education pathways and the validity of dual paradigms;
- Fair and appropriate reward for the Māori CHW sector is a powerful incentive to enter, remain and progress within this career. Rewards can be both financial and non-financial. Two key points are pay equity and recognition. Further work should occur linked to rewards and incentives including fair salaries linked to skills, roles and unique competencies offered by Māori CHWs;
- Training options and choices will consider pre and post entry to the Māori CHW workforce; this includes issues linked to career progression and mapping; cultural and peer support/supervision;
- Training will be cognisant of and reflect innovation led by the Māori CHW sector and anticipate new delivery models e.g. task shifting, Whānau Ora; Whānau-centric multi-disciplinary teams;
- Support services and systems that enable Māori CHWs to perform their frontline jobs should be developed; this is part of a multidimensional analysis of needs and support mechanisms that enhance workforce recruitment and retention;
- Assessment and support for the financial cost of training and career progression will be actively tackled to support the Māori CHW; this will range from knowledge of and access to scholarships through to study leave and Whānau support for study purposes;
- Training should be designed to be flexible to support Māori CHW accountabilities to in-work delivery as well as on-the-job learning. This may include assessing and re-orienting a range of delivery mechanisms which could range from more use of ICT technology through to combinations of online, class-room or marae-based study options;
- Broader staff exchange opportunities could be considered to share expertise and also experience;
- Tutor-led learning support for the duration of training programmes could be expanded;
- More exposure to learning communities (physical and electronic) could be facilitated;
- Support for those transitioning back into the workforce or coming from post-formal education may include CHW Preceptorship for new employees;
- Investigation of self-regulation/credentialing models for Māori CHWs, as compared to legislative regulation, should be assessed to inform recruitment and retention modeling.

## POU 4: Role

**Key Point: clear definition of the role of a Māori CHW will assist with recognition, recruitment, retention and smarter deployment.**

- With the revised interest in CHW roles internationally and domestically, this is an opportune time to put effort into defining the role of a Māori CHW;
- The important point will be to build on existing knowledge but not necessary limit role delineation is based on a historical or even current paradigm;
- Key issues include:
  - scope of practice; current and future situation; especially linked to Māori Models of Care;
  - Intersectoral scope – the impact of horizontal engagement;
  - Generalist and Specialist – Māori CHWs may develop into CHWs with special interests. This is akin to the GP or Nurses with Special Interests role expansion;
  - The impact and expectation of multi-disciplinary/interdisciplinary teams with a Whānau-centric practice needs to be explored further;
  - The WHO report on Task Shifting will need to be considered as part of this work.

## POU 5: Research & Evaluation

**Key Point: a targeted research and evaluation approach is needed for Māori CHWs. This can be linked into other developments but must have sufficient specificity to provide the evidence to support recognition, recruitment, retention and effective relationships.**

- There are many gaps in the research and evaluation literature specifically aimed at Māori CHWs; some priorities include:
  - Supply and demand: Workforce data collection, analysis, profiling, needs, jobs;
  - Impact/Outcomes: impact of Māori CHWs; including Community Development;
  - Cost effectiveness

## CONCLUSION

In conclusion, this paper has sought to stimulate sector discussion around the future role of Māori CHWs and in particular, how New Zealand stakeholders should come together and invest in 5 inter-related POU (solutions). We trust that this paper is accepted in this light and we suggest that if these POU are implemented in a cohesive manner, and if these solutions are endorsed and facilitated by Māori Community Health Worker leadership, this will create a comprehensive platform to rapidly advance this workforce and achieve unparalleled positive outcomes for families/Whānau, communities and systems. Hauora.com looks forward to the opportunity to engage with sector colleagues on these critical matters in the near future. Finally, we note that this paper has been endorsed by Te Whiringa Trust.

## GLOSSARY OF MĀORI WORDS

<b>Kupu (Word)</b>	<b>Aronga (Definition)</b>
Hui	Meeting
Māori	Indigenous person of New Zealand
Maturanga Māori	Māori models of health and traditional knowledge
Te Ara Mahi	The Work Pathway
Whānau	Family
Whānau Ora	Family health and wellbeing

## REFERENCES

- American Institute Of Medicine (2002) *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (National Academies Press: Washington).
- Barwick, H. (2000) Improving access to primary care for Māori, and Pacific peoples: A literature review commissioned by the Health Funding Authority accessed online at [http://www.moh.govt.nz/moh.nsf/0/4f31bb21ad92f9f0cc256f3f0073db3e/\\$file/hfaimprovingaccess.pdf](http://www.moh.govt.nz/moh.nsf/0/4f31bb21ad92f9f0cc256f3f0073db3e/$file/hfaimprovingaccess.pdf) in December 2010.
- Boulton, AF.; Gifford, HH. and Potaka-Osbourne, M. (2009) *“Realising Whānau Ora Through Community Action: The Role of Māori Community Health Workers”* in *Education of Health 9* (online), 2009:188.
- Broughton J. Te mahi niho hauora ki Ratana Pa: the dental health project at Ratana Pa. *New Zealand Dental Journal* Vol 91 1995
- Careerforce (2010) *Māori Workforce Strategic Thinking Summary* accessed online - <http://www.careerforce.org.nz/assets/files/Strat-thinking-summaries/Māori.pdf>; <http://www.careerforce.org.nz/Workplace-Health-and-Disability-Training-111.html>; in December 2010
- Crengle, S. (1997) *Ma Papatuanuku, Ka Tipu Nga Rakau: A Case Study of the Well Child Health Programme Provided by Te Whanau O Waipareira Trust* (Master of Public Health Thesis, Auckland, New Zealand.
- Corkery E., Palmer C., Foley M., Schechter C., Frisher L., and Roman S. Effect of a bicultural community health worker on completion of a diabetes education programme in a Hispanic population. *Diabetes Care* Vol 20(3) March 1997
- Crigler L and K Hill (2010) *Assessing and Improving Programs Extending Health Services to Communities: The Community Health Worker Program Assessment and Improvement Matrix (CHW AIM). Draft for Beta Testing*. Published by the USAID Health Care Improvement Project. Bethesda, MD: University Research Co., LLC (URC).
- Crump, SR.; Shipp MP. and McCray GG (2008) “Abnormal mammogram follow-up: do community lay health advocates make a difference?” in *Health Promot Pract.* 2008:9, 140-148.
- DHBNZ (2008) *Health Workforce Information Base Data Report Quarter 1 (snapshot at 30 September 2008)* DHBNZ accessed online at [http://www.dhbnz.org.nz/Site/Future\\_Workforce/HWIP/DHB\\_Base\\_Data\\_Reports.aspx](http://www.dhbnz.org.nz/Site/Future_Workforce/HWIP/DHB_Base_Data_Reports.aspx) in December 2010.
- Durie, MH. (1994) *Whaiora Māori Health Development* (Oxford University Press: Auckland).

Durie M (2007) *Māori Health Workforce Presentation, Makirikiri Marae, Dannevirke*, MidCentral DHB, MHWD Series, Palmerston North

Durie M (2009) *Pae Ora: Māori Health Horizons* (the second of three Paerangi Lectures by Professor Mason Durie) accessed online at [http://www.manu-ao.ac.nz/content/files/pae\\_ora.pdf](http://www.manu-ao.ac.nz/content/files/pae_ora.pdf) in December 2010.

Durie et al (2010) *Whānau Ora Taskforce Reports on Whānau Ora*, accessed online at <http://www.tpk.govt.nz/en/newsevents/news/Whānau-ora-taskforce-report-launch/>, November 2010.

Fedder, DO.; Chang, RJ.; Curry, S. and Nichols, G. "The effectiveness of a community health worker outreach programme on healthcare utilisation of west Baltimore city Medicaid patients with diabetes, with or without hypertension" in *Ethn Dis.* 2003: 13:22-27.

Giblin PT (1989). Effective utilization and evaluation of indigenous health care workers. *Public Health Rep.* 1989;104:361-367.

Gifford, H. (1999) *A Case Study of Whanau Ora: A Māori Health Promotion Model* Master of Public Health Thesis, Dunedin, New Zealand.

Haretuku, R (2010) *Te Whiringa Hui Report (Final Draft)* (unpublished).

Haretuku, R. (2000) "Māori Community Health Workers" accessed online at [www.nganaru.co.nz](http://www.nganaru.co.nz) in January 2011.

Hornblow A. *et al* (2002) "Workforce development: a quick fix or a collaborative process?" in *Journal of the New Zealand Medical Association*, 21-June-2002, Vol 115 No 1156

HWAC (2006) *Care and Support in the Community Setting (related to disability support services)* Ministry of Health accessed online at- [http://www.moh.govt.nz/moh.nsf/Files/hwac-publications/\\$file/hwac-care-support-community-setting.pdf](http://www.moh.govt.nz/moh.nsf/Files/hwac-publications/$file/hwac-care-support-community-setting.pdf) in December 2010.

Jimba, M. (2009) "Opportunities for overcoming the health workforce crisis" in *JCIE (2009) Global Action for Health System Strengthening, G8 Hokkaido Tokyo Summit Follow-up, Policy Recommendations to the G8* (Japan Centre for International Exchange: Tokyo).

*JCIE (2009) Global Action for Health System Strengthening, G8 Hokkaido Tokyo Summit Follow-up, Policy Recommendations to the G8* (Japan Centre for International Exchange: Tokyo).

Keelan T, Priston M, Searle P (2007) *He Paharakeke: Māori Health Workforce Profile. Selected regulated health occupations 2007* (Ministry of Health: Wellington).

Knobel, RF. (1992) "Medicaid and managed care with Kaiser Permanente in Hawaii" Presented at the Conference on Medi-Cal and Managed Care; November 17, 1992; Sacramento, California.

Knobel, RF. (1992) "Case management in Kaiser Permanente's Medicaid Program in Hawaii" Presented at the New Visions, New Ventures Conference; December 5, 1992; Oakland, California.

Lehman, U. and Sanders, D. (2007) "Community health workers: what do we know about them? The state of evidence on programmes, activities, costs and impact on health outcomes of using community health workers" (World Health Organisation: Geneva).

Lewin, S.; Dick, J.; Pond, P.; Zwarenstein, M.; Aja, GN.; van Wyk BE.; Bosch-Capblanch, S. and Patrick, M. (2009) Lay health workers in primary and community healthcare: review, The Cochrane Collaboration (Wiley Publishers).

Levine, DM.; Becker, DM. and Bone, LR. (1992) "Narrowing the gap in health status of minority populations: a community-academic medical center partnership" in Am J Prev Med. 1992; 8:319-323.

Love, MB.; Gardern, K. & Legion V. (1997) "Community health workers; who they are and what they do" in Health Education Behaviour, 24, 510-522.

McCormack, MC.; Brooks-Gunn, J.; Shorter, T.; Holmes JH; Wallace, CY. and Heagarty, MC. "Outreach as case finding: its effect on enrollment in prenatal care" Med Care 1989, 27:103-111.

Mock, J.; McPhee SJ.; Nguen T. (2007) "Effective lay health worker outreach and media-based education for promoting cervical cancer screening among Vietnamese American women" in American Journal of Public Health, 2007:97, 1693-1700.

MOH (2002) *He Korowai Oranga: Māori Health Strategy* (Ministry of Health: Wellington)

MOH (2005) *Raranga Tupuake: Māori Health Workforce Development Plan: Discussion Document* (Ministry of Health: Wellington)

MOH (2006) *Health Workforce Development: An Overview*, accessed online at [http://www.moh.govt.nz/moh.nsf/0/00D7472E7FD12281CC2571460082943E/\\$File/Health-Workforce-Dev.pdf](http://www.moh.govt.nz/moh.nsf/0/00D7472E7FD12281CC2571460082943E/$File/Health-Workforce-Dev.pdf) in December 2010.

MOH (2008) *He Tipu Harakeke: Recruitment of Māori in the Health and Disability Workforce* (Ministry of Health: Wellington)

MOH (2008a) *He Rito Harakeke: Retention of Māori in the Health and Disability Workforce* (Ministry of Health: Wellington)

MOH (2010) *Implementing the New Zealand Health Strategy* accessed online at [http://www.moh.govt.nz/moh.nsf/pagesmh/10535/\\$File/imp-nz-hth-strategy.pdf](http://www.moh.govt.nz/moh.nsf/pagesmh/10535/$File/imp-nz-hth-strategy.pdf) in February 2011.

MOH (2010a). Overview Wheel and Health Status Wheel - Tatau Kahukura: Māori Health Chart Book 2010, 2nd Edition. (Ministry of Health: Wellington).

MSD (2010) Overview of the Community Response Model, see [www.familyservices.govt.nz/working-with-us/funding-and-contracting/community-response-model/crm-forums.html](http://www.familyservices.govt.nz/working-with-us/funding-and-contracting/community-response-model/crm-forums.html) accessed online in February 2011.

Nemcek, MA. and Sabatier, R. (2003) "State of Evaluation: Community Health Workers" in Public Health Nursing, Volume 20, Issue 4, pp260-270.

Patrik, D.; Bigby, JA.; and Auerbach, J. (2009) "Community Health Workers in Massachusetts: Improving Health Care and Public Health" (Massachusetts Department of Public Health: Boston).

Penney, L. (1996) Hauora Ngati-Hine: An analysis of the process involved in the development and implementation of a hapu based primary health care service (Master of Public Health Thesis, Auckland, New Zealand)

Perino, S. (1992) "Nike-footed health workers deal with the problem of adolescent pregnancy" Public Health Rep. 1992; 107:208-213.

Public Health Commission (1995) He Matariki: A Strategic Plan for Māori Public Health (Public Health Commission: Wellington)

Ramage C, Bir J, Towns A, Vague, R, Cargo T and Niumata-Faleafa M (2005) *Stocktake of Child and Adolescent Mental Health Services in New Zealand*. The Werry Centre for Child and Adolescent Mental Health, Workforce Development, University of Auckland, New Zealand

Ratima M, Brown R, Garrett N, Wikaire E, Ngawati R, Aspin C and Potaka U. (2008) Rauringa Raupa: Recruitment and Retention of Māori in the Health and Disability Workforce. Taupua Waioara: Division of Public Health and Psychosocial Studies (AUT University: Auckland).

Rosenthal EL.; Brownstein, JN.; Rush, CH.; Hirsch, GR; Willaert, AM.; Scott, JR.; Holderby, LR. and Durrell, JR. (2010) "Community Health Workers: Part of The Solution" in Health Affairs, July 29:10, 1338-1342.

Ryall (2009) *Better Sooner More Convenient Health Discussion Paper*, accessed online at [http://www.national.org.nz/files/\\_0\\_0\\_HEALTH\\_lowres.pdf](http://www.national.org.nz/files/_0_0_HEALTH_lowres.pdf) , accessed online in November 2010

Shea, S. (2010) Strengthening the Unregulated Māori Health Workforce: A Background Paper for Hauora.com (Hauora.com: Auckland).

Social Services ITO (website) accessed online <http://www.socialservicesito.org.nz/content/workforce-development-project-launched> in December 2010.

Stewart, JC. And Hood, WR. (1970) "Using workers from 'hard-core' areas to increase immunization levels" *Public Health Rep.* 1970: 95:177-185.

Te Rau Matatini (2010) *Te Pataka Uara: Career Pathway for Whānau Ora Navigators and Practitioners for Consultation* (Te Rau Matatini: Wellington).

Warrick. LH.; Wood, AH.; Meister JS. And de Zapien, JG. (1992) "Evaluation of peer health worker prenatal outreach and education program for Hispanic farmworker families" *J Community Health*, 1992; 17:13-26.

WHO (2006) *World Health Report 2006: Working Together for Health* (World Health Organisation: Geneva).

WHO (2007) *Policy Brief: Community Health Workers – The state of the evidence on programmes, activities, costs and impact on health outcomes by community health workers*" accessed online at [http://www.who.int/hrh/documents/community\\_health\\_workers\\_brief.pdf](http://www.who.int/hrh/documents/community_health_workers_brief.pdf), January 2011.

WHO (2008) *Task Shifting: Global Recommendations and Guidelines* (WHO: Geneva).

Whitley, E. M., Everhart, R. M., & Wright, R. A. (2006). Measuring Return on Investment of Outreach by Community Health Workers. *Journal of Health Care for the Poor and Underserved*, 17, 6-15.

Witmer, A.; Seifer, SD.; Finocchio, L.; Leslie, J. and O'Neil, EH. (1995) "Community Health Workers: Integral Members of the Health care Workforce" in *American Journal of Public Health*, August 1995, Vol.85, No.8, pp1055-1058.

Viswanathan, M.; Kraschnewski, J.; Nishikawa, B.; Morgan, LC.; Thieda, P.; Honeycutt, A.; Lohr, KN. And Dan, J. (2009) "Outcomes of Community Health Worker Interventions: Evidence Report/Technology Assessment Number 181" (Agency for Healthcare Research and Quality: North Carolina).