Community development through partnership: promoting health in an urban indigenous community in New Zealand

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Abstract

Indigenous people who have been dispossessed of their lands and resources bear a disproportionate burden of health problems. Programmes aimed at improving their health status must operate within the context of colonisation history and the contemporary cultural renaissance whereby indigenous populations are asserting their rights to self-determination. Community development strategies incorporating empowerment as both means and end are consistent with the aspirations of the renaissance and reflect the principles of the Ottawa Charter for Health Promotion. This paper describes a formative and process evaluation of a community development partnership for health promotion between a health group and an urban Maori community in New Zealand. Key issues encountered related to trust, prioritisation of health, and appropriate research paradigms. Most significant among these was trust, or more specifically, distrust among Maori engendered by historical and contemporaneous experiences of contact with Europeans. Ultimately, the partnership achieved what it set out to do when the Maori partners took over the running of their own health groups and health programme. Building upon a detailed literature review and data from the evaluation, the paper offers a list of recommended procedures for the development of partnerships, applicable to health and other domains. Recommendations encompass preparatory steps, the formation of a partnership committee, programme planning and development, and the appointment of a community-based liaison worker. A conclusion of the research and premise underpinning the recommendations is that devolution of power is a key aspect of organisational process underlying successful partnerships involving professional groups and indigenous people.

Introduction

A common theme in the experience of the indigenous populations of North America, Canada, Australia and New Zealand is dispossession and alienation of their lands and resources as a consequence of European colonisation. Alienation and marginalisation within their own countries have had deleterious consequences for their cultural traditions and identity, social cohesion, self-esteem, and economic survival (Sutton, 1975; White, 1983; Murchie, 1985; Williams et al., 1992; King, 1997). In direct and indirect ways, their health has suffered. In contrast to the more dramatic and immediate impacts from epidemics of introduced diseases and illnesses in earlier years of European colonisation, the chronic effects of colonisation have been less dramatic but more widespread and persistent.
settlement, the health threats of to-day are more insidious and persistent, and are fuelled by the psychosocial and economic aftermath of dispossession (Thomson, 1984, 1989; Grossman et al., 1994; Willms et al., 1992; Cheadle et al., 1994; Johnson et al., 1995; MacMillan et al., 1996; Sellman et al., 1997).

Since the 1970s, there has been a growing ethnic renaissance among indigenous people world-wide, characterised by a reassertion of pride in their cultural traditions and ancestry, and demands for greater self-determination and redress of historical injustices (e.g. Jull, 1992; Gray et al., 1995; Nagel, 1996). A contributing factor has been the development of international networks linking indigenous groups across national boundaries and the dissemination of information about the experiences of self-determination among oppressed peoples through these networks (Orange, 1987; Thomas, 1996). The Maori of New Zealand, who are the main focus of this paper, are part of this renaissance. There are however many Maori, especially urban Maori, who remain alienated both from their own Maori culture and the dominant European culture (Duirie, 1994; Jackson, 1995; Ramsden, 1995).

The Ottawa Charter for Health Promotion (1986) states that, “to reach a state of complete physical, mental and social well-being, an individual or group must be able to realise aspirations, to satisfy needs, and to change and cope with the environment”. This cannot occur for submerged groups in society who are subject to the policy and decision-making power of a dominant group, until a more equitable power balance is achieved. ‘Enabling’ or empowerment (Labonté, 1990) has been advocated as the key concept in the Ottawa Charter as it represents a challenge to power imbalances in social relationships that rob subordinate groups of the capacity to exercise control over their own lives (Labonté, 1990). Green and Raeburn (1988) suggest that ‘enabling’ and ‘community’ are pivotal concepts for an integrated approach to health promotion as together they encapsulate a shift in power from bureaucracies to people. While there is no single path to achieving empowerment, community development stands out as one which has much to commend it for advancing the health status of indigenous people (Feather et al., 1993; Labonté, 1993).

Much of the published evaluation research literature relevant to community development initiatives is concerned with describing programmes delivered, with an emphasis on outcomes. Little attention has been paid to examining the efficacy of organisational processes behind the delivery of actual programmes and offering practical advice to others working in related areas on the basis of lessons learnt. This is not to deny the availability of a valuable body of theoretical material on organisational aspects of implementing community based programmes, drawing upon the writers’ first-hand experiences (e.g. Baum, 1990; Chavis and Florin, 1990; Labonté, 1990; Wallerstein, 1992; McLeroy et al., 1994). However, at a practical level, the task of programme planners and developers in applying this information in their communities can be fraught with challenges, often stemming from false assumptions, communication difficulties, and unresolved issues from the past. There is frequently a gap between knowing what is needed and knowing how to accomplish it.

This paper is written with a view to addressing that gap. It describes the organisational processes behind the development of a programme aimed at promoting healthy lifestyles among urban Maori in a low socio-economic status suburb in the city of Auckland, New Zealand. The research combined formative and process evaluation with an extensive literature search. Initially, it reviews evidence linking health status with socio-economic conditions and history, taking a close look at the situation of urban Maori and pressures affecting their health. It then discusses community development as a health promotion practice, suggesting that the principles of community development and the growing cultural renaissance among Maori may potentially be mutually reinforcing. In the final section, the information derived from the example and literature review is used to develop recommendations relevant to the formation of partnerships that are genuinely power sharing and which will facilitate the attainment of community development objectives.

Health status, culture and history

Morbidity and mortality data for Canada, North America, Australia and New Zealand evidence a disproportionate burden of physical and mental illness and early death sustained by their indigenous populations in comparison with their non-indigenous populations. For example, a review of the health status of Canadian aboriginal people (MacMillan et al., 1996) highlights their high prevalence of certain types of infectious diseases, diabetes mellitus, and social and mental health problems. It associates the disproportionate burden of physical disease and mental illness borne by aboriginal people with unfavorable economic and social conditions that are “inextricably linked to native people’s history of oppression”. In a similar vein, it is reported of Australian Aboriginal people that colonisation, disruption to traditional lifestyle and dispossession culminating in widespread poverty and powerlessness, have had an undisputed tragic effect on their health (Thomson, 1984, 1989; McEvoy and Rissel, 1992). A North American population-based study focusing on health status indicators for Washington State revealed that the greatest disparities were in urban areas between Native populations...
(American Indians and Alaska Natives) and whites (Grossman et al., 1994).

The 1996 New Zealand Census records the proportion of Maori descendants (Maori and part Maori) as 397,746 or 12.7% of the total population (Department of Statistics, 1997). An extensive survey of Maori health statistics by Pomare et al. (1995) included an analysis of data from public hospital discharges during 1992 for neoplasm, diseases of the circulatory, respiratory and digestive systems and mental disorder arising from all causes. Depending on disease type, the rate of physical morbidity was 1.4 (for neoplasm) to 2.6 (for diseases of the respiratory system) times greater in Maori compared with non-Maori, and the rate of mental disorder was 1.9 times greater in Maori (Sellman et al., 1997). Maori are disproportionately represented in risk-taking lifestyles (Durie, 1994).

From traditional times to the present, Maori have viewed health as an all embracing concept which emphasises the importance of spiritual, family, mental and physical aspects. For Maori, issues of Te Whenua (land), Te Reo (language) and Whanaungatanga (extended family) are central to culture and to health (Murchie, 1985; Pomare and de Boer, 1988). This holistic understanding is in contrast to the predominant western model emphasising physical aspects of health and sickness (Pomare and de Boer, 1988). A perception of alienating and culturally insensitive services is associated with delay in seeking diagnostic and therapeutic help (Smith and Pearce, 1984; Ngata and Pomare, 1992) and less satisfaction with the care received (Simmons et al., 1996).

Central to health promotion is the question of why this disproportionate burden of health problems among Maori exists. Maori leaders view the poor health status of their people as part of a profile of grievous effects stemming from a breakdown in traditional tribal structures, societal alienation, poverty, and a loss of pride, spirituality and identity, which they trace back to loss of lands and resources (e.g. Murchie, 1985; Gardiner, 1995; Ramsden, 1995). According to Pomare and de Boer (1988), rapid urbanisation, with its associated social, economic and cultural issues, is at the root of the unequal health experience of the Maori people. At the mid-point of this century, a quarter of the Maori population were urban dwellers. Almost 80% of Maori now live in the 16 major urban areas of New Zealand (Douglas, 1995). A major issue for urban Maori and one that is particularly acute for younger generations is struggle for identity:

“Many young people carry a burden of self doubt and shame for being Maori. Associated with this is a guilt for not knowing how to be the kind of ideal-ised Maori (of traditional times) who is presented to them” (Ramsden, 1995, p. 120).

Additional stresses have been generated by increased unemployment in rural and urban areas, stemming from the takeover of jobs by technology and rapid economic restructuring since the 1980s (Douglas, 1995; Henare, 1995). Lacking requisite skills and educational qualifications, the vulnerability of Maori was manifest in an increase in Maori unemployment rates from 12% in 1984 to 24.2% in 1991, compared with a general rate of 10.5% in 1991 (Henare, 1995).

The loss of socio-economic status in terms of jobs and earning capacity was coupled with an undermining of status in traditional Maori cultural terms. Traditionally, status embraced all aspects of the Maori world and its spiritual dimension, including Maori language, values, arts and the appreciation of land and the environment (Pomare, 1986). Urbanisation meant declining opportunities for Maori to become proficient in the practice of their culture, making high status, defined in traditional terms, a vanishing target. Indeed, traditional Maori indicators of socio-cultural status may have little salience for young Maori raised in an urban environment. This also precipitated some loss of respect for traditional leaders.

From a Maori perspective, the poor health legacy of their people can be explained by the loss of lands and status with the associated physical, emotional and spiritual trauma. The social scientist is obliged to consider the psychological mechanisms by which factors such as loss of identity, low self-esteem, loss of opportunities to fulfill meaningful roles in society, and poor attainment experiences might impact on health related behaviours. Self-efficacy (Bandura, 1982) is one concept that is receiving increasing recognition as a predictor of health behaviours, including the adoption and maintenance of healthy lifestyle behaviours and quitting unhealthy ones (Strecher et al., 1986). Basic to self-efficacy theory is the idea that self-referent thought mediates the relationship between knowledge and action (Bandura, 1982). Research has demonstrated the relevance of self-efficacy theory to smoking cessation, eating and weight control, contraception, adherence to medical regimens, alcohol abuse and exercise behaviours (DiClemente et al., 1985; O’Leary, 1985; Strecher et al., 1986; Clark et al., 1991; Kelly et al., 1991; Hurley and Shea, 1992). The concept of self-efficacy can be extended to embrace the notion of collective efficacy which suggests that “the strength of groups, organisations, and even nations lies partly in people’s sense of collective efficacy that they can solve their problems and improve their lives through concerted effort” (Bandura, 1982, p. 143).
Maori renaissance

The founding document of New Zealand, the Treaty of Waitangi (Orange, 1987), was signed in 1840 by a British Crown representative and over 500 Maori Chiefs. Only 39 chiefs signed the treaty in the English language; most signed a treaty in Maori language. Variations between the English and numerous Maori language versions left each party to the treaty with their own expectations about the power and rights that they would exercise. Difficulties of interpretation and implementation have been an ongoing source of contention (Orange, 1987). Notwithstanding the controversy and its subsequent failure to protect Maori from exploitation, the signing of the treaty was an affirmation of the importance of cooperation. In spirit at least, the treaty was about partnership and mutual respect between Maori and European.

From the 1840s to the present, the treaty has been kept alive by Maori protest based on demands for government to give effect to treaty promises (Orange, 1987). During the 1970s and 1980s, protests gathered momentum with demonstrations, long distance marches and land occupations bringing Maori grievances and their political will for redress into sharp focus (King, 1997). The treaty continues to constitute a rallying point for a Maori cultural renaissance. A hallmark of the renaissance has been the introduction of programmes for the regeneration of the Maori language, with pre-school children as a focus. The first Maori language pre-school (kohanga-reo) was established in 1981. By 1988 there were 521 and they were a context for increasing political awareness and activity (Thomas and Nikora, 1996). Renewed pride in New Zealand’s Maori cultural heritage is evidenced by the participation of large numbers of school children, Maori and non-Maori, in Maori language tuition and in Maori cultural groups.

Another sign of the vitality of the Maori renaissance has been the spread of marae (central communal meeting places) from rural to urban areas. From traditional times, marae have formed the hub of everyday life in Maori culture. The term ‘marae’ refers not just to a physical complex of buildings but

“It also embraces a human and spiritual dimension and has come to symbolise the essence of Maori health aspirations . . . It is where a person has turangawaewae (a place to stand), a sense of belonging or identity and where Maori values, cultural and health practices are reaffirmed” (Ngata and Pomare 1992, p. 45–46).

King’s assertion that the Maori revival gained impetus from urbanisation (King, 1997) suggests that the spread of urban marae and the cultural renaissance may be regarded as synergistic processes.

Community development, empowerment and health promotion

Community development as a public health practice has been defined as “the process of organising and/or supporting community groups in identifying their health issues, planning and acting upon their strategies for social action/change, and gaining increased self-reliance and decision-making power as a result of their activities” (Labonté, 1993, p. 237). Because community development is about consciousness-raising and stirring people to advocacy and action, conflict is commonly part of the process (Wandersman, 1984; McFarlane et al., 1994). Community development strategies echo the principles of the Ottawa Charter for Health Promotion (1986) in the importance placed on the participation of communities in defining and developing solutions to their own health problems:

“Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities, the ownership and control of their own endeavours and destinies” (Ottawa Charter for Health Promotion, 1986).

Empowerment is a multilevel construct applicable to groups, organisations and neighbourhoods as well as to individual citizens (Rappaport, 1987; Lord and Farlow, 1990; McFarlane and Fehir, 1994). Wallerstein (1992) proposes a definition that encompasses the linkages and interactions between change processes on an individual, organisational, and community system-wide level. Thus, empowerment is “a social action process that promotes participation of people, organisations, and communities towards the goals of increased individual and community control, political efficacy, improved quality of community life, and social justice” (Wallerstein, 1992, p. 198). Rappaport (1987) expounds an ecological theory of empowerment based on the study of people in context. Some key assumptions are (Rappaport, 1987, p. 139–140):

- The historical context in which a person, a programme or a policy operates has an important influence on the outcomes of the programme.
- The cultural context matters. The implication is that a diversity of settings and programmes with a variety of styles, attitudes, and goals is needed, com-
The conditions of participation in a setting will have an effect on the empowerment of members. Other things being equal, an organisation that holds an empowerment ideology will be better at finding and developing resources than one with a helper-helpee ideology. Locally developed solutions are more empowering than single solutions applied in a general way. The size of the setting matters. Settings that are small enough to provide meaningful roles for all members, yet large enough to obtain resources, are more likely to create the conditions that lead to empowerment. Empowerment is not a scarce resource that gets used up, but rather, once adopted as an ideology, empowerment tends to expand resources.

Community development strategies are based on collaboration and proceed from the formation of partnerships or, on a broader scale, coalitions (Labonté, 1993; McFarlane and Fehir, 1994; McLeroy et al., 1994). There is a strong will on the part of Maori to become more involved in both the planning and delivery of health care for their communities (Durie, 1994). At the same time, there is a lack of suitably qualified people among them who possess the necessary knowledge and skills to address prevailing health problems. It makes sense for Maori and suitably qualified non-Maori people to work together in partnerships or coalitions to improve Maori standards of health. The New Zealand government has become increasingly encouraging of innovations that incorporate Maori perspectives in health promotion and services delivery (Ngata and Pomare, 1992; Durie, 1994; Ministry of Health, 1997).

The challenge for health professionals and bureaucrats is to step down from their accustomed dominant and privileged positions and consider how they might complement and reinforce, rather than override, what the community already has available in the form of knowledge, skills and other resources (Baum, 1990). Appropriate roles they might adopt are those of consultant, advocate, mediator, supporter and resource person (Green and Raeburn, 1988; Watt and Rodmell, 1988; Labonté, 1990). A feature of community development that commends it for initiatives among indigenous people (Simmons, 1996). A South Auckland study revealed an age adjusted prevalence of diabetes among Maori of 4.8%, compared with 2.0% for Europeans and 3.6% for Pacific Islands people (Simmons et al., 1995). Moreover, compared with Europeans, Maori showed an earlier age at diagnosis, greater obesity, higher rates of smoking, poorer diabetes knowledge, poorer glucose control, and more end-stage renal failure and blindness. The main problem (95% of diabetes in Maori) is type 2 diabetes with obesity implicated as a major contributing factor. Research studies also suggest that many are being

Background to the research

New Zealand’s most populous and industrialised city is Auckland. South Auckland is a cultural mix of Maori, Europeans, and immigrants of Pacific Islands and Asian origin and their descendants. Census statistics for 1991 (Walker, 1993a,b) revealed that, out of a total population of 303,513 in South Auckland, 50,589 (16.7%) were Maori. Only 3783 Maori (7.5%) were over the age of 49, largely due to Maori returning ‘home’ once retired, as well as to their high rates of early mortality. Maori constituted the ethnic group with the highest proportions of unemployed (19.6%) and low-income recipients. The present research was centred in Otara which was created in the 1950s as a result of government policy to provide low cost rental housing for workers in the expanding South Auckland industrial area. In 1991, Otara’s population was 36,519 of whom 8292 (23%) were Maori and 15,681 (43%) were of Pacific Islands origin. Otara is a high unemployment/low income district (Walker, 1993a,b; Tantrum et al., 1995).

South Auckland has a disproportionate share of the health problems that are associated with crowded housing, poverty and unhealthy lifestyles (Jackson et al., 1998). Maori in South Auckland are part of a worldwide pattern of a high prevalence of diabetes among indigenous people (Simmons, 1996). A South Auckland study revealed an age adjusted prevalence of diabetes among Maori of 4.8%, compared with 2.0% for Europeans and 3.6% for Pacific Islands people (Simmons et al., 1995). Moreover, compared with Europeans, Maori showed an earlier age at diagnosis, greater obesity, higher rates of smoking, poorer diabetes knowledge, poorer glucose control, and more end-stage renal failure and blindness. The main problem (95% of diabetes in Maori) is type 2 diabetes with obesity implicated as a major contributing factor. Research studies also suggest that many are being
It is well established that much of the damage of diabetes can be prevented with early diagnosis, treatment and good glycaemic control (Simmons et al., 1997), and recent research suggests that primary prevention of type 2 diabetes is also possible (Simmons et al., 1997). Recommended preventative strategies focus on healthy lifestyle behaviours, namely: achieving and maintaining a healthy weight, eating a low fat/high fibre diet, and exercising regularly. All have wider health and wellness benefits (Simmons et al., 1997).

The South Auckland Diabetes Project (SADP) was formed to address the urgent need to control the diabetes epidemic in South Auckland. It is based at the local district hospital but functions independently. It links the gathering of research information to the development of initiatives for health promotion and the prevention of diabetes and its complications. The Maori and Pacific Islands communities are obvious foci of attention, given their high prevalence of type 2 diabetes and other lifestyle related diseases (Tantrum et al., 1995; Simmons, 1996). The SADP’s approach is based on forming partnerships with these communities and establishing programmes to train local people as community diabetes educators. Health promotion initiatives include health education, cookery skills teaching and exercise sessions, as well as free screenings incorporating weights and measurements, blood pressure testing, and laboratory tests for diabetes and lipids. The programme has previously been shown to be associated with increased diabetes knowledge and activity rates, reduced dietary fat consumption and weight control among a non-Maori group (Simmons et al., 1998).

The present paper describes a partnership for health promotion and diabetes prevention between SADP and Whaiora Marae (“w” is pronounced as ‘ʃ’), one of two marae in Otara. “Whaiora” means in search of the better things in life. Whaiora Marae is located on Catholic parish land alongside a church and school. The Church offered part of the land to the Maori Catholic Society to build a marae for the Maori and Pacific Islands people of Otara. Work on buildings was completed in 1977 through the voluntary contributions and labour of all ethnic groups associated with the church. Whaiora is a ‘marae of the four winds’, with no set protocol. Those using it determine the protocol according to their own traditions. While the elaborate carvings in the main meeting house are representative of tribes throughout New Zealand, it is symbolic of history and the spirit of partnership that the two central carvings supporting the roof depict Te Wherewhero, a prominent chief of the tribe who originally owned the land, and Bishop Pompellier, New Zealand’s first Catholic bishop.

Identification with many tribes is a characteristic that distinguishes most urban marae from their rural counterparts, which are usually associated with one tribal group and adhere to the protocol of that tribe. The communities of urban marae are more disparate and in a state of flux, making them almost impossible to define. As an urban marae, Whaiora Marae also lacks the elder support that is readily available to rural marae. It is administered by a Trust Board of 14 people and anyone who is a member of the marae is eligible for nomination. The only non-Maori Trust Board member is the Catholic priest who occupies a permanent position reserved for him as spiritual adviser. Whaiora Marae is the location for an employment training scheme operating under its own board of trustees which involves approximately 100 trainees and tutors annually. The marae complex also includes a kohanga-reo and flats for psychiatric survivors.

Several years previously, community diabetes and asthma clinics operated at the marae. They were initiated and run by a marae member with a vision for the health of her people, two doctors from the local district hospital, and the Catholic sisters who helped in a variety of ways, including free transport of patients. The clinics have since closed, ostensibly because of under utilisation, prompting an ongoing debate about the justification for the closures. In 1994, a partnership was formed between SADP staff and Whaiora Marae members to pilot a community-based programme as a response to rising incidences of type 2 diabetes and other lifestyle related diseases among Maori in Otara. Aimed at fostering healthy lifestyles among Maori, it was envisaged that the programme would comprise diabetes awareness sessions, nutrition sessions, exercise sessions, a support group for those affected by diabetes, and other health related interventions.

**The formation and operation of the partnership**

The partnership followed from an initial contact by SADP’s Maori cultural adviser and its medical director and diabetes specialist (DS) with Whaiora Marae members. The first partnership meeting was held in October, 1994, 7 months after SADP received written confirmation from the Marae Trust Board Chairman of their support for the partnership. The initial committee comprised: the wife of the chairman of the Trust Board; the principal of the employment training programmes operating at the marae; her human resources manager; SADP’s Maori liaison worker, the diabetes specialist; the evaluator (recently recruited to the SADP team); and a young female member of the marae willing to help with promotion and liaison tasks. The last-mentioned resigned after 2 months because of the demands of her role, as
well as for personal reasons, and a replacement could not be found. Other marae members were co-opted onto the committee temporarily to help in specific ways. The training programmes principal chaired most of the meetings, although the diabetes specialist also played a major role. The principal, who belonged to the largest extended family closely associated with the marae, was a daughter of founding members and a member of the marae Trust Board. The partnership committee met weekly for the first month, bi-weekly for the next month and then, after a break for Christmas, at least monthly throughout 1995.

Tasks performed by the partnership committee included planning and organising a health screening and education programme and promoting it within the marae community and the wider Maori community of Otara; planning and organising a major event to launch the education and exercise programme; developing a job description to establish a health liaison worker position and applying to the relevant government health funding body to obtain salary and costs to establish the position under the marae’s administration. The generation of training and employment opportunities for Maori was part of a vision for the continuity of the programme shared by all members of the partnership committee.

When the training programmes principal resigned from the partnership committee after 16 months, a replacement did not come forward from the marae and partnership committee meetings ceased. It was around the same time that SADP’s Maori cultural adviser died, with the consequent loss of her wisdom, guidance and support. Notwithstanding the cessation of meetings, communication between SADP and marae members was maintained, with the continuation of an exercise group, a diabetes support group, and diabetes education at the marae.

Overall funding for the pilot programme and evaluation was administered by SADP as part of an allocation from government for partnership interventions with Maori and Pacific Islands communities.

Research aims

Programme development was to be accompanied by research to (a) assess the effectiveness of the programme in controlling diabetes risk factors, with an emphasis on quantitative assessment (b) record information about organisational processes surrounding the development of the marae-based health programme and comment on factors contributing towards and/ormitigating success. The first aim was consistent with outcome evaluation, with an emphasis on providing the quantitative measures that form the basis of a positivist (Lincoln and Guba, 1985) medical research model. The second aim was consistent with formative and process evaluation, relying heavily on qualitative data collection methods. The present paper focuses on the second aim of the research: the formative and process evaluation. The two aims relate to the same programme content and participants.

The first phase of the programme was obtaining baseline weights and measurements, self-reports on eating and exercise habits, and diabetes knowledge scores. These were incorporated in health screening sessions with blood pressure testing and laboratory tests for diabetes and lipids. The research plan required that baseline measurements be obtained for 200 people before the intervention phase would commence. However efforts to involve new participants and data collection were to continue beyond the time when this target was reached because a primary aim of the partnership was to develop a continuing programme that marae members would eventually run for themselves.

Research method

Formative evaluation begins at the early stages of the conceptualisation and development of an organisation or programme, with the primary purpose of collecting information for ongoing organisational and/or programme development and improvement (Dehar et al., 1992). Process evaluation is aimed at elucidating and understanding the internal dynamics of organisational or programme operations. It implies an emphasis on looking at how an outcome was produced, rather than looking at the outcome itself (Patton, 1980; Altman, 1986).

The evaluator (J.V.) was a community psychologist who participated as an employee of SADP and member of the partnership committee. The tasks of formative and process evaluation suggest the appropriateness of qualitative data collection methods (Patton, 1980; Altman, 1986). Information was gathered through participant observation, with the evaluator attending every partnership meeting that was held, the programme launching event, other major promotional events, 15 meetings of the diabetes support group, and exercise sessions at regular intervals. Detailed written research notes were kept, with particular attention paid to recording participants’ comments and questions.

Together with the SADP’s Maori liaison worker, the evaluator was active in promoting the programme within the wider Otara community, visiting many Maori community leaders and groups. When presenting or promoting the partnership committee or the programme to anyone, the research component was declared. In-depth discussions about Maori health
issues were a consistent feature of these meetings. They were a source of information on Maori perspectives on Maori health issues in the past, the present and the future, and appropriate intervention strategies. The evaluator also conducted in-depth interviews with members of the partnership committee, the marae, and SADP’s Maori cultural adviser, Maori liaison worker and medical director and diabetes specialist. Interview questions varied depending on who was being interviewed. Common question themes were:

- the role of the interviewee and their organisation within the Otara Maori community;
- the nature of interviewee’s connection, if any, with the present pilot programme;
- perceptions of major health issues among Maori in Otara;
- lifestyles of urban Maori, particularly aspects impinging on health status;
- interviewee’s knowledge of past health initiatives in Otara;
- differences between urban and rural marae and particularly the challenges faced by urban marae;
- the strengths and weaknesses of the present pilot programme and how it could be improved;
- the lessons that health planners might draw from past experience and from the experience of the pilot programme.

When attending meetings with Maori organisations, leaders and the other marae in Otara, the evaluator was always accompanied by SADP’s Maori liaison worker who was fluent in Te Reo (essential to protocol), and on occasions, also by SADP’s medical director. Research notes were discussed with and corroborated by the interviewee, the Maori liaison worker, the medical director, or marae members, according to the situation. A detailed calendar of events listing all occurrences in date sequence was prepared. A content analysis (Patton, 1980) was performed by the evaluator on the totality of data. The resultant information was summarised in a draft report, copies of which were given to each of the marae Trust Board members, the training programmes principal, her human resources manager, SADP’s Maori liaison worker and SADP’s medical director. Their comments and suggestions were invited and incorporated in the final report.

Conducting the evaluation as an employee of SADP meant enhanced opportunities for first-hand observation and data collection, but a disadvantage was a loss of the autonomy and independence which is ideally associated with the evaluator role and gives greater importance to an evaluation, optimising its power to influence events. This last comment is made on the basis of comparison with the evaluator’s previous experiences of working in an independent, autonomous capacity. The evaluator joined the team with the intention of working from within to provide guidance and generate solutions to unsatisfactory eventualities, consistent with a formative evaluation approach. This report is based on lessons derived as much from mistakes that were made, as from what was done well.

### Participation rates

The programme was for the marae community, broadly defined as anyone connected with the marae in a cultural, spiritual, family or social sense. It was intended for frequent attenders at the marae, intermittent visitors, and anyone else whom marae members wanted to include. There was intensive promotion of the programme among those coming to the marae regularly (e.g. employment trainees and marae workers), the 14 kohanga-reo in Otara, and leaders of Maori interest groups in Otara.

Between November 1994 and December 1996, 446 people participated in health screening sessions for the recording of baseline measurements. Of these, 64% identified themselves as Maori or part Maori and 73% were female. The three largest community groups represented were employment trainees and tutors (42%), kohanga-reo parents and caregivers (22%) and marae elders, members and workers (12%). A full day health promotion event held at the marae to launch the programme was attended by 180 people. Education sessions about diabetes prevention and healthy lifestyles (organised either as a full-day session or 3 sessions of 90–120 min) were attended by 135 people, predominantly employment trainees and kohanga-reo caregivers and parents. During the period January 1996–October 1997, 156 exercise sessions were held, with an average attendance of 11 at each twice-weekly session (1831 attendances in total). A diabetes support group commenced monthly meetings at the marae in November, 1995 with attendances ranging from 3 at initial meetings to 16 in mid 1997. A minority of people are represented more than once in the preceding figures, having participated in more than one health promotion event or activity (as well as baseline screenings).

Eventual outcomes were the establishment and running of a health programme by The Whaiora Marae Trust Board, beginning with the creation of a health and welfare portfolio within the Marae Trust Board. They declared themselves a ‘smokefree’ marae, successfully applied for seeding funding, conducted successful health promotion days attracting 80–100 people and are planning more, are catering to provide low fat/high
fibre foods at marae events, and have begun weekly line-dancing sessions for exercise.

Key issues that emerged

From the outset, there were issues of conflicting paradigms related to trying to maximize community development aspects of the initiative while satisfying the need for quantitative evaluation. However, such issues were minimal compared with those associated with overcoming a residue of cynicism and suspicion among Maori and building the level of trust needed to establish a health programme on a firm footing. Issues of personnel and money became intertwined with issues of trust. Other challenges for the partnership committee were in the form of motivational issues related to the value placed by the community on a health programme.

Conflicting paradigms of medical research, quantitative assessment and community development

The medical model requirement for quantitative pre- and post-programme measurements limited the discretionary powers of the partnership committee in planning a programme. Because of the likelihood of contamination of pre-programme knowledge and self-report eating and exercise behaviour scores, the first component of the programme had to be obtaining baseline weights and measurements, self-reports on eating and exercise habits, diabetes knowledge scores and health screenings. A medical research model did not permit the choice for health education to precede screenings, a preferred sequencing that has subsequently been adopted.

The medical research model also demanded a minimum sample size to be able to attach significance scores to what might turn out to be small increments of change resulting from the programme. It took 9 months from the time of the first measurements and screening session to achieve the required number of 200 sets of baseline measurements. The time gap for a majority of participants meant a loss of momentum and immediacy when the intervention finally occurred. Some, predominantly employment trainees who had completed their training in the intervening 9 months, were already gone from the marae. Another problem was trying to recruit participants without imparting persuasive information about the seriousness of diabetes and the importance of early diagnosis, for fear of contaminating baseline knowledge scores.

Building trust

Trust, or rather lack of it, quickly became apparent as an issue both within the marae community, and to a larger extent, within the wider Maori community of Otara. The words ‘distrust’, ‘cynicism’ and ‘suspicion’ are descriptive of feelings frequently encountered in promoting the partnership’s agenda. At one extreme of the continuum were those who were not at all disposed to trust the motives of dominant culture members, believing that ‘only Maori know what is best for Maori’ and ‘only Maori can do for Maori’. At the other extreme of the continuum were those who had no firmly held cultural beliefs to defend and fight for. The principal of the training programmes could be placed at a point of balance between these two extremes. She was an impassioned advocate for her culture, but not to the exclusion of other cultures. She was able to recognise the potential in what the Maori and European partners had to offer, knowing how to work with those strengths, and most importantly, when and how to challenge constructively. One of her hopes for the health programme was that it would help her people to become more effective advocates for themselves.

Among factors that emerged as having fuelled distrust, cynicism and suspicion were: (1) the history of colonisation; (2) experience of government funding bodies seen as subverting self-determination by granting seeding funding and then imposing restrictions on successful programmes, tying funding to compliance; (3) inadequate funding for Maori to run things for themselves; (4) the activities of previous researchers seen as not returning the benefits of their research to participant communities; (5) a perception of self-serving agendas on the part of bureaucrats, and especially health managers, a case in point being the closure of the earlier diabetes clinic at the marae. The recurrent theme in all five factors was one of Maori having been used, and resisting being used yet again. Advice on the subject of trust from SADP’s cultural adviser was to be willing to adjust Western time frames to allow time for trust to build: “Maori have to see things for themselves before they believe them. The same will be true of this project”.

The sharing and allocation of staffing and funding emerged as a main standard by which judgements were formed and trust could be either garnered or dissipated. Key questions guiding the judgements of marae members were: “who benefits from the health programme?” and “where are the resources being channelled?” Marae members wanted to see some tangible benefits for their marae from the partnership, the creation of paid employment opportunities being of major importance. An application submitted to a government health funding body for a salaried health worker position administered by the marae represented an effort to gain a fairer balance of resources between SADP and the marae. Unfortunately, despite numer-


ous reminders, a reply was never received to this application although the same funding body had been the funding source for the main programme. This omission was an enormous blow to the partnership in terms of loss of credibility, the scuttling of hopes that the health programme might generate employment opportunities for members of the marae, and resultant difficulties in recruiting helpers. The creation of employment opportunities as a result of the health programme was an aspiration which was particularly important to marae members but was not fulfilled.

Another factor impinging on the trust issue was the presence of different interest groups at the marae, each with their own set of aspirations for the marae and predispositions to judge people and events. The presence of different iwi (tribal) groups on urban marae is in itself potentially fertile ground for differences to occur. As stated by one marae member, “we struggle to understand and appreciate other iwi”. Potential for conflict is also heightened when people can be both the beneficiaries of a decision and the decision-makers. A major weakness of the partnership committee was that it was not sufficiently representative of different interest groups at the marae, creating difficulties of communication. The training programmes principal was the partnership committee’s main link with the Marae Trust Board but this placed unfair pressures on her. The Trust Board Chairman and his wife were always supportive but their contact with the partnership committee was intermittent.

The value placed on a health programme

This issue has a major bearing upon how the partnership committee was viewed by marae members and the wider Maori community of Otara, and the size of the task it faced. The higher marae members rated the importance of having a health programme and the more they prioritised health, and diabetes in particular, relative to other needs, the easier the committee’s task was likely to be. Nobody within the Otara Maori community denied that diabetes was a problem among them, but as a disease which may be lacking in symptoms until it has inflicted serious damage, it was easily ignored. A marae member commented that 90% of the people closely associated with the marae had an immediate family member with diabetes, but it was not something to which they gave much thought. Interestingly, diabetes was also rated as a major health issue by rural Maori (Kirkwood et al., 1997).

Comments made by Maori during the course of the research referred to a prevailing apathy among their people, men especially, about taking health protective measures. Often it was framed as:

“Maori are lazy. It comes down to us to change ourselves in the end.”

“It’s hard to get Maori off their backsides to do things for themselves. Maori are like that.”

“Their attitude is ‘if they die, they die’ and there’s no point in worrying.”

The translation of a Maori proverb often quoted by SADP’s Maori cultural adviser to her people was, “it is you who can take control and look after yourself”.

Other comments that emerged in more detailed discussion addressed reasons:

1. Maori tend to have multiple crises in their lives. Health ends up as a low priority when people are struggling to provide for more pressing needs such as a roof over their heads and food on the table.
2. Maori consider themselves last of all. They are concerned for their children and grandchildren but not themselves. Many older women are at ‘the beck and call’ of others looking after their grandchildren and dealing with family problems.
3. It’s a matter of how people value themselves. If they don’t value themselves, they won’t look after themselves. (Self-esteem problems were not seen as relating to older men, but for the younger generation, unemployment made self-esteem a very real issue).
4. From childhood, they were conditioned to not waste food. Meat was a luxury and the fat was never discarded. “Old habits die hard”.
5. Older Maori tend to lack knowledge of basic human biology and influences on health.
6. Maori deny their health problems for as long as they can. Diabetes is easily denied for too long.
7. They regard the lifestyle changes they would need to make as too much to tackle.

The more extreme reluctance of men to display interest in health protection measures was viewed as reflecting a gender pattern that was not confined to Maori. Observations drawn from Maori men and women were: (1) men tend to think that they won’t be touched by illness (this denies the reality of the reduced life expectancy of Maori men, relative to Maori women and European men and women (Pomare et al., 1995); (2) men feel shy about discussing their health and do not want to admit to having health problems. They are apprehensive about how others will see them. Another consideration that applied equally to Maori men and women was that obligations towards their extended family (defined by birth and marriage) were paramount. As a result of intermarriage at different generational levels, an individual usually was connected with and had obligations towards a large number of people. Such obligations tended to displace personal health in their strata of priorities.

There was evidence to suggest that health protection rated very minimally with some people and they were inclined to weigh the potential benefits of the health
programme to be entirely in the direction of the SADP partners who might gain kudos and other rewards from success. Against the background of a wide range of viewpoints and attributions of priorities, the partnership committee faced a daunting task in encouraging Maori who were part of a scattered urban community to adopt lifestyle changes towards a healthier future. Generally, it was hard to get people to think proactively in relation to their health, and the importance placed on treatment clinics was part of this mind-set.

In conclusion, it should be recognised that the issues described, particularly those of trust and the value placed on the health programme, were felt by both parties to the partnership, although they were experienced in distinctive ways and presented differing challenges for each. The advice of SADP’s Maori cultural adviser that Maori have to see things for themselves before they believe them was confirmed by our experience as a sound premise to start out with. Community initiatives such as that on which this report is based require patience, perseverance, a shared long-term commitment, and willingness to constructively explore and develop new possibilities.

How to proceed to build partnerships for programme development

This section specifies some recommendations for procedures for building partnerships between professional health groups and urban marae communities, based on the preceding literature review and the lessons learnt through first-hand experiences of the research. It is divided into four parts:

- Preparatory steps.
- The formation of a partnership committee.
- Programme planning and development.
- The appointment of a marae liaison worker.

While the recommendations refer directly to a partnership with Maori and the opportunities offered by a marae setting, the underpinning themes of community development, empowerment and self-determination are pivotal to the advancement of the status, health and otherwise, of minority indigenous groups generally. Potentially, this gives the recommendations broader relevance beyond Maori to other indigenous people living in urban environments who are reasserting their cultural identity, and to other domains besides health. Furthermore, although the recommendations are addressed more towards professional groups, they might also be viewed as suggesting a set of appropriate expectations for community groups to have of partnerships with professional groups.

Preparatory steps

- With the help of a cultural adviser familiar with the local community, identify one or more key decision-makers within the marae community and arrange a meeting. The cultural adviser should be present at initial meetings and be available to consult on an ongoing basis.
- A successful partnership depends upon a shared purpose and commitment. Ascertain the level of support among the marae community for a health promotion partnership and their perceptions of possible benefits from it. If there are opposing factions, find out how representative they are and the nature of their objections. Discussion and negotiation may pave the way for more general support. Be clear about the different visions respective parties may have for the programme. A shared purpose does not exclude other goals.
- Evaluate what both parties can bring to the health promotion partnership in terms of: (1) what is already available at the marae in the form of facilities, networks, activities, people traffic, human resources and general services; (2) how the professional group can best complement the networks and resources of the marae for the programme to succeed.
- Prepare a budget allowing sufficient funding for a full-time position with support costs to be created at the marae for programme coordination. If funding is inadequate and there are no opportunities for generating more, the scope of the proposal may have to be narrowed, with a reassessment of priorities and timeline. Key questions are: can the programme operate within the more modest boundaries of available funding and still do justice to the aspirations of both parties? Should it proceed at all?
- A formal agreement (preferably written) should be negotiated and minuted by the representatives of both parties defining reciprocal rights, contributions, responsibilities and accountabilities, as well as procedures for resolving any issues that may arise subsequently. Discussion of the agreement may highlight gaps in understanding, which can then be clarified to minimise the potential for future disputes.
- Financial arrangements, including the basis on which space rental and other costs will be calculated and paid should be the subject of a written, signed agreement. Knowing who owns the facilities you want to use is prerequisite information.
- Proceed to the next stage only: (1) if there is strong support from within the marae community and the professional group for the partnership, (2) if both parties are satisfactorily positioned to meet the
Communication is vital. A procedure should be

The formation of a partnership committee

- A partnership committee, with marae representatives as the majority, should be formed to undertake planning and organisational tasks. Optimum committee size depends on the context and planned objectives. As a general rule, larger size may increase the available networks of communication and pool of knowledge and skills, extend opportunities for empowerment, but intensify problems of cohesion. Smaller size may mean better cohesion while limiting networks, knowledge and skills and the number of readily accessible helpers. Additional help and advice may be coopted as required.
- In its meetings, activities and all aspects of its functioning, a committee should operate as a prototype for what it wants to achieve in the community. A goal of empowering the community suggests a framework of values for committee operation centred around empowerment, mutual respect, self-determination, and incorporating cultural and grass roots community knowledge and strengths. The professional group should see themselves as a community resource, rather than as community benefactors, denoting a mind-set conducive to empowerment. Committee members need to be aware of their own individual power agendas that may be counterproductive to general project objectives. Self-serving power agendas that may be counterproductive to general project objectives. Self-serving power agendas undermine community development process (Chalip et al., 1996). The balance of decision-making power should be tipped in favour of marae representatives.
- A first task of the partnership committee should be to formulate a clear set of aims, objectives and suggested implementation strategies, reflecting the aspirations of both parties. An initial framework that is somewhat sketchy may be expanded as new information emerges. Ensure that all members, particularly newcomers, have a common understanding of the overall plan and their role in making it succeed. 'Talking past each other' (Metge and Kinloch, 1978) can happen all too easily in cross-cultural situations.
- Communication is vital. A procedure should be agreed between the partnership committee and the Marae Trust Board/Committee for the latter to be kept informed of progress, obstacles, issues and requests and to give feedback. Procedures will also be required for reporting to the parent body of the professional group and to programme funders.

Programme planning and development

- A community development model based on self-determination and empowerment should provide the frame of reference for the planning and implementation of the health promotion programme. The partnership committee should be regarded as a step in the progress towards the marae community initiating and owning their own health programme/s.
- The process should be geared towards achieving a programme that is culturally sensitive, clinically safe, and caters to heterogeneity among the target community. To increase sustainability, the programme should utilise and extend the marae’s own resources (exclusive of finance) as much as possible, as well as incorporate culturally appropriate clinical (e.g. family doctors) and other resources from the wider community.
- The process of programme planning and development should maximise opportunities for training to enable the marae community to expand their knowledge and skills. Providing a gradual transition over time into increasingly responsible roles will help prepare the marae community for running their own programme/s in the future.
- Positivist medical research models do not fit well with community development strategies. While quantitative measurements are useful, they are best incorporated as integral to process (e.g. weight measurements in obesity programmes) rather than being superimposed in a manner that interferes. Make use of formative and process evaluation to develop and improve the programme on an ongoing basis. Formative evaluation is especially recommended because it begins at an early stage of the programme when opportunities for influence are greatest, and helps resources to be channelled productively (Dehar et al., 1992).

The appointment of a Marae liaison worker

- The position of marae liaison worker should be created in conjunction with a detailed job description. Key responsibilities would include: coordinating the programme; networking (making contact with people) as a strategy for publicity and for recruiting participants; ensuring that wider community consultation occurs; the keeping of records; regular reporting to fulfil accountability requirements; and assistance with the gathering of evaluation feedback. It could be created as a shared position.
- The Marae Committee/Trust Board should administer and distribute salary and expenses payments in a way they consider fair to all marae helpers and to allay jealousies.
The appointee/s should be nominated by the Marae Committee/Trust Board although all partners should decide the final appointment. This approach should help to affirm community ownership of the intervention and increase the likelihood of satisfying the requirements of both partners.

The appointee/s should be capable of establishing credibility with local Maori community leaders who are potentially important channels of information and influence. This means having fluency in Maori language and knowledge of cultural protocols. Bear in mind that the liaison worker/s will become the main public face of the programme. Drive and initiative are essential qualities, as well as being good models of healthy lifestyle behaviours for others to emulate.

The majority of the liaison person’s working hours should be spent at the marae or in the community, with a lesser amount of time spent with the professional health group in their workplace for purposes of training, giving advice and maintaining contact.

The liaison worker should be assisted by others from within the marae community. This could be expected to: (1) generate more wide-reaching networks for recruitment and publicity; (2) offset the risks of relying on one person; (3) provide valuable practical and personal support to help diffuse the pressures of the liaison worker’s role; (4) extend the marae’s skill base.

The marae liaison worker and co-workers should be accountable to the Marae Trust Board/Committee via the partnership committee. Job boundaries need to be well defined to protect liaison workers from unfair demands and to ensure safe practice. As far as possible, boundaries should be communicated to others so they do not make inappropriate demands and target complaints unfairly.

Include volunteers as well as paid workers in training opportunities. Training of volunteers constitutes a strategy for community and individual empowerment, with the potential to yield long-term benefits, not the least of which is promoting programme sustainability (De Pue et al., 1987; Eng, 1993; McFarlane and Fehir, 1994). An ancient Chinese proverb of unknown authorship wisely advises: “Go in search of people . . . begin with what they know . . . build on what they have” (McFarlane and Fehir, 1994).

Conclusions

The main lesson of this paper is the importance of historical context as an essential consideration in the development and delivery of health services and health promotion programmes for Maori. What programme planners and developers need to be most careful to avoid doing is recreating the very conditions that, until recently, kept Maori as a submerged group in society and fuelled their sense of powerlessness. Time must be allowed for establishing trust if any real progress is to be achieved. It is suggested that this conclusion can be extended to other indigenous groups who share a common historical experience with Maori in terms of dispossession of their lands and resources, a consequent loss of status and cultural identity, and associated physical, emotional and spiritual trauma. A counteracting trend is the cultural renaissance that has gathered momentum since the 1970s among indigenous people worldwide. The reassertion of cultural identity and demands for self-determination, which are at the heart of the cultural renaissance, suggest the appropriateness of a philosophy of empowerment for guiding and reinforcing programmes aimed at improving the health status and social and spiritual well-being of indigenous people. Community development is an appropriate strategy because it incorporates empowerment both as means and end.

In this paper, we focused on the formation of partnerships between professionals and community groups as a way of actioning community development. The recommended procedures were intended to illustrate how individual and community empowerment can be incorporated in the operation of partnerships. A basic premise of this paper has been that devolution of power is a key aspect of organisational process underlying successful partnerships and coalitions involving professional groups and indigenous people.

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