

**The role of the Community Health Worker  
in a Māori person's health journey  
(A summary Report )**

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## **Health Care Aotearoa**

Health Care Aotearoa (HCA) is a Treaty of Waitangi based national network of community-driven and governed primary health care services. Its mission statement is ***Transforming social inequalities through community inspired health services.***

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## INDIGENOUS RESEARCH STATEMENT

Māori are the tangata whenua or indigenous people of Aotearoa / New Zealand. Our 'Māori' focus for this research stems from the knowledge that indigeneity is a key health determinant, characterised ultimately by shorter lives than non-indigenous peoples, even in industrialised nations (King et al., 2009) and, in New Zealand, even when controlled for other determinants such as income (Sporle, Pearce & Davis, 2002). Māori have the poorest health status of any ethnic group in New Zealand (Robson & Harris, 2007). This fact is a breach of the Treaty of Waitangi, New Zealand's founding document, and Maori rights as indigenous peoples.



### Background

Indigenous peoples in many countries have secured more control over community based health services, in the hope of improving access and responsiveness (United Nations, 2002), with claims that indigenous self-government is fundamentally linked to improved community well-being (Lavoie, Forget, Prakash et al, 2010; Durie, 1998, 2001).

By 2009, there were 264 recorded Māori health service providers (Māori providers) in New Zealand (MOH, 2009). Māori providers offer comprehensive primary health care, which usually includes medical care. While the majority of the Māori population access mainstream primary care services, surveys indicate that Māori are more likely to use a Māori provider if the option is available (MOH, 2008). Pilot studies have shown that Māori respond well to services that use Māori outreach workers (Ellison-Loschmann & Pearce, 2006). Crengle (2000) identified that Māori providers use Māori models of health and promote positive Māori development as the key philosophies underpinning Māori health services. Māori cultural processes are used as a basis for developing and delivering contemporary health services that support self-sufficiency and Māori control.

Māori providers continue to face a number of difficulties which limit their potential. A lack of good primary health data such as ethnicity data was reported to have limited the potential of many Māori health providers (Ellison-Loschmann & Pearce, 2006). Another challenge is the small size of the professional Māori health workforce, which is 3.2% yet Māori comprise 15% of the total New Zealand population (Medical Council NZ, 2009).. In addition, there are persistent challenges for Māori providers to attract Māori health workers, due to disparities in pay that exists between other health sector workers and those who work for Māori providers. According to Te Whiringa Trust, a national Māori Community Health Worker network, Māori CHWs make up at least half of the total Māori health workforce (Te Whiringa Trust, 2010).

Indigenous CHWs are a fundamental structure within indigenous health providers and in Canada they comprise greater than 40% of the First Nation health provider workforce (Parker & Kaufman, 2009). In New Zealand, Te Whiringa Trust, a national Māori CHW advocacy network claim Māori CHWs make up nearly half of the total Māori workforce. Boulton, Gifford, Potaka-Osborne (2009) acknowledge that Māori providers rely heavily on CHWs to implement their contracts. Therefore without them the indigenous health care system would collapse.

## RESEARCH AIM

This study explored the role of community health workers (CHWs) in the health journey of Māori.

## METHODS

A case study was undertaken of a Māori health service provider from within the membership of HCA. Sampling was purposive. Two Maori providers were invited to participate on the basis of set criteria; for example, that they employed CHWs and offered CPHC. After consent was given by the governance body, Kokiri Marae Health and Social Services (KMHSS) became the case study site examined for this research.

KMHSS is a long established urban health provider based at a marae (Māori meeting place) located in an industrial area in the Hutt Valley in the Wellington (capital city) region of Aotearoa / New Zealand, with a strong reputation for effectively engaging with Māori whānau (extended families). The main site is a modern marae epitome, and resembles an activity centre for Māori community leadership, collective health and well-being programmes and services within a te ao Māori (Māori knowledge, resources and worldview) environment. The kaupapa or Māori 'heart' of the organisation is transmitted through its founding people and their descendents who continue to be involved in the governance and operation of the organisation, and wider whanau including the workforce and community. Currently KMHSS and its affiliate general practice service provider Whaioranga o te Iwi serve a population of approximately 12000. Their health service users experience a high level of health and social needs. (see Figure 1)



Figure 1: Kokiri Marae Health and Social Services, Wellington region, New Zealand

KMHSS primary health care staff were invited at a staff meeting to participate in focus groups. Due to the transient nature of KHMSS service users, a random sampling method based on the receptionist phoning those who had attended for care on a particular date, was unsuccessful. Using the next consecutive date, service users were invited by their CHWs until a few service users had agreed to participate. The final sample is described in Table 1 by role and ethnicity. All staff and service users, except one, were of Maori ethnicity, and all were women.

Table 1: Sample, by Role and Ethnicity (n=15)

ROLE	NUMBER of Participants	Ethnicity of Participants
Managers	2	Māori
Receptionists	2	Māori
Nurses	2	Māori
Community Health Workers	4	3 Māori, 1 Pacific CHW
Service Users (patients)	5	Māori

Data collection was undertaken by TF in two staff focus groups and 4 service user interviews. The four CHWs participated in one focus group and the other staff members participated in a second group, both at KMHSS (see Figure 2). By their own choice, three service users were interviewed in their own homes, and two were interviewed jointly at KMHSS. Focus groups and interviews were audiorecorded, using a digital recorder, and transcribed in full by an employed transcriber. Key questions addressed in interviews and focus groups included the following:

- (All participants) What do you value most about (being) CHWs?
- (All participants) What do you/CHWs do in your/their roles?
- (Health service users only) How did you become involved with a CHW?
- (All participants) How are CHWs involved in your/people's health journeys?
- (All participants) Challenges and strengths regarding CHWs.



Figure 2: Focus group underway at Kokiri Marae (TF is 2<sup>nd</sup> from right)

Data analysis was undertaken by TF using an inductive ‘constant comparative method’ of analysis (Thomas 2006). This method involved the researcher reading and re-reading the transcripts of the interviews and focus groups, and checking the audio recordings when data were unclear. No software was employed to assist with the analysis; rather, the researcher highlighted key findings thematically on the transcripts, then combined all important quotes thematically. Preliminary thematic analysis was sent, along with transcripts, to the research mentors (PN and SC) and the service user (RG) for further analysis and thematic development of findings.

## FINDINGS

Four key themes arose out of our data analysis. The first finding relates to Māori service users’ experience of Māori CHWs as providing culturally distinctive care that is person and whanau-centred rather than centred on the health system. The second related finding is that CHWs play a vital role in improving people’s access not only to health care but to social services in general, and to the social determinants of health. The third theme is that CHWs add significant value as team members of a Māori comprehensive primary health care service, improving both service delivery and links with other agencies. Finally, there are significant challenges facing both CHWs and KMHSS, which employs them, with regard to the under-resourcing of the CHW role. Although derived from the experience of staff and health service users of KMHSS, these themes are likely to tell a more general story of the community health worker’s role in a person’s health journey within a Māori CPHC service provider.

Instead of reporting only on the four themes, all key findings are highlighted in a statement below, followed by a participant quote to illustrate it.

1. Māori CHWs offer person- and family-centred care that is culturally distinctive:

*It is great B [CHW] is from Ngati Porou [tribe], we know a lot of the same whanau. After that we were away and the relationship was paved. To me that is everything, I know they [CHWs] truly care... our own people.* **Health service user**

2. CHWs plan with whanau to achieve the outcomes they seek in their journey of care.

*Our commitment to tikanga is what guides our relationship with whanau when we go into homes we know we are visitors. Whanau lead the relationship not us. We are there to assist them achieve their goals, offer support and help them on that journey.* **CHW**

3. CHWs share knowledge to help service users manoeuvre both health and social services.

*Since I met D [CHW] it's like all these other services came with her.* **Health service user**

*My CHW helped me learn about the services out there that you can use. I reckon a lot of people who really need the services just don't know about them or they just don't know what to expect. Yeah that's how I got to start seeing a counsellor from some problems I was having.* **Health service user**

4. CHWs provide advocacy, leading to more effective outcomes from interactions with health and social services.

*People with high needs don't work like mainstream. A lot of the time they get moved on. There's a disconnect there and issues don't get addressed. We do a lot of advocacy and support so these issues get sorted and whanau get their needs met appropriately.* **CHW**

5. CHWs are critical CPHC team members who improve the overall effectiveness of the care delivered, and improve equity of service use relative to population health need.

*They fill in all the gaps, you know that stop me from getting the help I need.* **Health service user**

*Our roles [clinicians & CHWs] complement each other. We work in tandem so it's timely and meets the needs of whānau, not us.* **Nurse**

6. CHWs working collaboratively with colleagues to achieve effective population coverage and reduce resources waste by reducing missed appointments in other parts of the health system.

*The CHW role is critical not only in the implementation of our programmes but they also coordinate so many other process things involving our whanau from referrals, appointments, transport, or just supporting them in taking that first step to be involved with services to keep them well - we would be lost without them.* **Manager**

7. There is a lack of resource available to support CHW programmes, and so they are few in number relative to demand, and are overworked, underpaid, and lack ongoing professional development.

*It is difficult also because our funding only allows us to employ CHWs part time and these people need full time work. **Manager***

*We provide practical training support, which helps our CHWs be useful in their roles like, for example, they are all trained in budgeting advice. The programmes and funding don't cover the costs of ongoing professional development, supervision and issues like that. We absorb those costs ourselves. **Manager***

A story to highlight the role of CHWs in the health journey of Maori.

Before Ngaire (pseudonym) became involved with her CHW, she lived an isolated life with little social contact, in a state house far too big for one person and expensive to heat in the winter time. Ngaire spent her days in her bedroom to keep warm as it was cheaper to heat one small room rather than a whole house. She described her depression as an enduring illness which gripped her life soon after her first child. Prior to Ngaire's involvement with the CHW, her health care was described as a frustrating experience that frequently led to her needs not being understood and heard appropriately.

Ngaire described her CHW as "a life-saver" and someone that that finally started to help her with the things that really mattered in her life. *When I first met B, I couldn't even walk to my letterbox... I suffered terribly from loneliness and depression. My search for 'ora' (well-being) has been enhanced by the CHW. I am no longer isolated and my relationship with my son has got so much better...B has helped me through my loneliness. I get out there and have things to go to in the community now, like the Kaumatua (elders) groups at the marae. She helps me with my appointments too. I get my needs met better now and I am able to understand those health people.*

## **DISCUSSION:**

This study examined the role of the CHW in a Māori person's health journey through a case study of an indigenous comprehensive primary health care service provider within the HCA national network. Kokiri Marae HSS provided an ideal case study for this research, as it provided a rich setting, including a GP clinic, in which to explore the role of CHWs. The combined views of health service users, community health workers, receptionists, nurses and managers confirmed the value and breadth of the CHW role, embedded in cultural and community knowledge, and focused on addressing barriers to health care and social support for Māori. These findings are consistent with previous research that has highlighted the value and the complexity of the role of Māori CHWs. This research raises important questions about how CHWs could be better supported in their roles, both in policy and practice. Key points are summarised as follows:

1. Māori in this study, as is likely the case for others who experience poverty and high health need, are unable to manoeuvre in the complex systems of 'care'. As found in previous research, (Boulton, Gifford & Potaka-Osborne, 2009; Lehmann and Sanders, 2007) CHWs are important 'bridge' between agencies, services, communities and people with health need.
2. Indigenous CHWs engage in therapeutic relationships with people with whom they share community linkages, cultural knowledge and similar life circumstances. Shared

indigeneity was deemed important in this study, not simply the notion of ‘cultural competence’ that has been promoted widely in recent NZ health policy (Medical Council of NZ, 2005). CHWs are in the strongest position to hold that therapeutic relationship, if they are carefully chosen for the role.

3. Māori CPHC service providers rely heavily on indigenous CHWs to successfully reach Māori who at risk of service under-use relative to their need (Boulton, Gifford & Potaka –Osborne, 2009; Te Whiringa Trust, 2010). Similarly, other non-profit community driven primary health services in New Zealand committed to reducing health inequities employ CHWs to ensure their services are accessible, appropriate and comprehensive for populations with the worst health outcomes and lowest rates of health service utilisation (Crampton & Davis, 2004). The CHW role remains vulnerable to policy changes and funding cuts. There is a clear need to adequately resource CHWs in order to maximise their potential to improve health equity for Māori through the delivery of comprehensive primary health care. It is a key Māori health workforce development issue, as well as an issue for the development of CHPC.
4. Study limitations: The sample size in this study was small, yet rich data were collected. It is not possible to generalise the findings to all Māori CPHC providers or, even less, all indigenous CPHC providers who employ CHWs. Despite this reality, the trends found in this research are likely to be similar in comparable studies of other Māori CPHC providers and possibly other indigenous CPHC providers as well.

## **CONCLUSIONS:**

The role of the CHW within a multidisciplinary health team is analogous to a rugby team (see Figure 3). The most important player is the one who passes the ball to his/her try-scoring teammate; however, the player who scores the try (goal) is the one who receives both team and public adoration for putting points on the scoreboard. In primary and secondary health care, the doctor almost always scores the try, and is recognised as the most valuable player on the health care team. Yet, the player who got the ball (patient) to the try-scorer (doctor) is the most important player of all. CHWs are working behind the scenes, in the back row of the team, to ensure that people engage with health and social services. Without their efforts, many people, and many Māori people, would never receive the services to which they are fully entitled.



Figure 3: The New Zealand All Blacks: future Rugby World Cup Champions!

The three key points for policy / practice:

- **Greater attention to the value of CHWs, by primary care practitioners and policymakers alike, would go a long way to enhance the delivery of CPHC in Aotearoa New Zealand, particularly for the most vulnerable populations.** Despite the evidence for the important role played by CHWs in improving health equity for indigenous populations, CHWs remain ‘minor players’ in the primary care sector in Aotearoa New Zealand. If Maori health equity gains are to be made, there will need to be a stronger policy commitment to firmly establishing, and adequately resourcing, the role of CHWs in the primary health care team.
- **There are more Maori CHWs needed, and as part of Maori health workforce development, the role could be an ‘entry point’ into the health workforce.** Maori CHWs are a valuable resource to whānau, communities and the wider health system, and enable multidisciplinary interventions to occur in a manner that is acceptable to whānau and integral to the implementation of ‘By Māori for Māori’ care delivery models.
- **Maori providers are in a strong position to advocate for both the CHW role and to continue to promote CPHC by focusing on the political unacceptability of health inequities in Aotearoa New Zealand, particularly for the *tangata whenua*** Such health need remains a breach of indigenous rights and human rights.



Health Care Aotearoa Community Health Workers' Hui / Meeting

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For the full detailed research report – access the HCA website [www.hca.org.nz](http://www.hca.org.nz) from December 2011 onwards.

## REFERENCES

- Boulton, A. Gifford, H. Potaka-Osborne, M. (2009). Realising Whānau Ora Through Community Action: The Role of Māori Community Health Workers. *Education for Health, Volume 22, Issue 2, 2009*
- Crampton, P., Davis, P. (2004). 'Comparison of private for-profit with private community-governed not-for-profit primary care services in New Zealand.' *Journal of Health Services & Research Policy* (9) 2: 17-22
- Ellison-Loschmann, L., & Pearce, N. (2006) Improving Access to Health Care Among New Zealand's Māori Population. *American Journal of Public Health*. 2006 April; 96 (4): 612-617
- King, M., Smith, A., & Gracey, M. (2009). "Indigenous Health Part 2: the Underlying Causes of the Health Gap. *Lancet*, 374.9683:76-85.
- Lavoie, J., Forget, E., Prakash, T., Dahl, M., Martens, P., O'Neill, J (2010). Have investments in on-reserve health services and initiatives promoting community control improved First Nations' health in Manitoba? *Journal of Social Science & Medicine*, 2010, p 1-8.
- Lehmann U., Sanders, D. (2007) Community health workers: What do we know about them? The state of the evidence on programmes, activities, costs and impact on health outcomes of using community health workers. A Report. School of Public Health, University of the Western Cape South Africa.
- Ministry of Health (2008) *A Portrait of Health. Key Results of the 2006/07 New Zealand Health Survey*. Wellington: Ministry of Health
- Ministry of Health (2009) *Ka tika ka ora; Māori Provider Work Programme*. Wellington. Ministry of Social Development (2008). The Social Report.
- Parker T., Kaufman A. (2009). Guest Editorial: The Role and Impact of Indigenous Community Health Workers *Education for Health*, Volume 22, Issue 2, 2009 Accessed 17 May 2011, [http://www.educationforhealth.net/publishedarticles/article\\_print\\_378.pdf](http://www.educationforhealth.net/publishedarticles/article_print_378.pdf)
- Robson B, Harris R.eds. (2007). Hauora: Māori standards of Health IV. A study of the years 2000-2005. Wellington: Te Ropu Rangahau Hauora a Eru Pomare
- Sporle A., Pearce, N., Davis, P. (2002) *Social class mortality differences in Māori and non-Māori men aged 15-64 during the last two decades*. *New Zealand Medical Journal* 115: 127-131
- Te Whiringa Trust, (2010). Te Whiringa Hui 2010 National Hui Notes. Orakei, Auckland. Retrieved on 06 January 2011 <http://gromit.utopia.co.nz/~mchw/wp-content/uploads/2010/12/Te-Whiringa-Hui-Report-2010.pdf>

United Nations (2002) Health Needs of Indigenous People Stressed at Permanent Forum.  
Press Release HR/4597, Accessed 15April2011,  
<http://www.un.org/rights/indigenous/may16.htm>