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Drug Policy Update

Kaupapa Arai Whakapōauau

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See the

National Drug Policy website

www.ndp.govt.nz



Editorial

Drug control and whānau ora

In July, Māori efforts to reclaim a smokefree status took another step forward, with the launch of a five-year Māori Tobacco Control Strategy.

Let us congratulate the Māori Smokefree Coalition for developing culturally appropriate Aukati Kai Paipa programmes that have a quit rate of 29 percent. This is a great achievement, given the extremely addictive nature of cigarettes.

The success of the programme lies in developing a sound approach, and in training workers to gain skills and expertise to work with individual smokers and their whānau.

This tobacco control strategy came hot on the heels of a research report showing that Māori are dying ten years younger on average than Pākehā, mostly from cancers, heart disease and hypertension that often result from smoking.

Smoking, like addictions to alcohol and other drugs, can best be addressed by tāngata whenua within a whānau framework. By taking responsibility for each other, and making changes together,



Hon Tariana Turia
Associate Minister of
Health and Māori Affairs

family members can support individuals to break bad habits and improve their lifestyles.

This is the 'whānau ora' approach to health and wellbeing, that underpins the Maori Health Strategy 'He Korowai Oranga' – empowering whānau to take control of their own health and wellbeing.

The whānau ora approach requires whānau to take the initiative, to identify their priorities and develop plans to achieve their goals. Just as importantly, government agencies must work together with each other, and with whānau to support the whānau, not to direct them.

Many marae have worked extremely hard to be smokefree, just as many whānau have made a big effort to maintain smokefree homes.

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Editorial

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I find it very difficult to understand that, despite all the health promotion messages about second-hand smoke, in some homes and cars, adults still smoke around children.

As we strive to affirm our identity, language and culture, to maintain the integrity of our culture and whānau, we must examine all behaviours that impact adversely on us and address them.

As tāngata whenua do this for ourselves, we expect government agencies to support us. They, too, must change ingrained behaviours and cultural patterns.

Public servants need to learn and practise skills in interagency co-operation, recognising our people as members of whānau rather than as individual patients, listening and responding rather than initiating and controlling.

When whānau and government agencies have mastered their respective roles, we will see really effective policy developed and major improvements in the health of the nation.

We focus on Māori

This issue of Drug Policy Update has a particular focus on policies addressing the needs of Māori. Some of these policies are formally part of the National Drug Policy. Others are policies and strategies that departments and agencies have adopted as part of their relationship with Māori.

Although we highlight a number of key policies and documents, we cannot reflect the wide and impressive range of initiatives and work people are doing in New Zealand. So when you read this issue, please view it as a sample rather than a summary. A further point in this regard: as shown by health, there is a limit to what a single agency can achieve on its own – health status is determined not just by health services but also by jobs, income and lifestyles. That is also why the National Drug Policy has an interagency approach, and why so many agencies and groups choose to work collaboratively on important projects.

While we describe some issues according to the harm caused, the overall picture is not negative. Departments, agencies, groups and individuals show strength in many ways. A certain courage is required to honestly assess the situation, to admit mistakes and to correct them (eg, in *Decades of Disparity*). Skill and vision are needed to devise and adopt policies that will have real effect and not just be for show (eg, the Department of Corrections' Te Mahere Rautaki Māori). A commitment to organise and work with others on difficult issues will ultimately take policy to people's lives (eg, the National Māori Tobacco Control Strategy and Te Matariki).

Māori mortality in the past

For information about the evolution of public health policy regarding Māori, see *Māori Health and Government Policy 1840–1940* by historian Derek Dow. Early colonial times saw Māori people dying from numerous new afflictions. Massive immigration meant their size in relation to Europeans shrank fast. In 1840 Māori outnumbered Europeans by about 40:1, but by the late 1850s their numbers were roughly equal. Some periods saw dramatic falls in absolute population numbers. For example, in the 17 years from 1858 to 1874, the number of Māori people

fell from 56,000 to 47,000. European numbers rose in the same period to 300,000. At the time there was a widely-held view that the Māori race was dying out.

Many committed efforts were made to address the situation. But worse was to come. In 1895–6 the Māori population sank to as low as 42,113. Young Māori leaders rallied to the cause. By 1920, Māori numbers were climbing again and had reached 57,000. The estimated Māori population in June 2002 was 597,000.

Ministry responds to newly corrected mortality figures

In July, the Ministry of Health published Decades of Disparity: Ethnic mortality trends in New Zealand 1980–1999. It not only challenges previous measurements of ethnic mortality, it describes the fundamental reasons why some ethnic groups suffer greater mortality and what the solutions are.

In New Zealand, as elsewhere, inequalities in health exist between ethnic and socioeconomic groups, people living in different geographic areas, people belonging to different generations, and between males and females. These inequalities are not random: in all countries, socially disadvantaged and marginalised groups have poorer health, greater exposure to health risks and lesser access to high-quality health services. In addition, indigenous peoples tend to have poorer health. In New Zealand the extent of these inequalities is unacceptable.

Historically, there has been an undercounting of Māori and Pacific deaths. This happened because the way ethnicity was recorded on death registration forms was different from the way it was recorded in the census. *Decades of Disparity* gives reliable estimates to correct the historical record. It helps us in understanding trends in ethnic inequality in mortality over a period of major social change. Don Matheson, Deputy Director-General (Public Health) comments: ‘The results are of great concern: while life expectancy has improved dramatically for the majority ethnic group over the past 20 years, for Māori and Pacific ethnic groups it has remained static. The key contributor has been differential chronic disease mortality in middle and older ages, especially ischaemic heart disease, diabetes and cancer mortality.’

‘This information should mobilise all sectors of government and the community – not just the health sector – to redouble our efforts to address this legacy of increasing ethnic inequality in survival chances. At the same time, the health sector clearly has a special responsibility to improve access to and provision of health care for those in greatest need,’ says Dr Matheson.

Some key points from *Decades of Disparity*:

- For non-Māori non-Pacific people there has been a steady increase in life expectancy. For males, it rose from 70.9 to 75.7 years (an absolute increase of 4.8 years). For females, it went from 77.2 to 80.8 years (an increase of 3.6 years). In contrast, Māori males only increased from 64.6 to 65.8 years (1.2 years) and Māori females from 69.4 to 71.0 years (1.6 years).
- Māori are comparatively more at risk of lung cancer, prostate cancer, breast cancer, ischaemic heart disease, respiratory disease and suicide.
- Even for those diseases with decreasing rates over time among all ethnic groups (eg, cardiovascular diseases), the relative inequalities between ethnic groups have tended to increase over time.
- Smoking is strongly associated with increasing deprivation and negatively associated with increasing income.
- Those on low incomes are less able to afford nutritious or healthy food.

Where to from here?

Decades of Disparity analyses the data and makes some broad policy recommendations. Reducing socioeconomic disparities between ethnic groups will lead to a reduction in health gaps, although the time lags for chronic disease mortality may be measured in decades rather than years. Therefore, the results of this report clearly support ongoing efforts outside the health sector to reduce social and ethnic inequalities in health.

- Risk factors such as tobacco consumption, diet and obesity might be tackled head-on. However, such programmes will have to be carefully implemented so as not to be victim blaming or unintentionally contribute to the widening of ethnic health gaps.
- Deficit model approaches, which aim to make Māori change to better fit current institutions, rather than changing institutions to better fit Māori, are unlikely to be effective.

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Health Sponsorship Council/ Te Rōpū Whakatairanga Hauora

The Health Sponsorship Council (HSC) was established in 1990, under the Smoke-free Environments Act, to promote health and encourage New Zealanders to enjoy healthy lifestyles.

Its core business is focused on being a social change agent, marketing social messages to New Zealanders. It uses all communication tools available, including sponsorship, to promote its health brands and communicate its messages. Ultimately, the HSC seeks to influence thinking and action among at-risk audiences.

The HSC has developed four health brands (Smokefree, Auahi Kore, SunSmart and Bike Wise) within its social marketing stable and promotes these through a range of marketing and communication devices including selected sponsorships, promotions and educational programmes and resources. As ill health from tobacco use is the number one health issue facing New Zealand, the HSC's initial focus was on the development of the Smokefree and Auahi Kore brands (encouraging smokefree lifestyles among Māori).

Social marketing

The HSC uses social marketing to promote health messages.

Social marketing influences attitudes and behaviours on social and personal issues by promoting desirable attitudes and encouraging positive behavioural change. It is a social change tool that aims to increase the acceptability of specific social behaviours and practices. Social marketing involves the application of marketing principles and techniques to social issues. It involves communicating social messages to an audience in a credible way, with the aim of influencing their thinking and actions.

Auahi Kore - Smokefree Māori brand

The Auahi Kore brand has been developed as a counter to negative smoking statistics amongst Māori; research suggests that nearly half (45 percent) of all Māori are current smokers compared to 23 percent of non-Māori.

Auahi Kore is seen as the ally of Smokefree. While both aim to achieve similar goals – reducing smoking prevalence and consumption – they

achieve them using different processes. Auahi Kore aims to make Māori culture smokefree. To achieve this, Auahi Kore seeks to develop a strong relationship between being 'Māori' and being 'Auahi Kore'.

Auahi Kore is the main brand that provides a rallying point for tobacco control for Māori. By having the same device (or logo) as Smokefree the HSC aims to have a bicultural brand, which increases the reach and effectiveness of both.

As a national brand, Auahi Kore is available for use by any health agency trying to get the smokefree message into Māori communities. Through the Auahi Kore programme the HSC aims to increase the number of Māori settings that are smokefree eg, marae and whānau gatherings, and Māori-dominant sports events.

One of HSC's long-term partnerships has been with traditional Māori performing arts. The HSC has been involved with the national festival for many years and has seen this develop from an event with a large number of smokers to one where smoking is not allowed in the main viewing areas. A key part of this is that performers and the audience have embraced Auahi Kore, meaning the smokefree areas are largely self-policed.

Through partnerships with traditional Māori activities such as performing arts, tā moko and waka ama the HSC supports the concept that, traditionally, Māori were a non-smoking people. Recently, the HSC has included a focus supporting the concept of Matariki, which is about the Māori/Pacific New Year. As the HSC progresses it will continue relationships with organisations that strongly support the Auahi Kore kaupapa.

Both Smokefree and Auahi Kore are about making changes, even small ones. For example, the HSC suggests that an excellent first step towards encouraging acceptance of the Auahi Kore kaupapa is to not smoke around your children. In response to this concept it developed the 'Light up their eyes' promotion. By using Māori images and te reo (resources are available in both English and Māori) the HSC aims to make the posters particularly relevant and eye-catching for Māori.

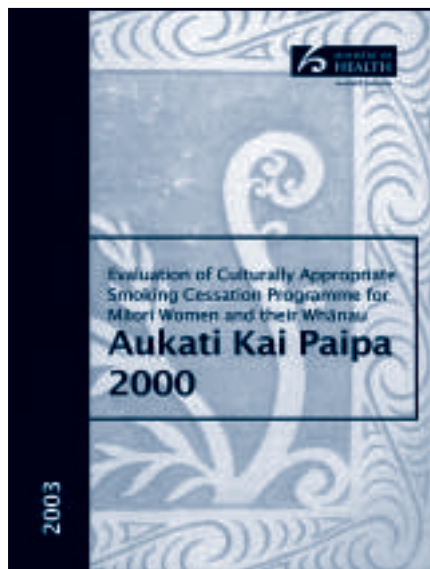
Contact: Iain Potter

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Aukati Kai Paipa 2000

An evaluation of a culturally appropriate smoking cessation programme for Māori women and their whānau was released in July 2003. The evaluation was prepared for the Ministry of Health by BRC Marketing and Social Research and Te Pūmanawa Hauora.



Programmes that combined Nicotine Replacement Therapy and counselling have been used successfully in other countries. Aukati Kai Paipa 2000, a smoking cessation pilot programme, was developed to test the viability of such an intervention in a Māori health setting. Māori played a major role in designing and delivering the programme.

The special nature of Aukati Kai Paipa that helped make it acceptable to Māori included:

- a Māori setting for programme delivery
- diversity in delivery of the programme
- delivery in a holistic health service setting
- quit coaches' strong ties with Māori communities
- the nature of quit coaching (counselling)
- whakawhānau (relationship-building) between pilot providers.

The pilot programme ran for two years from mid-1999, primarily targeting Māori women. It operated in seven locations, all of which were owned and operated by Māori. Counsellors and quit coaches were Māori. In effect, the programme was 'by Māori for Māori'. During the two years of the pilot, over 3200 Māori women and their whānau participated in the programme and its evaluation. This free service provided Nicotine Replacement Therapy in the form of skin patches and/or chewable gum, together with counselling support delivered by Māori quit coaches over a period of up to 12 months.

The specific objectives of the pilot programme and this evaluation were to:

- determine whether it reduced smoking prevalence, was an effective channel for delivering this intervention, was culturally acceptable, and was likely to be relatively cost-effective
- inform decisions about possible expansion of the programme following the pilot.

The Aukati Kai Paipa 2000 outcomes were as follows:

- Appropriate and accessible for Māori: the programme is acceptable to Māori participants, accessible and culturally appropriate.
- The programme is especially effective for Māori: the quit rate achieved by Aukati Kai Paipa 2000 is significantly higher than the quit rate recorded for Māori women smokers in the general population. Furthermore, given the sociodemographic characteristics and smoking/addiction profile of participants the programme should be viewed as especially successful.
- Aukati Kai Paipa 2000 is likely to be cost-effective: it will be important in any decision-making about the relative cost-effectiveness of Aukati Kai Paipa 2000 to consider that the programme has reached a 'hard-to-reach' group who tend not to access other services.

Aukati Kai Paipa 2000 is available on the Ministry of Health website at:
<http://www.moh.govt.nz>

Māori Tobacco Control Strategy Presented to Government

On 23 July, Apārangi Tautoko Auahi Kore (ATAK), the Māori Smokefree Coalition, presented its National Māori Tobacco Control Strategy 2003–2007 to representatives of the Government.

The ATAK coalition is made up of Māori health providers. As such, it is an important community network that directly focuses on Māori smoking.

The Strategy contains an overview of smoking-related harms as well as putting forward major policy proposals. The document suggests that:

- tobacco use has had devastating effects on Māori health, culture and language
- a third of Māori deaths (600–650) each year are due to smoking
- there is no evident decline in Māori smoking; 45.5 percent of all Māori smoke
- initiatives range from ‘by Māori for Māori’ programmes such as Aukati Kai Paipa to those within mainstream settings, such as the Quitline – Me Mutu
- the auahi kore community needs better co-ordination
- the vision is for Māori to reclaim their former traditional status as an auahi kore community.

The right to be healthy was fundamental to the Māori way of life prior to 1840. The Strategy seeks to encourage a full and effective Treaty-based decision-making process by and for Māori in all matters related to the development, governance and implementation of Māori auahi kore strategies.

Tobacco also affects the economic status of Māori. The cost burden from purchasing tobacco and the cost of tobacco-related absenteeism, premature death and illness is likely to be particularly severe for Māori.

Funding

The Strategy claims that government spending on tobacco control should be commensurate with tobacco-related revenues.

Connections with other policies and strategies

The Strategy notes its links with a number of related strategies:

- He Korowai Oranga – Māori Health Strategy
- Primary Health Care Strategy
- New Zealand Health Strategy
- National Drug Policy
- Māori Smokefree: Report on the hui for Māori smokefree programme development
- Framework Convention on Tobacco Control.

Tobacco industry

The Strategy characterises the tobacco industry as ‘the primary culprit behind the devastating effects that tobacco has had on the Māori population. This is an industry that has largely stayed in the background while the public health community has focused on countering the negative results of tobacco use.’ Any strategic framework must consider the tobacco industry in order to counter ‘the ongoing campaign that this industry wages against basic public health principles’ that deprives Māori of a valuable human resource.

Priority groups

The Strategy names three priority groups.

- Pregnant Māori women and their whānau. Nearly 60 percent of Māori women aged between 15 and 44 years are smokers. Forty-nine percent of Māori women smoke during pregnancy. There is a low demand from this group for cessation support.
- Rangatahi/tamariki. Rangatahi and tamariki have low success rates in quitting when they use existing treatment methods.
- Tāngata whaiora (Māori mental health clients, including polydrug users). This group has the highest smoking prevalence. There is also a high demand for cessation support from health workers and clients in this sector. Specialist approaches are required for an innovative cessation programme.

The Strategy calls for more investment in research, development of the Māori smokefree workforce, and litigation against the tobacco industry.

2003 National Auahi Kore Conference – He Matariki: A new beginning

A conference that plans to convert the National Māori Tobacco Control Strategy into priority actions took place 9–10 October. 'He Matariki: A new beginning' was held at Te Papa Tongarewa – The Museum of New Zealand. The Conference organising committee comprised Apārangi Tautoko Auahi Kore (ATAK), the Cancer Society, Health Sponsorship Council and Te Hotu Manawa Māori.

People attending the conference shared and developed innovative ideas and plans to make a difference to Māori tobacco control and to ultimately achieve Māori wellness. The organisers drew an analogy with traditional Māori explorers using the stars (the NMTCS framework) as guiding points to lead all waka (the audience) to their destination. 'Like our traditional explorers we are now embarking upon on a new journey for tobacco control among Māori by focusing on Māori aspirations for wellness.' The Conference theme was captured in the whakatauki:

*Huihuia mai nga rau o Matariki
He tohu no te whitu no te waru
Koia ra te oranga ki te ao marama*

*Assemble together the myriad stars of Matariki
Symbolic of new beginnings – a new growth and
austerity*

*This indeed is our salvation to wellbeing and
enlightenment*

The organisers noted that Māori tobacco control is a major health priority not just for Māori but for Aotearoa. The development of the National Māori Tobacco Control Strategy (NMTCS) signals a new beginning for people working in the Māori tobacco control arena. The NMTCS is a strategy developed from a tūturu Treaty-based framework, with a

particular focus on achieving Māori aspirations for wellness. The conference provided a new opportunity to unite for a concerted effort to make a real difference to Māori tobacco control.

'As we continue to move forward we need to think about where we have come from, what we have achieved and where we are going,' said the organisers. The conference explored:

- information sharing
- future strategies
- co-ordination
- collaboration
- measures of success.

Key outcomes anticipated from this Conference included:

1. a prioritised action plan for implementing the NMTCS
2. a clearer understanding of Māori tobacco control
3. a practical resource for planning and monitoring future work (includes a stocktake of current and proposed activities).

'He Matariki: A new beginning' aimed itself at several key stakeholder groups:

- Auahi Kore/Smokefree workers
- national Māori tobacco control providers
- researchers
- policy-makers and funders.

The Health Sponsorship Council administered the Conference on behalf of the Organising Committee. Contact Trevor Shailer, Kristal Hyde or Tane Cassidy on (04) 472 5777.

ALAC addresses alcohol and Māori

Māori whānau are one of three population groups targeted by the Alcohol Advisory Council (ALAC) in its drive to reduce alcohol-related harm in New Zealand.

ALAC is a Crown-owned entity. Its primary purpose is the encouragement and promotion of moderation in the use of liquor, the discouragement and reduction of the misuse of liquor, and the minimisation of the personal, social and economic harm resulting from the misuse of liquor.

To achieve this end, ALAC's strategic plan identifies three priority population groups – Māori, young people (aged 12 to 24) and Pacific peoples – and two priority intervention strategies that will drive all their activities.

The two intervention strategies focus on supply and provision of alcohol, and early intervention. While these will address the general population, they will also target Māori, young people and Pacific peoples.

There is evidence that Māori drinking patterns are different in some respects from those of other New Zealanders. Differences in drinking patterns, cultural values and social practices mean that specifically developed and targeted strategies are needed to reduce alcohol-related harm amongst Māori.

Although the proportion of Māori who drink is lower than that of the population as a whole, and those who do drink do so less frequently, the median annual volume of absolute alcohol consumed by Māori men is greater at 9.2 litres than the 7.4 litres consumed by men in the general population.

A recent national survey found that 44 percent of Māori male drinkers and 29 percent of Māori female drinkers consumed alcohol at hazardous levels. Māori drinkers were also more likely than most to drink five or more drinks on one occasion.

Māori also reported a higher incidence of problems arising from their own drinking and the drinking of others than did the population as a whole.

One in five Māori men considered their drinking was harming their health to a large or medium extent, and a similar proportion mentioned negative effects on their home life and finances.

Alcohol dependence or abuse is the leading cause of admission to psychiatric institutions for Māori men, and the second most common cause of admission for Māori women. Māori men are 2.7 times more likely to die of an alcohol-related problem than are non-Māori men.

To achieve its goal of Māori providers and Māori communities working together to reduce alcohol-related harm for Māori whānau, ALAC works to:

- resource Māori community development initiatives as a way of reducing alcohol-related harm
- support the further development and delivery of Manaaki Tangata and other health promotion programmes designed by Māori for Māori
- support the development of appropriate advertising and other marketing strategies for Māori to promote both moderation in the use of alcohol and the non-use option
- ensure all initiatives for age-related alcohol health promotion, especially those targeting youth and older people, also address the needs of Māori
- support the work of Māori wardens in the reduction of risky drinking practices by Māori
- ensure Māori communities are involved fully in developing policies on alcohol, including control regulation, education, treatment and research
- improve links between Māori communities and statutory agencies to ensure co-ordinated and integrated planning, and to avoid the separation of alcohol-related initiatives from other social and health-related initiatives.

ALAC hosted and supported a range of hui and wānanga with Māori communities to encourage and facilitate those communities to look at ways of addressing alcohol-related harm.

Support was also provided through training grants to upskill Māori working with whānau and through the Manaaki Tangata sponsorship programme that encourages safe alcohol use practices at Māori community events.

During the last financial year ALAC sponsored 58 separate events which covered a diverse range of activities including health expos, music concerts and regional sports awards.

One such event was Te Ra o Te Raukura, a health expo delivering wellbeing messages to Māori. It was originally established ten years ago by the local Māori radio station Atiawa Toa FM as a family day so that the local Māori community and kōhanga reo could fund-raise. The expo has since expanded into a major promotional event attracting more than 20,000 people.

ALAC works with Māori health providers. The Māori provider network was consulted through eight regional hui on the development of a high-quality assessment framework for Māori alcohol and drug services.

ALAC also strengthened its Māori capacity with the establishment of a Kaumātua Advisory Group. This Group both advises the Council and plays a key role in securing iwi and Māori community support to address alcohol-related harm.

ALAC is also working to establish a taumata, an advisory committee to provide leadership and guidance to both clinicians and Māori workers in the field.

The iwi radio programme designed to encourage rangatahi Māori to adopt safe-use practices with alcohol continued to be delivered through the Mai FM iwi radio network.

ALAC also worked to support current, and to provide assistance to establish new, Māori community networks. These will develop whānau and community programmes and initiatives to reduce alcohol and drug-related harm.

To find out more visit ALAC's website:
<http://www.alcohol.org.nz>

The Alcohol and Other Drug Treatment Sector Standard

The Alcohol and Other Drug Treatment Sector Standard (NZS 8157:2003) was officially launched at the recent 'Cutting Edge' conference held in Waitangi.

The standard provides minimum requirements that should be met by service providers offering treatment and support to the range of people who present with alcohol and other drug problems.

Although all mental health services will need to comply with the National Mental Health Sector Standard in particular, this Standard can be used by District Health Boards in contracting non-

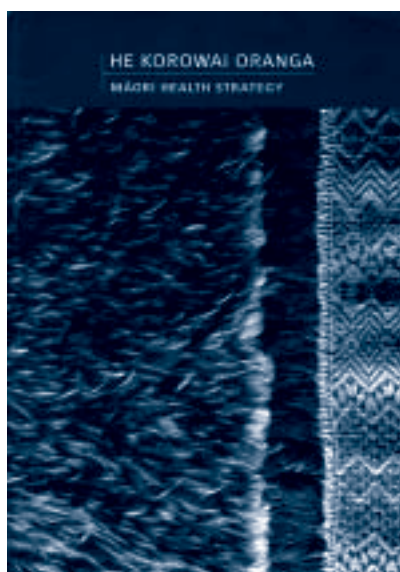
residential alcohol and other drug treatment services.

Towards the end of 2004, the Ministry of Health intends to undertake a review of the National Mental Health Sector Standard with the aim of ensuring alcohol and other drugs and problem gambling are better reflected throughout the new standard.

Copies of the new Alcohol and Other Drug Treatment Sector Standard can be purchased from Standards New Zealand, Private Bag 2439, Wellington 6020.

Four major health documents cover Māori health

The Ministry of Health has in the last two years produced four major health documents that focus on, or make clear comment on, the health of the Māori population. The first two documents are Government Strategies, the other two, Ministry documents. The documents consider the role of tobacco, alcohol and illicit drugs in the comparatively poor health of many Māori. They also propose useful actions the community can take to create improvements. Some of the key points from these documents are summarised below.



He Korowai Oranga: Māori Health Strategy

Reducing health inequalities between Māori and non-Māori is a key priority for the Ministry of Health. This was underscored in the national Māori health strategy and its action plan released by Health Minister, Hon Annette King and Associate Health Minister, Hon Tariana Turia.

He Korowai Oranga: Māori Health Strategy sets the direction for Māori health development in the health and disability sector for the next five to 10 years. Whakatātaka: Māori Health Action Plan 2002–2005 outlines what will be done to put the strategy in place.

'Improving the health status of Māori is a challenge all mainstream health and disability agencies must tackle,' said Director-General of Health, Dr Karen Poutasi, last November when she launched He Korowai Oranga: Māori Health Strategy.

Dr Poutasi said that, as a population, Māori have on average the poorest health status of any ethnic group in New Zealand.

'Māori life expectancy is eight years less on average than that of non-Māori, while Māori hospitalisation rates for all causes are nearly double those of non-Māori. This is not acceptable,' she said.

'We know that the factors that lead to poor health status are complex and include areas such as housing, income and education. Addressing these issues requires not only those in the health and disability arena, but also people in other sectors to understand the impact of their activities on health. We have to work together with Māori so we can improve health outcomes for all Māori around the country.'

She noted He Korowai Oranga and its action plan Whakatātaka expand on the principles and objectives for Māori in the New Zealand Health and Disability Strategies.

It also sets the direction for Māori health in other service or population-group strategies, including the Primary Health Care Strategy, the Health of Older People Strategy and the Public Health Strategy.

'The strategy and its plan are important pieces of policy that will help us all work on the very real quality of life issues whānau around New Zealand are facing. All families want the very best for their loved ones and the overall aim of He Korowai Oranga is all about that – supporting Māori families to achieve health and wellbeing,' Dr Poutasi said.

'It is important to note that this requires an approach that recognises and builds on the

integral strengths and assets of whānau, so that it encourages whānau development. Māori want more say in developing health and disability services to meet their needs, and this strategy will help achieve this.'

'There is a lot of work ahead of us if we are to get the desired health outcomes for whānau and Māori,' Dr Poutasi said.

'Some of this work is outlined in Whakatātaka, which looks at specific actions for the next two to three years. The Ministry, along with DHBs, will need to work closely with Māori to reach the goals of He Korowai Oranga.

'The Ministry will also be monitoring the implementation of He Korowai Oranga around the country so we can accurately gauge how well its overall goals are being met.'

The overall aim of He Korowai Oranga is whānau ora – Māori families that are supported to achieve the fullness of health and wellbeing within te ao Māori and New Zealand society as a whole. This aim builds directly from the New Zealand Health Strategy and the seven fundamental principles that should be reflected across the health sector, including acknowledging the special relationships between Māori and the Crown under the Treaty of Waitangi.

He Korowai Oranga recognises that both Māori and the Government have aspirations for Māori health and will play critical roles in achieving the desired outcome for whānau. Realising those aspirations requires putting into action the Treaty of Waitangi principles of partnership, protection and participation.

Three key threads woven throughout the strategy are:

- acknowledging Māori aspirations for rangatiratanga (control) over their own lives
- maintaining and building on the gains already made in Māori health
- reducing the inequalities that currently exist between the health and wellbeing of Māori and other population groups.

Whānau ora will be achieved through actions along four pathways:

- development of whānau, hapū, iwi and Māori communities
- Māori participation throughout the health and disability sector

- effective health and disability services
- working across sectors.

The Ministry of Health, District Health Boards (DHBs) and other government agencies are expected to work together with whānau, hapū, iwi and Māori communities and providers to achieve the objectives of He Korowai Oranga. The actions outlined in Whakatātaka must be progressed collaboratively and co-operatively within the sector and across sectors. Providers and national or local organisations such as the Public Health Association and other non-government organisations also have important roles to play.

The whole health and disability sector is responsible for improvements in Māori health and disability outcomes, and Māori development in the health and disability sector.

The implementation of the strategy is already under way, with many of its objectives and projects built into Ministry of Health work programmes and DHB annual and strategic plans.

Whakatātaka: Māori Health Action Plan 2002–2005

In their foreword to Whakatātaka, Health Minister, Hon Annette King and Associate Health Minister, Hon Tariana Turia noted, "Whakatātaka" is the weaving of strands, creating a pattern step by step, and eventually forming a taonga such as a korowai. The Māori Health Action Plan outlines the process to weave together both existing and the innovative activities across the health and disability sector, under the direction of He Korowai Oranga: Māori Health Strategy.'

The Ministry of Health's main roles in relation to Whakatātaka are to:

- provide leadership and support to DHBs, providers and Māori organisations in advancing the strategy, and to help co-ordinate their activities
- provide leadership in bringing other government sectors together to address wider issues affecting whānau health
- take the lead in a number of development projects
- progressively update the strategy and action plans, and advise the Government on other ways to improve Māori health
- manage DHB funding and performance
- monitor the implementation of the strategy

and, with iwi and Māori communities, evaluate its impact

- advise the Government on ongoing strategic and operational policy development.

Whakatātaka brings together the existing responsibilities of DHBs in regard to Māori health and places them in the context of the Māori Health Strategy. DHBs have statutory responsibilities to:

- recognise and respect the principles of the Treaty of Waitangi
- improve Māori health and reduce Māori health and disability inequalities
- involve Māori in their planning and decision-making
- build Māori capacity to provide for their own needs.

All DHBs must have Māori membership, and boards must ensure all their members are skilled and knowledgeable about Treaty of Waitangi and Māori health issues, and about their local Māori communities.

Over the next two to three years DHBs are expected to fully realise the potential of their relationships with iwi and Māori. They should be able to demonstrate sustainable results in improved access to services and better health and disability outcomes for Māori and their whānau.

Inhaling Inequality: Tobacco's contribution to health inequality in New Zealand

This report quantifies the contribution of tobacco to the loss in life expectancy experienced by males and females, different ethnic groups, and neighbourhoods varying in their degree of material deprivation. It concludes that the loss of health to tobacco accounts for about one-fifth of the gender difference in life expectancy at birth, one-quarter of the inequality between Māori and non-Māori, and one-third of the deprivation gradient. The report highlights the importance of tackling the root causes of social inequality, as well as treating the 'symptoms', such as smoking. Some key points:

- The prevalence of smoking among Māori was significantly higher compared to that in other ethnic groups.
- At the 1996 Census over 40 percent of all Māori

aged 15 and above identified themselves as current smokers, a level double that for Europeans.

- Māori smoking may largely be explained by the interaction between smoking and two sociodemographic factors: concentration of the Māori population in more deprived areas (which are associated with higher smoking prevalence) and their young population age structure (smoking prevalence peaks at young adult ages).

Reducing Inequalities in Health

This is a discussion document for the health sector. Ethnic identity is an important dimension of health inequalities. Māori health status is demonstrably poorer than that of other New Zealanders. Actions to improve Māori health also recognise Treaty of Waitangi obligations of the Crown. Pacific peoples also have poorer health than Pākehā. In addition, gender and geographical inequalities are important areas for action.

Addressing these socioeconomic, ethnic, gender and geographic inequalities requires a population health approach that takes account of all the influences on health and how they can be tackled to improve health. This approach requires both intersectoral action that addresses the social and economic determinants of health and action within health and disability services themselves.

Reducing Inequalities in Health proposes principles that should be applied to whatever activities we undertake in the health sector to ensure that those activities help to overcome health inequalities. The proposed framework for intervention entails developing and implementing comprehensive strategies at four levels.

1. Structural – tackling the root causes of health inequalities, that is, the social, economic, cultural and historical factors that fundamentally determine health.
2. Intermediary pathways – targeting material, psychosocial and behavioural factors that mediate the impact of structural factors on health.
3. Health and disability services – undertaking specific actions within health and disability services.

4. Impact – minimising the impact of disability and illness on socioeconomic position.

Intervention at these four levels should be undertaken nationally, regionally and locally by policy-makers, funders and providers.

The framework can be used to review current practice and ensure that actions contribute to improving the health of individuals and populations and to reducing inequalities in health. It also highlights the importance of factors outside the direct control of the health sector in shaping the health of our population. Those outside the health sector – particularly The Treasury, the social welfare, education, housing and labour market sectors, and local government – can contribute

significantly to the task of reducing inequalities in health. Success in reducing inequalities in health brings positive results for the individual, the economy and society. It enables New Zealanders to live healthier, longer lives. In turn, a healthier population will increase the country's prosperity.

For full texts of the four documents, visit the Ministry of Health website <http://www.moh.govt.nz>

Putting policy into action

Delaraine Armstrong of Ngā Manga Puriri, Northland, describes the service.

Ngā Manga Puriri is a network of 'communities for change', which means that we are Māori and mainstream providers, kaimahi, volunteers, community workers, kaumātua and kuia who all work with whānau, as either whānau groups or communities of whānau, throughout te Tai Tokerau.

While we originally came together to support whānau and communities affected by alcohol-related harm, over the past four years we have been able to 'bend' funders to be more responsive to our community-wide approach to supporting whānau with a range of challenges, including drugs, tobacco and gambling.

A key part of the network has been the realisation that there was no current blueprint for supporting Māori whānau and Māori communities in a modern context. So we have focused on leadership amongst those living in the communities in te Tai Tokerau to articulate the qualities and skills an agent for change who works with whānau should have. Those qualities, skills, values and practices are based in te Ao Māori and interpreted in a contemporary context.

We have tried to develop a vehicle to identify and provide training for those change agents and champions for change such as our kaumātua and kuia who work in their respective communities, by providing Te Wero me te Aranga: a training

programme mainly for Māori who work with whānau. Kaumātua and kuia now have a primary role in providing that programme in marae throughout te Tai Tokerau. It has been provided largely without funding so may not be flash, but is certainly heading in the right direction.

We see the fruits of these combined efforts in the strength of the network of people who share the same values and practices. They are role models for whānau wellbeing and live and labour in their own communities. They are now sharing their experiences with others, such as kaumātua and kuia in Ngai Tahu.

In November, 2003 they will host a national hui for kaumātua and kuia which will set the guidelines for doing similar things in a similar role in other communities throughout Aotearoa. In just a few lines, it is not possible to capture the real heart of the work, as there is no one thing which we have found to be the key ingredient to success.

Success comes from a combination of things which all gel together, like leadership, mentoring others, high-quality practice, supervision, kaumātua and kuia guidance, regular networking, training, common values and practices and having champions for change. Success needs sponsors who see the vision and understand the organic process which enables communities to determine their own standards of wellbeing and apply the principles in their own unique ways for the same outcomes.

Department of Corrections' Te Mahere Rautaki Māori

The Department of Corrections this year launched Te Mahere Rautaki Māori. This is its Māori Strategic Plan: 1 July 2003–30 June 2008.

The Department says that providing the 'right intervention' for Māori offenders begins with an acknowledgement of the specific needs of Māori. This places Māori cultural values, philosophies and practices to the forefront when considering solutions for addressing re-offending by Māori offenders. This approach is being incorporated in the Department's management of offenders from assessment to intervention, to ensuring that staff engage with Māori offenders in a way that is respectful of Māori culture and Māori world views.

The Department adopted a kaupapa statement for Te Mahere Rautaki Māori:

*Kotahi ano te kaupapa;
ko te oranga o te iwi.*

There is only one purpose (to our work); it is the wellness and wellbeing of the people.

Arising from this kaupapa statement is the department's policy statement: 'The Department of Corrections will work in partnership with Māori communities and government agencies to provide corrections services that will contribute to community safety and reduce re-offending. We will provide these services in a way that has regard to the Treaty of Waitangi as it affects Corrections so that "wellness and wellbeing of the people" is achieved.'

Māori Focus Units

There are five Māori Focus Units (MFUs) operating in our prisons, one each in Waikeria, Tongariro, Wanganui, Hawke's Bay and Rimutaka (Wellington). Each unit has 60 beds. The units provide a tikanga Māori environment. Within the units, inmates face the issues that lead to their offending. All units maintain links with local iwi, hapu and marae, and the staff are especially selected to support the kaupapa of the unit. The day is structured to include te reo and tikanga Māori activities, rehabilitation programmes, inmate employment and education.

An evaluation of the MFUs is planned for this financial year. Anecdotal evidence suggests there is significant attitudinal change amongst the inmates who live in them. Other cultural groups may benefit from the same approach. For example, a faith-based unit is due to be implemented at Rimutaka.

Priority areas

The Department has identified priority areas for the next five years:

- Māori involvement in decision-making within Corrections
- working more closely with Māori communities at a strategic and developmental level
- intersectoral approaches that will achieve better outcomes for Māori
- including and engaging Māori whānau and hapū
- a focus on early intervention and prevention
- integrating Māori world views in programmes and services
- building the responsiveness of the Department.

For all of these priority areas, the Department has listed its existing initiatives as well as new developments.

Tikanga Māori programmes

Māori providers deliver tikanga Māori programmes to offenders in the community and in prisons. They use Māori identity and values to motivate offenders to address their offending.

Rehabilitation programmes

A range of rehabilitation programmes address the factors underlying offending behaviour. These programmes are intensive and assist offenders to deal with, and be accountable for, their violence, alcohol and drug abuse and other factors relating to their offending. Alcohol and drugs play a significant role. Tobacco consumption is not a priority at this point, as offending rather than health issues is the biggest driver.

Youth Offending Strategy shows positive approach

In April 2002, the Ministry of Justice and the Ministry of Social Development published Te Haonga. This is the national Youth Offending Strategy: Preventing and reducing offending and re-offending by children and young people.

The Strategy builds on the strengths of the youth justice system and addresses its shortcomings. It keeps the foundations put in place by the Children, Young Persons, and their Families Act 1989. These include the use of police diversion when appropriate, Family Group Conferences, and the separation of youth offenders from the adult criminal justice system as much as possible. It is these foundations that make New Zealand a world leader in youth justice.

A successful Strategy has much to offer some young Māori. Since the early 1990s, young Māori have made up almost half of police apprehensions of children and young people. The Strategy details eight key principles to inform the youth justice sector: accountability, recognising the interests of victims, early intervention, protection, age and developmental appropriateness, best practice, consistency with the Treaty of Waitangi, and cultural responsiveness.

‘Protection’ means the vulnerability of children and young people entitles them to special protection during any investigation relating to

the possible commission of an offence. Responses to offending by Māori children and young people should be consistent with the principles of the Treaty, and support the aims and aspirations of Māori. They should also reflect the values, perspectives and cultures of the children and young people concerned, and strengthen the relationship between the Government and the different communities it serves.

The Youth Offending Strategy strongly supports early intervention and prevention initiatives to promote the wellbeing of children and young people, and their families and whānau. This includes working with families in the early years of a child’s life, as well as providing interventions as they grow older. By 2016, Māori are projected to constitute 27 percent of all New Zealanders under 17.

The Strategy has brought in positive new-style delivery mechanisms. These include local youth offending teams (Child, Youth and Family, the police, and the health and education sectors). These teams are overseen by a group of Ministers, and senior officials comprising the Youth Justice Leadership Group. There is also an Independent Advisory Group made up of key youth justice personnel, the Principal Youth Court Judge and community representatives.

Copies are available from the Ministry of Justice and Ministry of Social Development.

Ministry responds to newly corrected mortality figures

Continued from page 3

- Clinicians, managers, policy makers and governance bodies in the health sector have a particular responsibility to examine how their policies and practices contribute to the higher risk of premature mortality among Māori and Pacific populations.
- We need to scrutinise the ideologies that support the ongoing reproduction of social inequalities between Māori and non-Māori, and to determine how the circulation of these ideologies and stereotypes contributes to the maintenance of disparities.

A strengths-based approach and an insistence that the health sector takes responsibility for the part it plays in maintaining or reducing inequalities are embedded in current health legislation and consequential policy settings. This policy direction is supported internationally by the World Health Organization, which now monitors the performance of countries in reducing health inequalities. The Treaty of Waitangi also provides a foundation for the Crown to address Māori/non-Māori disparities. The evidence on ethnic inequalities in survival chances presented in *Decades of Disparity* shows the need to take action.

Māori providers address alcohol and other drug problems

A number of Māori health providers in many parts of the country seek to meet the needs of Māori in relation to the assessment and management of alcohol and other drug misuse and dependency. In offering a culturally relevant service they increase access and retention to treatment, which in turn have beneficial gains for individuals, whānau and the wider community.

Some of these dedicated services are NGOs while others are part of non-Māori organisations such as the DHB provider arm. The redevelopment of the dedicated Māori alcohol and other drug service specifications within the Ministry of Health, as well as practitioner competencies as part of the Drug and Alcohol Practitioners Association Aotearoa New Zealand (DAPAANZ), will further highlight the work of these services.

Services and practitioners that provide alcohol and other drug treatment from within a Māori framework can be found all over the country. For instance, in the far north members of the Ngā Manga Puriri network utilise much of the dynamics of whanaungatanga framework within their practice, while many other practitioners who have attended te ngaru training include the pōwhiri poutama models. Other places such as Ngā Punawai Aroha in Hastings are more eclectic in their approach.

Building on their success, some services are expanding. Rangataua Mauriora, based at Takapuwahia near Porirua, provides alcohol and drug counselling to rangatahi. It is opening a Wellington branch in October 2003. See <http://www.waiora.net.nz>

Much thought has also gone into development of a specialist workforce. Takarangi Metekingi works as an alcohol and drug counsellor/cultural therapist in Dunedin. With the support of a reference group, he is developing a list of clinical competencies for Māori practitioners working in the alcohol and drug field. These competencies

will next be considered by the Drug and Alcohol Practitioners Association of New Zealand. To contact Takarangi, email: moanahouse@earthlight.co.nz

A list of some Māori service providers can be found under 'Māori Health' on <http://www.moh.govt.nz>

Interesting websites



Valuable sites to visit and to tell others about.

<http://www.hpforum.org.nz>

Runanga whakapiki ake i te hauora o Aotearoa (Health Promotion Forum of New Zealand). National network of community groups promoting health. Includes transcript (December 1999 Newsletter) address by Professor Mason Durie on health promotion for Māori.

<http://www.alcohol.org.nz>

Site of Alcohol Advisory Council of New Zealand. Extensive data and material on alcohol, including its Māori unit, Te Rōpū Māori. History, manaaki tangata guidelines, strategy, sponsorships.

<http://www.healthsponsorship.co.nz>

National social change agent, the Health Sponsorship Council, markets health messages and brands, such as Smokefree and Auahi Kore. Includes info on the Quit/Me Mutu mass media advertising campaign, 'It's about whānau'. Data and resources.

<http://www.ndp.govt.nz>

The site of New Zealand's National Drug Policy has policy, information and links. Agencies work collaboratively. Useful data, media releases and material on drug-related legislation.