Tohatohaina atu ki te iwi – He kaupapa hauora Māori angitu

Takin' it to the people – Successful Māori health initiatives

He iti te kōpara kei te rērere ana i runga i te puhi o te kahika – *Although the bellbird is small it flies to the crown of the white pine. Achievement is not the result of stature. Even a person of humble station can attain success*

Uruuruwhenua Health and the Rural Otago PHO

Key contributor:
Francie Diver, Uruuruwhenua Health and Rural Otago PHO Māori Board member.

The Central Otago landscape is vast with significant numbers of seasonal workers coming into the area to service the fruit, wine and wool industries. From past experience the local Māori provider, Uruuruwhenua Health, and the Rural Otago PHO were aware that in particular the wool industry workers (the majority of whom are Māori) and whānau coming into the area had unmet health needs, for example, asthma, diabetes, CVD and sexual health.

Although Uruuruwhenua Health was actively engaging these workers and whānau, it was often difficult and problematic getting timely access to primary care services. The workers worked long hours, sometimes seven days a week, and had little knowledge of available health services. Nor were there effective relationships in place with health professionals.

To address these issues Uruuruwhenua Health and the Rural Otago PHO initiated a series of clinics using Services to Improve Access funding during 2008.

Evening clinics were held at various shearing quarters across Central Otago staffed by a GP and other health professionals, including a practice nurse, public health nurse, whānau ora worker and Māori mental health worker. The clinics were advertised through community networks, posters and flyers and importantly supported and promoted by the shearing contractors themselves - including information enclosed in workers pay packets.

The clinics were timed to begin at the start of the season and were well attended by the workers, their whānau and also the local community. As well as treating presenting issues, health promotion and better management of asthma and diabetes, the clinics enabled successful therapeutic relationships to be initiated between the health professionals in the region, the workers and their whānau. Along with the ongoing support of the whānau ora worker the initiation of these relationships "kanohi ki te kanohi" (face to face) ensured appropriate access throughout the season by workers and whānau to the required primary health services.

The health professionals knowledge of the wool industry and working with whānau was also greatly enhanced. This knowledge was able to be taken back and passed on to colleagues and clinical staff.

Similar clinics at shearing quarters within South Otago are also underway with the support of the Otago Southern Region PHO and Tokomairiro Waiora, a Māori provider based in Milton.

Hamilton East Medical Centre

Key contributor:
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This mobile practice nursing service is a joint venture between the Hamilton East Medical Centre (HEMC) and Waikato Primary Health with 28 hours per week funded by the PHO and seven hours by the practice. The practice also provides additional outreach immunisation resource.

The service improves access to primary health care for HEMC patients who for a range of reasons do not present to the clinic and are potentially experiencing health inequalities as a consequence. Key outcomes are focused on improved immunisation rate, care of the elderly and healthcare for patients identified as being at risk.

This service follows a similar model of care to that used successfully by many Māori providers and the former rural public health nurses by providing face to face visits to whānau within their own homes. Care is taken not to duplicate work being done by other services, e.g. wound care is still undertaken by district nurses.

The nurse assesses the patients health needs including analysis of the wider issues affecting their health, e.g. poor housing, lack of transport. A management plan is developed with the patient using the Flinders assessment model and the GP is kept fully informed at every stage.

Significant outcomes of the service, identified by independent evaluation include:

- Significant improvements in the number of Diabetic Annual reviews completed
- Improved monitoring and care of patients with complex problems and chronic disease(s)
- Increased referrals to other health and social services
- Reconnection of children with secondary services
- An increase in the percentage of children fully immunised at HEMC from 83.4% to 95.1%.

The service is successful in bringing care to people with known difficulties who are not accessing primary health care.

"It is hard for me to unravel some complex health and social problems in a short consultation with people with chronic conditions – to put my finger on things that might make a difference. She goes to their home and sorts it out."– GP comment.

These successful initiatives for improving Māori health were forwarded in response to our request in BPJ 18.