MAI Journal A NEW ZEALAND JOURNAL OF INDIGENOUS SCHOLARSHIP

DOI: 10.20507/MAIJournal.2024.13.1.12

UNDERSTANDING THE WORKFORCE FOR DIABETES MANAGEMENT WITH MĀORI AND PACIFIC PEOPLES

Using Tangata Hourua as the framework method for analysis of qualitative research

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Abstract

The aim of the study reported in this article was to explore the experiences of (1) people living with type 2 diabetes (T2D) and their whānau, and (2) kai manaaki, community health workers and dieticians who provide care to Māori and Pacific peoples living with T2D in the community. A key objective for this research was for its findings to inform workforce development strategies that will achieve equity for Māori and Pacific peoples with T2D and other long-term conditions. Using the Tangata Hourua framework, a Kaupapa Māori and Pacific research model, the experiences of people enrolled in Mana

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Tū—a mana-enhancing programme that supports people with poorly controlled T2D to "take charge" of their condition—and their whānau were gathered, analysed and then compared with the experiences of health workers. This approach has yielded new and rich knowledge strongly supporting the view that Māori and Pacific health workers who are based in the community are best positioned to make genuine relationships with Māori and Pacific clients and their whānau.

Keywords

diabetes, Indigenous, qualitative, Māori, Pacific peoples, workforce development

Introduction

Type 2 diabetes (T2D) is a common health condition in Aotearoa New Zealand. One in every four New Zealanders is pre-diabetic, with Māori, the Indigenous people of New Zealand, and Pacific peoples at significantly increased risk of developing T2D and its complications compared with other ethnic groups in New Zealand (Beaton et al., 2019; Harwood et al., 2018; Selak et al., 2018). T2D contributes substantially to the lower health status of Māori and Pacific peoples compared with New Zealand Europeans, with the gap predicted to increase along with T2D incidence (PwC, 2021). Such disparities in T2D are unjust and inequitable, avoidable, and detrimental to society.

Given the inequities in diabetes incidence by ethnicity in New Zealand, there is an urgent need for diabetes management programmes specific to Māori and Pacific peoples, including appropriate workforce development (Harwood et al., 2018; Selak et al., 2018). The current lack of effective programmes is partly due to the complex health, social and economic issues associated with T2D (PwC, 2021). However, one potential area for intervention is the workforce, as the benefits of an appropriately trained and culturally safe workforce are now well recognised, and positive effects on the treatment of diabetes in Indigenous populations have been reported (Beaton et al., 2019).The key features of such a workforce include an excellent understanding of the cultural beliefs, values and practices of intended recipients in addition to knowledge of their personal, family and community context of living with diabetes (Harwood et al., 2018). With the current health system reforms underway in New Zealand, including a commitment to deliver on equity, active protection, partnership, tino rangatiratanga and options for Māori (Future of Health, 2021), it is timely to plan, train and employ a workforce that will deliver on these commitments.

Diabetes care in New Zealand is currently provided by a wide range of people and services. Recently, a new type of workforce—kai manaaki (KM)—was introduced in communities via a programme called Mana Tū (which means "to stand with authority"). This Kaupapa Māori, Māori-led whānau approach to supporting Māori and Pacific peoples living with poorly controlled T2D and their wider whānau was delivered to almost 400 people across the North Island of New Zealand from 2017 to 2019 (Harwood et al., 2018). KM provide an intensive case management approach to diabetes self-management, supporting whānau (those with T2D diagnosis and their wider whānau) with poorly controlled T2D (defined as HbA1c > 64 mmol/mol) and addressing the wider social determinants of health (Harwood et al., 2018; Mullane, Harwood, Warbrick, Tane, & Anderson, 2022; Selak et al., 2018). A specific research framework, Tangata Hourua (lit., "strength in combining"; Mullane, Harwood, & Warbrick, 2022), was then developed in response to health-workforce-focused questions pertaining to the delivery of Mana Tū compared with other community-based health services for Māori and Pacific peoples with T2D.

Methodology

The study used qualitative methods underpinned by the Tangata Hourua framework (Mullane, Harwood, & Warbrick, 2022), an Indigenous research framework that draws upon Kaupapa Māori principles as outlined by G. H. Smith (1997), as well as Pacific values identified as common amongst Pacific communities residing in Aotearoa (Ministry for Pacific Peoples [MPP], 2018). Some of these core Māori and Pacific values and beliefs are outlined in Table 1 and can be understood as instruments through which Māori and Pacific people experience and make sense of the world (Marsden, 1988; Ryan et al., 2019). These instruments have been used to thematically analyse the data collected for this research study.

The Tangata Hourua framework has been used to accommodate, move with and adapt to the ever-increasing complexities of the growing Māori and Pacific populations in Aotearoa (Mullane, Harwood, & Warbrick, 2022) whilst showing the potential to positively inform robust research with

Māori and Pacific populations (Naepi, 2015). As a new, or at least adapted, way of doing research, the Tangata Hourua framework has multiple advantages, including being respectful to tangata whenua; being open to Pacific principles; addressing diverse Māori and Pacific identities; challenging the tensions in combining Kaupapa Māori with Pacific methodologies; and advancing knowledge, wellbeing and outcomes for future generations of Māori and Pacific peoples. The Western-oriented framework method (Gale et al., 2013) was used to apply the Tangata Hourua framework to the data obtained from the participant groups, enabling themes to be developed both inductively from the accounts (experiences and views) of research participants and deductively from an existing framework of themes. Key processes followed in using the framework method are outlined below.

Methods

Two sets of raw data were analysed, and the themes generated were then compared and contrasted using the combined qualitative approach of the Tangata Hourua framework, Kaupapa Māori and Pacific values, and the framework method (Gale et al., 2013). This combined analysis resulted in a unique set of themes derived from the views of Māori and Pacific individuals and whānau (as users of health services) and from those of the providers of health services (Kaupapa Māori and mainstream) that have not been published before.

A focus group method was chosen to promote individual and collective wellbeing. Key components in the protocol and process at the focus groups included:

- mihi by the lead researcher to initially greet and engage with participants (Lacey et al., 2011);
- opening with a karakia, and sharing genealogical, historical, cultural or sociopolitical links as a way of affirming a sense of familiarity and connectedness;
- informed consent forms being distributed to and signed by participants;
- locations that were accessible, appropriate and private;
- whakawhanaungatanga occurring at the beginning of the session to create a meaningful and reciprocal engagement, and to form a relationship that is sustained and maintained (Lacey et al., 2011); and
- discussions, recorded at each meeting, that were based around the following guided questions:
  1. What can you tell me about your role?
  2. What do you think is important to consider in working with Māori and Pacific peoples living with T2D?
  3. How do you know if you are effective?

On request, transcripts were sent to participants, who were invited to contact the lead author to discuss or request any changes to their interview statements. The transcripts were then reviewed by research team members (MH and IW) and discussed with the author in research hui. The language and subjective positioning of the author were explored from the perspectives of the research team and used to guide subsequent analysis.

Participants

The views of four stakeholder groups were sought in total: (1) KM, (2) community health workers (CHWs), (3) dieticians and (4) Māori and Pacific peoples with T2D and their whānau. Table 1 shows the ethnicity of the participants in groups 1–4.

Participants in groups 1–3 all delivered T2D programmes to Māori and Pacific peoples in the community and were asked their views on how best to meet the needs of Māori and Pacific peoples with T2D in the community. The primary data from groups 1–3 were collected by the lead author via focus groups. The views of participants in group 4 were sought via group interviews and consisted of Māori and Pacific peoples with T2D and their whānau, who were asked about their involvement of Mana Tū services and experiences working alongside a KM. The primary data from group 4 were collected by TT via interviews (see Tane et al., 2021) and are connected to the broader research programme that this study comes under (see also Harwood et al., 2018; Selak et al., 2018).

Ethics approval for groups 1–3 was obtained on 23 June, 2020 by the Auckland University of Technology Ethics Committee, reg. no. 20/8; ethics approval for group 4 was obtained from the New Zealand Health & Disability Committee (ref. 17/NTB/249/AM02). Research team.

The research team at the time of data collection and analysis comprised the lead investigator, workforce researcher and PhD candidate (TM—Fijian/Tongan woman); the lead Mana Tū researcher (MH—wahine Māori); the Mana Tū research manager and programme manager (TT—wahine Māori); and other members of the wider Mana Tū study, including other supervisors (IW—tāne

TABLE 1 Groups and ethnicity of participant types

Group	Type of participant	Number and ethnicity
1	KM – Mana Tū health workers	5 Māori, 1 Indo-Fijian
2	CHWs working in communities with mostly Māori and Pacific people with T2D	2 Māori, 2 Pacific people (Cook Island Māori and Samoan), 4 New Zealand European
3	Dieticians working in the same communities with mostly Māori and Pacific people with T2D	3 Pacific people (Tongan and Cook Island Māori), 4 New Zealand European
4	Māori and Pacific people with poorly controlled T2D enrolled in the Mana Tū programme and their whānau	32 Māori and Pacific people 10 whānau members

Māori, VS—New Zealand European woman, AA—wahine Māori).

Data analysis

The primary data from groups 1–3 provided credible evidence as to how health workers viewed their work delivering preventative diabetes programmes to Māori and Pacific peoples in the community.

The primary data from group 4, meanwhile, gave a voice to Māori and Pacific individuals and their whānau as to their experience of being part of a unique Kaupapa Māori service which included KM. The interviews with participants from group 4 had been analysed previously (Tane et al., 2021); the raw data was re-analysed for the current research project.

Every transcript was read and re-read to ensure the researchers' familiarity with the whole data set. Interesting segments of text were then highlighted—these could range from only a few words to parts of sentences or whole paragraphs—and were coded and interpreted in terms of their relation to the Tangata Hourua framework, with conceptually related codes grouped together, confirmed, and then given a brief definition which formed the initial analytical framework.

Results

The multicultural/multidisciplinary research team (details above) analysed the group 4 data that looked at the views of clients with T2D (and their whānau in some cases) on their experiences with KM staff delivery of the diabetes programme in community settings, which was then aligned to the views of the KM (group 1), then contrasted with the views of other health workers (groups 2 & 3) who delivered similar programmes. In the collective data thematically analysed using the Tangata Hourua framework, seven themes were identified, as outlined in Table 2.

1. Whanaungatanga, reciprocal relationships

Whanaungatanga is significant and can be described as knowing one's relationships to people and land, with relationships through blood ties and kinship often recited by elders, and relationships with other iwi and peoples across Polynesia (Mane, 2009). All participants in this study acknowledged that whanaungatanga was an essential component of health user–service relationship. Clients also noted that the culturally based approach to relationships of Mana Tū ensured the inclusion of extended whānau, so diabetes management became a whānau affair:

> I have been a frequent user of the service, being diabetic, plus also with my family … [This means the service] knows us, knows our conditions … has that relationship with us, which I think is really important for Māori. (Tane, Male)

The building and maintaining of relationships requires a sense of reciprocity, accountability and mutual respect (L. T. Smith, 1999; Tomlins-Jahnke, 2008). Implicit in these relationships are clear roles and responsibilities (Mane, 2009) which KM said supported them to establish a strong relationship, build rapport and consider things from another's perspective. This enabled them to build their knowledge and expertise. For one Māori KM, whanaungatanga meant taking the time to see it from their eyes, helping them to address things that are uncertain or correct any information that's not quite accurate, making a significant difference, which included valuing of their time and what they're talking about."

CHWs and dietician participants also agreed

TABLE 2 Tangata Hourua framework core Kaupapa Māori and Pacific values and themes

Core Kaupapa Māori principles	Definition	Core Pacific principles	Themes
1. Whanaungatanga	Process of establishing relationships	Caring and reciprocity	Reciprocal relationships
2. Ako Māori	Culturally preferred pedagogy	Connectedness and relationships between the individual, family and community	Reciprocal teaching and learning
3. Kaupapa	Philosophy		Shared vision
4. Whakapapa	Genealogy	Unity, holism	Connections of time and space
5. Tino rangatiratanga	Self-determination	Respect	Leadership
6. Tikanga	Customs, meanings, practices	Love/humility/caring	Doing and being right
7. Te reo	Māori language	Culture/language, customs and protocols	Informed

that whanaungatanga was essential to meaningful sustainable interactions. Two Pacific dieticians felt that the connection with the family occurred in steps: "build[ing] up a relationship, establishing a really good rapport … build[ing] trust to them." However, they also felt that this was more challenging in their roles as they were restricted by limited session times and funding. Clients reported similar experiences with non-Mana Tū staff: "Because no one has ever really worked with me, with my diabetes, ever. I just used to stay home and just do nothing" (Hine, Female).

2. Ako Māori, reciprocal teaching and learning

Ako acknowledges teaching and learning practices that are inherent and unique to Māori, as well as practices that may not be traditionally derived but are preferred by Māori (G. H. Smith, 1997). These practices are grounded in the concept of reciprocity, where everyone is empowered to learn with and from each other (Ministry of Education, 2022). Participants suggested that the location of diabetes management was critical to ako. The delivery of services in traditional cultural settings such as marae for Māori and churches for Pacific peoples was effective in shifting power to clients, due to their experience of cultural affirmation (Mullane, Harwood, Warbrick, Tane, & Anderson, 2022). Marae-based sessions received positive comments such as "Well from day one for me the marae was very welcoming you know. You sense, you feel a sense of aroha" (Mere, Female). A KM also saw the benefits of clients feeling empowered:

> Being based on the whenua of a marae is key to what we do and how we do it … Being on the marae and having the marae support, working within an organisation that is guided by Kaupapa Māori values.

Marae also provided a place where wider whānau felt supported to be engaged: "Having whānau and family there and involved because Māori and Pacific work is more whānau-based and collaborative ... connecting with the whole family" (Hone, Male).

Non-Māori and Pacific health workers also recognised the importance of being in their clients' comfort zones and getting out of their own in order to be effective, with a New Zealand European CHW commenting: "My feeling is we work in the community, we are based in Ōtara, people see us out there. We are not part of the hospital, we are in a place for people to come to and make it more comfortable."

3. Kaupapa, shared vision

Kaupapa or shared vision was reflected by the health workers who worked in multidisciplinary teams (MDTs). They felt MDTs enriched their work with Māori and Pacific peoples with T2D as they were strength-based—that is, different members of the health team had different roles based on

their strengths or expertise (Mullane, Harwood, Warbrick, Tane, & Anderson, 2022). This was strongly supported by clients: "So, must be about nine years. Eight or nine years I've been with [clinic name]. But I personally wouldn't change anything about it … everybody's incorporated" (Eru, Male).

A Māori KM noted that the MDT approach supported "the capacity of us to be the link between the clinicians and the whānau, 'cause a lot of the time the whānau was unable to be honest with the clinician for fear of judgement." A strength was that MDTs allowed the same message to be communicated but in different ways. KM also commented that having experts working together as a collective improves clients' knowledge and wellbeing, as well as service provider efficiencies.

4. Whakapapa, connections over time and space

For Māori and Pacific peoples, whakapapa is an important cultural practice that links people and specific places *together* (MPP, 2018; L. T. Smith, 1999). Participants spoke of the importance of making links, suggesting that having more Māori and Pacific health workers would improve healthcare and health outcomes: "Having a Māori [diabetes worker] is important for me 'cause they kind of understand the cultural element of things, and also the spiritual aspect of health … so, you know, having those common beliefs" (Naki, Male). This included common Māori values and the belief "that caring is aroha, and I always say manaakitanga" (Mere, Female). When these core Māori values were not present, as experienced with non-Māori and non-Pacific health professionals, their diabetes was often not controlled: "No one has ever really worked with me, with my diabetes, ever. I just used to stay home and just do nothing" (Hone, Male).

KM spent a lot of time initially remedying past hurts, undertaking significant groundwork with clients who had had negative experiences with other health professionals. One KM commented: "Basically, people are getting told off all the time … hence people won't pitch up to some of those appointments anymore … They think we are going to judge them and tell them what to do."All health workforce participants advocated for building the Māori and Pacific workforce, which they felt would best meet the needs of the clients and whānau, with one European dietician observing: "Greater recruitment of Māori and Pacific into health professional roles is really important … The reality is we don't have enough Pacific or Māori in the dieticians." One European CHW suggested:

> Having someone who is Māori or Pasifika working in the team is essential. Having a PI [Pacific Islander] involved in the delivery of the programme … from that ethnic background … she can engage with them in a way that I can't and that's good.

One New Zealand European dietician was acutely aware of their own conscious/unconscious biases: "To put it bluntly [it's] a very white health system … A whānau approach is definitely not included in the way we deliver our services."

5. Tino rangatiratanga, leadership

Tino rangatiratanga has been defined as self-determination, sovereignty, independence and autonomy. Individuals and communities experience tino rangatiratanga and positive wellbeing when hauora services include active protection, partnership, equity and options (Te One & Clifford, 2021). This aligned with participants' views about a diverse diabetes workforce providing choices: "[The KM has] been really helpful in regard to that knowledge and gaining different options" (Tangi, Female).

Having data on the effectiveness of various programmes supported workers in decision making, with one KM taking pride in the results achieved by Mana Tū at both individual and population level: "Mana Tū was a very successful programme, and the research shows that we did have major successes, and a few people have sustained the changes." They were able to recognise and articulate the role they played in achieving good outcomes: "Offering appropriate follow-up, appropriate cultural support and understanding what they are saying, all those things … we are loving them by removing barriers."

KM felt that leadership development, which was formally built into their professional development (PD), empowered and inspired them to want to do their best for clients: "They helped us to develop to the strengths of ourselves and recognise that when we needed some PD, we would upskill, yeah, and also to cater to our communities that we were working with."

6. Tikanga, doing and being right

Clients were clear the role of tikanga had in their diabetes management with Māori and Pacific whānau, which requires love and compassion, humility, and a sense of humour. Such an approach has wide-reaching benefits, as one participant said of Mana Tū: "I've found it beneficial. I've found it nurturing. I've found it learning. I've found that I've been given more options, so instead of

being crucified, of being judged, I've been taught" (Wiremu, Male).

KM had also had clear and definite views of how they were making a difference: "Connectivity, that they were happy to see me, and they wanted to see me … They were eager to try new things, they were excited. Just that they showed up [to the] appointment, they came." Some of the CHWs and dieticians also knew when they were making a connection through "aha moments": "They are smiling today … They brought their daughter or someone with them to learn some more with them."

It was noted by clients and their whānau that interactions could be different when they were dealing with non-Māori:

> There was another health nurse that I use to meet with, who I didn't get on with. She was not Māori and because of certain words that she said [to me] that I didn't agree with … we started arguing, and I was like, wow, that should not happen.

There was acute awareness from clients and their whānau as to who they thought best met their needs in ways that led to better engagement with the service provided, as outlined in the positive and negative experiences above. To complement these views, New Zealand European health workers reflected that they were not the most appropriate people to deliver these services and acknowledged the choice Māori and Pacific clients made when deciding not to engage with them.

7. Te reo, informed

Providing a strong foundation for clients' sense of wellbeing and belonging were Indigenous languages and culture, which facilitated healthy relationships within families and communities (MPP, 2018). Clients and whānau noticed when the right language and approaches were used, explained and understood. One whānau member commented: "[The client has] always come away being clear and understanding, because their kōrero is more important to her wairua as opposed to me and my sister trying to sort of awhi and take care of her" (Mere, Female).

KM also agreed that appropriate communication and language was important for fitting with the intended Māori and Pacific audience, which they felt was about "knowing their language, respecting the cultural differences, respecting them." One KM noted that language worked best when it was "simple … [with a] non-judgemental lens, taking that judgement out ... We don't use jargon from the clinic, we use everyday language that we/they know." Ensuring a strength-based approach meant their role was to "just chill out, listen … because a lot of times when they talk, they actually come up with the solution—you don't have to do anything. [We] don't make assumptions that we know any more than they do."

A Pacific CHW's approach to groups used the idea that the curriculum needed to educate and support clients to take ownership of their own health and environment, which included "breakfast clubs, student health councils, after-school sports, dance workshops, workshops, meetings with key stakeholders, a place for the kids to eat that's sheltered." Group education was also an integral approach of two Pacific dieticians, but one noted it came with challenges, such as

> the logistics of how to get a group of people together … I mean, do you try to get a pan-Pacific group together and deliver it in English or do you get a Tongan group … or a Samoan group together?

A New Zealand European dietician connected with the importance of "let[ting] them talk [and] tell the[ir] story—then you will pick up history" and had amended her practice to allow this. Overall, there was recognition amongst both clients and health workers of the importance of resources being contextualised to the culture individual clients identified with. Again, clients were clear about how they felt when communication was not clear: "I didn't fully understand it, and it wasn't explained properly" (Rangi, Male).

Discussion

This critical qualitative Kaupapa Māori and Pacific investigation into (1) the experiences of people enrolled in Mana Tū and their whānau, and (2) their experiences with KM (in contrast to other CHWs) has yielded new and rich knowledge. Our findings align with some of the core values and principles of the Tangata Hourua framework (Mullane, Harwood, & Warbrick, 2022). For participants in this research, whanaungatanga, or reciprocal relationships, enabled an inclusivity that included their extended whānau. Ako Māori, or "our way of being", was contextualised by whānau as to the location of diabetes management services, with recommendations for non-clinical, traditional cultural settings such as marae for Māori and churches for Pacific peoples. A kaupapa, or shared vision, was more likely to exist in MDTs which were strength-based in the sense that different members of the health team had different roles

based on their strengths or expertise (Mullane, Harwood, Warbrick, Tane, & Anderson, 2022). Whakapapa, or connections, occurred when clients saw "people like me" because those health workers best met their cultural needs.

For clients, tino rangatiratanga, or leadership, meant being able to make choices from a range of options on what would best suit them at that time; for health workers it meant support and validation of a Māori-for-Māori approach, feeling trusted, and being part of the organisation that offered PD programmes that were Kaupapa Māori- and Pacific-led. Tikanga for the clients was about the right way of doing things, which meant that being tika, or correct, in diabetes management with Māori and Pacific whānau requires love and compassion, humility and a sense of humour. The use of te reo, or the appropriate language, by health workers can inform and enable a strong foundation for connections between relationship, language and identity, which increased personal mana for Māori and a sense of wellbeing and belonging that facilitated healthy relationships within families and communities for Pacific peoples.

For the clients, their whānau and the KM involved in Mana Tū, there was a strong connection with a service that was culturally responsive and aligned to their own cultural values. Non-Māori CHWs and dieticians also agreed that a culturally responsive service was appropriate, which meant, among other things, the inclusion of more Māori and Pacific peoples to deliver the service in the community. A multidisciplinary approach was not a key feature brought up by the dieticians, but was heavily endorsed by the clients, whānau, KM and CHWs as an essential component of positive experiences. Non-clinical approaches and environments were also seen as an essential component, even by the dieticians who, traditionally, are based in a hospital setting.

In summary, clients and whānau appreciated and better engaged with health workers who (1) could meet their needs culturally; (2) spoke their language or spoke in non-clinical terms that could be easily understood; (3) understood who they were and the communities they came from; (4) provided services that were adaptable and non-clinical in their approach, such as where they were delivered; and (5) provided a multidisciplinary approach. The clients and their whānau highlighted how a multidisciplinary approach engaged them with their health worker and the services they provided. Furthermore, a multidisciplinary approach and collaboration between agencies and/or between lay and professional groups was seen as essential to improving services by all those who worked in this model of delivery.Other aspects that positively contributed to the client/whānau experience were face-to-face interaction and flexibility as to where the services were provided. Special mention was given to marae-based services, and the mixture of individual visits as well as groups, which they felt created a *whānau environment*. Building the feeling of tino rangatiratanga was important for the KM who worked under the Mana Tū umbrella, and this aligned with the government's priorities for health research and service development that contribute to Māori health and eliminate health inequities (Ministry of Health, 2022). This feeling was also spoken about by the clients and their whānau as something they were able to experience in their relationship with diabetes and their ability to control their destiny.

Strengths and limitations

As with all research, there are both strengths and limitations in this analysis. Firstly, qualitative research is subjective (Harris et al., 2006), and this study has presented accounts from clients and their whānau who were engaged with the Mana Tū programme about their experiences with KM and then compared those accounts with the experiences of other health professionals. Therefore, the findings are not generalisable beyond these samples. As the primary researcher's interpretation and subsequent analysis of client and whānau narratives is subjective (Braun & Clarke, 2006), peer and supervisor review were sought to ensure that the analysis was fair and balanced.

Conclusion

There is an urgent need for health services to acknowledge the challenges that many people face when engaging with the New Zealand health system. More integrated and seamless services are required that care for those who need them most (Ryan et al., 2019). Achieving equitable outcomes for Māori, Pacific peoples and people living with T2D in their communities demands a healthcare system that is specifically designed to achieve health equity.

Viewed optimistically, the recent health reforms provide an opportunity to create a transformative, equitable, accessible, cohesive and people-centred healthcare system that focuses on working in partnership with Māori, honouring te Tiriti o Waitangi and improving the wellbeing of all New Zealanders (Ministry of Health, 2022). This reset in the health system should not be viewed

as starting from scratch, as the collective pool of knowledge amassed by tangata whenua and by people from Moana-nui-a-Kiwa is both deep and broad. The understanding around hauora as holistic, with a focus on whānau, hapū, iwi and community wellbeing for all, not just a few, should be seen as a chance to centre Indigenous knowledge and leadership in a way that is focused on strength-based solutions to move Māori and Pacific health from the margins to the centre.

Acknowledgements

The authors wish to acknowledge the participants of the focus groups and the Mana Tū clients and their whānau who contributed their time and shared their views and stories for this research.

Glossary

ako Māori	culturally preferred pedagogy
aroha	affection, sympathy
awhi	embrace
hapū	subtribe
hauora	wellbeing
hui	gathering, meeting
iwi	tribe
kai manaaki	skilled case managers delivering the Mana Tū programme
karakia	prayer
kaupapa Māori	Māori values and knowledge
Kaupapa Māori	Māori approach; based within a Māori worldview
kōrero	conversation
mana	wellbeing, control
manaakitanga	hospitality, kindness
Mana Tū	lit., "to stand with authority"; a mana-enhancing programme that supports people with poorly controlled type 2 diabetes
marae	traditional meeting house
mihi	greeting
Moana-nui-a-Kiwa	Pacific Ocean
tāne	man
Tangata Hourua	lit., "strength in combining"; Indigenous research framework
tangata whenua	Indigenous people of New Zealand
te reo	Māori language
te Tiriti o Waitangi	the Treaty of Waitangi
tika	correct
tikanga	customs, meanings, practices; right or correct way to do things
tino rangatiratanga	self-determination
wahine	woman
wairua	spirit, soul
whakapapa	genealogy and lineage
whakawhanaungatanga	process of establishing relationships
whānau	family members
whanaungatanga	connection or reciprocal relationships
whenua	land

References

Beaton, A., Manuel, C., Tapsell, J., Foote, J., Oetzel, J. G., & Hudson, M. (2019). He Pikinga Waiora: Supporting Māori health organisations to respond to pre-diabetes. *International Journal for Equity in Health*, *18*(1), Article 3. https://doi.org/ggbf8m

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/fswdcx

Future of Health (2021). The future of health. https://www.futureofhealth.govt.nz/

Gale, N. K., Heath, G., Cameron, E., Rashid, S., & Redwood, S. (2013). Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC Medical Research Methodology*, *13*(1), Article 117. https://doi.org/f5khm7

Harris, R., Tobias, M., Jeffreys, M., Waldegrave, K., Karlsen, S., & Nazroo, J. (2006). Effects of self-reported racial discrimination and deprivation on Māori health and inequalities in New Zealand: Cross-sectional study. *Lancet, 367(*9527), 1958–1959. https://doi.org/dbj2wn

Harwood, M., Tane, T., Broome, L., Carswell, P., Selak, V., Reid, J., Light, P., & Stewart, T. (2018). Mana Tū: A whānau ora approach to type 2 diabetes. *New Zealand Medical Journal*, *131*(1485), 76–83.

Lacey, C., Huria, T., Beckert, L., Gilles, M., & Pitama, S. (2011). The Hui Process: A framework to enhance the doctor–patient relationship with Māori. *New Zealand Medical Journal*, *124*(1347), 72–78.

Mane, J. (2009). Kaupapa Māori: A community approach. *MAI Review*, (1), Article 1. http://www.review.mai.ac.nz/mrindex/MR/article/download/243/243-1710-1-PB.pdf

Marsden, M. (1988). *The natural world and natural resources. Māori values systems and perspectives* (Resource Management Law Reform Working Paper No. 29, Part A). Ministry for the Environment.

Ministry for Pacific Peoples. (2018). *Yavu: Foundations of Pacific engagement*. https://www.mpp.govt.nz/assets/Resources/Yavu-Booklet.pdf

Ministry of Education. (2022, May 10). *Creating a supportive learning environment*. https://senior-secondary.tki.org.nz/Health-and-physical-education/Pedagogy/Supportive-learning-environment#Ako

Ministry of Health. (2022). *Diabetes*. https://www.health.govt.nz/your-health/conditions-and-treatments/diseases-and-illnesses/diabetes

Mullane, T., Harwood, M., & Warbrick, I. (2022). Tangata Hourua: A framework drawing from Kaupapa Māori and Pacific research methodologies. *AlterNative: An International Journal of Indigenous Peoples*, *15*(1), 52–61. https://doi.org/k7rt

Mullane, T., Harwood, M., Warbrick, I., Tane, T., & Anderson, A. (2022). Understanding the workforce that supports Māori and Pacific peoples with type 2 diabetes to achieve better health outcomes. *BMC Health Services Research*, *22*(1), 1–8. https://doi.org/k7rv

Naepi, S. (2015). Navigating the currents of Kaupapa Māori and pan-Pacific research methodologies in Aotearoa New Zealand. *MAI Journal*, *4*(1), 71–84.

PwC. (2021). *The economic and social cost of Type 2 diabetes*. https://healthierlives.co.nz/wp-content/uploads/Economic-and-Social-Cost-of-Type-2-Diabetes-FINAL-REPORT.pdf

Ryan, D., Grey, C., & Mischewski, B. (2019). *Tofa Saili: A review of evidence about health equity for Pacific Peoples in New Zealand*. Pacific Perspectives Ltd.

Selak, V., Stewart, T., Jiang, Y., Reid, J., Tane, T., Carswell, P., & Harwood, M. (2018). Indigenous health worker support for patients with poorly controlled type 2 diabetes: Study protocol for a cluster randomised controlled trial of the Mana Tū programme. *BMJ Open*, *8*(12), Article e019572. https://doi.org/k7rw

Smith, G. H. (1997). *The development of Kaupapa Māori: Theory and praxis* [Doctoral thesis, The University of Auckland]. ResearchSpace. http://hdl.handle.net/2292/623

Smith, L. T. (1999). *Decolonizing methodologies: Research and indigenous peoples*. Zed Books.

Tane, T., Selak, V., Hawkins, K., Lata, V., Murray, J., Nicholls, D., Peihopa, A., Rice, N., & Harwood, M. (2021). Māori and Pacific peoples' experiences of a Māori-led diabetes programme. *New Zealand Medical Journal*, *134*(1543), 79–86.

Te One, A., & Clifford, C. (2021). Tino rangatiratanga and well-being: Māori self-determination in the face of Covid-19. *Frontiers in Sociology*, *6*, Article 613340. https://doi.org/g8tt

Tomlins-Jahnke, H. (2008). The place of cultural standards in Indigenous education. *MAI Review*, (1), Article 1. http://www.review.mai.ac.nz/mrindex/MR/article/view/100/107.html