

LITMUS

The literature review report on the design features to improve equity for Māori in the WCTO programme

Prepared for:
Ministry of Health
Te Manatū Hauora

8 August 2020

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Acknowledgements

This report was written by Liz Smith, Litmus Partner. We thank Maria Marama, Marty Rogers and Dr Nikki Turner for their advice, guidance, and peer-review. We also thank Alison Hussey, Principal Advisor and Anna Foese, Portfolio Manager of the Well Child Tamariki Ora team in the Ministry of Health for their advice and support.

Executive summary

Rationale and context for the literature review

The Ministry of Health (the Ministry) is reviewing the Well Child Tamariki Ora (WCTO) programme. The Ministry commissioned Litmus to do a literature review and qualitative research with whānau Māori to inform the review.

The purpose of the literature review is to understand the design features of models of care for child health and wellbeing, which increase enrolment, engagement, participation, and retention over time to improve equity outcomes for Māori. The qualitative research explores whānau Māori moemoeā of pēpi/tamariki health and wellbeing.

Strong evidence supports the value of having a universal proportionate well child programme in Aotearoa (i.e., one that offers services to all children and proportionately offers extra services to those who need more). However, inequities of access and outcomes for whānau Māori are evident within the WCTO programme, which is inconsistent with the Ministry's obligation under Te Tiriti o Waitangi (the Treaty of Waitangi; Te Tiriti).

Te Tiriti o Waitangi establishes the rights-based approach to the WCTO review

The redesign of the WCTO programme must align with the rights of Māori under Te Tiriti o Waitangi. The Ministry of Health's (2020, p.7) expression of Te Tiriti has four goals:

- **Mana whakahaere:** effective and appropriate stewardship or kaitiakitanga over the health and disability system.
- **Mana motuhake:** enabling the right for Māori to be Māori (Māori self-determination), to exercise their authority over their lives, and to live on Māori terms and according to Māori philosophies, values and practices, including tikanga Māori.
- **Mana tangata:** achieving equity in health and disability outcomes for Māori across the life course and contributing to Māori wellness.
- **Mana Māori:** enabling ritenga Māori (Māori customary rituals), which are framed by te ao Māori (the Māori world), enacted through tikanga Māori (Māori philosophy and customary practices), and encapsulated within mātauranga Māori (Māori knowledge).

Five principles guide the Ministry's approach:

- **Tino rangatiratanga,** which provides for Māori self-determination and mana motuhake. This means Māori are key decision-makers in the design, delivery, and monitoring of health and disability services.

- **Equity**, which requires the Crown to commit to achieving equitable health outcomes for Māori and to eliminate health disparities.
- **Active protection**, which requires the Crown to act, to the fullest extent practicable, to protect Māori health and achieve equitable health outcomes for Māori.
- **Options**, which requires the Crown to provide for and properly resource kaupapa Māori services in the WCTO programme.
- **Partnership**, which requires the Crown and Māori to work in partnership in the governance, design, delivery, and monitoring of health and disability services.

We have considered the findings of the literature review against these goals and principles.

Key insights from the literature reviewed

As Pihama et al. (2019, p. 49) conclude, the “distance between theory and practice seems vast.” The review of the WCTO programme offers an opportunity to at least narrow the distance, and at best remove it. The findings from the literature reviewed highlight ways to strengthen the alignment of the WCTO programme with the Ministry’s goals and Te Tiriti principles.

The key insights presented are consistent across the literature review on targeted child health and wellbeing programmes with proven positive outcomes for indigenous people. However, a lack of evidence exists on how to improve equity of outcomes within universal well child programmes. We have assumed the insights apply to both universal and targeted care within the WCTO programme. The insights presented below are interlinked and need to be used collectively to effect change.

1. The WCTO programme redesign needs to be framed on kaupapa Māori concepts of tamariki Māori health and wellbeing within the context of whānau Māori wellbeing and collective responsibility

The WCTO programme contributes to the goals of the Child Health and Wellbeing Strategy, an all-of-Government commitment to aspirations for the health and wellbeing of Aotearoa New Zealand children, their agency and contribution to family and community. For the Ministry to deliver on its obligations to Te Tiriti goals and principles, the WCTO programme also needs to embed kaupapa Māori understanding of child health and wellbeing situated in the collective wellbeing of whānau Māori.

A potential framework to use is *Te Taonga o Taku Ngākau* (Pihama et al., 2019) which is based on ancestral knowledge and wellbeing of tamariki Māori within the context of well and thriving whānau. The framework is premised on whānau Māori wellbeing being based on the interconnectedness of physical, mental, spiritual, and collective wellbeing. Pihama et al. note tamariki Māori and Māori communities will flourish through reclaiming traditional knowledge

of collective childrearing practices, strengthening connectivity and relations, Māori language and cultural practices.

The Ministry needs to work with Māori leaders, community and whānau Māori to determine the appropriateness of this framework or its iteration for the WCTO programme.

2. The WCTO programme redesign needs to integrate access and engagement enablers to deliver positive outcomes for whānau Māori

The redesign of the WCTO programme needs to be based on mātauranga Māori and tikanga Māori

The design, discourse, and delivery of the WCTO programme need to explicitly encompass the collective responsibility for enabling tamariki Māori wellbeing within the context of wider whānau wellbeing. The diversity of whānau Māori must be acknowledged, and whānau Māori need to be supported to strengthen their cultural connectedness. Whānau Māori need support to create their solutions based on mātauranga Māori.

Māori leaders, community and whānau are key decision-makers in the WCTO programme redesign, implementation and governance

Under tino rangatiratanga, Māori leaders, community and whānau Māori need to be involved in the redesign of the WCTO programme to ensure the programme is based on mātauranga Māori and tikanga Māori. Māori leaders need to be involved in the governance of the overall WCTO programme.

At a local or regional level, Māori leaders, community and whānau Māori need to be involved in the design, delivery and governance of targeted services linked to the WCTO programme. Working together on the programme design phase will build connections and trust between WCTO providers and the community, and will build local capacity.

Cultural safety and critical consciousness are vital elements in decreasing health inequities within the WCTO programme

WCTO providers and their staff need to challenge their culture and cultural systems within the context of achieving health equity. Health practitioners need to question how their biases, attitudes, assumptions, stereotypes and prejudices contribute to lower-quality healthcare.

The WCTO programme redesign needs to identify how cultural safety activities can be built into workforce training, professional development and accreditation. The design needs to ensure systematic monitoring and assessment of inequities are included in workforce and health outcomes. Working towards cultural safety needs to occur at the WCTO programme level (system level), provider organisation and practitioner levels.

The WCTO programme needs to develop a diverse, inclusive and culturally-safe clinical workforce. The role of non-clinical Māori staff is important in supporting access and engagement with services, and strengthening connections to culture. The roles of non-clinical Māori staff need to be respected and understood and effectively supported within enabling management and governance structures.

Partnership-based relationships between whānau Māori and WCTO providers are at the heart of the redesign of the WCTO programme

How the WCTO programme is delivered is as important as what is provided. Building trusting partnership-based relationships takes time and is based on both personal characteristics and a culturally safe, strength-based, and holistic way of working. Māori health professionals and support workers are critical in bringing cultural and environmental understanding of the local knowledge and values in the delivery of the WCTO programme. They can also strengthen whānau Māori connections in their communities and to their culture.

Flexibility in delivery mechanisms and content will enable access and support ongoing engagement with the WCTO programme

To increase access and engagement for whānau Māori, the redesign of the WCTO programme needs to incorporate choice, self-determination and partnership. A flexible approach is needed, which respects the diversity of whānau and their values, and supports their autonomy.

Access to the WCTO programme will be enabled through open and flexible entry. As a universal programme, the WCTO programme has open access. However, barriers such as structural racism, financial constraints and lack of awareness can stop or deter use. Access and engagement to the WCTO programme can be enhanced through a range of delivery mechanisms including home visits, clinics and group activities. Offering a range of delivery mechanisms recognises the diversity of whānau Māori and that their engagement preferences can change.

3. The WCTO programme needs to support intersectoral collaboration to address the social determinants of health and wellbeing

The WCTO programme needs to strengthen interlinkages across the health, social and education systems to offer intersectoral responses. The role of iwi-led and Māori providers delivering WCTO services will have an important role in creating multi-disciplinary and holistic support for whānau Māori.

Feedback from WCTO providers highlights interest in the use of community hubs to offer wraparound services to whānau Māori, and to work to address the social determinants of health and reduce inequities.

4. Funding amounts and contracting models need to be sufficient and flexible to advance equity for whānau Māori

In line with Te Tiriti principles, analysis is required to assess the equity of funding in the WCTO programme both in the amount and distribution. Contracting models need to be reviewed to ensure they support programme flexibility and options, and support service innovation within an indigenous wellbeing framework. Within the WCTO programme, funding for Māori communities must reflect the level of health need in those communities.

5. The WCTO programme needs a holistic, whānau-centred measurement framework which is responsive to whānau Māori, focuses on equity and ensures data sovereignty

Cram (2018) proposes measuring tamariki Māori wellbeing based on mauri, including ihi, wehi and wana. The use of this framework, or its ongoing development, needs to be considered within the context of the WCTO programme, which also collects screening and surveillance data on child health and development indicators. The latter are important markers which may determine the need for early intervention relating to a specific health or development issue. The development of the WCTO measurement framework requires working closely with whānau Māori, hāpu, iwi, Māori academics and clinicians.

Areas for further investigation

The literature review has highlighted areas for further or future investigation, including:

- Kaupapa Māori research and evaluation of the WCTO programme, particularly the universal component of the programme, which is needed to increase the evidence-base of what works in what context for whānau Māori.
- Kaupapa Māori research and evaluation, which is needed to create an evidence-base of new innovative targeted services and practices within or associated with the WCTO programme.
- A review of the current funding and contracting model for the WCTO programme to ensure it enables health equity.
- A more developed understanding of the WCTO programme within the wider health, education and social sector to ensure integrated collaborations support equity across the life course for whānau Māori.
- The need for the design of the proportionate universal model of the WCTO programme to be clearly articulated.

Next steps

We are currently analysing interviews with whānau Māori to understand their moemoeā of pēpi/tamariki health and wellbeing. On completion, we will review and may refine the insights from the literature review based on the wisdom and insights from whānau Māori and Māori leaders.

Overview of the literature review

The Ministry of Health is reviewing WCTO

The Ministry of Health (the Ministry) is reviewing WCTO. The review seeks to strengthen WCTO by¹:

- Improving sustainability and performance of the WCTO service
- Driving equitable health and development outcomes for children
- Enabling WCTO to contribute to wider child wellbeing more effectively
- Ensuring value for money.

This literature review is to inform the WCTO review

Large inequities exist for whānau Māori in child and maternity access and outcomes data (Ministry of Health, 2019a). Acknowledging these inequities, the Ministry commissioned Litmus to do a literature review and qualitative research with whānau Māori to inform the WCTO programme review. The qualitative research explores whānau Māori moemoeā of pēpi/tamariki health and wellbeing.

The purpose of the literature review is to understand the design features of models of care for child health and wellbeing, which increase enrolment, engagement, participation and retention over time to improve equity outcomes for Māori.

We used an iterative literature review process

We developed literature review questions and specifications, which are in Appendix 1.

We worked with the Ministry of Health's library to access both peer-reviewed and grey literature using the specifications. We reviewed the abstracts to assess whether they addressed the literature questions and requested the articles.

We used a critical appraisal checklist to determine the inclusion of the literature received in the review. We developed the checklist drawing on the Critical Appraisals Skills Programme (CASP)² to assess research rigour, Joanna Briggs checklist³ and the Canadian Aboriginal Ways Tried and True (Public Health Agency of Canada, 2015).

¹ See the Ministry website <https://www.health.govt.nz/our-work/life-stages/child-health/well-child-tamariki-ora-services/well-child-tamariki-ora-review>

² CASP qualitative checklist <https://casp-uk.net/casp-tools-checklists/>

³ <https://joannabriggs.org/critical-appraisal-tools> accessed on 4 April 2020.

This report presents key insights from the literature review

We have written the report to present the insights identified from the literature review. We have reflected on these insights in the context of Te Tiriti o Waitangi as the founding document of Aotearoa New Zealand, and the concept of proportionate universalism.

We acknowledge the limitations of this literature review

This review is not an exhaustive review of models and measures of indigenous children's health and wellbeing. The material reviewed is primarily from 2015 onwards to draw on the most recent work of researchers in this expanding field. We have included literature predating 2015 where relevant. We acknowledge other research before 2015 may have been omitted.

The review focused on programmes and theoretical work demonstrating improved outcomes for indigenous children. The review was limited to English language articles. We may have missed other relevant information presented in indigenous or other languages. A common theme across the literature is the need for more indigenous research into well child and tamariki ora programmes, and research with an equity lens.

The research predominantly describes targeted programmes for indigenous people in Aotearoa, Australia, Canada and the US. Most programmes identified were small-scale with local or regional delivery. Implicitly, all programmes are intended to reduce inequities for indigenous children and their families at a local and regional level.

Many papers cited are based on qualitative or indigenous research methods, as appropriate to the specific programme. The perceived limitations of qualitative research approaches in Western science are mitigated by the consistency in themes and findings across the studies.

The report has been peer-reviewed

Marty Rogers, Maria Marama, Māori researchers leading the primary research with whānau Māori, and Dr Nikki Turner reviewed the draft reports.

Context: A rights and needs-based approach to models of care for WCTO's proportionate universal programme

This section presents the rights-based and needs-based context to address health equities for whānau Māori in the WCTO programme. The section also details the rationale of the WCTO as a proportionate universal programme and explores other child health approaches. We draw on this framing to reflect on the findings from the literature review and to put forward design considerations for the WCTO programme.

Te Tiriti o Waitangi establishes the rights-based approach to the WCTO programme review

Te Tiriti o Waitangi is the founding document of Aotearoa New Zealand. The review of the WCTO programme must acknowledge the rights of Māori under Te Tiriti o Waitangi. As a public service department, the Ministry of Health has a responsibility to contribute to the Crown meeting its obligations under Te Tiriti o Waitangi (Treaty of Waitangi; Te Tiriti) (Ministry of Health, 2020).

The Ministry of Health's expression of Te Tiriti is based on four goals

The Ministry of Health (2020, p. 7) has four goals based on the foundations of preamble and the three articles of Te Tiriti and the Ritenga Māori declaration⁴:

- **Mana whakahaere:** effective and appropriate stewardship or kaitiakitanga over the health and disability system, which goes beyond the management of assets or resources.
- **Mana motuhake:** enabling the right for Māori to be Māori (Māori self-determination), to exercise their authority over their lives, and to live on Māori terms and according to Māori philosophies, values and practices, including tikanga Māori.
- **Mana tangata:** achieving equity in health and disability outcomes for Māori across the life course and contributing to Māori wellness.
- **Mana Māori:** enabling ritenga Māori (Māori customary rituals), which are framed by te ao Māori (the Māori world), enacted through tikanga Māori (Māori philosophy and customary practices), and encapsulated within mātauranga Māori (Māori knowledge).

⁴ Often referred to as the 'fourth article' or the 'verbal article'.

The Ministry's approach is guided by five principles

The Ministry seeks to meet its obligations through the principles of Te Tiriti o Waitangi, as articulated by the Courts and the Waitangi Tribunal (Waitangi Tribunal, 2019; Wai 2575 Claim). Five principles apply to the wider health and disability sector (Ministry of Health, 2020, pp. 7–8) and the review of the WCTO programme.

The five principles are:

- **Tino rangatiratanga**, which provides for Māori self-determination and mana motuhake. This means that Māori are key decision-makers in the design, delivery, and monitoring of health and disability services.
- **Equity**, which requires the Crown to commit to achieving equitable health outcomes for Māori and to eliminate health disparities. This includes ensuring equitable access and funding and encompasses freedom from discrimination, both conscious and unconscious.
- **Active protection**, which requires the Crown to act, to the fullest extent practicable, to protect Māori health and achieve equitable health outcomes for Māori.
- **Options**, which requires the Crown to provide for and properly resource kaupapa Māori services in the WCTO programme. This principle requires the availability and viability of kaupapa Māori solutions alongside mainstream services and the assurance Māori are not disadvantaged by their service choices.
- **Partnership**, which requires the Crown and Māori to work in partnership in the governance, design, delivery, and monitoring of health and disability services. This contributes to a shared responsibility for achieving health equity for whānau Māori.

The New Zealand Public Health and Disability Act 2000 (section 4) acknowledges Māori rights to equity of health outcomes as does the Government's support for the United Nations Declaration on the Rights of Indigenous Peoples, Articles 23 and 24 (United Nations, 2008).

A needs-based rationale exists in redesigning the WCTO programme

Colonisation has adversely impacted the health and wellbeing of whānau Māori

For Māori, colonisation and the resulting loss of land and culture has had a devastating effect on whānau health and wellbeing (Durie, 2017; Cram, 2019; King et al., 2018; Pihama et al., 2019; Moewaka Barnes & McCreanor, 2019). The key losses include the separation of whānau from their whenua, destabilising whānau, hapū and iwi identities; losses of language, economic and political independence, and whānau as a protective collective; and the undermining of the agency and autonomy of tamariki and women.

Māori experience significant health inequities compared to non-Māori

Māori have on average the poorest health status of any ethnic group in Aotearoa New Zealand (Curtis et al., 2019).

- In 2012–2014, Māori life expectancy at birth was 7.1 years less than non-Māori (Statistics New Zealand, 2014⁵).
- Māori receive less access to, and poorer care throughout, the full range of healthcare services (Davis et al., 2006; Ministry of Health, 2015, as cited in Curtis et al., 2019).
- Māori are more likely to live in areas of high deprivation than non-Māori. In 2013, 24% of Māori lived in an area with the highest New Zealand Deprivation score, compared with 7% of non-Māori (Ministry of Health, 2015).

Māori experience inequities in access to and outcomes from the WCTO programme

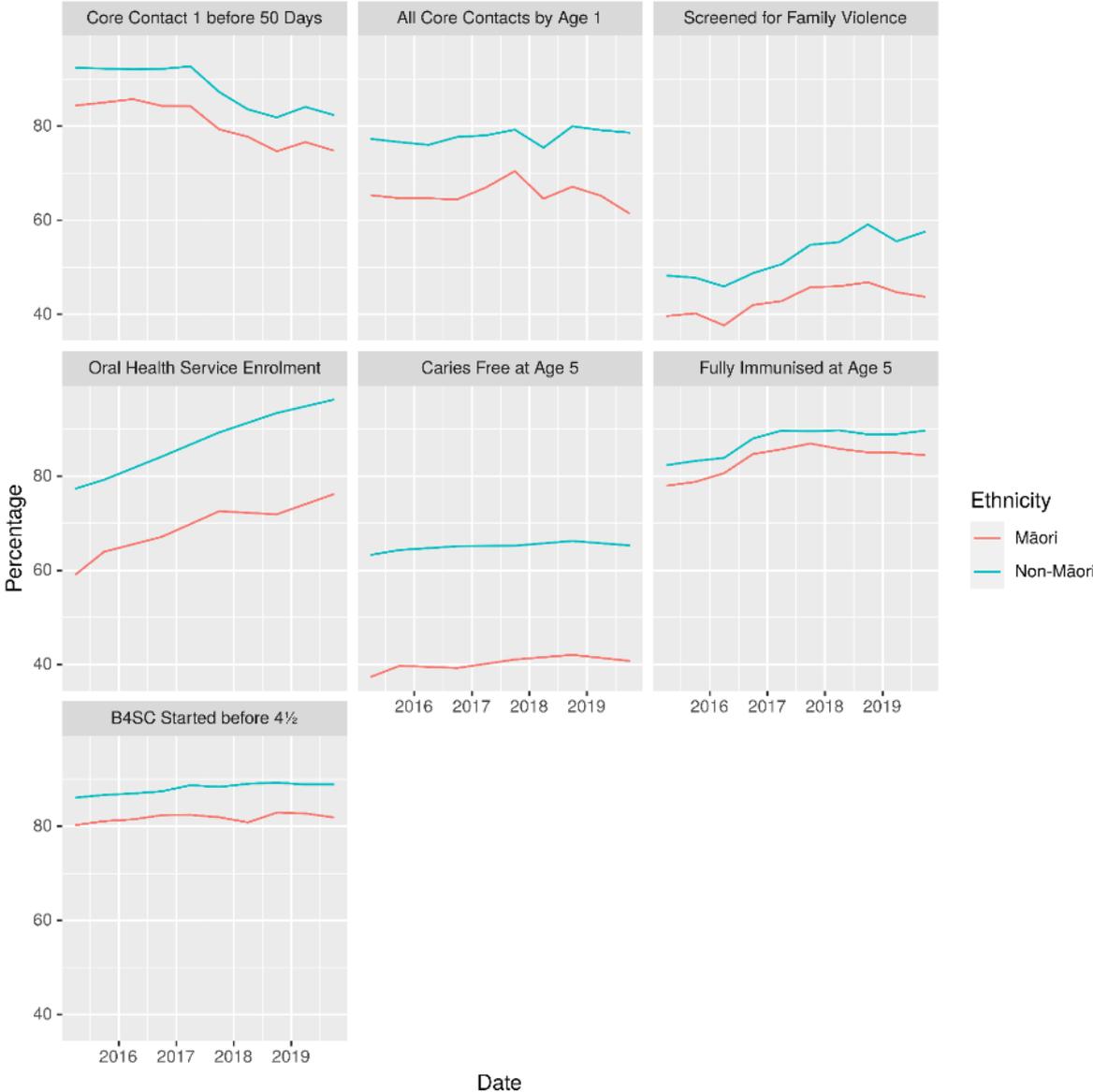
The Ministry of Health's WCTO Quality Improvement data between 2016 and 2019 demonstrates inequities in the WCTO programme (Figure 1).

- Whānau Māori participate at lower rates than non-Māori. Fewer pepi Māori receive their first core contact before 50 days and fewer receive all core contacts in their first year of life.
- Fewer tamariki Māori are enrolled in community oral services than non-Māori, and fewer are free of dental caries at five years.
- Fewer tamariki Māori at 4½ years participated in the Before School Checks.

No indicators display a substantial improvement in equity for whānau Māori over the period. Inequities for whānau Māori are also increasing across three WCTO indicators: received all WCTO core contacts by age 1, screened for family violence, and enrolment for oral health service.

⁵ <https://www.stats.govt.nz/information-releases/new-zealand-period-life-tables-201214>

Figure 1: Comparison of Māori and non-Māori access and outcomes from the WCTO programme for the period 2016 to 2019



Data source: Collated WCTO quality improvement data from 2016 and 2019 retrieved from <https://nsfl.health.govt.nz/dhb-planning-package/well-child-tamariki-ora-quality-improvement-framework>. Collation by James Reilly, Statistical Insights.

Research by Gibb et al. (2019) also highlights tamariki Māori are less likely to take part in the Before School Checks. As a result, these tamariki Māori may miss referrals for support to increase school readiness. These patterns of participation and outcomes, in the WCTO quality data and Gibb et al. (2019), highlight existing inequities for whānau Māori and their pepi/tamariki Māori.

Eliminating health inequities requires addressing the social determinants of health

Health inequities are due to unequal power relationships, unfair distribution of the social determinants of health, marginalisation, biases, unexamined privilege, and institutional racism (Robson & Harris, 2007, as cited in Curtis, 2019).

The Ministry of Health (2020) defines the drivers of health inequity as differential access to resources, services and opportunities on the basis of ethnicity and social positioning (e.g., age, gender, able-ness) and inaction or inappropriate action in response to health need.

Achieving health equity is a priority of the Ministry of Health

The Ministry's definition of equity acknowledges the differences in health status are unfair and due to differing access to resources.

In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes.⁶

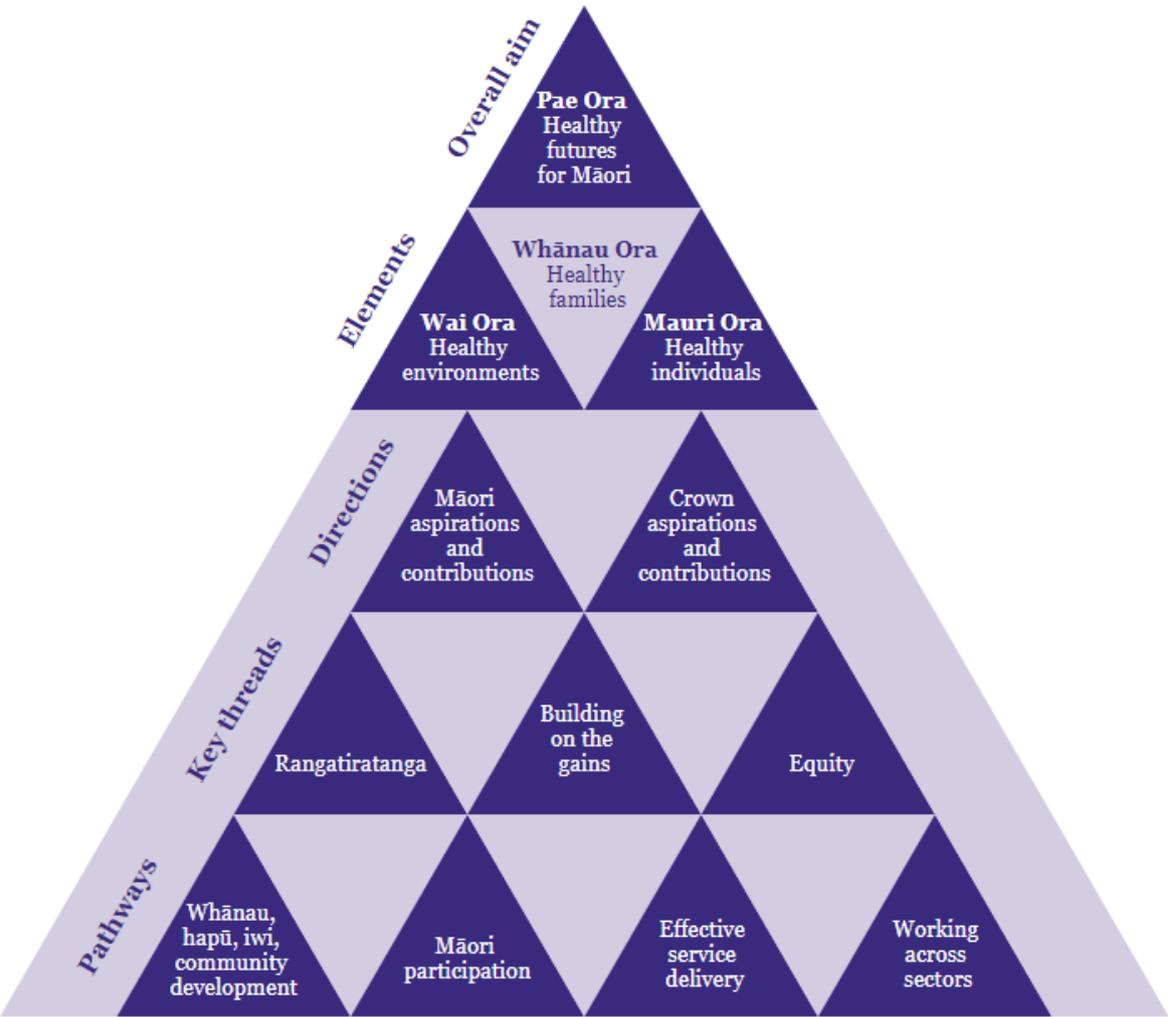
He Korowai Oranga is New Zealand's Māori Health Strategy

The Ministry of Health is collaborating with health and social sectors on a Māori Health Action Plan to address health inequities and deliver high-quality and effective services to support Māori aspiration for health and wellbeing.

Figure 2 presents the He Korowai Oranga framework and the overall aim of Pae Ora. We will draw on this framework in considering the implications of the literature review and primary research findings.

⁶ <https://www.health.govt.nz/about-ministry/what-we-do/work-programme-2019-20/achieving-equity> accessed on 4 April 2020.

Figure 2: He Korowai Oranga framework⁷



⁷ <https://www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga>

Philosophies underpinning well child health programmes from proportionate universalism to targeted services

To assess indigenous models of care, we need to first consider the different philosophies underpinning well child health programmes and their evolution.

Strong evidence highlights the benefits of well child programmes

Strong evidence demonstrates the impact of pregnancy and the first 1,000 days in shaping health, psychological and developmental trajectories through childhood into adulthood (Edmond, 2019). Identifying emerging problems early, and initiating intervention has significant benefits to children, families and society (Glascoe & Marks, 2011; Edmond, 2019). Intervening early in a condition or problem is likely to be more effective and less expensive than remediation later in life (Centre for Community Child Health, 2009).

Globally, well child programmes have been established to promote health, development and wellbeing through screening, surveillance, and support. They aim to increase protective factors for a healthy life course and facilitate interventions to reduce risk factors. In 2006, an international comparative study found health outcomes for children are better in countries with a universal system of well child healthcare (Kuo et al., 2006).

Ongoing debates exist about the types of well child programmes

Universal well child programmes offer all children in a population the benefit of a series of health checks and support

The benefits of universal well child programmes (Barlow et al., 2008) are:

- addressing the population paradox in that while poorer children are at greatest risk of vulnerability, a greater number of children across the population are also vulnerable
- being better placed to address problems before they reach clinical levels, and therefore more genuinely preventive
- being less stigmatising and potentially more acceptable than targeting parents with problems.

Universal services, however, run the risk of non-take up and not addressing vertical inequities when people with greater needs are not provided with greater resources (Starfield, 2011).

Proportionate universal programmes seek to reduce health inequities

The Marmot Review (2010) identified giving every child the best start in life as one of six key policies for reducing health inequalities. The concept of proportionate universalism was introduced as a key approach to reducing health inequalities due to the social gradient of health⁸.

The Marmot Review (2010) advocates health actions must be offered from a universal base (not targeted) with proportionate scale and intensity relevant to the level of disadvantage. He argues, targeting health actions to the most disadvantaged will not reduce health inequalities sufficiently, as a significant proportion of the population with health needs will miss out.

Differing interpretations and operationalisations of proportionate universalism exist

Over the last 10 years, the concept of proportionate universalism has had varying interpretations of both meaning and reach (Carey et al., 2015; Dierckx et al., 2019). Proportionate universalism can be interpreted as delivering higher doses of the same interventions to those facing greater disadvantage (Birch, 2010). However, offering more of the same service is unlikely to address existing health inequities due to the diversity of disadvantaged families (Gray, 2011).

Proportionate universalism can also refer to services being adapted to cater to different needs or membership of specific groups (Carey & Crammond, 2014). Targeted or enhanced services are therefore designed to meet the needs of specific population groups.

Targeted approaches alone have been criticised. Based on need, disadvantage or vulnerability, users of targeted services may feel stigmatised, resulting in poor uptake or adherence (Hurt et al., 2018). The use of eligibility criteria can increase health inequities for those excluded. Targeted approaches will not address inequities across the social gradient (Dierckx et al., 2019; Wright et al., 2009). Further, these types of approaches may address the consequences of inequity but not their cause (National Collaborating Centre for Determinants of Health, 2013).

Other targeted approaches exist which are enabling to specific populations

In Aotearoa, Whānau Ora was developed as a whānau-centred approach to support whānau wellbeing and development. This innovative approach was developed in response to existing social and health services not improving outcomes for whānau Māori. Whānau Ora differs from traditional social and health approaches that focus solely on the needs of individuals. Whānau ora recognises the strengths and abilities that exist within whānau and aims to

⁸ The social gradient in health is a term used to describe the phenomenon whereby people who are less advantaged in terms of socioeconomic position have worse health (and shorter lives) than those who are more advantaged.

support and develop opportunities that fulfil potential⁹. Whānau ora enables whānau Māori to identify their priorities and action their solutions.

Another example is purchaser-provider models in disability care where funds are given directly to individuals so that they may 'purchase' a service from providers. Proponents argue this approach is enabling and results in more client-focused service (Carey et al., 2015).

These examples are not reflected in well child programmes such as those delivering a prescribed evidence-base of prevention and early interventions for well children. However, they demonstrate strength-based, culturally safe and innovative approaches.

Internationally, proportionate universal well child health programmes are recommended

Edmond (2019) recommends both universal and targeted services for child health programme, and advises funders and providers to monitor coverage of the population receiving the universal service. Targeted services are also recommended to focus on children with growth, development, behaviour issues, or on families with risk factors. The proportionate nature may be additional contacts, or referral or signposting to other services.

Edmond (2019, p. 374) also recommends four levels of service delivery of differing intensity and focusing on differing needs: Universal, Universal Plus, Universal Partnership Plus, and Community. Cowley et al. (2018) defined these service levels as follows:

- The Universal Plus level of service is about indicative prevention, where action follows early identified needs or risks.
- Universal Partnership Plus refers to working with families facing more complex and long-term concerns where other health and/or social care services may be involved (e.g., Family Nurse Partnership programme).
- Community-level with collaboration across the local area, involving capacity-building and embedding health action and signposting across a geographical area to ensure the correct level of provision for families.

⁹ <https://www.tpk.govt.nz/en/whakamahia/whanau-ora/about-whanau-ora>

WCTO is a proportionate universal¹⁰ early childhood health and development programme

WCTO's primary goal is to ensure all families and whānau are supported to maximise their child's developmental potential and health status in the early years to establish a strong foundation for ongoing health and development (Ministry of Health, 2019a).

The WCTO programme is designed on the principle of universal provision of services for all children with additional services allocated, according to need. Core contacts are available to all children aged 0–5 years. The contacts provide the opportunity to identify growth, development, parenting or wellbeing difficulties and to develop a plan for support or referral. Additional contacts are available based on need, determined in partnership with the family.

Core contacts are delivered by health practitioners (midwives or registered nurses). Additional contacts may be delivered by either health practitioners/workers or kaiawhina. The WCTO schedule is delivered by the Royal New Zealand Plunket Trust (Plunket) and over 60 local Tamariki Ora providers contracted by District Health Boards (DHBs). Around 70% of Tamariki Ora providers are located in and governed by iwi-owned or Māori-led organisations.

Within the WCTO programme the levels of services discussed by Edmond (2019) are not explicit. However, the levels are evident across the health and social sector. For example:

- The Universal Plus can be seen in the linkages to primary, secondary and tertiary services within health and disability services, and Family Start and Whānau Ora
- Universal Partnership Plus can reflect Oranga Tamariki, Kainga Ora services, Start Well, and iwi and Māori services
- The Community level can reflect Placed Based Initiatives and community boards and District Health Board Partnership Boards.

We are seeking to improve outcomes for whānau Māori in a proportionate universal child health programme

Strong population and equity benefits exist for having a proportionate universal WCTO programme in Aotearoa. In line with Te Tiriti principles, consideration is needed on how to redesign the universal and targeted activities within the WCTO programme to improve outcomes for whānau Māori.

¹⁰ The words proportionate and progressive universalism are being used interchangeably in the literature. We have used the term "proportionate" as it had more consistent use in the literature and was used in the Marmot Review. We looked to define their different application but could not find any conclusive positions.

Key insights from the literature review

This section presents the key insights from the literature review on the design features of models of care for child health and wellbeing, which increase enrolment, engagement, participation and retention over time to improve equity outcomes for Māori.

Reflecting the literature specification, most of the models of care found are targeted or enhanced indigenous child health and wellbeing programmes. We focus on child health and wellbeing programmes and services that demonstrate effectiveness in improving access, engagement, and outcomes for Māori or other indigenous groups using them. As most models of care are targeted services, we cannot determine whether if scaled they would reduce inequities at a population level for indigenous populations.

We also sought literature to identify proven ways to increase access and engagement for indigenous people within universal child health and wellbeing services.

The findings presented draw heavily from the research of Aotearoa's world-leading Māori academics. We have demonstrated, where appropriate, alignment with other mainstream and indigenous literature.

We have used whānau Māori to refer to the “cornerstone of Māori society” which includes extended family and wider hapū and iwi’ (Pihama et al., 2019, p. 15). When referring to other indigenous literature, we have used “family”, which is limited to a western construct.

This section is set out to demonstrate the findings and interpretations underpinning the five key insights to inform the redesign of the WCTO programme to improve equity outcomes for Māori. The insights are interlinked and need to be applied collectively to effect change. In summary, the five key insights are:

1. Frame the redesign of the WCTO programme on kaupapa Māori concepts of tamariki Māori health and wellbeing within the context of whānau Māori wellbeing and collective responsibility
2. The WCTO programme redesign needs to integrate access and engagement enablers to deliver positive outcomes for whānau Māori
3. The WCTO programme needs to support intersectoral collaboration to address the social determinants of health and wellbeing
4. Funding and contracting models need to be sufficient and flexible to advance equity for whānau Māori
5. The WCTO programme needs a holistic, whānau-centred measurement framework which is responsive to whānau Māori, focuses on equity and ensures data sovereignty.

1. Frame the redesign of the WCTO programme on kaupapa Māori concepts of tamariki Māori health and wellbeing within the context of whānau Māori wellbeing and collective responsibility

Proportional universal child health services are based on explicit or implicit definitions or concepts of child health and wellbeing

We consider the definitions and concepts of child health and wellbeing below to inform the redesign of the WCTO programme to improve equity of outcomes for whānau Māori. The definition or concept of child health and wellbeing used, either explicitly or implicitly, sets the underpinning theory and values of the programme's design and delivery.

Concepts of child health and wellbeing are socially constructed and not value-free

While there is much interest in child health and wellbeing, no consensus exists on a definition, conceptualisation and methods to measure it (Tisdal, 2015). Some argue achieving a consensus agreement on a definition of child health and wellbeing is too challenging. Instead, they see child health and wellbeing more as an umbrella term for frameworks to measure the quality of a child's life (Moore, 2019).

Within measurement frameworks, child health and wellbeing are defined by the indicators used as proxies to measure wellbeing or its degree of absence. Measurement frameworks tend to be developed to assess a perceived problem rather than the framework determining the problem. Social problems are defined by changing values, interpretations, and interests within historical, institutional, and cultural contexts (Domínguez-Serrano et al., 2018). Child health and wellbeing definitions derived from measurement frameworks are most often constructed on societal, political, cultural values, and power dynamics.

Child health and wellbeing definitions are shifting away from deficit-based and individualised concepts

Historically, child health and wellbeing research was focused on identifying clinical or developmental issues or family, social, and economic problems. Child health and wellbeing was defined as the lack of illness, developmental issues, and lack of problems (Gleason & Narvaez, 2019). In this context, definitions of child health and wellbeing tended to be deficit-based and individualised in their focus. As Amerijckx and Humblet (2013, p. 404) said, this is "an oddly pathogenic approach".

Deficit-based definitions and measurement frameworks of child health and wellbeing are criticised for:

- Not focusing on the rights of the child, and their agency both in their present and future lives (Gleason & Narvaez, 2019; Domínguez-Serrano et al., 2018; Tisdal, 2015).
- Not acknowledging the role of families, communities and environments on child health and wellbeing, and children’s influence within these domains (Domínguez-Serrano et al., 2018; Tisdal, 2015; Cram, 2019).
- Focusing on interventions to address early adversity without focus on the contexts or supports that enable children to thrive, and assuming positive indicators equate to a positive life (Gleason & Narvaez, 2019; Moore, 2019).
- Focusing more on the objective markers of health and wellbeing with little consideration for subjective markers. Debate continues between using externally verifiable measures of objective wellbeing and the subjective and personally constructed perception of wellbeing (Tisdal, 2015).

Some child health and wellbeing measurement frameworks are also criticised as inappropriate for Māori and other indigenous populations due to:

- Not representing the lived realities of Māori and indigenous people and their children, within the context of their whānau and communities, and what indigenous children consider to be a good life (Cram, 2019).
- Adopting a “problem saturated focus” where indigenous children are benchmarked against non-Indigenous population groups (McCalman et al., 2015). Many researchers acknowledged this approach risks labelling indigenous children and their families as “problematic”.
- A lack of disaggregated and culturally relevant data for population sub-groups, including indigenous children (Halseth & Greenwood, 2019).

A more holistic perspective of child health and wellbeing is emerging

In 2013, Amerijckx and Humblet advocated for a more positive, multi-dimensional approach to child health and wellbeing. Over the last five years, more attention is being placed on children’s subjective wellbeing focusing on their rights and their role and agency within their families and communities (Domínguez-Serrano et al., 2018; Fava et al., 2017; Tisdal, 2015; Weiss-Laxer et al., 2020).

Moore (2019) demonstrates over time the shift in the United States to a whole-child approach with five broad domains of cognitive and academic development, mental and emotional wellbeing, social behaviour, physical health and functioning, and healthy relationships.

In Aotearoa, definitions of child health and wellbeing are also evolving to be strength- and rights-based, multi-dimensional, and inclusive of Māori and families and communities. The

Children's Commission's working definition of child wellbeing seeks to address many of the criticisms of the more deficit-based and measurement focused-definitions:¹¹

Wellbeing is a **positive state** and not simply the absence of negatives. Children experience wellbeing when their family and **whānau are connected** and united; relationships within and beyond the family and whānau are thriving; family and whānau members support each other; there are opportunities for **individual and collective growth**; and all members of their family and whānau have their needs met. A community has achieved child wellbeing when all children and their whānau have their **rights fulfilled** and the conditions are in place to enable all children to **participate in society and plan**, develop and achieve **meaningful lives**.

The Child and Youth Wellbeing Strategy is the holistic framework in which the WCTO programme sits

In 2019, the Department of Prime Minister and Cabinet developed the holistic and multi-dimensional Child and Youth Wellbeing Strategy (the Strategy).¹² The views of young people and children were sought to inform the Strategy's development. The Child and Youth Wellbeing Strategy includes an aspirational vision of **New Zealand as the best place in the world for children and young people**.

Te Tiriti o Waitangi is at the Strategy's heart. One of the nine principles for the Strategy recognises "Māori are tangata whenua and the Māori-Crown Relationship is foundational."¹³ The Strategy is required to give practical effect to Te Tiriti to achieve wellbeing for Māori children and young people through active partnerships between Government and Māori.

The Strategy has nine principles and six outcomes. Against each of the outcomes is a set of holistic indicators drawing on quantitative and qualitative indicators. The six outcomes are:

- Children and young people are loved, safe and nurtured
- Children and young people have what they need
- Children and young people are happy and healthy
- Children and young people are learning and developing
- Children and young people are accepted, respected and connected
- Children and young people are involved and empowered.

The Child and Youth Wellbeing Strategy is a framework for aligning government policy development and services, including the WCTO programme. The Strategy acknowledges the review of the WCTO as a key action to improve maternity and early years support under the

¹¹ <https://www.occ.org.nz/wellbeing/what-have-we-learnt-about-wellbeing/> accessed 17 June 2020

¹² <https://childyouthwellbeing.govt.nz/sites/default/files/2019-08/strategy-on-a-page-child-youth-wellbeing-Sept-2019.pdf> accessed 13 April 2020

¹³ <https://childyouthwellbeing.govt.nz/resources/child-and-youth-wellbeing-strategy-html#child-9> accessed 17 June 2020

outcomes of happy and healthy children. We also assume the WCTO programme, as a proportionate universal service, contributes to other child health and wellbeing outcomes.

The WCTO programme needs to be framed on kaupapa Māori definitions of child health and wellbeing

While Te Tiriti is at the heart of the Child and Youth Wellbeing Strategy, the Strategy does not make explicit a Māori model of child health and wellbeing. Durie (2017) states culture, including kawa¹⁴ and tikanga, is essential to identity, and the foundation for Māori wellbeing. Durie notes building strong cultural foundations are the steps to wellness. He acknowledges the diversity of whānau Māori and the need to nurture kaupapa Māori to enable all Māori to be part of te ao Māori.

As noted by Smith (1997, p. 446, as cited in Pihama et al., 2019) Te Tiriti principle of “tino rangatiratanga reinforces the goal of seeking more meaningful control over one’s own life and cultural wellbeing.” Under Te Tiriti obligations, the redesign of the WCTO programme needs to include and apply Māori definitions of child health and wellbeing.

In our discussion below, we draw primarily from Pihama et al.’s (2019) conceptualisation of Te Taonga o Taku Ngākau: ancestral knowledge and wellbeing of tamariki Māori within the context of well and thriving whānau. We focus on her work as it builds on other kaupapa Māori models describing the Māori view of health and wellbeing, including Te Whare Tapa Whā, Te Wheke, He Waka Eke Noa and others (Kingi et al., 2018). These models emphasise holistic and multi-dimensional aspects of health and wellbeing linked to spirituality and the environment. Central to these models is the connection between whānau wellbeing and individual wellbeing, including children, and also the collective responsibility for children.

Whānau Māori wellbeing is generated and transformed through Mātauranga Māori (Māori knowledge) and tikanga Māori (Māori custom) (Pihama et al., 2019)

Pihama et al. (2019) state tamariki Māori and Māori communities will flourish through reclaiming traditional knowledge of collective childrearing practices, strengthening connectivity and relations, Māori language and cultural practices. Matua rautia (traditional childrearing practice) sets a collective responsibility for nurturing and ensuring the wellbeing of children. Within matua rautia, the wellbeing of tamariki Māori is considered in the context of collective whānau wellbeing.

Pihama et al. (2019) note colonisation has produced inequalities and disparities, created economic poverty, negated te reo and tikanga Māori, and adversely affected the well-being of many whānau Māori. Through colonisation, many whānau Māori are separated from their cultural support networks, which has disrupted traditional and collective wellbeing. Recent

¹⁴ Kawa guides the development of relationships and trust and is intergral to marae encounters (Durie, 2017).

research has verified the contribution of indigenous knowledge to whānau wellbeing (Waitoki et al., 2016), and to developing effective community interventions (Pipi et al., 2003).

In this context, Pihama et al. (2019) put forward a six principled framework, based on mātauranga Māori and tikanga Māori, to transform the mental health and wellbeing for tamariki. The framework is premised on whānau Māori wellbeing being based on the interconnectedness of physical, mental, spiritual and collective wellbeing. As Pihama et al. note, to achieve positive outcomes for whānau Māori and tamariki Māori preventions, interventions need to be based on this interconnected framework.

The framework has relevance in considering the redesign of the WCTO programme to improve outcomes for whānau Māori. This framework aligns with the Ministry's four goals to give effect to its Te Tiriti obligations through mana whakahaere, mana motuhake, mana tangata, and mana Māori.

The six principles of the framework are summarised below (Pihama et al., 2019).

- 1. Whānau is multi-faceted and includes people with shared values within a larger support network.** The principle of whānau acknowledges the relationships Māori have with each other. Whānau and whakawhānaungatanga are key elements of collective wellbeing and collective nurturing and care for relationships. Whakapapa supports being well through knowing where whānau are from, offers guidance on future life paths, and to navigate complex systems. Whānau wellbeing is also linked to the connection between ancestral land and the environment (taiao), and responsibilities to uphold this relationship.
- 2. Taonga Tuku Iho¹⁵ is the cultural aspiration principle and the legitimacy of Te Reo Māori, tikanga and mātauranga Māori.** Mātauranga Māori is the inter-generational knowledge system which ensures an empowering and collective approach to the wellbeing of tamariki Māori. The use of te reo Māori creates identity, connectedness, and the sharing of culture, values and knowledge. Māori ways of knowing, doing and understanding create spiritual and cultural awareness and affirm the centrality of children within whānau, hapū, and Iwi.
 - Wairua is critical to wellbeing for tamariki Māori and whānau Māori, as spiritual and physical realities are intertwined. Emotions are closely connected to the spiritual and are framed within te reo Māori and mātauranga Māori. Emotional wellbeing is the ability to recognise and communicate emotions and is central to healthy relationships. Whānau Māori understanding their emotions is critical for tamariki Māori to be well and secure.

¹⁵ Taonga Tuku Iho are the treasures handed down from the ancestors.

- Tikanga is the applied practice of whānau and whakapapa, which is gifted intergenerationally. Tikanga is fluid and dynamic to adapt to the realities of whānau Māori.
3. **Ako are the teaching and learning practices unique to tikanga Māori and are based on living collectively and intergenerationally.** The imposition of other systems, ideologies and practices has adversely impacted ako as the opportunities to learn from listening to ancestors have been undermined. The connection with grandparents supports wellbeing for whānau. Within ako, the concept of tuakana-teina emphasises the reciprocal learning relationship between older and younger sibling. These teaching and learning practices reinforce the importance of role modelling and working collectively from a trusted relationship base.
 4. **Kia piki ake i ngā raruraru o te kāinga is the principle to alleviate disadvantages experienced by Māori communities.** The principle acknowledges and reinforces the relevance of Māori-derived initiatives to address socio-economic issues. The current system reinforces the adversity felt by Māori from colonisation through institutional racism and blaming whānau Māori for poor outcomes.¹⁶ For whānau Māori, articulating wellbeing and the vision of thriving tamariki can be difficult when living in poverty. Pihama et al. (2019) note that knowledge of whakapapa and tikanga can instil whānau confidence and support a range of collective solutions, and safe empowering spaces (kāinga).
 5. **Kaupapa is the collective vision, aspiration, and purpose of Māori communities.** The principle demonstrates the collective responsibility central to enabling tamariki Māori wellbeing. The independence and interconnectedness of whānau is central to wellbeing, both individually and collectively within the diversity of whānau. Wellbeing sits within connectedness and tamariki Māori are within these connections.
 6. **The tino rangatiratanga principle is fundamental to individual and collective wellbeing of tamariki Māori.** It reinstates collectivism of whānau and challenges the political authority to provide in meaningful ways. Tino rangatiratanga sits between the macro processes and whānau need for autonomy and transformation both internally and externally.

¹⁶ A third of Māori tamariki are exposed to vicarious racism through hearing and seeing another person experience racism. Whānau Māori who experience racism face difficulties obtaining health care and are dissatisfied with the care their child receives (Paine et al., 2017).

Kapapapa Māori conceptualisation of child health and wellbeing has similarities with other indigenous literature

Our focus is specific to whānau Māori. However, we acknowledge the themes discussed are similar to indigenous literature in other countries relating to the conceptualisation of child health and wellbeing, including:

- The structures, connections and relationships within families, wider family and communities and across generations, and the positive impacts and active role of children within these contexts (Rountree & Smith, 2016; Fraser et al., 2018; Marmor & Harley, 2018).
- The centrality of cultural values, language, and practices (Fraser et al., 2018; Marmor & Harley, 2018).
- The focus on spiritual wellbeing (Rountree & Smith, 2016; Priest et al., 2017; Halseth & Greenwood, 2019; Fraser et al., 2018; Munns & Walker, 2018)
- The importance of the connection to land and the environment (Marmor & Harley, 2018; Secretariat of National Aboriginal and Islander Child Care, 2011, as cited in Child and Family Health Service, 2016).

To improve outcomes for whānau Māori requires the WCTO programme to embed a holistic, collective approach based on cultural connectedness

The Child and Youth Wellbeing Strategy offers a holistic understanding of health and wellbeing of children and young people and acknowledges their agency and contribution to family and community. For the Ministry to deliver on the four Te Tiriti goals, the WCTO programme needs to embed kaupapa Māori understanding of child health and wellbeing.

The design, discourse, and delivery of the WCTO programme needs to explicitly encompass the collective responsibility for enabling tamariki Māori wellbeing within the context of wider whānau wellbeing. Whānau Māori need to be supported to strengthen their cultural connectedness, and the diversity of whānau Māori must be acknowledged. Whānau Māori need support to create their solutions based on Mātauranga Māori.

2. The WCTO programme redesign needs to integrate access and engagement enablers to deliver positive outcomes for whānau Māori

This section presents the findings on the design features of child health and wellbeing services proven to improve outcomes for Māori or other indigenous people who engage with the services. As the WCTO is a proportional universal child health and wellbeing programme, we have presented the design enablers at two levels:

- **Universal services**—We searched for enablers to increase access and participation of Māori and other indigenous people in universal child health and wellbeing services. This focus recognises, under Te Tiriti principle of options, whānau Māori should not be disadvantaged if they engage in mainstream services.
- **Targeted programmes**—We identified targeted child health and wellbeing programmes proven to increase access, engagement and outcomes for Māori or other indigenous groups. We undertook thematic analysis to determine the enablers in design, implementation and governance that contributed to improved outcomes. In these services, improving equity is focused on groups targeted by the programme in that community or region, and not the wider population.

Universal services—improving access and engagement for whānau Māori

We found limited literature focused on improving access and participation for Māori and other indigenous people within universal child health and wellbeing programmes. Most sourced literature focused on targeted programmes either within or associated with the proportionate focus of maternal or child health programmes. Across the literature, authors acknowledge a lack of research and evaluation on what works for whānau Māori in culturally adapted parenting programmes (Keown et al., 2018), and in universal proportionate well child services.

The literature on increasing access and engagement in universal services demonstrates the existing inequities in access and acceptability for indigenous people (Widdup et al., 2012; Rossiter et al., 2019). Others tested and identified strategies to improve access, engagement, and experience with the universal programme (Corcoran et al., 2017; Fraser et al., 2016; Jose et al., 2020). Much of this research starts from a deficit-base, perceiving parents and families as vulnerable, or a problem-focus base seeking to resolve complex needs. The research highlights strategies to improve access and engagement (e.g. trusting, non-judgemental relationships, strength-based and family-centred, continuity and flexibility,

culturally aware). The enablers identified are like those identified in targeted programmes. However, the strategies recommended are not based on an indigenous framing of child health and wellbeing within the family and wider community or indigenous leadership.

Targeted programmes—equity enablers identified for Māori and other indigenous groups

We identified interlinked enablers that support enrolment, engagement, and participation of indigenous people in effective targeted child health and wellbeing programmes. These enablers align strongly with Pihama et al.'s (2019) framework and Te Tiriti principles.

In summary, the enablers for effective targeted child health and wellbeing programme are:

- The programmes are based on indigenous knowledge and protocols
- Indigenous leaders, whānau and community are key decision-makers in the programme design, implementation, and governance
- The partnership between whānau Māori/families and providers are at the heart of effective programmes
- Cultural safety is a critical element in decreasing health inequities
- Flexibility in access, delivery mechanisms and content enable access and support ongoing engagement.

The enablers work collectively to support the access and engagement with child health and wellbeing services for indigenous people. No literature reviewed discussed the relative weighting of these enablers.

The programmes are based on indigenous knowledge and protocols

Programmes demonstrating effective outcomes for Māori and indigenous people are based on indigenous knowledge and values (Cram et al., 2018; Grace et al., 2016; Keown et al., 2018; Kildea et al., 2019; Lowell et al., 2015; Munns & Walker, 2018; Schwartz, 2015; Thomas et al., 2015; Vaughan et al., 2018). These programmes use holistic, strength-based and family and community-centred approaches based on indigenous understanding of child health and wellbeing, and include traditional health knowledge.

The outcomes identified relate to the programme's specific focus and reflected both health-based and indigenous markers of wellbeing, e.g.:

- Increased birth weight and improved cultural connections (Lowell et al., 2015)
- Reduced neonatal mortality, increased immunisation and seeking addiction treatment (Cram et al., 2018)

- Strengthen connection to culture and increased parental resilience (Munns and Walker, 2018)
- Improved parenting skills and child behaviour (Keown et al., 2018)
- Increased knowledge of child development (Grace et al., 2016).

Incorporating indigenous knowledge and practice increases access and engagement. The use of indigenous knowledge creates familiarity, safety through a sense of belonging, and strengthens the connection to culture (Lowell et al., 2015; Schwartz, 2015). As Ussher et al. (2016) highlight, the dominant culture defines a “good mother”. Not aligning to this socially constructed ideal can create guilt for families and discourage the use of services for fear of repercussions, (e.g., in the worst case, the removal of their children). Without the integration of indigenous knowledge, indigenous people may refuse to engage with services (Lowell et al., 2015; Halseth & Greenwood, 2019).

The Strong Women, Strong Babies, Strong Culture Program (Lowell et al., 2015, p. 3)

The program [sic], located in the Northern Territory of Australia, is designed on Aboriginal knowledge and practice in promoting maternal and child health. The aims are to:

- improve the health and wellbeing of all mothers and their newborn babies
- strengthen the family unit and help bring back cultural practices
- prevent and intervene in illness and disease before, during and following pregnancy
- provide a healthier community for future generations.

The program recognises the traditional cultural approaches to parenting and lifestyle. The program supports pregnant Aboriginal women and their babies through better diet, education and antenatal care, to increase the birth weight of babies and improve early childhood development. The program relies on senior women who encourage attendance at antenatal care clinics and provide nutrition advice. Connections and support for involvement in cultural events are an essential part of the program.

An evaluation demonstrated the program resulted in improved birth weight of babies and broader social and economic benefits, including employment for senior women.

The Ministry’s goal of mana Māori requires the enabling of ritenga Māori, framed by te ao Māori, enacted through tikanga Māori, and encapsulated within mātauranga Māori. Aligning with the recommendations of Pihama et al. (2019), the evidence supports the WCTO programme being based on Māori knowledge and values.

Indigenous leaders, whānau and community are key decision-makers in the programme design, implementation and governance

Effective child health and wellbeing programmes have community elders and leaders together with the wider community and families involved in design, implementation and governance (Schwartz, 2015; Gerlach et al., 2017; Thomas et al., 2015; Gerlach et al., 2018; Grace et al., 2016; Keown et al., 2018; Munns & Walker, 2018; Vaughan et al., 2018; Moore et al., 2015).

Involvement of indigenous leaders ensures the design is based on local indigenous knowledge and values

Community leadership and wider community involvement ensure the programme design is based on indigenous knowledge and values of the community. This localised approach recognises the diversity of indigenous people and differing regional values. Programmes based on local indigenous knowledge are whānau/family-centred, community-based, culturally safe, and culturally connected (Schwartz, 2015). Resources and processes developed incorporate indigenous language, symbols and cultural teachings (Vaughan et al., 2018; Keown et al., 2018).

Working together on the programme design phase builds connections and trust between providers and the community

Participatory research approaches are used to engage with communities in design processes (Keown et al., 2018; Munns & Walker, 2018; Gerlach et al., 2018; Halseth & Greenwood, 2019; Public Health Agency of Canada, 2015). Indigenous leadership ensures congruence between the identified problem and the proposed prevention or intervention solution (Keown et al., 2018; Schwartz, 2015; Lowell et al., 2015).

Community leadership and engagement during the design phase of the programme starts the process to build trusting relationships based on partnership. As Keown et al. (2018) note, the community gets to know the service provider, and the provider gets to know the community. Building relationships with the wider community helps overcome mistrust, especially that associated with structural factors such as systemic racism (Gerlach et al., 2017; Houkamau & Clarke, 2016; Paine et al., 2017).

The collaborative design processes shift parents/whānau and community from service users to partners in the programme (Keown et al., 2018; Moore et al., 2012). This engagement process, if implemented in a culturally safe way, creates awareness and support for the programme and increases the likelihood of use (Gerlach et al., 2017; Schwartz, 2015; Campbell et al., 2018; Keown et al., 2018; Public Health Agency of Canada, 2015).

Targeted child health and wellbeing programmes for indigenous people are designed through community-development or programme adaption

The literature highlights two ways to design targeted child health and wellbeing programmes for indigenous people—community-development or community adaption of manualised programmes¹⁷.

A community-development approach is where the community develops their preferred approach to address locally identified needs based on local knowledge. This approach advocates that government-prescribed programmes should not be introduced into indigenous communities as they will not be fit-for-purpose (Schwartz, 2015).

An example: The Mother’s Story (Schwartz, 2015, p. 49)¹⁸

The Mother’s Story approach to care in the Nuu-chah-nulth Nursing Program represents a partnership between a pregnant woman and the nurse. The strengths-based and client-centred approach includes a focus on the hopes and dreams of the mother-to-be and her family for a healthy pregnancy and a positive birth experience.

The late Ray Seitcher (?ii wa nuk) [sic] helped shape the Mother’s Story approach to care. Ray mentored nurses to appreciate Nuu-chah-nulth ways of looking after pregnant women, honouring family teachings that support women preparing for birth, and giving their babies the best start in life. A Nuu-chah-nulth philosophy of care was introduced into the Nuu-chah-nulth nursing framework alongside the standards of nursing practice, to guide the partnership approach.

In contrast, manualised programmes have been adapted to work effectively in indigenous communities. Critical to this process is the community’s desire for the programme as well as community leaders, the community and service users working to incorporate indigenous knowledge, values, and approaches. Examples of effective adaption are the Triple P Parenting Programme by Ngāti Hine Health (Keown et al., 2018), and Incredible Years Parenting Programme (Superu, 2015). These programmes have improved parenting skills and child behaviour. Common to the adaption of these programmes is engaging indigenous people in the programme, using indigenous language, knowledge and values, focusing on the collective, and being based on the community.

¹⁷ Manualised programmes have specified components and delivery which can be replicated across locations. Manuals are critical components to ensure treatment fidelity and enable evaluations of impact. Examples of manualised programmes are Triple P Parenting Programme and Incredible Years Parenting Programme.

¹⁸ We could not find an evaluation of this programme. However, Schwartz noted the programme as an example of promising practice in First Nations and Aboriginal Maternal and Child Health Programs in Canada.

Te Whānau Pou Toru—adaption of the Triple P Parenting Programme (Keown et al., 2018)

The Triple P parenting programme was adapted in collaboration with Ngāti Hine Health. A Collaborative Participation Adaptation Model (CPAM) was used to improve the ecological fit, cultural relevance, and acceptability of Triple P for whānau Māori.

The programme involved extensive community partnership with elders and community leaders, practitioners and parents to identify content and implementation. Triple P was rebranded to Te Whānau Pou Toru to reflect three pillars of positive parenting and to bring together the collective strength of whānau Māori to positive parenting. Resources were developed to illustrate how the programme principles and tikanga Māori work together. The collaboration strengthened community connections and enabled engagement with whānau Māori to build trust in the provider and programme.

The evaluation reported improved child behaviour and reduced inter-parental conflict about child-rearing compared to parents in the control group. The six-month follow-up showed ongoing improvements in parenting practice and high levels of whānau satisfaction.

Involving indigenous people in the design and delivery of services builds capacity

Working in collaboration and partnership builds capacity in indigenous communities to develop their solutions to meet their needs (Grace et al., 2016; Bradshaw et al., 2015; Keown et al., 2018; Halseth & Greenwood, 2019; Lowell et al., 2015). This finding reflects Pihama et al.'s (2019) position that whānau Māori and their communities have the solutions to resolve issues.

Working in partnership with indigenous people also builds the capacity of non-indigenous providers and programme designers to understand and apply indigenous knowledge and values in improving child health and wellbeing (Keown et al., 2018).

Best practice approaches require indigenous leadership and governance

Indigenous people are more likely to engage in programmes when decision-making is transferred to communities (Gerlach et al., 2017; Public Health Agency of Canada, 2015; Keown et al., 2018; Middleton et al., 2017). Reflecting mana motuhake, some effective child health and wellbeing programmes are located in, or delivered by, indigenous organisations (Lowell et al., 2015; Keown et al., 2018). As Halseth and Greenwood (2019) state, in Canada, this represents best practice when working with indigenous communities.

The literature reviewed, however, is relatively silent on best governance structures for these targeted programmes. Engaging and including indigenous leaders in design and implementation is occurring, but little evidence highlights a shift to power-sharing or devolving power to indigenous organisations. Only Kildea et al. (2019) cite the importance of indigenous governance in creating an effective, culturally responsive early intervention in a hospital-based tertiary maternity service. Lowell et al. (2015) also note the importance of

indigenous governance in mainstream health services. However, they highlight the lack of power-sharing related to the management and allocation of funding and resources.

Moore et al. (2015) challenge the need to move away from traditional governance and leadership structures to address inequities. However, Moore et al. only recommend engaging and asking questions of indigenous communities. Thomas et al. (2015) state leadership is an essential component of constructive partnerships, with effective leaders seen as having responsibility, vision, authority, and resources to implement culturally appropriate service plans. However, leadership here refers to leaders within the provider organisations and not indigenous leadership.

Lowell et al. (2015) and Vaughan et al. (2018) highlight that governance and managerial structures can impede targeted, indigenous-led programmes. Both cite the significant work done by indigenous workers in programmes to ensure those in management and governance positions understand the programme and its benefits. They also note challenges in ensuring funding sustainability and adequacy of funding to reimburse the holistic family-centred work.

At least 43 iwi-led and Māori organisations are delivering the WCTO programme within their regions in Aotearoa. Cram et al. (2018), using the evaluation findings of Family Start, conclude services delivered by Māori organisations had improved health-related outcomes for tamariki Māori, including immunisation rates and primary care enrolment. Cram et al. suggest this difference may reflect that Māori providers are offering a holistic service and can provide improved coordination across services.

Māori leaders have governance over the delivery of the WCTO programme within their organisation and to their people. However, no sustained formal governance structure exists with Māori representation across the WCTO programme in Aotearoa. Under tino rangatiratanga, which provides for Māori self-determination and mana Motuhake, this is a significant oversight.

The partnership between whānau Māori/families and providers are at the heart of effective programmes

Moore et al. (2012) found how services are delivered is as important as what is provided. Taking time to build trusting relationships with indigenous communities and whānau Māori/families who use the service is a critical component of effective child health and wellbeing programmes (Lowell et al., 2015; Keown et al., 2018; Schwartz, 2015; Skerman et al., 2015; Ussher et al., 2016; Cram et al., 2018; Munns & Walker, 2018; Middleton et al., 2017; Wright et al., 2019; Vaughan et al., 2018; Thomas et al., 2015; Superu, 2015). As Mildon and Polimeni (2012, as cited in Cram, 2018) conclude, programmes that do not have a strong focus on relationship building are unlikely to work for indigenous families.

Relationship building takes time. Indigenous people can be suspicious of the motivations of government agencies or programmes. Schwartz (2015) notes building relationships and trust can take up to three years.

The development of trusted relationships between whānau/community and providers of child health and wellbeing are based on both personal characteristics and a strength-based and holistic way of working. The literature identifies the following themes as necessary in building relationships with whānau/families based on trust:

Positive personal characteristics

- Friendly
- Respectful of culture and practice
- Non-judgemental and affirming attitude
- Effective communication skills
- Demonstrate cultural awareness and sensitivity (discussed further below).

A strength-based, whānau-centred and collective way of working

- A partnership approach working in a way with whānau which respects their knowledge, builds on their strengths and makes them feel capable
- A focus on the holistic needs of whānau, and not a tasked-based approach focused solely on one child or individual
- Shared decision-making with families
- Expertise in child health and wellbeing to create a sense of trust in guidance offered.

Delivery aspects of continuity, flexibility and choice

- Consistency of interaction with the same provider to get to know each other and build trust
- Time to connect and listen
- Flexibility to meet immediate needs of importance to whānau, while delivering the prescribed content in the programme
- Choice to connect to other services and actively removing barriers to engagement.

These elements align with Moore et al.'s (2012) literature review, which identified critical aspects of effective service delivery in sustained nurse home visiting programmes for vulnerable families least likely to use professional services¹⁹. Moore et al. (2012) caution the factors identified are necessary but not sufficient for positive outcomes. They note positive change requires the use of evidence-based interventions to address the needs identified by

¹⁹ Moore et al. (2012, p. 8) defined vulnerable families and children as families whose children arrive at school poorly equipped to benefit from learning and social opportunities, and those who face multiple problems and require a lot of support.

the parents. This caution reinforces the tension between manualised programmes versus innovative community-developed programmes based on local knowledge and practice.

Indigenous workers have critical roles in effective programmes

Local indigenous health professionals and support workers bring a cultural and environmental understanding of the local knowledge and values in the delivery of child health and wellbeing services (Middleton et al., 2017; Campbell et al., 2018). They have a shared understanding of cultural heritage, empathy and mutuality (Munns & Walker, 2018). Some evidence indicates indigenous health workers achieve better outcomes than qualified nursing staff due to their cultural heritage and relationship-building capacities (Schwartz, 2015).

Indigenous people working collectively with health professionals can increase access to and engagement with child health and wellbeing programmes (Middleton et al., 2017; Kildea et al., 2019; Lowell et al., 2015; Vaughan et al., 2018). However, indigenous people can face challenges in seeking to support the work of health professionals. A lack of role clarity can exist between the role of indigenous health workers and health professionals. Middleton et al. (2017) highlighted the benefits of Aboriginal workers and midwives working together to achieve improved birth outcomes for Aboriginal and Torres Strait Islander women. The model assumes the relationship is based on an equal partnership and shared knowledge exchange. However, maintaining these partnerships is challenging due to a lack of commitment from senior managers or recognition by other health staff. Vaughan et al. (2018) also note this challenge as well as indigenous staff managing the potential tensions between community values and the values in a role prescribed by a government agency.

Lowell et al. (2015) highlight the work of indigenous health workers can be 'invisible' occurring through their networks and connections within the community. Through their networks, indigenous staff can strengthen whānau/family's connections in their communities and to their culture. Due to their commitment to their community and the complexity of the work, indigenous staff need support to avoid the potential for burn-out (Ussher et al., 2016).

A high-functioning team is critical to the success of the programme

As indicated above, one health worker or health professional will not on their own create a successful programme. As Schwartz (2015) highlights, effective child health and wellbeing programmes are situated in high-functioning teams which connect and communicate regularly. High-functioning teams engage in ongoing education and training through reflective practice. Without this wider supportive structure, the staff in child health and wellbeing programmes cannot thrive to support indigenous families and communities.

Cultural safety is a critical element in decreasing health inequities

The literature reviewed highlights the central importance of both child health and wellbeing programmes for indigenous people being culturally appropriate and those that deliver them

being culturally competent. Across the literature reviewed, a range of terminology is used including cultural sensitivity, cultural awareness, cultural responsiveness, etc. Curtis et al. (2019) also note mixed definitions and understandings of cultural competency and cultural safety.

Curtis et al. (2019, p. 1) state, “Eliminating indigenous and ethnic health inequities requires addressing the determinants of health inequities which includes institutionalised racism and ensuring a healthcare system that delivers appropriate and equitable care.” Curtis et al. explore the differences between cultural competency and cultural safety at both health practitioner and organisation levels to achieve equitable health care.

Curtis et al. (2019) state focusing on the cultural competency of health professionals to gain an understanding of indigenous culture is limiting as it ignores inherent power dynamics and imbalances. Curtis et al. recommend health organisations and professionals move towards cultural safety and critical consciousness.

Dr. Irihapeti Ramsden first put forward the term ‘cultural safety’ in the 1990s (Ramsden, 2015). In 1992, the Nursing Council of New Zealand made cultural safety a requirement for nursing and midwifery education with a focus on power relationships and patient rights (Papps & Ramsden, 1996).

The shift to cultural safety and critical consciousness creates an active reflective process requiring health organisations and professionals to challenge their culture and cultural systems within the context of achieving health equity. Health practitioners need to question their biases, attitudes, assumptions, stereotypes, and prejudices contributing to lower quality healthcare. Curtis et al. (2019) acknowledge cultural safety and critical consciousness is more confronting and challenging. However, advancing health equities for whānau Māori must include a critique privilege and power.

Curtis et al. (2019, p. 4) recommend the following definition of cultural safety is adopted by healthcare organisations.

Cultural safety requires healthcare professionals and their associated healthcare organisations to **examine themselves and the potential impact of their own culture on clinical interactions and healthcare service delivery**. This requires individual healthcare professionals and healthcare organisations to acknowledge and address their own biases, attitudes, assumptions, stereotypes, prejudices, structures and characteristics that may affect the quality of care provided. In doing so, cultural safety encompasses **a critical consciousness** where healthcare professionals and healthcare organisations engage in ongoing self-reflection and self-awareness and **hold themselves accountable for providing culturally safe care**, as defined by the patient and their communities, and as measured through progress towards achieving health equity. Cultural safety requires healthcare professionals and their associated healthcare organisations **to influence healthcare to reduce bias and achieve equity within the workforce and working environment**.

The Medical Council of New Zealand/Te Kaunihera Rata o Aotearoa (2019 and 2019a) has adopted and is applying the definition through its cultural safety standards.

Consistent with the goal of mana tangata, cultural safety and critical consciousness has relevance and value. The WCTO programme redesign needs to identify how cultural safety activities can be built into training, professional development and accreditation, and ensure systematic monitoring and assessment of inequities are included in workforce and health outcomes. Working towards cultural safety needs to occur at the WCTO programme (system level), organisation and health practitioner levels.

We also need to consider workforce composition and focus on building a diverse and inclusive clinical WCTO workforce and ensure culturally safe and reflective practice. The role of non-clinical Māori staff is also important in supporting access and engagement with services and strengthening cultural connections as recommended by Pihama et al. (2019). As demonstrated, their roles need to be respected, understood and supported within enabling management, leadership and governance structures.

Flexibility in delivery mechanisms and content will enable access and support ongoing engagement

Effective targeted child health and wellbeing programmes emphasise the need for flexibility at multiple levels to support access and ongoing engagement for indigenous people.

Access to programmes is enabled through open and flexible entry and the removal of barriers

A universal proportionate well child programme links to a range of targeted services, including additional contacts delivered within the programme, targeted holistic services for indigenous families and communities, and specialised services supporting a specific family or child need. Access pathways to these targeted services vary depending on their purpose. Access to holistic services for indigenous families and communities may be via open invitation and self-referral. Targeted programmes focused on addressing a family or child need may be via referral by health or other professional after reaching the eligibility threshold for the services.

Targeted child health and wellbeing programmes can have criteria to assess families' eligibility to access them, e.g., the Nurse Family Partnership (Kitzman et al., 2019). Schwartz (2015) recommends eligibility criteria are not used, and that services are available for all families. Access criteria can be stigmatising and put families off using services. The use of eligibility criteria can also restrict access to families who need support but do not meet the threshold. Eligibility criteria can be viewed as a tool to restrict and manage resources. Schwartz argues offering open and flexible entry recognises the diversity of families and how their needs can change across the life course.

For indigenous families to access programmes, they need to be aware of them. They need to see the programme as useful, culturally safe, and relevant as demonstrated through promotion and importantly, word-of-mouth support within their community. They also need a positive experience when they engage. The literature indicates a lack of awareness can prevent access to targeted services, and some families require advocacy and practical support to access services they know little about (Moore et al. 2012; Rossiter, et al., 2019; Wilk et al., 2018).

Families can have a range of access barriers including financial constraints, a lack of transport, transience and housing insecurity, and distrust of services (Middleton et al., 2017; Pullon et al., 2015). However, as Paine et al. (2017) describe, structural racism also prevents caregivers from accessing care. In this context, seeking to increase access to child health services for indigenous people requires action targeted at the health system. This finding reinforces the importance of applying cultural safety and a critical consciousness lens at organisational and health professional levels.

Access and engagement to child health services can also be enhanced through a range of delivery mechanisms

Indigenous families and whānau Māori are diverse with differing strengths, contexts and environments. Recognising this diversity, Schwartz (2015) advocates the delivery of programme components through a combination of home visits and group activities.

Home visits improve access to child health and wellbeing programmes (Cram et al., 2018; Superu, 2015; Schwartz, 2015; Adams et al., 2019). With home visits, families are more relaxed in their environment, and providers can use a relational process to work collectively to support families (Gerlach et al., 2017). Home visits also remove known barriers, such as lack of transport and access to childcare (Superu, 2015).

The HomVEE (Home Visiting Evidence of Effectiveness) review (Mraz Esposito et al., 2014) has demonstrated the effectiveness of home visits. Family Spirit²⁰ is a culturally congruent, family-strengthening, American Indian home-visiting programme. In the HomVEE review, Family Spirit met all the review's criteria for effectiveness. Family Spirit has increased adolescent mothers' involvement and knowledge of childcare, and their positive maternal role attainment and having a positive maternal self-image.

Group activities run outside of clinical settings also show promising results as they strengthen community networks and connections and links to culture. An evaluation of a maternal and child health programme in Australia's Northern Territory found informative walks with indigenous healthcare workers contributed to the programme's success (Lowell et

²⁰ <https://homvee.acf.hhs.gov/implementation/Family%20Spirit%C2%AE/Model%20Overview>

al., 2015). The “going out” enables the teaching of natural medicine and “bush tucker” and offers an opportunity for pregnant women to exercise.

For service delivery in clinics or community hubs, flexible arrangements can also support access for families such as walk-in appointments, longer appointments, meeting outside clinics and regular office hours (Gerlach et al., 2017; Schwartz, 2015; Thomas et al., 2015)

Ongoing engagement is supported through flexibility in programme content delivery

Child health and wellbeing programmes are made up of a range of components, including screening and surveillance for child health and wellbeing, and family and parent support, education and guidance. Effective indigenous child health and wellbeing programmes tend to have the flexibility to tailor interactions and services to meet families’ holistically defined needs and preferences (Lowell et al., 2015; Keown et al. 2018; Schwartz, 2015; Cowley et al., 2018; Adams et al., 2019). As Schwartz (2015) states, having flexibility means programmes can help families to realise their dreams and aspirations. Within manualised programmes, (e.g. Triple P-Positive Parenting) providers must flexibly deliver services to meet families’ priorities while maintaining a focus on programme fidelity (Keown et al., 2018).

To increase access and engagement for whānau Māori in the redesign of the WCTO programme, the insights from effective child health and wellbeing programmes for indigenous people needs to incorporate partnership, choice and self-determination. Working in a partnership requires a flexible approach which respects the diversity of whānau, their values, and supports their autonomy.

3. The WCTO programme needs to support intersectoral collaboration to address the social determinants of health and wellbeing

Māori are over-represented in high deprivation areas and have the poorest health status of any ethnic group in Aotearoa New Zealand (Curtis et al., 2019). To address existing inequities, the literature reviewed recommends an intersectoral, cross-agency approach focused on the social determinants of health. The intersectoral approach is essential to overcome the consequences of poverty and the associated health and social inequities (Keown et al., 2018; Bradshaw et al., 2015; McCalman et al., 2015; Halseth & Greenwood, 2019; Coles et al., 2016).

Halseth and Greenwood (2019, p. 11) define intersectoral collaboration as the collective actions of various government, non-government and community organisations working across health, housing, education, transportation, social welfare, and other sectors. The benefits of intersectoral, cross-agency collaborations are a comprehensive response to community issues, less fragmentation of services, improved communication across sectors, effective use of limited resources, and a reduction of duplication and gaps (Halseth & Greenwood, 2019; Munns et al., 2018).

The literature reviewed suggests a lack of integration exists, particularly across health and education sectors in Aotearoa (Pullon et al., 2015; Dossetor et al., 2019; Halseth & Greenwood, 2019). Working intersectorally is not easy within current government contracting and reporting structures, and requires experienced staff who are supported to work in different ways (Moore et al., 2012). As Halseth and Greenwood (2019) acknowledge, research is needed on what types of intersectoral collaborations work and in what contexts.

Thomas et al. (2015) observe integrated processes and shared tools are needed to enable collaboration across agencies. Drawing across the literature, the factors contributing to effective partnerships across agencies include:

- Working with a culturally appropriate model of care (which may be location-specific)
- Effective leadership within and between organisations
- Being able to facilitate effective working relationships
- Organising shared training opportunities across agencies and with community
- Encouraging the sharing of human and material resources and data
- Promoting the benefits of partnerships between agencies (Bradshaw et al., 2015; Thomas et al., 2015; Middleton et al., 2017; Keown et al., 2018; Wright et al., 2019).

Kildea et al. (2019) provide an example of effective cross-agency collaboration. In 2013, a multi-agency partnership between two Aboriginal Community Controlled Health Organisations and a tertiary maternity hospital, was set up based in an indigenous-controlled community hub. The hub provides a culturally enabling environment, where women and families access multi-disciplinary maternity and infant care, and indigenous Family Support Workers connect and secure care pathways for women and families.

The welcoming design of the hub enables families to connect, interact, share and learn from each other and community elders. Most staff are indigenous and well connected to the community. Linkages within the local family doctors at Aboriginal Community Controlled Health Organisations are fostered through shared electronic health records, phone and in-person communication. Kildea et al. (2019) demonstrated this model of care was effective in improving birth outcomes.

In line with mana whakahaere, the redesign of the WCTO programme needs to take a system perspective. The redesign needs to consider the wider health, social and education system and the intersectoral responses needed to address the social determinants of health. Consideration is also needed on the structure of the WCTO programme in the context of the universal, proportionate, community and intersectoral levels.

The Ministry of Health's sector engagement on the WCTO programme highlights interest in the use of community hubs to offer wraparound services to whānau Māori to address the social determinants of health and reduce inequities (Ministry of Health, 2019b and 2019c). The role of iwi-led and Māori providers delivering WCTO services will have an essential role in creating multi-disciplinary and holistic support for whānau Māori.

4. Funding and contracting models need to be sufficient and flexible to advance equity for whānau Māori

Adequacy of funding and funding structures influence participation in targeted parenting programmes (Robertson, 2014). A common theme across the literature on targeted indigenous child health and wellbeing programmes is the lack of and uncertainty of long-term funding to deliver a holistic and whānau-centred programme (Schwartz, 2015; Vaughan et al., 2018; Moore et al., 2012; Cram et al., 2018; Thomas et al., 2015; Bradshaw et al., 2015).

A lack of funding can undermine the sustainability and legitimacy of services within the wider health system and the community (Schwartz, 2015). A lack of funding also impacts on the availability of the programme and increases staff stress and workload to meet community expectations of a holistic wraparound service that extends beyond their contract (Campbell et al., 2018; Moore et al., 2012). The uncertainty of sustainable funding also creates significant work (and anxiety) for programme providers in having to advocate for ongoing funding (Vaughan et al., 2018; Campbell et al., 2018). Funding structures also adversely impacted on collaboration across services (Thomas et al., 2015).

Schwartz (2015) recommends that determining equity and coverage in indigenous child health and wellbeing programmes requires an analysis of current programmes and their funding. This analysis needs to include the amount of funding, given existing service gaps in many communities. Schwartz (2015) goes further, to strongly recommend no new programmes are introduced until funding inequities are resolved. Schwartz also calls for increased long-term funding, up to 10 years, for indigenous communities to establish consistent and reliable services.

In Aotearoa, current government contracting models tend not to contract for the long-term or offer the needed level of flexibility. However, government contracting is evolving. The Ministry of Health entered into a 10-year National Telehealth Service partnership-based contract with Homecare Medical. Place-Based Initiatives are trialling different commissioning models for NGOs to support whānau holistically. Māori organisations (and others) providing Family Start and Whānau Ora services can combine funding streams to deliver a holistic service to whānau. As Cram et al. (2018) recommend, more research is needed to understand the ways to enable providers to integrate programmes from different funding sources.

In line with Te Tiriti principles, analysis is required to assess the equity of funding in the WCTO programme both in the amount and distribution. Contracting models also need to be reviewed to ensure they support the need for flexibility and options, and to create a solid foundation for ongoing innovation within an indigenous wellbeing framework.

5. The WCTO programme needs a holistic whānau-centred measurement framework which is responsive to whānau Māori, focuses on equity and ensures data sovereignty

A range of approaches is used to assess the effectiveness of targeted programmes

Approaches to assess child health and wellbeing outcomes vary across the targeted child health and wellbeing programmes cited in this literature review. This variation reflects the design and intent of the programme or intervention, its maturity and size, and the evaluative approach used.

Some programmes, usually large scale, mature and targeting a specific demographic group, use quantitative evaluation approaches focusing on physical health or other single-dimensional health measurements (Vaithianathan et al., 2016; Segal et al., 2018; Keown et al., 2018; Enns, 2019; Kitzman et al., 2019).

In contrast, more localised and smaller programmes, particularly in indigenous settings, use qualitative approaches to assess holistic child health and wellbeing aspects with family and community (Campbell et al., 2018; Vaughan et al., 2018; Thomas et al., 2015; Munns et al., 2017; Lowell et al., 2015; Schwartz, 2015). Equity of access is assessed at the community-level and was not explicitly discussed at a population level. A common theme across the literature reviewed is the lack of appropriate national disaggregated data on wellbeing indicators specific to indigenous children and communities.

An indigenous framework is needed to measure tamariki Māori wellbeing within the WCTO programme

As discussed, measurements of child wellbeing have been criticised as deficit-focused and not depicting the lived reality of tamariki Māori and whānau Māori. Cram (2019) reviews a range of Māori models for assessing child wellbeing in the context of whānau wellbeing. Drawing on this collective knowledge, Cram proposes a tamariki Māori wellbeing indicator set based on mauri—the spark of life and the interconnection between tamariki Māori and Māori whānau wellbeing. The set has three elements and uses a Māori-centric lens, based on Māori values and principles. As summarised from Cram (2019):

- **Kia mau i a rātou te ihi** is the essential force which gives confidence and esteem to a child moving in the world, both te ao Māori and te ao hurihuri. The child's esteem is aligned to people and place through whakapapa. Cram puts forward seven indicators for

ihi: birth registration, living in a multi-generation household, family relationship, te reo is spoken, knowledge of whakapapa, connection to a marae, importance of spirituality.

- **Kia mau i a rātou te wehi** is the wonder of children looking forward with excitement. Cram's seven indicators are: self-rated health, living in a smokefree home, feelings of safety, taking part in early childhood education, attendance at kura/school, feeling cared for, and spending time with family.
- **Kia mau i a rātou te wana** is the child's love and thrill of life and looking forward to making decisions about the future and set goals. The seven wana indicators are whānau wellbeing, satisfaction with life, physical activity, cultural esteem, feeling like part of a school, people at school care, and engages in school activities.

Cram (2019) acknowledges measuring tamariki Māori wellbeing within the framing of mauri needs to be tested, especially with tamariki and whānau Māori. The use of this framework, or its ongoing development, needs to be considered within the context of the WCTO programme, which also collects important screening and surveillance data on child health and development indicators. The latter are important markers which may determine the need for early intervention relating to a specific health or development issue. To develop a WCTO measurement framework requires working closely with whānau Māori, hāpu, iwi, Māori academics and clinicians.

Data collection and use needs to be responsive to Māori, focus on equity and ensure data sovereignty

Reid et al. (2017) state health research conducted in Aotearoa must contribute to improving Māori health and eliminating health inequities. The use of data and research need to meet a range of Māori expectations. Reid et al. set out responsibilities against which health researchers are required to demonstrate an understanding, including confirming the research:

- is a strategic priority for Māori
- informs the elimination of ethnic inequities
- incorporates traditional or contemporary Māori processes
- supports Māori development, including workforce development
- is based on an explicit relationship with Māori
- actively protects Māori rights, including cultural and intellectual property rights.

Reid et al. (2017) go further, noting health researchers must also consider Māori expectations, including:

- Respecting and upholding Te Tiriti
- Impacting positively on Māori and improving Māori health
- Involving Māori in the research and data governance to uphold Māori ethical principles

- Facilitating greater communication and transparency
- Accountability to Māori through sound reporting and dissemination.

Reid et al. (2017) highlight the importance of data ownership and guardianship of datasets, especially when included in “big data” such as the Integrated Data Infrastructure (IDI)²¹. Within the WCTO programme, significant data is collected from whānau Māori over the first five years of tamariki Māori lives. More consideration is needed around data stewardship and data sovereignty of the data collected within the framing of the Te Tiriti obligations.

In Aotearoa, Te Mana Raraunga²² (the Māori Data Sovereignty Network) is advocating for Māori data sovereignty. Te Mana Raraunga states data innovations are occurring in the absence of robust Māori data governance with accountability back to Māori/iwi. Te Mana Raraunga states Māori data (including data about Māori, data used to describe Māori collectives and data about te ao Māori) is a living tāonga and subject to Māori governance (Ballantyne and Style, 2017). Work is ongoing on operationalising data sovereignty claims to ensure data use is in the best interests of Māori. Within the WCTO programme redesign, the use and governance of WCTO data require working collectively with whānau Māori, hapū and iwi to determine appropriate processes and governance.

²¹ <https://www.stats.govt.nz/integrated-data/integrated-data-infrastructure/>

²² <https://www.temanararaunga.maori.nz/>

Conclusions

Strong evidence supports the benefits of a universal proportionate well child health and wellbeing programme to reduce equity gaps and deliver positive outcomes for all children. However, inequities of access and outcomes for tamariki Māori are evident in the current WCTO programme.

We conclude this literature review by returning to reflect on the Ministry's obligations under Te Tiriti o Waitangi. To recap, the Ministry of Health's expression of Te Tiriti is based on four goals: mana whakahaere, mana motuhake, mana tangata, mana Māori. The Ministry's approach is guided by five principles: tino rangatiratanga, equity, active protection, options and partnership.

The literature review findings highlight the design features of effective indigenous child health and wellbeing programmes, which support positive outcomes for indigenous people. These features align with the Ministry's goals and Te Tiriti principles. Embedding these inter-connected design features is likely to contribute to increasing access for whānau Māori and engagement with the WCTO programme, and potentially improve equity of outcomes.

Based on the findings, the redesign of the WCTO programme needs to incorporate the following insights collectively:

- The WCTO programme redesign needs to be framed on kaupapa Māori concepts of tamariki Māori health and wellbeing within the context of whānau Māori wellbeing and collective responsibility.
- The WCTO programme redesign needs to integrate access and engagement enablers to deliver positive outcomes for whānau Māori, including:
 - Being based on mātauranga Māori and tikanga Māori
 - Having Māori leaders, whānau Māori and community as key decision-makers in the programme design, implementation, and governance (both locally and nationally)
 - Prioritising, enabling and supporting the development of trusting partnership-based relationships between whānau Māori and WCTO providers
 - Having cultural safety and critical consciousness as a critical reflective guide for WCTO providers and clinical and non-clinical staff
 - Offering flexibility in access through a tiered proportionate universal service, a range of delivery mechanisms, and flexible delivery of content.
- Adequate funding allocations and effective contracting models are needed to advance equity for whānau Māori.
- The WCTO programme needs to support intersectoral collaboration to address the social determinants of health and wellbeing for whānau Māori.

- A holistic whānau-centred measurement framework for the WCTO programme is needed, which is responsive to whānau Māori, focuses on equity, and ensures data sovereignty.

Areas for further investigation

The literature review has highlighted areas for further or future investigation including:

- Kaupapa Māori research and evaluation of the WCTO programme, particularly the universal component of the programme, which is needed to increase the evidence base of what works in what context for whānau Māori.
- Kaupapa Māori research and evaluation, which is needed to create an evidence base of new innovative targeted services and practices within or associated with the WCTO programme.
- A review of the current funding and contracting model for the WCTO programme to ensure it advances equity of outcomes.
- A more developed understanding of the WCTO programme within the wider health, education and social sector to ensure integrated collaborations supporting health equity across the life course for whānau Māori.
- The need for the design of the proportionate universal model of the WCTO programme to be clearly articulated, particularly the proportionate component.

Next steps

We are currently analysing interviews with whānau Māori to understand their moemoeā of pēpi/tamariki health and wellbeing. On completion, we will review and may refine the insights from the literature review based on the wisdom and insights from whānau Māori and Māori leaders.

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Appendix: Literature review specifications

The literature review sought to answer five questions

1. How is child health and wellbeing in the context of whānau health defined in the literature?
2. How is child health and wellbeing defined in indigenous communities?
3. What are the models of care for child health and wellbeing that reduce inequities for Māori and other indigenous groups through increased enrolment, engagement, participation and retention?
4. How do the models of care for child health and wellbeing work to reduce inequities for Māori and other Indigenous groups? More specifically, how do these models of care work to:
 - increase enrolment, engagement, participation and retention?
 - enable parents/whānau/community as partners?
 - build a relationship and trust to enable engagement, participation and retention?
5. What are the measurable outcomes for these models of care to demonstrate equity of access, experience, and health and wellbeing outcomes?

We used the following inclusion criteria

- Studies relating to children and their families from conception to five years
- Literature demonstrating the features of models of care across the life course that are delivering equitable outcomes for Māori or indigenous populations
- Literature published from 1 January 2015 to 1 January 2019
- Literature in the health domain
- International and Aotearoa New Zealand literature published in English
- Grey literature sourced from Aotearoa New Zealand.

We have excluded the following from our literature review

We excluded studies that described programmes:

- in developing countries
- for children over five years; although we did briefly look at literature on the features of models of care across the life course that are delivering equitable outcomes
- treatment programmes
- that are domain-based.

We reviewed and refined the inclusion and exclusion criteria on reviewing the initial results of the literature search.

We worked with the Ministry of Health’s library

We requested the library searched and extracted the results using the following databases, and others recommended by the Library team:

- Ovid MEDLINE
- Cochrane Library
- PsycINFO
- EBSCO
- ProQuest.

We included government websites:

- The Treasury
- DPMC
- Ministry of Health
- Ministry of Social Development
- Oranga Tamariki
- Social Investment Agency
- Te Puni Kōkiri
- Ministry of Education
- Health Quality and Safety Commission
- Health Promotion Agency
- New Zealand College of Midwives.

We used the following search terms

Question	Potential search terms
1. How is child health and wellbeing defined in the literature?	<ul style="list-style-type: none">▪ Infant/Baby wellbeing▪ Infant/Baby health▪ Healthy infant/baby▪ Child wellbeing▪ Child health▪ Healthy child▪ Family health▪ Family wellbeing▪ Maternal child health▪ Maternal child wellbeing

Question**Potential search terms**

2. How is child health and wellbeing defined in Indigenous communities?	As above with focus on: <ul style="list-style-type: none">▪ Māori▪ First nation/Indigenous/aboriginal▪ Colonisation
3. What are the models of care for child health and wellbeing that reduce inequities for Māori and other indigenous groups through increased enrolment, engagement, participation and retention?	<ul style="list-style-type: none">▪ Preventative health program/mes: preventive health program/mes: Anticipatory guidance program/mes▪ Prenatal health/wellbeing program/mes /models of care for positive life outcomes▪ Models of care for baby health / wellbeing▪ Models of care for positive life course outcomes▪ Models of care for child health/wellbeing▪ Maternal and baby/ Mother and baby programme▪ Universal program/mes▪ Progressive universal program/mes▪ Episodic program/mes▪ Child surveillance program/mes▪ Child screening program/me (well child program/me*) or (well child visit* or well childcare)▪ Healthy (baby or babies) program/me*▪ Healthy (child or four-year) program/me*▪ Healthy baby/ healthy child▪ Before school or b4 school or b4school or before school program/me or pre-school health/wellbeing checks▪ Health visiting program/mes▪ Australian well child programmes▪ Indigenous child wellbeing model▪ Child-centred program/mes▪ Integrated models of care▪ Whānau-centred program/me▪ Family centred program/me▪ Parent program/me▪ Parent partner program/me▪ Whānau/family partnership▪ Whānau ora* Mauri ora▪ Indigenous program/me (or Aboriginal or First Nations program/me)▪ Indigenous screening / surveillance▪ Equitable/equity for Indigenous populations/Māori

Question**Potential search terms**

	<ul style="list-style-type: none">▪ Addressing inequalities in program/me enrolment* engagement* participation* retention * health and wellbeing outcomes▪ Addressing inequities in program/me enrolment* engagement* participation* retention * health and wellbeing outcomes▪ Baby/Child equity outcomes▪ Vulnerable children outcomes▪ Vulnerable families outcomes▪ Life course health and wellbeing outcomes▪ Culturally sensitive screening▪ Maternal child health programme
4. How do the models of care for child health and wellbeing work to reduce inequities for Māori and other Indigenous groups? More specifically, how do these models of care work to: <ul style="list-style-type: none">– increase enrolment, engagement, participation and retention?– enable parents as partners?– build relationship and trust to enable engagement, participation and retention?	<ul style="list-style-type: none">▪ Enrolment in program/me▪ Engagement in program/me▪ Participation or retention in program/me▪ Barriers to participation or retention▪ Enablers to participation or retention▪ Program design or delivery▪ Best practice principles▪ Program/me engagement or retention or participation▪ Family or parent engagement or retention or participation▪ Relationships trust▪ Parents as partners▪ Family as partners▪ Community engagement in program/me▪ Community support in program/me
5. What are the measurable outcomes for these models of care to demonstrate equity of access, experience and health and wellbeing outcomes?	<ul style="list-style-type: none">▪ Baby health and wellbeing outcomes▪ Socially vulnerable outcomes: vulnerable families outcomes▪ Life course outcomes▪ Child outcome measures▪ Child equity measures▪ Indigenous child outcome measure

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