Evaluating Māori community initiatives to promote Healthy Eating, Healthy Action

HEATHER HAMERTON1*, CHRISTINE MERCER2, DENISE RIINI2, BRIGHID MCPHERSON2 and LAURIE MORRISON3

1Taiorangahau, Pacific Coast Applied Research Centre, Bay of Plenty Polytechnic, Tauranga, Aotearoa New Zealand, 2School of Nursing, Waiariki Institute of Technology, Rotorua, Aotearoa New Zealand and 3School of Public Health and Psychosocial Studies, AUT University, Auckland, Aotearoa New Zealand

*Corresponding author. E-mail: heather.hamerton@boppoly.ac.nz

SUMMARY

Māori, the indigenous people of Aotearoa New Zealand, experience poorer health than non-Māori across a range of health measures. Interventions focused at an individual level have proved largely ineffective; ‘bottom-up’ approaches where communities determine their own priorities may be more sustainable than ‘top-down’ approaches where goals are determined by health authorities. The purpose of this paper is to illustrate an innovative health promotion programme aimed at improving Māori health and to discuss the importance of ownership and control of health initiatives by Māori. Evaluators conducted a comprehensive evaluation of a Healthy Eating Healthy Action programme in six small Māori health agencies, gathering information from programme managers and coordinators, participants and wider community members about what changes were occurring at individual, family and community levels. Effective interventions built on cultural values and practices and were delivered by Māori with close connections to the community. Changes in nutrition and physical activity made by participants also benefitted their wider families and community. The changes demonstrated subtle but important shifts in thinking about healthy eating and healthy activity that in the longer term could lead to more measurable change towards improved quality of life for people within communities.

Key words: indigenous health promotion; community empowerment; evaluation

INTRODUCTION

Māori, the indigenous people of Aotearoa New Zealand, experience poorer health than non-Māori across a range of health measures, including having a shorter life expectancy and higher rate of disability and core chronic illnesses than the general population (Harwood and Tipene-Leach, 2007; Ratima and Ratima, 2007). The purpose of this paper is to describe an innovative health promotion programme in one region of Aotearoa New Zealand that aimed to improve the health of Māori and identify factors that contributed to its success. We begin with information about Māori health disparities and contributing factors, focusing on family- and community-level interventions and on the importance of culture in Māori models of health. We then describe an evaluation of a health promotion programme in six Māori communities and findings that suggest that health promotion programmes that are community owned and based on cultural values and practices are more likely to be successful and sustainable.

Health disparities between Māori and non-Māori populations within Aotearoa New Zealand have been widely documented over time, and do not appear to have improved in recent years. Currently, Māori life expectancy is almost 8 years lower than non-Māori for both
genders (Cormack, 2007). The most common causes of death for Māori of both genders are chronic diseases, such as ischaemic and other heart disease, lung cancer, diabetes and chronic obstructive pulmonary disease (Robson and Purdie, 2007). Like other indigenous peoples, Māori experience a high prevalence of obesity and type II diabetes (Voyle and Simmons, 1999; Simmons and Voyle, 2003). These statistics are similar to disparities reported for indigenous populations in colonized countries elsewhere, for example Canada (Mundel and Chapman, 2010) and Australia (Penm, 2008; Australian Institute of Health and Welfare, 2009).

In spite of the health disparities reported above, information on risk and protective factors such as nutrition and physical activity demonstrates that differences between Māori and non-Māori are either fairly small or negligible. For example, data compiled from 2007 to 2008 physical activity surveys showed that Māori adults were the most active group, with 53.5% meeting national physical activity guidelines compared with 52.6% of Pacific peoples and 48.9% of European New Zealanders (SPARC, 2010). The 2002 Children’s Nutrition Survey showed that the prevalence of eating the recommended number of servings of vegetables and fruit was similar for both Māori and non-Māori children. Among adults, Māori were only slightly less likely than non-Māori to meet the recommended daily intake of fruit and vegetables (Parnell et al., 2003).

Although in individual cases it is possible to link health status to behavioural and lifestyle factors such as high fat diets and smoking, the statistical evidence suggests that health is also affected by broader structural factors (Wilkinson and Pickett, 2009). For instance, research in Aotearoa New Zealand has found that social and economic factors also contribute to Māori health inequalities (Howden-Chapman and Tobias, 2000; Ministry of Health, 2002; Blakely et al., 2004; Taskforce for Whānau-Centred Initiatives, 2010). While it is not possible for health programmes to directly address structural factors that lead to health inequalities, one implication is that programmes need to be targeted at the level of the family or community while not neglecting the importance of individual change (Curtis et al., 2007; Taskforce for Whānau-Centred Initiatives, 2010).

Increasingly researchers are finding that family-, cultural- and community-based initiatives are proving more successful in the longer term than individually focused ones, and that the ripple effects of the former can improve the health of the entire group as well as that of target individuals. Collaborative models, such as Tyler and Horner’s (2008) family-based collaboration model, offer promise since they can be tailored to lifestyle and resources. Their model builds on family strengths and health-related goals and concerns, including identifying barriers to success (Berg-Smith et al., 1999). In Aotearoa New Zealand, the recently implemented Whānau Ora initiative takes a similar approach, targeting health services at the level of the whānau (family), and specifically attempting to identify and meet the aspirational aims of families (Taskforce for Whānau-Centred Initiatives, 2010).

At a community level, Laverack and Labonté (Laverack and Labonté, 2000) have proposed that community-led ‘bottom-up’ approaches to health promotion, where communities are encouraged to determine their own priorities, are likely to be more sustainable than ‘top-down’ approaches determined by health authorities and funders. A ‘bottom-up’ approach results in communities assuming greater responsibility for identifying health issues and greater control over managing and addressing them, although outcomes may only be apparent over a longer period of time.

Consistent with the Whānau Ora approach, New Zealand research has already shown that health promotion programmes that enable communities to take ownership of their own health initiatives and develop programmes to meet their needs within their own cultural frameworks may be more useful than programmes imposed from outside. For example, Simmons and Voyle (2003) proposed that, in the case of Māori, conventional approaches to health education and health services are insufficient, and that increased consideration needs to be given to how the settings in which services are offered influence diabetes prevention and earlier diagnosis. They suggest that settings in which Māori identity, values and cultural practices are affirmed maximize the potential for enhancing cultural sensitivity and generating self-efficacy, creating a more supportive environment for sustainable health behaviours.

Indigenous models of health are based on understandings that, for indigenous peoples, health is linked to indigenous world views and indigenous development (Durie, 2004). Mason Durie (Durie, 1999, 2004) has proposed a Māori health promotion model: Te Pae Māhutonga.
The Southern Cross constellation of stars visible in the skies in the southern hemisphere has long been used to assist navigation in the South Pacific Ocean, and consists of four stars arranged in the form of a cross, with two stars in a straight line which point towards the cross (the two pointers) (Durie, 1999, 2004). The six dimensions of Te Pae Māhutonga represent the six stars of the Southern Cross: Mauri Ora (te Ao Māori), Waiora (Environmental protection), Toiora (Healthy Lifestyles), Te Oranga (Well-being) representing the four stars making up the cross itself, with Ngā Manukura (Leadership) and Te Mana Whakahaere (Autonomy) representing the two pointers. Thus in Durie’s model, leadership and autonomy are considered essential foundations for successful health promotion. Additionally, good health within this model requires access to a secure cultural identity, access to land, language and cultural resources and the ability to participate fully in society, alongside healthy lifestyles and a healthy environment.

The Te Pae Māhutonga model thus recognises and promotes the importance of Māori-led and Māori-controlled interventions as essential for health promotion. The importance of community control over health interventions and programmes has been similarly promoted by others (e.g. Labonté, 1997; Laverack and Labonté, 2000; Leeuw, 2007). Health agencies are generally unable to exercise a great deal of influence over broad structural inequalities such as poverty. However, through a community development approach, they may be able to work at a community level to ensure that structures and resources are available to enable community members to take leadership of health initiatives (Germann and Wilson, 2004).

As part of the New Zealand Health Strategy aimed at reducing health disparities, 13 population health objectives were identified which included improving nutrition, increasing physical activity and reducing obesity (Ministry of Health, 2000). Physical activity and nutrition initiatives formed the basis of a strategic project to combat obesity and type II diabetes through a ‘Healthy Eating Healthy Action’ (HEHA) strategy (Ministry of Health, 2003). The project was broad and far reaching in concept, encompassing agencies that had previously worked in isolation, with overall co-ordination provided by the Ministry of Health and Sport and Recreation New Zealand (SPARC).

As part of the HEHA strategy, a Māori health organization in a regional centre of Aotearoa New Zealand developed a programme that aimed to improve the health of Māori communities. The programme, called Project REPLACE, invited participants to gradually change their behaviour by replacing one unhealthy behaviour with a healthier alternative. Specifically, REPLACE is a mnemonic that is detailed in Table 1.

The primary objective of Project REPLACE was to promote and foster the development of environments and practices that support healthy lifestyles for Māori by targeting identified populations who displayed metabolic, cardiovascular, mechanical, social and cancer-related consequences of obesity. This was a new initiative but designed to enable participants to improve their health by using available health promotion models as appropriate (Bay of Plenty District Health Board, 2007).

The organization allocated small amounts of funding to six small community-based Māori health agencies who were encouraged to set their own goals and craft their programmes to meet the needs of their particular communities. Key elements of the project were to recognize the aspirations of Māori and to include families (Bay of Plenty District Health Board, 2007, p. 5). The overall objective was to promote and foster the development of environments and practices that supported healthy lifestyles for Māori, while targeting identified populations considered to be at risk.

In the initial stages of Project REPLACE, each health agency wrote monthly reports designed to provide both qualitative and quantitative information about Project REPLACE programmes.

Table 1: Project REPLACE

| Replace 1 short drive in the car with a walk |
| Replace 1 pie you would normally eat with fruit |
| Replace 1 television programme to get out and exercise |
| Replace 1 takeaway meal with a home cooked one |
| Replace 1 alcoholic drink with juice |
| Replace 1 cigarette with a glass of water |
| Replace 1 negative thought with a positive one |
and participants, including measures of individual change using health indicators such as weight, BMI, blood pressure and body measurements. However, the Māori health organization overseeing Project REPLACE noted that important contextual information was not being recorded, making interpretation difficult. The organization subsequently revised the reporting template with an emphasis on the recording of ‘quality of life’ indicators, based on the Ottawa Charter. In this revised template, four health promotion principles were used to monitor change:

(i) create supportive environments;
(ii) develop personal skills;
(iii) strengthen community action; and
(iv) reorient existing health services.

Agencies were then no longer required to report individual health indicator measures. At this same time, they were encouraged to integrate HEHA principles into their existing programmes, rather than continue to offer separate HEHA programmes.

EVALUATING PROJECT REPLACE

At the same time that Project REPLACE was being implemented, a team of evaluators was engaged to conduct process and short-term outcome evaluation of the programme, to document the interventions being implemented and to evaluate their effectiveness in reaching Māori, and in modifying community practices and individual behaviours. A kaupapa Māori (Kaupapa Māori is based on Māori values and principles which guide all aspect of the process) approach to evaluation was used by the team of Māori and non-Māori evaluators, since the team was mindful that in the past much research had been conducted ‘on’ Māori in ways that perpetuated colonial values (Bishop, 1996; Bishop and Glynn, 1999), and consequently had misrepresented Māori understandings and ways of knowing and denied Māori ownership of their own knowledge (Smith, 1999).

A kaupapa Māori approach required face-to-face engagement with participants, in order to establish relationships of trust, and to allow them to report their conceptions, responses and experiences of the programmes in a fashion appropriate to them (Smith, 1999; Jahnke and Taiapa, 2003). Visiting and observing the programmes in action provided valuable information, and it was important for the evaluators to listen respectfully to all informants as the holders of expert knowledge regarding the impact and usefulness of Project REPLACE in their lives, and the lives of their families and communities. Interviews and focus groups were therefore the main data collection methods. The evaluation team was mindful of the generosity and cooperation of the communities visited, and on each visit ensured that they brought a koha (Koha is an example of reciprocity in Māori tradition, and involves the giving of gifts by visitors), usually in the form of healthy food. This ensured the establishment of reciprocal relationships, another important principle for kaupapa Māori evaluation. Reciprocity was further enhanced through the evaluation team-sharing information with participants and programme staff about successful initiatives.

Data collection instruments incorporated the Whare Tapa Whā (literally meaning ‘four-sided house’) model of Māori health that describes four dimensions of health that encompass the whole person, including te taha tinana (body), te taha hinengaro (mind, emotions), te taha wairua (spiritual) and te taha whānau (extended family) (Dorie, 2001). Community focus groups contributed to an understanding of how Project REPLACE impacted on families and the wider community, including iwi (tribe) and hapū (sub-tribe, made up of a group of people descended from a common ancestor).

The information gathered during the evaluation was mostly qualitative. In recognition of the unique ways in which each agency implemented Project REPLACE in their community, a case-study approach was used to report the evaluation findings. Case studies enabled evaluators to report the subtleties and intricacies of complex situations and to include unanticipated findings. Common themes were then identified across all six sites evaluated, and examples of good practice were described. Comprehensive evaluation findings are reported elsewhere (Hamerton et al., 2010); in this paper we have focused on particular findings that we believe may have applicability for the delivery of health promotion programmes in other indigenous communities.

FINDINGS AND DISCUSSION

This section will begin with information about the different ways in which the various agencies
implemented Project REPLACE, then describe and discuss some of the main findings.

**Implementing Project REPLACE initiatives**

Each health agency was commissioned to develop, manage and provide programmes with the overall goal of achieving family well-being by providing tools for people to change their lifestyles. Individual plans were developed by the agencies to improve nutritional knowledge, increase physical activity, reduce obesity and educate particular groups in their community about healthier lifestyles. Each used the four dimensions of health described earlier (physical, mental, spiritual and family/social) (Durie, 2001) as the foundation for their programmes.

Nutrition programmes focused on providing information about affordable healthy food, how to read food labels and determine portion sizes. Cooking demonstrations emphasized the preparation of healthy low-fat food that used fresh ingredients and was fast and easy to prepare, such as stir fries. Participants exchanged healthy recipes and learned about menus suitable for vegetarians and those with diabetes or who wished to lose weight. Some agencies focused on educating parents about healthy food for their children.

Some groups established community gardens, which participants reported to be a worthwhile initiative, as they often involved a range of age groups, and the produce could be shared. Due to limited financial and spatial resources, some garden beds were built from fruit pallets or car tyres. Having built-up garden beds meant that the older people were able to garden without having to bend over. Elders were also able to pass on their gardening skills to others, in particular young people, a component of health-promotion that has been favourably reported in other indigenous settings (Mundel and Chapman, 2010). Research has also demonstrated that when children are involved in growing vegetables, they may be more likely to enjoy eating them (Morris and Zidenberg-Cherr, 2002; Morris et al., 2002; Alaimo et al., 2008). In one locality, the local farmers’ market was used to promote healthy eating and home-grown produce.

Increased physical activity was promoted through group sessions such as tai chi, martial arts or line dancing adapted to suit Māori participants by using familiar Māori music or movements. Other popular forms of physical activity were stretching and traditional massage, chair exercise, Nordic walking and aquarobics. One agency established a very small gym in a garage which local people could join; this initiative made fitness equipment available to the community for reasonably low cost.

Sometimes the two goals of healthy eating and physical activity were combined. For example, participants went on expeditions together to gather seafood, or gathered fallen fruit from local orchards. Other ways that the co-ordinators made use of limited resources were by encouraging participants to base exercise programmes around housework, or to join a ‘walking bus’, so that children were safely accompanied to school and opportunities for physical exercise were maximized.

Another effective initiative was the establishment of a healthy eating policy at one of the health agencies, to ensure that healthy eating was incorporated into all services they offered. Agency staff monitored the contents of the refrigerator closely and immediately removed unhealthy items such as sugary drinks. They also noted it was important for the health agency staff to be role models in influencing others to make lifestyle changes for the sake of their and their family’s health.

There is no more cream or [full fat] milk, cakes. We eat healthy all the time now. I have to lead by example and that was hard at first, but having only healthy food has been beneficial for not only me but my staff (Health Agency Manager). Such a notion of role modelling is supported by Germann and Wilson (2004) who argue that community development must be advanced and practised by the agency that is advocating it.

**Ripple effects**

Project REPLACE rests on the notion outlined in Table 1 above that small changes such as replacing one unhealthy activity or choice with a healthier alternative can make a big difference to people’s health and quality of life. In every site, participants, managers and co-ordinators all reported that small, healthy changes were being made. In one agency a policy of having only healthy food led to changes for all people who used the facilities. In another, participants reported that participating in aquarobics classes not only helped them be more physically fit, but also improved their mental well-being and
fulfilled social needs. In yet another site, one participant reported that her lifestyle changes were not only going to improve her physical health and reduce obesity, but would prevent her from developing more serious health problems in the future. She also reported she was modelling healthy choices for her grandchildren. All of the above examples demonstrate how small changes were having a ‘ripple’ effect on others. Further information about these changes and how they affected others are reported below.

In addition to participants reporting changes in their lifestyle and better health on all of the Whare Tapa Whā dimensions, family and community members had also noticed changes in homes and community settings such as marae (traditional Māori community centre, used for a range of cultural, spiritual and social purposes) and schools. Individual participation, both healthier eating and increased participation in physical activity, was beginning to lead to changes within the whole whānau:

...Sharing my knowledge with whānau, like the children. Get my whānau to buy into the project. Roll on effect like decreasing smoking. Through my knowledge my daughter has taken up a more healthy lifestyle riding her bike and walking. Generally the whānau are eating healthier.

A community person who had visited one of the agencies said:

Yeah, I saw some of the health changes when we had food at the health agency prepared by the women. They got their vegetables out of their garden; they had planted their own vegetables as well. There was a really neat older woman on the programme as well and she brought some really good skills with her about the old time cooking.

Changes to the food that was offered at the school were also noted, with one person reporting:

I can tell that [she] has changed….We could always rely on [her] to bring up the fry bread, now we get rewena bread. Yes, I have definitely seen small changes in [our community].

Other changes were also noted as the same school removed pies from the menu, instead insisting ‘…that only healthy food be provided at school’ (Community informant). These changes were not confined to one community.

In another, people were also noticing changes to eating habits ‘now my grandchildren are eating healthier rather than going to the snack bar at school or eating a pie or something’.

Not only were the older members of the community benefitting from the principles of Project REPLACE; replacing one activity, such as watching television, with participation in exercise, but they were also valued for the knowledge that they could pass on to the next generation. The growing, preparation and cooking of vegetables from the community gardens resulted in healthier food being provided for gatherings on the marae.

Reports of healthier food being served on the marae and at school and the planting of community gardens demonstrated how small changes in thinking and behaviour had a wider effect. Co-ordinators utilized the willingness of family members to be role models and to teach others as a strategy to ensure that knowledge would be passed on. These examples demonstrate a ‘ripple’ effect, where changes made by a person in one area of their life affected other areas as well, and where changes made by one person began to influence others around them. Research conducted elsewhere (Page and Fletcher, 2008) has similarly noted that when a person changes just one small thing towards a healthier lifestyle, they set in motion a series of changes. The principle of change in one area affecting another is supported by other collaborative models, such as that offered by Tyler and Horner (2008).

Shifts in priority and focus occurred in Project REPLACE during the time it was implemented. Agencies came to view individual measures on a range of health indicators as less important than adapting programmes to suit their particular environments. These shifts are in keeping with the Ottawa Charter principles. In the process of moulding programmes to fit community needs, each agency assumed greater control and responsibility for incorporating Project REPLACE activities and principles within their broader cultural framework. The benefits of this framework were seen as holistic and empowering for both participants and their families.

Māori-focused activities

Māori-appropriate practices were incorporated into Project REPLACE in a number of ways
and were highly valued by participants. All of the programmes incorporated cultural values and implemented activities that were specifically Māori in focus; each agency did this in different ways. Some adapted exercise programmes to give them a Māori flavour; others incorporated learning about traditional healthy food. Several examples are provided below.

In one agency, several people noted that through their participation they were learning or being reminded of traditional practices that had been forgotten or replaced by fast food lifestyles. As one participant noted:

She told me that she was taking the girls out to get kina (a kind of seafood). She would organise for when they would go, organise correct footwear, clothing and then she spoke about how good the kina was for them. For some, they didn’t even know what a kina was let alone the goodness from them, especially for iron. So it was an introduction to the local resources and the health benefits.

The experience of reflecting on the diet and exercise patterns of their ancestors reinforced the embedded wellness messages of Project REPLACE and appeared to strengthen the resolve of participants to ‘walk the talk’ and pass those benefits on to their grandchildren. In a similar fashion, having designated Project REPLACE co-ordinators and visible programmes within the agency and the community often led to other staff in the agency wanting to integrate healthy principles into their programmes also. The health agency operated on a kaupapa Māori philosophy, underpinned by collaboration and sharing.

Participants indicated that they valued programmes that were marae based, grounded in Māori values and delivered by Māori. One person noted:

You see, what the funders need to take note of is the inclusive way in which we Māori exercise. It involves fun, laughter and the opportunity for us all to laugh at ourselves.

Elders who participated appreciated that the programme was delivered in a way that made them feel safe.

One particular aspect of this Māori focus that many participants commented on was being able to socialize with others from their own whānau while engaging in Project REPLACE. This aspect is explored further below.

Whānaungatanga

The success of Project REPLACE was closely bound into whānaungatanga, the most highly rated aspect of Project REPLACE overall. [Whānaungatanga is a term that refers to family relationships, or connectedness that comes from belonging to the family. Whānaungatanga includes being obligated or committed to other members of the community because they are part of the broader whānau (family).] Whānaungatanga was important in several ways. Firstly, participants reported that being in a group made them more accountable for making changes, and that they were more likely to continue with exercise and healthy eating when they had the support and encouragement of a co-ordinator and a group. Participating in Project REPLACE provided opportunities to have fun while engaging in activities that were benefitting their health. Social support, reduced isolation and whānaungatanga resulted from their participation. These outcomes were not specified in the HEHA plans as desirable or intended, but were clearly valued by participants.

The support given to, and received from, the co-ordinator was also related to whānaungatanga in some communities. The co-ordinators who had greatest success in implementing Project REPLACE belonged to the communities with whom they were working. ‘She is from our family’ explained one participant. Since the co-ordinator was working with family members, participants did not perceive that they were being judged. As one said:

We know we are big and we do know why, and so she comes in at a level where we want to engage in what she is doing... she is very humble, she is from our hapū.

This participant did not need to be told she and her family needed to change their diet to minimize the risk of diabetes; she knew that. What she did need was support from someone who would be able to work alongside her to achieve the goals that she had determined for herself. The co-ordinators were from the same community. Therefore, they were not ‘outsiders’ imposing their programmes or values, but rather adapting Project REPLACE philosophy to meet the needs of the community. Another participant said of a different co-ordinator ‘She’s committed to wellbeing which motivates us and inspires others’.
Therefore, although the co-ordinators faced some challenges such as attendance and trying to offer the programmes on a minimal budget, sustainability was rooted in whānaungatanga. Having fewer people coming to the classes became an incentive for maintaining the programme, as there was more one-to-one coaching through the exercises, and participants felt that because the co-ordinator travelled a long way, the least they could do was to attend. These communities appreciated that failure to use the equipment or make use of the programmes may result in losing them; reporting that the availability of the programme and expertise might only be noticed when it was missing.

**Sustainable change**

Initiatives that drew on and reflected cultural values were the most highly valued by participants and their families. Such initiatives are also likely to be more sustainable because they are rooted in familiar values and practices, some of which have been compromised by modern living. Others have also found that cultural and community-based initiatives prove to be more successful over time, especially when the initiative is aimed at the long term (Laverack and Labonté, 2000). Through the relatively slow and gradual mechanisms of embedding small changes into the ‘culture’ of communities and families, improved health practices will be most sustainable. Sustainability may be better achieved by focusing on small visible successes that affect relatively small numbers of people in small programmes.

Cultural values and practices in indigenous communities are passed on to younger generations by elders. In Project REPLACE, we found evidence that some of the elders who participated were actively involved in transmitting traditional practices, including a return to healthier activities such as gathering seafood, to younger generations. Many clearly saw themselves as role models.

Other writers have reported that colonization is at the root of health inequalities and in particular the poorer health of indigenous communities across a range of health measures (Mundel and Chapman, 2010). It is likely that colonization is similarly implicated in the health of Māori communities, through mechanisms such as institutional racism and differential access to health care (Reid and Robson, 2007). Programmes that give Māori communities greater control over the services they receive, and that are embedded in Māori frameworks and cultural values are most likely to be successful and sustainable in the longer term (Simmons and Voyle, 2003). Changes in the short term may be relatively small, but evidence collected elsewhere suggests that ‘bottom-up’ change that is owned and initiated within a community will build capacity, be empowering and be more likely to lead to sustainable change over time (Laverack and Labonté, 2000).

Government funding for HEHA programmes was subsequently withdrawn. However, the expectation was that the principles of healthy eating and healthy action would continue to be incorporated into all of the programmes offered by the health agencies. While integration had occurred to some extent during the time period of the evaluation, discontinuation of funding meant that there would no longer be designated HEHA ‘champions’ within each agency. Despite the withdrawal of designated funding for HEHA programmes, anecdotal information collected more recently suggests that at least some of the HEHA principles have been sustained.

**CONCLUSION**

The changes resulting from Project REPLACE were illustrated clearly through several distinct findings. Firstly, participation of health agency staff illustrated a crucial buy-in to the importance of creating and promoting healthy lifestyles, and of staff being role models for the rest of the community, to whom they were often related. Secondly, opportunities to adapt Project REPLACE to the needs of health agency, co-ordinators and the community meant that the programme co-ordinators were able to establish a model that was responsive to the changing environment and clientele. Both these aspects taken together led to improved acceptability of the healthy nutrition and physical activity message in the wider communities within which the health agencies are embedded, resulting in raised awareness and change at a community level. Whānaungatanga and the provision of activities within a Māori framework underpinned the success of the project, which was no longer measured in terms of weight loss, but in terms of healthier community lifestyles.

In the Māori communities who participated in Project REPLACE programme, success should be measured not by continuance of
the programme itself, but by the sustained community-led changes that have incorporated Māori values and practices into health promotion activities. These activities will be enhanced by recognition of the importance of values such as whānaungatanga and enhancement of Māori cultural identity. Measuring long-term change at family and community levels was beyond the scope of this evaluation, but early indications were that for these communities the seeds of change were being sown as families were prompted to look towards more traditional healthier foods and health practices and how these could be incorporated into their modern lifestyles.

ACKNOWLEDGEMENTS

We wish to acknowledge the support of the Bay of Plenty District Health Board, Ngā Mataapuna Oranga and cultural advisor Kuku Wawatai throughout this evaluation. We also wish to thank staff of the six health agencies involved who gave so generously of their time and expertise. Finally, we wish to thank all of the many participants who generously shared their stories with the evaluation team.

FUNDING

This work was supported by the New Zealand Ministry of Health [Grant No. 323315/00].

REFERENCES


Mā ori community initiatives to promote Healthy Eating, Healthy Action


