

# IMPLEMENTING CONSUMER HEALTH RESEARCH: EMPIRICAL RESULTS LEADING TO SOCIAL INNOVATION IN NEW ZEALAND

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## ABSTRACT

Health research is often regarded as fragmented, competitive and highly specialized. However, there is often little effective communication and consultation between producers of health research and end users. Given this, a Consumer Participation and Community Engagement Framework was adopted by the Waitemata District Health Board. Local research also indicated that consumer and provider perspectives create opportunities for innovation and new co-developed knowledge. Accordingly, a mentored group was established. A long term outcome has been promoting sustainable and effective co-design for better health. Thus an innovative programme was established to co-create capacity building for consumers and professionals alike.

## INTRODUCTION

Health research is not uncommonly regarded as fragmented, competitive and as a highly specialized activity in which groups of researchers from a range of scientific disciplines frequently work in isolation from other disciplines. Moreover, methodological approaches and the value placed upon them differ across academic disciplines and their associated professions (Riehl & Roy, 1974; Zemke & Clark, 1996) and also across cultures (de Rivero, 2003). Put in an overly simplistic way, those who derive their experience from the physical sciences tend to mainly pursue positivistic (quantitative) evidence based approaches whereas those who are steeped in the humanities lean mainly towards interpretative (qualitative) approaches and procedures. This means that while positivists mainly seek *results*, interpretavists mainly generate *findings*. Such divergences can adversely impact upon teamwork competency within health service organisations, and contribute to the fragmentation or segregation of health service experience for consumers. Significantly, there is often little effective communication and consultation between the producers of health research and end users (Pang et al., 2003, p.815).

This is an international trend. Not surprisingly, therefore, greater involvement of lay people in database management teams was recommended following a review of 105 clinical databases in UK (Black, Barker, & Payne, 2004), and an Australian review came to a similar conclusion (Daly, McDonald, & Willis, 1992). Such recommendations reflect a change from *professional centred* to *people centred*

services, and also an acknowledgement that the management of chronic disorders on a day-to-day and year-to-year basis should almost unequivocally involve a partnership between members of the community' and professionals. Thus there has thus been a shift from an over-emphasis on personal individual healthcare to a more balanced focus on individuals, family or social groupings and population health. Consumers matter.

Involving consumers in the whole process of undertaking research, from the initial selection of topics to be explored, through to participating in report writing is, however, an unexplored area. We assert that despite this apparent absence of consumer involvement, there is considerable scope for collaborative approaches to be mounted. There are effectiveness gains to be derived in health delivery from the facilitation of engagement between well-networked consumers and professionals; there are, equally, positives to gain in service delivery by promoting co-operative skill and resource development, and there are benefits to reap by creating contexts within which to develop and follow appropriate research practices (Oliver et al., 2004; Waterman, Tillen, Dickson, & Koning, 2001). The contention is that *real world science* can help inform decisions by stakeholders (Amador & Fitzpatrick, 2003). Consumer perspectives, therefore, are basic to the design and local development of primary health care and innovative service integration. Regrettably, however, consumer research remains underdeveloped in New Zealand.

## RESEARCH METHOD

In essence, the situation being reported in this paper comprises a *case study* and the research remains ongoing. Methodologically, arguments could be advanced which would suggest that the case study is largely informed by *appreciative inquiry*, an approach to health research that appears to be gaining traction in Australia but which has yet to be discovered within Zealand. Although Durie (2004) has written about the promotion of indigenous health in New Zealand, and has adopted the symbolism of the four stars that constitute the Southern Cross, his approach does not harness an appreciation of consumer participation in research as a vehicle for promoting change. Notably, neither does the Australian literature.

The advantage of appreciative inquiry is that the emphasis is on strengthening positives within a status quo by coaxing stakeholders towards improving outcomes so that these (outcomes) reflect a previously identified and articulated ideal. Given this, it is not surprising that the majority of the recent literature from Australia pertains to either regional health promotion (e.g. Adams, Dixon & Guthrie, 2004), indigenous health promotion (Brough, Bond & Hunt, 2004; Brown, 2004; Carson & Bailie, 2004) or clinical solutions (e.g., Wood, Fowler, McAullay & Jones, 2005).

There is, however, no evidence of work being undertaken on the matter of promoting *health for all* through social entrepreneurship. And neither is there evidence of appreciative inquiry being intentionally lassoed in order to strengthen consumer capacities for becoming involved in health research. In the case of this study, appreciative inquiry did not form the founding methodology and neither did the notion of community based action research<sup>ii</sup>. Instead, the present development was triggered as one consequence of a postgraduate thesis project undertaken by Boyd (2005).

The thesis by Boyd (2005) investigated the validity of social entrepreneurship models and strategies in the development of primary health care services within the Waitemata district, the largest District Health Board (DHB) in New Zealand. The investigation was undertaken during 2004 and early 2005 and the intention was to gauge the success and impact of the implementation of Primary Health Organisations (PHO) in the District. During the course of this investigation, preparation undertaken for the administering of an electronic survey highlighted the absence of a discernable consumer database from which and into which, feedback and learning loops could be activated. In other words, it was discovered that within the Waitemata District Health Board (Waitemata DHB), there were few organisational frameworks and support structures for any form of consumer research.

In the event, an electronic questionnaire was developed and 280 questionnaires were distributed electronically. Usable responses from 204 (73%) respondents were received. Hence, the electronic questionnaire returns ( $\sum N = 204$ ) and the ensuing interviews that were conducted with key informants ( $\sum N = 25$ ) became the primary sources of data but the overall data involved only a small consumer input. In summary, although the present ongoing developments could become 'conveniently' reconfigured in order to make the overall exercise align with notions of how an appreciative inquiry is configured, the

reality is that it was an intentional development that was carefully cultivated during and after a postgraduate research exercise . It was, however, neither a serendipitous event nor a hugely planned event – rather – it was a phenomenon that evolved through nurturing and mentoring over time.

## **RESULTS**

It is important to note that on a range of questions, consumer responses to the original survey clearly indicated that consumer perspectives differed from the perspectives of service providers. Furthermore, although several consumer advisers or liaison people are employed by the DHB, Waitemata DHB appeared to be at the low end of consumer research capability. In the original thesis study, there was a good fit between qualitative and quantitative results. Each dataset highlighted a considerable gap in consumer research and pointed to the need for service providers and funders to develop an improved knowledge of their market (including both enrolees and those not enrolled). They especially need to gain an improved understanding about research from the perspective of community members.

A key recommendation was to pilot trial a consumer mentored research group. Such a group, it was recommended, would be formed and developed in order to assist those involved in the provision of primary care (and others on the periphery of that service) to grow knowledge about health related needs whilst extending perceptions of health outcomes at the community level.

From the outset, it was determined that objectives of the pilot should include the initiation of, and facilitation of an interactive learning programme within a consumer-friendly venue. A desired outcome was that published papers and/or presentations would be developed by participants over time. An innovative programme was established to co-create mentoring, skill development, research project support and networking opportunities for consumers. This paper now shares results of that action learning and details highlights from the first year's journey.

## **TRADITIONAL METHODS**

In this country, and others, health care decision making has been much more strongly influenced by professionals than consumers. Notable exceptions in New Zealand include the National Health Committee and consumer forums and at times, a national Renal Service Advisory Group with strong, articulate and compassionate advice from consumers. Observations indicate that professionals and consumers can (together) develop a system level view with dimensions that neither can develop alone. Successful initiatives have had budget for travel, hospitality, facilitation, education, decision analysis, publication and dissemination.

## **NEW EXPECTATIONS FOR CO-LEADERSHIP**

There are twenty one District Health Boards in New Zealand, each of which *own* public hospitals and services and all of which have statutory responsibilities for funding and contracting other services for their local populations. These other services include Non-Government Organisation services, and Primary Health Organisations (PHOs).

PHOs are the coordinating agencies for funding and strategy implementation for general medical practitioners, practice nurses and other team members. Funding includes laboratory tests, pharmaceutical subsidies and Care Plus for people with high medical/service needs. Additional funding is available to communities with high numbers of indigenous Maori, migrant and established generations of people from Pacific Islands, and people living in areas recognised as exhibiting economic and/or other deprivation. Some of this is referred to as funding for 'services to improve access'.

In fact, PHOs are the New Zealand Labour Government's vehicle for funding primary health care<sup>iii</sup> and for changing the health service delivery system. Community pharmacists, general medical practitioners (GPs) or primary care practitioners, general practice dentists and nurses are examples of personnel who provide primary services. Secondary services, however, are more specialised; they are

relevant to a specific subset of the population and are usually accessed as a consequence of a referral coming from a primary care practitioner. The intention is for Primary Health Organisations, over time, to become a focal point for designing and delivering more comprehensive services, services that are relevant to the needs of local people.

But although the PHO as a focal point for delivery is fundamental to the delivery of contemporary health services, this paper is mainly concerned with community engagement in healthcare decision making. It is by no means ironical that a requirement of New Zealand's Primary Health Care Strategy (2001) is that PHO governance Boards include a consumer perspective. And neither is it ironical that there exists a requirement that they are not to be dominated by any one professional group such as doctors. Instead, co-leadership of health services (i.e. with consumers) has become the espoused mantra and this represents a significant paradigm shift not only for most of the public but also for health service practitioners.

## **POLICY FRAMEWORK**

The first PHO's were established in July 2002. There are currently 81 PHO's covering approximately 3.8 million New Zealanders, with six PHO's in the Waitemata DHB catchment. In 2003, Waitemata DHB, which serves a population of half a million people, adopted a Consumer Participation and Community Engagement Framework. While mental health services had a history of consumer and family advisers, the framework triggered new roles in children's and older people's services. The roles emphasise greater and improved linkages with communities of interest and are still evolving. They have a range of titles such as 'family worker', 'consumer liaison', and 'consumer adviser'. They are each situated within the non-regulated workforce and the level of access to knowledge, research findings, to having meetings with data analysts, policy analysts, strategy developers, and mentors varies considerably. Their capacity to apply presentation skills equally varies and the same comments appear to be relevant for community members who serve on PHO governance boards.

The formal framework has also strengthened and clarified the potential role of consumer link organisations. These now operate along geographic and ethnic lines in each of the three territorial local authorities. Hence there are now HealthLink Waitakere, HealthLink Rodney and Community Voice North Shore and there are also indigenous Maori, Pacific and Asian networks. But these are systemic alterations rather than process adaptations.

Achieving truly effective participation and engagement, which is what process adaptation involves, require a culture change. Ideally, a new culture should involve integration, a merging or blending if you like, of the perspectives of health care which consumers can bring to bear with the views of health care professionals. The challenge is to ensure that the views become intertwined to create new knowledge, to evolve fresh syntheses of practice and delivery.

The fact is that the directions and the research findings which stemmed from Boyd's (2005) research, suggested that a mentored research programme for consumer liaison people would be both timely and apt. Accordingly, such a scheme was launched. The goals of the scheme were to raise the capabilities and capacity of groups and individuals working with community members and to reduce the asymmetries between professionals and collated consumer input.

## **DESIGN SPECIFICATIONS**

A project plan was developed and initial marketing research was conducted by referring to key people from within the community as well as liaising with a senior official of the Tertiary Education Commission (TEC). The initial exploration of the idea also included a detailed presentation of the idea at an innovation symposium during which the ideal, the idea and the potential content were shown to attendees and invitations to participate were given<sup>iv</sup>.

It was suggested that content and 'toolkit' foci should enable participants to develop a basic understanding of foundational concepts such as health, the human development process from birth to death, an understanding of disease from varied cultural perspectives, an appreciation of demography, a grounding in the purposes and types of research, and consideration of why and how consumers and professionals alike

can become better informed by systematically critiquing literature and approaching research in a collaborative and ethical fashion.

In addition, it was suggested that participants should learn generic skills surrounding how to effectively access and utilise information, and how to conduct documentary analysis in order to critically appraise the impact of policies. As well, it was proposed that they should learn about sampling, survey design, data management and analysis using both quantitative and qualitative approaches as well as mixed methods and a mixture of methods. To that end, it was recognised that learning about the skills involved in applying sound interview techniques and undertaking elementary statistical analysis was important as was the skill-set required for the interpretation of qualitative data.

But beyond that, learning how to construct valid reports and gaining experience in writing for a series of audiences (using a range of voices) was considered to be important as was the managing and facilitating of a range of meeting formats whilst deploying, as appropriate, a suite of presentation skills. Moreover, it was accepted that it was important that participants should not only know about how to commission or undertake research, but also how to assume either an active leadership, partnership or even an adjunct role in health research activities that involved consumers. It was clear that the programme needed, in effect, to offer participants an opportunity to partake in a smorgasbord of understandings which had as accompaniments and condiments, a wide range of research and communication skills. And all this was to be geared towards addressing the learning needs of a wide range of consumers and professionals from a broad range of settings drawn from a very large and varied geographical footprint.

From the outset, therefore, it was recognised that facilitators (i.e. faculty) would need to be interdisciplinary and had to be able to address reductionist and systems research. They needed to be approachable and competent and also need to be able to embrace and work within both mainstream and Maori perspectives. But although design specifications included being able to access academic rigour and resources, a co-goal was to avoid learners becoming intimidated by the experience. An intentional goal, therefore, was to ensure that the experience would not be daunting or intimidating for first-time users of tertiary institutions. Hence, it was also considered essential that a degree of flexibility should be apparent which would engender support and guidance for small groups and solo-operators, each of whom would be encouraged to undertake *mentored* research projects. Achieving legitimate access to specialised knowledge, to computers, to the reports of analyst was also a design feature so that 'connector' consumers could become better informed and thereby precipitate information diffusion to wider networks.

In summary, the design expectations were ambitious, broad and yet interlaced with specificity. The intention was to precipitate a process of personal growth and community development within and across selected representative from health consumer groups and professionals. This was to be an organic process of capacity building and clearly, in that regard, the Waitemata DHB was to become involved, in a social entrepreneurial endeavour that was centred on the provision and facilitation of systematic community education.

An initial group of approximately twenty people was considered an optimum number to form a core corpus. The expectation was that approximately fifty per cent (about ten) of those people would be on-going contributors with relevant skills and networks. Further and future cohorts could subsequently address specific gaps and needs as these became discerned.

## IMPLEMENTATION

Twenty eight people indicated specific interest from the initial marketing research. Project resourcing was minimal and the concept of an intersectoral Advisory Group including people from Justice, Housing, Health, tertiary education and Social Development was reduced in priority until the programme became established.

The programme commenced in June 2005. The design was for an initial two-day workshop followed by monthly one-day workshops for a year. A research retreat in a rural area was chosen as the home site for the programme and an agreement was made with its owner who is also the programme's main facilitator. There was an expectation that informal learning sets and/or mentoring as individuals or small

groups would occur as research questions were formed and prioritised. At the initial workshop, participants agreed on the programme's style, with discussion and summary comments including:

Interactive; not spoon fed; sessions with an opening and closing ...  
Interaction with specialists in different areas raised...  
Consideration of relevant data; a vehicle to open opportunities for learning within the DHB.

They also requested content, for example:

How to read critically a proposal;  
How to review literature;  
How to assemble a search;  
How to write a research proposal;  
Interviewing skills;  
Facilitation skills;  
Finding out stuff!! Eg through internet and library  
Interpreting qualitative data;  
How to use resources;  
How to manage a research budget; report writing.

Participants were asked to complete a baseline pre-test at the beginning of the programme to stocktake their existing capabilities and their interests. (A similar questionnaire is to be administered at the conclusion of the programme). The pre-test written questionnaire had three sections which canvassed the experience that group members had in undertaking different aspects of research, the experience they may have had in helping with research and finally, their interest in learning about different aspects of research.

A scoring system was used to determine the level of knowledge and background experience of participants<sup>7</sup>. It was found that by and large participants had little or no knowledge of research involving Maori or Pacific with almost two-thirds of respondents have never been involved with this. Presenting research studies to others was also an area for development with eighty per cent of participants indicating that they lacked experience in this. (Of course, subsumed by implication within this domain is the capacity to read and understand what a research study is actually reporting and hence, critically reviewing research is a skill that needs to be learnt in tandem.)

It was found that some sixty per cent of respondents indicated that they had difficulty in planning and designing research, and developing an application for research funds was also an area that warranted development (some seventy per cent of the group reported that they did not have strong experience in this domain). Participants also reported that they had minimal experience in working with Maori and Pacific peoples. It is suggested that this finding assumes a degree of importance when the epidemiological patterns and demonstrable inequalities in health are considered with respect to Maori and Pasifika peoples. As a consequence of this finding the inclusion of experienced mentors in ethics and practicalities of health research related to Maori and Pacific populations assumed an even greater level of importance.

Respondents also indicated that they had minimal experience in generating reports and in making submissions which is especially important given that preparing applications for funding is a requisite to making things happen. And perhaps not surprisingly, this was a domain that was found to be outside the experience of most participants. Finally, requests to learn more about qualitative research were expressed and it is speculated that this reflected an understanding that these methods are appropriate to the objectives of those consumers who were participating.

## **STRATEGIES USED**

Most facilitators of learning are acutely aware that intentionally harnessing a range of teaching media and offering an appropriate suite of learning activities continue to be key ingredients for promoting effective change within the cognitive framework of those who are learning. Adults in particular need to be involved with the learning and they also need to be able to adjudge that the learning tasks they are meeting have relevance to their situation. If, as Wilbur Schramm has noted, all media can become deployed as

campaign media and a range of media are typically more effective than a medium on its own, then it follows that a series of different tools and methods should be used to exchange knowledge and promote learning in a programme such as this. Thus, for instance, the following strategies were used amongst others:<sup>v</sup>

- Introductions involved group process and a range of tasks were accomplished through small group processes. For example, during one session, participants were asked to refine their understanding of the notion community in relation to themselves by designating and explaining where, within a room that arbitrarily represented the world, they had been born, where they lived and which place on the globe they thought of as 'home'. An example of small group work involved activities as simple as having participants draw the 'ideal' researcher and draw a pictorial representation of the research process which they then explained to others. Indeed, group work, not only as a plenary but also within a range of sub-groups, was a constant feature of the programme;
- Interactive presentations were used. For example, in order to teach the rudiments of Elementarism (role theory), groups were asked to devise and present a socio-drama which the remainder of the class then critiqued;
- Handouts were given and access to publications was facilitated. These were frequently provided after a session (rather than during the session) and in addition, the possibility of participants being able to access selected electronic resources and/or the Waitemata DHB library was canvassed. In fact, participants to date have not accessed the DHB library but this is largely felt to be a consequence of four factors - the so called tyranny of distance, a lack of time, an absence of concerted encouragement by the facilitators and a degree of reluctance by consumers to enter what is perceived to be the inner sanctums of territory frequented by 'professionals'.
- Surveys to evaluate needs were administered. The administering of a needs assessment pre-test was discussed earlier and does not need to be revisited here;
- Surveys were designed by participants and pilot trials were conducted to raise issues in interactive ways. An important addenda must be made here and that concerns the matter of ethical behaviour and the gaining of ethical approval. Participants were involved in detailed discussions about ethics and in equally detailed discussions about ethics and Kitanga Maori research. Thus although they did design and critique survey instruments that could be trialled, such tools were subjected to rigorous ethical scrutiny during sessions;
- Access to creativity tools, props, materials was a constant. Aside from an ample supply of A2 size post-its, a range of props were available. For example, during one session, each person wore a hat and assumed colour determined roles that corresponded to Edward De Bono's Thinking Hats;
- An electronic connecting group was formed. Although this has been formed, Ethernet gremlins have thus far constrained the level of participation. It is intended that this communication medium be strengthened in the coming few months;
- Special invitations were made to significant others in order to help build networks and partnerships with people engaged in social development and/or research from a consumer perspective. For instance, representatives from the Tertiary Education Commission attended as did a field worker from the Ministry of Social Development. Postgraduate students who were conducting research into health matters came and came again and a number of participants brought others who have since declared an interest in joining a second cohort of participants.

As noted earlier, this programme traversed matters aimed not only at growing specific research skills but also at developing an understanding of health research. Content, therefore, was traversed in tandem with processes and practices that might augment understanding and personal growth. This duality of emphasis is important because content and process hold equally important places within the toolkit of an

effective researcher. Hence the range of topics that have been covered to date, whilst important, do not warrant detailed description here and neither do the processes discussed demand an intricate account<sup>vii</sup>. Instead it is more relevant to note that the prime purpose of this programme can be crudely sheeted home to that fashionable term, 'capacity building'. Thus the assertion we are making here is that capacity building is more likely to become maximised whenever a blend of content and process matters are intentionally programmed. Finally, we reason that this should occur in a manner that not only engages a range of media but also follows sound andragogical principles.

## SUMMARY

As noted at the outset of this paper, the Waitemata DHB adopted a Consumer Participation and Community Engagement Framework in 2003 in order to better serve its half million consumers. Following this, the thesis by Boyd (2005) investigated the validity of social entrepreneurship models and strategies in the development of primary health care services within the Waitemata district, the largest District Health Board (DHB) in New Zealand. Significantly, Boyd (2005) found that there is often little effective communication and consultation between the producers of health research and end users and she concluded that in this regard, consumers perspectives matter. She contended that consumer perspectives are fundamental to the design and delivery of primary health care and innovative service integration but, as we have noted, consumer research remains underdeveloped in New Zealand.

As a consequence of Boyd's (2005) work, the Waitemata DHB has initiated an innovative mentoring programme designed to facilitate consumer skill development, research project support and networking opportunities. In essence, the directions and the research findings which stemmed from Boyd's (2005) research, suggested that a mentored research programme for consumer liaison people would be both timely and apt.

It was accepted by the Waitemata DHB that a number of health consumers and professionals should be recruited as participants. The intention was that they would learn how to commission and undertake research, and also how to assume supportive roles in health research activities that involved consumers. The intention was to precipitate personal growth and community development within and across selected representative from health consumer groups and professionals.

A pre-test written questionnaire was administered to people who had been recruited for the programme and this surveyed the experience that group members had in undertaking and helping with research and in learning about aspects of research. Findings were used to inform the programme design which sought to grow specific research skills and an understanding of health research processes.

Now that the programme is two thirds through its first iteration, we can report that there has been a high level of customer satisfaction. Participation has remained relatively constant and participants have indicated that they have enjoyed the workshops and the venue at which these have been presented. They have also commented that matters traversed have impacted upon their organisations (e.g. a code of values for disabled people has been adopted by a range of agencies including a local government authority).

The workshops have enjoyed considerable technical success in that participants have learnt to use software packages such as EndNote (a tool that is still not universal to academics and professionals) and Inspiration (a simple mind-mapping and presentation tool that can also be used for report preparation). They have also learned by doing so that they are now very able to present and talk to well prepared and researched PowerPoint presentations. And above all, they have grown as a network of competent advocates for the rights of consumers and as individuals who are able to work co-operatively with health professionals within their PHO and the Waitemata DHB footprint.

All-in-all, then, this appears to be a quality programme that enjoys a high level of acceptance. It is clear that this project has been delivered on time and within budget. Programme objectives have been met as have the strategic business objectives of the DHB. And there have been a number of unexpected benefits such as the exploration of the development of a respite retreat for full-time carers and a small number of research projects that can be realistically described as 'work in progress!' In addition, a number of participants (consumers and professional) have availed themselves of research guidance whilst furthering their own continuing professional development.



It is intended that this programme continue for at least another year. But while the DHB has set aside some funding, it is intended that further funding be sought from other agencies and it is also hoped that this programme will become the subject of a more formally run appreciative inquiry as well as evaluation research. After all, social entrepreneurship of this calibre warrants such scrutiny so that others who are adopting the scheme might in the end improve upon it form a research informed platform.

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## NOTES

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<sup>i</sup> In a society such as New Zealand, the notion of *community* can be problematic – which community, which culture, whose values, whose mores? In this paper, therefore, the term community is taken as embracing spatial, social, professional, cultural and spiritual dimensions of the common denominator which is people!

<sup>ii</sup> The reason that it was not akin to Action Research is obvious. Action research presumes that a problem will spawn intentional and successive phases of conducting a reconnaissance, an intervention and a subsequent evaluation. This present work did not assume that there was a problem and it did not apply the Action Research cycle. Instead it was intentionally allowed to evolve through careful mentoring and nurturing.

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iii . Primary health care refers to first line services, relevant to the total population, which people can access directly.

iv Some 28 people formally nominated their willingness to participate in the scheme. Other people signified that they would like representatives from their own agencies to be considered as possible participants. The presentation also had the additional benefit of heightening consumer awareness of the scheme.

v It should be noted that  $\Sigma N$  comprised only twenty participants and the data obtained were mainly intended to determine the learning needs of the group. Subsequent pre-and post analyses will be undertaken but the learning gaps which hopefully will have been bridged over time will almost certainly involve mainly qualitative reporting.

vi These are hardly in the realm of 'rocket science' but it is important, sometimes, to take note of the basics.

vii For example, survey design and data analysis are specific skills requiring that relatively standard procedures be followed but the processes of being culturally sensitive and applying procedures of triangulation whilst ensuring that validity and reliability are addressed demands evaluative understandings rather than specific skills.