Rural and remote communities:

Health needs and aspirations of Pacific peoples

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Abstract

In Aotearoa New Zealand, Pacific peoples have worse health status and substantially limited access to healthcare, particularly in remote and rural communities, when compared to the general population. In addition, Pacific peoples are underrepresented in the Aotearoa health workforce, including within the medical workforce. There is a need for a fit-for-purpose health workforce with the skills and commitment to care for Pacific peoples living in remote and rural communities. In the context of the University of Waikato's preparations to establish the Aotearoa Graduate Entry Medical School, this Masters study explores the perspectives and aspirations of rural Pacific peoples with the aim of understanding their health needs and their expectations of healthcare, particularly medical care.

This qualitative study is underpinned by the Pacific-valued and respect-based Pacific Post-Development Research Framework. The study design includes survey questionnaires, semi-structured interview and focus groups within a *talanoa* – a Pacific form of discussion/dialogue – space. Research participants will be Pacific peoples (n=9) over the age of 18 years and living in rural Te Rohe Pōtae (South/West Waikato region). The research data was explored using thematic analysis and focused coding.

The study suggest rural Pacific peoples want more healthcare services options with better accessibility, and that caters to their cultural differences. They aspire to see more Pacific doctors in their rural communities, as well as a health workforce that is responsive to their cultural needs.

Keywords: Pacific peoples, rural, remote, health, inequities.

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Pursuing Haven

A Tongan proverb which explains the struggle by seafarers to reach land during stormy weather. The proverb refers to someone who is trying hard to achieve their goal despite the challenges in life. It reflects the journey I encompassed to complete this thesis.

This journey has undoubtedly tested me in so many ways, but thanks to the individuals listed below, who helped steer and row the *vaka* (boat), I was able to complete the voyage.

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Glossary

Anga fakaTonga: Is the Tongan way or Tongan custom.

‘Atakai: Enviromental

‘Atamai: Mind or mental.

Biomedical viewpoint: Focuses on biological factors and is utilised in most western healthcare contexts.

Bu ni Ovalau: Coconut tree

Fa’aSamoa: Refers to the traditional Samoan lifestyle, identity, or way of life (Anae, 2022)

Faikava: Refers to venues used for kava drinking. Tongan literal meaning ‘to do kava’.

Fetuutuunai: Navigation

Foaki ‘ofa: Giving

Fonofale: Holistic house

Hafakasi: Mixed Tongan

Iwi: The largest political grouping in Māori society before European contact; a group of people connected by a common ancestor or ancestors; literally: bone; modern meaning: tribe (Taonui, 2005).

Kainga: Community

Kaupapa Māori: A Māori way. Connected to philosophies and principles.

Kava: A crop of the Pacific Islands also known as Piper methysticum

King Country: Colonially (Government) imposed name for Te Rohe Pōtae

Laumalie: Spiritual

Māori Health Authority: An independent Public Health agency in Aotearoa responsible to enhance *tino rangatiratanga* and strengthen *mana motuhake* for *hauora Māori* and ensure greater influence throughout the entire health system to support *whānau* to take control of their own health and wellbeing (Māori Health Authority, 2022, para. 10).

Māori peoples: Indigenous people of Aotearoa New Zealand

Me’a ‘ofa: A gift or donation.

Moana: Oceania

Ngāti Maniapoto: The main iwi of Te Rohe Pōtae

Pacific Peoples: Refers to seventeen diverse ethnic groups (StatsNZ, 2019b) who have settled in ANZ and have ties to the Pacific islands (HQSC, 2021, p. 17).

Pacific Post-development Methodological Framework: A combination of the Fijian Vanua Research methodology with post-development theory (Aporosa, 2014).

Pākehā: Māori term of a person of European ancestry

Palangi: Pacific term for a person of European ancestry

Primary care: Considered the first point of contact in the community of healthcare. Primary care is often seen as general practice. The term primary care also relates to first points of contact but is considered wider than general practice and includes and health services in community settings, such as pharmacies (WDHB, 2019, p. 68).

Sino: Physical or body.

Talanoa: A conversation, chat, sharing of ideas and talking with someone (Tecun et al. 2018).

Talanoa fakataautaha: One on one talanoa

Tangata whenua: The people/original inhabitants of the land

Te Reo Māori: The language of Māori

Te Rohe Pōtae: A region in the west of the North Island, between Waikato and Taranaki. It is an area of gently sloping hills and valleys, with limestone landscapes that include caves and sinkholes. The highest peak on the North Island [of ANZ] is Mt Ruapehu, an active volcano. The harbour at Kāwhia has a sizable estuary (Pollock, 2015b, para. 1).

Te Tiriti o Waitangi: The document that is in Te Reo Māori (*Te Tiriti* as its shorter form). Not the same English version of The Treaty of Waitangi document.

Tikanga: Correct Māori procedure or custom (Moorfield, 2022).

Tivaevae: Patchwork

Vā/Va: The sacred, spiritual, and social spaces of human relationships between researcher and researched that Pacific peoples place at the centre of all human/environment/cosmos/ancestors and animate/inanimate interactions (Anae, 2019, p. 1).

Vakaturaga: Regarded as a person who regularly displays respect (of a chiefly manner).

Vanua: Land, culture and people

Whānau: Family

List of abbreviations

ANZ: Aotearoa New Zealand

DHB: District Health Board

GCH: The geographical classification of health

GP: General practitioner

HWAC: Health Workforce advisory committee

HQSC: Health Quality and Safety Commission of New Zealand

MoH: Ministry of Health

PPdMF: Pacific Post-development Methodological Framework

PRE: Pacific relational ethics

WDHB: Waikato District Health Board

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Chapter One: Introduction and Methodology

1.1 Underserved and underrepresented: Pacific peoples in rural Aotearoa New Zealand

The Aotearoa New Zealand [ANZ] Government's (2021) recent health reform outlines significant structural changes to health delivery services. This includes the establishment of a new Māori Health Authority to drive health development for the indigenous population. The health reform entails "a greater emphasis on primary healthcare and ensuring fairer access" (New Zealand Government, 2021, para. 2), with this aimed at addressing service delivery inequities to underserved communities (Pae Ora (Healthy Futures) Bill 2022 (85-3)). A key driver to that reform is the *Health and Disability System Review*, commonly referred to as The Simpson Report (2020). This reports that although New Zealand life expectancy at birth compares favourably with Organisation for Economic Co-operation and Development's [OECD] indicators, "outcomes are not equitable across populations and life course, particularly for Māori, Pacific peoples …", with those negative outcomes increasing for ANZers living in rural environments (Simpson, 2020, p. 14).

The Simpson Report (2020) is not alone in highlighting this rural urban health concern divide, with earlier health documents observing similar correlations (Ministry of Health, 2020; Pacific Perspectives Limited, 2019; Simpson, 2019). Moreover, while the Simpson Report (2020) details the "longstanding inequities in health outcomes between Pacific and non-Māori non-Pacific peoples in New Zealand" (p.21), data about Pacific peoples who live rurally and remotely are either absent or underrepresented. This is due to a partial reliance on international evidence and data to inform the ANZ health and disability system. The Simpson Report cites an urgent need for "good local evidence, research and evaluation", particularly research focused on the health of Pacific peoples in rural and remote ANZ, to fill the knowledge gap (Simpson, 2020, p. 52). Additionally, this report acknowledges Pacific underrepresentation in the ANZ health workforce, and in the medical workforce, stating that increasing the proportion of Pacific peoples in the workforce is crucial (ibid, 2020, p. 195). It is anticipated that the meeting of these priorities will make a substantial difference to the persistent disparities in the health outcomes for Pacific peoples in rural and remote communities (ibid, 2020, p. 29).

This study, which is part of a larger project that includes a Māori focus, will inform the knowledge gap, by exploring the health aspirations of Pacific family groups living in rural Te Rohe Pōtae. The 'sister' project, which explores the perspectives and aspirations of rural Māori in Te Rohe Pōtae, was undertaken by my colleague Victoria Maikuku. The term "rural" will be defined in the following chapter as part of the literature review.

In their recent vision and strategy document, the Waikato District Health Board (WDHB) warned that they would "not be able to provide the health service our people need unless

we do things a different way" (2020, para. 2). The findings from this study will not only advise the Pacific health aspirations knowledge gap but also assist that "different way" by also informing the curriculum of the nursing degree programme at the University of Waikato. It will also support the development of the proposed medical school dedicated to graduating doctors who will have the knowledge and skills to deliver high-quality culturally safe healthcare to Pacific peoples in rural communities. This aligns with the Health Workforce advisory committee's (HWAC) statement that "a major culture change (or paradigm shift) is required" (2003, p. 2).

Driving this study is the research question and methodology, which will now be explained.

1.1.1 Research question

This study aims to answer the following overarching research question: What are the health aspirations and perspectives of Pacific peoples' living in the rural and remote community of Te Rohe Pōtae (South/West of Waikato)? The investigation of this question is underpinned by a modern cultural friendly methodology that is embedded throughout all phases of the study, and inclusive of selected methods.

1.1.2 Definitions and Terminology

Prior to discussion of their aspirations and perspectives, I will define some important terms that are used throughout this thesis and provide an explanation of my reasoning for selecting them.

1.1.2.1 Pacific peoples

The umbrella term 'Pacific peoples' is used in ANZ to refer to seventeen diverse ethnic groups (StatsNZ, 2019b) who have settled in ANZ and have ties to the Pacific islands (HQSC, 2021, p. 17). This is also inclusive of those from Realm countries, a term I will engage with in Chapter Two. When I use 'Pacific peoples' in this thesis, I also refer to them as "indigenous peoples of the Pacific, wider *whānau* [family] of *tangata whenua* [people of the land] of Aotearoa, and current partners in a reciprocal relationship with the government" (Heath Quality Safety Commission [HQSC], 2021, pp. 11-12). Additionally, using the term 'Pacific peoples' is endorsed by both the Health Research Council of New Zealand [HRC] and the Ministry of Pacific Islands Affairs [MPPA] (HRC, 2014, p. 2). Not only is the term 'Pacific peoples' inclusive, it is also very broad. There is an assumption that 'Pacific peoples' are homogenous. This is not the case; each Pacific ethnic group culturally differ from one another. Thus, it is crucial to understand that a one-size-fits-all strategy is not ideal as this thesis develops.

1.1.2.2 Aotearoa/New Zealand

In this thesis, Aotearoa and the combination of "Aotearoa New Zealand" (ANZ) will be used interchangeably. Aotearoa refers to the Te Reo Māori (indigenous language) name for the land, and has recently been pushed via petition request to officially change the country's name back to it (New Zealand Parliament, 2022, para. 2). Prime minister, Jacinda Ardern made a comment saying "I hear more and more often the use of Aotearoa interchangeably with New Zealand and that is a positive thing" (TVNZ, 2020, para. 2). The combined "Aotearoa New Zealand" recognises the societal change that numerous people in the nation, including the Prime Minister as noted in the preceding quotation, have embraced. It acknowledges unification between *tangata whenua* (indigenous peoples of the land) and government, as well as the shift to honouring *Te Tiriti o Waitangi* (Te Reo Māori version of 'the Treaty'). When referring to the government or, as it shows up in the text, New Zealand will be used.

1.2 METHODOLOGY

This study is guided by the Pacific Post-development Methodological Framework (PPdMF). Developed by Aporosa (2014, p. 175), this approach is informed by the respect-based ethos of *vakaturaga* (Fiji), *anga fakaTonga* (Tonga), *fa'aSamoa* (Samoa), and *tikanga* (Māori). It provides a Pacific framework to ensure a high level of culturally appropriate ethical practice, focused on the dignity and care of others over oneself (Aporosa et al, 2021). PPdMF combines post-development theory with Nabobo-Baba's (2006) *Vanua research framework*. Post-development is described by Aporosa (2014) as an "evolving ideology founded upon culture, traditional knowledge and self-determination aimed at eliminating external hegemony" (p. 165), whereas the *Vanua research framework* provides a Pacific-specific application of post-development by "encouraging the use of local systems, self-determination … practices and models of culture" and behaviour (Aporosa, 2014, pp. 86-87). The PPdMF was chosen as it has pan-Pacific application (Aporosa, 2014).

It is important to note that by choosing to adopt Aporosa's (2014) PPdMF over other Pacific methodologies in my research, this is not intended to undermine or diminish the value of other Pacific methodologies. Rather, I seek to respectfully show how my knowledge has evolved through considerations of crucial key post-development challenges that eliminate Western-Northern hegemony, by accentuating local systems, knowledge and empowerment (Aporosa, 2014, p. 165).

The Health Research Council of New Zealand (HRC) (2014) urges researchers working with Pacific peoples to not simply acknowledge, but also familiarise themselves with, Pacific cultural values as these influence ethical factors (p. 6-10). Pacific values are included within cultural identity, spirituality, healthy relationships, family support, communication and strength of participation in social activity (Kapeli et al, 2021, p. 532). These factors also support culturally friendly environments. I strived to ensure my data collection spaces

reflected a Pacific culturally friendly environment and included culturally valued elements such as the provision refreshments and/or *me'a 'ofa* (gifts) for participants (HRC, 2014). *Me'a 'ofa* aids reciprocity, culturally remunerating research participants for their knowledge and time. Curry (2003) points out that reciprocity aligns with post-development concept and is fundamental to creating social ties and identity formation, together with being a significant determinant of quality of life (p. 418).

During one of the nine data collection sessions, a second methodology, *faikava*, was also used. This methodology utilises a traditional *kava*-use space inclusive of *talanoa* (which will be explained shortly). *Kava* (botanical name *Piper methysticum*), is an indigenous plant of the Pacific Islands and a drink made from the ground rhizome of the shrub (Aporosa, 2021, p. 76). *Faikava* is the process of preparing *kava* for consumption at a gathering and typically involves groups of people either from the same church, region, or those who share the similar interests (Vaioleti, 2013, p. 200). The *faikava* methodology has been guiding Pacific-focused research data collection for more than 20 years and is endorsed by the Health Research Council of New Zealand (Aporosa et al, 2021, p. 82-83).

Before discussing the methods employed in this study, the next section will explain the research community and why they were selected.

1.2.1 Research Site

This study concentrated on three rural research sites in Te Rohe Pōtae ('King Country', South/West of Waikato) in ANZ. They are Ōtorohanga, Kāwhia and Te Kūiti . An explanation of these sites, including challenges in obtaining accurate demographic data for Te Rohe Pōtae, will be explained in Chapter Two. Ōtorohanga served as the main research location and it included seven of the nine participants. One participant came from Kāwhia, while another came from Te Kūiti. Details about the lower number of participants at these research sites will be addressed in the following section, *The challenge of COVID-19*. Five one-on-one interviews were done at the participants' preferred café in their town. Four people participated in the group interview, which was held in one of the participants' homes.

1.2.2 The challenge of COVID-19

Te Kūiti was originally selected as the main research site during the project's planning phase starting March 2021 due to its larger proportion of Pacific peoples (see table 1, Chapter 2). Data collection was planned to start in October 2021; however, this was disrupted following the August 2021 COVID-19 outbreak, which had an immediate, and then repeated, waves of infection, in Te Kūiti. As a result, participant recruitment and data collection were continually postponed. Doing interviews with Pacific peoples via video or phone call is not an ideal as it opposed Pacific values, particularly values linked with *vā*. The concept of *vā* will be explained in the following section under the heading, *Talanoa*.

Continual disruptions in access to Te Kūiti led to a research site change to the Ōtorohanga and Waitomo districts as explained earlier, with data collection being done between April and July 2022. However, COVID-19 continued to impede participant recruitment, and together with time constraints, limited research participant numbers from the intended thirty individuals to nine. A demographic breakdown for the nine participants is presented in Chapter Three.

Three methods were used to gather data from the nine research participants. These, together with the data analysis, my positionality as the researcher, and ethical considerations used as part of the PPdMF and faikava methodology, will now be explained.

1.2.3 Methods

1.2.3.1 Talanoa

Talanoa as a method is critical to the collection of the research data. Tongan researchers Doctors Timote Vaioleti and Sitiveni Halapua were the first to introduce and develop *talanoa* as a Pacific methodology within educational research (Anae, 2019; Baice, 2021; Fa'avae et al, 2016; Halapua, 2000; Tecun et al, 2018; Vaioleti, 2006). Halapua (2002) explains that,

> *Talanoa* comes from two words *tala*, "to tell" and *noa*, "zero or without concealment", and… involves frank expression without concealment in face-to-face dialogue. It embodies our understanding of inner feeling and experience of who we are, what we want, and what we do as members of a shared community. (p. 1)

Talanoa simply means talking, but it alludes to Pacific cultural forms of talking (Vaka et el., 2016, p. 538). *Talanoa*, as a method, takes place in groups (or at least two individuals) that involves the sharing of stories about a topic that are looked into to unravel meanings and connotations of the subject and hopefully come to an agreement on the idea (Vaka et el., 2016, p. 538).

Anae (2019) lists the Pacific research methodologies of *vanua* (land); *kakala* (flower); Kaupapa Māori (land, community land family considerations); *fonofale* (holistic house), *tivaevae* (patchwork); *fetuutuunai* (navigation); *bu ni Ovalau* (coconut tree), explaining that a key component of these approaches is *talanoa*, or face to face dialogue. She adds that it is the "context of the relational social and sacred *vā* between the researcher and the researched and how Pacific Relational Ethics (PRE) is embodied and enacted throughout their interactions" (p. 8). A key claim made by Anae (2019) is that *vā* (Tonga)/*va* (Samoa) is a symbolic concept critically linked to connection between people, places, and ideas (p. 5) that trace back to Polynesia through its languages (Baice et al, 2021, p. 77). According to Fa'avae et al (2021), the combination of *talanoa* and *vā* is "a core life force inherent in our collective *Moana* (Oceania) peoples' relational sense–making and meaning–making" (pp. 6-7). Therefore, indigenous people perceive their existence holistically, where all things are

interrelated (HRC, 2014; Kapeli et al, 2021; Meyer, 2001; Mika, 2017), and in which *talanoa* linked to *vā* is their dominant means of communication and understanding. This means *talanoa* is an essential tool when doing research by, for, and with Pacific peoples (Havea et al, 2020, pp. 139-140).

It is also important to mention the link between *talanoa*, *vā* and proximity, space and intimacy. Depth of *vā* is critically associated with trust (Fa'avae, Jones & Manu'atu, 2016, p. 140). Trust is essential to ethnographic research data quality (Anae et al., 2001, pp. 40-1). Consequently, disrupting *vā* can unintentionally cause some pushback from Pacific communities and ultimately compromise the objectives of the study. To aid trust and *vā*, which is likely to increase accuracy, I commenced each of the *talanoa* sessions by welcoming and thanking my participants for agreeing to participate in my research. It was important to establish *vā* through casual *talanoa* since it was the first time we had met, thus, inviting them to initially share a little about themselves and vice versa helped break the ice. By building trust between my participants and myself through *talanoa*, there were able to speak comfortably and honestly. Therefore, it was important that the research data was collected face-to-face to provide the creates opportunity for the creation and maintenance of *vā* and in turn research data accuracy. This was challenging, particularly with COVID-19 as explained in the previous chapter.

To further contribute to *vā* and cater for a culturally friendly environment, refreshments were provided during the *talanoa* sessions, or a *me'a 'ofa* (gift) was given to participants to thank them for their time and contribution afterwards (HRC, 2014).

1.2.3.2 Survey forms

To gather demographic data from the participants, I used survey forms (Appendix A). These were given to participants at the end of each of the *talanoa* session, and allowed for the gathering of background information and socioeconomic data.

1.2.3.3 Semi-structured interviews

A series of semi-structured interview questions were developed and grouped into themes to assist this study. These are attached at Appendix B. The delivery of the questions were regulated by whether I was doing a '*talanoa fakataautaha'* session (one on one *talanoa*), or a family *faikava* session. Using semi-structured interviews allowed for collection of open-ended data and flexibility to explore the health aspirations of the participants, which often meant delving deeply into personal and sensitive issues (Dejonckheere & Vaughn, 2019, pp. 2-3). The questions were essentially used as a guide and was typically follow-up with 'why' to allow for further explanation.

The survey and interview data collected through *talanoa* was analysed with the aim of understanding the health experiences and aspirations of my Pacific participants. That analysis process will now be explained.

1.2.3.4 Data analysis

To analyse the data, an inductive thematic analysis was adopted (Braun et al, 2015, pp. 12-13). I started by listening to the audio recordings to manually create a verbatim transcription. The next step of thematic analysis required me to immerse myself in the data. Maher and colleagues (2018) explained this immersion as exploring "all the possible nuances and relationships, to view data from a variety of perspectives, and to move from micro- to macro view, in order to support analytic imagination necessary for understanding and theory generation" (p. 12). This aided the initial coding of the data which was done in Microsoft Word, highlighting areas deemed relevant, then using the comments function to assign an initial code to it. Once coded under dominant themes, I then organised the codes with their excerpts into an excel sheet where I searched, reviewed and named themes. Kiger and Varpio (2020) described themes as patterns or meanings that are actively constructed and "derived from a data set that answer a research question, as opposed to mere summaries or categorizations of codes" (p. 846). The findings were informed by the interpretive reflections on my meaning of these patterns (Goodall, 2000, as cited in Saldana, 2009, p. 116) from the *talanoa* sessions. The themes were further amended and refined through *talanoa* with my thesis supervisor.

My interpretive reflection of the data was done through an ANZ-born Pacific lens. Therefore, my positionality as a Pacific person born in ANZ influenced that interpretation, which I will now explain.

1.2.4 Positionality: Wanting desperately to be 'white' or hybrid identity?

Research is never neutral or apolitical (Halse & Honey, 2005; Lather, 1991). Through the research process, my inherent characteristics such as my ideas, values, beliefs and social background, accompany me, influencing every methodological and analytical choice I make (Fasavalu & Reynolds, 2019, p. 12; Holmes, 2020, p. 1; Vanner, 2015, p. 3). According to Fasavalu and Reynold (2019), this is one's positionality in relation to the social political environment of the research, also referred to as 'insider/outsider' (p. 11). I am a Tongan-Polish woman, who was born, raised and schooled in Kirikiriroa (Hamilton), ANZ.

I have experienced the best of both worlds by growing up in ANZ and interweaving that with my Tongan household upbringing. Marrying the two cultures has aided in framing my relationality to place and people, as well as shaped the way I understand and value things. The phrase "the canoe never retraces the same path" is well-known among Pacific seafarers (Palaita, 2015, p. 35). My understanding of this saying is the canoe in the ocean metaphorically depicts our voyage in life—how we are not confined to travelling in parallel paths—and that, like the occasionally unforeseen conditions of the ocean, different situations arising on our journey through life may alter our courses.

I'm still continually learning what my immigrant parents find to be effective, and also what the Westernised system has shown to be effective for me. I am aware that this can be perceived by more traditional Tongans as *fie palangi* (wanting desperately to be 'white'), especially as I pursue higher education which calls for me to be more critical, and challenge not only Eurocentric norms, but also traditional ways of thinking and being. The term *fie palangi*, however, can be culturally offensive and can imply a disregard for traditional values.

My mindset echoes that of my ancestors, who were canoe builders and navigators who left their lands, or as Hau'ofa (1994) describes as going "into the unknown, to discover and populate all the habitable islands east" (p. 155), in quest of different ways to live life. Without subjugating my Tongan culture to Eurocentric ideas, I am currently navigating the waters of academia as a novice Pacific researcher at the University of Waikato, with ambitions to serve my Pacific community and *foaki 'ofa* (giving) through my research. This creates a tension as my academic investigator places me in both an 'insider' and an 'outsider' role, which will now be explained.

1.2.4.1 'Insider/Outsider' and power relations

Living outside of the Pacific community I was investigating, and meeting most for the first time, participants likely perceived me as an 'outsider'. However, as I previously explained, a member of the research team came from the community, introducing me and bridging aspects of the 'outsider' divide and giving me, albeit, a small level of 'insider' status, particularly as Pacific peoples tend to be very welcoming of other Pacific peoples.

Conversely, being born in ANZ, rather than Tonga, contributes in a small way to 'outsider' status. Added to this, my ancestry on my paternal side, which I have never interacted, is Polish. Further, I have only visited Tonga once. On the other hand, my mother who is full Tongan, raised me *anga faka-Tonga* ('the Tongan way') by taking me to a Tongan church and speaking Tongan at home, giving me 'insider' status. Although I am only *hafakasi* (mixed Tongan), and my complexion is lighter than my mother's, I nevertheless identify and consider myself to be Tongan. These are the tensions and challenges of 'insider' and 'outsider' status, which can also create power imbalances.

Knowing how to appropriately handle the bias of power relationships with participants is a crucial factor when negotiating the complex and nuanced engagements associated with positionality (Kohl & McCutcheon, 2015, p. 752). Methodological problems can result from power dynamics that develop during the research process in which institutional privilege as researchers divides researchers from participants (Britton, 2020, pp. 1-3). I sought to embrace Flavell and Cunningham's (2022) advice and put the needs of my participants first, avoiding "the power structures that already weighed in favour of the dominant culture" (p. 6). This is also a critical aspect of the PPdMF associated with Pacific respect-based values and anti-hegemonic practice within the theory of post-development. By giving my

participants the chance to actively participate, whether it be by working with them to assist my own self-reflection or the co-construction of themes and ideas, I felt I was able to minimise negative power dynamics (Flavell & Cunningham, 2022, p. 5).

Power relations and positionality, when not outworked correctly, have the potential to compromise ethical standards. Ethical considerations integrated throughout this study is the focus of the next section.

1.2.5 Ethics

As an enrolled post-graduate student at the University of Waikato, there are rigorous research ethics and guidelines to adhere to when conducting your own research. However, as an academic researcher working with Pacific communities, ethical elements should be self-determined by Pacific communities, as entailed by the PPdMF ideology. Within the Waikato University's Human Research Ethics Committee (WUHREC) (2019) *Human Research Ethic's Application* is a section entitled "Cultural safety" which states, "researchers are required to respect the cultural, social and language preferences and sensitivities of participants" (p.6). While I see value in this, the statement is nevertheless open to the interpretation of the researcher as 'respect' is subjective to each individual. In the case of Pacific peoples, respect values are highly prescribed and defined. I would argue that Pacific values hold researchers to higher account than the written 'standards' of ethics committees. Therefore, while ethics approval was sought and gained, this was more so a formality as my study and participant interaction were guided by Pacific values and the PPdMF.

Ethics to undertake this study was awarded by WUHREC in June 2021 (HREC[Health] 2021#40). That approval is attached at Appendix C. I was then permitted to begin the recruitment process after ethics were authorised. The following information pertains to the recruitment process.

1.2.6 Recruitment

The combination of purposeful sampling and snowball sampling was used when recruiting participants. Purposeful sampling is described by Patton (2002) as,

> The logic and power of purposeful sampling lie in selecting information-rich cases for study in depth. Information-rich cases are those from which one can learn a great deal about issues of central importance to the purpose of the inquiry thus the term purposeful sampling. (p. 230)

My colleague who conducted the 'twin' or Māori version of this study, as a member of Te Rohe Pōtae, initiated most of the recruitment through purposeful sampling. After I had attracted a few participants, snowballing was used. As noted earlier, I am not from the community where the intended participants belong to, therefore, snowballing made it easier for me to acquire individuals that fit the criteria (Naderifar, 2017, p.2). It is commonly

a lengthy process that lasts until data saturation, and it relies on current participants to find new participants (Naderifar, 2017, p. 2). As was previously indicated, COVID-19 made things more challenging, particularly with snowballing. This was especially true given that participants were in lockdown and had their own priorities to worry about other than looking for additional people to recruit for the study. This was another reason why it was difficult to get the desired 30 participants.

Primary methods of initial communication with my participants were email, phone call, text or Facebook messenger, when information sheets (Appendix D) were distributed or explained. A participant recruitment poster (Appendix E) was uploaded on the STEM Māori and Pacific students email *pānui* [update or announcement], which is a weekly email that gets sent to Pacific students in the School of Science, Health and Engineering at the University of Waikato. If verbal consent was not obtained over the phone during the initial interaction, written consent (Appendix F) and information about the study was reiterated before the *talanoa* sessions started.

1.3 Thesis Structure

Chapter Two opens by evaluating important publications that deal with Pacific health in order to show how the health of Pacific peoples compares to that of other ethnic groups in ANZ. I then discuss Pacific demographics on a national level, before focusing on rural Pacific demographics, and finally the district health board (DHB) region where Te Rohe Pōtae is situated. The topic then shifts to a brief description of Realm Countries and their rights, as well as how this influenced the selection of the research sites. The discussion then returns to regional health disparities, followed by priority areas in the Waikato DHB (WDHB) region. Identifying Te Rohe Pōtae's demographic information is challenging due to historical factors associated with colonial systems. The issue will be addressed, along with an elaboration of Te Rohe Pōtae.

Following an explanation of spatial equity, which is important since it connects to some of the difficulties Pacific peoples face, comes an exploration of possible barriers for the inequities that will already be highlighted. The focus of the discussion then switches to a general description of the Pacific health workforce and how, in order to achieve fair results for Pacific health, it is currently substantially behind where it should be. Then, I provide a short outline of the Pacific Provider Development Fund [PPDF], and its present repercussions on the study's research locations. Following this description, I argue how the PPDF has potential to better support rural Pacific peoples.

The topic then turns to highlight the knowledge gap regarding rural Pacific peoples' health across influential Pacific reports. I make the claim that a lack of precise definition of what is meant by 'rural' contributes to the issue throughout Pacific reports. The Geographical Classification of Health [GCH] will then be used to illustrate rurality and the classification's potential future application.

Given the information gap regarding Pacific peoples' health in a rural context, it is beneficial to then investigate the literature on rural health in ANZ to gain some of understanding of health within a rural setting. The chapter ends with a summary and an explanation of the attributes of a doctor, which will serve as discussion points for Chapter Three and Chapter Four.

Chapter Three commences by introducing my research participants as well as a number of observations made while collecting the research data. The focus of this chapter is the findings and analysis based on data collected during the field research to address the research's aim: what are the health aspirations and perspectives of Pacific peoples' living in the rural and remote community of Te Rohe Pōtae (South/West of Waikato)? My analysis elaborates on the semi-structured questions that I categorise into three main groups, namely, 'health and wellbeing', 'rural and remote', and 'healthcare needs'. Where appropriate, I will also refer to the material from Chapter Two to reflect on ideas or statements made by participants.

Chapter Four summarises the key ideas of the thesis and ties everything together. The knowledge gap, the fundamental discoveries, and how these discoveries inform the research question are all reviewed in this chapter. The chapter concludes with a summary of how I've contributed to the topic, a concluding statement, and the limitations of the study.

Chapter Two: Literature review

2.1 Introduction

"It's very difficult to navigate the health system"
Pacific community participant from Hastings, ANZ

This quote from a 2020 report (Ministry of Health [MoH], 2020, p. 13) serves to illustrate the feelings of a Pacific person regarding the healthcare they receive in Aotearoa. In comparison to their European counterparts, Pacific peoples in ANZ experience, on average, have higher rates of unmet need for care, with 33 percent of them acknowledging not going to see their primary-care practitioner when they should have (Pacific Perspectives, 2019, p. 6). But why do Pacific peoples feel this way? And what can be done to change this? This study will attempt to answer these questions. To aid that investigation, this chapter reviews selected publications that address Pacific health in ANZ.

2.2 Pacific peoples in Aotearoa: How are we faring in terms of health?

As mentioned in Chapter 1, The Simpson Report, cited as "the most comprehensive integrated look at the New Zealand Health and Disability System in a generation" (Simpson, 2020, p. 1), states that Pacific peoples' health outcomes in ANZ are inequitable (p. 14). When compared with the average ANZer of European ancestry, Pacific peoples have shorter life expectancy by 6.3 years, a higher mortality rate of 619.5 (per 100,000 population), a higher likelihood of hospitalisation (43.6 percent for those aged 0-4 years and 34.6 percent for those aged 45-64 years), and a higher prevalence of risk factors such as daily smoking, current smokers, obesity in adults and children (Simpson, 2020, p. 20). Notably, Pacific adults and children have the highest obesity in ANZ (Ministry of Health [MoH], 2020, p. 13). In a comparison with non-Pacific adults, Pacific adults are 2.5 times more likely to be obese (MoH, 2020, p. 13), whereas Pacific children are 3.3 times more likely to be obese when compared with non-Pacific children (MoH, 2020, p. 13). Additional comparisons between Pacific adults and non-Pacific peoples include: Pacific adults are three times as likely to have diabetes; Pacific adults are 1.2 as likely to experience psychological distress; Pacific adults are twice as likely to have had teeth removed due to tooth decay, an abscess or gum disease; and 24.3 percent of Pacific adults are identified as hazardous drinkers (Ministry for Pacific Peoples [MPP], 2020, pp. 97-103).

In the interim report to the 2020 ANZ Health and Disability System Review, completed just prior to COVID-19, it says:

> Of all ethnic groups in New Zealand, Pacific peoples are among those most affected by inequities in the socioeconomic determinants of health, including living in areas of high socioeconomic deprivation, being unemployed and having low weekly earnings. These factors can affect health directly (for example, through damp, cold, and overcrowded conditions, which increase the transmission of infectious diseases) and indirectly (for example, by limiting opportunities to engage in health-promoting behaviours). (Simpson, 2019, p. 25).

Furthermore, the MoH (2014, 2020), a government body, and the health and education consultancy group Pacific Perspectives (2019) have issued reports summarising Pacific peoples' health in ANZ, which informed the Pacific dimensions in the Simpson Report (2020). Collectively these earlier reports show that there has been steady improvement in health and service outcomes for Pacific peoples over the years since the first national strategy, known as *Pacific Health and Disability Action Plan* (MoH, 2002). Despite the reports suggesting some progress in primary healthcare for Pacific peoples, such as improvement in access to services (MoH, 2020, p. 4), and improved life expectancy at birth (improvement is slower and lower than other ANZers) (Pacific Perspectives, 2019, p. 16). The health disparities for Pacific peoples, however, are not reducing (MPP, 2022, p. 25; MoH, 2014, p. 24; MoH, 2020, p. 4; Pacific Perspectives, 2019, p. 5). Before delving into variables that contribute to these heath discrepancies for Pacific peoples, I will first discuss the Pacific demographics in ANZ and the WDHB region.

2.2.1 Demography

Almost one in ten ANZers are Pacific people (StatsNZ, 2019b). The 2018 census results showed that the Pacific population (381,642) increased their percentage of the overall population from 7.4 percent in 2013 to 8.1 percent in 2018 (StatsNZ, 2019b). The 10 largest Pacific populations are Samoan (47.9 percent), Tongan (21.6 percent), Cook Islands Māori (21.1 percent), Niuean (8.1 percent), Fijian (5.2 percent), Tokelauan (2.3 percent), Tuvaluan (1.2 percent), i-Kiribati (0.8 percent), Tahitian (0.5 percent), and Papua New Guinean (0.3 percent) (StatsNZ, 2019c). This diverse population is young and growing, with projected population growth rate of 1.9 percent (0.49-0.54 million) for Pacific peoples in 2028 (StatsNZ, 2022). In addition, 66.4% of Pacific peoples are ANZ-born (StatsNZ, 2019b).

Urbanisation is widespread among Pacific peoples. More than 85 percent of Pacific peoples reside in seven DHB catchment regions (StatsNZ, 2019a). These consist of the three DHBs of Auckland and Wellington, as well as Canterbury and Waikato DHBs. The Auckland region is home to two thirds of ANZ's Pacific population, with more than half residing in the Counties Manukau DHB (StatsNZ, 2019a). Smaller DHBs with a lower number of Pacific peoples, on the other hand, have seen the most rise in their numbers

of Pacific peoples and are anticipated to see even more growth in the future (HQSC, 2021, p. 21).

Simpson (2020) estimates that although only two percent of Pacific peoples reside in rural areas (p. 15), ANZ will have a significant rural population in 20 years (Simpson, 2019, p. 21). According to projections, rural areas will expand at a 14 percent quicker rate than other major urban regions (a 100,000-person increase over current figures) (ibid, 2019, p. 21). From a healthcare perspective, this has come concerns. As Pacific peoples are concentrated in distinct areas, there are opportunities for locally-based initiatives and specialised health programmes for these larger Pacific communities (Pacific Perspectives, 2019, p. 11). Consequently, this results in less Pacific-specific services being delivered in the regions with fewer Pacific people of which are projected to experience greater growth (Pacific perspectives, 2019, p. 11). A dilemma explored later in the chapter.

Pacific peoples make up 4.5 percent (20,619) of the population in the Waikato region (StatsNZ, 2018g). The districts in the WDHB that the most Pacific peoples live in are Hamilton City (Greater Hamilton) (9815, 6.1 percent), South Waikato District (3077, 12.8 percent), and Waikato District (North Waikato) (3175, 4.2 percent) (StatsNZ, 2018a; StatsNZ, 2018c; StatsNZ, 2018f). However, the highest concentration of Pacific peoples live in South Waikato (12.8 percent of the population of South Waikato 24,042) (StatsNZ, 2018c). Interestingly, I made the effort to move the focus away from South Waikato due to the dense concentration of Pacific people from Realm Countries in Tokoroa. Outside of the 15 Pacific islands that make up the Cook Islands (with those 15 islands represented as 'stars' on the flag of the Cook Islands nation), Tokoroa historically has the biggest Cook Islands Māori population in ANZ, or as locals refer Tokoroa to as "Cook Island's 16th star" (Kirkeby, 2021, para. 2).

The following will provide a quick explanation of Realm Countries and their entitlements, and why this caused the attention to shift away from this area.

2.2.2 Realm VS non-Realm

The Realm countries, sometimes referred to simply as 'the Realm', are described by Quentin-Baxter (2021) as "a way of referring to all, or to any one or more, of the five countries or territories in respect of which the Sovereign in right of New Zealand is the head of state" (p. 586). Three of the Pacific nations that comprise the Realm are Tokelau, Cook Islands and Niue (Government House, 2022, para. 2; Quentin-Baxter, 2021, p. 586). Everyone who currently resides in any area of the Realm has the status of a New Zealand citizen by right, as a result of colonisation and other historical factors (see Quentin-Baxter, 2021, pp. 580-586 for details). Thus, Pacific peoples from Tokelau,

the Cook Islands and Niue have Realm country entitlement, meaning they have automatic access to healthcare.

Those from Fiji, Samoa and Tonga, among other Pacific nations that are not part of the Realm, are not automatically granted these advantages. Instead, non-Realm countries need to first go through the lengthy process of obtaining either permanent residency or citizenship, or they must be a work visa holder who is qualified to stay in ANZ for at least two years to get the same healthcare accessibility (New Zealand Government, 2021, para. 6; New Zealand Immigration, 2022). If Pacific peoples do not meet any one of the previously mentioned visa criteria, they must acquire travel and health insurance or pay hefty international fees for public health (MoH, 2012, para. 3; New Zealand Immigration Concepts, 2022, para. 6).

This was, and continues to be, more difficult for non-Realm countries to access healthcare in ANZ, than it is for Realm countries. The intention is not to imply that Realm countries have no hurdles to getting healthcare, rather, this thesis recognises that both Realm and non-Realm Pacific countries face several challenges to healthcare access. However, because there were more Cook Island Māori at Tokoroa, which is in South Waikato, the focus of this study was shifted away to other research sites with a more balanced distribution of Pacific peoples from both Realm and non-Realm countries. They already have a Pacific-specific organisation established there in South Waikato, which is another factor; this topic will be covered in more detail later in the chapter. I have covered the distribution of Pacific peoples in the WDHB region, I now present a brief discussion of the state of Pacific peoples' health in the area.

2.3 The health of Pacific peoples in the Waikato DHB

The WDHB's strategy to enhance the health and wellbeing of Waikato residents is outlined in the *Waikato District Health Board 2021-22 Annual Plan* [the plan] (2021b). The report found that "there are persistent equity gaps for Māori and Pacific peoples in the Waikato DHB catchment" (Waikato District Health Board [WDHB], 2021b, p. 26). One of the key documents that guided the direction of the plan is *Te Korowai Waiora Waikato Health System Plan* (Waikato District Health Board [WDHB], 2019). According to their report, Pacific peoples in the Waikato had shorter life expectancy (74 years for males and 78 years for females) than the non-Pacific non-Māori (80 years for males and 84 years for females) (WDHB, 2019, p. 13). Particularly, it was found that South Waikato and North Ruapehu, which includes my research site of Te Rohe Pōtae, which I will explain shortly, had much shorter life expectancies than the rest of Waikato (WDHB, 2019, p. 13). Pacific mortality rates were almost double that of non-Pacific non-Māori rates (WDHB, 2019, p. 13). They also report a rise in preventable diseases, such as diabetes, which affects one in twelve Pacific adults; 19 percent of Pacific children had

asthma; excessive cholesterol in 10 percent of Pacific people; and high blood pressure in 15 percent of Pacific people (WDHB, 2019, p. 15). Overall, it would appear that, similar to the overall condition of Pacific health on a national level, there are significant health inequities among Pacific peoples in the WDHB. North Ruapehu is part of the designated rural area of Te Rohe Pōtae that was chosen for investigation in this study. The focus was moved to other places of the Te Rohe Pōtae area, as described in Chapter One, even though North Ruapehu itself was an area that needed to be concentrated on. That area, Te Rohe Pōtae, will now be explained.

2.4 'The boundary of the hat'

In the previous chapter, within the methodology section, it was explained that this study concentrated on three rural sites in Te Rohe Pōtae. Historical aspects linked to colonial structures make it difficult to accurately identify demographic data for this area. This difficulty, together with an explanation of Te Rohe Pōtae, will now be presented.

The identification of demographic profile data specifically for Te Rohe Pōtae is challenging due to a discrepancy that exists between how local Māori understand their regional boundaries – and, in-turn, my research sites – and how the New Zealand government, particularly the Waikato District Health Board, views these areas. That discrepancy has its origins in events starting in the 1860s, when Ngāti Maniapoto, the main iwi of Te Rohe Pōtae, supported by affiliate tribes from Taranaki and Waikato, fought against the British colonial government in the Māori Land Wars. This was followed by a lengthy period (1864 to the early 1880s) in which Ngāti Maniapoto sheltered the exiled Māori King Tāwhiao from Waikato, leading Te Rohe Pōtae being given the name, 'King Country' [Government imposed] (King & Ritchie, 2015a, p. 84-85; Pollock, 2015b, para. 7). Europeans and the colonial government were prohibited from entering the territory.

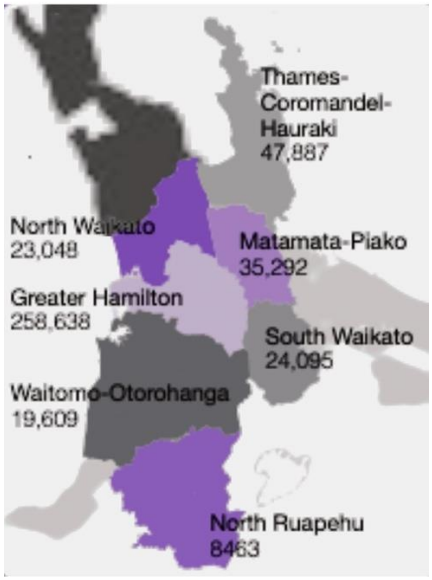
'Te Rohe Pōtae', loosely translated as 'the boundary of the hat', acquired this name after the exiled King Tāwhiao marked local boundaries on a map by throwing his hat down (King & Ritchie, 2015a, p. 84-85; Pollock, 2015b, para. 7). European settlement was negotiated in the 1870s (Pollock, 2015b, para. 8). Although there have been several adaptations to the boundary lines since they were established by King Tāwhiao (see King & Ritchie, 2015b, pp. 90-91 for details), Te Rohe Pōtae primarily consists of three districts, Ōtorohanga, Waitomo and the northern two-thirds of Ruapehu district. However, Te Rohe Pōtae is not officially recognised as a region by Government, regardless that a regional identity and defined boundary exists for Ngāti Maniapoto (see Figure 1) (Pollock, 2015a, para. 7).

Figure 1: Te Rohe Pōtae region map

Note. This map shows the region's major towns and settlements, district boundaries, highways and rivers. Adapted from "Story: King Country Region", by *Te Ara- The Encyclopaedia of New Zealand*, 2015 (https://teara.govt.nz/en/interactive/34819/king-country-region-map). Adapted with permission 2022.

Figure 1 shows the geographic position of Te Rohe Pōtae [Waitomo, Ōtorohanga and North Ruapehu] as recognised by Ngāti Maniapoto. This sits within the WDHB region as shown in Figure 2. The WDHB is one of 20 district health boards in ANZ. These health boards are charged with delivering or funding health services within their designated district (Waikato District Health Board [DHB], n.d., para. 1). The three districts of Te Rohe Pōtae have a combined land area of 12.268.43km² (StatsNZ, n.d.), making them the largest territorial local authority within the WDHB boundary in terms of landmass.

Figure 2: Waikato DHB's Population



Note. This map shows the territorial local authorities within Waikato DHB boundaries. Adapted from "Waikato Health System Plan Te Korowai Waiora", by *Waikato DHB*, 2019 (https://www.waikatodhb.health.nz/assets/Docs/About-Us/Key-Publications/Plans/7bf3d1e7ca/Waikato-Health-System-Plan-Te-Korowai-Waiora.pdf). In public domain.

By comparing Figure 1 and Figure 2, this shows the discrepancy between how the WDHB interprets its territorial local authorities within the WDHB boundaries in comparison to that of Te Rohe Pōtae (DHB, 2019, p. 13). Furthermore, rather than two autonomous districts, WDHB combines the two as Waitomo-Ōtorohanga (see Figure 2). Although these discrepancies between how Māori and the New Zealand Government view boundaries may appear minor, this, nevertheless, leads to inaccuracies in demographic data understandings, the generalising of health system design, planning and investment priorities across the vast territory. This is particularly important considering the *Waikato Health System Plan Te Korowai* (WDHB, 2019) report informs the ANZ government on recommendations for improving health outcomes and equity in the Waikato.

Despite the fact that the region is not officially recognised by the ANZ government, Te Rohe Pōtae and, particularly, the Ōtorohanga district, was the focus data collection site for this thesis. Due to the time, resources and scope of this research, covering the entirety of Te Rohe Pōtae would be challenging, therefore, the focus was narrowed down to the Ōtorohanga district. Table 1 lists the rural towns visited during data collection. Ōtorohanga and Kāwhia are situated in the Ōtorohanga District, while Te Kūiti is located in the Waitomo District (see Figure 1). Given that each of the three towns were categorised as being within one of the 'rural' category levels (see Table 1 and Appendix I), they were chosen as research sites as they had Pacific peoples living in the town and, therefore, provided representation of rural Pacific peoples.

Ōtorohanga is situated 56.6km from the nearest urban city, Hamilton, and has a population of 3,027, 2.7 percent of whom are Pacific (see Table 1). Te Kūiti, located a little farther south

of Ōtorohanga, had just one participant despite having a somewhat larger population of 4572, and a greater percentage of Pacific peoples at 5.6 percent (see Table 1). Kāwhia, with a population of just 400 and being the most rural and remote of the three research sites, had only one participant. It should be highlighted that the period between the 2018 census and the completion of this thesis is likely to have resulted in considerable demographic changes. The research sites seem to be understudied in general, and this extends to issues relating to Pacific peoples' health.

A member of the research team, who is a well-established member of both Ōtorohanga and Te Rohe Pōtae communities, contributed to the attractiveness of the research sites. After living there for 34 years, this research member has built numerous ties and connections, which has been tremendously beneficial for recruiting my participants. This alleviates concerns relating to familiarity, accessibility, and the openness of participants who are meeting me for the first time, to have someone from the community establish the connection. In a Pacific context, this is often referred to as *vā*, the idea of relational positionalities (Fasavalu & Reynolds, 2019), which is explained earlier in Chapter One.

Table 1. Towns visited during the data collection period: April-July 2022

District	Town	Total population 2018	Pacific population 2018 (%)	No. of participants	Geographical Classification of health (GCH)	Distance to Hamilton
Ōtorohanga District	Ōtorohanga	3,027	2.7	7	R1	56.5 km (42 min)
	Kāwhia	400	-	1	R3	77.5 km (1 hr 4 min)
Waitomo District	Te Kūiti	4,572	5.6	1	R2	75.9 km (56 min)

Note. Various adopted sources, see Appendix G.

After detailing the health inequities that exist for Pacific peoples on both a national and regional scale, as well as the difficulty to identify demographic data for the region, it is critical to have an understanding of how Pacific peoples view health. The Pacific viewpoints of health will now be briefly discussed as this can provide some insight into the heath inequities they face. Following this discussion, some of the factors leading to these health disparities will be detailed.

Mo'ui lelei: Pacific wellbeing

Evidently, the biomedical 'one-size-fits-all' model of care in ANZ—which often doesn't take into account Pacific worlds views—fails to be responsive to the needs of the diverse Pacific population (HQSC, 2021, p. 96; MoH, 2020, p. 11-12; MPP, 2022, p. 17; Pacific Perspectives, 2019, p. 6). The way that Pacific peoples perceive their wellbeing is profoundly influenced by their worldviews (HQSC, 2021, p. 19; The Treasury, 2018, p. 10), and these beliefs can have the power to affect how they behave and make decisions about their health (Kolandai-Matchett et al. 2017, p. 2; MoH, 2014, p. 22;

MPP, 2021, p. 81). Pacific peoples, like other indigenous groups, have a holistic viewpoint that takes in account all four dimensions—physical, mental, cultural and spiritual (MoH, 2014, p. 2; Pacific Perspectives, 2019, p. 11). Societal expectations founded on the role of *fāmili* (family), *kāinga* (community), and religion, as well as the primacy of relationships that mutually reinforce one another, are all part of the distinct perspectives of Pacific peoples (MoH, 2020, p. 15; The Treasury, 2018, p. 10). For example, due their soceital expectations, a typical Pacific person may prioritise sending money back to the islands for family or religious obligations over paying for healthcare services. The elder Pacific generation, many of whom were born in the islands, tend to have a strong spiritual conception of health, viewing illness, death, and disability as manifestations of God's will (Fonua-Faeamani, 2017, p. 284). This includes the idea that mental illnesses are brought on "by possession by evil spirits or deceased relatives as retribution for wrongdoing by the affected individual or members of the family" (ibid, 2017, p. 284). It is also crucial to keep in mind that the ANZ Pacific population is evolving because of the increasing numbers of ANZ-born Pacific peoples (StatsNZ, 2019b), intercultural marriages, and rising levels of education (Ataera-Minister & Trowland, 2018, p. 9; Fonua-Faeamani, 2017, p. 283; Thomsen et al. 2018, p. 9). Therefore, it cannot be assumed that all Pacific share the same worldviews. I go on to provide a Pacific health model that may represent Pacific ways of thinking.

2.5.1 Fonua Model

A Pacific health model that underpins Pacific peoples' worldviews is the *Fonua* model by Dr Sione Tu'itahi, a Tongan socio-ecological framework, that has a pan-Pacific application (Tu'itahi, 2009). The Tongan motto, *Ko e 'Otua mo Tonga ko hoku Tofi'a*, which translates to God and Tonga are my inheritance, places a great emphasis on the *fonua* [land] of Tonga, similar to *vanua* (Fijian) and *whenua* (Māori). Tongans also refer to *fonua* as placenta, *faitoka* [grave] and people of the land (Fehoko et al. 2021, p. 5). Instead of focusing on health on an individual scale, the *Fonua* model embodies five cyclic dimensions—*Laumalie* (Spiritual), *'Atamai* (Mental), *Sino* (Physical), *Kainga* (Community), and '*Atakai* (Environment) (Tu'itahi, 2009). The levels *Taautaha* (individual), *Fāmili* (family), *Kolo* (Local), *Fonua* (National), and *Mamani* (Global) are also included (ibid, 2009) (see Appendix H for more details). Pacific peoples would benefit hugely from improved access rates and better health outcomes if health services integrated culture and Pacific worldviews (MoH, 2020, p. 15; MPP, 2022, p. 19). This thesis subsequently investigates and verifies participants' sense of beliefs and perspectives on health.

I will now concentrate on the potential causes of the health disparities noted earlier in the chapter. It is important to first explain spatial equity since it interrelates with some of the challenges faced by Pacific peoples.

2.6 Spatial equity

The MoH (2019) defines equity as,

> 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 advantages require different approaches and resources to get equitable health outcomes. (para. 4)

In other words, removing obstacles that are out of a person's control is necessary to work towards health equity (Woodward & Kawachi, 2000, p. 924). There does not seem to be a clear agreement on what defines spatial equity (Whitehead et al., 2019a, p. 271), even though spatial equity might be seen as a crucial element in reaching health equity, especially in rural areas (Dalton et al., 2013, p. 2; Whitehead et al., 2019b, p. 5). One of the themes that emerged, from Whitehead's et al. (2019a) recent systematic review on spatial equity definitions, is the 'needs-based distribution' (pp. 271-271). This is relevant to this thesis because it supports the idea that communities with greater health requirements, such as rural Pacific peoples, should be given more resources, such as Pacific-friendly health facilities, than places with fewer health demands (ibid, 2019a, pp. 271-272). Chapters Three and Four explore the kinds of resources that rural Pacific populations need and aspire to.

Additionally, accessibility gives individuals the chance to utilise important activities and receive services they need (Lee & Miller, 2018, p. 47). Fundamentally, Whitehead et al. (2020) states that, "The spatial equity of health services is dynamic and should be monitored regularly to ensure that current and future service distributions match population needs" (p. 5). They go on to say that access to health and equity is not confined by geography (ibid, 2020, p. 5). The five pillars of accessibility of services, which Levesque et al. (2013) conceptualised, entail non-spatial variables including "Approachability", "Acceptability", "Availability and Accomodation", "Affordability", and "Appropriateness" (p. 5).

Inequities that exist for this high-needs rural Pacific population and their causes will be elucidated through the stories shared in Chapter Three. With some understanding on spatial equity and non-spatial factors now in place, the discussion now segues back to the overlap and challenges associated with the health discrepencies for Pacific peoples.

2.7 The obstacles to quality healthcare

Contributing to these heath discrepancies for Pacific peoples, according to earlier findings from Pacific Perspectives, there may be a gap and disconnection between primary healthcare providers and Pacific peoples (Southwick et al. 2012, p. 19). They learned that: general practitioners (GPs) were less likely to note strong rapport with Pacific patients; 87.2 percent of Pacific adults during their primary care consultation process indicated always receiving respect and dignity, a figure much lower than that of adults in the overall population; and only 68.2 percent of Pacific adults indicated their conversations regarding their healthcare and treatment were discussed to the level of their satisfaction (Pacific Perspectives, 2011, p. 21; Southwick et al. 2012, p. 19).

The main barriers that exist for Pacific peoples' quality healthcare in ANZ relate to cost, cultural and communication factors, location of services/transport, appointment times, discrimination and racism, and family and other commitments (Brown, 2018, p. 111; HQSC, 2021, p. 69; MoH, 2020, p. 30; Pacific Perspectives, 2019, p. 6; Southwick et al. 2012, p. 20). These obstacles resemble those that have been emphasised globally for rural peoples (World Health Organisation [WHO], 2021, p. 1). More details regarding these barriers for Pacific peoples are provided in the sections that follow.

2.7.1 Costs

In terms of cost, indicators of unmet need from the NZ Health Survey 2020-21 revealed 15.2 percent of Pacific adults had not visited a GP in the past 12 months due to cost (MoH, 2021a, p. 4). Similarly, Pacific adults were two times as likely as non-Pacific to not have collected a prescription because of affordability, whereas Pacific children were 3.6 times more likely to not have a prescription filled as a result of cost than non-Pacific children (MoH, 2021a, p. 5). This data demonstrates that there are major financial hurdles to optimal medical care of long-term conditions [LTC] in this population, considering the high incidence of LTC and prevalence of chronic diseases among Pacific peoples (Pacific Perspectives, 2019, p. 27). Other costs associated with long-distance travel are covered in more detail later in this section.

2.7.2 Communication

According to HQCS and Pacific Perspectives, communication barriers are related to how, what and where information is communicated, as well as who is delivering the information (2021, p. 71; 2019, p. 30). Communication barriers, found in Brown's (2018) research for Pacific and Māori families, were that they felt under-informed by healthcare providers. This lack of information made it difficult for them to navigate hospital systems, understand what support services were available, whether they

qualify for them, and what to anticipate at different phases of care (pp. 118-127). The recent ANZ patient experience survey revealed that a lesser proportion of Pacific adults—particularly the older people (45-64 years, and 65+ years) compared to non-Māori, non-Pacific—responded with 'yes' to the question, 'Have you been involved in decisions about your care and treatment as much as you wanted? (HQSC, 2019). The Pacific population in ANZ has relatively low levels of health literacy (Fonua-Faeamani, 2017, p. 278). Additionally, some of the literature has revealed that Pacific families felt alienated and perplexed by language barriers and the use of medical jargon (Brown, 2018, p. 118; MoH, 2020, p. 13; Southwick et al., 2012, p. 8). This included medical phrases such as "evidence-based" and "clinical trials", as well as specialised positions such as "oncologist", "haematologist", and "neurology" versus "neurosurgery" (Brown, 2018, p. 118).

2.7.3 Location and transport

In the study by Southwick et al., Pacific peoples and healthcare workers recognised accessibility to transportation as a significant barrier to accessing primary healthcare, particularly in the Auckland region (2012, p. 14). The study's Pacific families specifically mentioned that their biggest challenge was the distance they had to drive, with others citing their dependency on having family members with a car and that are free to take them as a problem (ibid, 2012, p. 45). Similar to this, Brown's (2018) research highlighted that Māori and Pacific households lacked the financial means to pay for the capacity to travel great distances at short notice (p. 120). This can be problematic as in Whitehead et al. (2019) report their findings showed that, compared to their European counterparts, "Pacific patients were statistically significantly more likely to bypass their closest GP service" (p. 6). Furthermore, they discovered, "Pacific patients had the greatest difference in bypass rates between residents of high- and low-deprivation areas, and were 1.5 times more likely to bypass their closest GP when living in areas of low deprivation" (ibid, 2019, p. 7). They suggested that Māori patients, in particular, would choose to go to the Māori service provider clinics instead of the nearest GP service (ibid, 2019, p. 6), which may also apply to Pacific peoples. In essence, it appears that Pacific peoples choose not to visit the GP they are closest to for a number of reasons, which forces them to travel further for services and incur more costs. The reasons Pacific peoples choose to bypass their nearest GP remains unclear. In Chapter Three, potential explanations for this will be offered.

2.7.4 Appointment times

"That's what holds a lot of people back- they have no time off work or they don't have any sick leave. They need to go to work to get that money, to pay the bills, to feed the family and they 'neglect' their health. They 'neglect' their appointments", a comment by

a healthcare worker in Counties Manukau (HQSC, 2021, p. 67), clearly articulates this barrier to healthcare for Pacific peoples. Suitable appointment times have been found to impact the way Pacific peoples experience healthcare (Brown, 2019, p. 31; MoH, 2020, p. 13; Southwick et al., 2012, p. 14). Another common issue is 15-minute appointments not being satisfactory or enough between Pacific patients and their healthcare worker, and having difficulties making appointments to see their desired GP (Southwick et al., 2012, pp. 8-9). The previously listed constraints such as location, transportation and costs also tie into whether they can attend appointments.

2.7.5 Cultural

Pacific peoples' experiences with the healthcare system have been hindered by dominant monocultural worldviews, racism and discrimination that are embedded within systems and structures (HQSC, 2021, p. 10; Pacific Perspectives, 2019, p. 6). One Pacific midwife voiced her concern and stated, "I don't see the point in going to see someone who doesn't understand me culturally … . It's not a system that's built on Pacific values, that recognises the Pacific worldview and context and ways of living" (HQSC, 2021, p. 28). Across numerous publications, there is a strong voice asserting some form of cultural barrier, such as: the lack of cultural responsiveness (Brown, 2018, p. 123); services that are not culturally appropriate (Fa'alogo-Lilo & Cartwright, 2021, p. 757); cultural safety problems (MoH, 2020, p. 13); and feeling cultural discomfort while addressing health issues with non-Pacific healthcare workers and being culturally offended via tone of voice (Southwick et al., 2012, pp. 20, 49).

More thorough planning on the Pacific workforce plan to grow this workforce is one of the enablers identified by The Simpson (2020) report that would improve Pacific health, while also complementing and completing a cohesive system (pp. 179, 195). I will briefly talk about the current snapshot of the Pacific health workforce to show how it is not responsive to Pacific peoples' diverse health needs.

2.8 Under-represented Pacific health workforce

A trend that has remained static since the *Pacific Health and Disability Workforce Development Plan* (MoH, 2014) is the under-representation of Pacific peoples in the health and disability workforce in ANZ (HQSC, 2021, p. 77; Medical Council of New Zealand [MCNZ], 2021b, p. 6; MoH, 2020, p. 20; Simpson, 2020, p. 197). Despite there being over 8.1 percent of Pacific peoples in ANZ, only 2.1 percent of doctors who identified as Pacific were found in the 2021 Medical Workforce survey (MCNZ, 2021b, p. 6). There should be 1,431 Pacific doctors in ANZ if the number of doctors represented the population's ethnic composition, yet the survey indicates there is only 331 Pacific doctors (ibid, 2021b, p. 6). The imbalance is substantial and significantly below the point

at which it needs to be, in order to attain equitable outcomes for health (MoH, 2020, p. 20).

In addition, the Pacific nursing workforce in ANZ has followed a similar pattern. There has been slight improvement, however, when compared to the corresponding snapshot of practising nurses in ANZ; the proportion of Pacific nurses has stayed constant (Nursing Council of New Zealand [NCNZ], 2020, p. 1). The analyses on the data for nurses renewing their Annual Practising Certificates found that of the 54,456 practising nurses in ANZ, four percent (Total 2,355, Samoan 685, Cook Island Māori 228, Tongan 370, Niuean 108, Tokelauan 86, Fijian 718, other Pacific peoples 160) of the total nursing workforce, two percent of nurse practitioners, four percent of registered nurses, and five percent of enrolled nurses identified with at least one Pacific ethnicity (NCNZ, 2020, pp. 5, 21). Other workforce categories in which Pacific peoples are under-represented include midwifery (2.5 percent Pacific midwife workforce) (Midwifery Council, 2021, p. 6) and dentistry (1.2 percent Pacific dentist workforce) (Dental Council, 2021, p. 29).

While there is more Pacific representation in care and support roles (including hospital orderlies, cleaners and healthcare assistants), there is still a greater need for increased Pacific inclusion throughout all areas of the health and disability workforce in ANZ (HQSC, 2021, pp. 77-79). Addressing these workforce shortages is imperative, since diversified ethnic representation is widely associated with improving healthcare access and quality for said disadvantage populations (Barwick, 2000, p. 23; HQSC, 2021, p. 77; MoH, 2020, p. 19; New Zealand Government, 2022, para. 3; Salsberg et al., 2021, p. 1; Wilbur et al., 2020, p. 222). Depsite the significant disparity in the percentage of Pacific doctors in the workforce, there has recently been considerable progress at undergraduate and graduate levels (MCNZ, 2021b, p. 7). Before delving into this rise in graduates, it worth briefly exploring the plans and efforts being made at the University of Waikato to better equip graduates for rural Pacific and Māori communities.

Exciting things are underway at the University of Waikato Te Whare Wānaga o Waikato [UOW] including the new nursing programme and proposal for a Aotearoa Graduate Entry Medical School [AGEMS] (Kerr, 2021; The University of Waikato Te Whare Wānaga o Waikato [UOW], n.d.-a, n.d.-b). With 1704 clinical hours for their nursing curriculum—most given by any other provider—the small, but expanding nursing school at UOW offers eight undergraduate and postgraduate study options (UOW, n.d.-a). To alleviate the workforce imbalance, an extra 4,000 nurses are required (UOW, n.d.-a). UOW hopes to help fill parts of this gap through its nursing programme, which has an emphasis on equity, wellbeing and Māori and Pacific health (ibid, n.d.-a).

The proposed AGEMS is being offered as a potential solution to the scarcity of healthcare professionals, particularly in the rural primary healthcare sector (UOW, n.d.-

c). Additionally, the proposed AGEMS offers an 'only graduate entry' education to students who already have an undergraduate degree in any field, and are recruited from under-resourced and underserved rural, remote, Māori and Pacific communities (Kerr, 2021; UOW, n.d.-c). These partnerships will give students access to immersive clinical learning in these communities; a method that has demonstrated to be effective in other countries at building qualified healthcare workers who offer care for populations with high needs (Burton, 2019; Strasser et al., 2018). Rural Pacific high-needs communties will be driving this research, and the findings will be embeded to help design and develop the nursing and proposed AGEMS curriculum at UOW.

The rise in Pacific medical students and graduates will now be summarised, followed by a description of one of the factors that contributed to this development, which will become more relevant as the chapter unfolds.

2.9 Positive developments in the Pacific health workforce

From 2015 to 2019, the percentage of students starting medical school who identified as Pacific climbed significantly - rising from 3.6 percent to 9.7 percent (ibid, 2021b, p. 7). In terms of graduates, Auckland University reported that seven percent of medical graduates in 2021 were Pacific (one percent increase from 2020). The equivalent figure for Otago University Pacific medical students was 6.6 percent in 2021 (1.3 percent decrease from 2020) (ibid, 2021b, p. 7). Collectively, this progress reflects the work and priorities set out to increase the Pacific health workforce in the *'Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014-2018* ['Ala Mo'ui] report, specifically through the utilisation of the Pacific Provider Workforce Development Fund [PPDF] (MoH, 2014, pp. 10-12). The PPDF, funded the following activities,

> Health Science Academies in Auckland, mentoring for students studying health-related subjects (i.e., Pacific Orientation Programme at Otago (POPO) mentoring-University of Otago; mentoring Auckland tertiary insititutions), Pacific Health and Disability Workforce Awards (scholarships). (ibid, 2014, p. 10)

Increased enrolment in science subjects in the final three years of high school among students of Pacific descent was the aim of these financially supported initiatives (ibid, 2014, p. 10). This, in turn, was intended to increase and retain the proportion of Pacific students studying in a health degree at university (ibid, 2014, p. 10). Consequently, as seen by the percentages mentioned previously, efforts made by the tertiary providers, and help from the PPDF, progressively increased the number of Pacific medical students and graduates over time (MCNZ, 2021, p. 7).

Ultimately, I gave an illustration of how the PPDF influenced the recent growth of Pacific medical students via allocation of funding back in 2014. After all, funding and coordinated plans often lead to health advancements in the long run. I now will give a brief explanation of the rationale of PPDF, its current impact on the study's research sites and, how, if thoughtfully distributed, it may benefit the Pacific rural population in the area.

2.10 The Pacific Provider Workforce Development Fund

The workforce actions in the updated *'Ala Mo'ui* report, *Ola Manuia: Pacific Health and Wellbeing Action Plan 2020-2025* [Ola Manuia] (MoH, 2020) inform how the PPDF is spent. The PPDF, funded and overseen by the MoH, strives to improve the health outcomes for Pacific peoples by strengthening "the sustainabilty of Pacific health providers, and support the delivery of health services with a distinctive Pacific focus" (MoH, 2019, p. 4). Aere Tai Pacific Midland Collective [Aere Tai], one of the four main Pacific Provider Collective Networks in ANZ is worth noting, given that they manage the Pacific workforce initiatives and programmes across the WDHB (and the other DHBs in the Midland region) (MoH, 2019, p. 11). The Aere Tai collective's main provider, Hamilton-based K'aute Pasifika [K'aute], provides various health, eduation and social services for Pacific peoples and other disadvantaged groups in Hamilton (ibid, 2019, pp. 11, 52). Ōtorohanga and Te Kūiti, two of the rural research sites for this study, are listed as receiving services from K'aute on the MoH website (MoH, 2021b, para. 4), although details concerning K'aute's initiatives that explicitly target these Pacific rural communities outside of Hamilton appears to be unclear.

In contrast, neighbouring district, South Waikato, a primarily rural region with a high Cook Islands Māori population has its own Pacific-run organisation within Aere Tai. This collective, based in Tokoroa [87.7 kms from Ōtorohanga, 107.1 kms from Te Kūiti, 127.9 kms from Kāwhia], is called the South Waikato Pacific Islands Community Services [South Waikato PI] (MoH, 2019, p. 67). Similar to K'aute, South Waikato PI provides a range of on-site or in-the-home health checks, education and other community services (MoH, 2021c, para. 1). In addition to having a higher concentration of Pacific peoples, South Waikato has lower life expectancies than the rest of the WDHB region, as was previously mentioned in the Chapter. Thus, it is unsurprising that the WDHB Annual Plan sets a high priority on delivering more comprehensive holistic health and social services to Māori and Pacific peoples, particularly in Tokoroa (WDHB, 2021b, p. 47). On the contrary, what is often forgotten is that a significant proportion of the population come from a Realm country, therefore they immediately have greater accessibility to healthcare over Pacific peoples from non-Realm island nations who have to pay a lot more for healthcare. Moreover, as I indicated earlier in the chapter, there are opportunties for locally-based initiatives and specialised health services for communities

with a higher proportion of Pacific peoples. South Waikato is a good demonstration of this. Whereas, nearby regions such as Te Rohe Pōtae who do not have a significant percentage of Pacific peoples are likely to be neglected and can only rely on non-Pacific health services (Pacific perspectives, 2019, p. 11).

One distinction between the two Pacific service providers is that, in comparison to South Waikato PI, K'aute doesn't seem to place as much emphasis on the rural-based Pacific population. Again, this doesn't come as a shock since K'aute is situated in Hamilton, an urban region, so concentrating their efforts and resources there is reasonable. Yet, this begs the question, who will prioritise and focus on the health needs of the Pacific peoples in the rural towns of Te Rohe Pōtae? There seems to be a knowledge gap in this area, which, when addressed, may influence government funding such as the PPDF, to better distribute resources to this underserved and vulnerable population.

To illustrate the depth of the knowledge and acknowledgement gap about Pacific rural health in ANZ, the following section presents a quick summary of the main national Pacific health reports.

2.11 What the data 'doesn't' tells us about rural Pacific health

Reference to rural Pacific peoples in health reports is mostly absent. Each of the aforementioned Pacific peoples' health reports was subjected to a word search to determine the frequency of the word 'rural'. *The Health System review Pacific Report* had no mention of 'rural' in their report (Pacific Perspectives, 2019). For the MoH's (2014; 2020) two Pacific reports, 'rural' was only mentioned twice. The topic was not explicitly explored in the report's body, it was only briefly mentioned when discussing how technology may help 'rural' Pacific peoples overcome access obstacles (MoH, 2020, p. 20) and in the Appendix (p. 41). Additionally, the *Bula sautu* report does not specifically use the term 'rural'. However, they do refer to "smaller communities of Pacific peoples" in Wairarapa and Whanganui (HQSC, 2021, p. 85), although the HQSC are vague about how these population groups are classified as 'smaller communities. It is possible they are smaller urban communities? Moon (2006) emphasises that "places matter when it comes to understanding health and healthcare" (p. 38). Yet, these Pacific reports which are informed by StatsNZ, and published by government agencies and departments such as the MoH and HQSC, are ambiguous and inconsistent when categorising rural and remote communities (Fearnley et al. 2016, p. 77). Additionally, Pacific Perspectives Ltd (2011, 2019) and MPP (2020, 2022) do not use the term 'rural' in their reports.

Overall, these Pacific reports have a dominant focus on urban Pacific peoples' health, despite acknowledging the projected growth of Pacific populations away from the bigger urban areas are large (HQSC, 2021, p. 85; Pacific Perspectives, 2019, p. 11).

The COVID-19 pandemic not only put the world's health systems, including ANZ, to the test, in terms of emergency readiness (Simpson, 2020, p. 90), but as previously discussed, impacted this study. It wasn't until the COVID-19 epidemic that some of the challenges smaller Pacific populations endure living outside of the main urban areas were brought to light. It is worth briefly discussing the impact of COVID-19 on Aotearoa Pacific peoples and what this meant for Pacific peoples who lived outside of major metropolitan areas.

2.12 How did Pacific peoples do during COVID-19?

HQSC (2021) recently published an in-depth analysis of the health status of Pacific peoples in ANZ, taking COVID-19 into account in their report (p. 6). Referred to as *Bula Sautu. A window on quality 2021: Pacific health in the year of COVID-19*, their report resonates with was said about the Pacific health disparities in the previously mentioned Pacific reports. However, HQSC's (2021) point of difference is highlighting how health systems were drastically impacted by COVID-19, and how Pacific peoples were positioned in the midst of the pandemic. In the peak of the COVID-19 outbreak and lockdown in August to September 2020, 59 percent of the confirmed cases were Pacific, with 10 percent of these Pacific cases leading to hospitalisation (HQSC, 2021, p. 85). The distinct status of the small, but expanding, Pacific communities out of the urban Auckland DHBs, as well as the varying implications of viral control efforts on those communities were the interesting findings that were emphasised (HQSC, 2021, p. 85). It was recognised that inequities may be amplified or be unique in nature for these smaller Pacific populations, namely those in the Wairarapa and Whanganui (HQSC, 2021, p. 85). Communities outside the main metropolitan areas stressed feelings of being invisible or forgotten in the COVID-19 response (HQSC, 2021, p. 85). These smaller Pacific communities depended on mainstream services because Pacific providers had more pressure meeting the needs of the bigger communities (HQSC, 2021, p. 85). COVID-19 showed, in this way, the injustices of what HQSC (2021) describes as "a system that is systematically limited in its geographical reach despite the clear need" (p. 85).

Similarly, in Australia, National Rural Health Commissioner Paul Worley, emphasised that the most vulnerable rural and isolated communities with less access to key health services will bear the brunt of the impact of the COVID-19 epidemic (2020, p. 5976). While the HQSC COVID-19 findings are valuable, the case study presented was limited to the "smaller communities of Pacific peoples" setting (HQSC, 2021, p. 85). As was already

established, HQSC is evasive when it comes to defining what constitutes a 'smaller community'. Therefore, HQSC's findings have limited applicability to rural Pacific peoples, suggesting there is still a lack of any substance specific to the health needs of rural Pacific peoples.

While there is scant research specifically addressing the health needs of Pacific rural communities, the absence of a universally accepted definition of what characterises 'rural' is a problem for exploring rural health inequities in general. With a working definition of rurality, when linked to health in ANZ, being important to my study, this will now be considered.

2.13 Fit-for-purpose rurality classification

Without an internationally agreed-upon definition of 'rural' for health purposes (Fearnley et al. 2016, p. 79; Grobler et al. 2015, p. 8; Muula, 2007, p. 1), this has typically been defined as 'not urban' or 'not metropolitan' (Fearnley et al. 2016, p. 79). In ANZ, rurality has been defined in more than 15 ways (Nixon et al. 2021, p. 2). The usage of rural and urban categorisation, which, inaccurately, accounts for communities that utilise rural or urban healthcare, is a dilemma when evaluating rural health inequities (Simpson, 2019, p. 31). Previous definitions have appeared to be problematic for health research, namely the StatsNZ's Urban Rural Experimental Profile (UREP) as it neglected to take service access into consideration (Fearnley et al. 2016, p. 77). UREP has since been replaced in 2020 by the Urban Accessibility (UA) classification (StatsNZ, 2020, p. 6). Dr Jesse Whitehead and colleagues recently developed and tested the Geographical Classification for Health (GCH), which was built upon Statistical Standard for Geographies Review 2018 (SSGA18) and UA (Nixon et al. 2021, p. 4; Whitehead et al. 2021, p. 16). The GCH typology consists of two urban (U1 and U2) and three rural (R1, R2, R3) categories informed by population size and travel time thresholds (Whitehead et al. 2021, p. 18). GCH is also informed through authentic input from said communities and rural health stakeholders (ibid, p. 8).

For the purpose of this thesis, I have adopted the GCH's definition to classify my rural research sites that aided the data collection phase (see table 1 and Appendix I). Each of the three research sites for this study fell under a different rural category (R1, R2, R3) demonstrating how the GCH shows the diversifying levels of rurality. Referring back to the Simpson Report (2020), it highlights the need for sustainable and equitable access to health and disability services for rural New Zealanders (p. 14). I argue the need to clarify the barriers specifically for rural Pacific peoples, which will inform how, and what services will be delivered. In order to support successful delivery, it is also necessary for a clear and practical understanding of what 'rural' is. This understanding is lacking in Pacific reports that are supposed to paint an accurate picture of the state of health of

‘all’ pacific peoples in ANZ. The fit-for-purpose ANZ ‘rural-urban’ health classification, the first of its kind, can contribute to this understanding and help reveal the discrepancies in rural health that have been hidden by earlier classifications (Nixon et al. 2021, p. 4). In addition to using the GCH, rural Pacific communities’ perspectives of their perceived rurality will be explored in this thesis.

The chapter has thus far unravelled health discrepancies and challenges for Pacific peoples in an urban context; however, it has been previously noted that data on Pacific peoples in rural settings is mostly non-existent. As such, it is worthwhile looking into the research on rural health in ANZ to provide some insight of the rural characteristics and potential points of reference, even though it is not Pacific-specific. The following is a succinct outline of the current state of rural health in ANZ as detailed mainly in The Simpson (2020) report.

2.14 Snapshot of the health of the ’invisible’ rural peoples of ANZ

Despite having little information, ANZ’s rural health situation is quite comparable to that of other countries (Simpson, 2020, p. 164; Strasser, 2003, pp. 457-459; WHO, 2021, pp. 1-3). In accordance with the Simpson (2020) report, “indications are that people living in rural towns can have poorer health outcomes, including lower life expectancy, than people living in cities or surrounding rural areas, an effect that is accentuated for rural Māori and disabled people” (p. 21). Māori and disabled people are higher priority demographics in rural areas; no mention is made of Pacific peoples. Interestingly, the report makes the claim that people in rural areas have lower expectancies compared to the urban population, however does not support this claim with any quantifiable evidence. Previous comparisons of mortality rates in urban and rural areas in three MoH reports, failed to find consistent rural-urban gaps (MoH, 2007, 2010 & 2012, as cited in Crengle et al., 2022, p. 2). Dr Crengle and colleagues (2022) have recently published research, the first of its kind, with quantitative evidence using GHH that highlights living in rural areas leaves Māori more susceptible to significant amendable mortality rates (p. 2).

Suicide rates in rural areas continue to be higher (Simpson, 2020, p. 15). Regardless of the fact that anybody may be impacted by mental illness, people in rural areas are more vulnerable due to socioeconomic factors, namely poverty, availability of cheap housing, unemployment and unpaid labour, family violence and social isolation (ibid, 2020, p. 115). The obstacles that rural communities must overcome in order to access Tier 1 and Tier 2 services include distance, transport and poorly scheduled appointment times (ibid, 2020, p. 107). These obstacles resemble those that the Pacific peoples, discussed earlier in the chapter, also encounter.

Unfortunately, there are a variety of workforces that consistently face a shortage, but it is typically harder when attracting and retaining staff in rural areas than in metropolitan ones (ibid, 2020, p. 182). A larger proportion of the doctors are based urbanely than rurally, according to the MCNZ (2020) report (p. 32). Compared to the 61.5 percent of the urban population, more than 76.8 percent of doctors work in urban localities (ibid, 2020, p. 32). Rural regions account for around one-quarter of the population, yet only 10.5 percent of doctors work there (ibid, 2020, p. 32). The same pattern is visible in the GP workforce (ibid, 2020, p. 32). The Simpson report emphasises the necessity for customised workforce plans, especially ones for rural populations and Pacific peoples, to supplement the overall workforce plan (p. 203). Since the National Health Committee's [NHC] (2010) initial report on rural health published in 2010, there is an urgent need for a more up-to-date version.

Intriguingly, the Simpson (2020) report made note of the fact that expanding virtual services will lessen the need for patients to travel and enable additional rural services (p . 154). Virtual services may be practical and useful for the majority of the rural population, but it begs the issue of how certain they can be that this is what rural Pacific peoples' desire? This thesis serves to discover what types of services and health workers rural Pacific peoples want.

Overall, it seems that solid evidence regarding rural peoples' health in ANZ is very limited, and it is worse for rural Pacific peoples where the evidence seems to be mostly absent. Although rural health inequities in ANZ are seldom acknowledged, the methodology used to collect most of the rural data across the literature is either vague, or doesn't correspond with the current GCH; which takes service access and proximity to bigger urban regions into consideration. This research utilises the GCH typology, as well as the input of participants' perspectives of rurality which will hopefully lead to more accurate representation of rural perspectives. In Chapter Three, these viewpoints will be examined in greater detail.

2.15 Summary

During the discussion of the literature there were several points in which rural Pacific peoples were absent, namely the health statistics and inequities highlighted in Pacific reports by MoH (2014, 2020), HQSC (2021), MPP (2020, 2022), and Pacific Perspectives (2011, 2019). One of the reports did, however, use the term "smaller communities of Pacific peoples" (HQSC, 2021, p. 85). But, as was mentioned earlier, the issue with this classification, is its vagueness. Collectively, these Pacific reports, alongside the Simpson (2020) report, have highlighted that Pacific peoples have shorter life expectancies than non-Pacific and non-Māori, and also have a higher prevalence of numerous health risk factors. These findings also appear to corroborate with the findings for the Pacific

population, specifically in the WDHB region. While these reports talk a lot about health disparities and barriers for quality healthcare that Pacific peoples in ANZ face, the focus is mainly on the urban Pacific population. There is an apparent knowledge gap for rural Pacific peoples; their needs, aspirations and wants, in relation to the ANZ healthcare system, have been ignored.

Additionally, in the literature that talks about rural health in ANZ, namely the Simpson (2020) report, the priority seems to be on Māori and disabled rural populations (p. 21). There is only very brief mention of Pacific peoples in the rural sector, and it is only when highlighting Pacific rural demographic figures—in which the interim report acknowledges that the rural-urban classification "does not accurately account for populations that access rural or urban health services" (Simpson, 2019, p. 31). Therefore, I would like to know what this means for what has already been said regarding rural health. Could there be inconsistencies in rural health, of which we are unaware, as a result of previous misclassifications?

This research seeks to fill some of this knowledge gap by investigating a small group of rural Pacific people in Te Rohe Pōtae using the following research question: What are the GP health aspirations and perspectives of Pacific peoples living in the rural and remote community of Te Rohe Pōtae? Prior to digging into this, it is worth explaining the attributes of a doctor—as described by the MCNZ—that will provide points of reflection for Chapters Three and Four.

2.16 Good Medical Practice

The Good Medical Practice publication by the MCNZ (2021a) outlines the standards expected of doctors in all facets of their professional conduct, as well as the core values that constitute good medical practice (pp. 2-5). The MCNZ wants doctors to be competent in the following areas of professionalism: "caring for patients", "respecting patients", "working in partnership with patients and colleagues", "acting honestly and ethically" and "accepting the obligation to maintain and improve standards" (2021a, p. 8). Each of these attributes is then further delineated, with guiding principles and requirements given to each. As there are several topics to explore, I will extrapolate on a select few that I deem relevant for this thesis.

I elaborate on "respecting patients" as my first focus. The underlying principles in this first attribute are to build relationships based on trust, to be mindful of cultural diversity and safety, to treat patients with respect, and to honour their right to confidentiality and privacy (ibid, 2021a, pp. 12-16). It is interesting to note that cultural factors from the Pacific reports were previously discussed in this chapter as obstacles to accessing quality healthcare. "Working in partnership with patients and colleagues" is a further

crucial quality worth mentioning. Providing patients with the information they desire or need in a manner that they can comprehend is one of the two principles that stood out. The other was respecting their right to collaborate in making choices concerning their treatment and care (ibid, 2021a, pp. 17-20). These principles, once again, mirror the concerns that were brought to light by some of the Pacific reports earlier, notably communication barriers. Specifically, Pacific families felt there was a lack of information, that they weren't included in decisions about their treatment and care, and that they were overwhelmed by medical jargon and language difficulties.

As this explanation is not meant to be exhaustive, not all attributes and circumstances have been addressed (see MCNZ, 2021a for details). A handful of the attributes and principles that are set out by MCNZ were acknowledged and can serve as links in the next chapter. The following chapter will investigate the findings and the results from the rural Pacific peoples in Te Rohe Pōtae, which utilised the methodology PPdMF as described in Chapter One.

Chapter Three: Data Analysis, Results, and Discussion

This chapter presents the results of the semi-structured questions (see Appendix B) asked of the participants during the research data collection phase. Following analysis, the semi-structured questions were grouped into three overarching topics, namely, 'health and wellbeing', 'rural and remote', and 'healthcare needs'. That analysis and topic grouping also led to several questions and answers being integrated. Therefore, in some cases, it could appear specific questions, as presented in the semi-structured question list, have been removed. This is not necessarily the case. Additionally, where applicable, I will draw on literature from the previous chapter to expand on participant comments or themes.

Prior to presenting the findings of the first of the three overarching topics: 'health and wellbeing', I will first explain my research participants and several points of observation noted during the research data gathering. This gives context to participant responses.

3.1 Those at the coal-face: my participants

The explanation of the research sites was provided in the introductory chapter. A breakdown of the research participants from the research sites is shown in Table 2.

Table 2. Participant Characteristics

Participant Code	Gender	Ethnicity	Research Site	GCH
Participant 1 (P1)	Female	Fijian	Ōtorohanga	Rural 1
Participant 2 (P2)	Female	Fijian	Ōtorohanga	Rural 1
Participant 3 (P3)	Male	Fijian	Ōtorohanga	Rural 1
Participant 4 (P4)	Male	Fijian	Ōtorohanga	Rural 1
Participant 5 (P5)	Female	Cook Island Māori	Ōtorohanga	Rural 1
Participant 6 (P6)	Female	Cook Island Māori	Ōtorohanga	Rural 1
Participant 7 (P7)	Female	Tongan	Ōtorohanga	Rural 1
Participant 8 (P8)	Female	Cook Island Māori	Kāwhia	Rural 3
Participant 9 (P9)	Female	Samoan	Te Kūiti	Rural 2

Since the Pacific rural communities are small, I will purposely be vague when describing the participants to protect their anonymity. Nine participants took part in this research (two males and seven females). Their ages ranged from late 20s to late 60s. Four of the participants identified as Fijian, three identified as Cook Island Māori, one as Tongan, and the other Samoan (six non-Realm and three Realm participants). Three were ANZ born, six had grown up in Fiji and Samoa before migrating to ANZ when they were younger. Six of the Ōtorohanga participants are enrolled in the Ōtorohanga Medical Centre, while three choose to utilise the Te Awamutu Medical Centre [28.1 kms away] or Hamilton [56.6 kms away]. The Kāwhia participant uses Te Awamutu Medical Centre [59.8 kms away], and Te Kūiti

participant is enrolled at the Te Kūiti Medical Centre. Each participant was given a code, for instance P1, which I've utilised throughout this chapter to link a quote with a specific participant.

3.2 Observations (data gathering)

The duration of each of the *talanoa* sessions varied, with the shortest one lasting forty-five minutes and the longest, the group *faikava* session, lasting four hours. Of the nine interviews that took place, seven of them lasted around one and a half hours. Personal narratives about events that had happened lately, and in the past, pervaded the *talanoa* sessions. The *talanoa* was guided by a series of basic questions, but there was freedom for the discussion to veer off in to other directions if the participant felt that certain subject was particularly significant. It is important to note that the *talanoa* has no restrictions, and the participants decide how they want to explore any given idea (Vaka et al., 2016, p. 538).

Due to the data-driven nature of an inductive approach, a few responses in the *talanoa* sessions would deviate from the topic, thus producing some uncommon, but noteworthy ideas (Braun et al, 2015, p. 848). For instance, the *talanoa* sessions with more than one person tended to stray off topic, or their response would address another question, so questions required paraphrasing and re-sequencing to be in line with the interview context. Vaioleti (2006) offers a further explanation for this, stating that "*talanoa* is flexible, it provides opportunities to probe, challenge, clarify and re-align" (p. 25). The nature of a *talanoa* group also offers a challenge or justification to one another's accounts and disclosed knowledge (Vaioleti, 2006, p. 25). I also observed that hosting the *talanoa* session in a casual venue, like a café or their house, substantially improved the *talanoa* because they appeared to be more at ease participating in the *talanoa*. The results of the first of the three overarching topics, 'health and wellbeing', are now presented.

3.3 Health and wellbeing

Following Pacific protocols of introduction, all nine participants were asked the first research question which was, *what is health and wellbeing to you*? Eight out of the nine participants were unanimous in that they believed that physical elements, such as diet, exercise and doctors, contributed to their health and wellbeing. An example of this was participant four, a Fijian-born male, who stated, "*Health is more like exercising, not going doctors often, having hospital visits for like twice a year or something like that*" (P4), which captured the views of the majority. Southwell et al. (2012) report a similar finding among their participants who discussed in-depth the need of a nutritious diet, exercise, rest and sleep for staying in good health (p. 39). Southwick et al. (2012) also comment that health is often "taken for granted and not challenged by a well-developed understanding of illness" (p. 37). This appeared to be reflected in *talanoa* at the family *faikava* data collection session

when one of the men—a fit rugby player—attempted to delve deeper into the issue of health and wellbeing, but was cut off by one of the females also in the *faikava* space. That female participant interruptedly said in response to the male participant's comment, "*And I also thinks it's about mental health, yeah I think that's at the top"* (P4). That prompted the female participant to rebut with, "*Yeah but other than that we hardly talk about that*" (P2).

The importance of mental health was mentioned by just over half of the participants. The low percentage is not surprising as the topic of mental health can be culturally taboo for many Pacific peoples. This is reflected in a comment made by participant two: "*If you can't see it then it's not a health issue, if it's all in here [head] then there's nothing wrong. You have to be bleeding for it to be a health issue"* (P2). This phenomena is also discussed in the *Te Kaveinga- Mental Health and Wellbeing of Pacific Peoples* report, which illustrates the stigma connected to mental health was higher among Pacific peoples and that they express negative views of those who struggle with mental illness (Ataera-Minister & Trowland, 2018, p.6).

Interestingly, the participant voice was not strong in conveying a holistic view on health. Only three of the nine participants shared a common narrative that was connected to an all-encompassing perspective on health, where they touched on cultural, spiritual, and *whenua* (land/environment) aspects. For instance, one stated "*it's more than just going to the gym or more than brushing your teeth*" (P5) and another, "*It's not even about the doctors*" (P8). Rather, health is "*like having a good outlook, having some goals and aspirations*" (P5) and "*Going back to our natural environment, using our own resources, how can we look after ourself with the skills and knowledge that our ancestors used to look after their selves*" (P8)".

This is very similar to what the Pacific health models *Fonua* by Tongan academic Sione Tu'itahi, as explained in Chapter Two (Action Point, 2018) entails, that symbolises the wholeness of Pacific peoples. For instance, the five components of the *Fonua* philosophy are *sino* (physical), *'atamai* (mental), *laumalie* (spiritual), *kainga* (community), and *'atakai* (environmental), all of which are interdependent and complementary to one another (Action Point, 2018). Although not all participants shared they had a holistic understanding of health when initially asked what health and wellbeing means to them, it is reflected later in their responses to questions that address what they want from healthcare workers which will be discussed later in the chapter.

It is also important to note that the answer you receive when you ask a Pacific person what they consider health and wellbeing, can vary depending to whom you are speaking. Factors, such as an individual's age, health status, family background and culture, influence what a healthy lifestyle means (Talemaitoga, 2010, p.1). Ultimately, it appeared that participants' perceptions of health and wellbeing went beyond the mere absence of disease. There were instances when a mental component was mentioned explicitly, while references to the

spiritual, cultural and environmental importance were more oblique. Overall, the physical aspect of health, which determines one's health condition, is the ongoing theme that emerges from the replies to this question.

In question two, which sought to generate more understanding on the theme of health and wellbeing, the participants were asked where they go when they feel unwell or are injured. This will now be addressed.

A common response that came up when participants were asked where they go when they felt ill or injured, was that they were reluctant to visit the doctor. One participant stated, "*you know we can just treat it at home*" (P3). Another participant commented, "*just take a panadol, I'll be fine*" (P1). This kind of attitude is also reflected in two Pacific reports where only one in five Pacific peoples would go to a doctor for help (Ataera & Trowland, 2018, p. 38) and the other report where a third of Pacific peoples reported not seeing their practitioner when needed (Pacific Perspectives Limited, 2019, p. 6).

However, a third of the participants stated that their first option when they are feeling unwell is to opt for 'natural' or cultural remedies as participant eight voices, "*If I feel myself getting sick, I get kawakawa and kumara leaves, garlic and lemon, and I just make my own*" (P8). Similarly, another participant said, "*but if I'm like unwell, that's when I will go to my significant places, my cultural places. That would be like my homestead, walking along the banks of our river"* (P5). This coincides with the *'atakai* (environmental) dimension of the *fonua* model of health, mentioned earlier.

I was then able to gather responses on where people go for medical services and what services they are able to access if their initial choices don't work, by using prompts and probing during the interviews which will be discussed now.

Six of the nine participants stated they go to their local doctors (Ōtorohanga Medical Centre for those in Ōtorohanga, and Te Kūiti Medical Centre for participant in Te Kūiti). It's interesting to note that three of my participants said they go to Te Awamutu Medical Centre despite not living there, which is a 50-minute drive from Kāwhia and 30 minutes from Ōtorohanga. This is consistent with the preceding pattern that Pacific peoples in the Waikato were more inclined to bypass the closest GP (Whitehead et al., 2019, p.6). Later in the chapter, the causes of this bypass are explained.

Regarding the kinds of services sought out by my participants, the Ōtorohanga participants indicated that they had access to a few basic services in Ōtorohanga, including their general practitioners, dentists, dieticians and pharmacists. It was reported that Te Kūiti residents also have access to the same, if not more, primary services, with the Te Kūiti hospital serving as an additional resource. Concerning the services offered at Kāwhia, it was made

clear that there were few options and no specialised services, simply a general practitioner service. Fundamentally, all participants were unanimous in that they had either been referred to or had chosen to go to Hamilton (located 50-60 minutes away) for health services such as the hospital or other specialised care. The participants' general happiness with the medical care they receive will be discussed in the section that follows, along with some of their personal experiences.

Are you satisfied with the level of care you receive from your doctor? was another question posed to the participants. Eighty percent of the participants claimed to be satisfied, although one participant argued against this, while another participant remarked, "*I just think to myself, that's as best as I'm going to get in this town*" (P5). The participants shared a wide range of experiences they'd had with their health services that I will not be able to cover in depth due to the scope of this study; nonetheless, I will present a summary of both the positive and negative themes that surfaced.

The majority of participants, with the exception of one, were able to share at least one or two positive recollections, which included factors such as the service being good, with kind empathetic staff, the recent rise in the number of Māori staff, and familiarity with staff. For example, a participant commented, "*I think we're comfortable [be]cause we know some of them at the medical centre*" (P1).

Participants, however, appeared to be more outspoken about their poor interactions with the healthcare system. This comprised of issues such as their family doctor being limited with time, so having to be assigned to different doctors each time, and services being less accessible during and after COVID-19 (e.g., no after hours, harder to secure appointments, and longer wait times for specialist appointments/surgeries). Regarding the effect COVID had on the services, one statement was made in the following manner,

> *Well because it's Covid it's so different. So, when you ring up, you don't automatically get in. And because he's [the doctor] doing different jobs, it might be a week before you actually see a doctor, so you're best to look after yourself*. (P6)

Some other issues that were raised included being referred to services in Hamilton, challenges linked to the affordability of travelling, service and prescription charges and, overall, just being too "westernised" (P8).

These themes reflect many of the variables influencing Pacific peoples' access to care and usage of services in Chapter Two. Firstly, it was explained earlier that timely appointments had an influence on how Pacific peoples experience healthcare (Brown, 2019, p. 31; MoH, 2020, p. 13; Southwick et al., 2012, p. 14). Additionally, the issue of COVID-19 impacting the quality and availability of healthcare services in their rural areas, matches the smaller Pacific

communities in Wairarapa and Whanganui mentioned earlier by HQSC— where they complain about being invisible and forgotten during the COVID-19 pandemic (2021, p. 85). Also, costs associated with travelling, services and prescriptions were all mentioned as a main barrier to engaging with the healthcare system (HQSC, 2021, p 69; MoH, 2020, p. 30; Pacific perspectives, 2019, p. 6).

Some participants complained about not feeling cared about and being hurried. P1's statement exemplifies this,

> *I took my daughter once and I just had a few things to check and she [nurse] was like "ugh, well, we don't have time for all those things, just one thing". So, I just went with the thing, the most urgent thing that I knew about her. But she had other issues. Sometimes you feel rushed. And, plus, we don't want to argue or stand our ground sometimes. We've always been told to just not talk back or … respect your elders or someone with authority.*

Additionally, participants feel that if they go to the doctors repeatedly for the same reason, they shouldn't have to pay the full price again, knowing that their GPs will merely prescribe paracetamol. This can be exemplified through P8's experience where she shared,

> *Well, it's horrible because I've had asthma my whole life since I was born. So, I'm going in to the doctors saying I need more pumps because I've still got asthma. But every three months I have the same test just to make sure I've got asthma still, and I'm like, does it go away? Are you waiting for it to go away or … ? Or am I just paying you $45 to give me a paper every three months. So, yeah, I pay $60 to see the doctors and tell them I've still got asthma, and then $15 to get my pump*.

Similar complaints from Pacific participants are included in the report by Southwick et al. (2012), which claims that this is the reason why many patients get put off seeking early medical care. The belief appears to be, 'if you have to pay for follow-up visits, you may as well wait until your condition goes away on its own or the treatment is obvious and can be properly handled at the first consultation' (pp. 45-46).

P1 expressed a comparable view when she said,

> *I take my daughter to TA Mahoe [Te Awamutu Medical Centre, 28.1 kms away], yeah just 'cause down here I had a bad experience. Yeah, took her here [Ōtorohanga Medical Centre] once for, she had headaches, then they gave her antibiotics. Went back home, got worse, then they told me to take her down to Te Kūiti, and then they gave Panadol. Came back home and that night I had to ring the ambulance and then*

> *she was just in pain so she was taken to Waikato [Waikato Hospital, 56.6 kms away] and then put her in ICU [Intensive Care Unit]*.

When Māori and Pacific families presented their sick child to different health providers and ERs as described in Brown's (2018) study, they appear to have received similar treatment to participants in this study, being sent home with painkillers only to return due to the child's condition worsening (p. 109). Doctors working in cooperation with patients was one of the qualities of a doctor that was emphasised at the end of Chapter Two which emphasises the importantance of respecting the patient's right to participate in decisions concerning their treatment and care (MCNZ, 2021a, pp. 17-20). Here, we see an example of how the participants had not been given the opportunity to rightfully partake in the decision-making for treatment and care, which led to a negative experience for my participants. Moreover, it is for the aforementioned reasons that these two participants chose to travel further to access healthcare and forgo using their local (closest) GP services.

An additional point of interest is that three of the nine participants shared unpleasant experiences with male doctors. As one of the participants stated, "*you'll have a doctor that is quite rough, just when he does his checks"* (P7). Another reported, "*I don't think he genuinely cares about our [Pacific] people. Like we've got a lot of complaints at the moment, a lot of families are not happy with the service but they don't have any other choice"* (P8). The fact that these participants were females is also important to note, since the males appeared to have no problem. Interestingly, in Canuto et al. (2018) study on indigenous males of Australia, one of the main barriers to accessing healthcare services for these males was if the doctor was female (p. 8). Although, there seems to be cultural gender-based issues for accessing health in other studies (Brown, 2019, p. 124; Canuto et al. 2018; Pacific Perspectives, 2019, p. 15), that doesn't appear to be the case for the participants in this study. Rather, the female participants' bad experiences with male were not culturally linked, instead citing care, both psychically and empathetically.

Another noteworthy element that was previously reported as positive was familiarity with staff. An example of how this is experience in the opposite, is with a participant who stated,

> *We've got a little medical centre [in the participants town] but I don't go there because I work with them, like I do the church groups and I do the school and I don't really want them to know my medical or personal side. So, I just went to the … [name of medical centre removed for anonymity, 50 mins away] one. It's a small community and everyone knows everyone and then they change stories, so I don't go there.* (P8)

This example of P8's experience provides another justification for why Pacific peoples prefer to drive past their nearest GP and travel elsewhere. Depending on the circumstance, familiarity with doctors for Pacific peoples may be both beneficial and a burden.

Coincidentally, Ape-Esera et al. (2009) discovered that some Pacific people would prefer to receive their healthcare from someone with a different ethnicity to them. Similar to what P8 said above, there were some concerns regarding confidentiality due to the smallness and closeness of the communities (Ape-Esera et al., 2009, p. 129). P5 supports this, highlighting the complexity of the issue in her comment,

> *I don't mind the whole connection kind of thing, but, when it comes to your personal wellbeing and shit going on with you, then it's like, oooh, I'd prefer to keep it to myself… So there, I've just gone and flipped on what I said earlier, about having these relationships.*

This topic, patient concerns over confidentiality, will be further discussed in Chapter Four.

Overall, the common trend that emerges from the responses to this research question was that while the healthcare service was generally reported as adequate, there are certain areas where it could be improved, which also reflects recommendations in government reports on Pacific health (MoH, 2020, p. 4; Pacific Perspectives, 2019, p. 16). The following overarching topic is what constitutes 'rural and remote'; I began this discussion by asking my participants if they *feel* 'rural and remote'.

3.4 Rural and Remote

To expand on the quantitative data presented in the previous chapter that attempted to define rural (Fearnley et al. 2016; Grobler et al. 2015; HQSC, 2021; MoH 2014; 2020; Muula, 2007; Nixon et al. 2021; Whitehead et al. 2021), I sought qualitative data from my participants aimed at understanding their perceptions of being and living 'rural' to expand on that earlier work. When asked if participants consider themselves to be rural and remote, seven of the nine interviewees felt they were rural, but not remote. This was not always the case thought. For instance, when five of the seven participants first moved to Ōtorohanga, they considered this rural and remote. However, they explained that as they became accustomed to the environment, their perception changed from rural and remote to simply rural. For example, one of the participants shared, "*well it depends on the person really, like a person who just moved there, ya know?"* (P4). Another participant commented, "*but now it's so easy to just drive out to Hamilton* [56.5 kilometres away] *because we do it quite often. So now it just doesn't seem like a long time"* inferring, proximity to Hamilton removed feeling of living remote (P1). Conversely, two participants felt they were both rural and remote. It is also important to keep in mind that these two participants are not from Ōtorohanga like the remainder of the group, but live a longer distance from Hamilton, thus their experiences in their town may have influenced their view of what is rural and remote.

Some of the criteria identified by participants as contributing to why they consider a place is rural and remote included ideas such as, accessibility to medical centres and main infrastructure (i.e., hospital and specialist clinics). This is also shown in the work of Whitehead et al (2021) and Nixon et al (2021), in which distance and accessibility, among other factors, contribute to rurality classification. Participants also named surrounding communities that they described as rural and remote namely, "Taharoa" [88.8 kms from Hamilton] (P5), "Pirongia" [32.3 kms from Hamilton] (P1), "Kāwhia" [77.5 kms from Hamilton] (P3), "Bennydale" [110 kms from Hamilton] (P2), and "Marakopa" [104.9 kms from Hamilton] (P3). It appears distance from a major city, in this case, Hamilton, with a population of 160,911 (StatsNZ, 2018a), influences understandings of remote in addition to rural. Overall, it appears that the Ōtorohanga participants see themselves as rural, which aligns with the R1 GCH typology (refer back to Table 1.). Whereas the two participants from Kāwhia and Te Kūiti regard themselves as both rural and remote, which also corresponds with how GCH classified Kāwhia (R3) and Te Kūiti (R2).

A follow-up question was asked of participants about their healthcare needs living rurally when compared to the healthcare needs of people living urbanely: Participants were asked whether they agreed or disagreed that the healthcare needs of rural and remote communities are different to people living in the larger towns and cities? "*It is [different], your life would be easier, everything is there [in the urban environment]*" (P9) stated one participant who encapsulating the views of the other participants. The remaining participants stated how their healthcare requirements varied from those living in urban locations; overriding themes were that they had limited healthcare provider options in the rural setting and must therefore spend vastly more on travel expenses to get specialised or emergency services out of town. For instance, one participant stated, "*like for us it's just that one medical [centre/facility], and it could get hectic, like overboard packed"* (P7). Conversely, another participant commented,

> *I know some whanau in the weekend, if there's health problems, we tend to go up to Te Awamutu, to Mahoe Medical Centre, so we can access that. But that costs a bit of money though, that's quite expensive. Or you know, you go to Anglesea [the accident and emergency clinic in Hamilton], it does get more expensive the more you travel*. (P5)

Thus, location of services and distance appear to be distinct healthcare barriers for these rural participants, which appears to be a recurrent issue across other literature that focused more on urban Pacific peoples (Brown, 2018, p. 111; HQSC, 2021, p. 69; MoH, 2020, p. 30; Pacific Perspectives, 2019, p. 6; Southwick et al. 2012, p. 20), as was explored in Chapter Two. The Simpson Report (2020) also highlighted distance and transport as barrier for rural communities when accessing Tier 1 and Tier 2 health services (p. 107). This is further supported by Pacific rural community members in Tokoroa [87.7 kms from Ōtorohanga,

107.1 kms from Te Kūiti, 127.9 kms from Kāwhia] who also report that a major concern living rurally is around healthcare access (MoH, 2019, p. 67).

Despite the fact that the majority of participants claimed they do have different health needs, one individual disagreed and remarked, "*I think it doesn't matter where you live, if you live here or in Hamilton"* (P2), suggesting similarities between rural and remote dwellers and urbanites. On the whole, participants felt they had health requirements that were different to many living in urban areas. Additionally, the participants also reported health needs were different when viewed from the position of ethnicity. This will now be explained.

When asked if they had different, or the same, healthcare needs as their Pākehā (person of European ancestry) and/or other ethnic community members, all participants, except one, agreed. As Pacific islanders, they felt physically and culturally different to other ethnic community members, as explained previously through the *Fonua* model, thus, have different healthcare needs. For example, one participant said,

> *…yeah, physically. Especially in our diet, we grew up in a different culture. So, we've been brought up with different foods and whole different diet than Pākehā. So that might have some sort of impact on our health and health needs*. (P4)

Not only do diets differ for Pacific peoples, when there is an attempt to eat healthy a participant commented that, "*I try healthy eating, when my daughter does her healthy eating, our shopping bill goes up"* (P1). This correlates with Pacific participants in the MoH (2020) report where a participant states, "*eating healthy is expensive. Cheap food with the least nutritional value (mostly takeaways) is affordable and convenient. We can't be healthy, living in these conditions*" (p. 13).

The importance of *kainga* (community or family) a dimension of *fonua*, was also reported as playing a fundamental role in the wellbeing of Pacific peoples and in turn, healthcare service providers must take these cultural considerations into account. P5 illustrates the importance of *kainga* in the following quote:

> *Let them know that sometimes if we, you know, we have heaps of whanau [family] that want to go [to the doctor]. If someone's feeling unwell and they are needing to access health, then maybe there will be five people that go with them, to tautoko [support] them and they will talk for them. Yeah sometimes we go in groups.* (P5)

Difficulty communicating with healthcare professions was also identified as revealing a difference when compared with Pākehā. For instance, half of my participants believed that a

language barrier exists for Pacific peoples when using and accessing healthcare services. An example of this is when P9 shared:

> *Sometimes you know how the Palangi [Pacific term for a person of European ancestry] ask a lot of questions because they digging in more on simple things, but some of the Samoans they just go in and explain but don't dig into that much, like 'I got a headache' but that's it? They don't say much about it and dig into the issue, like there's different type of headaches, but they don't explain it well because it's hard for them. But with the Palangi people, I can tell they spend a little more time in there because they explain every little important detail.*

Similarly, a qualitative study of Samoan patients discovered that prioritising language and trust with GPs influence good adherence to long-term medications (Pacific Perspectives Limited, 2019, p.32). Communication was described in the study as a particular issue for families for whom English was a second language, and it was noted that Pacific families tended to be reluctant to enquire further when necessary (ibid, 2019, p. 30). Furthermore, MCNZ (2021) stresses the importance of supporting and assisting patients in understanding (p. 17). This means that should healthcare providers come across a patient with poor English, it is their job to arrange a competent interpreter for the patient (ibid, 2021, p. 20), as it is part of their rights as a patient according to the Health and Disability Commissioner (1996). Though the participants were not directly asked if they had ever utilised or been provided with an interpreter, this was not mention as part of *talanoa* in which language barriers were discussed.

An interesting point made by one of the participants concerning the COVID-19 pandemic and differences when compared with Pākehā. They stated that they,

> *…never saw anything [*advertising*] pitched at islanders to get vaccinated. The only time that I saw that was when I went to Te Kūiti because Ōtorohanga didn't do that. At the medical centre, it was the Maniapoto Marae Trust Fund that was doing all the vaccinations, that's when I saw different languages.* (P6)

The dominate view by participants regarding whether they had distinct heath requirements in contrast to Pākehā and/or other ethnic groups is that they do. Their needs differed especially when it came to their distinct diets or *sino* (physical) dimension, *kainga* (community) aspect and also with language.

This present overarching theme, which sought participants understanding on living rural and remote, established that their healthcare needs as rural Pacific Islanders differ from those living in urban areas, particularly in the city of Hamilton. This focus of the third overarching

theme was to understand what changes and improvements participants would like to the present healthcare services. This will now be explained.

3.5 Healthcare needs

Given that some of the participants' answers overlapped, the last three questions on their healthcare needs will be presented under two subheadings, 'healthcare services' and 'healthcare workers'. I will start by discussing the types of services that participants want more of, and how these could be improved.

3.5.1 Healthcare services

It was evident that the participants strongly supported the need for additional doctors. Having more doctors could also address the other common issue participants discuss about not having an assigned family doctor, or as one of the participants recommended, "*being assigned a family doctor would make a big difference*" (P3). Admittedly the health workforce is stressed, under pressure and in serious need of increased staff numbers as was discussed in Chapter Two (Simpson, 2020, p.182). These pressures are greater in rural areas suggesting that recommendations such as the assigning of a specific doctor to a family is unlikely to occur for some time.

It was clear that the participant voice was strong in wanting more doctors "*of our own*" (P8) and "*of similar colour to us*" (P6). When asked if they were more or less likely to book with a Pacific doctor, participants unanimously responded that they were more likely to do so. The growth of Pacific and Māori doctors may be the key to addressing most of the issues raised by participants in this study. However, the rationale underlying this will be addressed later as it relates to the sort of healthcare workers participants seek.

Another feature of the healthcare service that participants deemed problematic was the consultation booking system. Some participants reported having to wait at least two days to secure an appointment, and once they had their booking, they were not allocated sufficient consultation time. For example, participant five stated,

> *…yes, we do need more than 15 minutes, it's not like you're herding sheep. But I also blame the booking system, that's that economic sustainability. So, they just allocate those 15 minutes, get in, get out, that's an administrative or business strategy.* (P5)

For another participant, it was even worse, revealing, "*yeah, I was just told six minutes, get in and use it wisely"* (P6). These statements represented the views of the majority of the participants. This was an issue highlighted in Chapter Two where it was also found that the fifteen-minute appointment was insufficient to adequality address the health needs or most

patients (Southwick et al., 2012, pp. 8-9). Although not explicitly noted in this question, it was previously reported that the remaining three participants seem to be satisfied with the booking system and the allotted time.

Language comprehension, as mentioned previously, was another aspect that participants wanted utilised in services through translators and also language-friendly health promotion material. An example of this is when participant nine stated,

> *…maybe a translator would be best or just have a tool. I think when they read it some of the people understand reading it, because some of the doctors they speak really fast and you don't know what he's talking about. Sometimes you read then you understanding rather than listening, yeah just getting a translator or the written terms ready for when a person comes so they can read through before they discuss further.* (P9)

Similarly, another participant stated that, "*ideally I'd like to see messages, in different languages"* (P6). The *Ola manuia* (2020) report includes language usage and implementation as one of its initiatives for enhancing Pacific peoples' access to and navigation of the health system (MoH, 2020, p. 37). However, it doesn't seem as though that particular initiative has had any uptake or reached the rural Pacific peoples such as participants P9 and P6.

Another intriguing element concerning health promotion, as previously touched on, is that two of the participants believed they had been excluded from Pacific-related initiatives in Ōtorohanga when compared with Te Kūiti. For instance, one participant commented,

> *Te Kūiti, because of their socioeconomic status, they have got strategies to improve health for whanau. But that's not here. You don't have that here in Ōtorohanga. You don't have that same promotion, you don't have that same outlook here, it's more like user pays here. I think we're looked at a bit more affluent than down the road, that we don't need those [health promotion] services. But I see that we do, we do need our iwi here, we do need sort of support here in Ōtorohanga.* (P5)

The WDHB (2021b) has indicated that enhancing access and outcomes for Pacific and Māori rural populations is one of their priorities, although a predominant focus appears to have been place on Tokoroa with little reference to other rural communities such as Te Rohe Pōtae, Ōtorohanga, Te Kūiti or Kāwhia (p. 47). Given that the research sites weren't particularly included in the WDHB (2021b) report, this might be one of the reasons why the participants weren't exposed to any Pacific-based health promotion. The participant from Te Kūiti may further support the assertion made by P5, since, in her account, K'aute Pasifika, a Hamilton-based Pacific-run organisation, has, in the past, provided mobile health,

education, employment and social services in Te Kūiti a few times during the year. She said, "*they normally come here and help out the peoples' driving licences, nursing service, like checking blood sugar, diabetic people, we always go there. Would be good to see them once a month"* (P9).

As a result of these observations, it appears that rural Pacific communities in Ōtorohanga are being isolated from some Pacific-based services. In Chapter Two, I discussed Pacific-specific interventions and services being delivered in areas with a higher concentration of Pacific peoples (Pacific Perspectives, 2019, p. 11). This suggests that the reason area such as Ōtorohanga are being excluded when compared with Te Kuiti and more specifically Tokoroa is because they have a smaller Pacific population (see Table 1.).

There was also suggestion by participants that having a hospital nearby or improving the services at the current rural hospital/s would be beneficial. P7 remarks, "*it would be nice to have an actual big hospital. There's one in Te Kūiti, but people are still needing to travel to Hamilton"*.

Themes that arose from the health service question included the need for additional doctors especially of Pacific Islander descent, that communication problems should be addressed by putting a focus on language through translators and language-friendly health promotion material, and that there should be more Pacific-based health promotion/care. The skills and characteristics that participants would want to see more of in their healthcare workers and future graduates will now be explored.

3.5.2 Healthcare workers

Participants were asked to give a description of their ideal healthcare workers and future graduates. Eighty percent of the participants indicated they wanted more healthcare workers who educated them better, with less medical jargon. For example, one participant said, "*don't use medical terms, not everyone will know what they are talking about*" (P2). Another commented, "*don't look so damn … like you're up here [inferring taking an elevated status]. The communication needs to be at a level that we can understand, not too academic*" (P5). Again, language appears to be a recurring issue that needs to be addressed, but, in this instance, it's assuming patients have good health literacy. One of the obstacles identified in the *Ola manuia* (2020) report is that Pacific peoples face difficulty comprehending medical jargon (p. 13). This is an important observation when considered against Southwell et al. (2012) who reported that even people with high English skills struggle with medical jargon (p. 66). These are themes that were highlighted in Chapter Two.

An interesting point made by one of the participants was, "*the ideal person [health care worker] has to have a spiritual connection to the place otherwise why are you here? You may as well be in Timbuktu. And they want to grow the community*" (P6). This aligns with the WHO (2021) recommendation on the importance of enrolling students from a rural background in health-related tertiary programmes and the impacts this would have on the positive development of the rural and remote health workforce (p. 26). However, when looking through a Pacific or indigenous lens, it is more than just 'coming from a rural background', it is also important that one has a good sense of relatedness and connection to the land (Baice et al. 2021, p. 77); also known as *vā* (Anae, 2019, p. 5) and *whanaungatanga* [Māori notion of connectedness] (Wilson et al. 2021, p. 3547), a concept explained in Chapter One. Therefore, rural health workers with a strength of *vā* and *whanaungatanga* with their place of practice with greatly enhance their level of practice.

Another common response from participants was a genuine desire for health care workers who possessed good people skills. Seven responses reported the importance of friendliness. For example, one participant stated:

> *Friendliness? Because some are not that friendly. Because you rock up and I know that they are under pressure but it's not our fault you get a grumpy doctor that's very busy and you feel like you're not priority or you're taking up their precious time, or someone else should be there*. (P1)

Another participant commented, "*I know it's hard work, but a smile, just the basics*" (P9).

Five participants emphasised the need for healthcare workers to have patience, with one saying, "*be patient, take their time with patients*" (P2). Other essential people skills included, "*someone with respect*" (P9), "*making that eye contact*" (P5), and actively listening, or as one participant asserted, "*someone who can help the people speak out, like dig out exactly what they want, instead of being rushed*" (P9). Many of the opinions expressed by the participants also align with the MCNZ expectations of a proficient doctor. These attributes include putting patients' needs first, respect, and listening attentively to and doing something about their concerns and preferences (MCNZ, 2021, p.6). Sadly, it appears that some of the healthcare workers in the rural towns where my participants live do not reflect expected MCNZ expectations.

While it is essential to utilise and be informed about certain people skills that are Pacific friendly, having a cultural understanding is also critical. This brings the discussion to the most often emphasised characteristic that participants desire from healthcare professionals.

It is widely acknowledged that providing high quality care for Pacific peoples depends on the ability to integrate their cultural settings, worldviews and understanding of the holistic

health and wellbeing into the delivery of health services (MoH, 2020, p. 12). Having a high level of cultural competency was clearly regarded as the most important skill necessary to healthcare workers by participants. One participant's response illustrates this and reflects the feelings of the majority of the participants: "*cultural skills, the fact that they can understand a cultural view of health*" (P8). This likely explains the reason why participants previously expressed a high desire for more Pacific doctors, since they would presumably have the necessary cultural knowledge embedded in them by default. Participants provided examples of this in their comments, such as one who stated, "*if there's more Pacific Islanders trained in the new medical, more Pacific Islanders will go to them because they understand*" (P9). Another stated, "*they should bring out more Pacific and Māori doctors only because they will connect well with our people … they already know the ins and outs of the health of Pacific people*" (P7).

On the one hand, it cannot be assumed that people of Pacific ancestry share the same worldviews, or have a heightened sense of cultural awareness. In Chapter Two, I discussed the diverse and evolving Pacific population in ANZ, including intercultural marriages and the growing number of Pacific peoples who are born in ANZ. A Tongan-Samoan Registered Nurse in O'Connor's (2018) study acknowledges that although growing up in a Pacific household from young, she eventually lost touch with her cultural heritage and felt the need to "relearn ways of communicating, I have to listen more, step back and observe more" (p. 17). These kinds of factors need careful consideration, especially when the comparatively small Pacific workforce who are often over-worked (Workforce Development Council, 2022, p. 49), are expected to bridge cultural gaps (New Zealand Human Rights Commission, 2022, p. 11); just because they are of Pacific ethnicity does not equate to depth in their cultural knowledge or ways of doing.

Contrary to expectations, over half (*n*=5) of the participants shared reflections in the *talanoa* sessions about non-Pacific doctors and healthcare professionals who showed the capacity to be culturally reflective; even though participants unanimously claimed they were more likely to book with a Pacific doctor. One participant, for example, stated, "*yeah but it's always good to have a Pākehā* [doctor]" (P3), while another participant stated particularly:

> *There's a lady down here; she can speak a little Samoan, she's at the Te Kūiti hospital, used to work at Middlemore hospital so she picked up on little words and the basics, she's a Palangi [*Pacific term for a person of European ancestry*] and she's quite helpful.* (P9)

It is interesting to note that two participants provided an example of an 'ideal' non-Pacific doctor they both had in Hamilton, prior to relocating to Ōtorohanga. Listed below are their accounts of their interactions with this particular doctor:

Everyone goes to him because he presents himself to all races … you want more people like him. He's a good example. That's my parents' doctor and they love him. It's the little things he spots in people, he'll do anything and go beyond just to help people, even if its money related reducing costs just a little bit, everyone is thankful for what he does. He's what you want in places like this, he's mastered the skillset the people skillset. He's the man. If you had someone like him come out to the country side, I see a big change and I can see everyone feeling comfortable to come in. He keeps stuff confidential, like when people are struggling with their immigration stuff. (P7)

He's no islander, but he is like an islander. He understands us. He engages more with us rather than just, he's just always been very understanding, very bubbly you know everything other doctors don't have nowadays. And he's not an islander but you feel comfortable to go to him. You'll explain something to him and he'll be like "ohh so this is what's happened and this". You don't feel, I don't know like some of them just brush you off, but he has a little talanoa [talk or discussion] with us. (P1)

This has also been my experience with this particular doctor because he is also my doctor. Notwithstanding the participants' preference for more Pacific people in the workforce, it is clear from the present comments, together with my personal experience, that there is a capacity for non-Pacific persons to have a high degree of cultural reflection, understanding and competency.

3.6 Summary

In an attempt to answer the question: *what are the health aspirations and perspectives of Pacific peoples living in the rural and remote community of Te Rohe Pōtae?*, participants affirm the critical need to grow the Pacific workforce. However, growing the workforce doesn't simply mean *throwing more bodies at the front line*. Simply put, we don't need more physical 'bodies' who have no ability to culturally reflect. We require a workforce that is cognisant of the health inequities and needs of Pacific peoples, particularly the needs reported by participants in this chapter. Although there is a clear need for more Pacific doctors, nurses and axillary health care workers, my participants also reported that there is clearly space for those who are non-Pacific in ethnicity, specifically those who understand and work in a culturally competent manner with Pacific peoples.

The final chapter will review and synthesise several key themes from this chapter and the preceding chapter. This will include comments on how this study has contributed to the literature. Limitations of this study are then explained, followed by suggestions for future studies and a final closing statement.

Conclusion: The Future of Pacific Rural Health

Substantial changes must be made to Pacific rural health provision. This need was highlighted by drawing on commentary in the Simpson (2020) report, the Pae Ora (Healthy Futures) Bill (85-3), and a number of Pacific health documents. In Aotearoa New Zealanders (ANZ), "outcomes are not equitable across populations and life course, particularly for Māori, Pacific peoples …", according to the Simpson (2020) report, with those unfavourable outcomes getting worse for rural ANZers (Simpson, 2020, p. 14). Pacific peoples life expectancy is less than Europeans, they have greater hospitalisation rates, and a higher prevalence of various health risk factors than the ordinary ANZer of European heritage (ibid, 2020, p. 20). In addition, Pacific peoples are among those who are most impacted by imbalances in the socioeconomic factors that affect health across all ethnic groups in ANZ (Simpson, 2019, p. 25).

This thesis examined a number of government Pacific publications and discovered that, while health and service outcomes have steadily improved since the implementation of the first Ministry of Health (MoH, 1997) national Pacific strategy *Making a Pacific Difference: Strategic Initiatives for the Health of Pacific People in New Zealand*, the health disparities for Pacific peoples are not reducing (Ministry for Pacific Peoples [MPP], 2022, p. 25; MoH, 2014, p. 24; MoH, 2020, p. 4; Pacific Perspectives, 2019, p. 5). As the emphasis of this thesis narrowed to the regional level, the Waikato District Health Board [WDHB], it was found that there are ongoing equity gaps for Pacific peoples living there as well (WDHB, 2021b, p. 26).

Collectively, the reports explored in Chapter Two by Simpson (2020, 2019), the Waikato District Health Board (WDHB, 2021a, 2021b), MoH (2014, 2020), Health Quality Safety Commission (HQSC, 2021), MPP (2020, 2022), and Pacific Perspectives (2011, 2019) unravelled health statistics, inequities and barriers for Pacific peoples in ANZ. While this is all valuable information, it is based only on the urban Pacific population. Consequently, there is a dearth of information on Pacific peoples who reside in rural areas—a population that frequently has worse health outcomes than urban (WDHB, 2021b, p. 47; Simpson, 2020, p. 14). Although Simpson's (2020) projection that just two percent of Pacific peoples live rurally (p. 15), rural areas are anticipated to grow 14 percent faster than urban regions (p. 21).

The ANZ rural population, in general, appears to be understudied, and the majority of the material that is available comes from sources outside of ANZ (Simpson, 2020, p. 52). However, the priority groups in rural areas appear to be Māori and disabled people (ibid, 2020, p. 21). The Simpson (2020) report emphasised the scarce evidence on issues concerning Pacific peoples' heath is not easily accessible or gathered in ANZ; and that there is a pressing demand for "good local evidence, research and evaluation" (p. 52). This thesis provide some of that "local evidence" and fill aspects of the knowledge gap about rural

Pacific health, by exploring the health aspirations and perspectives of Pacific peoples living in the rural and remote community of Te Rohe Pōtae.

Through a combination of the literature review and semi-structured *talanoa* sessions, I made a number of discoveries pertaining to the experiences a small group of Pacific peoples living in the rural towns of Ōtorohanga, Te Kūiti and Kāwhia shared when navigating the healthcare system. The key discoveries will now be discussed and are arranged under headings that correspond to the themes explored in Chapter Three.

4.1 Rural Pacific perspectives on health and wellbeing

Participants were asked to elaborate on their understandings of health and wellbeing. Similar to the widely accepted biomedical viewpoint, the majority believed that physical factors including one's nutrition, physical exercise and doctors were important to one's overall health. Small references were also made about how mental, spiritual, cultural and environmental dynamics played in their sense of health and wellbeing. Some participants struggled to articulate their meanings of health due to a few constraining factors (see Limitations); hence, it is challenging to make definitive claims. Overall, it appeared on the surface that the biomedical perspective of health is strong among the participants. Surprisingly, this does not reflect the same Pacific worldviews that were described earlier in the literature review in Chapter Two, in that Pacific peoples' view of health was mostly reported as holistically (MoH, 2014, p. 2; Pacific Perspectives, 2019, p. 11). However, as the *talanoa* sessions progressed, participants express what they wanted from healthcare professionals. These responses show notions of holism and that their views of health and wellbeing do transcend beyond the mere absence of disease therefore aligning more-so with literature.

Extrapolating the participants' views on what constitutes 'health' and/or 'wellbeing' is essential, as it is these worldviews that ultimately influence their decisions as to which health services to utilise and whether to use them at all. Through these findings, presented from a rural Pacific perspective—a high-needs population that is understudied and assumed to have the same views as the Pacific urban population, serves as a critical step in addressing the health needs of this underserved rural Pacific population. The existing system of healthcare is not yet premised on this understanding.

Information was also gathered about how the participants felt their health needs differed to the health needs of Pacific peoples living in urban areas. The recurring theme was that they had limited options for their healthcare, which meant higher travelling expenses and bypassing nearest health services to access specialised or emergency services out of town. These findings strongly corroborate with the literature on urban Pacific peoples reviewed in Chapter Two, which found that access to healthcare was hampered by distance and

placement of health facilities (Brown, 2018, p. 111; HQSC, 2021, p. 69; MoH, 2020, p. 30; Pacific Perspectives, 2019, p. 6). Although the themes of service location and distance were present in all of the narratives, participants from R3 and R2 (more 'rural' than R1) provided more compelling examples, indicating these barriers are exacerbated the more rural a participant lived. In sum, rural Pacific peoples appear to have similar health needs to urban Pacific peoples, but since they are farther away from main infrastructure and facilities, the adverse effects on their health are magnified.

4.2 Enhancing rural Pacific peoples' healthcare experiences

Three major areas of concern were raised in relation to the health services the participants desired more of. The first dominant issue, that served as an obstacle was a lack of effective communication when accessing healthcare or knowing what services were available. Participants clearly aspired that services should prioritise using their Pacific languages, whether through interpreters, printed material in Pacific languages, and/or Pacific orientated health promotion. This aligns with discussion in Chapter Two in which Pacific families in Brown's (2018) research who, due to communication barriers, felt under-informed and struggled to understand the support services available to them. I argued in Chapter Three that the absence of Pacific-specific health initiatives and promotion in Ōtorohanga (R1)—which can also extend to Kāwhia (R3)—may be due to lower Pacific population numbers than that of the other towns in the WDHB region. Conversely, the Simpson Report (2020) states that community needs, not merely population size, should guide planning and funding for services (p. 4).

A pivotal discovery was a participant from Te Kūiti (R2) who noted that K'aute [Hamilton-based Pacific health provider], offered mobile health services once every several months and that these services had benefitted them. In my earlier discussion in Chapter Two, I note that Pacific Provider Development Fund, which funds Pacific organisations like K'aute, primarily focuses its efforts and resources on urban Pacific peoples in Hamilton. I supported the notion that rural Pacific peoples in Te Rohe Pōtae—a neglected community due to the lower Pacific population—should be considered in the planning and implementation of PPDF, because they exclusively depend on non-Pacific health services.

The consolation booking system was the second key area where participants felt services could be improved, as they had to wait a long time to get an appointment, and didn't have enough time allotted for them during consultation. Lastly, there was a significant emphasis by all of the participants on the need for additional doctors, particularly Pacific doctors. These findings reflect earlier discussion in Chapter Two about the under-representation of Pacific peoples in the health workforce. I also pointed out that although there are shortages in a range of workforces, it is more

difficult for rural areas to attract and retain workers (Simpson, 2020, p. 182). So, for the rural Pacific community who have voiced their desires for more Pacific doctors, these two factors make their circumstances more difficult to fulfil this need.

I did point out though that merely increasing the Pacific workforce may not be enough to address these needs if members of that workforce lack cultural responsiveness. In Chapter Three, I make the case that the workforce cannot simply rely on Pacific ethnic people to fill cultural gaps. The high prevalence of pan-ethnic identities and a growing body of ANZ born Pacific peoples (Tamapeau & Kingstone, 2018, p. 8) has led to differing, shifting and in some cases an absence of Pacific worldviews, particularly among the younger generation, who will make up the Pacific peoples' future workforce. From a health perspective, the clash and absence of worldviews will be problematic and may impede health outcomes for Pacific peoples.

Participants were asked to describe the ideal skills and attributes they wanted in healthcare workers and future graduates in their communities. The participants in the study reported that communication with healthcare workers needs be at a level that they can understand. They want health workers who can educate them and not confuse them with medical jargon. Communication skills were also highly desired by Australia's Indigenous peoples, who sought to have jargon broken down and to confirm their comprehension through paraphrasing (Woolley et al., 2013, p. 94). In addition, healthcare workers with good people skills, like friendliness, smiling, appropriate eye contact, actively listening and building relationships through trust are the main skill-based attributes participants in this study desired. These statements echo the characteristics outlined by the Medical Council of New Zealand [MCNZ] (2021a) in Chapter Two, which described how doctors should listen to their patients and address their problems and preferences, as well as provide the information they need in the way that they can understand (p. 6).

Despite the participants' emphatic belief that their communities required doctors with whom they could establish connections, there were some concerns about confidentiality because of the closeness of their communities. This was a dilemma I discussed in Chapter Three, where academics concluded that as a result of the smallness and closeness of Pacific communities, some Pacific peoples prefer to access healthcare from non-Pacific healthcare professionals (Ape-Esera et al., 2009, p. 129). The same issues of familiarity in the urban Pacific context seem to mirror the remarks made by the participants in this research. However, I contend the consequences are greater for rural Pacific peoples because of the much lower percentage they make up in rural communities.

Participants overwhelmingly agreed that attitude-based attributes such as having patience, being respectful, caring and understanding were essential for high quality healthcare. Of interest was the desire for healthcare workers to have a spiritual connection to the rural location. In Chapter Three, I argue that through a Pacific lens, this spiritual connection is more closely aligned with one's *va* to the place, than simply the WHO (2021) recommendation of graduates "coming from a rural background" (p. 26). The dominant knowledge-based qualities that participants aspired for healthcare professionals to embody were cultural skills and understanding. They accentuated the importance for their cultural needs to be understood and accommodated for, such as having *fāmili* [family] present when they participate in challenging healthcare processes. My earlier discussion in Chapter Two, which summarised the attributes as specified by the MCNZ (2021a), supported the participants' aspirations for cultural competence and safety (p. 12).

Although participants were adamant that their communities needed more Pacific doctors, they also acknowledge that quality healthcare can also come from non-Pacific healthcare professionals. For instance, several participants cited a specific non-Pacific doctor as exemplifying the qualities of a culturally responsive doctor. Interestingly, that doctor also happened to be my doctor, with me also corroborating the observations of my participants. In light of the above, both this doctor and K'aute in conjunction with the attributes described by the participants and MCNZ (2021a), offer a model that may serve as a blueprint for Pacific rural health and potentially other parts of the country. This blueprint may also help shape the curriculum of the University of Waikato's nursing programme, and assist the establishment of the proposed Aotearoa Graduate Entry Medical School at the University of Waikato (as explained in Chapter Two) which will aim to graduate GPs who are equipped to deliver culturally responsive healthcare to rural Pacific communities.

I suggest this research has made several contributions to health literature. These will be now presented.

4.3 Contributions to the literature

The literature on Pacific worldviews, specifically related to health is relatively new. It was discussed in Chapter Two that Pacific peoples tend to view health holistically (MoH, 2014, p. 2; Pacific Perspectives, 2019, p. 11; Thomsen et al., 2018, p. 15). I also explained that the Pacific health model that encompasses Pacific values (Tu'itahi, 2009). This research supports and builds on that literature, but it does so explicitly from the perspective of rural Pacific peoples. The barriers to healthcare for urban Pacific peoples as explored in Chapter Two, which include elements such as cost, cultural and communication factors, location of services, transportation and appointment times, have been well documented in the

literature (Brown, 2018, p. 111; HQSC, 2021, p. 69; MoH, 2020, p. 30; Pacific Perspectives, 2019, p. 6; Southwick et al. 2012, p. 20). The obstacles for rural Pacific peoples accessing healthcare have been understudied, with this study identifying a number of themes that overlap with literature focused on the urban Pacific population. In addition, there was, until this present study, limited understanding on what Pacific peoples aspire from their doctors (Ape-Esera et al., 2009, p. 129; Southwick et al., 2012, pp. 7-8), and particularly from the perspective of rural Pacific peoples. This research identified that rural Pacific peoples' desire doctors who are active listeners, who want to build relationships, are respectful and who have cultural understanding and are cultural responsive.

This study has also contributed to the limited body of literature on the overall rural health population in ANZ. In Chapter Two, I contend that earlier classifications of 'rural-urban' in a health context are inaccurate because communities that use rural or urban healthcare services were not factored (Simpson, 2019, p. 31). As a result of this misclassification, rural health disparities may be obscured (Nixon et al., 2021, p. 4). Furthermore, this indicates that the majority, if not all, of the few available research on rural health in ANZ have presented an unreliable portrayal of the health of rural ANZers. The Geographical Classification for Health [GCH], a recent 'rural-urban' health classification developed by Dr Jesse Whitehead and colleagues (Whitehead et al., 2021), was utilised in this study, thus contributing to the GCH methodology.

This research has also provided some insight in to the experiences of Pacific peoples with the healthcare system in the Te Rohe Pōtae region, particularly Ōtorohanga. The little research on Te Rohe Pōtae mainly focuses on historical events between Māori and the New Zealand government (King & Ritchie, 2015a ; Pollock, 2015b) together with Māori health inequities (Robinson, 2012, p. 87; Waitangi Tribunal, 2020, p. 126), but not the Pacific population. Moreover, the scarce research on Pacific rural populations in the WDHB region has focused predominantly on one rural environment, Tokoroa (WDHB, 2021b, p. 47; MoH, 2019, p. 67).

This study revealed several areas of additional investigation. These are now described.

4.4 Suggestions for further research

This research yielded a number of new learnings, but it also generated several queries. Firstly, it is recommended that additional research is undertaken with a wider group of Pacific peoples in Te Rohe Pōtae due to the lower than desire participant count (*n*=9) in this study (also see Limitations). That larger number of participants which likely strengthen some findings and also provide more in-depth results. It is also recommended that future research widen to the Pacific communities of North Ruapehu which is a high priority rural area within

Te Rohe Pōtae which the current study was unable to explore. Further, it would be valuable to compare that additional North Ruapehu work with findings in this study.

This research had four Fijians, three Cook Islands Māori, one Samoan and one Tongan, yet other Pacific Island nations were not included. A more diverse ethnic representation in further rural studies may reveal slight cultural differences between the groups and, consequently, differing aspirations.

This research focused on rural Pacific peoples between the ages of 27-68 years old. Further research should examine the views of rural Pacific youth (18-24 years old) regarding wellbeing together with their experiences of rural healthcare. Research on rural Pacific youth should be expanded to include a comparison between ANZ-born and Pacific Island-born perspectives of health to examine the effects of the evolving Pacific identities.

There were limited males (n=2) involved in this study. It would be valuable to conduct more research that explores rural Pacific males perceptions of wellbeing, rurality and the healthcare system. It may also may be fruitful to have a male only *talanoa* group to fully capture their views as it is possible that some males held back in the mixed gender family *faikava* session, particularly in discussions about their health (also see Limitations).

Quantifiable data on the health of rural Pacific peoples, such as mortality rates, health-risk factors and other health inequities, is sparce. Future studies could include this focus and gather quantitative information to determine whether the health outcomes for the Pacific population living in rural areas are statistically and significantly worse than those in urban areas.

Most of the literature on rural health in ANZ is based on earlier inaccurate definitions of 'rural-urban' (Nixon et al., 2021, p. 4). More rural-based health research in ANZ should be undertaken in combination with the GCH typology—that is informed by population size, travel time thresholds as well as input from rural communities and stakeholders (Whitehead et al. 2021, p. 8, 18)— to increase the awareness and application of this fit-for-purpose rural methodology.

This research included Pacific peoples from all three GCH levels of rurality (R1, R2 and R3) but mainly R1 (*n*=7)—the least rural of the three categories. In comparison to R1 and R2 participants, the R3 participant in this study looked to have significantly less options for healthcare, and resided in a more remote and undeveloped location. I suggest carrying out additional research on Pacific peoples who live in rural regions categorised as R2 and R3 to understand how their health experiences differ from those of R1 residents.

It is suggested that research be undertaken that focuses on the rural health workforce, their relationships and their understanding of Pacific cultural needs.

Participants in this study weren't specifically questioned about their interactions with or knowledge of Pacific health organisations such as K'aute or the South Waikato Pacific Islands Community Services Trust. I suggest further study should be conducted on the experiences of rural Pacific peoples in Te Rohe Pōtae with these Pacific organisations.

Lastly, research on the viewpoints of the Pacific health workforce is scarce, and much less is known about the rural Pacific workforce. I recommend research seek understanding of Pacific health workers in both urban and rural settings to examine and compare the challenges they encounter when delivering services to Pacific peoples. Additional research is encouraged in relation to the worldviews and cultural responsiveness of the Pacific health workforce.

A number of limitations need to be taken in to account as I draw this thesis to a close. These limitations will now be explained.

4.5 Limitations

The COVID-19 outbreak created major challenges for the research, particularly with participant recruitment, and resulting in the reduction of an expected thirty participants to nine. This understandably reduced participant diversity (i.e., could not recruit the preferred range of Pacific ethnic groups possible in the cohort and meant greater weight was lent to individual narratives with less chance to explore whether particular views were one-offs or not). Even though this research contributes to the scarce literature on rural Pacific health perspectives, it would be unwise to generalise the worldviews and experiences of the nine participants in this study to all Pacific peoples across ANZ.

Although efforts were made to bridge my 'outsider' divide (as explained in Chapter One), there was still a possibility that my positionality as someone from 'out of town' caused constraints to the study. Even though I made efforts to *talanoa* and establish *vā* by inviting participants to share about themselves and vice versa, it is possible that more time was needed for this part of the interview. Some participants possibly held back or felt *mā* [shy] to speak about their genuine experiences, which may have misrepresented aspects of their rural health needs.

While one of the strengths of the family *faikava* session is bringing voices together, it sometimes means that certain voices are less heard. It may be that the males in the study felt they could not articulate their viewpoints, as openly as they wanted, due to the presence of females in the interview, including myself. Within Pacific cultures, there are

certain topics that are taboo and culturally inappropriate to discuss in the presence of both genders. Future studies would benefit from gender specific *faikava talanoa* sessions.

The way the data was analysed and presented could also be a potential limitation. The transcripts were coded through my own interpretation. In Chapter One, I explained my positionality as a Pacific person born in ANZ and how this difference in worldview may influence my interpretation. To mitigate this as much as possible, I sought clarification of cultural words and concepts with participants. Nevertheless, it is acknowledged there may still have been some elements that I missed, misinterpreted, or both, which could have skewed the findings.

Despite the aforementioned limitations, I feel confident that this study has, in a small way, contributed to the literature on the theme of Pacific rural health care aspirations.

4.6 Concluding statements

The pages of this thesis go beyond an investigation; they are personal. My positionality in this research as an 'outsider', because I was not born or raised in Te Rohe Pōtae, was addressed in Chapter One. However, I now will present my mum's story to convey how I connect with, not only the place, but also the stories shared by my participants.

Before moving to ANZ in 1997, in Tonga, my mum stayed in Nakolo [40-minute drive to the main town Nuku'alofa]. My cousins, who stay in town refer to Nakolo as '*uta*, which is commonly known as 'the bush' or being far from town. Similar to the difficulties when defining what rural is, the term '*uta* might have varied meanings depending on the context. Because my mum lived in a fairly rural area of Tonga, it was not a surprise that she and my late Polish dad, decided to reside rurally in ANZ. Kāwhia was the community where they settled in early 1997—one of the rural and remote research sites for this study. Their settlement in this area, however, had to be cut short due to circumstances beyond their control. During her short stay in Kāwhia, mum was pregnant with me. Due to the difficulties of her pregnancy, she left Kāwhia to seek medical attention in Hamilton [77.5 kms away]. The local Kāwhia medical system failed to provide this. With no car or assistance to travel back and forth to Hamilton hospital, remaining in Kāwhia was out of the question. Sadly, the lack of suitable medical care in Kāwhia that forced my parents to move away remains to this day, more than 20 years later, reflecting a dire need for an improved Pacific rural health care system.

This personal story is lived out in my data. This narrative illustrates the enduring nature of the challenges faced by my rural Pacific participants. It appears that the more things change, such as with policy, and with more emphasis on Pacific health needs and interests, the more

things stay the same. We are still hammering on about the same thing twenty-five years later. But what, if anything, has changed?

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Appendices

The following appendices correspond to the thesis' initial title: **'Creating culturally responsive rural doctors – Maaori and Pacific peoples' perspectives and aspirations for health'**. After finishing the results chapter, the title was modified to more accurately capture the findings and conclusions.

6.1 Appendix A: Participant survey form

Survey	
Full name:	
Age:	
Gender:	
Ethnicity:	
Marital Status:	
Occupation:	
Renting or owning:	
Place of birth:	
Duration of residence in this community:	
Location of previous residence:	
Underlying health conditions:	
Underlying health conditions of any family members:	
Current health care provider:	
Contact details:	
Phone number:	
Email:	
Home Address:	
I _____ confirm that the information provided herein is accurate and correct. Date:_____	

6.2 Appendix B: Draft participant semi-structured interview schedule

DRAFT INTERVIEW SCHEDULE

Questions will be delivered slightly differently depending on whether it is an individual interview, or a whanau group discussion, or a community group focus group. Questions are grouped into three sections or themes.

1. **HEALTH: we're interested in learning more about how you view and experience health**
   - What is health and wellbeing to you? What do these words/concepts mean to you and your whanau (groups interview) and community (group interview)?
   - Where do you go when you're injured or not feeling well?
   - What kind of care/range of services do they offer?
   - Are you happy with the care you receive? What have been some of your positive and negative experiences? (No names please)

2. **RURAL AND REMOTE: We want to understand the unique needs of rural and remote Māori and Pacific communities.**
   - The government and other agencies and organisations refer to some places as 'rural and remote'. Would you describe Ōtorohanga and the surrounding Ōtorohanga/Waitomo district as rural and remote?
   - Would you agree or disagree that the healthcare needs of rural and remote communities are different to people living in the larger towns and cities? Different to Māori and other ethnicities living in towns and cities?
   - Do you have different or the same healthcare needs as your Pakeha and or other ethnic community members?

3. **YOUR HEALTHCARE NEEDS**
   - What kinds of services and healthcare workers do you want and need in your community?
   - What are some of the skills and characteristics that you want to see in the different healthcare workers in your community?
   - If there were a Pacific/Māori doctors would you be more likely or less likely to book in with them? Why/why not?
   - Finally, what do we need to teach/grow in our medical school students so they can best serve Māori/Pacific peoples living in rural and remote communities? Pakeha students? International students? Māori and Pacific students?

4. **FINISHING: is there anything else that you would like to share?**

6.3 Appendix C: Ethics Approval, University of Waikato

The University of Waikato
Private Bag 3105
Gate 1, Knighton Road
Hamilton, New Zealand

Human Research Ethics Committee
Roger Moltzen
Telephone: +64021658119
Email:humanethics@waikato.ac.nz

THE UNIVERSITY OF WAIKATO
Te Whare Wānanga o Waikato

12 July 2021

Victoria Maikuku & Janina Galewski
Te Huataki Waiora School of Health
DHECS
By email: maivictori14@gmail.com
ninatangataewaha@gmail.com

Kia ora Victoria & Janina

HREC(Health)2021#40 : Creating culturally responsive rural doctors: Maaori and Pacific peoples' perspectives and aspirations for health

Thank you for your responses to the Committee feedback.

We are now pleased to provide formal approval for your project.

Please contact the committee by email (humanethics@waikato.ac.nz) if you wish to make changes to your project as it unfolds, quoting your application number with your future correspondence. Any minor changes or additions to the approved research activities can be handled outside the monthly application cycle.

We wish you all the best with your research.

Regards,

Emeritus Professor Roger Moltzen MNZM
Chairperson
University of Waikato Human Research Ethics Committee

6.4 Appendix D: Participant Information Sheet

Te Huataki Waiora
School of Health
The University of Waikato
Private Bag 3105
Hamilton, New Zealand

Phone +64 7 858 5185
www.waikato.ac.nz

THE UNIVERSITY OF WAIKATO
Te Whare Wānanga o Waikato

PARTICIPANT INFORMATION FORM

Mālō e lelei, Tālofa, Ni Sa Bula Vinaka, Kia orana, Fakaalofa lahi atu, Mālō ni and warm Pacific greetings.

Project Title:

Creating Culturally Responsive Rural Doctors: Maaori and Pacific peoples' Health Aspirations and needs.

Purpose

The aim of this research is to gather interpretations, aspirations, and perspectives of health. This will include a series of talanoa with Pacific rural and remote communities.

What will I have to do?

You will be one of 30 participants who would be part of community focus groups or semi-structured interviews to talanoa with me about your health needs and aspirations, and what you believe is needed for a medical school to cater to rural and remote communities. This talanoa will take approximately 30-90 minutes or longer, at time and place that suits you. This can be either at a local hall or your own place, wherever you're most comfortable. Questions will be sent to you a week before we meet to talanoa.

Who is doing the study?

The lead researcher for this study is Janina 'Ofa Galewski, Master of Health, Sport, Human Performance student. The lead researcher's advisor is Dr. Apo Aporosa.

Who can take part in this research?

I'd like to hear from a variety of Pacific people's including men and women over the age of 18 who live in Te Kuiti. You are welcome to bring other friends and family with you.

If you fit this criteria and would like to participate please contact me or my supervisor:

Lead Researcher:
Janina 'Ofa Galewski
Ph: 022 6789949
Email: jog3@students.waikato.ac.nz

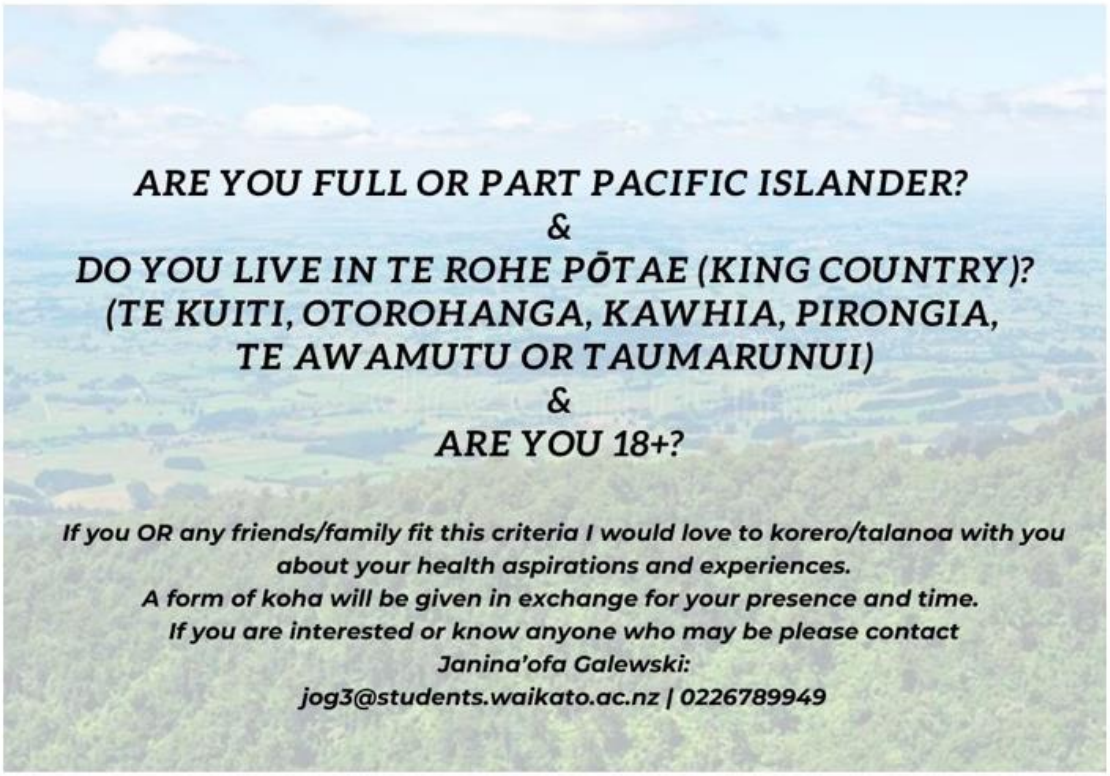
Lead Researcher's supervisor:
Dr. Apo Aporosa
Ph: 07 838 4466 ext. 8282 or 021 838478
Email: aaporosa@waikato.ac.nz

6.5 Appendix E: Participant Recruitment Poster

Tauira lead research:

All of the details are below in the poster. if you have any other patai, do not hesitate to contact Janina' ofa Galewski.

THE UNIVERSITY OF WAIKATO
Te Whare Wānanga o Waikato



6.6 Appendix: F: Participant Consent Form

Creating Culturally Responsive Rural Doctors: Pacific perspectives and aspirations.

Malo e lelei I Janina ‘Ofa Galewski am doing a research study on Pacific perspectives as part of my Masters at Waikato Univeristy, Hamilton, New Zealand.

My supervisor for this research is Dr Apo Aporosa, Research Fellow and Lecturer

This study has been approved by the Waikato University Research Ethics Committee

Can you please help me by allowing me to interview you so that I can get a better understanding of your health needs living in a rural and remote community.

Before we start I will tell you your rights as a participant:

- You do not need to participate, the study is completely voluntary.
- You can refuse to answer any question.
- You can withdraw from the study up to 3 weeks after transcript receipts are given.
- The information you give will be kept confidential. Your name will not be used unless you give permission first.
- You may ask any questions about the study at any time during participation
- You can have access to the findings of the study once it is completed

Your participation in this research study will be appreciated.

Many thanks.

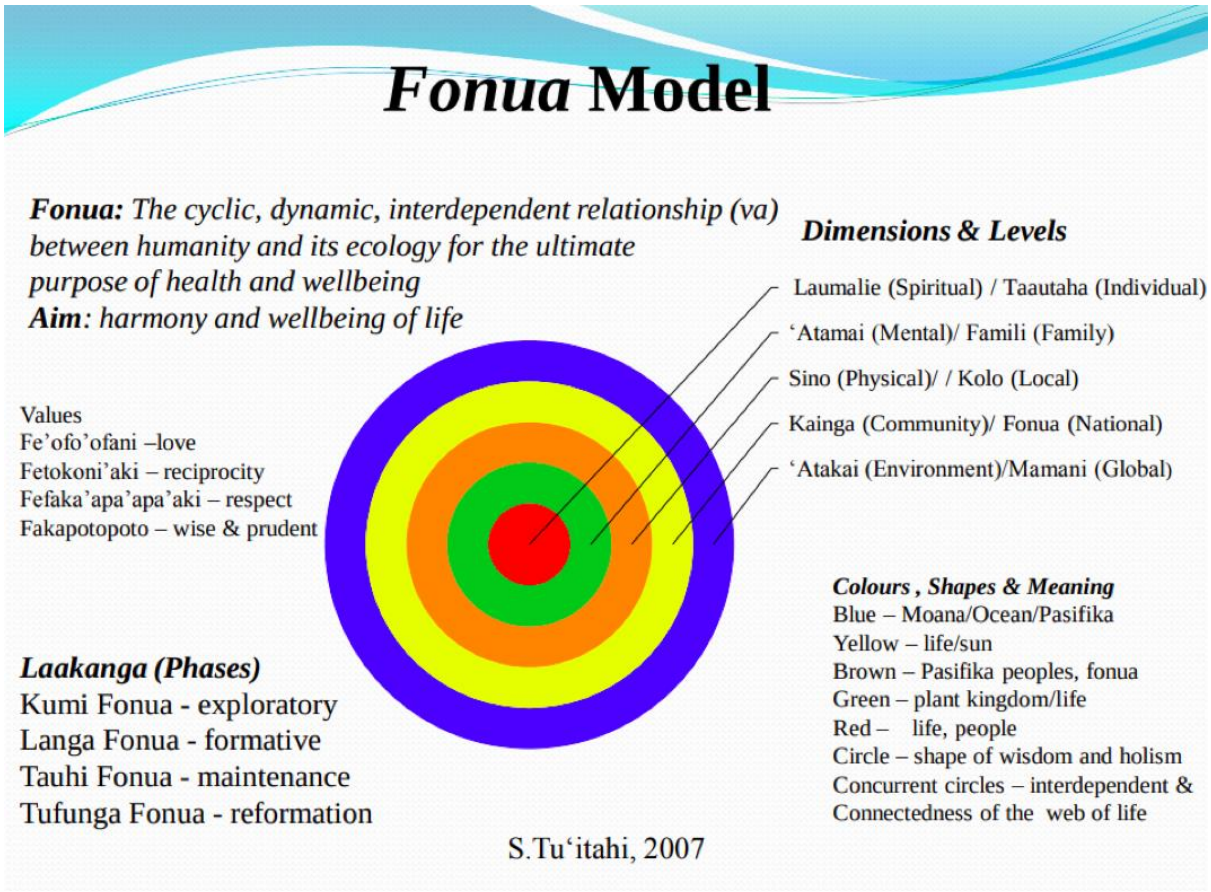
My signature confirms that I have read and understand my rights, and I am happy to participate in Janina’s Master research entitled Creating Culturally Responsive Rural Doctors: Pacific perspectives and aspirations.

_____	_____	_____
Sign	Print	Date

6.7 Appendix G: Adopted sources for research sites table

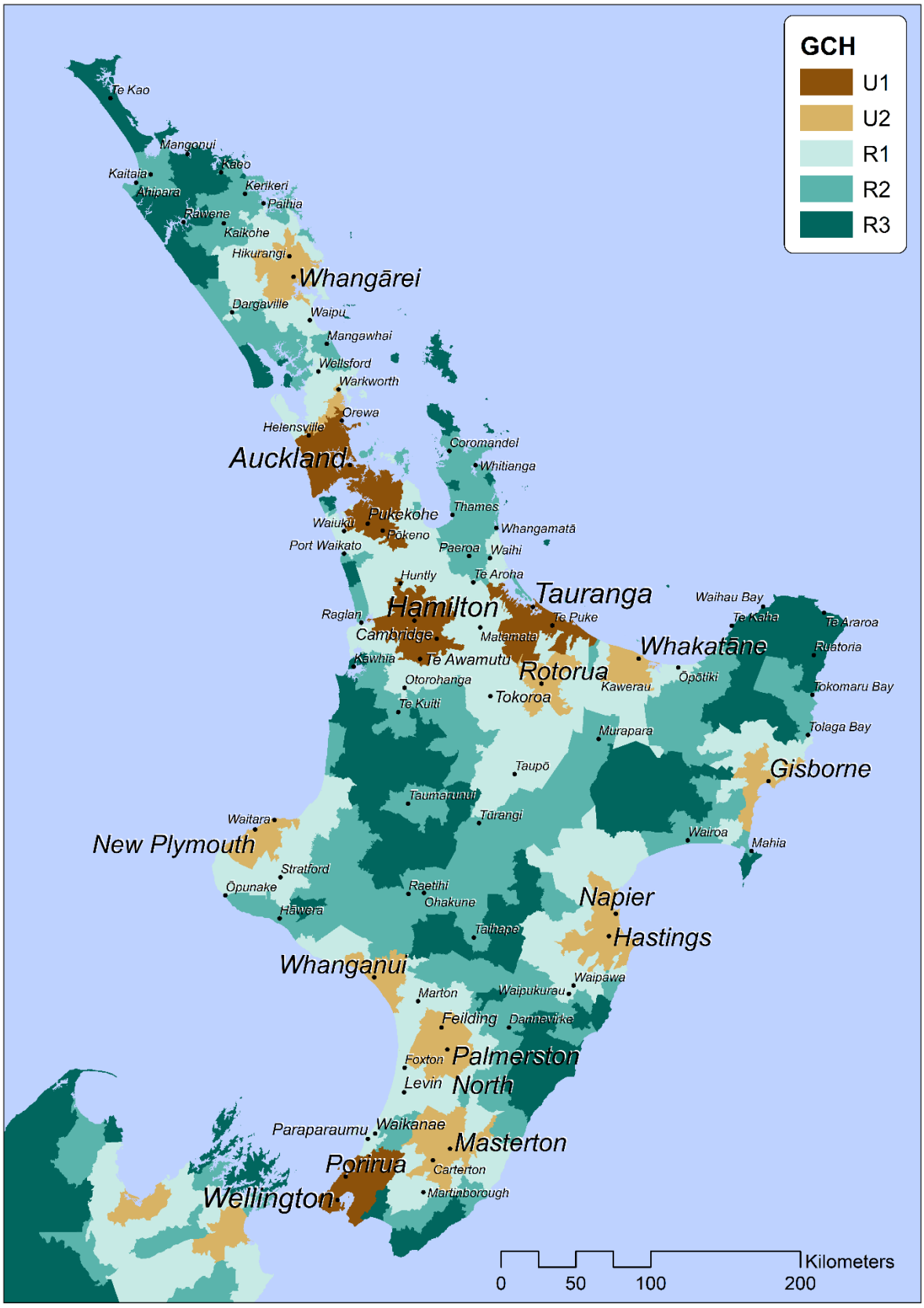
The population data for Ōtorohanga was adapted from *Ōtorohanga*, by StatsNZ, 2018b, (https://www.stats.govt.nz/tools/2018-census-place-summaries/otorohanga). CC BY 4.0. The population data for Kāwhia was adapted from *City Population*, by Brinkhoff, 2018, (https://www.citypopulation.de/en/newzealand/northisland/waikato/1191__kawhia/). CC BY 3.0. The population data for Te Kūiti was adapted from Te Kūiti West, by StatsNZ, 2018e, (https://www.stats.govt.nz/tools/2018-census-place-summaries/te-kuiti-west#ethnicity-culture-and-identity). CC BY 4.0. The population data for Te Kūiti was adapted from Te Kūiti East, by StatsNZ, 2018d, (https://www.stats.govt.nz/tools/2018-census-place-summaries/te-kuiti-east#ethnicity-culture-and-identity). CC BY 4.0. The data for GCH was adapted from *The geographic classification for health: Methodology and classification report,* by Whitehead et al, 2021, (https://blogs.otago.ac.nz/rural-urbannz/files/2021/07/The-Geographic-Classification-for-Health-Methodology-and-Classification-Report-May-2021.pdf). In public domain. The distance between Ōtorohanga and Hamilton data was adapted from *Map Data- Otorohanga to Hamilton*, by Google, n.d., (https://www.google.com/maps/dir/Otorohanga/Hamilton). In public domain. The distance between Kāwhia and Hamilton data was adapted from *Map Data- Kāwhia to Hamilton*, by Google, n.d., (https://www.google.com/maps/dir/Kāwhia/Hamilton). In public domain. The distance between Te Kūiti and Hamilton data was adapted from *Map Data- Te Kūiti to Hamilton*, by Google, n.d., (https://www.google.com/maps/dir/Te+Kuiti/Hamilton). In public domain.

6.8 Appendix H: The Fonua Model



Tu'itahi (2009)

6.9 Appendix I: Geographical Classification for Health (North Island, ANZ)



(Whitehead et al, 2021, p. 29)