A cultural analysis of New Zealand palliative care brochures

Mary Louisa Simpson¹,*, Kay Berryman², John Oetzel¹, Tiwai Iti³, and Rangimahora Reddy³

¹Management Communication, University of Waikato, PB 3105, Hillcrest Rd, Hamilton 3240, New Zealand,
²Waikato-Tainui College for Research and Development, Hamilton, New Zealand, and
³Rauawaawa Kaumātua Charitable Trust, Hamilton, New Zealand

*Corresponding author. E-mail: mary@waikato.ac.nz

Summary

Low utilization of palliative care services by Māori remains despite increases in services designed to meet Māori needs. The purpose of this study is to explore palliative care information brochures in the context of Māori principles of well-being and communication protocols, and health literacy. We examined 99 brochures from palliative care services in New Zealand and held two focus groups with 12 Māori elders (kaumātua) and extended family (whānau) members. Taking a cultural-discursive approach incorporating Māori worldviews, we analysed textual and conceptual features of the brochures. The findings centred on cultural connection and disconnection within the brochures and serve as a critique of the prominent messages currently presented in these brochures. The findings raise questions about the capacity of agencies to convey culturally resonant messages to kaumātua and their whānau. We identify implications of palliative care brochures for health literacy of provider organizations as well as kaumātua and whānau.

Key words: Māori kaumātua, palliative care, communication, health literacy

INTRODUCTION

Low utilization of palliative care services by Māori remains despite increases in services designed to meet Māori needs (Moeke-Maxwell et al., 2010). Reasons include patient and extended family (whānau) uncertainty about what palliative care means; providers’ lack of understanding of Māori models of health and cultural beliefs in care for the dying (Ajwani et al., 2006) and differences between palliative care providers and whānau on what is good end-of-life care (MacLeod, 2008; Bellamy and Gott, 2013).

Low Māori health literacy may contribute to low utilization of palliative care services by Māori, with Māori health literacy being lower than other groups in New Zealand, and Māori elders (kaumātua—indigenous older people 55-years-plus) having the lowest health literacy of any group (Minister of Health, 2010). Health literacy is a dynamic, multidimensional concept concerning communication about, and understanding of, health issues and services by providers and those groups who will benefit from knowing about them (Nutbeam, 2000, 2008; Zarcadoolas et al., 2006; Peerson and Saunders, 2009; Mogford et al., 2011). Health literacy for kaumātua is especially significant because kaumātua are cultural role models and contribute to whānau well-being and wider society (Durie, 2003).

The lack of appropriate information may also play a role in low utilization of palliative care services by
Māori. New Zealand research identified the need for more publically available information about palliative care and for providers to better describe their services (MacLeod et al., 2012). Effective health communication and health literacy have positive outcomes for end-of-life journeys (Sparks and Nussbaum, 2008). Therefore publically available information and descriptions of palliative care services should resonate with Māori cultural and health knowledge to be accessible to Māori kaumātua and their whanau.

Print media are promoted as effective ways to support communication between health professional and patients. Reasons include that many patients forget most of what a health professional says soon after leaving (Manning and Dickens, 2006); that health professionals’ time constraints have fostered reliance on patients and families reading to access health information (Friedman and Hoffman-Goetz, 2006) and that reading can assist patients and families whose capacity to absorb new, or complex information in face-to-face situations is affected by emotional state, vulnerability following diagnosis, and strange, medical environments (Friedman and Hoffman-Goetz, 2006; Lautrette et al., 2007). Such reasons, however, are located within Western medical and health-professional perspectives and print resources are commonly developed by such providers. Thus the capacity of print resources to effectively communicate culturally resonant health messages remains a central issue.

In contrast to communication via print media, Māori communication protocols tend to rely on face-to-face interaction. Thus, print resources should be examined for their ability to communicate effectively with Māori. This study focused on Māori kaumātua and their whānau encounters with palliative care information in print brochures. We adopted a cultural-discursive analytical framework comprising Māori worldview and communication protocols (Mead, 2003; Higgins and Moorfield, 2004; McClintock et al., 2012), Māori models of well-being (Pere, 1984; Durie, 1985, 2003) and cultural dimensions of health literacy (e.g. Zarcadoolas et al., 2006).

LITERATURE REVIEW

In order to explore how culture shapes perceptions of print information, we outline dimensions of Māori culture including Māori models of well-being, features of Māori communication protocols and principles of the Treaty of Waitangi (the founding agreement between Māori and the Crown signed 1840). We also introduce dimensions of health literacy within these major sections as health literacy is an important frame for health and health care in New Zealand.

Māori models of well-being
Māori models of well-being contribute to cultural understandings of health literacy. Cultural health literacy concerns collective beliefs, customs, worldview and identity that guide engagement, interpretation and action associated with health (Zarcadoolas et al., 2006). Māori models of well-being include the following: Te Whare Tapa Whā (four corners of the house; Durie, 1985, 2003); Te Wheke (the octopus; Pere, 1984) and Te Pae Mahutonga (Southern Cross constellation; Durie, 2003). The values identified in these models are consistent with other indigenous communities in Canada (Hanson, 2010), the USA (Arenella et al., 2010) and Australia (McGrath, 2010).

Each model takes a holistic approach to well-being, with five dimensions being consistent within the models: physical well-being and healthy lifestyles; emotional and mental well-being; spirituality; cultural heritage and access to Māori worldviews (Te Ao Māori) and extended family. These components provide a foundational understanding that can be used to interpret and make sense of print information about palliative care.

Māori communication fundamentals
The principle of ‘a face seen’ (kanohi kītea) underpins Māori interaction and nurtures well-being, social bonds and kinship ties. Thus, face-to-face (kanohi ki te kanohi) communication is central to Māori and critically, the basis of relationships and community well-being (Mead, 2003).

Two communication processes epitomize values of Māori well-being: a greeting (mihi), and a ceremony of welcome (pōwhiri) (Mead, 2003). To mihi is to greet a person, or group, and acknowledge connections through extended family (whanaunga), genealogy (whakapapa) and location (whenua). In making such connections, the foundation for the new relationship or setting is established.

The pōwhiri is a formal process of welcome and encounter (Mead, 2003), and engagement and participation (McClintock et al., 2012), that takes place on a marae (community meeting place), but is adapted for other settings (Higgins and Moorfield, 2004). The hosts (tangata whenua) welcome the strangers/visitors (manuhiri) onto the marae in several steps including: calling the visitors onto the marae (karanga); formal speeches by hosts and visitors (whaikōrero) and ‘making the strange familiar’ (whakararata) where hosts and visitors greet each other before the first meal together (Mead, 2003; McClintock et al., 2012). From a communication perspective, the pōwhiri is a formal ceremony that establishes the relationship between groups and enables joint work through that relationship.
Interaction involves multiple communication goals where even if a task is the primary goal, people simultaneously try to achieve identity and relationship goals (e.g., Tracey and Coupland, 1990). For Māori, the mihi and pōwhiri demonstrate that relational and identity goals need be addressed before the task can be undertaken and remain paramount even while working on tasks. It is important to understand Māori cultural emphasis on relationships and on communication structures. We argue that understanding these cultural dimensions in relation to information brochures may help to better inform and engage Māori kaumātua and whānau as they navigate access to information about palliative care services.

The Treaty of Waitangi: principles of participation and partnership

The Treaty of Waitangi (Treaty), signed between the British Crown and over 500 Māori chiefs in 1840, established a constitutional relationship between the Crown and Māori (Muircroft et al., 2010). Differences in the Māori and English language versions led to the Government establishing several principles (Orange, 1987) that can be applied to address inequities in Māori access to palliative care services (Muircroft et al., 2010). Two of these principles, participation and partnership, are relevant for this study. Participation means Māori involvement in planning and decision-making especially in areas that impact directly on Māori (Durie, 2003). Partnership requires relationships where Māori share decision-making and exercise authority and responsibility in relation to their communities (Durie, 2003). Importantly, the other partner must see the relationship as such—particularly where power differentials exist.

The Treaty principles of participation and partnership in conjunction with understandings of Māori communication protocols enable us to assess their potential for cultural resonance with kaumātua and their whānau. Much has been written about Treaty principles and models of Māori well-being and their application to Māori health care (e.g. Durie, 2003), but research about their application to palliative care is limited (e.g. Muircroft et al., 2010). The Treaty principles of participation and partnership, however, resonate with political health literacy. Political health literacy enables individuals and communities to critically examine information, events and issues and make decisions to benefit community health (Nutbeam, 2008; Mogford et al., 2011; Strecker et al., 2014). While there is little discussion of political health literacy in the context of palliative care, kaumātua, their whānau and communities need to know how to assess services’ capacity to meet their needs and be involved in decision-making about service development and provision.

Apart from studies about levels of health literacy (Minister of Health, 2010), research has tended to focus on cultural responsiveness of New Zealand palliative care providers (e.g. Muircroft et al., 2010; Bellamy and Gott, 2013); challenges for palliative care providers working with older people from different cultures (Frey et al., 2013); and New Zealanders’ knowledge of palliative care services (MacLeod et al., 2012). Research is needed to explicitly address cultural health literacy in the context of Māori models of well-being, and meeting palliative care needs of Māori kaumātua and their whānau. Therefore this study focuses on print media used to support information needs of kaumātua and whānau about palliative care. It explores the following research questions: What do palliative care brochures communicate to Māori kaumātua and whānau? To what degree are these messages consistent with Māori models of well-being and communication?

METHODS

We used two community focused research approaches, kaupapa Māori (Māori-centred) and community-based participatory research (CBPR), as an overarching methodology. Kaupapa Māori approaches normalize Māori worldviews, language and cultural practices (Kennedy and Cram, 2010) and embody the validity and legitimacy of Māori as indigenous peoples (Mane, 2009; Smith, 2012). Māori define processes so that the research is conducted in culturally appropriate ways and the outcomes target Māori whānau and wider community.

CBPR is a collaborative approach that involves partners in the research process, recognizes the unique strengths that each partner brings and combines knowledge and action for social change (Israel et al., 2005; Wallerstein and Duran, 2006). Our research team comprised Māori and Pākehā (New Zealanders of European descent), with most of the team, including the principal investigator, being community-based Māori researchers. Consistent with CBPR, we used an advisory board comprising 10 kaumātua and health care workers who ensured the cultural integrity of the research and gave cultural oversight, guidance and input into the research procedures carried out by the team.

Data collection

In September 2011 we emailed 33 hospices and palliative care services and 16 sent documents via post within the given timeframe. After excluding material aimed at audiences other than palliative care service users, our final dataset was 99 brochures. Three data collection procedures were adopted. First, two researchers (one Māori
and one Pākehā) reviewed the texts and categorized them into six sets: general service information (n = 25); patient and family services (e.g. counselling, funeral planning, spiritual care; n = 25); specific medical or technical information (n = 19); bereavement, grief and loss (n = 15); when someone is dying (n = 14) and services for Māori (n = 1). They ranked them according to the following criteria: presence of Māori language and images; clarity of title; use of images and relevance to title; font size and density of text.

Second, three Māori women with experience in palliative care and formally connected with the research were community informants (Patron, 2002). They assessed the brochures according to Māori images and language, density of text and font size and technical vocabulary and categorized brochures within each set as ‘the best’ and ‘the rest’. Their selections were then compared with the researchers’ choices to create a set of ‘best’ (n = 15) and ‘the rest’ (n = 10) for later use with whānau hui (focus groups).

Third, we conducted whānau hui of ~90 min each with 12 whānau members from six distinct whānau groups to review the 25 brochures. Participants’ ages ranged from 32 to 78 years and included 4 females and 8 males; 11 Māori and 1 non-Māori. All participants had experience in end-of-life care of a partner, close friend or whānau member. Our questions encouraged participants to share their views and cultural knowledge in explaining their responses to the brochures. They were invited to comment on how the brochures may be helpful to themselves, kaumātua and whānau, and offer ideas for improvements.

**Data analysis**

The full dataset analysis used a cultural-discursive approach incorporating Māori worldviews. The cultural part of our analysis focused on Māori communication protocols (Mead, 2003) and the emphasis on relationships including Māori principles of well-being such as whanaungatanga (extended family ties, relationships) and wairuatanga (spirituality; Pere, 1984; Durie, 1985, 2003). We also considered issues of cultural health literacy. The discursive part of our analysis focused on forms of expressions as they related to cultural, functional and technical health literacy. This meant examining features of the text—including images—and indexing them systematically (Foss, 2008).

One Māori and one Pākehā researcher undertook the analysis to provide cultural insider and outsider approaches and some confirmation of themes. The whānau hui were transcribed and analysed using thematic analysis (Braun and Clarke, 2006). The brochures were read to identify key words, phrasing, vocabulary and images (Foss, 2008) and how they resonated with Māori worldviews. Finally, the researchers considered how words and images reflected Māori principles of well-being and the dimensions of health literacy.

**FINDINGS AND DISCUSSION**

We framed this study around two research questions about how palliative care brochures communicated to Māori kaumātua and whānau and the degree to which these messages were consistent with Māori models of well-being and communication. The findings concern three key themes: (a) connecting communication; (b) disconnecting communication and (c) connecting communication preferences with information needs.

**Theme 1: connecting communication**

The first theme concerned how messages connected with kaumātua and whānau cultural identity needs. This connection was evident in uses of Māori images and symbols, Māori language (te reo Māori), and in expression of identifiably Māori values and dimensions of well-being.

First, Māori cultural images, symbols and designs appeared in seven of the 99 brochures. Five brochures used the kōrū (fern spiral; symbol of new life) and six brochures used single Māori symbols. The whānau hui participants endorsed the inclusion of Māori images and symbols in palliative care brochures. One in particular stood out for them: the greenstone (pounamu) on a front cover. The spiritual meaning of the pounamu and its life force (mauri) were deeply respected. As one person said of the symbols; ‘things that draw me in are Māori, something to look at Māori and it sort of makes me feel a bit more at home I guess, more family, just more me’ (WH5).

This leads to the second connection: the brochures’ expression of Māori cultural values and principles of well-being. Three brochures used Māori terms to name values, such as ‘Whaكةута: Mutual respect’ (B76) and ‘Manaakitanga’ (care and hospitality; B70). Nine brochures mentioned ‘wairua’ or spiritual needs, with two focusing on the topic specifically. Wairuatanga was discussed in-depth by whānau hui participants, and the combination of topic and image was important to them. One brochure stood out for them in a positive way; ‘understanding spiritual care’ (B7): ‘we thought the words were enhancing and the picture [park with trees and garden] is like real peaceful . . . that spiritualness and that’s more us’ (WH5). Some brochures stated an openness and willingness to support a wide range of spiritual worldviews: ‘We want to respect your cultural and spiritual needs so please let us know what they are’ (B13).
Third, 10 brochures referred to the Te Whare Tapa Whā model of well-being with one in te reo Māori. A further three used Māori with English equivalents: ‘the physical (tinana), social (whānau), emotional (hinengaro) and spiritual (wairua) aspects’ (B3, B71). Five used only the English terms of this holistic approach to care. Whānau hui participants responded positively to the te reo Māori used here rather than the specific model of well-being. Throughout whānau hui discussions, however, the components of this model of well-being were evident in the constant talk about needs for whānau presence, ‘spiritual care’ and ‘excellent care’ (WH5), as well as comforting ‘kōrero [talking together]’ with the dying person (WH4).

Fourth, te reo Māori appeared in 47 brochures. Thirty-eight used single words or short phrases, with ‘family/whānau’ appearing most often (29 brochures), and ‘prayers and karakia’ appearing the next most frequently (4 brochures). Nine brochures included te reo Māori in songs (waiata), proverbs (whakatauki), or headings. Two were written fully in te reo Māori (B69, B70). Whānau hui participants responded positively to brochures using te reo Māori. As one participant offered; ‘I felt it was me and I saw it; it’s the Māori thing that would attract me to it. You know, not anything else’ (WH5). Participants stressed, however, that ‘not everyone speaks Māori’ (WH5), and that providers needed to cater for non-speakers of te reo Māori.

Finally, Māori communication protocols were used in one bilingual brochure (B76). The author introduced herself with a mihi in Māori to explain her connections (with land, genealogy and whānau), before explaining her role in supporting Māori patients. She then identified Māori values central to a ‘good relationship’ and her approach which recognized partnership, the Treaty and Māori principles of well-being. Whānau hui participants appreciated this approach.

Theme 2: disconnecting communication
The second key theme concerned how messages—text and images—communicated disconnection for whānau hui participants. Three sub-themes emerged; cultural gaps, mixed messages and technical barriers.

Cultural gaps
The first cultural disconnection occurred with the lack of identifiable local landscapes that whānau hui participants could link with a given palliative care provider. In the dataset of 200 images (77 brochures), the majority were generic landscapes (n = 66) and bodies of water (n = 20) with only 13 captioned. Whānau hui participants were able to name two landscape images.

The second cultural disconnection occurred with the absence of identifiable Māori people. Of the 43 images of people, it was difficult for whānau hui participants to identify Māori. However, participants pointed out images with people of two or more generations (n = 7), because they saw them as whānau images. Yet, the majority of these images were of pairs or couples (n = 23) and older people (~60-years-plus; n = 29), with only eight showing younger people (~18–30-years). One whānau hui discussed the importance of images of younger people in the brochures because they thought young people needed to be aware of palliative care. One participant offered: ‘a lot of the younger generation . . . are sort of blasé about all this sort of thing; you know, you live forever’ (WH5).

The third cultural disconnection occurred with butterfly images, which were prominent in the brochures (n = 21). Whānau hui participants asked about the butterfly’s relevance to palliative care and its short life-span: ‘How long does a butterfly live? They don’t live very long do they?’ (WH4). Kaumātua in particular did not easily accept the butterfly as a metaphor for transformation in relation to palliative care. Further, a ‘cheap butterfly’ image (WH4) came under scrutiny by both whānau hui. Participants questioned the proximity of a ‘clip-art’ butterfly image to a ‘tāonga pounamu’ (treasured greenstone). In their view the butterfly did not match the spiritual significance and mauri of the greenstone.

The final cultural disconnection was apparent in the use of the written word. Authors’ lack of awareness of Māori cultural values was evident in the comparison of the texts and whānau hui participants’ comments. One illustrative example of this problem appeared in brochures about grief. Included in a list of possible effects of grief, four brochures stated people may experience ‘hallucinations where you see or hear them [loved one]’ (B17, B26, B27, B30). The term ‘hallucinations’ indicates something imagined and not ‘real’. Whānau hui participants, however, often mentioned hearing their terminally ill whānau member talking to those who were ‘on the other side’. They were not hallucinations, but rather integral to Māori spirituality.

Mixed messages
The first disconnection resulting from mixed messages occurred when images and text contradicted each other’s meaning. The first example was a brochure with the words ‘family/whānau’ alongside images of two older women (B11). The whānau hui participants expected to see multiple generations in the image. A second example was an image of a bed with a white bedspread and green leaves placed on top. Kaumātua said the image meant death and contradicted the text ‘Carer support and respite
care’ (B16). A third example was an image of a comic airplane with the title ‘Taking Control’ (B85). The topic concerned preparing a will and whānau hui participants saw the image as disrespectful of the topic.

The second disconnection from mixed messages occurred in uses of Māori symbols and images. The first example was the various koru images (n = 11). Kaumatua were concerned that it be ‘tika’ (correct) and chose one because it was complete: ‘it shows all new shoots and the larger fern and it’s the correct way around’ (WH4). The second example was the use of a panel that kaumatua saw as incorrect, because it did not go edge-to-edge to signal ‘eternity’ (B76). Whānau hui participants stressed, however, that ‘correctness’ may be different for Māori from other iwi (tribes) and it was important that providers know this.

**Technical barriers**

There were two ways in which technical issues resulted in disconnection for whānau hui participants; written structure and specialized vocabulary. The first disconnection resulting from technical barriers occurred with the written structure of the brochures. Forty brochures contained at least one sentence of 30 words or more, with the longest being 72 words. Below are two examples of different structures that convey the same content

(a) Occasionally in the last hours of life there can be a noisy rattle to the breathing due to a build-up of mucus in the chest that the person is unable to cough up. (B37)

(b) Breathing may become noisy due to the coughing and swallowing reflexes slowing down. (B42)

The first contains too much information for one sentence, while a second conveys the same message more directly and in one-third of the words. Whānau hui participants liked brochures that were easy to read and complained about the amount of information. As one participant offered, ‘Pamphlets would work for me but . . . to me that’s too much information in one go’ (WH5).

The second disconnection resulting from technical barriers occurred with specialized vocabulary. Some brochures provided information about medical procedures and used both formal and informal terms; ‘cannula (needle)’ (B91); ‘intravenous/subcutaneous fluids (a drip)’ and ‘pain relieving drugs (analgesics)’ (B87). Although both formal and informal terms were used to help understanding, the additional words and brackets created visual clutter.

The third disconnection resulting from technical barriers, and related to specialized vocabulary, occurred with cultural assumptions within the text. Some texts assumed a certain level of knowledge on behalf of the reader. Several brochures explained palliative care as care for those with life-limiting illness and stressed that supporting families or whānau was part of that care. Alongside these statements, however, were terms such as ‘physiological’, ‘psychosocial’ and ‘multidisciplinary’. Such concepts are located within specialist health domains of knowledge, and not necessarily available to kaumatua and whānau.

**Theme 3: connecting communication preferences with information needs**

The participants in one whānau hui debated the brochure as a suitable form for communicating palliative care information. As a source of information, the brochures were not seen as ideal, but whānau hui participants acknowledged that the information was important to know if kaumatua and whānau are to successfully access palliative care services.

Whānau hui participants reported being practical and gave several examples of learning from each other to access palliative care. Some also noted that gaining knowledge through face-to-face communication although preferred, may not be available. As one participant offered:

> Unfortunately we’ve got a lot of Māori whānau who don’t have that . . . whanaungatanga where there’s a group thing . . . these pamphlets are for people who don’t have other people they can hold hands with and say “we’ll do this together”. (WH5)

In response to this statement, whānau hui participants suggested the possibility of DVDs or ‘something at . . . the hospital [where] they had this screen . . . something that was available for people like me to watch’ (WH5). Another participant offered:

> Hearing from other Māori that have been through the same thing and how they dealt with it . . . I think that would help me more [and] give me more information to . . . help Mum and Dad if they were in that situation. (WH5)

These whānau hui participants suggest alternatives to brochures to access palliative care information. They acknowledge the need for information and to identify ways for Māori kaumatua and whānau to not only access palliative care information, but to also be visible in the medium.

**Central considerations**

The findings show that, where used appropriately, Māori language and communication protocols, and principles of
health and well-being connected with whānau hui participants. Barriers were evident in contradictions between cultural images and text, written structure and technical vocabulary and the brochure itself as a communication device. Unfortunately, the majority of brochures did not resonate with kaumātua and whānau and demonstrate a lack of cultural health literacy on the part of providers.

The first finding demonstrates the value of culturally orientated communication. The presence of Māori images and symbols, te reo Māori, the mihi and expression of Māori cultural values (Mead, 2003; McClintock et al., 2012) and dimensions of well-being (Pere, 1984; Durie, 1985, 2003) connected with whānau hui participants. Such presence communicates respect for Māori cultural values and practices (MacLeod, 2008) and therefore suggests, at least in part, that some providers, albeit a limited number, demonstrate understandings of cultural health literacy.

The second finding demonstrates the problems of culturally challenging communication. Limited, and sometimes incorrect, use of Māori cultural images, the absence of culturally relevant images of landscapes and people, lengthy text and technical vocabulary contributed to cultural disconnection. This suggests that the brochures reflected the technical and professional cultural health literacy of palliative care providers, rather than the health literacy strengths of kaumātua and whānau. Technical health literacy highlights the ability to use, understand and explain specialist, medical and technical terms and processes associated with diagnoses, interventions and service delivery (Zarcadoolas et al., 2006). The finding also endorses previous research that found health care providers who use and understood technical terms were not always able to explain them to patients (Gott et al., 2011; Barnes et al., 2012).

Critically in the current study, the lack of cultural connection combined with a mismatch between technical health literacy of providers and kaumātua and whānau, resulted in disconnection from potentially valuable palliative care information. Accepting that written documents are one part of active communication and education activities (Barnes et al., 2012), providers need to recognize Māori cultural values (MacLeod, 2008) and models of well-being (Muircroft et al., 2010) if they are to better describe their services (MacLeod et al., 2012) in ways that connect with Māori kaumātua and their whānau.

The third finding suggests that brochures as a communication device for sharing palliative care information did not fit culturally with the whānau hui participants in this study. While some brochures demonstrated efforts to communicate in culturally meaningful ways with Māori, the communication characteristics of the brochure prevent it from catering for face-to-face interaction that is fundamental to Māori communication (Mead, 2003). In addition, cultural differences in communication (Bellamy and Gott, 2013; Frey et al., 2013) and in prioritizing relational, identity and task communication goals have implications for cultural health literacy of palliative care providers, kaumātua and whānau.

Participants offered alternatives to printed media and wanted Māori to be more visible in them. The information brochure as a support for health professional–patient communication (Friedman and Hoffman-Goetz, 2006; Manning and Dickens, 2006; Lautrette et al., 2007) needs to be reconsidered by palliative care service providers in partnership with Māori kaumātua and their whānau. Such an approach avoids the ‘passive dissemination’ that fails to account for specific needs (Strecker et al., 2014, p. 344). It invokes the Treaty principles of participation and partnership (Durie, 2003) to promote a health communication and health literacy approach (Sparks and Nussbaum, 2008) that ensures kaumātua and their whānau know about, can access and can share what they know with others about palliative care. In this respect, health literacy of kaumātua and their whānau is about equity and empowerment (Peerson and Saunders, 2009).

CONCLUSION

The purpose of this study was to examine palliative care information brochures in terms of Māori principles of well-being and communication protocols, and cultural dimensions of health literacy. Specifically, we examined how palliative care brochures communicated to Māori kaumātua and whānau, and the extent to which these messages were consistent with Māori models of well-being and communication.

The study has implications for practice and theory. First, practitioners can create palliative care print media that demonstrate cultural health literacy by consulting with local kaumātua. Co-creating palliative care media would enable palliative care providers to address, first, identity needs of kaumātua and whānau by being informed by Māori cultural values and principles of well-being (Pere, 1984; Durie 2003; Mead, 2003), and second, relational needs through adapting Māori communication protocols (Higgins and Moorfield, 2004; McClintock et al., 2012). Working together with kaumātua to critically analyse information about palliative care in print media would also help develop providers’ cultural health literacy; this would influence decisions in wider Māori communities and therefore also develop Māori political health literacy (Zarcadoolas et al., 2006; Nutbeam, 2008; Strecker et al., 2014). Such action models the Treaty principles of participation and partnership (Orange, 1987; Durie, 2003).
Second, if providers want to serve kaumātua and their whānau, they need to acknowledge that institutional and health-professional cultures dominate current palliative care messages. Providers need to create cultural space for kaumātua and their whānau to contribute to and develop informational material about palliative care. Given kaumātua and whānau preferences for face-to-face interaction, providers should consider how best to approach Māori in local communities in ways that attend to Māori identity and relational dimensions of communication. The pōwhiri is a first step in welcoming (Mead, 2003) and engaging (McClintock et al., 2012) local Māori kaumātua in the ongoing development and provision of palliative care information.

The Treaty of Waitangi and its principles (Orange, 1987) and Māori models of well-being (Pere, 1984; Durie, 1985, 2003) highlight the desire of Māori to lead culturally informed responses to community identified health issues. This combination determines that Māori kaumātua, as keepers of the culture (Durie, 2003; Taskforce on Whānau-Centred Initiatives, 2010), need to lead in developing palliative care information resources, so that such resources resonate with Māori identity and relational cultural values, and principles of well-being. In so doing, kaumātua and whānau political health literacy and provider cultural health literacy are enhanced.

Third, in terms of theory, the study highlights the benefits of rotating the focus from individual to organization and encouraging the ‘two-way street’ of health literacy (Sparks and Nussbaum, 2008). A recent report (Workbase, 2013) supports earlier calls to shift the focus of health literacy from the individual to health organizations (Minister of Health, 2010). While Māori kaumātua have been identified as having the lowest health literacy of any group in New Zealand (Minister of Health, 2010), the small number of brochures in this study to include Māori cultural references indicates that overall, palliative care providers have low cultural health literacy. Palliative care organizations must interrogate their medical and health-professional orientation to health literacy in order to communicate effectively with, and meet the palliative care needs of, kaumātua and their whānau (Muircroft et al., 2010; MacLeod et al., 2012). Palliative care providers need to build their own cultural health literacy capacity if Māori kaumātua and their whānau are to participate, contribute and benefit when accessing and using palliative care services.

Finally, the study’s limitations are largely grounded in the small number of participants and whānau hui. While the study does not aim for generalizability, cultural differences in iwi may have illustrated variations in the resonance of messages. Engaging with local kaumātua to create print materials would be one way to allow for local variation. Further, the study may have benefited from involving palliative care providers to interact with whānau to understand some of the give and take around palliative care messages.

In conclusion, Māori utilization of palliative care services is negatively impacted by cultural differences and providers’ lack of cultural understanding (Bellamy and Gott, 2013; Frey et al., 2013) and, as our study shows, the way these play out in print resources. The brochures studied provided good palliative care information, but largely failed to meet the cultural and technical health literacy needs of kaumātua and their whānau. To connect with kaumātua and their whānau palliative care print material must address Māori principles of health and well-being and Māori communication protocols. To achieve this, palliative care providers need to create political and cultural space for Māori kaumātua and their whānau to take cultural leadership in developing palliative care resources that meet their needs.

ACKNOWLEDGEMENTS

We would like to thank the Board of Trustees of Rauawaawa Kaumātua Charitable Trust for their support of this project. We also wish to acknowledge the contributions of other research team members to the overall project: Linda Tuhiihi Smith, Maui Hudson, Mere Balzer, Beau Haereroa, Keri Thompson, Rachel McClintock, Ariana Waller, Peter Kirk, Ross Lawrenson and Rawiri Blundell.

FUNDING

This article was supported by a grant from the Health Research Council and Ministry of Health, New Zealand (Reddy, PI) Ref 11/744-Reddy JVCO210-Literacy. The views expressed are those of the authors and not necessarily the funding agencies.

REFERENCES


Bellamy G., Gott M. (2013) What are the priorities for developing culturally appropriate palliative and end-of-life care for older people? The views of healthcare staff working in New Zealand. Health and Social Care in the Community, 21, 26–34.


GLOSSARY

Māori language terms used twice or more within the article are listed below. For first and single use terms, the English approximation is given in-text.

<table>
<thead>
<tr>
<th>Te reo Māori</th>
<th>English language approximation</th>
</tr>
</thead>
<tbody>
<tr>
<td>īwi</td>
<td>Tribe, people</td>
</tr>
<tr>
<td>kaumātuatua</td>
<td>Respected older person(s), elders</td>
</tr>
<tr>
<td>kaupapa Māori</td>
<td>Māori philosophy and principles, Māori-centred</td>
</tr>
<tr>
<td>koru</td>
<td>Fern spiral; symbol of new life</td>
</tr>
<tr>
<td>Māori</td>
<td>Indigenous people of New Zealand</td>
</tr>
<tr>
<td>marae</td>
<td>Māori community setting, gathering place, ancestral home</td>
</tr>
<tr>
<td>mauri</td>
<td>Life force</td>
</tr>
<tr>
<td>mihi</td>
<td>Greeting, introduction</td>
</tr>
<tr>
<td>Pākehā</td>
<td>New Zealanders of European descent</td>
</tr>
<tr>
<td>pounamu</td>
<td>New Zealand greenstone</td>
</tr>
<tr>
<td>te reo Māori</td>
<td>The Māori language</td>
</tr>
<tr>
<td>wairuatanga</td>
<td>Spirituality</td>
</tr>
<tr>
<td>whānau</td>
<td>Family unit</td>
</tr>
<tr>
<td>whānau hui</td>
<td>Focus groups</td>
</tr>
<tr>
<td>whanaungatanga</td>
<td>Family ties, relationships</td>
</tr>
</tbody>
</table>