TE TIRATU

Hauora
Ōtorohanga

2026

“Ko te whenua te pou, ko te iwi te mauri.”

The land is the pillar, the people are the life force

He Whakamihi | Acknowledgements

He mihi nui ki a Ngāti Maniapoto, ki ngā hapū o te rohe, me ngā whānau o Ōtorohanga. Ngā mihi ki ngā kaimahi me ngā ratonga hauora, ratonga pāpori, kura, marae, me ngā rōpū hapori i tuku kōrero, i whakatika whakaaro, i tautoko hoki i tēnei mahi. Ka nui te aroha ki a koutou katoa.

We acknowledge the whānau who shared their experiences, the providers who continue to serve under pressure, and the iwi and community partners who guide this mahi. Your voices shape this report and the direction it takes. Ngā mihi nui ki a koutou katoa.

This report has been prepared by Te Tiratū Iwi Māori Partnership Board. The Board has a statutory role to represent the hauora priorities, needs, and aspirations of Māori communities in te rohe o Waikato.

Ngā Ihirangi | Contents

Whakarāpopototanga
| Executive Summary

This report provides a place-based overview of the hauora environment in Ōtorohanga and surrounding communities, including Kāwhia. It draws on demographic data, socio-economic indicators, provider insight, and iwi perspectives to examine how health and social services are experienced by Māori whānau in this rural district.

Ōtorohanga functions as a local service hub within Te Rohe Pōtae, supporting both township residents and surrounding rural communities. While the district benefits from strong community cohesion, active iwi leadership, and committed local providers, structural pressures continue to influence equitable access to care. Māori whānau experience higher levels of deprivation, lower median incomes, and greater exposure to housing quality challenges. Rangatahi face barriers across education and employment pathways, and access to timely healthcare remains shaped by cost, transport, and workforce availability.

Kāwhia presents distinct circumstances within the district. Its coastal isolation, limited on-site clinical capacity, and seasonal population growth increase reliance on outreach services and private transport. These conditions create additional continuity challenges for whānau requiring ongoing or specialist care.

Local providers demonstrate strong commitment to relationship-based care, cultural responsiveness, and collaborative practice. However, workforce shortages, service fragmentation, and funding constraints continue to limit the system's ability to consistently deliver integrated, whānau-centred models of care.

Overall, Ōtorohanga reflects both strength and structural constraint. Addressing long-standing inequities will require sustained investment in rural workforce development, transport solutions, service integration, and kaupapa Māori-led approaches aligned with iwi aspirations for mana motuhake and intergenerational wellbeing.

He Karanga ki te Wā
| Call to Action

These are not new problems. They are pressure points. The opportunity is to act where change will have the greatest and most immediate impact for whānau.

What this means: Move the system upstream to catch risk earlier, maintaining contact, and preventing avoidable deterioration.

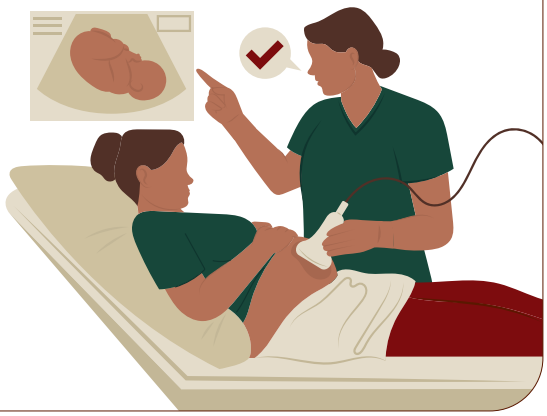
Shift Earlier – From Crisis to Prevention

- Earlier action for diabetes and heart risk
- Structured follow-up (not ad hoc)
- Early intervention for rangatahi before escalation

What this means: Access should not depend on geography. Core services need to exist locally and consistently.

Bring Care Closer to Home

- Local diagnostic access (X-ray, ultrasound, imaging)
- Outreach services for hapū Māmā
- Reduced travel burden and delays



What this means: Whānau shouldn't fall out of the system when needs fluctuate. Support must stay in place across the full journey.

Build Continuity – Not Crisis-Only Support

- Permanent addiction (alcohol and other drugs) support in town
- Follow-up after relapse or missed appointments
- Continuity of clinicians

What this means: Early-life investment shapes long-term outcomes. Systems must wrap around whānau, not expect them to navigate alone.

Protect the First 1000 Days and Young Whānau

- Support for young Māmā
- Immunisation follow-through beyond infancy
- Hospital-to-home continuity

What this means: Urban-designed systems don't translate to rural contexts. Flexibility must be built in.

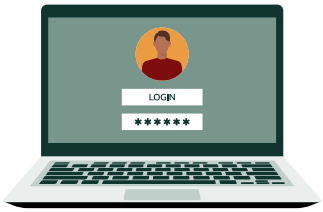
Design Rural Systems for Rural Realities

- Same-day access and longer appointments
- Flexible referral and discharge rules
- Follow-up after missed appointments

What this means: Coverage isn't enough. Rural systems need stable, skilled people embedded locally.

Strengthen the Local Workforce Backbone

- Dedicated long-term condition roles (e.g. diabetes nurse)
- Rural workforce retention
- Supported telehealth with on-site facilitation



What this means: Better understanding leads to earlier engagement, stronger relationships, and improved outcomes.

Grow Health Literacy, Trust and Engagement

- Plain-language care and communication
- Community-based education (wānanga)
- Ongoing trust-building with consistent clinicians

What this means: The system must organise itself around whānau. Not the other way around.

Connect the System Around Whānau

- Whānau navigator roles
- Shared care planning across services
- Clear pathways in and back into care

Te Kaupapa - Purpose

The purpose of this report is to provide a comprehensive overview of the hauora environment in Ōtorohanga. It identifies the health, social, and community services operating in the district and examines how these services support Māori whānau. The report looks at how manaakitanga, whanaungatanga, and kotahitanga are reflected in how services actually operate on the ground across service delivery, as well as the gaps, constraints, and pressures that influence whānau access to equitable health and wellbeing support.

Ōtorohanga has been selected as a focus locality due to its significant Māori population, its role as a service hub for surrounding rural communities, and the presence of both mainstream and kaupapa Māori services. Māori whānau in Ōtorohanga and nearby rural areas often experience compounded access challenges related to cost, transport, workforce availability, and service configuration, making it a critical location for place-based hauora analysis.

This report is intended for whānau, Te Tiratū Iwi Māori Partnership Board, health and social service providers, funders, planners, and decision-makers, as well as iwi, hapū, and community organisations seeking a clearer understanding of local service strengths, pressures, and opportunities.

Ngā Whāinga - Objectives

This report aims to:

- Identify and map existing health, social, and community services operating in Ōtorohanga
- Examine how services engage with and support Māori whānau, including how manaakitanga, whanaungatanga, and kotahitanga are reflected in practice
- Consider gaps, constraints, and pressures that influence whānau access to equitable health and wellbeing support
- Highlight strengths and opportunities for collaboration, service improvement, and system-level change aligned with Māori aspirations for hauora

Me Pānui Pēnei
| How to Read This Report

- This report provides a place-based view of hauora in Otorohanga, drawing on Whānau Voice, provider insight, and selected system data to understand patterns of access, pressure, and opportunity. It is not intended to be a comprehensive audit of services or a clinical assessment of health outcomes.
- Data included in this report supports understanding of local trends and pressures rather than measuring prevalence or assessing provider performance. Where town-level data is limited or unavailable, regional or proxy data has been used alongside lived experience shared by whānau and providers.
- Findings should be read as indicative and grounded in local knowledge and experience. The report is designed to support planning, advocacy, and informed discussion about how systems can better respond to the needs of Māori whānau in Otorohanga and Kawhia.

He Tirohanga Whānui ki te Hauora | Hauora Overview

Ōtorohanga supports a wide surrounding rohe, including Kāwhia and neighbouring farming communities. While positioned between Te Awamutu and Te Kūiti, it does not hold the same level of embedded specialist services. Many whānau travel outside the district for scans, hospital appointments, and specialist care. Distance and transport are part of everyday health realities.

Primary care services are present, and many Māori whānau are formally enrolled. However, both whānau voice and provider insight suggest engagement is not consistent. Long GP wait times, specialist delays, cost pressures, and rural travel requirements influence when and how care is accessed. Fifteen-minute appointments are often described as rushed. In a small-town setting, visibility and privacy also shape help-seeking behaviour.

Providers consistently describe late presentation, particularly for diabetes, mental health, and addiction-related concerns. Whānau are often seen once conditions have progressed. This reflects structural barriers, financial strain, mistrust, and fatigue with navigating fragmented systems. Engagement is shaped not only by availability, but by whether care feels safe, culturally grounded, and worth the effort required to reach it.

Primary care data confirms a significant burden of long-term conditions among Māori. Diabetes and pre-diabetes are highly prevalent. Asthma, cardiovascular disease, and smoking-related risk remain elevated. Mental health referrals are sustained, and providers describe trauma, methamphetamine-related harm, and relapse patterns among rangatahi. These pressures sit within limited workforce depth and infrastructure.

At the same time, strong protective factors remain visible. Rongoā Māori, mirimiri, marae engagement, kapa haka, and intergenerational support continue to act as sources of strength where care is relational and culturally responsive.

Whānau engagement in Ōtorohanga is not consistent. Some experience strong, relationship-based care. Others delay until issues are advanced. Cost, geography, workforce capacity, and system rigidity all influence whether care is accessed early or late. Concentrated health need sits alongside limited infrastructure, meaning delays can quickly escalate into complexity.

Ngā Tohu Hauora i te Hapori | What We're Seeing in the Community

Key Hauora Insights in Ōtorohanga and Kāwhia

Key hauora patterns identified through this analysis are explored in more detail in the sections that follow.

Issue Area	What the Data Shows	Whānau & Provider Voice	Why This Matters
Primary care access	2,436 Māori enrolled with PHO services across age groups. Younger Māori population concentrated in Ōtorohanga township; older Māori population in Kāwhia.	Engagement is described as hit or miss. Some whānau maintain routine care, while others present only when conditions become acute. Once trust is disrupted, re-engagement can be difficult.	High enrolment does not mean equitable engagement. Late presentation increases complexity and avoidable escalation.
Deprivation & cost pressure	54.3% of Māori live in NZDep deciles 9–10. Median income below national Māori averages. Nearly half of Māori households live in non-owned housing.	Whānau describe choosing between petrol, kai, power, and appointments. Prescriptions and repeat visits create cumulative strain.	Financial pressure directly shapes when care is accessed and whether follow-up is sustained.
Transport & geographic isolation	Kāwhia residents travel to Ōtorohanga, Te Kūiti, or Hamilton for diagnostics, pharmacy access, and specialist care. No local pharmacy in Kāwhia.	Travel requires time off work, childcare, and fuel. Missed appointments are often linked to logistics rather than disinterest.	Transport barriers disrupt continuity and increase reliance on urgent or crisis services.

Issue Area	What the Data Shows	Whānau & Provider Voice	Why This Matters
Long-term conditions & late presentation	220 Māori diagnosed with diabetes (202 Type 2). 211 Māori with pre-diabetes (HbA1c 41–49). 74 recorded cardiovascular events. No permanently embedded diabetes nurse.	Providers report very high HbA1c levels at first diagnosis. Pre-diabetes present but follow-up not always consistent. Smoking compounds cardiovascular risk.	Delayed identification reduces prevention windows and increases avoidable disease progression. Nearly equal diabetes and pre-diabetes numbers signal a critical prevention opportunity.
Respiratory & environmental burden	433 Māori coded with asthma. 35.1% of Māori households report damp housing (6.1% always; 29% sometimes).	Whānau describe housing challenges and heating costs. Respiratory flare-ups common in winter.	Housing quality directly influences respiratory illness and avoidable primary care demand, especially for tamariki and kaumātua.
Addiction & relapse	No permanently based AOD clinician in Ōtorohanga. Reliance on outreach and referral thresholds.	Methamphetamine relapse reported. Drop-off occurs when eligibility criteria are no longer met.	Without continuous, trauma-informed support, relapse cycles repeat and impact whānau stability.
Maternal & early-life pathways	59% fully immunised at 8 months; 70% at 24 months. Young Māori population in township; Kāwhia median age significantly higher. Travel required for scans and specialist maternity care.	Young māmā face transport barriers. Immunisation uptake drops after infancy.	Early-life disruption compounds long-term inequities across generations. Prevention gaps appear early.
Mental health & rangatahi	59 primary mental health referrals in past 12 months; 43 severe diagnoses recorded.	Trauma-linked anxiety, ADHD, kura disengagement, and youth justice involvement described. Limited local therapeutic capacity.	Early intervention gaps contribute to long-term social and health inequity. Demand likely exceeds recorded referrals.

Issue Area	What the Data Shows	Whānau & Provider Voice	Why This Matters
Workforce depth	Small primary care workforce. Visiting specialist model. Nurse-led delivery in Kāwhia. No permanent diabetes or AOD clinician.	Providers describe high caseloads and minimal buffer. The system works because staff stretch beyond capacity.	Limited workforce depth increases fragility when demand rises. Rural systems operate without redundancy.
Trust & system experience	Preventive engagement inconsistent over time. Smoking prevalence remains high (35%, highest in mid-life).	Providers report that once trust is broken, some whānau disengage entirely and return only when symptoms are severe.	Trust is foundational. Without it, prevention becomes reactive and late, compounding chronic risk over time.

Ko te Reo o te Whānau me ngā Ratonga | Whānau Voice and Provider Voice

Whānau describe the cumulative weight of cost and logistics rather than a single barrier:

> **"It's not that you don't want to go. It's just everything adds up."**

Transport, particularly for Kāwhia whānau, continues to shape access:

> **"If the car's not going, the appointment's not happening."**

Providers speak openly about late presentation in long-term conditions:

> **"By the time we see them, it's already progressed."**

Workforce fragility is acknowledged across interviews:

> **"We're managing, but there's no room for extra pressure."**

Across engagement, kaupapa Māori providers are consistently identified as strengthening trust and continuity. Where care is relational and culturally grounded, whānau are more likely to stay connected. Where systems feel rushed, rigid, or financially heavy, disengagement increases and re-engagement becomes difficult.

Sources: Desktop Research Report (2025); Te Tiratū engagement (2025); Provider interviews (2025).

Ngā Kaha me te Ara Whakamua | Strengths and Direction

Despite operating with limited depth, Ōtorohanga and Kāwhia are supported by strong relational foundations. Primary care remains trusted and relationship-based. Kaupapa Māori services, marae-connected support, midwifery coordination, and community-led initiatives provide culturally grounded, accessible care. Whānau networks remain visible and active, and collaboration across providers continues to hold the system together.

At the same time, sustained pressure exposes structural gaps that require strengthening. Workforce depth, local diagnostic access, addiction support, transport flexibility, and earlier long-term condition intervention are central to improving outcomes. High deprivation concentration and lower-than-national income levels mean cost and continuity barriers remain significant. Strengthening prevention, embedding navigation, expanding rural workforce capacity, and improving system flexibility will be critical to supporting hauora across Ōtorohanga and Kāwhia.

Ngāti Maniapoto expectations regarding leadership and decision-making:

Ngāti Maniapoto engagement in this report is grounded in rangatiratanga and mana motuhake, not participation alone. Where Maniapoto hauora priorities are identified, Maniapoto expects to play a clear and active role in determining how those priorities are interpreted, designed, and progressed:

- Supporting the definition of hauora aspirations, values-based priorities, and kaupapa Māori approaches grounded in Te Kawau Rukuroa and Hinematua.
- Participating in the co-design and influencing service models, access pathways, and system settings that affect Maniapoto whānau, particularly where those settings intersect with rural realities, equity, and whānau-centred care.
- Providing our Maniapoto matauranga over cultural integrity, tikanga alignment, and iwi-specific approaches, including what is acceptable, adaptable, or non-negotiable for Ngāti Maniapoto.

The role of Te Tiratū is to reflect and advocate for these expectations within system planning, commissioning, and accountability processes. This includes ensuring that engagement with Maniapoto moves beyond consultation into shared authority, clear leadership roles, and arrangements that uphold Maniapoto decision-making where whānau, hapū, and iwi interests are directly affected.

This distinction is critical to achieving equitable and enduring hauora outcomes. Without it, system responses risk defaulting to generic, centrally designed solutions that do not reflect Maniapoto realities, aspirations, or responsibilities to future generations.

Te Tukanga | Methodology

Te Hōkaitanga - Scope

The analysis is centred on Ōtorohanga and its immediate service catchment. Regional or district-level data is included only where necessary to provide context or where local data is unavailable.

The report considers:

- Health services and access
- Social and whānau support services
- Education and workforce pathways where they influence hauora
- Housing and place-based pressures that affect wellbeing

Te Ara - Approach

This report uses a Kaupapa Māori, mixed-methods approach. Whānau Voice is central to understanding how the health system operates in practice, particularly where access, affordability, and trust shape decisions about care. (Smith, 1996; Walker, Eketone & Gibbs, 2006).

Qualitative insight was gathered through whānau kōrero, provider interviews, and community engagement (Walker et al., 2006).Quantitative data includes demographic information, selected health indicators, and service-use signals from sources such as Census 2025, Whaitua, PHO data, and Te Whatu Ora publications.

These sources are considered together to build a holistic picture of hauora in Ōtorohanga, recognising the importance of understanding lived experience alongside system context.

Ngā Āhuatanga Raraunga - Data considerations

Access to detailed town-level data has been limited in some areas. Where this has occurred, alternative data sources and qualitative insight have been used to support analysis. The report does not attempt to model prevalence, funding, or workforce need. Its purpose is to support shared understanding and inform future planning and advocacy.

Ngā Kaupapa Here me te Pūnaha - Policy and System Context

National and regional health strategies shape how services are designed and delivered in Otorohanga, but local realities often determine how well those services work for whānau.

The Pae Ora (Healthy Futures) Act 2022 established Te Whatu Ora and Iwi Māori Partnership Boards, including Te Tiratū, to strengthen Māori leadership, equity, and accountability within the health system. Te Tiratū's regional priorities align closely with issues raised locally, including access to primary care, screening equity, maternal and child health, mental health, and long-term conditions (Te Tiratū IMPB, 2024).

The role of Ōtorohanga as a rural service hub brings it within the scope of the Rural Health Strategy, which recognises the additional barriers faced by rural communities, including distance, workforce shortages, and limited local service options. These settings provide important context for understanding why pressure continues to build locally, even where services are present.

Te Horopaki o te Wāhi me te Tangata | Place & People Context

Ōtorohanga is a small rural township within Te Rohe Pōtae. It supports surrounding farming communities and the coastal settlement of Kāwhia. Unlike larger centres, services operate at a smaller scale, supporting a dispersed population across farmland, coastline, and inland rural areas.

Whānau travel into the township for primary care, schooling, groceries, and essential services. For more specialised care and secondary services, residents often travel onward to Te Kūiti or Hamilton. This layered access pattern shapes how and when services are used.

There is no hospital located in Ōtorohanga. Acute and inpatient services are accessed through Te Kūiti Hospital. Distance, workforce capacity, transport reliance, and service scale influence how hauora is experienced locally.

Sources: Stats NZ (2023). Census 2023 data accessed via Stats NZ ArcGIS Instant Atlas mapping application. https://statsnz.maps.arcgis.com/apps/instant/sidebar/index.html?appid=3a406ce8fbb14367ab5caae21c07ab8b

He Kōrewha ki a Ōtorohanga me Kāwhia | Ōtorohanga and Kāwhia at a Glance

What we're looking at	What this looks like in Ōtorohanga/Kāwhia
The community	Ōtorohanga is a rural township grounded in strong community cohesion, deep whakapapa ties, and a culture of whanaungatanga. Kāwhia is a coastal Māori community with high deprivation and strong cultural identity grounded in whakapapa and whenua.
Community role	Ōtorohanga supports surrounding rural communities, including Kāwhia, Waitomo, and the wider Te Rohe Pōtae. Whānau travel into town for primary health care, education, social services, employment, and community support.
District Population	**Approximately 10,410 residents.** Estimated increase to 10,700 residents (June 2025).
Māori population distribution	**3,384 residents identify as Māori,** representing around 30% of the district population. Kāwhia has a significantly higher Māori population, with 55.6% of residents identifying as Māori.
Ōtorohanga Township	**Approximately 3,180 residents**

He Kōrewha ki a Ōtorohanga me Kāwhia | Ōtorohanga and Kāwhia at a Glance continued...

What we're looking at	What this looks like in Ōtorohanga/Kāwhia
Ōtorohanga Age profile	**Median age 38.3 years district-wide.** Median age for Māori is 30.4 years. Residents aged 65 years and over make up 16.9% of the district population. Kāwhia has a median age of 57.8 years.
Kāwhia population	**370,** with 57% identifying as Māori.
Kāwhia age profile	**Median age 57.8 years.** One third of residents are aged 65 years and over, and 12.7% are under 15 years.
Iwi connections	Ngāti Maniapoto through Te Nehenehenui, alongside Ngāti Hikairo and Waikato-Tainui, hold strong whakapapa connections across the rohe.
Health infrastructure	There is no hospital located in Ōtorohanga. Acute and inpatient services are accessed through Te Kūiti Hospital.
Service pressure context	Rural spread, coastal isolation, workforce capacity, travel distance, and deprivation patterns shape how whānau access services.

Sources: Stats NZ Census 2023. Māori figures reflect Māori descent population. Māori ethnicity totals (3,384; 30%) are reported separately. Ethnicity and descent are distinct Census measures.

Te Tirohanga Whānui ā-Taupori | Population Overview

Māori are present across both Ōtorohanga township and the surrounding rural planning areas. This distribution means that access, transport, and workforce planning cannot be township-focused alone. Rural spread directly shapes how and when whānau engage with services across the district.

Across Ōtorohanga District, 3,384 residents identify as Māori by ethnicity (Census 2023), representing approximately 30 percent of the total population. When measured by Māori descent, the total is 3,654 residents (35.0 percent), reflecting the wider whakapapa-connected population.

Area	Māori Descent Population (2023)	Total Population (2025)
Ōtorohanga Township	1,509 (47.5%)	3,180
Pirongia Forest	504 (51.2%)	984
Honikiwi	444 (27.7%)	1,602
Maihiihi	483 (25.8%)	1,875
Te Kawa	249 (21.1%)	1,182
Puniu	465 (29.3%)	1,587
Ōtorohanga District	**3,654 (35.0%)**	**10,410**

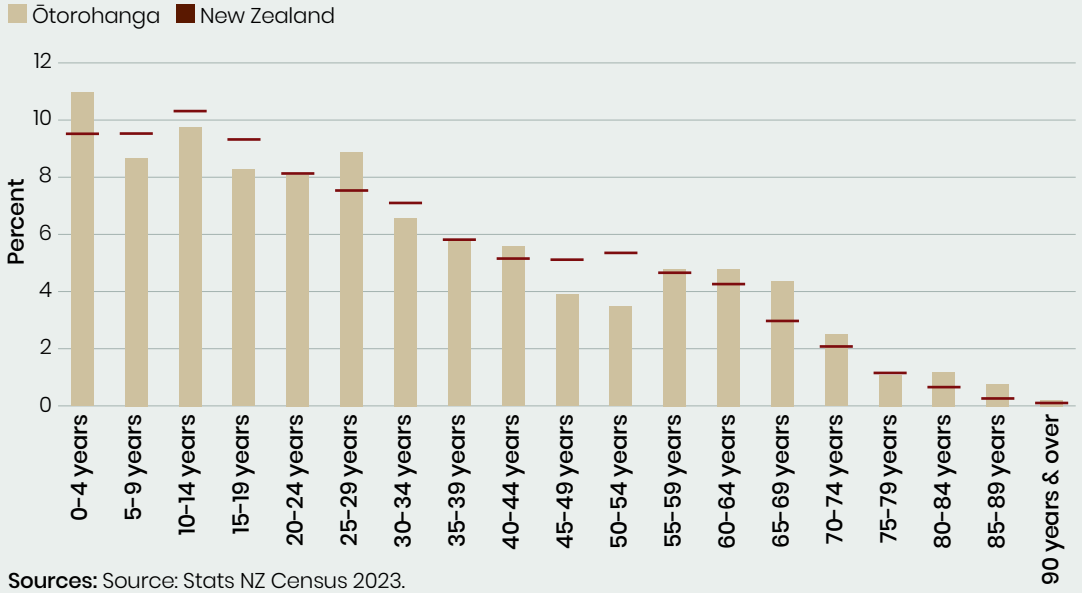
Sources: Stats NZ Census 2023. Māori figures reflect Māori descent population. Māori ethnicity totals (3,384; 30%) are reported separately. Ethnicity and descent are distinct Census measures

Māori are strongly represented within Ōtorohanga township itself, where nearly half of residents identify as Māori descent. Significant Māori populations are also present across rural areas including Pirongia Forest, Honikiwi, Maihiihi, Te Kawa, and Puniu. This confirms that Māori whānau are present across the full service catchment rather than concentrated in one locality.

Kāwhia presents a distinct demographic profile. While the permanent population is small (378 residents), more than half identify as Māori. The median age in Kāwhia is 57.8 years, with a higher proportion of kaumātua compared to the district average. Seasonal population increases further influence service demand, particularly during holiday and peak visitor periods.

Across the district, the median age is 38.3 years, while the median age for Māori is younger at 30.4 years. This younger Māori age profile, alongside an ageing coastal population in Kāwhia, means service demand spans early-life support, maternal and rangatahi needs, working-age health pressures, and increasing long-term condition management for older residents.

Percentage of Māori ethnic group population by five-year age group, Ōtorohanga and New Zealand 2023 Census



Sources: Source: Stats NZ Census 2023.

Between 2013 and 2023, the population of Ōtorohanga District remained relatively stable, with modest change over the decade. Māori continue to represent a significant proportion of the district population, with a particularly strong presence in Kāwhia and Ōtorohanga township.

Ōtorohanga District (total population)

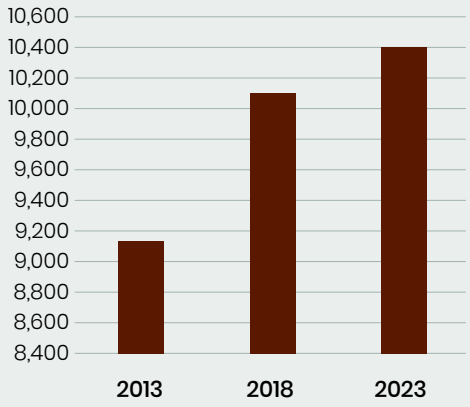


Figure 1a. Total Population Growth – Ōtorohanga District (2013–2023) (Stats NZ 2023)

Stability in overall numbers indicates that service pressure is shaped less by rapid population growth and more by structural realities, including workforce depth, rural distance, and the age profile of the community.

Despite its size, Ōtorohanga maintains strong community cohesion and deep whakapapa ties. These relational strengths shape how whānau support one another and remain a key foundation of the local hauora landscape. However, rural distance, transport reliance, workforce limitations, and service scale continue to influence how that hauora is experienced in practice.

Ko Ngā Here ā-Whenua, ā-Iwi hoki | Whenua and Iwi Connections

Ōtorohanga and Kāwhia sit within a landscape shaped by whakapapa, marae, and enduring relationships between whānau and whenua. These connections are not symbolic. They continue to guide how wellbeing is understood, how services are experienced, and how collective responsibility is carried across the district.

Ngāti Maniapoto – Te Nehenehenui

Te Nehenehenui holds deep whakapapa connections across Ōtorohanga and Kāwhia. Their aspirations for hauora consistently centre:

- Whānau-centred wellbeing
- Early support and prevention
- Culturally grounded, trusted services
- Strengthening Māori workforce pathways
- Connection to whenua and culture as protective factors

These priorities strongly align with the whānau voice captured in this report, particularly the call for earlier intervention, trusted relationships, and services that are embedded locally.

Ngāti Hikairo

Ngāti Hikairo maintains strong ancestral ties to Kāwhia and the surrounding coastal communities. Their aspirations emphasise:

- Strengthening local services
- Supporting whānau to access care closer to home
- Upholding cultural identity and mana
- Improving pathways for tamariki and rangatahi

Given the geographic isolation of Kawhia and high Māori population, these priorities are directly reflected in the access pressures identified throughout this report.

Waikato-Tainui

Waikato-Tainui whānau living in and around Ōtorohanga contribute to the cultural and social fabric of the locality. Their wellbeing priorities include:

- Whānau wellbeing across the life course
- Access to culturally safe services
- Stronger integration across health, education, and social sectors

Across iwi, there is clear consistency. Hauora is understood as relational, intergenerational, and grounded in whenua. The aspirations of iwi closely mirror what whānau and providers are describing locally — the need for earlier action, stronger local workforce capacity, improved coordination, and services that uphold mana.

Āhuatanga Ōhanga me te Tūāhua Rawakore | Socio-economic and Deprivation Snapshot

Socio-economic pressure in Ōtorohanga is not evenly distributed. For Māori whānau, deprivation is highly concentrated and shapes everyday access to housing, income security, and care.

Census 2023 data shows that 35.1 percent of Māori live in NZDep decile 7 areas, 36.3 percent in decile 9, and 18 percent in decile 10. No Māori are recorded in deciles 1–6 locally. This concentration reflects overlapping pressures rather than isolated hardship.

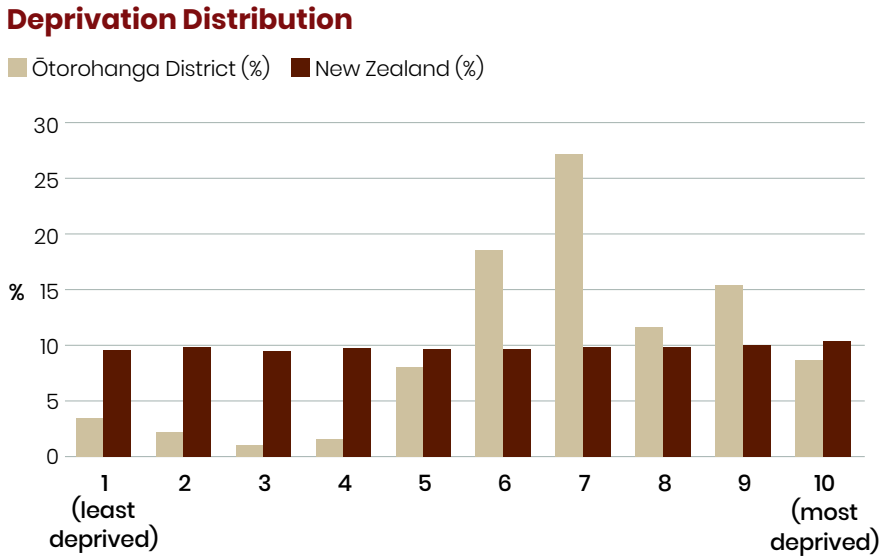


Figure 3. Socioeconomic Deprivation Distribution – Ōtorohanga District (NZDep 2023) (Stats NZ 2023.

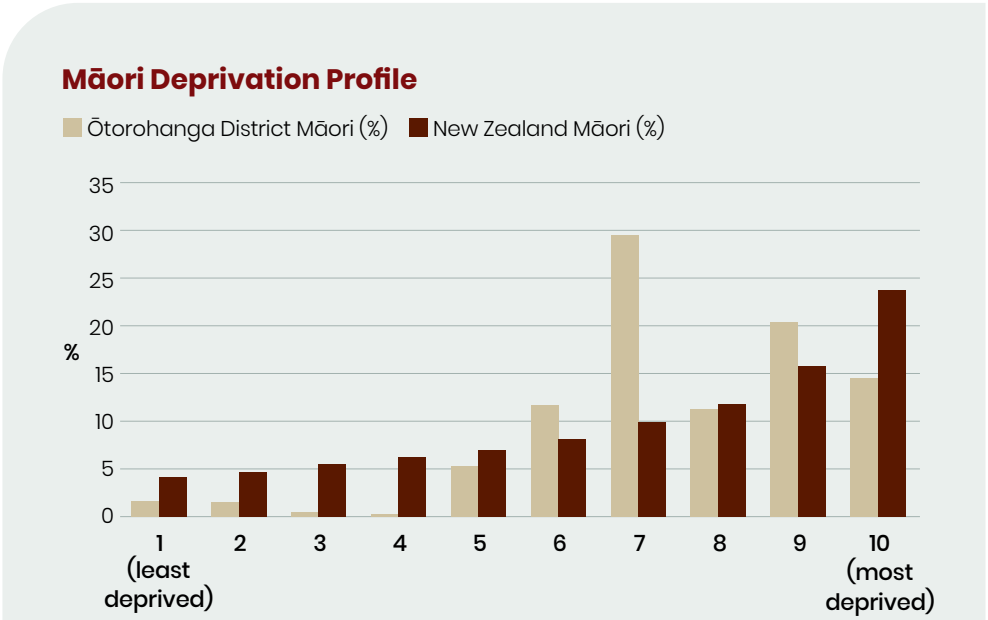


Figure 4. Māori Deprivation Profile – Ōtorohanga District (NZDep 2023) (Stats NZ 2023)

The geographic of Kawhia isolation intensifies these realities. Travel to Ōtorohanga or Te Kūiti is often required for schooling, primary care, diagnostics, and specialist appointments. For some whānau, the cost and time involved directly influences when care is accessed and whether follow-up can be sustained.

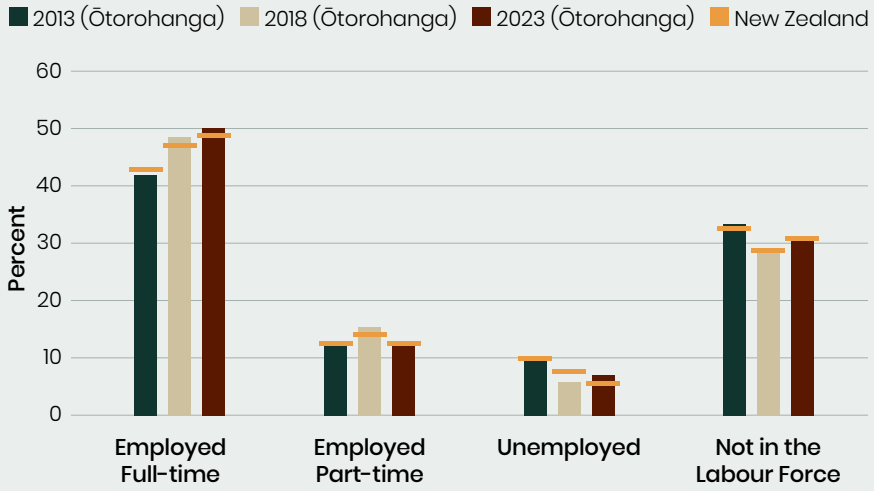
The district also carries two distinct demographic patterns. Ōtorohanga township has a younger Māori population, with a median age of 30.4 years. Kāwhia, by contrast, has a median age of 57.8 years and a higher proportion of kaumātua. The overall district median age is 38.3 years. This means demand spans early-life investment, working-age pressures, and increasing long-term condition management.

Whare Awhina, Ōtorohanga central community hub, providing social

Te Utu Noho me te Whiwhi Mahi | Cost of Living and Employment Snapshot

Employment patterns in Ōtorohanga reflect the district's economic base and workforce profile.

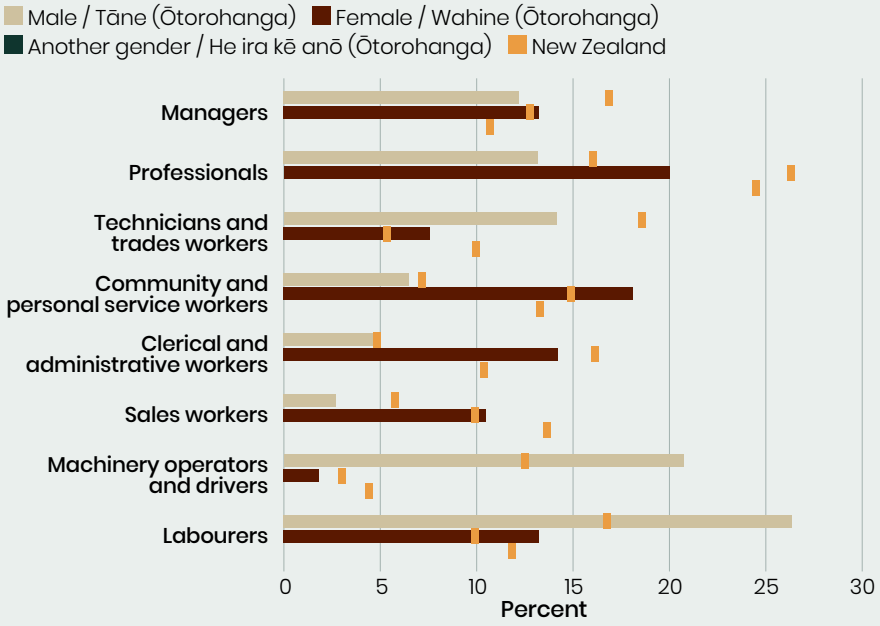
Median personal income ($) of the Māori ethnic group population, by age, Ōtorohanga and New Zealand 2013-2023 Censuses



Among Māori, 49.9 percent are employed full-time and 12.6 percent part-time. Unemployment sits at 7.3 percent, while 30.8 percent are not in the labour force. While workforce participation is steady, employment alone does not remove financial pressure, particularly where income levels remain below national averages.

Workforce participation reflects both gendered employment patterns and the physical nature of local work.

Percentage of Māori ethnic group population by gender. By occupation, Ōtorohanga and New Zealand 2023 Census



Among Māori tāne in Ōtorohanga:

- 26.4 percent are employed as labourers
- 20.8 percent as machinery operators and drivers
- 14.2 percent as technicians and trades workers
- 12.3 percent as managers
- 13.2 percent as professionals

Among Māori wāhine:

- 20 percent are employed as professionals
- 18.1 percent in community and personal service roles
- 14.3 percent in clerical and administrative work
- 13.3 percent as managers
- 13.3 percent as labourers

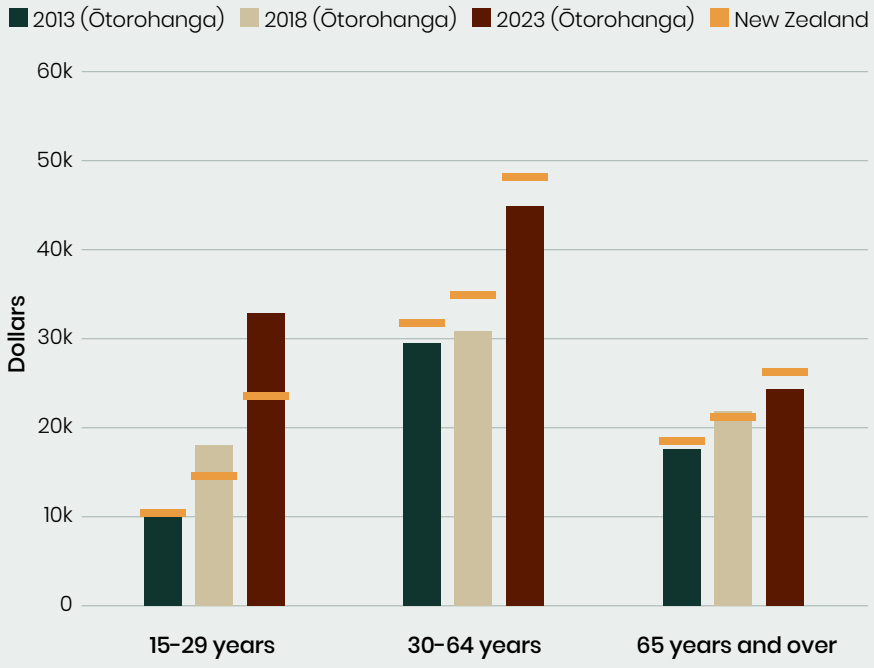
Compared with national Māori patterns, Ōtorohanga has:

- Higher proportions of Māori tāne in labouring and machinery roles
- Lower proportions in professional and managerial roles
- Strong representation of Māori wāhine in service and caring occupations

These patterns matter. High representation in physically demanding occupations increases injury risk and long-term musculoskeletal strain. Shift-based and manual roles can also limit flexibility for attending appointments, managing chronic conditions, or accessing preventive services.

When combined with income levels that sit below national Māori averages, employment does not necessarily translate into financial security. Instead, many whānau are balancing physically demanding work with transport costs, caregiving responsibilities, and rising living expenses.

Median personal income ($) of the Māori ethnic group population. by age, Ōtorohanga and New Zealand 2013-2023 Censuses



Median personal income for Māori aged 30–64 years in Ōtorohanga is $45,100, below the Median personal income for Māori aged 30–64 years in Ōtorohanga is $45,100, below the national Māori median of $48,700.

For Māori aged 15–29 years, median income is $33,100, and for those aged 65 years and over it drops to $24,600.

This age gradient is important. Younger Māori are entering the workforce in lower-income roles, while older Māori rely on more limited fixed incomes. Working-age adults earn below national Māori averages, despite high participation in physically demanding occupations.

Median household income across Ōtorohanga District is $76,900, compared with $97,000 nationally. In a district where private transport is essential and fuel costs are ongoing, this income gap influences everyday decisions about health care, prescription uptake, follow-up appointments, and preventive care.

Income does not sit in isolation. When combined with high representation in manual occupations and concentrated deprivation, financial flexibility remains constrained for many whānau. This shapes patterns of delayed care and unmet need over time.

Te Tirohanga ki Ngā Whare Noho | Housing Snapshot

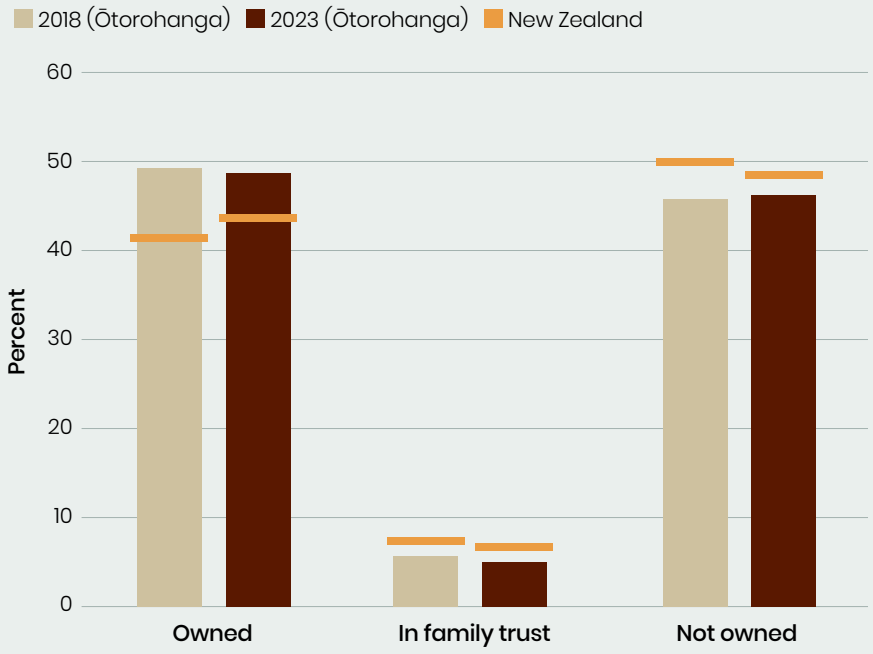
Housing in Ōtorohanga is shaped by limited supply and an ageing housing stock. Availability of larger homes is constrained, and options for social housing are fewer than in larger centres.

Ngāti Maniapoto – Te Nehenehenui

Among Māori households in Ōtorohanga:

- 48.8 percent own their home
- 46.3 percent live in non-owned housing
- 4.9 percent hold housing in family trusts

Percentage of households with at least one Māori ethnic group member, by tenure type, Ōtorohanga and New Zealand 2013-2023 Censuses



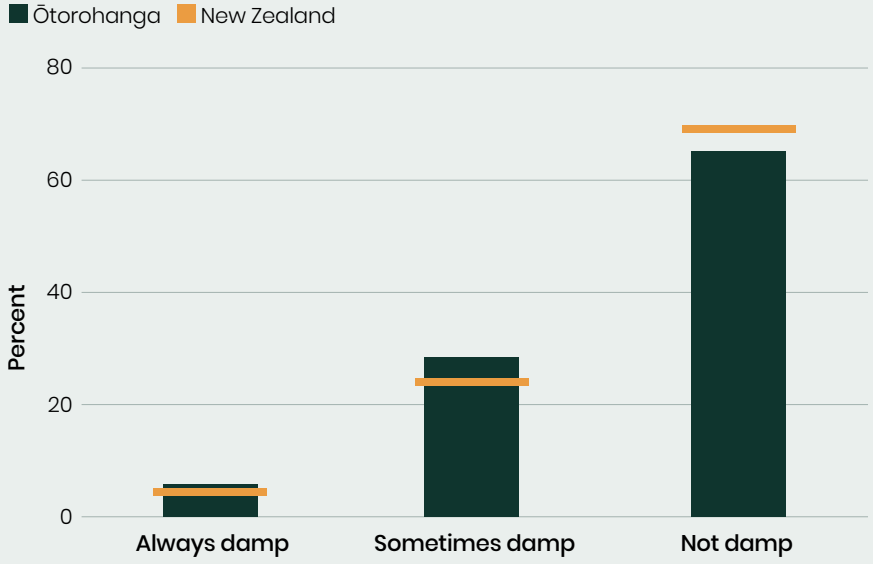
While ownership and rental rates sit relatively close together, nearly half of Māori households remain exposed to rent increases and reduced housing stability.

Median weekly rent for Māori households has increased from $230 in 2018 to $340 in 2023. Although lower than some urban centres, this rise is significant when considered alongside lower household incomes and the additional cost of transport.

Housing condition remains an important determinant of health. Among Māori households in Ōtorohanga:

- 6.1 percent report always damp housing
- 29 percent report sometimes damp housing
- 6.8 percent report visible mould always present
- 19.5 percent report visible mould sometimes present

Percentage of households with at least one Māori ethnic group member, by dwelling dampness indicator, Ōtorohanga and New Zealand 2023 Census



Cold or damp homes increase respiratory illness risk and contribute to avoidable primary care demand, particularly for tamariki and kaumātua. Housing quality and stability therefore have direct implications for local health service pressure.

Ngā Paetohu | Key Indicators

Indicator	What this looks like in Ōtorohanga	Why this matters for hauora
Deprivation concentration	54.3% of Māori live in NZDep deciles 9–10; none in deciles 1–6.	Over half of Māori live in the highest deprivation deciles (9–10). Deprivation is heavily concentrated and shapes housing quality, income stability, and access to care.
Employment status	49.9% employed full-time; 12.6% part-time; 7.3% unemployed; 30.8% not in the labour force.	Workforce participation is steady, but nearly one third are not in the labour force. Income instability affects care continuity and household resilience.
Occupation profile	26.4% labourers; 20.8% machinery operators and drivers; 14.2% trades workers.	High representation in physically demanding roles increases injury risk and may limit flexibility for appointments and long-term condition management.
Income levels	Median personal income (30–64 Māori) $45,100 vs $48,700 nationally; median household income $76,900 vs $97,000 nationally.	Lower-than-national income reduces financial flexibility in a transport-dependent district and influences when care is accessed.
Housing stability	46.3% of Māori households live in non-owned housing; median rent $340 (up from $230 in 2018).	Rental exposure and rising costs increase housing insecurity and reduce financial capacity for preventive care.
Housing condition	35% report damp housing; 26% report visible mould.	Housing quality directly influences respiratory health and avoidable primary care use.

Source: Stats NZ Census 2023; NZDep 2023.

Kitenga 1: Ngā Ārai kia uru moata | Finding 1: Barriers to timely access and early engagement

Ko tā mātou e kite ana - What we are seeing

Ōtorohanga operates within a thin rural service base. Services are present, but many are not permanently embedded in town. Specialist, AOD, and some youth supports rely on travel to Te Awamutu or Te Kūiti, or operate through visiting models.

Māori enrolment spans all age groups locally. However, when compared with Census population figures, total enrolment suggests that a portion of the Māori population may not be reflected in local PHO registration. While Census and PHO measures are not identical, the difference raises questions about under-enrolment, mobility, or inconsistent continuity with primary care.

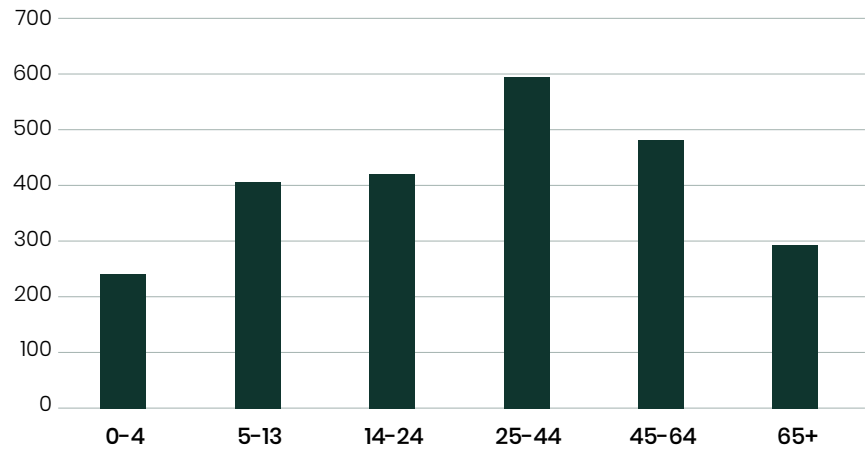


Figure 5. Enrolled Māori Population by Age Cohort – Ōtorohanga/Kāwhia PHO. Data source: Primary care data extract

The closure of the local X-ray service in January 2026 removed consistent local diagnostic access. Weekly sonography clinics for hapū māmā had previously been fully booked. Imaging now requires travel outside the district, increasing cost and coordination pressure.

Referral timing requirements and eligibility thresholds further shape continuity. When processes are not completed immediately, whānau can fall out of support.

Ko tā te whānau i kite ai – What this looks like for whānau

For many whānau, accessing care is not a single appointment — it is a chain of barriers.

> **"You can have whānau travelling all that way for a hospital appointment that's only ten minutes long."**

Travel means arranging petrol, time off work, childcare, and navigating transport systems that are not always straightforward.

> **"Community transport and St John can be really hard for whānau to navigate."**

For young māmā and rangatahi, transport is often the first barrier.

> **"A lot of our young māmā don't have cars, so organising transport is always difficult."**

In a small-town setting, visibility also shapes engagement. Walking into a service can feel exposed. For some rangatahi, this contributes to avoidance.

Engagement in Ōtorohanga is not simply delayed, and it is often fractured. Providers describe persistent non-attendance, disengagement from follow-up, and re-presentation only at crisis point. Cost, travel, system rigidity, and broken trust compound over time. For some whānau, the system no longer feels responsive or worth the effort required to access it.

Ko te kōrero mai a ngā ratonga - What providers are telling us

Across primary care, public health, AOD, and youth services, the message is consistent: engagement is inconsistent and frequently crisis-driven.

> **"Ōto sits between services that are located in Te Awamutu and Te Kūiti."**

> **"A lot of our whānau don't come in regularly — they come when things are already really bad."**

Providers describe a system where geography, funding rules, and timing requirements shape whether care continues.

> **"If referrals aren't done straight after the appointment, we can't keep people on the books — that puts pressure on both whānau and clinicians."**

This creates a cycle where missed appointments lead to discharge, discharge leads to disengagement, and re-entry often happens only once health has deteriorated.

Ko ngā take i hirahira ai - Why this matters

When engagement is fractured, prevention collapses. Care shifts from early intervention to reactive management. Travel burden increases, coordination weakens, and escalating complexity is absorbed within primary care. In a system with limited embedded specialist depth, disengagement compounds pressure quickly.

Access and trust are not peripheral issues in Ōtorohanga — they are central determinants of when and how whānau receive care.

Kitenga 2: He nui ngā Mate Tauroa me te Tōmuri kia tae ngā Whare Haumanu | Finding 2: High Chronic Condition Burden and Late Clinical Presentation

Ko tā mātou e kite ana - What we are seeing

PHO data confirms a significant and established burden of chronic conditions among Māori in Ōtorohanga and Kāwhia.

Diabetes is concentrated across adult age groups, predominantly Type 2. Pre-diabetes numbers remain high, signalling an active prevention window that is narrowing. Cardiovascular events increase from mid-life onwards. Gout rises steadily through adulthood. Asthma spans all age groups, including tamariki and rangatahi.

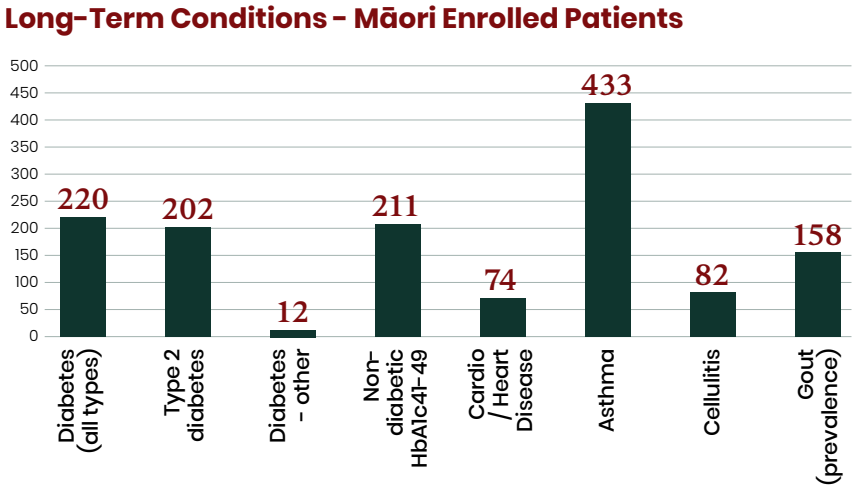


Figure 6. Selected Long-Term Condition Counts – Māori Enrolled Patients. Data source: Primary care data extract. Source: New Zealand Health Survey, Ministry of Health. Waikato regional Māori adult estimates (indexed to NZ Māori = 100)

Smoking prevalence increases sharply from adolescence into adulthood, reinforcing cardiovascular and respiratory risk across the life course.

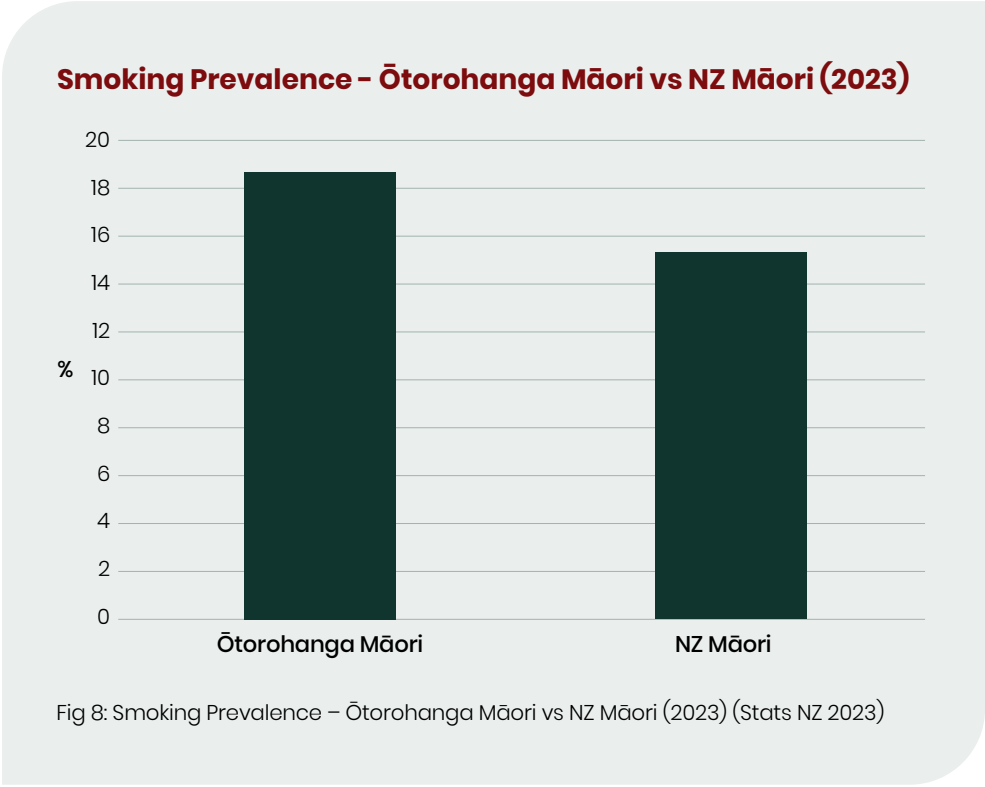


Fig 8: Smoking Prevalence – Ōtorohanga Māori vs NZ Māori (2023) (Stats NZ 2023)

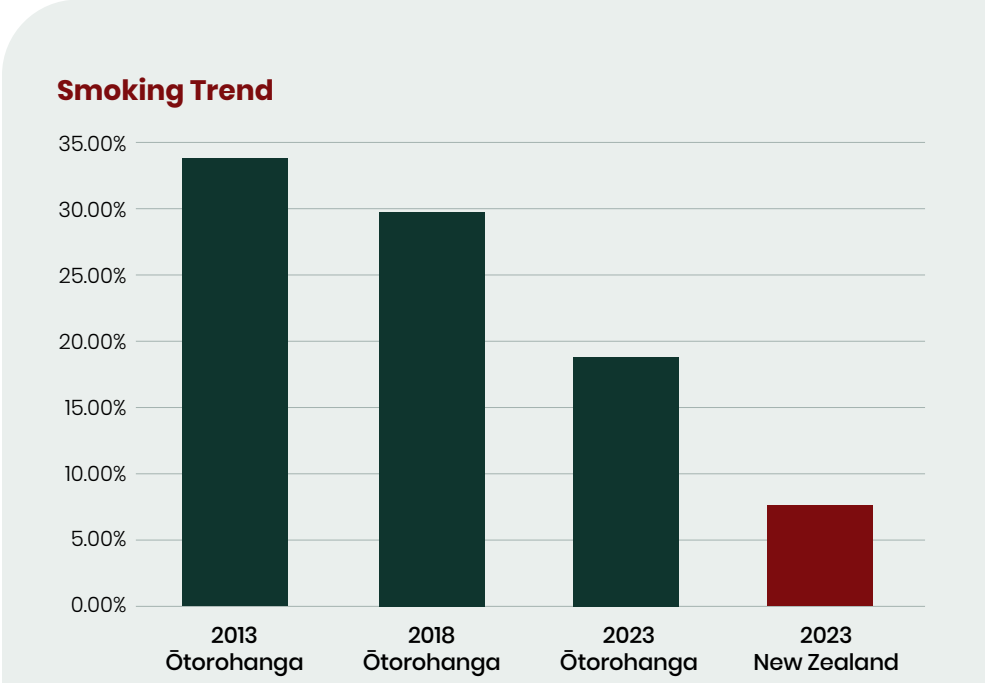


Figure 9. Smoking Trend – Ōtorohanga Māori (2013–2023) (Stats NZ 2023)

Regionally, long-term condition burden among Waikato Māori exceeds the national Māori average in several areas. Mental health diagnoses and referrals sit alongside these conditions, meaning risk is layering rather than occurring in isolation. Chronic disease in Ōtorohanga is not emerging, it is already embedded.

Long-Term Condition Burden - Waikato Māori vs NZ Māori (index = 100)

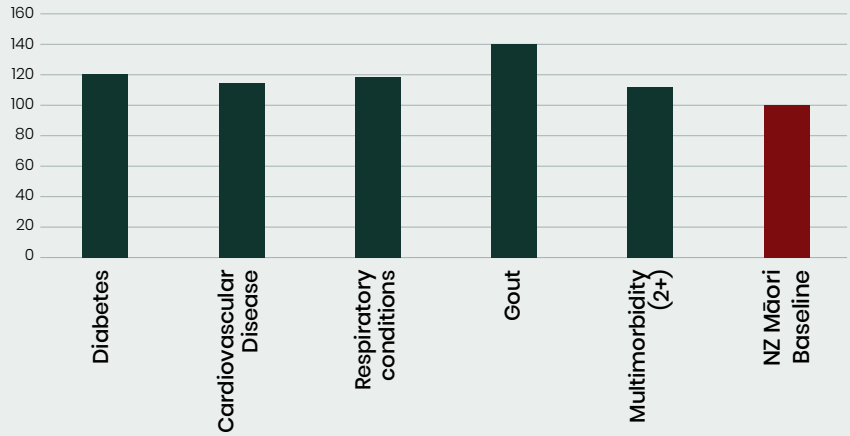


Fig 10: Long-Term Condition Burden – Waikato Māori vs NZ Māori (Index = 100) Waikato Māori adults experience higher rates of several long-term conditions relative to the national Māori average (Index = 100 baseline).

Activity limitation increases with age, reinforcing the cumulative impact of chronic disease across the life course. Chronic disease in Ōtorohanga is not emerging, it is already embedded and progressing.

Activity limitation by age

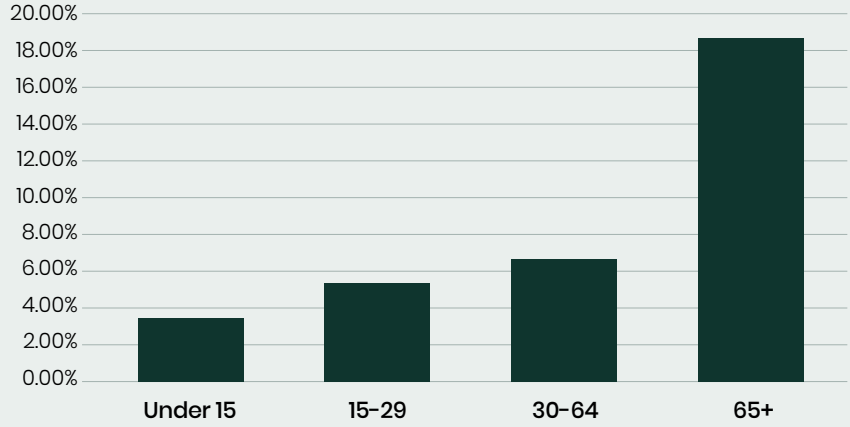


Figure 11. Activity Limitation by Age – Ōtorohanga (Stats NZ 2023)

Ko tā te Whānau i kite ai - What this looks like for whānau

For many whānau, chronic conditions are not diagnosed early. They are discovered once conditions are frequently identified once symptoms are already affecting daily life.

> **"We see very high HbA1c levels - some whānau are presenting with levels over 100."**

By the time diabetes is detected, management becomes intensive: medication escalation, glucose monitoring, dietary education, and complication screening all at once.

Respiratory illness is persistent across age groups.

> **"Respiratory issues are something we see a lot as well, across all ages."**

Smoking remains visible from adolescence into adulthood, reinforcing risk layering.

Chronic disease often sits alongside housing stress, financial strain, and mental health pressure. Whānau are managing multiple conditions while also navigating transport and cost barriers. Prevention becomes secondary to survival.

Ko te kōrero mai a ngā ratonga - What providers are telling us

Providers describe chronic disease as a sustained workload rather than occasional presentation.

> **"There's no diabetes nurse down here."**

> **"Diabetes alone could take Monday to Friday with the amount of education and support that's needed."**

Without locally embedded specialist roles, diabetes education and escalation support are absorbed into general practice and nursing capacity.

Providers consistently report late clinical presentation.

> **"By the time they come in, it's already really high."**

Smoking cessation referrals are made, but uptake does not match prevalence. Monitoring often depends on relational continuity and whether whānau return.

Ko ngā take i hirahira ai - Why this matters

Late presentation shifts care from prevention to escalation. High pre-diabetes levels signal future diabetes growth. Smoking prevalence compounds cardiovascular and respiratory burden. Without earlier screening, sustained engagement, and embedded specialist support, chronic disease pressure will continue to intensify within a workforce already stretched.

In Ōtorohanga, chronic condition management is not a future risk, it is a current strain.

Kitenga 3: Nui noa atu ngā mate Hauora Hinengaro, Warawara hoki | Finding 3: Mental Health and Addiction Demand Exceeds Local Infrastructure

Ko tā mātou e kite ana - What we are seeing

Mental health and addiction demand in Ōtorohanga is sustained, layered, and increasing in complexity.

PHO data shows ongoing referrals to primary mental health services across youth and adult age groups. Severe mental health diagnoses are recorded from early adulthood onwards. Providers indicate that recorded data likely under-represents actual need.

There is no permanently embedded adult AOD service in Ōtorohanga. Support is delivered regionally or through visiting models. Engagement often depends on travel, availability, or short-term contracts.

Methamphetamine use remains highly visible across Ōtorohanga and surrounding communities. Addiction presentations frequently intersect with trauma exposure, housing stress, financial pressure, and justice involvement.

Post-treatment pathways are limited. Once eligibility thresholds are no longer met, structured support often reduces — even when vulnerability remains.

Ko tā te Whānau i kite ai - What this looks like for whānau

Mental health and addiction presentations are rarely isolated.

> **"PTSD is mainly through crisis. We're working with a lot of trauma, sexually abused girls."**

> **"There's quite a bit of relapse for rangatahi too – AOD relapse."**

Methamphetamine use was described as widespread and increasingly visible.

> **"We're seeing drug-induced psychosis. Meth use in Ōto, Te Kūiti, Maniapoto – it's huge."**

The impact extends beyond the individual.

> **"Meth has a ripple effect – health, finances, whānau."**

Concerns were raised about prenatal exposure and developmental impact.

> **"Mamas smoking while hapū. FASD and meth babies – the number will start rising."**

When formal treatment ends, support often drops away.

> **"After treatment, AOD – what happens then? Whānau are still struggling."**

Ko te kōrero mai a ngā ratonga - What providers are telling us

Providers describe infrastructure that does not match the level of acuity.

There is no permanent AOD base embedded in Ōtorohanga. Engagement often depends on travel, visiting clinicians, or short-term programmes.

Eligibility thresholds determine who can remain in service.

> **"They don't meet the criteria anymore, but they still need help. When they don't hit the criteria or tick the boxes, they fall through the cracks."**

Engagement is often crisis-driven rather than preventative.

> **"Whānau don't know we're here until they really need the service."**

Mental health and addiction demand in Ōtorohanga is sustained, trauma-linked, and increasing in complexity.

Ko ngā take i hirahira ai - Why this matters

In the absence of embedded AOD infrastructure, relapse risk increases and continuity weakens. Trauma, addiction, housing stress, and youth vulnerability are intersecting within a system that is structurally thin. When eligibility thresholds dictate support rather than need, vulnerability compounds.

Ōtorohanga is not experiencing isolated mental health presentations, it is managing cumulative addiction and trauma pressure within limited infrastructure.

Kitenga 4: Maunutanga Rangatahi, Kohuki, me te iti o ngā Tūāhanga Taiohi

| Finding 4: Rangatahi Disengagement, Trauma and Limited Local Youth Infrastructure

Ko tā mātou e kite ana - What we are seeing

Rangatahi in Ōtorohanga are presenting with layered and sustained need.

Youth services supporting Ōtorohanga are not all physically based in town. Some contracts sit locally, but delivery occurs from Te Kūiti or surrounding centres. This creates access gaps, particularly for rangatahi without reliable transport or stable whānau support.

Education disengagement is not short-term. Providers describe young people who have been out of kura for extended periods before reconnecting with any formal service. Foundational literacy gaps are visible among some rangatahi accessing programmes.

Youth presentations frequently intersect with trauma exposure, anxiety, ADHD, addiction exposure, justice involvement, and housing instability. Prevention initiatives have existed locally, but sustained infrastructure remains limited.

Ko tā te Whānau i kite ai - What this looks like for whānau

Youth services are often the first consistent point of contact after long periods of disengagement.

> **"We've got kids who go years without being in kura, and we're often the first ones to actually see them when they finally come through."**

Programmes must be adapted to meet rangatahi where they are.

> **"We tailor our licensing programme. Some can't read or write."**

Trauma sits underneath many presentations.

> **"Trauma is the biggest thing for our rangatahi."**

> **"Anxiety and ADHD are everywhere, heaps of it."**

Some rangatahi are carrying adult responsibilities prematurely.

> **"We've got 16-year-olds living like adults, on their own... They shouldn't have to live like this."**

Short-term initiatives have shown impact, but continuation is inconsistent.

> **"Mau rākau was a big hit in Ōto. It was effective... but the continuation of the wānanga and hui just doesn't happen."**

Ko te kōrero mai a ngā ratonga - What providers are telling us

Youth need intersects with justice and addiction systems.

> **"Kids shouldn't be in jail. They should be in rehab."**

Providers describe visiting rangatahi in jail and advocating in court, often becoming the most consistent adult in their lives.

Relational access remains central.

> **"You've got to get to the matriarch of the whānau to get your foot in the door."**

Despite strong relationships, youth infrastructure is not deeply embedded or resourced at the level of need. Engagement can be strong when relationships are built — but consistency depends heavily on workforce capacity and programme continuity.

Ko ngā take i hirahira ai - Why this matters

When trauma, educational disengagement, addiction exposure, and housing instability intersect early in life, escalation risk increases. Without stable, locally embedded youth infrastructure and sustained prevention models, disengagement deepens and vulnerability compounds.

Rangatahi in Ōtorohanga are not disengaged by choice. They are navigating layered pressure within limited support systems.

Ōtorohanga College, the local secondary school supporting rangatahi education.

Kitenga 5: Ngā Ara o Te Whare Kōhanga me ngā Paraheahea | Finding 5: Maternal Pathways, Young Māmā and Early Whānau Vulnerability

Ko tā mātou e kite ana - What we are seeing

Ōtorohanga is supporting a significant number of young māmā within a small population base. Providers report more than 40 young wāhine pregnant within a nine-month period, including those under 18.

Local initiatives, including early trimester programmes and hospital-to-home transition support, have strengthened engagement. However, specialist and diagnostic pathways remain fragile.

The closure of the local X-ray and imaging service in January 2026 removed consistent local sonography access. Weekly sonography clinics for hapū māmā had previously been fully booked. Imaging now requires travel outside the district.

Maternal care relies heavily on nursing-led coordination. Communication between midwives, general practice, and external specialists is not always seamless. Transport barriers remain significant, particularly for young māmā without reliable vehicles.

Immunisation coverage at key early milestones remains below optimal levels, increasing preventable vulnerability in infancy.

Ko tā te Whānau i kite ai - What this looks like for whānau

> **"We've had over 40 young māmā pregnant in the last nine months, including under 18s — that's a big number for a small town."**

> **"A lot of our young māmā don't have cars, so organising transport is always difficult."**

For many young māmā, appointments involve coordinating petrol, time off work, childcare, and travel across multiple towns. Where diagnostic services were once local, travel is now required — increasing cost and logistical strain at a critical time.

Hospital-to-home transitions require active follow-up for medication understanding, immunisation scheduling, breastfeeding support, and recovery. Without stable transport or housing, continuity becomes fragile.

Ko te kōrero mai a ngā ratonga - What providers are telling us

Providers describe maternal support as intensive and relational. Nursing teams frequently act as the central coordination point between midwives, specialists, and whānau. Funding support through Maniapoto Marae Pact Trust has strengthened Māori-focused engagement and earlier connection with services.

However, infrastructure depth remains limited. Diagnostic access is no longer local. Workforce capacity is thin. Continuity depends heavily on individuals holding relationships together.

Ko ngā take i hirahira ai - Why this matters

Pregnancy and early infancy shape long-term health trajectories. When young māmā face transport barriers, reduced diagnostic access, and fragmented pathways, risk increases for both mother and pēpi.

In Ōtorohanga, maternal care sits within a small system where continuity depends on coordination and relationship rather than structural depth. Strengthening local diagnostic access, transport support, and workforce stability will be critical to improving early-life outcomes for Māori whānau.

Kitenga 6: Te Raukaha o te Hunga Mahi me te Mehameha o te Pūnaha ā-Tuawhenua | Finding 6: Workforce Capacity and System Fragility in a Rural Setting

Ko tā mātou e kite ana - What we are seeing

The health and social service system in Ōtorohanga is small and workforce-dependent.

Primary care is heavily nurse-led. Chronic condition management, immunisation follow-up, maternal coordination, and hospital-to-home transitions are largely absorbed locally.

There is no dedicated diabetes nurse. There is no permanently embedded adult AOD service. Youth contracts are held locally but not always delivered locally. Specialist services are largely accessed outside the district. Diagnostic capacity reduced significantly following the closure of local imaging services in January 2026.

Recruitment and retention remain ongoing challenges. Visiting models and short-term contracts fill gaps, but do not provide depth. Funding thresholds and eligibility criteria shape who can access support and for how long.

The system continues to function, but it operates with limited redundancy.

Ko tā te Whānau i kite ai - What this looks like for whānau

When workforce capacity is thin, access depends on availability rather than need.

Visiting services may operate monthly. Missed appointments can mean extended delays before the next clinic. Specialist follow-up often requires travel. Without reliable transport, continuity weakens.

Eligibility criteria determine continuation of support. When thresholds are no longer met, services reduce — even when vulnerability remains.

In a small-town setting, visibility can also shape engagement. Confidentiality concerns affect help-seeking behaviour, particularly for rangatahi.

Ko te kōrero mai a ngā ratonga - What providers are telling us

Youth need intersects with justice and addiction systems.

> **"There's no diabetes nurse down here."**

> **"The move to a national system has been really messy. Not knowing who your manager is or what's changing makes things difficult for staff."**

Referral rigidity compounds strain.

> **"If referrals aren't done straight after the appointment, we can't keep people on the books — that puts pressure on both whānau and clinicians."**

Despite this, collaboration across providers remains strong. Relational bridges help mitigate fragmentation. However, reliance on goodwill rather than structural depth leaves the system vulnerable.

Ko ngā take i hirahira ai - Why this matters

Ōtorohanga does not have multiple layers of backup. When workforce capacity tightens, impact is felt quickly.

Limited specialist embedding, reliance on visiting services, funding rigidity, and transport dependency create fragile continuity. In a locality already managing chronic disease burden, mental health demand, youth vulnerability, and maternal coordination, thin infrastructure increases the risk of escalation.

Strengthening workforce depth and stabilising locally embedded services will be essential to sustaining equitable care for Māori whānau.

He Karanga kia Mahia
| Call to Action

This section outlines the changes whānau want to see first in Ōtorohanga and Kāwhia. These priorities reflect the realities of rural isolation, cost pressures, long waits, limited local services, and the need for culturally grounded, trusted care.

1. Whakaitihia te Uru Tōmuri ki ngā Whare Haumanu | Reduce Late Clinical Presentation in Chronic Disease

Rangona ai ngā whānau i te aha? – What whānau are experiencing

- Very high HbA1c levels at first presentation.
- Pre-diabetes present but not consistently followed up.
- Smoking compounding cardiovascular and respiratory risk.

Me tīni i te aha kia whakapai ake ai? – What needs to change

Shift from opportunistic management to structured, proactive follow-up.

Ko te āhua ka pēneitia? What this could look like locally

- Fund a dedicated 0.6–1.0 FTE diabetes / long-term condition nurse in Ōtorohanga
- Automatic recall and 3-monthly follow-up for HbA1c > 64 mmol/mol
- Structured cardiovascular risk screening for Māori 30+
- Embedded smoking cessation referral at every chronic condition review
- Protected prevention clinic hours within primary care

2. Whakarauoratia te uru ki te aromatawai – Restore Local Diagnostic Access

Rangona ai ngā whānau i te aha? – What whānau are experiencing

- Travel for imaging following closure of the local X-ray service.
- Hapū māmā travelling for scans previously available locally.
- Delayed diagnostics contributing to escalation.

Me tīni i te aha kia whakapai ake ai? – What needs to change

Reintroduce accessible local diagnostic capacity.

Ko te āhua ka pēneitia? What this could look like locally

- Mobile imaging service operating weekly in Ōtorohanga
- Funded outreach sonography sessions for hapū māmā
- GP-direct imaging booking pathways to reduce referral lag
- Diagnostic transport support bundled with referral

3. Whakapūmautia te AOD me te Tiaki Rongoā | Stabilise AOD and Post-Treatment Continuity

Rangona ai ngā whānau i te aha? – What whānau are experiencing

- Methamphetamine-related relapse.
- No permanent AOD base in town.
- Drop-off when eligibility criteria are no longer met.

Me tīni i te aha kia whakapai ake ai? – What needs to change

Embed continuous, trauma-informed AOD support.

Ko te āhua ka pēneitia? What this could look like locally

- Fund a permanently based AOD clinician in Ōtorohanga
- 6–12 month structured relapse-prevention follow-up post-treatment
- Integration of AOD screening within primary care appointments
- Clear referral re-entry pathways when relapse occurs

4. Whakakahangia ngā ara ki te Whare Hauora ki te Whare Kōhanga hoki – Strengthen Maternal and Early-Life Clinical Pathways

Rangona ai ngā whānau i te aha? – What whānau are experiencing

- High numbers of young māmā.
- Travel for scans.
- Transport barriers delaying appointments.
- Immunisation drop-off after infancy.

Me tīni i te aha kia whakapai ake ai? – What needs to change

Protect early-life pathways through embedded support.

Ko te āhua ka pēneitia? What this could look like locally

- Mobile ultrasound clinic fortnightly
- Funded transport vouchers for hapū māmā
- Nurse-led hospital-to-home follow-up within 72 hours postpartum
- Immunisation recall system with active follow-up beyond 6 weeks
- Midwife vaccination scope expansion

5. Whakamahea te Uru Mā Tāwariwari o te Haumanu – Improve Access Through Clinical Flexibility

Rangona ai ngā whānau i te aha? – What whānau are experiencing

- Delayed GP access.
- Referral timing rigidity.
- Missed appointments resulting in discharge from services.

Me tīni i te aha kia whakapai ake ai? – What needs to change

Introduce flexibility within rural referral and booking models.

Ko te āhua ka pēneitia? What this could look like locally

- Protected same-day acute appointment slots
- Extended appointment times for multi-condition whānau
- 2-week referral grace periods before discharge
- Dedicated whānau navigation role embedded in primary care

6. Me aro ki te Mate Hinengaro o te Rangatahi me te Kohuki | Address Rangatahi Mental Health and Trauma Early

Rangona ai ngā whānau i te aha? - What whānau are experiencing

- Long-term kura disengagement.
- Trauma-linked anxiety and ADHD.
- Youth justice involvement.
- Relapse in rangatahi.

Me tīni i te aha kia whakapai ake ai? - What needs to change

Shift from crisis response to structured early intervention.

Ko te āhua ka pēneitia? What this could look like locally

- Embedded youth clinician physically based in Ōtorohanga
- Trauma-informed screening within school-linked clinics
- Court-linked health navigation support
- Sustained kaupapa Māori youth wānanga (minimum 12-month funding cycles)

7. Whakapakaritia te hohonutanga o te Rāngaimahi o te Tuawhenuahuki | Strengthen Rural Workforce Depth

Rangona ai ngā whānau i te aha? - What whānau are experiencing

- No diabetes nurse.
- Heavy reliance on practice nurses.
- Visiting specialist model only.
- Ambulance delays.

Me tīni i te aha kia whakapai ake ai? - What needs to change

Increase workforce depth and reduce single-point fragility.

Ko te āhua ka pēneitia? What this could look like locally

- Fund permanent long-term condition nurse role
- Rural retention incentives for clinicians
- Locally based Māori workforce development scholarships
- Telehealth specialist clinics supported by on-site nurse facilitators

8. Whakapakaritia Whakatere Whānau me te Hāngai o te Pūnaha - Strengthen Whānau Navigation and System Coordination

Rangona ai ngā whānau i te aha? - What whānau are experiencing

- Confusion around referrals, eligibility, and next steps.
- Missed appointments without follow-up.
- Fragmented communication between GP, midwifery, hospital, AOD, and youth services.
- Repeated storytelling across services.
- Discharge from services when referral timing thresholds are not met.

Me tīni i te aha kia whakapai ake ai? - What needs to change

Embed structured navigation support within primary and community care so whānau are not expected to manage complex rural pathways alone.

Ko te āhua ka pēneitia? What this could look like locally

- Fund a dedicated whānau navigation role embedded within primary care in Ōtorohanga
- Automatic follow-up contact within 48–72 hours of missed appointments
- Shared care plans across primary care, maternity, AOD, and youth services
- Referral re-entry pathways that prevent discharge due to timing rules
- Appointment preparation and discharge debrief support for high-needs whānau

9. Whakapakaritia te Mātauranga Hauora, te Reo Matatini, me te Whakawhirinakitanga - Strengthen Health Education, Literacy and Trust

Rangona ai ngā whānau i te aha? - What whānau are experiencing

- Limited understanding of conditions like diabetes, heart risk, and mental health pathways.
- Confusion about referrals, eligibility, and follow-up.
- Uncertainty about what services exist locally.
- Reduced trust in the system, leading to delayed engagement.
- Whānau often only present when symptoms become severe.

Me tīni i te aha kia whakapai ake ai? - What needs to change

Health education and navigation must be proactive, culturally grounded, and ongoing — not delivered only at diagnosis or crisis point.

Ko te āhua ka pēneitia? What this could look like locally

- Dedicated whānau education sessions for diabetes, heart health, mental health and AOD
- Plain-language care plans provided after every diagnosis
- Follow-up calls to check understanding, not just attendance
- Community-based education wānanga delivered in trusted spaces
- Consistent clinician continuity to build trust over time

Cervical Screening Coverage - Māori (25-69)

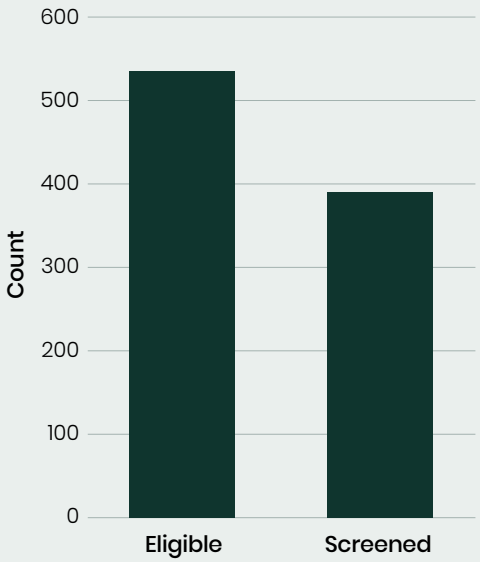


Fig 11: Cervical Screening Coverage – Māori (25–69) Data source: Primary care data extract

Bowel Screening Participation — Māori Ōtorohanga (2022-2025)

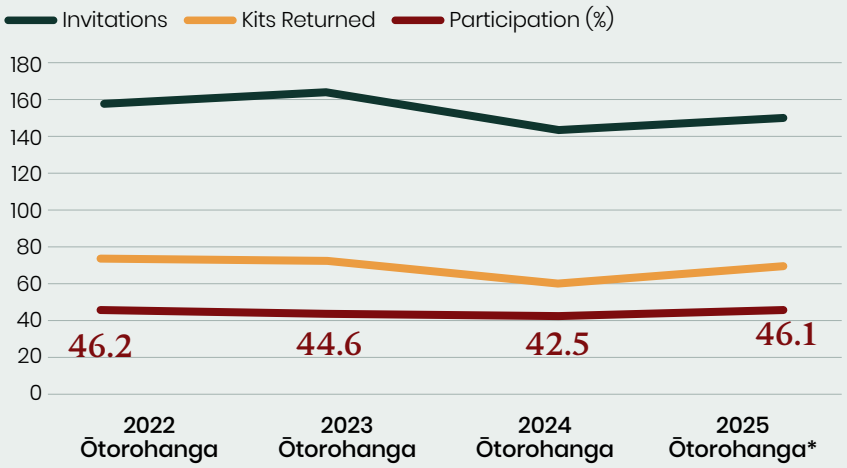


Fig 12 Source Health NZ

Breast Screening Coverage — Māori Ōtorohanga (2022-2025)

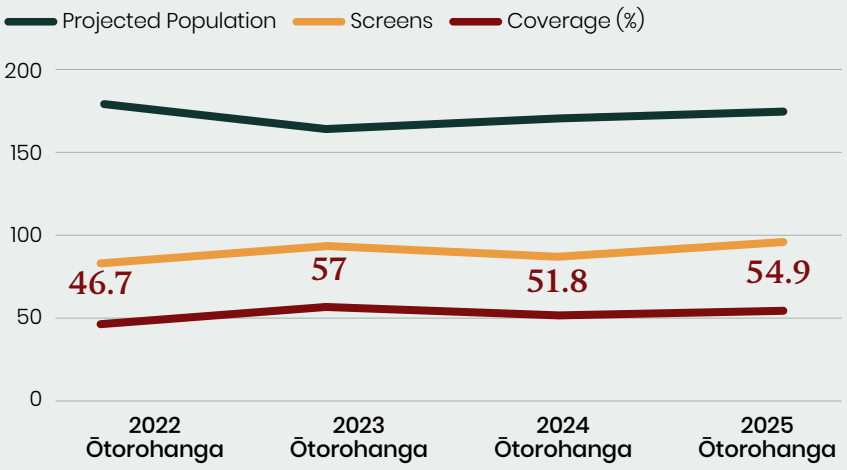


Fig 13 Source Health NZ

Cervical Screening Coverage — Māori Ōtorohanga (2022-2025)

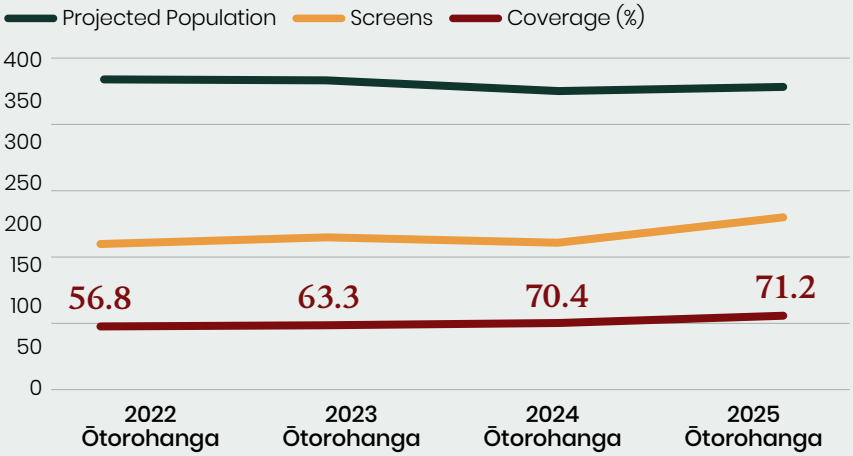


Fig 14 Source: National Cervical Screening Programme Data Warehouse, Health NZ; Stats NZ population projections. Extracted 10 February 2026. Ethnicity prioritised Māori. Coverage calculated as screens divided by projected eligible population based on HPV test date. *2025 data preliminary due to 6-month kit return window.*

Housing Quality Indicators

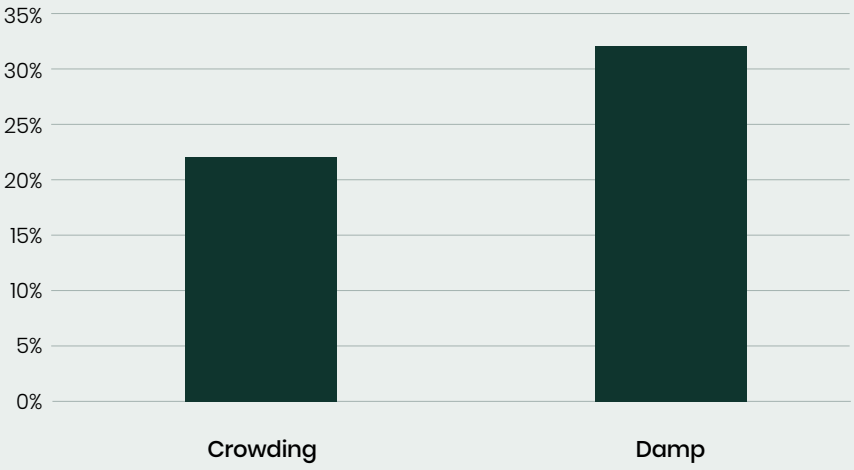


Fig 13 Source Health NZ

Ngā Ratonga Hauora me te Uru | Local Health Services and Access – Ōtorohanga and Kāwhia

Ōtorohanga and Kāwhia are supported by a small but critical network of primary care, kaupapa Māori providers, community services, and regional specialist teams. In a rural district, service depth is limited and much of the system relies on small teams, visiting clinicians, and strong inter-provider relationships.

The organisations below are identified as priority services due to their central role in local access, continuity of care, and support for whānau experiencing higher need.

Te Whare Haumanu o Ōtorohanga | Ōtorohanga Medical Centre

Ōtorohanga Medical Centre is the principal general practice providing primary healthcare to whānau in Ōtorohanga township and surrounding rural King Country communities. It is the central access point for everyday, acute, and preventative care across the district.

The practice delivers GP and nurse-led services, with nurses playing a key role in chronic disease management, immunisation, cervical screening, respiratory care, cardiovascular risk assessment, and preventative monitoring. Onsite pathology services reduce travel burden, and scheduled radiology clinics provide limited local access to X-ray and ultrasound through visiting providers.

While the service provides broad clinical coverage for a rural practice, access can become constrained during peak demand periods. Appointment availability is influenced by workforce capacity, and standard 15-minute consultation funding can limit extended review for complex, multi-condition whānau. Enrolment restrictions also affect new residents seeking to access care.

Cost remains a barrier for some whānau, particularly for repeat consultations and non-funded services, despite Community Services Card subsidies.

Standard GP consultation cost (enrolled adults): approximately $30.50, or $20 with a Community Services Card.

He Pitopito Kōrero - Additional service detail

- Routine and acute GP consultations across all age groups
- Nurse-led clinics for diabetes, respiratory care, cardiovascular risk, and preventative screening
- Childhood and adult immunisations
- Cervical screening (HPV self-test or clinician-collected sample)
- Minor procedures and injury care
- Onsite pathology services
- Scheduled visiting radiology clinics
- Digital access via MyIndici patient portal
- After-hours virtual GP access through Ka Ora Telecare

Kāwhia Health Centre (Te Whare Oranga o Kāwhia)

Kāwhia Health Centre provides primary healthcare to whānau in Kāwhia township and surrounding harbour communities, including Aotea, Maketu, Marokopa, and Te Waitere. As the only local primary care provider in the area, it plays a critical role in maintaining access for geographically isolated whānau.

The clinic operates with a small rural workforce model, including a part-time GP and registered nurses who deliver much of the day-to-day care. Services include general consultations, chronic disease monitoring, immunisation, cervical screening, minor procedures, and referral coordination to regional services.

The clinic's presence significantly reduces the need for travel for routine care. However, specialist services, advanced diagnostics, and pharmacy access require travel outside Kāwhia. Limited GP availability and rural workforce recruitment challenges continue to shape service capacity.

Despite these structural constraints, the service maintains strong relational trust within the community.

Standard GP consultation cost (enrolled adults): approximately $15 for most adult age groups.

He Pitopito Kōrero - Additional service detail

- Routine and acute GP consultations
- Nurse-led chronic disease monitoring (diabetes, respiratory, cardiac)
- Childhood and adult immunisations
- Cervical screening
- Minor procedures and injury care
- ECG and lung function testing
- Mental health referrals
- Referral coordination to Te Awamutu and Hamilton services
- After-hours virtual GP support via Ka Ora Telecare

Mate Hinengaro me te Ratonga Warawara | Mental Health and Addiction Services

Ōtorohanga and Kāwhia are supported by a small but critical network of primary care, kaupapa Māori providers, community services, and regional specialist teams. In a rural district, service depth is limited and much of the system relies on small teams, visiting clinicians, and strong inter-provider relationships.

The organisations below are identified as priority services due to their central role in local access, continuity of care, and support for whānau experiencing higher need.

Ōtorohanga Counselling Services – Whare Awhina

Whare Awhina provides free counselling and social support services for individuals, tamariki, rangatahi, and whānau in Ōtorohanga. The service operates as a low-barrier access point and plays a central role in early intervention and prevention.

In addition to counselling, Whare Awhina functions as a broader community wellbeing hub, supporting whānau experiencing financial stress, housing instability, and social pressures that directly affect health engagement. The service is locally trusted and accessible, but capacity is limited, particularly for more intensive or long-term therapeutic support.

Cost: Free counselling services for eligible residents.

He Pitopito Kōrero – Additional service detail

- Free individual counselling
- Tamariki and rangatahi support
- Whānau-centred counselling
- Budgeting and financial guidance
- Foodbank coordination
- Social service navigation and advocacy
- Referral pathways to regional mental health services

Mate Hinengaro, Mate Warawara o te Tuawhenua ki te Tonga | Rural South Community Mental Health and Addiction Service

Rural South Community Mental Health and Addiction Service, delivered by Te Whatu Ora Waikato and based in Te Awamutu, provides secondary mental health and addiction support for moderate to severe presentations across Ōtorohanga and Kāwhia.

Access is referral-based and prioritised according to acuity. While the service provides specialist assessment, treatment, and follow-up, eligibility thresholds and workforce capacity influence wait times and continuity. Lower-acuity or relapse-prevention support often remains within primary care or community services.

Travel or outreach models are required for most whānau in Ōtorohanga and Kāwhia.

Cost: Publicly funded for eligible referrals.

He Pitopito Kōrero – Additional service detail

- Specialist mental health assessment
- Addiction assessment and treatment
- Multidisciplinary clinical team support
- Crisis response coordination
- Community-based follow-up
- Referral-based access through GP or hospital

Taumarunui Community Kōkiri Trust – Mental Health and Addiction Outreach

Taumarunui Community Kōkiri Trust provides kaupapa Māori mental health and addiction services across the wider rohe, including outreach support for Ōtorohanga residents.

The service delivers culturally grounded counselling, addiction recovery programmes, and whānau-centred therapeutic approaches. Engagement is relational and holistic. While highly valued, delivery depends on outreach models rather than permanent locally embedded clinicians.

Cost: Publicly funded for eligible clients.

He Pitopito Kōrero – Additional service detail

- Kaupapa Māori addiction counselling
- Whānau-centred recovery programmes
- Trauma-informed support
- Mirimiri and culturally grounded therapeutic approaches
- Outreach delivery into Ōtorohanga

Kaupapa Māori Health Services

Ngā Puna o Wairere – Rongoā Māori

Ngā Puna o Wairere provides ACC-registered rongoā Māori services, including mirimiri and holistic healing grounded in tikanga Māori. The service supports physical, emotional, and wairua wellbeing for whānau managing pain, injury recovery, stress, and long-term conditions.

The service is community-based and relational. Capacity is limited by practitioner availability and ACC session caps.

Cost: ACC-covered for approved claims; private sessions available.

He Pitopito Kōrero – Additional service detail

- ACC-registered rongoā Māori
- Mirimiri and holistic healing
- Support for injury recovery
- Pain management
- Stress and trauma support
- Community-based delivery

Ngāti Maniapoto Marae Pact Trust

Ngāti Maniapoto Marae Pact Trust provides kaupapa Māori mental health, addiction, housing, and whānau ora services across the Maniapoto rohe, including Ōtorohanga residents.

The service supports whānau experiencing complex health and social needs, working across housing, mental health, addiction, and community wellbeing. Much of the delivery is regional or outreach-based rather than permanently embedded in Ōtorohanga.

Cost: Publicly funded for eligible programmes.

He Pitopito Kōrero – Additional service detail

- Kaupapa Māori mental health support
- Addiction services
- Supported accommodation
- Whānau ora navigation
- Social and housing support
- Community-based programmes

Te Tiaki Kaumātua, Hauā hoki | Aged Care and Disability Services

Te Kāinga o Beattie me te Hōhipera – Beattie Home and Hospital

Beattie Home and Hospital is the primary aged-care provider in Ōtorohanga, delivering residential and hospital-level care for kaumātua and adults requiring ongoing clinical oversight.

The facility supports long-term care, respite, rehabilitation, and end-of-life care. Demand is influenced by population ageing and limited alternative local facilities.

Cost: Funded through residential care subsidies and private contributions.

He Pitopito Kōrero – Additional service detail

- Residential aged care
- Hospital-level care
- Respite care
- Rehabilitation support
- Palliative care
- 24-hour nursing oversight

Ngā Ratonga Hauora Mā te Tamaiti me te Whānau | Child and Family Health Services

Plunket – Ōtorohanga

Plunket provides Well Child services for pēpi and tamariki in Ōtorohanga, including growth checks, breastfeeding support, and developmental monitoring.

The service supports early-life health engagement and works alongside primary care and midwifery services. More complex needs require referral to regional services.

Cost: Free Well Child services.

He Pitopito Kōrero - Additional service detail

- Well Child / Tamariki Ora checks
- Growth and development monitoring
- Breastfeeding support
- Parenting guidance
- Referral coordination for additional needs

Ngā Ratonga Ohotata, Tūnuku hoki | Emergency and Transport Services

St John – Ōtorohanga

St John provides emergency ambulance services across the district, responding to urgent and life-threatening situations in both township and rural areas.

Transport services are critical in reducing access barriers for rural whānau attending hospital and specialist appointments.

He Pitopito Kōrero - Additional service detail

- Emergency ambulance response
- First aid and urgent care support
- St John Health Shuttle (weekday hospital transport)
- Coordination with regional hospitals

Ngā Whakakapi | Conclusion

Ōtorohanga and Kāwhia are places where whānau look after each other. Where providers know our aunties and our kids. Where community organisations step in quietly when things get hard. That relational strength is powerful, and it is one of the greatest assets this community has.

At the same time, the patterns in this report cannot be ignored. Chronic conditions are often identified late. Addiction relapse happens without continuous local follow-up. Rangatahi fall out of education and struggle to re-engage. Young māmā face transport barriers. Whānau sometimes disengage from care because trust has been worn down or because the system feels complicated and hard to navigate. Engagement cannot be assumed. It has to be built and rebuilt.

The system here is not broken, but it is thin. It is thin in workforce depth, thin in diagnostic capacity, thin in specialist presence, and thin in flexibility when whānau miss an appointment or fall outside eligibility rules. When there is no buffer, even small gaps can have long-term consequences. That pressure builds quietly over time.

The way forward is not complicated, but it does require commitment. Investing in local nursing roles, embedding permanent addiction support, strengthening youth services, restoring diagnostic access, and supporting whānau navigation would significantly strengthen continuity and trust. Supporting kaupapa Māori providers and rural workforce retention is central to improving outcomes for Māori whānau.

Ōtorohanga has strong foundations. The relationships are here. The commitment is here. With sustained support and practical strengthening of the local system, this community can move beyond simply managing pressure and toward building long-term hauora equity for Māori whānau.

This report is not the end of the kōrero. It is a starting point for coordinated, local action grounded in the realities of this place.

Whakakōpani - Poupoa te whenua, kia mauri ora ai te iwi ka tika. Tēnā tātou e te whānui, ko tēnei kōrerohanganui ka whakatakototia ki mua i te aroaro, kia mārama te titiro ki te huarahi hei hikoinga.

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Ngā Āpitihanga | Appendices

Ngā Tūraru me ngā Whakamauru – Risk and Mitigations

Risk	Description	Mitigation Approach
Access to detailed data	Access to some detailed, town-level data, including PHO-level data, has been delayed due to factors outside project control, affecting the timing of certain aspects of analysis.	Analysis has continued using alternative sources including Census data, the Whaitua tool, Te Whatu Ora publications, and provider/whanau insight. Drafting, analysis, and engagement have progressed in parallel. Key data contacts have now been identified, and targeted data requests are underway to support integration once received.
Workforce and provider availability	Engagement with some providers has required rescheduling to align with availability across health and education settings.	A staged engagement approach has been used, supported by flexible scheduling and follow-up kōrero to validate and strengthen emerging findings while maintaining overall progress.
Managing scope and timelines	Balancing depth of engagement and analysis with agreed reporting timelines remains an ongoing consideration.	Timeframes have been reviewed where appropriate to support meaningful engagement and analysis. The approach remains adaptive, with priorities reviewed regularly.

He Tūtohi Raraunga me ngā Puna Kōrero | Data Tables and Sources

Selected datasets were sourced from Stats NZ, Whaitua, PHO enrolment and condition prevalence, and other relevant sources. The tables within this report provide the quantitative foundation for the trends and signals discussed in the main sections.

The main report focuses on interpretation and implications rather than reproducing full datasets.

Ngā Tepenga Raraunga me Te Whakamāoritanga - Data Limitations and Interpretation

The data referenced in this report comes from multiple sources, including PHO datasets, national surveys, and regional indicators. These sources are not always aligned in definitions, classifications, or reporting practices. Apparent differences between datasets may therefore reflect methodological variation rather than actual differences in service delivery or population need.

In some cases, small numbers and aggregation methods limit the reliability of conclusions, particularly at the local or sub-population level. Certain datasets also lack sufficient transparency to allow full interrogation of assumptions or data handling processes. Where town-level data is unavailable or suppressed for privacy reasons, regional data has been used for context only.

Accordingly, while the data provides useful directional insights, it should not be relied upon in isolation for definitive decision-making. Interpretation requires caution, contextual knowledge, and triangulation with qualitative evidence, including Whānau Voice.

Te Take me te Whakamahinga Raraunga - Purpose and Use of Data

This report brings together Whānau Voice and a selection of health system data to understand access and system pressures in Ōtorohanga . The information presented is intended to support shared understanding and informed discussion, not to judge individuals, assess provider performance, or claim precise local prevalence.

- Contextual data: Some data in this report is regional rather than town-specific. It is included to provide context where local data is limited or suppressed, and to support understanding of system patterns.
- Integrated perspective: By combining local service data, regional indicators, and Whānau Voice, the report aims to illuminate pressures and access patterns without attributing causality or assessing individual behaviour.
- Kaupapa-aligned approach: Whānau Voice is central to understanding system pressures. Data is used to support learning and shared understanding, not to define communities, measure individual behaviour, or evaluate service effort.

Tepenga - Limitations

This report has the following limitations:

- Reliance on secondary data sources
- Limited Māori-specific town-level data for some health indicators
- Absence of service-level performance analysis
- Absence of cost, funding, or workforce modelling

These limitations are consistent with the purpose of the report, which is to support system sense-making rather than programme evaluation.

The information within this report is subject to what was sourced at the time of drafting it noting that services change.

Ngā uiui rarunga tukua ki - Data requests can be made here:
Whakapā mai | Contact us - Te Tiratū Iwi Māori Partnership Board

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