Whakawhanaungatanga - networking in public health.

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Introduction

The Māori caucus of the Public Health Association has a history almost as long as that of the PHA and its predecessor, ANSERCH. Active from the early stages of the PHA were Māori health workers like Connie Hassan in Otago and Utiku Potaka, who assisted the PHA with their conference in Palmerston North in 1994. Developing and maintaining networks is an important aspect in the practice of a public health worker. Why else do we attend the annual conference of the Public Health Association? For those interested in Māori health it is face to face contact with Māori that brings about the building and maintenance of relationships and networks. Maintaining active networks provides a mechanism for testing new ideas and applying old ideas to new situations.

This is an account of the six years of the Māori caucus of the Public Health Association (PHA) and the Māori caucus, presented as a case study of network building to meet the needs of Māori health workers, researchers and policy makers in the health sector prior to the election of the present Government.

A Māori caucus was called at the Public Health Association (PHA) conference in Dunedin (1995). What was celebrated was the largest gathering of Māori at the PHA conference for some time. The Māori caucus of 1995 passed two resolutions; to repeat the gathering at future PHA conferences, and to establish a working party for a putative Māori Health Association (MHA). The following year a number of hui were held to develop proposals for a Māori voice in health with the purpose of developing recommendations for the consideration of the Māori caucus at the following PHA conference in Auckland (1996). Hui were held in Wellington (2), Auckland and Christchurch in the year leading up to the Auckland conference of 1996.

The establishing of Māori caucus positions on the PHA executive, the inculcation of the Treaty of Waitangi into the way the PHA does its business, and support for the Māori caucus were some of the outcomes of a lot of hui.

Here is the rest of the story.

Te Timatanga

The development of the Māori caucus of the Executive Council of the PHA (1996) started with an act of collusion. The President-elect, Dr Bob McKegg, and Executive Council member Connie Hassan sought a new strategy to lighten Connie's substantial time commitment to the PHA while the Waka Hauora was established in Otago as a new way of delivering health services to remote communities. At the 1995 annual conference in Dunedin, Māori caucused one wintry evening. The caucus hui galvanized Māori interest in public health at a time when

the health sector was undergoing substantial reform with the establishment of the Regional Health Authorities (RHA) and the Public Health Commission (PHC). The perception of competition brought about by the health reforms of the 1990s had put a great deal of pressure on collaborative arrangements and new strategies were required to maintain the networking required to maintain cohesion in public health. Outside of the PHC the public health work force was isolated, without a voice and their high morale was falling. The public health workforce had few opportunities for collaboration and many Māori health workers found themselves in similar positions. Māori wanted to establish active networks in the health sector.

Māori Caucus: Otakau 1995

The Public Health Association Annual Conference, Knox College, Thursday 29 June 1995.

Back row: John Broughton (Otago University), Benita Wakefield, ?, Keriata Stuart, (MoH Research Group), Kim Workman (DDG Māori health, MoH) (obscured), Tim Rochford (TPK), Andrew Sporle (HRC), Johnny Whaanga (MOH), Chris Cunningham, (Massey University), Richard Tankersley (Lincoln University), Rev Maurice Gray, Paora Howe (TPK), Te Kani Kingi (Massey University), Peter Morrison, Daphne Ropiha (MOH), Thomas Maniapoto (Tainui MAPO), John Waldon (Massey University).

Middle Row: unknown supporters (2), Aroha Terry, Connie Hassan, Elizabeth Cunningham (yellow scarf), Annemarie Gillies (Massey University).

Front row: Christine Maxwell, and whānau tautoko

The Māori participants at the 1995 PHA conference gathered to discuss the development of a Māori Health Association. The ensuing debate planned for the next stage by turning the korero into action with the establishment of a working party. Representatives of the Ministry of Health and The Ministry of Māori Development provided funding and plans were made for the working party. The working party was charged with the development of the structure, role, time frame and budget for addressing issues to do with Māori health. The tasks of the Working Party (Māori Health Information Group, MHIG), to be completed before the end of July 1996, was to;

1. prepare a budget for the development hui to discuss the prepared proposals

2. agreement on a time and venue for the development hui
3. prepare proposals for the Māori Health Association.

The proposal for the MHA was to address the structure, kaupapa, time frame and the budget of the prospective Māori Health Association. Hui were planned for Wellington hui (August 23, 1995 at the Airport Hotel, Kilbirnie), Christchurch (September 28-29, 1995 at Te Rehua Marae), Auckland (November 20-21, 1995 at the Tainui MAPO Offices, and a final meeting in Wellington (February 2-3, 1996 at the offices of Te Puni Ko kiri). The time frame was finalised at the first hui in Wellington.

A review of current issues and resources was undertaken in order to satisfy prospective funders. It was important that the proposal for the MHA did not duplicate functioning resources already in place. After membership of the working party was confirmed at Wellington, the caucus continued networking and recruiting more members between meetings to eventually establish a critical of mass of skilled Māori. The proposed MHA was to be based upon a formalised structure where roles and accountability are clearly defined.

The working group included Thomas Maniapoto (Tainui MAPO), Keriata Stuart (Ministry of Health), Andrew Sporle (Health Research Council of New Zealand), Morris Gray (Centre for Māori Studies and Research Lincoln University), Paora Howe (Ministry of Māori Development), Bonita Wakefield (Rehua Marae), Daphne Ropiha (Ministry of Health), Christine Maxwell (Te Rōpu Tautoko Trust), John Waldon (Te Pūmanawa Hauora ki Manawatu), Te Kani Kingi (Te Pūmanawa Hauora ki Manawatū), along with the support of Rerehau Pounsford (Ministry of Māori Development).

The first hui - Airport Hotel, Wellington

The development of ideas on the structure and organisation of the proposed Māori Information Group began with many and diverse ideas. The synthesis of the ideas that emerged at the Wellington hui was completed by the end of the hui. A change in structure was suggested along with a new working name for the proposed Māori group – ***The Māori Health Information Group.***

Initially the MHA was to be comprised of three coordinated groups who would carry out their work under the auspice of a charitable society (registered under the Charitable Societies Act). The three groups would be a *Kaumātua Advisory Group*, a *Technical Advisory Group*, and a *Kaimahi Group*. All three groups would be selected from the whole country (by shoulder tapping), with a professional part time/full time coordinator employed at a National Office (like the PHA).

The *Kaimahi Group* was to be the shop-front of the Māori Health Information Group in the beginning and as the MHA was established they would take on a higher profile role as the mouth-piece of the MHA. The *Kaimahi Group* would work in partnership with the *Technical* and *Kaumātua* groups. This work was to be coordinated by the professional worker. The role and function of the *Technical* and *Kaimahi Group* would eventually be combined, but during the first few years, the two groups were to operate as distinct groups in order to facilitate discussion. The *Kaumātua* group would provide oversight and advice on tikanga and other

important issues. The detail of the organisational structure was to be determined after the aims and the objectives of the MHA h ad been decided.

Christchurch hui

In the depths of winter, the MHIG got a warm reception at Rehua marae. The team continued the hui through the night to formulate a vision, purpose and strategic intent for the Māori caucus. With the guidance of Paora Howe the group's discussion concluded with the following points.

Vision: to be an independent voice for Māori health development.

Purpose: to be an excellent forum for Māori participation

Strategic intent:

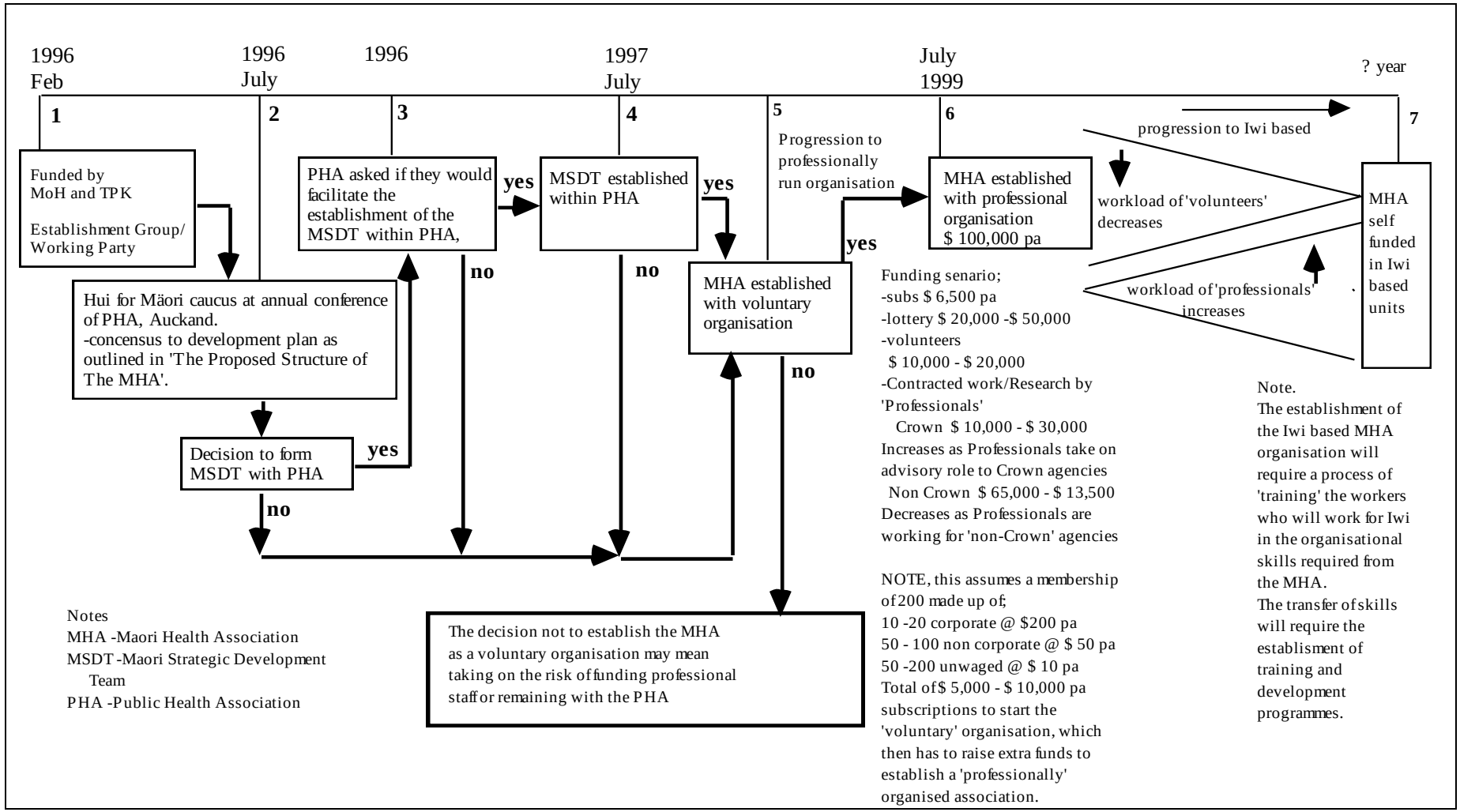
1. gather and disseminate health information
2. influence and develop agencies
3. advocacy
4. validation

Objectives

1. to improve access for Māori to quality health information
2. to provide advice to strategic agencies
3. to advocate for Māori health needs
4. to ensure the appropriateness of Māori health information
5. to build alliances with key health agencies
6. to identify non-Māori health resources and match them with Māori health needs
7. to protect Māori health needs

Wellington and Auckland Hui

The final two hui for the working party were held in Auckland and Wellington. The final report was prepared in the TPK offices in Wellington where the team brought together the recommendations made to date. The final report included a set of recommendations for the Māori caucus at the PHA conference in Auckland. A flow diagram was developed from the points people had raised during the hui of the preceding year.


1996
Feb
1996
July
1996
1997
July
July
1999
? year
1
2
3
4
5
6
7
Funded by
MoH and TPK
Establishment Group/
Working Party
Hui for Mäori caucus at annual conference of PHA, Auckand.
-concensus to development plan as outlined in 'The Proposed Structure of The MHA'.
Decision to form MSDT with PHA
yes
no
PHA asked if they would facilitate the establishment of the MSDT within PHA,
yes
no
MSDT established within PHA
yes
no
Progression to professionally run organisation
yes
MHA established with voluntary organisation
no
MHA established with professional organisation
$ 100,000 pa
progression to Iwi based
workload of 'volunteers' decreases
workload of 'professionals' increases
MHA self funded in Iwi based units
Funding senario;
-subs $ 6,500 pa
-lottery $ 20,000 -$ 50,000
-volunteers
$ 10,000 - $ 20,000
-Contracted work/Research by 'Professionals'
Crown $ 10,000 - $ 30,000
Increases as Professionals take on advisory role to Crown agencies
Non Crown $ 65,000 - $ 13,500
Decreases as Professionals are working for 'non-Crown' agencies
NOTE, this assumes a membership of 200 made up of;
10 -20 corporate @ $200 pa
50 - 100 non corporate @ $ 50 pa
50 -200 unwaged @ $ 10 pa
Total of $ 5,000 - $ 10,000 pa subscriptions to start the 'voluntary' organisation, which then has to raise extra funds to establish a 'professionally' organised association.
Note.
The establishment of the Iwi based MHA organisation will require a process of 'training' the workers who will work for Iwi in the organisational skills required from the MHA.
The transfer of skills will require the establisment of training and development programmes.
Notes
MHA -Maori Health Association
MSDT -Maori Strategic Development Team
PHA -Public Health Association
The decision not to establish the MHA as a voluntary organisation may mean taking on the risk of funding professional staff or remaining with the PHA

The resulting discussion at the PHA conference in Auckland was succinct and to the point and the recommendation that the PHA executive be approached to host the MHIG and continue to host a Māori caucus. The Executive Council responded to this request with an offer to host the Māori caucus. Two members of the MHIG were nominated onto the PHA executive. During the next three years the Māori members of caucus were nominated onto the Executive of the PHA to provide a voice for Māori and assist with policy making for the PHA. In 1999, Dr Bob McKegg stepped down as President and Dr Fran McGrath led the PHA into the new millennium. During the following year the rules of the PHA were updated to reflect a more active relationship with Māori.

Effective Public Health Policy for Māori

The PHA is New Zealand's premier non-government advocate for public health. Within its rules and regulations is an intention to carry out its mandate "*in the spirit of the Treaty of Waitangi".*

The role of the Māori caucus became one of developing more interest in health and gathering people who had an interest in public health. Māori caucus took on the substantial task of preparing a report on how the PHA could be more responsive to Māori. A report was prepared by the Māori Caucus that outlined how Executive Council of the PHANZ could strategically advocate for Māori health and fulfil its mandate. The focus of the report was the introduction of a checklist for the PHANZ's development of policy, as well as its implementation and evaluation.

The proposal was submitted as a remit and the following PHA conference in 2000 and adopted in principle. The proposal was refined during the following year. A workshop was held for the whole Executive Council in 2001 and the checklist was trailed. The outcome was a proposal that the Māori caucus organise the PHA annual Conference for 2003. This proposal is being developed.

The remit follows.

In order for PHANZ to better advocate to Government and other agencies:

1. PHA must secure a consensus with Māori caucus on strategic public health issues in order to have a **clear vision** of PHANZ's role in public health;
2. **All policy** directed towards public health will have an impact on Māori health and therefore it is an issue of how much of an impact there is and how that is managed;
3. The PHA must identify **stakeholders** outside Government;
4. A PHA analysis will give consideration to the **implications for Māori** with the checklist;

because:

1. The PHANZ has undertaken to realise its **commitment** to *The Treaty of Waitangi* and therefore, to advance Māori health development;
2. An analysis of issues that may impact on Māori is a **fundamental aspect** of public health policy development.

A framework for informing the PHA's policy development process was presented to the PHA's Executive. The framework, as recommended by Cunningham and Taite, had three principal first order criteria (elements) based on reasonable expectations of health policy for Māori (Cunningham & Taite 1998). Effective health policy should:

1. support health gains for Māori (policy outcomes)
2. be responsive to Māori needs and expectations (policy outcomes and policy development process), and
3. be analytically sound (policy development process)

A checklist for policy analysis and supporting information is outlined in the checklist *He Taura Tīeke* (Ministry of Health, 1995) and a checklist would be selected and adapted meet the circumstances in which the policy is likely to be applied. A draft checklist would then be assessed against the three characteristics of policy outlined above. The types of measures that may be incorporated into the specific policies and practice of PHANZ are also suggested for initiating the checklist process.

Conclusion

The Māori caucus was inevitable given the new opportunities that were generated by Māori during the health reforms of the 1990s. The reforms had offered new opportunities and roles for Māori as providers and critical consumers (now that there were explicit Māori health goals). The role of Māori in the PHA was made clear with the presentation of the proposal by the MHIG to the PHA's Executive Council. Māori participation in the policy making of the PHA and in testing its rules provided new opportunities for the PHA to champion new areas of public health of interest to Māori. A thread that ran through the whole process was the networking that Māori carried out and how Māori included others in this process. The inclusion of the PHA into the networking gave rise to more explicit policy making for the PHA and a solution to some very good intentions that the rules be carried out "*in the spirit of the Treaty of Waitangi".*