MĀNGERE INTEGRATED HEALTH CARE

Community Statement of Aspirations for Health and Wellness in Māngere

Owning our health in Māngere
and working together to create our wellness

25 February 2009

MĀNGERE INTEGRATED HEALTH CARE

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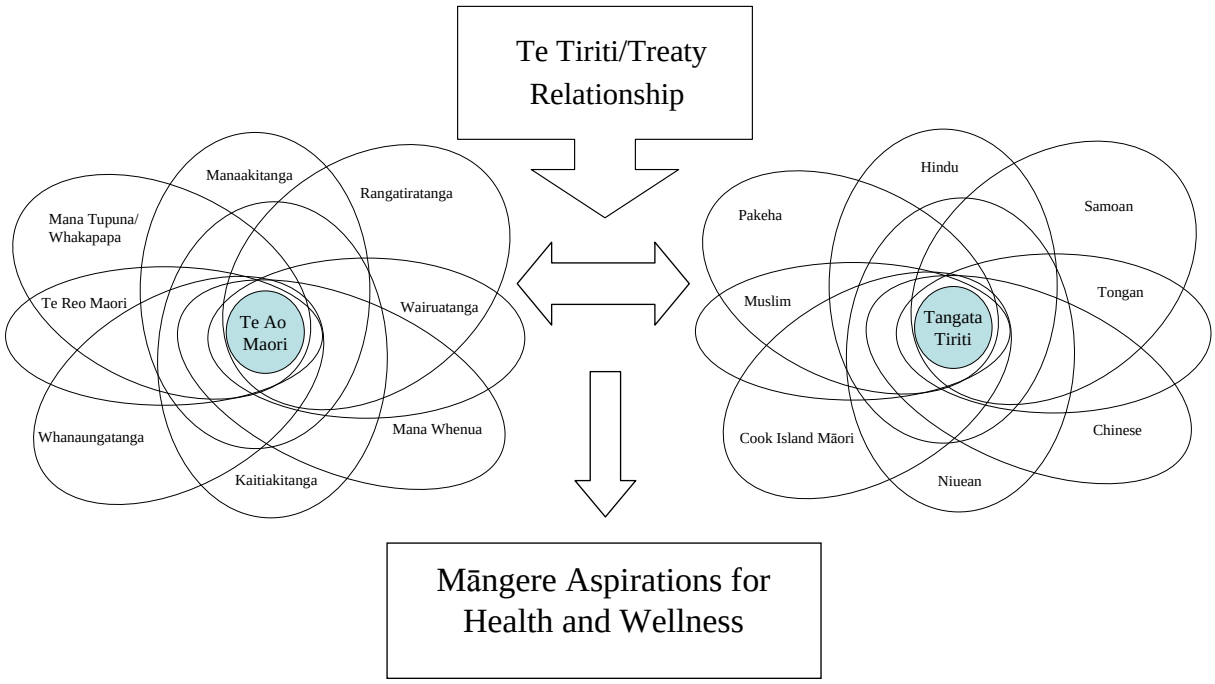
Community Statement of Aspirations for Health and Wellness in Māngere

Introduction

We the people of Māngere have looked for a way to express ourselves as a whole community. There are many models and options. The one that effectively includes us all and expresses important things about our relationships together is to be found in the Treaty of Waitangi. In both its versions it provides a model and a guide to the way we choose to organise our common life. As Tangata Whenua[1] and Tangata Tiriti[2] we also choose it as an organising mechanism to understand and develop our relationships with each other. This will have ongoing implications for the way we wish to receive health services and how we wish to lead and participate in the development of Primary Care looking forward.

In Māngere we choose to own our health and work together to create our wellness. As Tangata Whenua and Tangata Tiriti we understand what this means in a variety of different ways.

As Tangata Whenua we acknowledge that Mana Whenua exercise mana whenuatanga in this rohe. In relation to our health, we know that the relationships we develop with each other express our culture, tikanga, values and principles in ways that sustain us and our uniqueness. Currently we do this principally on our marae but also in the community. It is now our wish to express leadership more overtly on a wider front in Māngere in the interests of the health of our whole community and the people who live here. This arises out of our understanding of our leadership responsibilities as Tangata Whenua in this rohe.



[1] **Tangata Whenua** – Generic term for Mana Whenua, Taura Here and Urban Māori
Mana Whenua – Maori who are tied culturally to the area by whakapapa and ancestors who lived and died there
Taura Here – Maori, resident in the area, but belonging to waka and tribes from other parts of NZ
Urban Maori – Maori who by choice or loss are outside tribal structures

[2] **Tangata Tiriti** – those whose right to belong in this country and to the land is by virtue of the Tiriti/Treaty of Waitangi

Tangata Tiriti communities have signalled their interest to participate in the development of Primary Care alongside Tangata Whenua. At this stage those communities are Samoan, Tongan, Hindu, Muslim, Pākehā, Cook Islands Māori, Chinese and Niuean.

A strong theme of MICH community leadership is inclusiveness. This operates within a coherent and interconnected framework which is forward looking and this statement is a significant snapshot of our aspirations for health and wellness at this time. Looking forward the emergence of additional groups to participate in the development of Primary Care in Māngere is welcomed as is the ongoing development of the way the community thinks about its health and wellness from a leadership perspective. MICH is a work in progress.

Key Features of the Māngere Community's Aspirations for Health and Wellness

Each Tangata Tiriti community has drawn up a statement of its specific aspirations for health and wellness at this point. Tangata Whenua have done the same and included an additional reflection on its community-wide responsibilities that arise from traditional cultural obligations from a Māori perspective.

The key overarching aspirations of Tangata Whenua cover the following areas:

Participation in decisionmaking in areas that affect the development and delivery of health services and wellness initiatives for the whole of the community in ways that bring balance and an ability to include through:

- the practice of rangatiratanga – the action of weaving the people together
- demonstrating manaakitanga in practice
- connecting the health and wellness of people to the health and wellness of the land
- advocating strategic leadership initiatives that promote the integrated care of our people and mobilising them to take action on those initiatives

The key aspirations of Tangata Tiriti can be summarised in terms of the common themes running through the different declarations from the various communities. There is a specific Tangata Whenua declaration as well. All declarations stand alone. This summary brings them together. Key themes are:

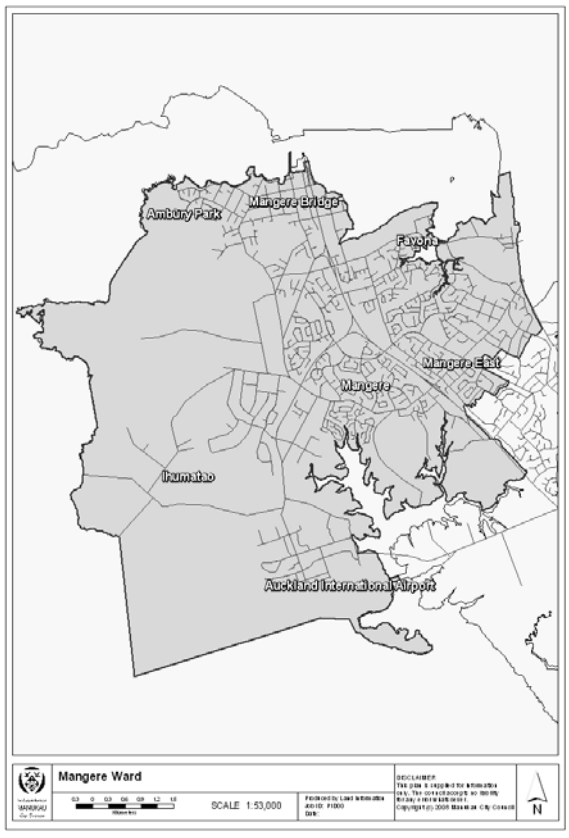
- Relationships are a key driver of action relating to service development and delivery
- Leadership operates from the perspective of the community as principal stakeholder
- Community participation at individual, family and community level needs to empower people not confirm them as passive recipients of service
- Power sharing as a practical enabler of change
- Importance of education and capacity development regarding knowledge of self and health
- The importance of knowing how to analyse and work with cultural difference
- The need for a wholistic approach to working with people and the community as a whole
- Care vs. cure, prevention vs. intervention, philosophy vs. lifestyle

Scope of the Māngere Statement

From a Māngere-wide perspective, the community aspirations for health and wellness are able to be presented under the following 7 headings:

1. Defining Māngere and the people of Māngere
2. How we think about our problems is how we think about their solution
3. The role of culture in service integration and the importance of "relationships" in service delivery
4. Working with a relationships perspective in our personal and professional roles in health and wellness
5. Ongoing learning and capability development for the Māngere community
6. Community examples of where change and development is needed
7. Ongoing training and development for doctors and other health professionals

Defining Māngere and the people of Māngere



Mangere Resident Population (2006 Census)

	Ethnic Group	Total	%
Maori	Maori	9480	
Pacific	Samoan	12857	
	Cook Island Maori	5455	
	Niuean	2814	
	Tokelauan	322	
	Tongan	8661	
	Fijian	440	
	Other Pacific Peoples	115	
Asian	Chinese	803	
	Indian	3196	
	Southeast Asian	997	
	Other Asian	363	
Other	Latin American/Hispanic	54	
	Middle Eastern	41	
	African	83	
	Other	0	
	NZ European (incl. New Zealander)	6500	
	Other European	762	
	Not Elsewhere Indicated	5038	
Total		57980	

It is important to understand the Māngere community when working with its people. In Māngere we live our lives with each other as peoples with histories and values. These are good in themselves. We all have a history and there are key cultural values that operate in the way we live.

In owning our health we do so in terms of our identities as people. Our collective view of our common life in Māngere is also informed by who we are. Our identity is highly specific to us as the people of Māngere. We never were and will not be seen as anonymous health consumers who just happen to live in this area.

We are Mana Whenua and Tangata Whenua in Māngere. As Mana Whenua we have a long history of being connected with the land of this area. We understand that our responsibilities to own our health include the health of the land and all the people of Māngere.

We are also Tangata Tiriti and come with proud cultural traditions that are important to state and preserve in the way we own our health.

We place a central importance on a practical acknowledgement of our spiritual dimension and assert that the provision of health services needs to address this aspect of our identity in order to be relevant and therefore of use to us. We express our spirituality in a variety of different ways and we expect those who provide services to know these things and to work with us accordingly. We bring our spirituality with us when we seek the support of health professionals and other related agencies. We do not leave it at the door.

We further state that as our children and their children grow and become part of our communities as adults and parents themselves that they will retain their cultural identity. This needs to be acknowledged and respected when health professionals and other related agencies work with us. When cultural acknowledgement occurs in practice it enables us to have a positive faith in both the healing process and the relationship we can have with health professionals and others.

When such an acknowledgement is absent there is a danger, well known to us, of mental health problems arising from assimilation whereby a person loses contact with their base and becomes “not from here” “not from there”, in fact “not from anywhere”. This is not a part of our future in Māngere.

In the words of Potatau Te Wherowhero, the first Māori king:

Kotahi te kowhao o te ngira E kuhuna ai te miro ma, te miro whero Me te miro pango. I muri i a au Kia mau ki te whakapono Kia mau ki te tumanako Kia mau ki te ture Engari, ko te mea nui rawa ko te aroha, tetahi ki tetahi	There is but one eye of the needle Through which the white, the red and the black threads must pass. After I have gone, hold fast to the Faith, to Hope and to the Law of the land But most importantly Hold fast to love for one another

In Māngere we value our worldviews as an important part of our identities as people. As we own our health we will lead from the perspective of who we are, Tangata Whenua and Tangata Tiriti together in this place we call home.

How we think about our problems is how we think about their solution

Across the Māngere community we don't all think in the same way about the world, about our problems and therefore about solutions.

The western philosophical paradigm was not always committed to the segmentation of the world in order to understand how everything worked. Arguably in the 21st century it is time to review the degree to which of modern specialised knowledge has obscured both the need to connect the various parts of our life and to identify approaches that will do this effectively.

A Tangata Whenua worldview values interconnection. So too does a Hindu worldview. Interconnectedness is a reality for many Pasefika cultures as well. In cultural terms the interconnection of everything that exists, living and not living, has a direct relationship to the health of people and communities. The implications of this are that the mind:body dichotomy is not relevant to many in our community.

Across the Māngere community we believe that taking responsibility for our own health and that of our family means taking direct responsibility for the management of the following areas:

- Emotional
- Spiritual
- Physical
- Psychological

Owning our health implies that our primary focus will be on prevention rather than cure. As we progressively manage this across Māngere, with support, there will be two main benefits:

1. Improved effectiveness of those services that need to be offered once they have been integrated and further developed, and
2. Improved effectiveness in the overall health spend in Māngere.

One group in our community expressed its view on connectedness and on what owning health means as follows **"What you eat, so you think. What you think you become"**. Another view from a Tongan group expressed the same sentiment in a different way:

"A healthy family is a happy family. I need to be happy first and then I can be healthy. There is a strong emphasis on owning solutions. If I don't own them they won't work for me. If I do own them I take responsibility for action and demonstrate that I can do it in practice"

The leadership implications of our taking ownership of our own health are considerable. Some of the key directions are set out as follows:

1. We will participate in decisionmaking regarding the development and delivery of health services and wellness initiatives from a whole of community perspective informed by our inclusive relationships framework
2. We will insist that those who take actions that affect the lives of our people do so in a more wholistic fashion in support of our aspirations

3. We will grow our knowledge and confidence to care for each other and share knowledge of how to do this effectively in Māngere
4. We will take opportunities to become informed about the health and wellness of people and communities in Māngere
5. We will advocate for strategic leadership initiatives that promote the integrated care of our people and mobilise our people to take action on those initiatives
6. We will champion the importance of relationships and relationship development in the design and delivery of heath and other services to the people of Māngere
7. We will challenge the further segmentation of our common life as a strategic health issue and promote integration in ways that make space for different tikanga across the community
8. We will support the integration of the way we would like services to be delivered on the basis that we have an integrated worldview
9. We will set standards that articulate an inclusive approach to the achievement of the common good in Māngere
10. We will encourage the setting up of development structures that suit the way different communities wish to work looking forward

Clearly this implies change and change in key concepts such as Quality. We believe the term has become consumerist and the system is stressed along with the people in it.

We understand MICH to be a social movement that will involve a renegotiation of power relationships from a community leadership perspective. The community is committed to provide sustained leadership to ensure that future benefits are achievable for our people across Māngere. We believe that will be good for all of us.

The role of culture in service integration and the importance of "relationships" in service delivery

Integration of services in Māngere is a cultural issue not a management or service delivery issue. When it is treated as process development with an added dimension to accommodate cultural difference, our experience is that the issue of culture is effectively sidelined.

All cultures participating in MICH have stressed the importance of not segmenting the physical, mental and spiritual dimensions of health. As we aspire to live in a more integrated way, so too we require our services to operate in ways that are consistent with that degree of interconnectedness. Therefore it is important to signal the need to respect the cultural lead in any future development that seeks to integrate services and enhance service delivery.

When we state that we wish to focus on wellness and not sickness, we are articulating a highly integrated concept that relates to who we are, how we see the world and how we would like our health services to engage us. This is why the cultural lead is important to the development of primary care in Māngere.

Culture and language are intertwined and so when people speak their own language, talk of empowerment and confidence to manage their own health makes sense. We wish to have the fear of visiting a doctor removed because our people cannot communicate with

the doctor nor the doctor with them. This level of language difficulty applies in some parts of our community more than others. In parts of the Tongan and Samoan communities this difficulty is extreme for some elders because they cannot speak English. For others it is the feeling of disconnect with the culture of the service and style of service delivery and they do not find it acceptable to ask questions. It is not their way. The disconnect doesn't stop the professional dispensing of health. However it does continue to disempower people and reduce their confidence to own their health.

We know that time spent to establish good relationships with significant others including professionals, community agencies and other support is an important part of asking for help or giving advice. Developing good relationships between patients and doctors and between doctors and patients is the practical mechanism whereby culture can lead and there can be an outlet for important values around welcome, hospitality and respect. These fundamental values operate throughout the communities of Māngere and can be worked on in a coherent way in terms of a Tiriti/Treaty of Waitangi Relationships Framework. These values and the variety of practices that give them life need to become part of the normal operating environment in all general practices, service providers, NGOs and government agencies if service delivery is to focus on the patient and their family as principal stakeholders.

Therefore it is important to state that there is a difference between a relationships approach and a transactional approach to the delivery of health care and service delivery from related agencies. That difference relates to the prior step which is the acknowledgment of the person in relation to their identity and culture prior to working with them.

Working with a relationships perspective in our various roles in health and wellness

A relationships approach to working with the Māngere community essentially revolves around cultural difference. An active and effective approach needs to proceed from an understanding of how to form and maintain relationships across the culture gap. Our experience is that there is review and learning to be undertaken across agencies in order for this to be successfully achieved. Through other workstreams of MICH there is an opportunity to work on these matters.

Some key areas of community concern are:

1. Communication
2. Handling gender issues
3. The role of doctors and
4. Working with community ideas for health and wellness

On arrival at a general practice or an agency office/NGO, support is needed to enable the discussion and the whole experience to work well for the person who may be present on their own or with whānau. Support is needed because many of our people find themselves in a powerless position. This position only changes when the more powerful participant (the agency, the professional) reduces their power. When this happens, engagement is possible. So too is a relationship and a practical working together.

Many community members have a strong preference to communicate with health professionals and related staff in their own language. This is an issue of empowerment

and it is acknowledged that it presents a number of challenges some of which are logistical.

The feeling from a number of different communities is that when professionals use a person's own language when working with them, it makes a strong signal about the intent and direction of interpersonal engagement. It can be an encouraging signal to the person and usually invites a positive response. This can be a key starting point for relationship development.

Some members of our community have expressed the need for greater understanding of "time" from their perspective. The feedback is that when there is an understanding that a person can take the time that they need, they are more likely to open up to share the issues they need to in order to get help that is relevant. Time slots often work counterproductively for patients and this needs to change.

In addition to language there are issues relating to gender matching that are important to our community.

In some communities within Māngere there is resistance for female patients to see male doctors and vice versa. The issue relates to privacy and the importance of preserving male and female roles in the various cultures which hold this to be important. There are logistical issues concerning how to work with the reality of too few male or female doctors and other staff. However this challenge presents a practical opportunity to explore the value of male and female roles in health and how gender separation can strengthen the mana of males and females in relation to wellness.

In moving to a position whereby the Māngere community signals ownership of its health and wellness, there are implications for the role of the doctor as currently understood.

One dimension was illustrated by a group of Chinese new settlers who spoke of their bewilderment when confronted by New Zealand doctors who gave advice without providing a medicinal cure. In this situation there was the strong view that the doctor was not doing the job properly.

A shift to a more supportive, collaborative relationship between doctor and patients is important. Moving from "expert dispenser" to "expert supporter" will involve a change in the role of doctor. We believe it is worth both parties working at this as it is important that doctors are confident in their role as doctors and important that patients have faith in the doctor as well.

When doctors are confident and act as expert supporter then at the psychological level the efficacy of their advice is increased in the eyes of the patient. In no part of the community did people want to become the doctor. Their desire for change springs from the general view that they want the services around health to be focused on them and their health not driven by the systems requirements of the health service, its current aspirations, funding and measurement regimes and its development looking forward.

The community has ideas for developing and maintaining its health and wellness and these ideas are an important expression of the power of community leadership. The call was for a working together with others on community ideas and community-led initiatives not for an increase in agency programmes where the community are simply passive recipients. Some of these ideas are as follows:

- Positive parenting programmes for migrant groups within the wider community
- Support groups for solo mums, general parenting and reflecting on the issues of drugs and alcohol in such groups
- Endorsement and encouragement of healthy activities that Māngere people currently do – walking, bowls, exercise classes, swimming, gym and developing greater enjoyment from learning to develop healthy eating.
- Interest in body "warrants of fitness" at different stages throughout life and developing a greater first aid ability in the community and confidence to apply it
- Liaison with acupuncture, physiotherapy and chiropractor services coordinated at the general practice setting

When these and other community-led initiatives are worked through with those communities, there will be a growing community confidence to show leadership and offer direction for such activity.

Ongoing Learning and capability development for the Māngere community

Community education assumes a base of respect for people. There is resistance to "being told" as opposed to working with others to find out.

If the starting point regarding health and wellness is the community rather than health professionals and other agencies, it follows that the way awareness, knowledge and skill acquisition needs to be approached should also reflect a community lead.

If there were fewer programmes and more places/people to visit to seek advice, that would begin the practical realignment towards acknowledging community ownership of health.

Communities have raised a number of issues relating to areas where they need to know more or to become more skilled. They also raised areas where health professionals and agency staff need to develop knowledge and skill in order to be effective:

Community ongoing learning and capability development	Health professionals and agency development
▪ Learning related to the health system itself, e.g. the role of the family doctor as coordinator or expert supporter ▪ Alcohol abuse ▪ Dementia, especially the detection of early onset dementia ▪ Targeted understanding of the risk factors for different diseases across all cultural groups together with community driven strategies for addressing these matters ▪ Getting a greater understanding of what I can do myself and when I need others to help me.	▪ Knowledge of and ability to work with people's ethnicity in an engaged manner from their perspective ▪ Acknowledging that people have a right to health information relating to services but need to get it differently so they actually understand it. ▪ Developing a more targeted and useful way to provide information relating to the questions people are asking ▪ Health professionals, community health workers and social workers reoriented to help increase community ownership of health and wellness and improve community skill and confidence to act effectively

There are a range of examples of useful mechanisms and practices that would assist with the process of realigning health towards greater community ownership:

- Help lines
- Providing electronic tools for people to use interactively,
- Advice centres,
- Having health and community workers join community meetings to discuss health issues as part of a community agenda
- Getting onto the agendas of church committees, marae committees and other community gatherings where people like to meet
- Using internet tools like social networking, blogs and websites

Community examples of where change and development is needed

Communities raised a number of issues that they believe to be important and which they would like to work on with support stakeholders for change and development. These are:

1. Costs
2. Facilities
3. Traditional medicine
4. Cultural practices relating to food and cleanliness
5. Services

Costs

In some communities the issue of cost is a vexed one. In some Pasefika communities there are practices of pooling costs for some individuals to receive medication. Cost may be a factor when people leave the decision to seek help until too late or when a condition has become very serious. Over the past 20 years political parties have sought to drive down the cost of the health system but the strategies do not seem to have had any empowering effect on communities to manage health more effectively. When economic drivers dominate, the systems act powerfully on people's confidence to take control of their own situation. This is why in some communities the priority for things other than health is in evidence. However from a relationships perspective in some Samoan communities, placing a priority on funding basic needs, the church, weddings and funerals makes more sense from the perspective of remaining integrated than the alternative which is to engage in a health and related agency system from which people feel disconnected.

From a relationships perspective the interesting question is if people were acknowledged, engaged and supported within the professional and agency network for who they are, would their view of funding priorities change?

Facilities

Some communities mentioned that when visiting a doctor to discuss their health they needed to go to a place where they felt comfortable. In some cases people would travel considerable distances to achieve that. The issue related to the relationship with the doctor and was often described in terms of trust. Others articulated the need for health facilities to have a look and feel of "home". The concept of home or being at home is connected with the acknowledgement of the person in the context of an engaged relationship.

There are also issues related to colour schemes in surgeries and agency offices. The eyes and emotions of a number of Pasefika communities are used to seeing more colour than is to be found in "corporate office" type colour schemes.

There are issues relating to the hours of work for clinics. There is also a need for more flexible hours of work so that family members do not need to take time off work to accompany family members to visit the doctor for language or cultural reasons or for more general support (say for children).

The notion of "clinicians to the people" was coined and this expression summarised a view that while it is important to have a range of facilities within easy proximity to each other, facilities do not drive development from a community perspective. It is worth considering taking services to where people are once there is a relationship to support that particularly in the light of there being insufficient clinics to cover the need for primary care services. There are also ongoing issues concerning overcrowded surgeries and long queues.

There was discussion of the implications of waiting to consult a doctor (often at a hospital) given the Muslim prayer schedule. People need to pray 4 to 5 times a day at particular times and for this to occur, a place to pray is needed together with a place to conduct ablutions as part of the prayer process.

Traditional medicine

Within our communities there are a range of traditional approaches to health and wellness that work. Past attempts within secondary care to acknowledge rongoa Māori have been managed on the basis of risk, i.e. the patient provides a list of rongoa and the hospital assesses whether these will have an adverse affect on western treatments and what needs to be stopped. In effect the western treatment becomes the norm and traditional medicines are "other". This is a powerful approach that is a long way from patient ownership of health.

Across our communities today there are examples where the first preferred route is traditional medicine and at a later stage a doctor will be considered. Many Pasefika people use a range of options such as prayer for healing within the family, prayer with the pastor or elders of the church, particularly in serious cases, and anointing with oil. Traditional fofō involves the use of selected plant leaves to massage the body and/or drinking the juice from selected leaves, when available, for the purpose of cleansing the body and promoting healing.

Taken overall, our reflection on traditional practice is that it is less about who is right and who is wrong and more about what could be done well/better **together** if health service provision was informed and guided by a different kind of relationship between the various parties.

Cultural practices relating to food and cleanliness

A Muslim value around cleanliness relates primarily to ablutions and to food. Toilet facilities need to be designed in such a way that there is easy access to clean water for washing within the toilet cubicle. The design needed is similar to a disabled toilet.

Halāl restrictions on food and the need for medicines to be free of alcohol and animal ingredients suggest that Halāl and its place in the health of people needs to be better understood.

Tongan groups expressed an interest to have a shared discussion with health professionals and agencies on the strengths and weaknesses of traditional foods that are part of the cultures of Māngere. There is perceived to be value both ways in such a discussion.

Services
Participation in the activities of local swimming pools and gyms is seen as good overall but there is a need to some provision for particular religious requirements (for Muslim communities) regarding the segregation of males from females. Current arrangements prevent participation.

Ongoing training and development for doctors and other health professionals

The training of health professionals from a community perspective needs to be focused on the diverse communities of Māngere. There is a need to understand the cultural and religious dimensions to the various cultural groups and to know how to respect and engage people who belong to those groups.

An indicator of the effectiveness of such development would be the increased level of engagement of the community in productive and mutually beneficial relationships regarding health and wellness.

It was felt by some that a booklet setting out the key cultural understandings of the various cultures in Māngere including worldviews, values and key practices would be a good start to learning and development. If it was done across the whole of the Māngere community, such a booklet could also contain information on services that are available locally.

There is probably a need for some ongoing cultural advice for health professionals and agencies. This would logically come from the various communities and would need some central coordination to keep things alive, relevant and moving forward.

Conclusion/Next Steps

This Community Statement of Aspirations for Health and Wellness in Māngere is a reflection of the hopes and desires of the people of Māngere for health and wellness. It is our view at this time in the life of the Māngere community.

The statement of aspirations is an integrated and comprehensive analysis that is informed by the relationships we have with each other, with the land and our environment. As such it needs to be reflected on by us as Tangata Whenua and Tangata Tiriti as we move forward.

We expect the document to form the primary reference point for those who work with us in Māngere as they support us in our role as principal stakeholders within the community. The document sets out different starting points and ways of working that now need to be engaged by health professionals and the variety of groups and agencies working for the people of Māngere.

It is our strong belief that when the support relationship role and function of service providers is correctly understood and operating, that will be a moment whereby the reality and benefits of community leadership of Primary Care in Māngere will be obvious to see.

The Māngere community is an open community and new groups who wish to participate in this community led process are welcome.

The Community Statement of Aspirations for Health and Wellness in Māngere is the statement to guide the development of initiatives for development and change in Workstreams two, three and four of the MICH work programme.

Further information on www.mich.org.nz

25 February 2009