Te Kāwanatanga o Aotearoa

Te Puni Kōkiri
MINISTRY OF MĀORI DEVELOPMENT

He whakarāpopototanga o te arotake motuhake o MCCF

A summary of the Māori Communities COVID-19 Fund independent evaluation

Summary

This document is a summary of the Māori Communities COVID-19 Fund independent evaluation report commissioned by Te Puni Kōkiri and undertaken by DTK and Associates.

Whakatauki

Tē tōia, tē haumatia
Not dragged, not shouted

The metaphor is based on the traditional method of launching a large canoe. The dragging of the canoe cannot be done without its being followed by the shouting. Nothing can be achieved without a plan, a workforce and a way of doing things.

Creative Commons

This work is licensed under the Creative Commons Attribution 4.0 New Zealand License.

To view a copy of this license, visit http://creativecommons.org/licenses/by-nc/4.0/

Published by

Te Puni Kōkiri
ISBN:
Hōngongoi/July 2023

Contents

Section 1. Background and purpose 3
Section 2. Methodology 4
Section 3. Analysis 5
Section 4. Findings 6
References 8

Section 1. Background and purpose

Aotearoa New Zealand's experience of and response to COVID-19 was different and more successful in its early stages than in most other countries (Baker, Wilson & Anglemyer, 2020). The initial early success enabled the Government to keep COVID-19 out of communities long enough to establish a nationwide vaccination delivery programme (Baker, Kvalsvig, Verrall & Wellington, 2020).

The arrival of the Delta and Omicron variants exposed some weaknesses in the health system and shortcomings in the design of the vaccination delivery programme. These were, for example, the widespread inequity of outcomes and the number of underserved priority populations (Henare, 2021), the mainstream vaccination delivery programme being heavily focused on age-based prioritisation (rather than addressing inequities related to other factors, e.g. ethnicity), a mismatch between a demand for health services and the ability to meet that demand (Department of the Prime Minister and Cabinet, 2021) and the financial pressures in the health system and how those pressures impacted sustainability (Ministry of Health, 2020).

The vaccination programme was also unable to ensure that indigenous people had access to the resources to tailor health care to their needs (Te Rōpū Whakakaupapa Urutā, 2021), and it could potentially reproduce inequity for Tāngata Whaikaha, rural communities, children and tamariki in care, as well as Māori and Pasifika people (Jones, King, Baker & Ingham, 2020).

As the Cabinet understood the above weaknesses, they turned to Te Puni Kōkiri, with support from Te Arawhiti and the Ministry of Health, to lead, develop and deliver the Māori Communities COVID-19 Fund (MCCF). The MCCF was initially set up as a two-phase initiative. The first phase aimed to support activities to boost Māori vaccination rates (which were significantly lower than the overall rate). The second phase aimed to build the resilience of vulnerable Māori communities and support them to adapt to a COVID-19 environment, including the COVID-19 Protection Framework which had been introduced.

Consistent with its operating style, Te Puni Kōkiri designed the implementation of the MCCF to enable a locally-led and whānau-centred approach. This required high trust contracting, strong relationships with kaitono / providers and working closely with iwi and Māori community leaders and Whānau Ora Commissioning Agencies.

In February 2022, additional funding was approved to build on Phase 2 and support community resilience in response to the Omicron outbreak (Phase 3). Te Puni Kōkiri was the lead agency in the administration of the MCCF. Te Puni Kōkiri, Te Arawhiti and the Ministry of Health all managed contracts during Phases 1 and 2. Te Puni Kōkiri and Te Arawhiti managed Phase 3 contracts.

In total, $128,980,000 was spent across all three phases of the fund.

The objectives of the MCCF were as follows:

1. **Phase 1:** Rapid Vaccination Acceleration – expanding and/or establishing contracts with existing and/or new providers and partners to achieve Māori vaccination uplift, with a focus on driving vaccination demand.
2. **Phase 2:** Whānau, Iwi and Community resilience – investing in Māori-led, community-designed preparedness initiatives for COVID-19 responses as the regionally led response work further develops.
3. **Phase 3:** Māori Omicron Response Funding – enabling communities (particularly iwi) to mobilise community-based approaches to support at-risk whānau to access available health and welfare, working alongside other government approaches.

MCCF was rapidly deployed to high-need communities, enabled by effective working relationships across Te Puni Kōkiri, working cooperatively with other agencies, to back kaimahi based in regional offices across the motu to support locally-led and whanui-centred actions.

As the MCCF was a significant investment, Te Puni Kōkiri commissioned an independent evaluation of the fund, conducted by DTK and Associates. The specific evaluation questions were as follows:

1. Did MCCF assist in improving vaccination uptake between October 2021 and June 2022?
2. Whether and how the MCCF helped improve vaccine uptake and build community resiliency, in the context of introducing the COVID-19 protection framework?
3. What lessons were learnt about collaboration between the three institutions: Te Puni Kōkiri, Te Arawhiti and the Ministry of Health?

Section 2. Methodology

To answer the evaluation questions, the evaluators used content analysis of documents, analysis of vaccination data, Āta and Q-methodology.

Content analysis

Content analysis involved analysing documents including investment settings, proposals, contracts, milestone and investment reports, and monitoring information.

Analysis of the vaccination data

Vaccination data was downloaded from the Ministry of Health website and was last updated on 7 March 2023. DHB residence was based on the primary address Te Whatu Ora had for an individual, mapped to the previous DHB areas. The data included the population denominator change recommended by Statistics NZ.

Q-methodology

Q-methodology was selected as the best method for capturing objective data about the stories people tell about subjective phenomena (Brown, 1980; McKeown & Thomas, 1988), such as the experience of providers and officials working within the MCCF. Unlike research methods that involve qualitative interviews that are then content analysed, Q-method takes a quantified snapshot of a person's viewpoint and compares it to every other participant's viewpoint. Two card sorts were conducted: a vaccination uptake and resilience sort (relating to the evaluation questions 1 and 2, see above), and a collaboration sort (relating to the evaluation question 3, see above).

The evaluation involved interviews with 59 kaitono, regionally based kaimahi and Wellington-based officials conducted between September 2022 and November 2022. Interviews used an Āta approach as a way of engaging in inquiry. Within Te Ao Māori, Āta means being respectful for each other in such a way as to create wellbeing for all involved in the research process (Pohatu, 2013). In practical terms, it means focusing on relationships, negotiating boundaries, and creating and holding a safe space. For this research process, the Āta approach meant that the research moved at the speed and pace of the participants, rather than the needs of the official process (Forsyth & Kung, 2007).

Section 3. Analysis

The data from the Q-method sorts was analysed using specialist software to find which solution best cohered with the opinions of the interviewees. In essence the analysis reduces the information collected to a few composite (or average) sorts that best statistically represent the views of a group of participants who had similar sorts. Eight factors in each sort appeared to be statistically significant, from which four narratives (relating to the evaluation questions 1 and 2) and three narratives (relating to the evaluation question 3) were developed that appropriately represented the most prominent and distinct perspectives on how the MCCF helped whānau and communities build resilience and reduce inequity, and on the cooperation between the three government agencies involved, respectively. The Table below shows these narratives, along with the proportion of variance explained by each narrative and key points from each.

Table: MCCF narratives, proportions of variance explained by each narrative and key points from each narrative. (** The percentage of the sorts that each factor (narrative) explains. The greater the percentage, the more variance is explained by the given factor.*)

Narrative	Variance %*	Key points
Vaccination and resilience sort		
1. E hara taku toa i te toa takitahi, he toa takitini - strength comes from the community and not the individual	33%	• MCCF enabled kaitono to support whānau in rural and remote locations to access information about vaccines and to get vaccinated. • MCCF enabled kaitono to assist whānau who were socially isolating or had whānau members who were socially isolating.
2. Waiho i te toipoto kaua i te toiroa - keep close together and not far apart	11%	• MCCF enabled whānau to keep tamariki and rangatahi in school. • MCCF funding was flexible enough to deal with changing circumstances. • MCCF enabled whānau to mitigate the impact of enforced social distancing.
3. Mā roto hoki kia ora ka pai te kōrero - the korero is always agreeable when we are refreshed by the renewing of relationships	7%	• MCCF funding made it possible for “trusted messengers” to have conversations with whānau in ways in which those whānau felt heard and seen. • MCCF assisted in addressing vaccine hesitancy and access inequity.
4. Mā te ngākau aroha koe e ārahi - let a loving and compassionate heart guide decision-making, especially in times of change	7%	• MCCF helped ensure tāngata whaikaha were assisted, and able to manaaki one another and their whānau.

Collaboration sort		
1. Shared mission and the weavers	20%	• The officials involved in the implementation were focused on the shared mission to reduce disproportionately poor access to COVID-19 information and vaccination services for older people, those living in rural areas and Māori - all these groups are at risk of severe outcomes from COVID-19 infection. • However, the officials did not think they spent enough time critically examining one another's work or building an implementation approach that was as fully integrated for kaitono as they wanted.
2. Shared Context and Motivation enabling Free and Frank	14%	• MCCF cooperation between agencies had a shared context underpinned by a shared level of motivation and commitment, enabling free and frank conversations. • However, given the pace of the roll-out the officials and kaimahi believed that the MCCF delivery could have done more to actively build trust with kaitono and integrate kaitono feedback.
3. The Weavers Again	13%	• Te Puni Kōkiri staff at all levels of the organisation were central to the success of the MCCF. • Officials are increasingly expected to work openly, in public, and to engage genuinely. • However, officials and kaimahi did not think MCCF sought sufficient feedback from providers or actively managed the power imbalances that generate through contracting relationships.

Section 4. Findings

The quantitative analysis of vaccinations rates found that the MCCF successfully mobilised support for rapid vaccination activities. In doing so, it helped communities build resilience by mitigating the impact of COVID-19. The figure below shows vaccination data (completed primary course – two doses) at the start (October 2021) and at the end of the MCCF (June 2022). Most regions got up to around 70% to 80% of the Māori population fully vaccinated.

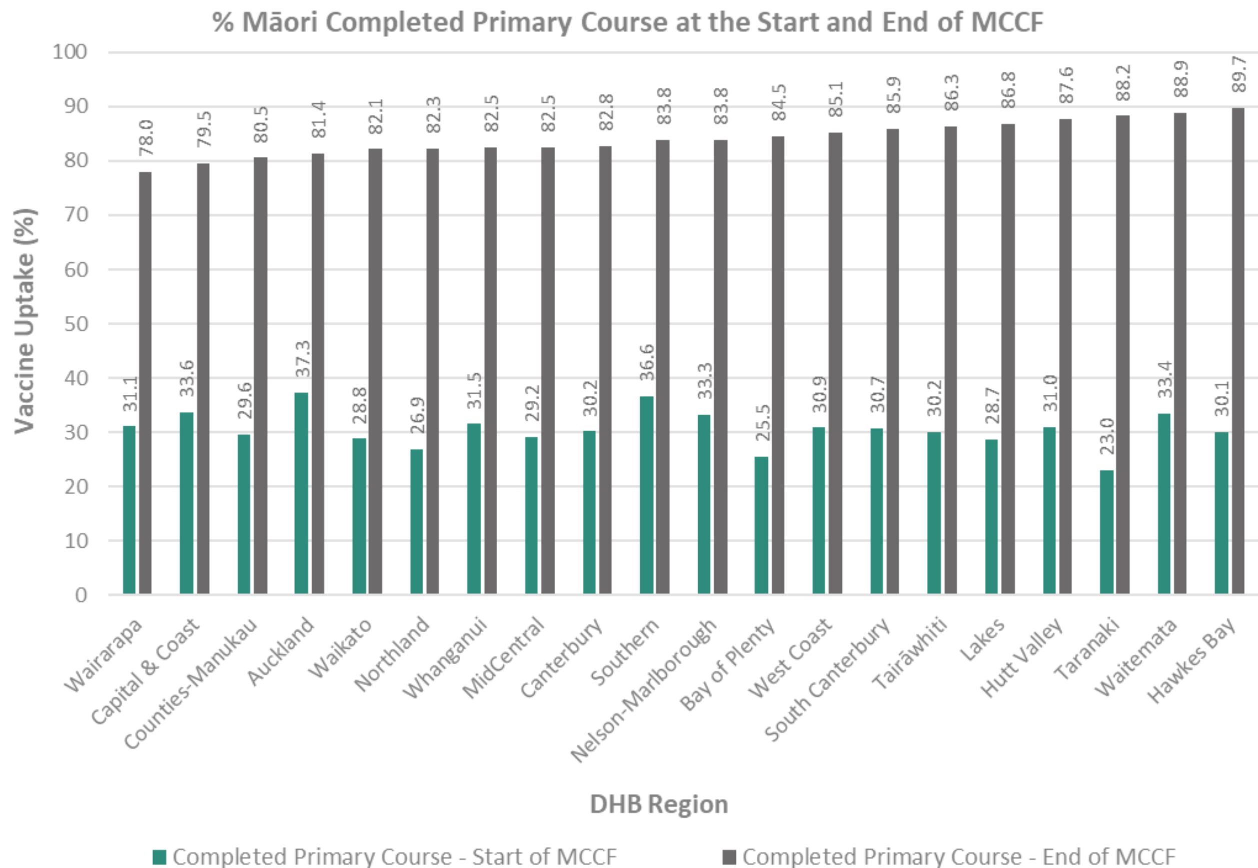
As described in the findings highlighted in the table above the MCCF improved equity of access by offering additional vaccination services in areas with high-priority populations and low access to vaccines.

In addressing access inequity, the MCCF also improved equity in outcomes by funding services that practically reduced the administrative burden on whānau living in rural and remote areas, tamariki and rangatahi, gang members and their whānau, and tāngata whaikaha, so they could access vaccine information and vaccination services.

The reduced burden includes a combination of the following:

- reduced learning costs (such as finding out who in the whānau was eligible for vaccination, and when and where to get information or a vaccine)
- reduced psychological costs (such as reducing the stress and stigma involved in interacting with people often unknown to the whānau)
- reduced compliance costs (such as streamlining application processes and reporting).

Figure: Proportion of Māori who had completed a primary course (2 doses) of the vaccine at the start and end of MCCF, by region



MCCF investments overcame weaknesses in the mainstream vaccination delivery programme by ensuring information and services were targeted at whānau, whanui and hapori and those with the greatest need. It also finds that some investment benefits have been shared in a way that has built resiliency and bolstered some underserved communities.

The leadership of Te Puni Kōkiri at all levels of the organisation was critical to the success of the MCCF. As a result of Te Puni Kōkiri's leadership, and the cooperation between the three agencies (Te Puni Kōkiri, Te Arawhiti and the Ministry of Health), a nationally enabled and locally-led approach was established and that was fundamental to the success of the MCCF.

The senior leaders worked hard to simplify a complex operating environment and manage competing demands. It is also apparent that the shared purpose and goal drove the priorities of each agency and motivated their staff daily.

Te Puni Kōkiri kaimahi were critical to the success of the MCCF, particularly those based in the regions with their deep understanding of their communities and the Crown/Māori relationship. Regional kaimahi were proactively scanning the environment, working across organisational and institutional boundaries, generating and smoothing information flow and balancing the needs of the authorising environment and the communities they work in.

References

Baker, M. G., Kvalsvig, A., Verrall, A. J., & Wellington, N. (2020). New Zealand's COVID-19 elimination strategy. Med J Aust, 213(5), 198-200.

Baker, M. G., Wilson, N., & Anglemyer, A. (2020). Successful elimination of Covid-19 transmission in New Zealand. New England Journal of Medicine, 383(8), e56.

Brown, S. R. (1980). Political subjectivity: Applications of Q methodology in political science. Yale University Press.

Department of Prime Minister and Cabinet (2021) 14 May 2021 DPMC-2020/21-956 Health Reform: Strategy and Approach to Legislation, Wellington, New Zealand.

Forsyth, H., & Kung, N. (2007). Ata: A philosophy for relational teaching. New Zealand Journal of Educational Studies, 42(1/2), 5-15.

Henare, P. (2021, October 21) Introduction of the Pae Ora (Healthy Futures) Bill — First Reading. https://www.parliament.nz/en/pb/hansard-debates/rhr/combined/HansDeb_20211027_20211027_28.

Jones, B., King, P. T., Baker, G., & Ingham, T. (2020). COVID-19, intersectionality, and health equity for indigenous peoples with lived experience of disability. American Indian Culture and Research Journal, 44(2), 71-88.

McKeown, B., & Thomas, D. (1988). Q Methodology, Newburg Park.

Ministry of Health. (2020). Health and Disability System Review. 2020. Health and Disability System Review – Final Report – Pūrongo Whakamutunga. Wellington, New Zealand.

Pohatu, T. W. (2013). Āta. Ata: Journal of Psychotherapy Aotearoa New Zealand, 17(1), 13-26.

Te Rōpū Whakakaupapa Urutā. (2021). [4 June Online Interview]. Dr. Rāwiri McKree Jansen perspective on RSV and its impact on Māori. https://www.facebook.com/watch/?v=916337558953226

Te Puni Kōkiri
MINISTRY OF MĀORI DEVELOPMENT

Te Puni Kōkiri, Te Puni Kōkiri House, 143 Lambton Quay, PO Box 3943, Wellington, New Zealand
PHONE Waea 0800 875 663 (0800 TPK MMD), **FAX** Waea Whakaahua 0800 875 329 (0800 TPK FAX)
WEB tpk.govt.nz, **FACEBOOK** facebook.com/tepunikokiri