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**Hei aha nga whakaaro o Ngāti Ruanui mō te Whānau
Ora/How do Ngāti Ruanui Iwi Whānau members
define Whānau Ora?**

A thesis presented in partial fulfilment of the requirements for the degree of

Master of Philosophy
(Nursing)

At Massey University, Palmerston North,
New Zealand

Te Moana Campbell-Knowles
Ngāti Ruanui, Ngaruahinerangi, Tangahoe, Tainui, Ngāti Porou

2012

Acknowledgements

E hara taku toa, I te hoa takitahi

Mine is not the strength of one alone

Katahi o taku toa, he toa takitini

it is the strength of many.

I would firstly like to thank the individuals of Ngāti Ruanui who participated in this research - ten wonderful people who generously shared their stories and experiences. It has been a humbling experience to have the privilege of interviewing you, and listening to your insights and wisdom. I sincerely hope that the outcome of this study has done your whakaaro the justice it deserves, and that the findings are of benefit. I would like to thank Te Whānau o Te Rau Puawai at the Manawatu campus of Massey University. The tautoko, awhi and manaaki that I received from you inspired me not to give up and to continue with this journey. My acknowledgement also to the Māori Health Research Council for the scholarship I received in 2010 which allowed me to take the necessary time off from work to complete this research.

My sincere thanks go to my supervisors, Dr Petula Brannelly and Dr Amohia Boulton. Your clarity of thought and patience has enabled me to stay focused on this kaupapa. Thanks also to Dr Will Edwards for your invaluable feedback throughout this journey. Special thanks to my colleagues and friends, Mere Brooks, for teaching me 'to fly' and Cilla Rei for your never-ending encouragement, assistance and guidance. Bouncing off one another and managing the tears, the laughter, and giggles along the way and reminding me that it is ok to be 'me'. Words cannot express the appreciation I have for your belief and patience in me. Thanks also to Dale Boyce for your technical skills.

To my immediate whānau, you have been unwavering in your support and strength. To Nicola and Johnny, Keriann and Mikey, Georgia and Rawhiti and my eleven mokopuna, you are the reasons for me doing this study in the first place. To my brothers and sisters and extended Whānau, your regular question of 'How's it going with your mahi?' was always welcomed. To Raymond, my husband for the unenviable task of putting up with me, the early hours of the morning meant the

'marathons' in front of the computer were never too lonely or bleak. Your wonderful aroha has been a joy, and I am privileged to have you by my side.

Dedication

This thesis is dedicated to the Campbell whānau and our wonderful parents, Ropata and Miriama Campbell who taught us the value of “it’s all about whānau”, never to “cease to dream” and always to strive continuously to attain “the dream”. My mother wrote the words to this song, not only for my nephew Michael Campbell, but also hope for the future for all Māori. Her wish was for mokopuna to be proud of who they are and to strive to work hard to reach their dreams and chosen goals. I dedicate this thesis to my mother and all of her mokopuna.

MAURI TU – MAURI ORA – KIA KAHA RA

<i>Tena koutou, tenei au e whakanui nei</i>	<i>This is my biggest wish for the health</i>
<i>E whaka wai ora, e aku mokopuna</i>	<i>of my grandchildren</i>
<i>E hapai nei, i te reo Māori</i>	<i>Also to lift and carry on with the learning</i>
	<i>of the Māori language</i>

Chorus

<i>Kia kaha ra, e tama e,</i>	<i>Be strong my grandson</i>
<i>Kia mau tonu, te matauranga</i>	<i>Hold fast to your knowledge</i>
<i>Kia puawai, to moemoe a</i>	<i>Your dreams will blossom</i>
<i>kia kaha ra, kia kaha ra</i>	<i>Be strong</i>
<i>Mau mahara mai, kia koe</i>	<i>Thinking of you day and night</i>
<i>I te ao, I te po, kia mau tonu</i>	<i>Have faith in your inner self</i>
<i>te rongo pai, te rangimarie</i>	<i>Be calm, be patient</i>

Chorus

<i>No reira ra , e tama e</i>	<i>Therefore my grandson</i>
<i>Kia mau mai nei, nga honore</i>	<i>you have achieved your goal</i>
<i>Me te iwi e, e tau nei</i>	<i>and honour, and also for</i>
<i>Te iwi Māori e</i>	<i>the Māori people</i>

Written by Miriama Campbell. CD programmed, produced and engineered by Richie Campbell (jnr) at Kahu studios, Glenfield, Auckland. Vocals – Richard (snr) and Kathleen Campbell.

Abstract

In Aotearoa New Zealand poorer health outcomes for Māori have been well documented. There is growing evidence that limited contact between whānau members has a potential negative impact on the health and wellbeing within the whānau. The term Whānau Ora has been widely used and variously defined by Māori over many years however there is no single shared definition of Whānau Ora, and little understanding about how it can be implemented by Māori health providers as a service delivery framework. This research expands on existing knowledge of Whānau Ora by identifying definitions, gathering data about Whānau Ora values and concepts, cultural beliefs and practices.

This research is informed by the worldview of healthcare for Māori. A number of hui (meetings) were held where Ngāti Ruanui iwi members were consulted and ten Ngāti Ruanui participants were interviewed. These participants identified meanings of Whānau Ora that included ‘being Māori’ and who they are (whakapapa) and how this translates to ‘how they live’ (Matauranga Māori), ‘self-definition’ (tino-rangatiranga) and how Whānau Ora is the ‘way forward’ to address past and present issues such as colonisation and inequalities.

This research employed a Māori-centred qualitative methodology which allowed Māori and Western belief systems their own integrity whilst working side by side, utilizing the energy of the two systems. Localising the research to Ngāti Ruanui Iwi members was intentional, to understand what members considered important. As the integrity of the participants was a central concern in the research, a methodology was adopted that was respectful and valued the participant’s worldview. Participants regarded Whānau Ora as a mechanism to assist whānau to “move on”, and advance as Māori. Whānau Ora was also regarded as an important future model of health that has the potential ‘do away’ with disparities and assist Māori in their efforts to strive for good health. The research concluded that Māori health outcomes will be much improved when they are delivered in ways that meet the cultural needs of Māori. The roles and responsibilities of the Crown must ensure that these changes develop and are done in collaboration with Māori organisations themselves which will ensure that any changes reflect the philosophies of Whānau Ora: optimal wellbeing.

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Glossary of Māori Words and sayings

A

Aotea waka	single canoe outrigger
Aotearoa	New Zealand
Aroha	love
Atua	heavenly father
A tuku iho	cultural heritage
Aukati Kai Paipa	quit smoking
Awa	river
Awhi	support, caring, helping people

H

Ha a Koro ma e Kui ma	the breath of life from forebears
Hapū	sub-tribe, pregnant woman
Hauora	health and wellbeing
Hawaiki-Rangiatea	Tahiti
He Korowai Oranga	The cloak of health, The Māori Health Strategy
Hinengaro	emotional and mental health
Hui	meeting, gathering, bring together

I

Iwi	tribe
-----	-------

K

Kai	food
Kaiako	Māori language tutor
Kainga	home
Kaitiaki	guardian

Kaitiakitanga	guardians to the welfare of people
Kaikaranga	caller
Kaikorero	orator
Kanohi kitea	to be seen, face to face
Karakia	prayer
Kaumatua	elder
Kaupapa	strategy or theme
Kautu-ki-te-rangi	handle of the paddle of Aotea waka,
Kawanatanga	governorship
Koha	gift
Kohanga Reo	early childhood, language nest
Korero	talk
Kia tupato	be cautious
Kura kaupapa	primary schools
Kuia	older women
M	
Mahi	work
Māori	indigenous people of Aotearoa
Mana	prestige, power
Mana ake	uniqueness and positive identity
Manaaki	caring for others
Manaakitanga	acknowledges the mana of the people
Manuhiakai	sub-tribe in Nga Ruahinerangi
Mana whenua	land occupied, right of ancestral claim
Marae	meeting ground
Matauranga	education, knowledge

Matua	parent
Mauri	life force
Mihi	to welcome, introduction
Mimi	urine
Moana	ocean
Mokopuna	grandchildren
Muaupoko	tribe in Whanganui
Muru	restorative justice
Muru me te raupatu	confiscated lands
N	
Nga Pakeke of Ngāti Ruanui	Kaumatua group in Ngāti Ruanui
Ngāti Hine	tribe in Northland
Ngāti Ruanui	tribe in Taranaki
Ngāti Ruanui Hauora	Ngāti Ruanui Health Centre
Nga Ruahinerangi	tribe in Taranaki
Nga Rauru	tribe in Wanganui
Ngāti Apa	tribe in Wanganui
Ngāti Ruanui Tahua	Ngāti Ruanui health-social services
Noa	common, free from tapu, safe
P	
Pa	meeting place
Pakakohe	tribe in Taranaki
Pākehā	non-Māori, European, Caucasian
Papakura	Auckland
Papatuanuku	the earth mother
R	
Rangātiratanga	freedom, dominion, ownership

Ranginui	sky father
Rapuora	Māori Womens Welfare League Report
Rohe	district
Rongoa	traditional Māori medicine
Roopu	a group of people
T	
Taonga	treasure
Tainui	tribe in Waikato, Huntly
Taiporohenui	land and marae in Hawera
Tamariki	children
Tangata whenua	people of the land
Tangahoe	tribe of Taranaki
Tangihanga	ceremony for those who have passed
Taranaki	region in Aotearoa
Tapu	protected, sacred, unsafe
Te ao Māori	the world of Māori
Te Moana Nui a Kiwa	the Pacific Ocean
Te Kete Hauora	Māori Health Directorate
Te Reo Māori	Māori language
Te Runanga of Ngāti Ruanui	Governing body of Ngāti Ruanui
Te Tai Tokerau	tribe in Northland
Te Tiriti o Waitangi	The Treaty of Waitangi
Te Whare Tapa Wha	a Māori Model of health
Te Whiti-I Rongomai	prominent leader from Taranaki
Tikanga	custom
Tinana	physical body
Tino-rangātiratanga	self-determination, control

Tipu Ora	Māori programme-healthy families
Tipuna	ancestors
Titokowaru	chief of Ngāti Ruanui
Tohunga	traditional Māori healer, expert
Turi	high chief of Ngāti Ruanui
W	
Waiora	possessing health
Wahine	woman
Waka	canoe
Waikato	region in New Zealand
Wairua	spirit
Wairuatanga	spirituality
Wanaanga	learning, university
Whanganui	town and region in New Zealand
Whangai	foster children
Whakama	embarrassment, shy, shame
Whakapapa	genealogy
Whakatohea	tribe in Opotiki
Whakawhānaungatanga	establishing relationships
Whānaungatanga	relationships, connections, networks
Whānau Ora	family optimal health and wellbeing
Wharekai	dining room
Whenua	land, placenta
U	
Ukaiipo	mother
Uri	descendent
Uri o Ngāti Ruanui	descendent of Ngāti Ruanui

Utu

justice, rights of an individual

List of Abbreviations

A&OD	Alcohol and Other Drugs
HEAT	Health Equity Assessment Tool
MOH	Ministry of Health
MSD	Ministry of Social Development
NHC	National Hauora Coalition
NRTT	Ngāti Ruanui Tahua Trust
RHC	Ruanui Health Centre
TDHB	Taranaki District Health Board
TKM	Te Kawao Maro – The Taranaki District Health Board Māori Health Strategy
ToW	Treaty of Waitangi
TPK	Te Puni Kōkiri
TWTW	Te Whare Tapa Wha/Māori Model of Health
TWPK	Te Whare Punanga Korero – The Taranaki District Health Board governing body representing Taranaki Iwi members.

Chapter One Introduction

The purpose of this research project is to contribute to a body of knowledge that enables informed and evidence-based provision of Whānau Ora services by Ngāti Ruanui and can contribute to other Māori health providers. The intention is to contribute to the development of a Whānau Ora framework to underpin health service delivery. The research question is “*Hei aha nga whakaaro O Ngāti Ruanui mō te Whānau Ora - How do Ngāti Ruanui Whānau members define Whānau Ora?*” Ngāti Ruanui Iwi members explored the concept of Whānau Ora in interviews about their experiences of accessing health and social services. The key objectives of this research were to:

1. Extract definitions of Whānau Ora through policy document analysis.
2. Interview key community stakeholders, Ngāti Ruanui Whānau members about their interpretation of Whānau Ora.
3. Explore health and illness experiences to consider aspects of Whānau Ora.
4. Provide recommendations based on the findings of this research about Whānau Ora informed services.

This research developed from a desire to examine Whānau Ora in one area, acknowledging that Whānau Ora is necessarily defined differently by different iwi and therefore likely to have differences in service provision for Māori. Whānau Ora has a diversity of interpretations and understandings and emerging definitions and potential applications. Whānau Ora has not yet been defined by Ngāti Ruanui iwi members and so they were interviewed for this research. For the purposes of this research, Whānau Ora is described as optimal health and wellbeing for Māori. This undertaking has provided me with the opportunity to investigate within my iwi service provision for Māori and how Whānau Ora may impact on better health outcomes.

Introducing the researcher - Uri O Ngāti Ruanui

As a descendent of Ngāti Ruanui, my whakapapa (descent lines) come through both my parents. I am the youngest of fourteen children and my parents were Ropata Wahawaha Campbell and Miriama Te Poihi Hikuroa Barrett. I developed a clear understanding of the relationships with the whenua (land), spiritual guidance, and a sense of reality which came from a very humble background but also fortunate to be

brought up in two worlds Pākehā and Māori. Our Whānau were brought up on a farm and lived opposite Taiporohenui marae. At this marae, the wharekai (dining room) is Kautu-ki-te-rangi, named after the handle of the paddle of the Aotea canoe. In John Houston's book, "Māori Life in Old Taranaki", various tribal leaders are mentioned including Panenui Hauraranga of Taiporohenui who was married to my grand-aunt Te Moana Campbell. This kuia brought up my father and uncle and I am named after her. There are many memories of hui, church, bible class, Sunday school, birthdays, weddings and tangihanga which took place at the marae. Whakawhānaungatanga was the 'norm' for us growing up there, surrounded always by kuia, koro, aunties and uncles and caring, loving parents. We were taught the values of whakapapa, tikanga, wairua, hinengaro and aroha. We were also taught to rise to the challenge of any adversity, however at that time we were part of a generation that were taught not to learn Te Reo, but the importance of an education in the Western world. Growing up in a large Whānau was about relationships that have developed over time and holding strong to the belief that aroha, manaaki and that 'sharing the load' would 'lessen the load'.

Positioning myself in the Research

Ki te taha o te Matua

Ko Taranaki te Maunga,

Tangahoe te awa,

Aotea te waka

Hamua Hapotiki te hapū,

Ngāti Ruanui Te Iwi

Ko Taiporohenui Te Marae

Ko Areka Campbell raua ko Waiata Tito oku matua tupuna

Ko Ropatawahawaha Campbell raua ko Miriama Te Poihi Hikuroa oku matua

Te Moana Campbell-Knowles ahau

Tihei Mauriora

I have been employed by Ngāti Ruanui Tahua Trust in a small rural GP practice (Ruanui Health Centre) since 2003, firstly as a Whānau Ora nurse and then as an Early Intervention Alcohol and Other Drugs nurse (A&OD). Supporting tangata whaiora (unwell person) with mental health and addiction problems has been

challenging due to poor outcomes that this group experiences. Intergenerational drug and alcohol abuse, financial hardship, illiteracy, limited access to health and social services, transport, housing and the stigma of mental health are some of the factors that tangata whaiora encounter. The research interviews, although not with this specific group, prompted a series of reflections having witnessed first-hand in the community the suffering and the inequities Whānau face and this has reinforced my commitment to Māori development. Even though there have been improvements in healthcare for Māori, the current situation of the state of the Māori world such as high unemployment rates especially for young people, over-representation in the prison and mental health populations means that promotion for Whānau Ora - optimal health and wellbeing, remains a priority. The aspiration for Whānau Ora is to bring together health, education, social services and justice services, for a coherent and robust approach to Whānau optimal health and wellbeing.

Preparation and initiation of the study

Knowledge of my tupuna who are no longer with us, and being fortunate to grow up on a 'pa' (meeting place) and witnessing not only the wonderful whakawhānaungatanga and aroha but also the deterioration of health due to urbanization and the impacts of limited Whānau support have guided me to pursue the best healthcare for our iwi and has been one of the driving forces to pursue this research. My parents Ropata Wahawaha Campbell and Miriama Campbell have been a guiding light for me, their quiet but incredible wisdom, expression of their trust and faith in their Whānau, their relationship with whakapapa, whenua, mauri, aroha, wairua, karakia and their means of nurturing and healing have shaped, influenced and taught me what it is to be Māori, a wahine and a mokopuna O Ngāti Ruanui, Tangahoe, Nga Ruahinerangi, Tainui, Ngāti Porou.

Chapter Two Literature Review

Introduction

There is a lack of research evidence related to defining and using a Whānau Ora approach for Māori to achieve maximum health outcomes as it is a relatively new topic that is in development from policy into practice. There is also a paucity of literature related to cultural beliefs and practices for Māori relating specifically to Whānau Ora approaches among Māori, describing Māori Whānau and their experiences of their health care from a Māori worldview.

This literature review falls into two main areas which are presented in two chapters. The first discusses current issues for Ngāti Ruanui, and how they have been influenced through the processes of colonisation and urbanisation. This discussion includes the background of Ngāti Ruanui, Māori health development and the determinants of Māori health. An historical overview of Māori health history, colonization, indigenous health status and the Treaty of Waitangi (ToW) and the impact on health for Māori is discussed. The second area of discussion is specific to strategies to overcome health disparities with the development of changes since 1980s. This includes a contextual analysis of Ngāti Ruanui Tahua Trust, and an examination of whānau as a family system, and various definitions of Whānau Ora are explored.

The literature review was carried out using the Massey University library catalogue. Databases such as CINAHL, Web of Science, e-Journals, PubMed were searched using consistent search terms. Google Scholar was used to investigate searches through the databases, and the social science librarians were consulted. A thorough search of theses identified ten Masters research theses and two Doctoral theses related to the topic. The search terms and broad topic areas reviewed were

- Indigenous and Māori knowledge (matauranga)
- Whānau ora
- Māori health development
- Hauora
- Māori-centred qualitative research

Within each of these broad topics particular fields were more extensively searched. For example within the field of Whānau ora, literature relating to the following areas was investigated:

- research and definitions of Whānau Ora.
- Whānau within a Māori worldview.
- theoretical and conceptual development of Whānau Ora.
- critique Whānau Ora.
- policy Whānau Ora.
- future development for Whānau Ora.

Key words were Māori, Māori-centred, whānau, and Whānau Ora, hauora, indigenous, aboriginal, First nations, disparities, determinants, urbanization, whānaungatanga, hapū, iwi, collective responsibility, Treaty of Waitangi, health and wellbeing. Searches were made of related government websites such as Ministry of Health (MOH), Ministry of Social Development (MSD), and the Ministry of Māori Development Te Puni Kōkiri (TPK), who have all contributed to the development of Whānau Ora and all have a role in resourcing and supporting Whānau Ora. These sources provided valuable and broad research and policy resources which have been incorporated into this literature review to inform this research. As the research is concerned with the meaning of Whānau Ora for Ngāti Ruanui, these broad resources are discussed alongside the situated and localised context of the people themselves.

Ngāti Ruanui Background

Aotea is the canoe

Turi is the man on board

Te Roku-o-whiti is the paddle

Close to the side, the paddle

Encircle the side, the paddle,

Forward, standing, the paddle,

Forward, flying, the paddle,

Forward, springing the paddle,

Forward, flapping the paddle.

Name the handle of my paddle, then,

After Kautu-ki-te-rangi.

From the awa of the Aotea canoe. The awa was a karakia for the calming of the sea, and for securing a prosperous voyage.

Translated by S. Percy Smith.

Early History

From the seventh to the fourteenth centuries, the canoes of the Polynesians traversed Te-Moana-nui-a-Kiwa, the Pacific Ocean seeking new lands (Houston, 1965). The origin of Ngāti Ruanui was Hawaiki-Rangiatea (Tahiti) and chiefs and priests from different islands came to Hawaiki-Rangiatea for important ceremonies, and to teach ancient lore. Turi, who was of high descent and his followers departed from Hawaiki-Rangiatea on board their waka (canoe) Aotea, described as a large single canoe outrigger. These ancestors came to Aotearoa from Hawaiki-Rangiatea and landed somewhere on the northeast coast of the North Island (Houston, 1965). Contemporary DNA sequencing technology is placed alongside Māori traditions of this ancestral journey which ended in Taranaki (Sole, 2005). The tribes that trace their ancestry to the Aotea include Ngāti-Ruanui, Nga Rauru, Whanganui, Ngāti-Apa and Muaupoko (Houston, 1965).

Ngāti Ruanui is closely related to several other iwi, especially those that claim descent to Nga Ruahine and Nga Rauru, and are merged and indeed tangled, in geography and bloodlines. There are other geographically distant iwi with strong links with Ngāti Ruanui, in particular to the tupuna Ruaputuhanga and her links to Waikato and also Te Tai Tokerau. It is fully acknowledged that the histories of Nga Ruahine, Tangahoe and Pakakohe are inextricably intertwined in the Ngāti Ruanui story, especially up to the end of the nineteenth century when Nga Ruahine was usually recognized as part of Ngāti Ruanui. Perhaps the best example is Titokowaru, the rangātira of the Manuhiakai hapū of Ngaruahine who led the Ngāti Ruanui challenge against the colonials during the wars in 1868-1869. Both Titokowaru and Te Whiti-O-Rongomai resisted colonial expansion, but, as indigenous people throughout the world were discovering, the human tide from Europe was unstoppable (Sole, 2005).

Regardless of the strategy employed, and in spite of short-term gains, Titokowaru, Te Whiti, and numerous other indigenous leaders suffered the loss of their lands, and

many of their people, through the processes of colonisation within the space of fifty years. Sole (2005) argues that Ngāti Ruanui suffered greatly and unjustly from land confiscations following the Taranaki wars and the first decade of the twenty-first century has seen the successful achievement of the Ngāti Ruanui Treaty of Waitangi settlement and delivery of a Crown apology. In 1996, the Waitangi Tribunal determined that the Crown had acted unfairly in its conflict with Ngāti Ruanui. Te Runanga O Ngāti Ruanui is now the governing body of the iwi. The Runanga manages the assets of the iwi, and represents the iwi in political consultations with the New Zealand Government.

Ngāti Ruanui population

Ngāti Ruanui is an iwi located in South Taranaki. In the 2006 census, 7,035 people claimed affiliation to the iwi (tribe). However, most members now live outside the traditional areas of the iwi. In 2001 the population of Ngāti Ruanui was 5,675 but only about 1,000 of these now live in or near the traditional rohe (area). About sixty percent reside in cities of 30,000 or more; almost 1,000 live in Auckland with another 750 in Wellington (Sole, 2005). At the start of the twentieth century Ngāti Ruanui were geographically marginalised and isolated from their reserved lands, living in rural, marae-centred communities with very little meaningful contact with the local Pākehā communities (Sole, 2005).

The 1908 Western Māori Electoral Roll shows enrolled Ngāti Ruanui were concentrated in the villages of Aotea-Weriweri (Nga Ruahine, Umutahi, and Inuwai), Okaiawa (Nga Ruahine, Manuhiakai, and Otakeho (Nga Ruahine, Ngāti Haua). Ngāti Ruanui between the Waingongoro and Tangahoe rivers were centred on five main settlements: Ngarongo-Ketemarae (Araukuku) Keteonetea (Ngāti Tanewai), Matangara (Hapotiki), Taiporohenui (Hamua), and Taukokako (Ngāti Hawe), although at that time only four individuals indicated Tangahoe as their hapū. South of the Tangahoe River almost all voters identified Ngāti Hine as one of their hapū, centred on three kainga: Meremere (Ngāti Hine, Nga Ariki), Te Takere (Ngāti Hine, Pakahohe) and Pairoa (Ngāti Hine, Ngāti Tupito, Pakakohe).

Significantly, of the 357 enrolled voters in 1908 only twelve lived in Hawera, Manaia and Patea combined, and this trend would continue until the 1950s when

Māori throughout Aotearoa began to flood into the towns and cities (Sole, 2005). This migration of Ngāti Ruanui from a rural Taranaki existence into the towns was a response to increased mechanization of agriculture and the closing of dairy factories due to improved transport and economies of scale. For example in the mid 1950s, ten of the eleven staff at Tawhiti dairy factory were men from the Taiporohenui community who would be forced to seek other employment when the factory closed in the 1960s. Throughout South Taranaki small communities in Alton were extinguished by the closure of dairy factories in the 1960s and 1970s (Sole, 2005). Furthermore, the Ngāti Ruanui exodus was also catalysed by the parallel rise of manufacturing in the cities. The continued drain of Ngāti Ruanui away from the rohe (area) in the last decade now is now probably driven by the increasing proportion of young Ngāti Ruanui who leave for tertiary education and do not return (Sole, 2005).

Indigenous Health Status and Colonisation

Māori are the indigenous people of New Zealand, comprising 14.5 per cent of the population in 1996 (Statistics New Zealand, 1997). Churchill (1996) and Jackson (1996) describe colonisation as the dehumanization of indigenous peoples to a) believe that they have a lesser right to the resources and territory in their control than the newcomers and b) power and resource are obtained from the indigenous inhabitants and redistributed to the newcomers. Horton (2006) suggests that indigenous peoples are consistently marginalised from the political, economic and social mainstream, and their ability to strengthen their cultural identities is getting harder. For most indigenous peoples poverty is endemic, political representation is weak, access to education is highly variable, and displacement and human rights violations are common (Barton, 2008). Poor health experienced by indigenous groups compared to others in their population is considered the most difficult problem of all. This is demonstrated through systemic inequalities and consistent disparities experienced by indigenous peoples when compared to the non-indigenous population (Bramley, Herbert & Chassin, 2004).

Māori in Aotearoa recognized the importance of healthy communities (Durie, 1998). Māori Public health effectiveness depended on a system of communal safety and integrity of a collective entity. Since survival demanded a united approach to day-to-day existence for Māori, individual licence took second place to the interests of the

group as a whole (Durie, 1998). Pre-colonial Māori maintained a good level of health compared to their European counterparts, possessing successful rongoa or healing methods (Durie, 1998). As a result the Māori population suffered a dramatic increase in mortality and morbidity as a result of colonisation, going from a population of an estimated 150,000 down to 42,000 by 1896 (Durie, 1998). Furthermore, King (2005) has noted the population reduced to as low as 20,000. Māori health advocates such as Maui Pomare, Te Rangi Hiroa and Apirana Ngata worked tirelessly at community and political levels to introduce strategies to assist in reducing the number of illnesses related to deaths and disease for Māori (Durie, 1998). Strategies included introducing Māori Health Inspectors who were responsible for health promotion within various Māori communities, and the training of Māori registered nurses with the vision to work with their own people (Abbot, 1987a, 1987b, 1987c; Holdaway, 1993).

Prior to the arrival of European people (Pākehā), Māori were healthy with very little illness and disease (Buck 1966; Papakura, 1938). Mortality among children was low and there were no records of endemic or epidemic diseases. Diseases such as typhoid, tuberculosis, and measles were unfamiliar to Māori until European contact (Buck, 1966). Measles, influenza, typhoid, scarlet fever and mumps were all to take their toll, though towards the end of the century higher levels of immunity meant a reduced incidence especially in the older age groups. Apart from the epidemics there were other diseases which added to the high mortality rates and progressive depopulation. Tuberculosis remained a serious problem in New Zealand and Māori communities well into the twentieth century. By the middle of the nineteenth century it was widely prevalent, crowded living conditions promoted its rapid spread (Durie, 1998). Today, Tuberculosis continues to occur in some areas in New Zealand and 350-440 cases were reported recently (Ministry of Health 2010) and continues to be spread in poor and overcrowded housing.

By early 1900, mortality rates increased due to the 1918 influenza epidemic that spread throughout the world. Māori demonstrated less resistance to the epidemic than Europeans. Examination of death rates suggest that Māori fatalities were estimated to be four and a half times higher (King 2005), and possibly, as much as

seven times higher than Pākehā (Lange, 1999). By 1950 mortality rates began to improve as exposure to European diseases developed natural immunity. Māori life expectancy continued to increase during 1960 and 1970. As it currently stands, Māori have a life expectancy that is 9 years shorter than their Pākehā counterparts (Ministry of Social Development, 2008). The gap in life expectancy between the indigenous and non-indigenous populations is estimated to be 17 years for Australia, 9 years in New Zealand, 5-7 years in Canada and 4-5 years in the USA (Anderson, Crengle, Leialoha Kamaka, Chen, Palofox, Jackson-Pulver, 2006; Ring & Brown, 2003).

Access to health services was identified as a factor in the death rates to introduced diseases. In the period 1924-1936 Māori children who died did not receive medical attention from a doctor. Binney (2010) explains that it was not simply a matter of reluctance by the families to seek medical help, although their belief that unexplained illnesses was caused by makutu (witchcraft) or by a violation of tapu (unsafe), rendering European doctors irrelevant. It was not until 1935 that a medical certificate of death was actually required for Māori. Consequently, there was no legal basis for contact with the European medical world. The lack of medical contact, the high mortality rate, and the overall death reveal the profile of a 'third world' community (Binney, 2010).

Durie (1998) suggests interventions such as a collective Whānau, were found to be of little use when used to treat the diseases brought to New Zealand by the Pākehā. By the close of the eighteenth century a mission of health reform within Māori communities had begun and by 1900 the tide was turning. The threat of total extinction was over and significant increases of Māori population and improved life expectancy demonstrated a capacity for growth and by the close of the century, a mission of health reform within Māori communities had begun (Durie, 1998). Colonial processes have imposed a range of injustices on tangata whenua (Belich 1986; Belich 1990; Smith 1999). Ongoing processes over a century and a half, undermined Māori self-determination and development, marginalizing Māori as a disadvantaged and oppressed minority in their own land, visited by diverse harms in the political, economics, health, education and social spheres (Adjwani, Blakely,

Robson, Tobias & Bonne 2003; Spoonley, Mc Pherson & Pearson, 2004; Statistics New Zealand, 2004). These understandings have fuelled a considerable amount of research aimed at describing the status of Māori, explaining the etiology of their condition and ostensibly informing policy and other interventions designed to improve Māori well-being (Edwards, McCreanor & Moewaka-Barnes, 2007).

Urbanisation

Urbanization and its subsequent negative effects upon social cohesion and social strengths has been a major contributor to variability in the state of Māori wellness (Robson & Harris, 2007). It is a major factor for alienation within Māori society. By the 1970s more than 80% of Māori lived in urban settings. One key outcome has been that new patterns of nutrition for Māori emerged. Malnutrition was less a problem, but the balance achieved by adding kaimoana (seafood) and other natural food resources to the diet was lost to an almost exclusive reliance on foods readily available purchased from supermarkets and fast food outlets (Durie, 2003).

Te Hoe Nuku Roa was a study of over 700 Māori households where it became clear that access had become limited to customary sources of food such as kina (sea eggs), puha (prickly thistle) and rewena (potato) bread, as most respondents had only eaten them once in the past twelve months. Fewer still had access to the harvest of customary foods and slightly more than half had assisted in making a hangi. A degree of culture loss for Māori was identified. Many families were able to maintain ongoing links with hapū and iwi. Māori resilience has nonetheless been striking. Fifty years of urbanization has demonstrated that it has been possible to live side by side with other New Zealanders without being totally assimilated into a homogenous way of life (Durie, 2003).

The most enduring material cultural asset for Māori has been the marae (Durie, 2009). Despite an extensive urbanization process that occurred in the last fifty years, and the prospect that marae would become deserted memorials to a former era, the reverse has occurred. Marae flourish in traditional tribal areas but have also been developed in urban and metropolitan centres associated with schools, universities, hospitals and Māori urban communities. Marae have been constructed in overseas countries where significant Māori communities now reside and as global travel

increases, it is likely that overseas marae will be a world-wide network based on hapū, communities of interest, and global travellers who seek to retain a cultural anchor in an otherwise assimilating environment (Durie, 2009).

Tiriti o Waitangi/Treaty of Waitangi

Wilson (2004) states that the Treaty of Waitangi (ToW) signed in 1840 (Sole 2005) is referred to in health and social policies. The ToW is an agreement between Māori and the Crown that outlines arrangements for Governorship, with the purpose to protect the rights and interests of Māori. While Article One of the Treaty ceded kawanatanga (governorship) to the Crown, Article Two guaranteed Māori tino-rangātiratanga (the right to self-determine) over the lands, villages and taonga (everything held as a treasure). Health is considered a taonga by most Māori, although 'Crown' representatives have debated the relevance of this point with regard to the Treaty. Article Three guarantees the protection of Māori, and the same citizen rights as British citizens under the governorship of the Crown. It is Article Three that establishes the right for Māori to experience the same health status as other New Zealand citizens (Wilson, 2004).

The ToW provides a fundamental framework for Māori health in Taranaki (Taranaki District Health Board, 2009a). It requires Taranaki District Health Board to establish mechanisms to enable Māori to contribute to decision making and participate in the delivery of health and disability services based on the New Zealand and Public Health and Disability Act 2000. The Taranaki District Health Board is an agent committed to assisting and meeting these obligations (Taranaki District Health Board, 2009b). Contributors from the Māori health sector to the development of the *Te Kawau Maro – Taranaki Māori Health Strategy 2009-2029* fulfil a principle of kaikaitianga/guardianship role in terms of supporting and guiding the Treaty principles. Durie (1998) suggests that the ToW was intended to provide a partnership between Māori and the Crown. Unfortunately, the perception of partnership held by the two Treaty partners differed greatly. For a long time, the effect of the ToW upon health for Māori was negligible. More than 100 years were to pass before the ToW was to be actively recognized as a means of supporting and advancing improvement in health status - in the first century of existence, no true partnership was recognized.

The ToW became a vehicle to further advance the process of dispossession rather than to protect what already existed (Wenn, 2007).

Furthermore, the first article in Māori ultimately accommodated a very loosely worded transfer of sovereignty. The ToW made significant guarantees of Crown protection of Māori taonga (treasures) while guaranteeing that Māori also retained control over Māori resources in article two. In article three the ToW guaranteed Māori the same rights and privileges as British subjects enjoyed in 1840. In common with all treaties this one was written with the future in mind. Although the ToW was declared a simple nullity in 1877, because it has never been incorporated in to New Zealand law by a specific Act of Parliament, it was acknowledged as the founding document of New Zealand in 1992 (Durie, 1998). Raising the question about the constitutional position of Māori beyond 2020, the relevance of the ToW is a platform for development. The ToW provides an important, useful, durable and enduring leadership framework for defining and shaping sector response to eliminate inequalities and improve health outcomes for Māori (Durie, 2003).

Determinants of Health

For the purpose of this research Whānau Ora is about optimal health and wellbeing. The determinant's of health for Māori is not attributed to one or two influencing factors, but is a combination of factors. Furthermore, health outcomes reflect complicated combinations of past and present, individual and group, home and nation. Determinants may include income, housing, education, poverty, ethnic inequalities, racism and access to health services. There have been significant improvements in Māori health status over the last forty years, but despite this, Māori health continues to lag behind that of non-Māori (National Advisory Board on Health and Disability, 2002). Research indicates that people in the lowest socio-economic groups consistently have the poorest health; and this causative relationship between health and socio-economic conditions is well established (Durie 2001; Howden-Chapman & Cram, 1998).

Analyses using the New Zealand Deprivation Index have shown that in deciles 1 to 7, differences of life expectancy between Māori and non-Māori are 5.3 years for women. For the most deprived deciles 8-10, the difference is 8.2 years and 10.1

years, respectively. More than half of the Māori population lives in areas ranked deciles 8-10 (Ellison, Loschman-Pearce, 2005). Ellison-Loschman, and Pearce (2005) state that Māori men were more than twice as likely as non-Māori to die prematurely and that mortality rates among Māori men were significantly higher in each socio-economic class grouping, and mortality differences among these men were greater as well. There is increasing evidence (Ellison, Loschman-Pearce 2005) that Māori and non-Māori differ in terms of access to primary and secondary health care services and that, given the disparities in mortality they received lower than expected levels of quality hospital care than non-Māori. One survey showed that 38% of Māori adults reported problems with obtaining necessary care in their local area, as compared with 16% of non-Māori. Māori were almost twice as likely as Non-Māori (34% vs. 18%) to have gone without health care in the past year because of the cost of such care.

Significant mortality and morbidity rates, high deprivation index scores and under-utilisation of health care for Māori are significant issues that identify a need for alternative health service provision and health promotion to decrease disparity. In order to provide some solutions to these problems there are a range of Māori health initiatives, policy changes, and development that promote a Whānau Ora approach that incorporates cross-government responses. Whānau Ora aims to address social factors such as low income, poor housing, poor education, poverty, and disparity which is discussed in the next section of this chapter.

Disparities include differences by age, gender, socioeconomic position, ethnicity, impairment and geographical region (Robson & Harris, 2007). Health inequalities are defined as differences that are unnecessary and avoidable, and considered unfair and unjust. Robson and Harris (2007) argue for equality, and when unequal outcomes are apparent for Māori, deficit theory is used that ignores systematic and structural bias. However, addressing inequalities is essential. Signal, Martin, Reid, Carroll, Howden-Chapman, Ormsby, Richards, Robson & Wall (2007) reported the New Zealand study "*Tackling health inequalities moving theory to action*", which highlighted inequalities and provided solutions for effective intervention. Workshops involving 24 participants used the Health Equity Assessment Tool (HEAT) and

intervention framework to focus on the health sector. These series of workshops investigated and used ethnicity as a case study to explore racism as the driver of inequalities. They identified a range of institutionalised mechanisms within their own health institutions that create and maintain health inequalities and a range of ways to address them. Further training of staff, politicians, providers, developing inequality objectives into key strategies, policy documents and using Māori Models of health in policy making, in order to better meet the needs of Māori was recommended (Signal et al. 2007).

The contributions of interpersonal and institutional racism significantly influence poor Māori health outcomes and inequalities between Māori and non-Māori in Aotearoa (Harris, Tobias, Jeffreys, Waldegrave, Karlson, & Nazroo, 2006). Harris et al. (2006) examined the 2002 to 2003 New Zealand health survey data for the effect of self-reported experiences of racial discrimination in health. When participants were asked about experiences of an ethnically motivated attack (physical or verbal), or unfair treatment because of ethnicity by a health professional, in work or when gaining housing, Māori reported the highest prevalence (34%) of ever experiencing any forms of racial discrimination, and were 10 times more likely to experience multiple types of discrimination compared to Europeans and others (4.5% versus 0.5%). Both nationally and internationally there is increasing evidence to suggest that racism is a major determinant of health, and a fundamental driver of ethnic inequalities (Bhopal, 2006; Harris, et al., 2006; Nairn, Pega, McCreanor, Rankine, Barnes, 2006; Robson and Harris, 2007).

Mental Health and Addictions

One area that Māori are particularly over-represented is in mental health and addiction (Ministry of Health, 2006). My professional experience as a mental health nurse gave me an insight into the gaps in mental health service provision that confront nurses in everyday practice. It is difficult to work as a clinician with tangata whaiora solely on individual needs in a medical model without addressing group or whānau needs for maximum health outcomes. It is important to provide an approach that addresses the inclusion of wider whānau networks to provide long-term outcomes. Mental health service provision would therefore benefit from a cultural and Whānau Ora approach in assessment processes and a mapping pathway to

achieve optimal health and wellbeing. Māori entering mental health services are not always diagnosed correctly because of the lack of cultural input (Mental Health Commission, 2007b) and treatment plans seldom recognise cultural components for tangata whaiora (Mental Health Commission, 2007b). Mental health services that do not take into account the significance of culture to presentation, assessment, treatment and follow-up create a greater likelihood of poorer outcomes and reduced health gains (Mental Health Commission, 2007a).

Research describing mental health, mental disorders and suicide among Māori highlight the increasing concern about Māori mental health over recent decades (Robson & Harris 2007). The MaGPie study found increased risk of depression, anxiety, and substances disorders among Māori (MaGPie Research Group 2001, 2003, 2005). Overall rates of suicide among Māori are 1.5 times higher than non-Māori. The presence of suicide among the very young under 15 years is higher for Māori than non-Māori, and the proportion of these that are Māori is of particular concern and has been noted in other research (Beautrias 2001; Sargent and Baxter, 2005). Hodges, Maskell, McLennan and Collings (2005) conclude that the minority status of Māori has aggravated aggressive colonisation; loss of traditional lands, authority and control, low socioeconomic status, poor health and substandard housing, loss of the indigenous language and cultural identity. They also suggest there is a common perception that suicide was a relatively rare even in traditional Māori society and that suicide by Māori in modern New Zealand is an unfortunate by-product of colonisation.

A study of practice that utilised social networks and family in Northern Scandinavia to commence psychosocial treatment from the outset, managed to reduce hospitalization rates to about 25% of other services (Drury & Munro, 2008). These services have more than 80% of their clients working five years later, and 75 % showing no residual signs of psychosis. They appear to have all but eliminated psychiatric chronicity in their area with a decline of 'high user' numbers. There is much to learn from Northern Scandinavia especially in the act of engagement, that we may serve Whānau better. This article reviews the skill of hospitality (manaakitanga), which they term as the art of creating an atmosphere where the

respect and integrity (mana) of all participants are enhanced. The challenge in mental health crisis situations is to get the right participation, and when this challenge is not met, the client may be overpowered by coercive treatments, and the long-term cost is high for both the client and society (Drury & Munro, 2008).

Te Hononga 2015 provides a single, unifying picture of the sector for 2015 from the perspective of the Mental Health Commission (Mental Health Commission, 2007b). The meaning of Te Hononga is to connect physically, socially and spiritually. It is about achieving connectedness and synergies whenever people come together, whether it is a Whānau and communities as part of services, systems and sectors (Mental Health Commission, 2007b). The main purpose of the report is aspirational in its aim to improve the health status of the people of New Zealand. The report identifies that wider determinants of life skills all contribute to better health outcome. This demands a high level of interactivity within the health sector and the wider society to promote that common purpose. This report also states that Māori will be actively involved in all levels of service monitoring, oversight, governance, planning, delivery and development.

Summary

The migration of Ngāti Ruanui Iwi members to urban cities had a significant impact on their health and wellbeing. With the significant effects of colonisation, a degree of culture loss and the undermining of self-determination and development, Ngāti Ruanui iwi members were disadvantaged and an oppressed minority in their own land which marginalised their ability to participate in the political, education, social and health spheres. Building inequality objectives into key strategies using Māori Models of health are needed in policy in order to meet the health and social needs of Māori. Another challenge is in mental health services so it was suggested that manaakitanga as an integral aspect of Māori culture, the art of creating a skill of trusting and an atmosphere where the mana of all participants are enhanced, is introduced in assessment for Māori. Despite the evidence linking Māori health status, deficit explanations continue to be circulated. The ToW is a relevant document for Māori and is referred to in a variety of health and social policies as it provides an important, useful, durable and enduring leadership framework to address negative social and health outcomes for all Māori (Durie, 2003).

Chapter Three Strategies to overcome health inequalities

Māori have on average the poorest health status of any population group in New Zealand and for many years there have been governmental strategies and interventions that aim to reduce health inequalities for Māori (Houkamau, 2010). Evidence suggests that the economic and social reforms of the 1980s and 1990s had a significant effect on Māori health status. There was little decrease in Māori mortality rates over the two decades despite a steady decline in non-Māori mortality rates (Ajwani, Blakely, Robson, Tobias & Bonne, 2003; Blakely, Tobias, & Atkinson, 2008). During the economic reforms of the 1980s, Māori rates of unemployment went from being equal, to three times that of non-Māori. Māori were more likely to experience lower incomes and poorer living conditions (Ajwani et al., 2003). The changes that occurred at the time of economic reform in New Zealand coincided with no further improvements in Māori health (Collings & Ellis, 1997; Durie, 2001; Howden-Chapman & Cram, 1998; National Advisory Committee on Health and Disability, 2002; Robson, 2004). The developments of the past twenty-five years will be described in this chapter.

All iwi now regard health as a high tribal priority and most have developed health programmes delivered by their own people, but prior to 1984, fewer than five iwi included health as an item on their agenda (Durie, 2009). Iwi health initiatives include environmental programmes, marae-based health provision, marae smokefree and sport and exercise programmes, and health governance including policy development. Within urban Māori communities, delivery of health services has assumed a higher priority, and includes early interventions for child health, mental health services, and walk in clinics that offer a wider package of care for Whānau (Durie, 2009). The establishment of six Māori health research centres since 1993 that employ Māori tikanga and research methods alongside conventional approaches, demonstrates the relevance of Māori knowledge to understanding contemporary health problems (Durie, 1998). Other recent initiatives contribute to capacity building in health to improve health outcomes for Māori, such as Māori nursing education programmes instituted in 2009 that prepare to train nurses to work effectively with Māori using a mix of Māori and non-Māori methods and theory

(Durie, 2009). Furthermore there has been a growth in the Māori health workforce and parallel growth of Māori health providers.

Capacity building to increase the numbers of Māori working in all areas of the health sector has shown significant increases. Between 1984 and 2009 the number of medical practitioners has increased from around 50 to over 250; from four dentists in 1984 there were 48 in 2009; and in 2009 there were more than 300 Māori mental health and addiction workers (Durie, 2009). There have also been increases in the number of health support workers, community health workers, health professional and cultural advisors that has created a total workforce that has changed New Zealand's health sector. As a result of the drive towards Māori participation in health, there are now 200 Māori health service providers in New Zealand. Māori are represented in the governance of District Health Board, and throughout the Ministry of Health and government (Durie, 2009).

Lawson-Te Aho of the Families Commission (2010) suggests that iwi are the political vehicle and voice for Māori and have an instrumental role in whānau development. One of the political roles of iwi is to work alongside the Crown and its government agencies is to maintain whakapapa (genealogy) based relationships in order to exercise status as mana whenua to maintain external influence, prestige and power in a tribal area. In the Families Commission strategic plan three iwi, Ngai Tahu, Tainui and Ngāti Porou agree that whānau development can be progressed. The Ngai Tahu 2025 Strategic Plan "Vision 2025" is an example of what is important in the future development and survival of whānau. Ngai Tahu uses the guiding statement "Tino-rangatiratanga – Mo Tatou or self-determination for us and our children". They also aspire to whānau wellbeing by engaging in activities that enhance physical, emotional, mental and spiritual health. Whānau is their social foundation, whakapapa identifies and unites them and whenua sustains their existence (Lawson-Te Aho, Families Commission, 2010).

The Whakatupuranga Waikato - Tainui 2050 strategy articulates the desire of the iwi to equip generations of Tainui Whānau so that they have the capacity to be self-determining to exercise tino-rangātiratanga at the personal and whānau level. Three

critical elements that underpin Tainui are recognition of the importance of tribal history, matauranga, reo and tikanga. The second element is the creation of a culture for success to lead the creation of opportunities and choices and to promote diligence among tribal members of all ages to pursue success in all of their endeavours. The third element is self determination for economic independence and this relates the growth of tribal assets (Lawson-Te Aho, Families Commission 2010).

Te Runanga o Ngāti Porou Strategic Plan 2009-2012 has a vision statement that re-affirms the knowledge base of Ngāti Porou and the application of the wisdom and knowledge to all Ngāti Porou cultural, economic, social and political developments that contribute to the prosperity and survival of Ngāti Porou Whānau (Lawson-Te Aho, Families Commission, 2010). Iwi development is an emergent driving force, orchestrating development and utilising the state and other external contributors, in supporting and resourcing that development (Lawson-Te Aho, Families Commission, 2010). Therefore since health has appeared on the agenda as an important factor, many initiatives and strategies have focused on improving participation so that services are developed and delivered in a way which meets health and social needs of iwi in Aotearoa (Durie, 2009).

Policies – Government strategies

Torjman (2005) suggests that policy is a broad concept that embodies several different dimensions. The challenge is to articulate in a comprehensible and a cogent way the meaning of this term. Policy development is a series of decision-making process about how best to achieve a specific objective (Torjman, 2005). Policy implementation has seen a renaissance of Māori culture and health and social policy. The revival of Māori culture and identity is reflected in the resurgence of te reo (Māori language) and in the form of immersion kura (schools). From pre-schoolers at kohanga reo (early childhood), to kura kaupapa (primary schools) and Māori wananga (Universities), Māori and non-Māori now have opportunities to be educated in te reo Māori (May, 1999). Māori have also claimed their right to have equitable health and this process started with government commitment to health strategies such as He Korowai Oranga (Ministry of Health, 2002a) which intended to place whānau at the centre of public policy and challenge Māori to create environments that enable whānau to shape and direct their own lives to achieve the quality of life

Māori are entitled to as tangata whaiora in Aotearoa/New Zealand. Resources were secured for Māori led initiatives such as Māori community and marae based clinics (Durie, 2003; Durie, 2005; Ministry of Health, 2002a; Ratima, 1999; Wepa, 2005).

Furthermore, Wilson (2004) suggested that He Korowai Oranga links the New Zealand Health Strategy with the Primary Health Care Strategy and Te Puawaitanga, the Māori mental health framework (Ministry of Health, 2002a). The partner to He Korowai Oranga is the action plan to implement He Korowai Oranga, Whakataka (Ministry of Health 2002b), which sets out the government expectations of the publicly funded health and disability providers to improve whānua ora. A feature of Whakataka is the recognition that traditional Māori health practices, such as rongoa (natural remedies), mirimiri (massage) and karakia (spirituality) are an integral part of the health services Māori access. More recently, inter-departmental government strategies developed as potential solutions to address longstanding inequalities, bringing all sectors together understand their role in relation to health, and for whole of government sector to work with Māori to address these issues.

Whānau Ora: Report of the Taskforce on Whānau-Centred initiatives (Durie, Cooper, Snively, Grennall, Tuaine, 2010) found that Whānau Ora is about self-determination and self-management. Long-term dependency on outside agencies is not consistent with Whānau Ora, and the aim is to enable Whānau to assume responsibility for their own affairs (Durie et al. 2010). The consultation process focused on gains in health, education and social-inclusion as well as economic gains such as expanding asset base and cultural gains including participation in Te Ao Māori (the Māori world) based on notions of collectivity. During the consultation process, hui participants often regarded the overall aim of the Taskforce as synonymous with the broad aims of Whānau Ora, even though interpretations of Whānau Ora varied. Durie et al., (2010) further explains that while not all Māori are able to affiliate to hapū, iwi or a Māori organisation, all are members of a whānau. More than any single institution, whānau has the potential to convert risk and threat to safety, security and the realisation of human potential. The use of the term of whānau is not limited to traditional definitions but recognises the wide diversity of

families represented within Māori communities. It is up to each Whānau and each individual to define their whānau for themselves.

In the Families Commission (2011) report *Definitions of Whānau – A Review of Selected Literature* the purpose is to inform the Families Commission's Whānau Strategic Framework 2009-2012 (see below). The overarching working definition of Whānau Ora is "Whānau Ora is achieved when Whānau are the best they can be". It is expected that this definition will evolve over time as further understanding is gained. The review of selected literature on Whānau Ora and its application in social policies, social service provision, iwi development and the Whānau Ora Taskforce clarifies some of the key themes that the Families Commission considered when developing a working definition of Whānau Ora:

- Has to be defined by whānau themselves
- Is an integrated approach to whānau wellbeing
- Is founded on Māori values, worldviews and cultural practices and identity
- Is a strengths-based approach
- Involves the inter-generational transmission of knowledge and
- Whānau are capable of developing and leading their own solutions

In these themes, whānau are recognised as the key site for change and the place to focus efforts to improve social and health outcomes for Māori (Families Commission, 2011).

The role of the Families Commission is to inform, debate and advocate for whānau development led by whānau and to support the work of other agencies such as Te Puni Kōkiri (TPK), the Ministry of Social Development (MSD) and the Ministry of Health (MOH) who are concerned with Whānau Ora. Families Commission (2011) state that the most recent Whānau Strategic Framework 2009-2012 is a critical part of the commitment to the needs, values and beliefs of Māori as tangata whenua. The report (Families Commission 2011) *Whānau, Yesterday and Tomorrow* achieves a milestone in delivering on that strategy and makes a significant contribution to the knowledge resources of the government. Consultation with whānau, Māori service providers, researchers, iwi and organisations took place to discuss the whānau strategy.

Clear messages were received:

- Whānau Ora is a non-negotiable outcome
- Listen to the voices of Whānau
- Speak out for vulnerable Whānau
- Inform best practice

The Commissions Whānau Strategy recognizes that past research has often been about Māori, not with Māori. For many years this has meant that Māori have been described in terms of deficits, where whānau success or failure is measured by indicators that do not recognize kaupapa Māori frameworks (Families Commission, 2011). Whilst it is true that Māori lifestyles include the broadest range of human experience, as is also the case with any other culture, Māori have a right to explore best-case scenarios of whānau, hapū and iwi development.

Development of Ngāti Ruanui Tahua Trust– A Whānau Ora health and social provider.

Ngāti Ruanui Tahua Trust (NRTT) is an iwi-owned health and social service located in Hawera that provides health (Ruanui Health Centre), social (Iwi Social Services) and Early Childhood Education and Kohanga Reo for Ngāti Ruanui iwi members and others. This section presents analysis of archived documents retrieved from Ngāti Ruanui Tahua Trust (NRTT), for the purpose of identifying the principles and values Ngāti Ruanui used to develop Whānau Ora. One of the defining features of NRTT is its whānau, hapū and iwi foundation with governance representatives mandated by individual marae processes. It also places value on Whānau Ora as a critical pathway to achieving health and social wellbeing for whānau. The approach to meeting health needs has been developed with the broader context of advancing social, economic, cultural and environmental capability of whānau, hapū and iwi. Such an approach is fundamental in an inequalities framework for promoting the Whānau Ora approach. NRTT recognizes that a focus on health alone can not address negative health status and that health improvements occur through collective responsibilities that contribute to reclaiming, restoring and enhancing physical, emotional, mental, spiritual, cultural and whānau wellbeing. The key principles which provide the foundation of NRTT are:

- Mana atua – acknowledges the spiritual realm from where all things are conceived

- Mana tangata – acknowledges the divine essence of life force (mauriora) that is each person’s birthright
- Mana whenua – acknowledges the relationship with the land
- Whakapapa, taonga tuku iho, Whānaungatanga, manaakitanga, kaitiakitanga and aroha – are life principles that are inextricably bound to mana atua, mana tangata and mana whenua.

The goals of NRTT contribute to the advancement of whānau, hapū and iwi through initiatives that;

1. Effectively contribute to the wellbeing of whānau, hapū and hapū.
2. Assist and support whānau, hapū and iwi through innovative approaches to reach their full potential in a global community.
3. Co-ordinate a cohesive and effective approach to the provision of health services through positive and fruitful relationships with their enrolled population, other providers, government and its agencies, and the wider South Taranaki community.
4. Utilise traditional pathways to create and shape future pathways for the social, economic and environmental advancement of whānau, hapū and iwi.

The Taranaki Report-Kaupapa Tuatahi and reducing inequalities

The development of NRTT originates from historical (1926) iwi and hapū events. The Taranaki Report came out of the Waitangi Tribunal and the Taranaki Māori Trust Board was formed (Waitangi Tribunal, 1996). Māori health was in decline, and in response to improving Māori health in Taranaki, Te Whare Punanga Korero (Governance) and Te Kawao Maro (Taranaki Māori Health Strategy) were formed, supported by Taranaki District Health Board in 2001. After Primary Health Organisations (PHOs) were established in 2001, NRTT joined with Te Atiawa in North Taranaki in 2003 forming Te Tihi Hauora, to improve access and health promotion (see below for more discussion). Today, NRTT is part of the National Hauora Coalition. Whānau Ora, as a concept, is a development from the idea of hauora, as it values diversity, community, inter-dependence and recognises that health must take account social constructs, not just physical symptoms (Ministry of Health, 2002a).

In 1926, the Government established a Royal Commission to inquire into confiscated land and other grievances under Justice Sir William Sim (Waitangi Tribunal, 1996). The Commission reported that the confiscation of land in Taranaki could not be justified and recommended an annual payment of 5,000 pounds in perpetuity. In 1996 the Waitangi Tribunal ruled that Taranaki Māori were dispossessed of the land, leadership, means of livelihood, personal freedom and social structure and values. The taking of land (Wenn 2007) not only makes people poor, it also makes them susceptible to diseases that flourish under conditions of poverty, overcrowding and malnutrition. It destroys or disrupts social networks that provide practical and emotional support in times of need. As discussed previously, moves into urban areas resulted in Māori whānau in Taranaki becoming disenfranchised, no longer able to gain support from their extended Whānau and their values and beliefs such as Whānau Ora or having a healthy whānau was difficult to maintain. As iwi are the political vehicle and voice for whakapapa whānau (Families Commission 2011) and the ToW Article two guarantees iwi rangātiratanga or chieftainship over resources and matters pertaining to the iwi collective (Lawson-Te Aho, Families Commission, 2010) opportunities were taken to improve the lives of people who remained in the area. There have been many iwi initiatives which have taken advantage of health reforms (Durie 1998) promoting health programmes rather than an isolated medical venture consistent with the Whānau Ora philosophy of collective responsibility rather than individual responsibility.

Taranaki District Health Board (TDHB) was established January in 2001, and is responsible for providing and funding health-care services, for the 102,858 people in the Taranaki region. As a Crown agency, the TDHB considers the Treaty of Waitangi principles of partnership, proactive protection of Māori health interests, participation, co-operation and utmost good faith to be implicit conditions of the nature in which the TDHB responds to Māori health issues (Taranaki District Health Board, 2009a). Reducing inequalities is a key government priority which recognizes that people from lower socio economic groups have poorer health, greater exposure to risk factors and poorer access to health services (Taranaki District Health Board, 2009a). In Taranaki, significant inequalities in health exist between Māori and the rest of the Taranaki population. Māori feature significantly in low socio-economic status and have consistently poorer health outcomes in comparison with the rest of

the population. The Taranaki response to improving Māori health in the region is to support and strengthen the capacity of Māori providers, to make health services more accessible to Māori and to improve information gathered for planning and monitoring purposes. The TDHB uses the term Whānau Ora to apply to health services regardless of whether they are early intervention, public health education, treatment and disease management (Lawson-Te Aho, Families Commission, 2010).

Te Whare Punanga Korero (TWPK) is the regional Māori health governance body comprised of representation of the eight iwi of Taranaki and formalizes the Treaty of Waitangi partnership between Taranaki Māori and TDHB. The agreement stipulates that TWPK should be consulted early, and entitled under Article Two of the Treaty of Waitangi to be involved from a governance perspective, in TDHB's planning, purchasing and monitoring decisions that affect Māori health within the Taranaki region.

Te Kawau Maro – Taranaki Māori Health Strategy 2009-2029

Te Kawau Maro (TKM) (Taranaki District Health Board 2009b) is the Taranaki Māori Health Strategy. It represents an expression of rangatiratanga (self-determination) under the ToW, governed, managed, and predominantly staffed by Māori, and outlines the various components of the Māori sector who participate in health service provision decision-making at all levels and strengthen the ability to practice and protect those things that are important to Māori cultural wellbeing. TKM is also used as the strategic framework (Taranaki District Health Board 2009b) that seeks the attainment of Whānau Ora over a twenty-year time span and represents a generation of health and socio-economic advancement. It identifies five strategic priorities which are,

1. Improve access
2. Building Māori capacity to do more
3. Improve mainstream services to be more Māori-friendly.
4. Prioritise strategic relationships
5. Monitor performance.

This strategic framework allows a collective approach to social and health needs and the ability for them to coordinate, collaborate and to address the socio-economic needs such as unemployment, education, housing and justice issues. TKM

recognizes that the significant pathway to Māori health improvement is through primary intervention. Given the make-up of the population and the limitations of resources, collaboration and integration are essential to accelerate the achievement of improved health outcomes. Through effective collaboration within health and between sectors such as housing, social services, education and justice systems, service providers, commercial and not-for profit organizations (such as NRTT) are essential to achieving Whānau Ora (Taranaki District Health Board 2009b).

Taranaki District Health Board (2009b) uses the wellness model of “Te Pae Mahutonga” based on the Southern Cross Star Constellation (see figure 1), to express the dimensions of Whānau Ora. Te Pae Mahutonga designed by Durie (1998) holds significance for Taranaki as its development is attributed to Sir Maui Pomare who in early 1900 adopted a five point health promotion plan to capture the important elements of Māori wellness. Te Pae Mahutonga builds on these dimensions to incorporate the challenges ahead and the increasing need for integrated approaches to achieve Māori health improvement. TKM has added Tinana Ora as a dimension that emphasizes the need to address the current status of Māori health as a pathway to wellness. Together all seven components reflect a local brand of Whānau Ora. All these components are essential for those involved in supporting whānau to achieve Whānau Ora (Taranaki District Health Board 2009b). These include:

1. Mauri Ora – cultural identity
2. Waiora – physical environment
3. Toiora – healthy lifestyles
4. Te oranga – participation in society
5. Nga manukura – leadership
6. Te mana whakahaere – autonomy
7. Tinana ora –physical wellbeing

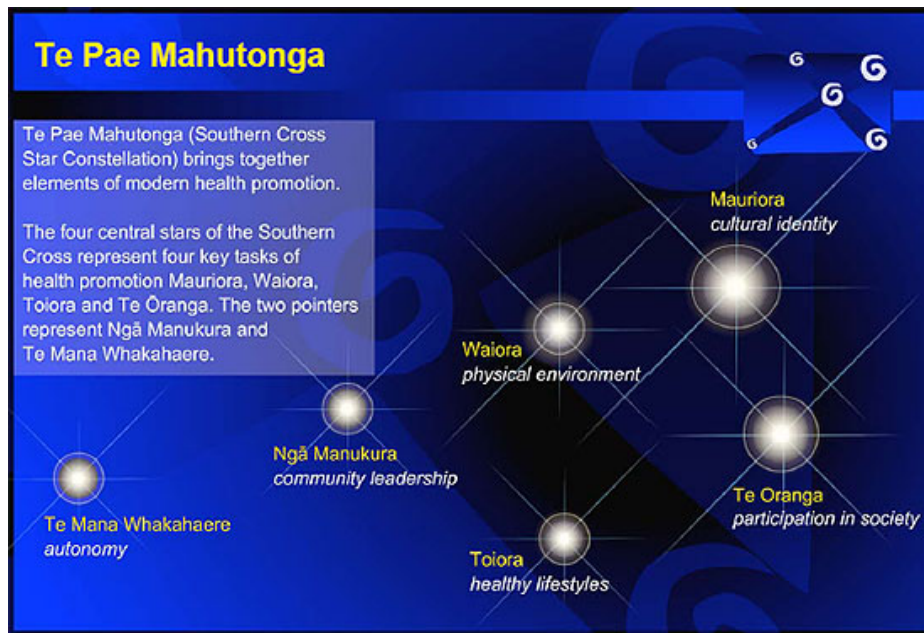


Figure 1

Taranaki District Health Board (2009b)

Te Tihi Hauora

NRTT joined with Te Atiawa in North Taranaki in 2003 forming Te Tihi Hauora O Taranaki, to improve access and health promotion and is committed to working with whānau, hapū and iwi to ensure that services are meeting their needs. Te Tihi Hauora O Taranaki is aimed at contributing to the advancement of whānau, hapū and iwi through initiatives that

- affirm mana motuhake
- acknowledges mana atua, mana whenua, mana tangata
- contribute to reclaiming, restoring and enhancing physical, emotional, mental, spiritual, cultural and Whānau wellbeing

(Te Tihi Hauora O Taranaki 2009).

Iwi and hapū-based health providers are governed by the tikanga of the iwi as tikanga determines the boundaries, obligations, rights, duties and responsibilities to which any Māori health provider must adhere. The rules of tikanga may compel Māori health providers to take extra time when dealing with a client, to observe specific protocols or to involve other people expert in things Māori in particular therapy or intervention. The fundamental values of Whānau Ora is about achieving and meeting health and social needs with a collective approach involving expert people in service delivery (Ngāti Ruanui Health Services, 2008).

Ngāti Ruanui Tahua Trust – Ruanui Health Centre

As part of Te Tihi Hauora O Taranaki (2009) NRTT owns and operates Ruanui Health Centre opened in February 1996 and established by kaumatua of NRTT as a response to the poor health status and barriers faced by whānau, hapū and iwi, with a holistic view to improving health and social status of Ngāti Ruanui whānau by delivering quality health initiatives. A health needs analysis was undertaken with whānau of Ngāti Ruanui at that time and has guided the development services over the last fifteen years (Ngati Ruanui Health Service 2008). Today, Ruanui Health Centre has a General Practice clinic with an enrolled population of 3500 clients. The Community team services the wider south Taranaki area providing mainly nursing based services for Whānau Ora, Disease State Management Tamariki Ora, Outreach Immunisation Service, Aukati Pai Paipa, Alcohol and other Drugs service, Kaumatua Ora, Taiaohi Oranga, Breast screening health promotion, Kaiawhina support and Mirimiri. Ngāti Ruanui Health Services (2008) reports that its Māori health plan maintains that Ruanui Health Centre contributes to addressing inter-sectoral issues including housing, unemployment and education affecting health and wellbeing of Ngāti Ruanui Whānau, hapū, iwi and the wider community. Ruanui Health Centre strives to establish a solid foundation to advance this key strategic area to deliver a Whānau Ora approach with both a clinical and a community team.

Ngāti Ruanuitanga – The Cultural Framework

NRTT is driven by a strong desire of Ngāti Ruanui iwi to achieve mana motuhake for all whānau, hapū and iwi and live according to the traditions of their tupuna where wairua is strong and vibrant, and iwi have fully developed their intellectual, emotional and physical well-being and are confident, secure and pro-active in all aspects of the social, cultural, economic and political life of NRTT. Maturanga Māori informs and guides NRTT in their policy development and decision-making. In the cultural framework, kaupapa and tikanga help shape, focus and maintain values using the principles of manaakitanga, mana, whānaungatanga, wairuatanga, mana whenua, tiakitanga and te reo. These are described and defined in some detail below. All this discussion is based on the Ngati Ruanui health plan 2008-2015 (Ngati Ruanui Health Service, 2008).

Kaupapa – Manaakitanga

Manaakitanga acknowledges the mana of the people, of things tangible or intangible. It elevates the wellbeing or importance of those things to an equal or greater status of importance than ones' own, whereby mana is enhanced, improved and maintained. This could be manifested through the expression of one's aroha, hospitality, generosity, mutual respect, reciprocity, support and understanding shown to the recipient or those things considered of importance.

Nga Tikanga

- NRTT fosters the wellbeing and status of its people of Ngāti Ruanui.
- To ensure that a course of action set down is deemed to enhance, maintain or encourage Ngāti Ruanuitanga.
- To preserve, to maintain, to enhance and encourage the mana and wellbeing of their Uri (descendents), of those and injustice things considered of value, of all their places, natural resources and taonga (treasures).
- To promote a just society, to work for the elimination of poverty and injustice and to create an environment where the care and welfare of one's neighbour is still important.
- To ensure that Ngāti Ruanui agree to work together, treat each other with respect and harmonious relationships. (Ngati Ruanui Health Service, 2008).

Kaupapa – Mana

Mana is the celestial strength given to all living and non-living things. In people it manifests itself in qualities such as altruism, humility, diplomacy, knowledge of benefit to the people, and leadership. In an organisation, it is demonstrated through commitment, integrity, honesty and 'walking the talk'. As people, mana is reflected on the promotion of self-determination for Ngāti Ruanui as an expression of the rights of mana atua, mana tupuna and mana whenua (Ngati Ruanui Health Service, 2008).

Nga tikanga – Mana

- To recognise the origins of mana, that derives from tupuna and atua.
- To recognise and acknowledge the authority of Whānau, Hapū in their respective rohe.

- To determine actions in the cultural guardianship, responsibilities and commitments that protect, guard and take care of the places, natural resources, taonga and the mauri of these places, resources taonga and its Uri.
- To determine their own actions in decision-making.
- To enhance the relationship between kawanatanga and tino-rangātiratanga and mana Motuhake as provided in the ToW.
- To acknowledge, nurture the conduct and the activities of the NRTT and its leaders which are reflective of the attributes of the Rangātira (leaders). (Ngati Ruanui Health Service, 2008).

Kaupapa- Whānaungatanga

Whānaungatanga is the close relationship developed and generated between members of a whānau group through working together. It is the principle that binds individuals to the wider group and affirms the values as a collective. Whānaungatanga is interdependence with each other and recognition that the people are the wealth. It also determines the interrelations and interactions that one has to another through the use of a common theme or kaupapa. (Ngati Ruanui Health Service, 2008).

Nga Tikanga – Whānaungatanga

- To acknowledge and articulate where they are from, how they interact, interrelate to each other and to their stories.
- To relate all issues and commitments concerning the NRTT to the uri, marae, hapū and iwi.
- To promote respect for all cultures and ensure New Zealanders have an understanding of, and respect for, the status of NRTT.
- To promote Whānaungatanga as the model of significant collective arrangements. (Ngati Ruanui Health Service, 2008).

Kaupapa – Wairuatanga

Wairuatanga is the belief of a sanctum, the spiritual essence of the unseen domain that co-exists alongside the physical world. It is the pathway that has been paved to the unknown by their people who have gone before them. It expresses through intimate connection of the people to the maunga, awa, moana and marae and to

tupuna and the atua. These connections are affirmed through knowledge and understanding of atua Māori and must be maintained and nourished towards the achievement of wellness. It is central to the everyday lives of Ngāti Ruanui people and their world view. (Ngāti Ruanui Health Service, 2008).

Nga Tikanga – Wairuatanga

- To encourage, maintain and promote spiritual identity and connection with the land, sea and air.
- To breakdown secular and non-secular divisions and provide a unified and holistic approach to life.
- To promote the importance of wairua for NRTT and uri wellbeing. (Ngāti Ruanui Health Service, 2008).

Kaupapa – Mana Whenua

Mana Whenua is the principle that defines Māori by the land occupied by right of ancestral claim. It defines turangawaewae and ukaipo, the places where you belong, where you count, where you are important and where you can contribute and is essential Māori wellbeing. The places Māori find themselves, their strength, and their energy are where Māori have mana whenua. Once grounded to the land and home, Māori are able to participate in society in general and in a positive and productive manner (Ngāti Ruanui Health Service, 2008).

Nga Tikanga – Mana Whenua

- To ensure that the NRTT is representative of the uri.
- To assist uri to establish and maintain connections to their own land, sea and air.
- To develop arrangements that fosters a sense of ukaipo, of importance, belonging and contribution within the organisation.
- To develop a paepae team that will take their advice and guidance from Ngāti Ruanui whānau, hapū and iwi in the first instance and to promote mana whenua, mana moana and mana irirangi as the basis for land, sea and air management policies (Ngāti Ruanui Health Service, 2008).

Kaupapa – Tiakitanga

Tiakitanga embraces the spiritual and cultural guardianship of Te Ao Marama, it is the responsibility derived from whakapapa. Kaitiakitanga entails an active exercise of responsibility in a sustainable manner beneficial to resources and the welfare of the people. It promotes the growth and development of Māori people in all spheres of livelihood so that Māori can participate in a future of living in good health and in reasonable prosperity. Preserving and maintaining Ngāti Ruanui so they can continue to fulfil their function and duties implicit with this kaupapa (Ngati Ruanui Health Service, 2008)

Nga Tikanga- Tiakitanga

- To protect the mana of uri, marae, hapū and iwi.
- To protect, guard and take care of the places, natural resources, taonga and the mauri of those places, resources, taonga and uri.
- To ensure the revival, retention and maintenance of Ngāti Ruanuitanga.
- To promote and contribute to survival of Ngāti Ruanui as people.
- To foster and promote sustainable management and growth of the economy so as to provide a stable and secure environment for future generations.
- To create a clean, safe environment by promoting the protection and restoration of our natural environment (Ngati Ruanui Health Service, 2008).

Kaupapa – Whakapapa

Whakapapa provides NRTT with the framework for understanding historical descent, pattern and connections amongst all living things living and non-living. It is a ‘family tree’ of the universe. All things have a whakapapa, they are all related. Everything living and non-living, descend from the same ancestral and celestial force. It is the bridge that links them to their ancestors, defines their heritage and gives them the stories that define their place in the world. It helps NRTT to know who they are, from whom they descend, and what their obligations are to those who came before them. Whakapapa for NRTT confirms an individual’s membership within the kin groups that constitute to a society and provides the means for learning about the history of their tupuna. It is also a tool utilised in analysing when synthesising information and knowledge (Ngati Ruanui Health Service, 2008).

Nga Tikanga -Whakapapa

- To confirm NRTT genealogical links, relationships through four kin groups, whānau, hapū, iwi and waka.
- To encourage the view that all Ngāti Ruanui are related towards developing co-operation and unity.
- To support endeavours by uri to establish their Iwi connections, find their place in the world and become positive contributors to wider Ngāti Ruanui society.
- To validate all issue, businesses, and matters concerned through the knowledge interpretations and understanding of whakapapa (Ngati Ruanui Health Service, 2008).

Kaupapa - Te Reo

Te reo Māori is the cornerstone of all that is Ngāti Ruanui. It is the language of tupuna. It is the conduit of the muted thought through to the spoken word. It is the cornerstone of all that is Ngāti Ruanui, whereby it serves as the medium through which Ngāti Ruanui explains its worldview in their own dialect and words. It is the voice of the people during communicating and decision making. Accelerating the revival of Te Reo is a central focus of the NRTT (Ngati Ruanui Health Service, 2008).

Nga Tikanga – Te Reo

- To communicate in the sound, dialect and voice that is the language of Ngāti Ruanui.
- To ensure the revitalisation of Te Reo Māori.
- To promote wider recognition of Te Reo as the preferred language of Ngāti Ruanui.
- To promote the development and growth of Te Reo Māori both as the indigenous language of New Zealand but also as the appropriate language to carry Ngāti Ruanui knowledge and contemporary customs.
- To provide a platform of understanding of the Ngāti Ruanui values and principles (Ngati Ruanui Health Service, 2008).

Ngāti Ruanui in 1991 and 2009

The extent to which Whānau Ora is required is dependent on the extent of social problems facing the population of a certain area or iwi. The following is a comparison of two sets of data, as far as is possible, to show a portrait of the area from 1991-2006. In the development of Whānau Ora in this area (Department of Statistics 1993) profiles Ngāti Ruanui based on data collected in the 1991 Census of Population and Dwellings. The profiles present a wide range of information on the social and economic well-being of iwi to formulate strategies to assist their future development. The topics covered include age composition, education, labour force characteristics and income. Recently, the Berl Economics report (Berl Economics 2008) presented an economic profile of Māori in the Taranaki region. It identifies and discusses the assets of the region but also identifies lower qualifications and working in less productive occupations. Ngāti Ruanui has a relatively youthful age structure. In 1991, over one-third 36 % of all members were aged less than 15 years, while only 4% were aged 60 years and over. This distribution mirrors that of the total population.

Māori in the Taranaki region still have a significantly younger age profile generally (Berl Economics, 2008).

Age distribution of Ngāti Ruanui in 1991

Age groups	Total Ngāti Ruanui	Total Māori ancestry
0-14yrs	36%	37%
15-29yrs	30%	30%
30-44yrs	18%	19%
45-59yrs	11%	9%
60 plus	4%	5%
Total	100%	100%

Table 1

Age distribution of Ngāti Ruanui in 2006

Age groups	2006
0-29yrs	60%
30 plus	40%
Total	100%

Table 2

Education

One in four Ngāti Ruanui have tertiary qualifications. The figures for educational achievement are consistent for Ngāti Ruanui and other Māori. In 1991, tertiary qualifications were held by over a quarter (28%) of Ngāti Ruanui aged 15 and over. A further 25% had only school level qualifications, while under half (44%) had no formal qualifications.

Tertiary Qualifications (Department of Statistics 1993)

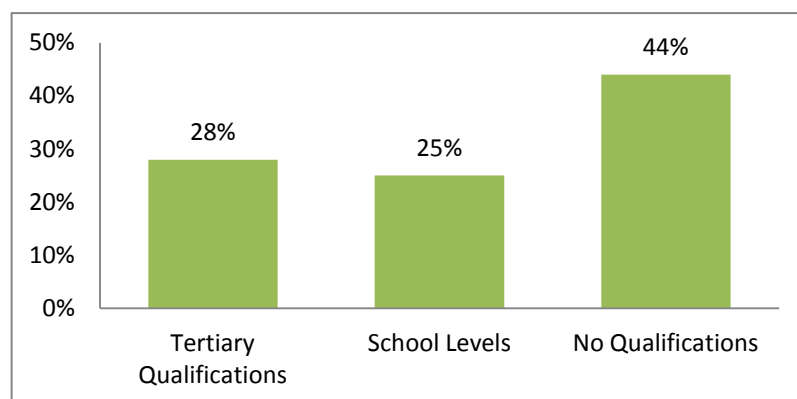


Figure 2

Ngāti Ruanui women were slightly more likely than men to hold any school qualifications, but a slightly higher proportion of men held tertiary qualifications. Of all Ngāti Ruanui men age 15 and over, 30% had tertiary qualifications with 25% of women. Amongst Ngāti Ruanui with tertiary qualifications, the most common qualifications for men were trade and technicians certificates. For women, teaching or nursing certificates or diplomas and trade qualifications predominated (table 3). Berl Economics state that in 2006, 6% of Māori in the Taranaki region left school

with little or no formal attainment compared to only 9% of European school leavers and 22% of Māori nationally. There is a much higher proportion of Māori population in decile 10 and conversely in deciles one to four the proportion of non-Māori is much higher (Berl Economics, 2009). The deprivation index for Taranaki shows that Māori make up significantly higher proportion of Taranaki residents in deprivation deciles 8, 9 and 10, relative to New Zealand.

Labour force

Ngāti Ruanui labour force participation levels similar to total Māori. At the time of the 1991 population census, the total number of Ngāti Ruanui of working age 15 years and over was 2,019. Of this group 59% were in the labour force. The level of labour force participation for Ngāti Ruanui was very similar to that for the total Māori population, except at total Māori. Overall, 60% of all Māori of working age were in the labour force.

Labour Force (Department of Statistics 1993)

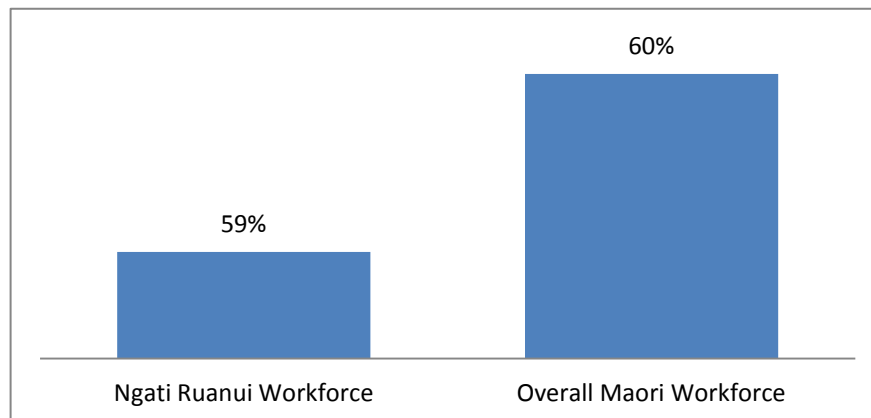


Figure 3

Unemployment highest among youth. Unemployment rates for all Ngāti Ruanui members reflect the position of Māori in New Zealand labour market. 24% of Ngāti Ruanui in the labour force was officially unemployed at the 1991 Population Census, compared with 21% of all Māori. High unemployment levels were also recorded in the 20-24 yr age group, with three in every ten Ngāti Ruanui (30%) at these ages seeking work. Unemployment levels declined in successively older age groups.

Youth Unemployment (Department of Statistics 1993)

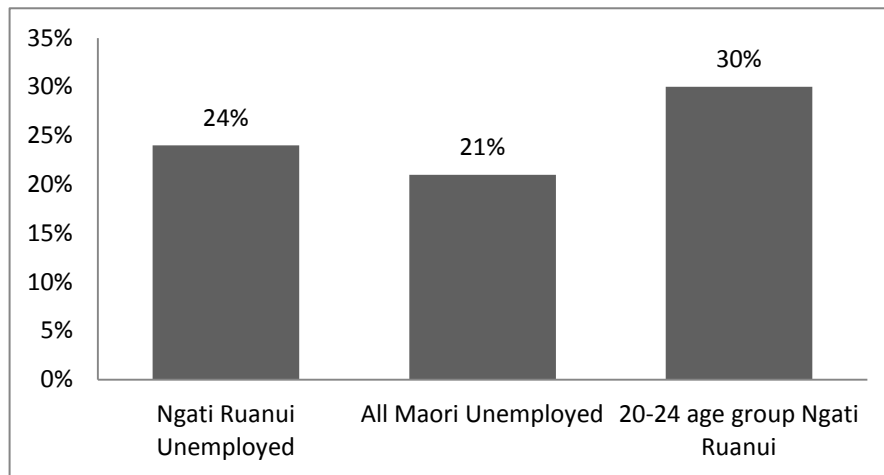


Figure 4

In the Berl Economics report 47% of people were receiving the unemployment benefit and 41.5% of those receiving the Domestic Purposes Benefit were Māori. In 2006 the average weekly income for Māori in Taranaki was \$553.00 compared to \$651.00 for non-Māori while the median incomes for both groups are similar at \$516.00 and \$524.00 respectively. Māori incomes are lower than for non-Māori in the Taranaki region. Over 40% of Māori households have annual incomes under \$40,000 compared to only 33 percent of non-Māori. In 2006 of the 5800 crimes in Taranaki where apprehensions were made, 47% were Māori. The proportions are higher for violent crimes (51%) and property damage (50%).

The comparison of 1991 from the Ngāti Ruanui statistical profile and the Berl report of 2006 for education and employment reveal that Māori have lower personal and household incomes than non-Māori in the region. With the prospect of the low percentage of Māori with tertiary qualifications, lower participation in the labour force, higher crime and a higher proportion of deprivation index deciles of 8, 9 and 10 present significant social problems facing the population. There is a relatively young Māori population that is growing faster than non-Māori in Taranaki. With the expected growth of the region and the need for skilled and unskilled labour, Māori have the opportunity to the region's economic prosperity. Whānau Ora is seen as an opportunity to address these issues affecting Māori. Despite the many definitions of Whānau Ora, the theme of change and transformation characterises Whānau Ora through cultural development and the restoration of cultural practices (Durie et al. 2010).

Summary

For the purposes of this research the term ‘hauora’ is used to describe a range of practices and therapies which would not perhaps in a western sense, usually are associated with the care of patients but in traditional Māori culture are entirely appropriate. Outcomes for health services for Māori will be much improved when they are delivered in ways that meet the cultural needs of Māori. This view is substantiated by international and national research studies. These studies report comparable results that advocate a match between health consumers and the professionals they work with. Cultural and clinical competence needs to be intrinsic and available. Achieving this goal requires that health services continue to develop a sound clinical and cultural pathway that evolves as and when change is required (Tupara & Ihimaera, 2004). In practical terms any health intervention with Māori should be based on a kaupapa Māori paradigm that combines Māori values and beliefs with modern medical interventions and technology, as and when required. A Whānau Ora approach which incorporates Māori models of health alongside a clinical pathway to assess the health and social needs could be achieved through Iwi based services that have the potential to develop further services some already offer, to accommodate Māori for all of these issues.

NRTT have been developing their Whānau Ora model of health for some time to improve the needs of their iwi members. The principles and goals of NRTT and the principles and values of Whānau Ora have been outlined in this chapter. Since the early days of colonization and the decline of Māori health for Ngāti Ruanui up until now, has seen significant challenges for the iwi. Extensive urbanization that has occurred in the last fifty years and its subsequent negative effects upon the social cohesion and social strengths for Ngāti Ruanui has been a major contributor to the state of their wellness. The degree of culture loss and the disruption in links between hapū and iwi has been at a personal health and wellness cost. While the costs have been significant, resilience has nevertheless been striking. However, the reality for Māori providers is that they are faced with multiple pressures and multiple drivers. There have been significant improvements in service delivery for Ngāti Ruanui whānau. In a holistic approach, health is not viewed in isolation from other areas of broader socio-economic determinants of health. As discussed here, NRTT has the

ability to proactively strengthen and build relationships towards a Whānau Ora approach inclusive of the broader determinants of health and social needs.

Chapter Four Whānau Ora

This chapter brings together the previous discussions to outline Whānau Ora definitions, approaches and frameworks and how it is influenced by and may replace other models of health. The key points that have been discussed are the role of whānau as the basis for interaction with health providers to reduce health inequalities by addressing broad social and health needs to improve social and health outcomes. Whānau is widely regarded as a fundamental building block for Māori society (Durie, 2001; Turia 2006) and Whānau Ora is defined as healthy families. Whānau means ‘family’ and to ‘be born’ and is applied in an intensive and extensive manner; connecting an individual through blood ties, interests, place and space. Strength and unity, bound together by shared ancestry, values and beliefs, and goals are all components of whānau. Ora is described as energizing and signifying life, as opposed to ill health, safe as opposed to being unsafe (Wenn, 2007). Metge (1995) describes whānau as encompassing the principles of nurturing, caring and compassion. She describes a spectrum, at one end of which exist whānau, whose members are determined strictly by ancestry or whakapapa where spouses and whangai or foster parents/children are omitted. At the other end of the spectrum are kaupapa whānau, who are not related through any ancestral link, but who are bound by a shared commitment, such as when people work collaboratively in order to meet specific purposes.

Whānau Ora has been used interchangeably as term for whānau wellbeing. Durie et al. (2010) suggest that Whānau Ora can have broader definitions. These include:

1. Group wellbeing and how it operates as a whole to achieve health and wellbeing for its people.
2. Self-determination with the aim of enabling whānau to assume responsibility for their own affairs.
3. Concerns with ongoing inter-generational transfers which include the transmission of values such as knowledge, culture, technologies, lifestyles and can transfer from older generations to younger or from younger to older.
4. Strong cultural codes of conduct, protocols to guide interactions within the whānau as well as cultural preferences for food, recreation and socialisation are integral to Whānau Ora.

5. Interaction with wider society such as educational institutions, health clinics and social service agencies.
6. Socio-economic wellbeing with sectoral approaches.
7. Whānau Ora is distinctive because it recognises a collective entity, endorses a group capacity for self-determination, has an intergenerational dynamic, is built on a Māori cultural foundation, asserts a positive role for Whānau within society and can be applied across a wide range of social and economic sectors

(Durie et al. 2010).

Whānau has also been used as a synonym for family and sometimes as an equivalent of household. Many Māori families do in fact spend much of their lives as members of the household units rather than extended families and may have infrequent contact with other Whānau members. Similarly a two-generational unit may often be the norm, at least on a day-to-day basis. City living has resulted in extended neighbourhood relationships so that, rather than drawing on the resources of the wider whānau, metropolitan Māori families may depend on community when immediate help is needed. That does not diminish their connections to their own whānau but recognizes the realities of their situations and the difficulties they may have in connecting other whānau members (Durie et al. 2010). Turia (2006) suggests that Whānau Ora is about the opportunity to re-empower families to take responsibility for their lives. While whānau satisfaction is an important indicator of provider effectiveness, there is greater reliance on measurement indicators that are capable of measuring increases in whānau strengths such as the capacity to care for each other, to transmit knowledge and values, to model healthy lifestyles, provide access to Te Ao Māori, and to transfer language, culture and ethics between generations.

Taonga tuku iho are literally ‘treasures from the ancestors’ which are collected over a long period of time which guide and monitor our lives today and in the future. Whānau and whakawhānaungatanga are seen as treasures (Bishop, Glynn, 1999). Durie et al. (2010) note that a Whānau Ora approach to health and social services for Māori incorporates holistic interventions built around group needs rather than solely on the needs of individuals. Ensuring local representation in decision making,

minimal bureaucracy, sustainability and adequate resourcing, a research and evaluation component and quality relationships between whānau providers and iwi can have a means of addressing issues of Māori health.

Wicked Problem

Whitehead (2000) states that equity is concerned with creating equal opportunities for health and bringing health differentials down to the lowest level possible. Sheridan, Keneally, Connelly, et al, (2011) confirm that in New Zealand inequity for Māori is a complex problem that has been termed “wicked”. Wicked problems are complex and have many interdependencies, are often multi-causal, not stable, and usually have no clear solution and rarely sit within the responsibility of one organisation. Addressing the wicked problem of health inequity requires a whole government approach. The required system levers include policy, funding, contracts, monitoring, attitude, education and culture. In considering the cultural component of this statement and addressing health inequalities for Māori there is limited evidence of policy, practice, of health equity and the system often failed to act in the face of known equity (Sheridan et al. 2011). These authors argue that New Zealand’s approach to health equity is inextricably linked to “who we are as people” building on a history and culture of promoting human and indigenous rights (Sheridan et al. 2011). Honouring the ToW as a historical document, a living contract and applying it in policies as a holistic construct consistent with the underpinning principles in all Māori models of health and wellbeing (which is discussed in the next section), and Whānau Ora may be the pathway forward to address the “wicked problem” and the health and social inequities in New Zealand.

Māori Models of Health

Durie (1998), states that the gradual introduction of Māori concepts and models of health in medical routines was not entirely welcomed, but nor was it dismissed outright. By the mid-1970s there was some recognition that ethnicity and culture had implications for health. Māori views were often taken at face value, even though they could not be rationalized in medical terms (Durie, 1998). As Māori participation in the health debate escalated, a number of Māori perspectives were advanced that emphasized the value of traditional belief systems to health, though not necessarily at the expense of Western medical practice. Greater balance was the goal. The Te

Whare Tapa Wha model which is discussed in the next section has a consistent theme of integration which falls in line with the fundamental values of Whānau Ora (Durie, 1998).

The model of Te Whare Tapa Wha representing four aspects (wairua, Whānau, tinana and hinengaro) provides direction for health and development. Wairua focuses on the spiritual and the key aspect of faith and wider communion with themes that health is related to unseen and unspoken energies. Hinengaro is the emotions and mental capacity to communicate to think and feel and that the mind and body are inseparable. Tinana is the capacity for physical growth and development and having good physical health is necessary for optimal development. Whānau is the extended family and the capacity for people to care, share and those individuals are part of the wider social systems (Durie, 1998).

Pere (1998) states that Te Wheke (the octopus) is a Māori model of health which illustrates a family perspective comparing health to an octopus. Each of the eight tentacles symbolizes a particular dimension of health while the body and head represent the family unit. The intertwining of the tentacles indicated the close relationships between each dimension. Like Te Whare Tapa Wha, the model included wairua (spirituality), tinana (physical) hinengaro (the mind), and Whānaungatanga (relationships and the extended whānau). The other dimensions are mana ake (uniqueness and positive identity); mauri (life-sustaining principle in people and objects including language; ha a Koro ma a Kui ma, literally the breath of life that comes from forebears and an acknowledgement that good health is closely linked to positive awareness of ancestors; whatumanawa, the open and health expression of emotion necessary for health human development; waiora, total well-being for the individual and the family represented in the model by the eyes of the octopus (Durie, 1998). Furthermore, (Durie 1998) suggests that in 1988 the New Zealand Board of Health advocated five principles: holism, empowerment, social and cultural determination, equity of access and devolution, and effective resource use. The Board had borrowed extensively from Māori views and writings (Durie, 1998). By 1990 Māori views on health made a significant impact on New Zealand health services generally and more importantly they had given Māori people the

necessary confidence to challenge the system and reclaim a more active participatory role in society and within the health sector (Durie, 1998).

Whānau, Hapū and Iwi

Cram and Pitama (1998) identify whānau as family systems for Māori, upheld by tribal lore, spiritual beliefs and protocol. Individual and group safety and the preservation and maintenance of resources were ensured. Durie (1998), Pere (1998), Jackson (1988) and Reid (1999) maintain that whānau is the growing centre which spreads to hapū (wider kin group) and then to iwi (tribe). A whānau represented by living people, is the manifestation of whakapapa (genealogy) and the physical reality of tapu (unsafe), as well as the intangible connection to their ancestors and the natural environment. To know where we come from, why we are here and where we are heading are human questions. First and foremost the principle is to take responsibility and allow self-empowerment (tino-rangātiratanga) by whānau, hapū and iwi. The way in which people are related through whakapapa is highly valued and passing on this information to children enables them to take pride and a sense of belonging through their heritage. Nurture, learning and growth within Whānau are the sources of Iwi vitality and key's to the power of whakapapa (Durie, 1998).

It could be argued that the renaming and re-constructing of Māori whānau concepts and practices have systematically eroded the legitimacy and validity of Māori self-definitions and Māori knowledge. Coney (1993) ToW argues the British or colonial law has undermined the indigenous family system. New Zealand family law typically does not incorporate Māori understandings of whānau. Implicit in most legislation is the idea that the family means only the nuclear family, that the guardianship of children belongs only to the parents, and that the state has the right to intervene and decide what should happen when serious problems arise. This directly conflicts with the understanding of whānau, which is protected by the wider framework of hapū (wider kin group) and iwi (tribe). These wider kin groups and tribes have responsibilities to the whānau and identifying the intricate relationship between other levels of kin group is paramount (Baker, 2001).

To understand Māori values and ideals it is essential to appreciate the concepts of collective responsibility. This idea is central to a Māori view of human nature and

the nature of the world we live in. Māori collective responsibility extends beyond the family, beyond the tribe beyond the Māori race to all living things - it extends to the lands of the waters of the earth, it extends to Earth and Sky themselves (Marsden, 1975). Tauri (2005) argues that although Māori represent 14.5 of the total population Māori in New Zealand, they make up to 50% total prison population and 45% of offenders serving community sentences and in 2007 Māori made up between 40-45% of all police apprehensions. This overrepresentation has seen a cultural renaissance of addressing this situation in developing separate justice processes based on Māori philosophical practices (Tauri, 2005). The solution is to change from a Pākehā concept of individual responsibility to a Māori concept of collective responsibility. Māori offenders often lack moral responsibility and personal sensitivity to the worth of others. This reflects the offender's inadequate sense of self-worth. To do something towards restoring the sense of self-worth in young Māori, Jackson (1988) advocated that we incorporate the Māori ideas of mediation and restoration in place of the Pākehā adversarial system within the criminal justice system.

Jackson (1988) suggests that the application and involvement of whānau would reinforce the Māori concept of restitution and the restoration of balance. Furthermore, he argues that the use of utu and muru or the standard method of resolving a dispute in traditional Māori law, and the incorporation of ideas of group responsibility to an aggrieved victim rather than a distant symbol of the state, helps heal the hurt in a way not often possible in the existing adversarial system. It would also reinforce the sense of shame placed on the offender because there is no doubt, that as in traditional time, his Whānau would make him aware of the burden his wrong had imposed upon them. The point about healing the hurt is important. Utu and muru are not simply revenge, or retributive punishment. The most basic tenet of Māori law is that the rights and obligations of the individual and community are mutual and interrelated. Each person has individual rights but collective responsibilities. During the 1980s in New Zealand the system of criminal justice ignored these basic Māori values and beliefs, and was so inappropriate for Māori offenders (Jackson, 1988).

Responding to these injustices the development of restorative justice based on Māori theories for Māori individuals have been developed into more collaborative efforts for individuals, whānau, hapū and iwi. This collective responsibility may also make a difference in reducing the over-representation of Māori offenders in the prison population in New Zealand. Kruger, Pitman, Grennall, McDonald, Mariu, Pomare, Mita, Maihi, Lawson-Te Aho (2004) suggests that a tool for practitioners working in a Whānau, hapū and Iwi violence prevention kaupapa, which features whānau at the centre of a collective focus on Whānau transformation and change. It is a model based on the idea that education combined with collective whānau action are liberating and can lead to change and transformation in whānau (Kruger et al. 2004). This framework is in line with the fundamental philosophy of Whānau Ora incorporating a collective focus that can be part of the implementation of restorative justice initiatives.

Walker (1997) re-affirms this concept that Māori have an ideal of a shared life; if wealth and power are to be pursued at all they should primarily be collective wealth and collective power. This concept of collective responsibility is not well understood by Pākehā, as they are to a more individualistic approach to responsibility (Walker, 1997). Jackson (1988) argues that in the New Zealand criminal justice system that the practice of focusing upon the individual rather than the community can be harmful, both to the individual Māori offender and to the communities to which they belong. Restorative justice involves all those affected by a crime they must be involved in finding a solution and need not to be limited to the criminal justice system but equally applicable in fields of social, education and health reforms where people have been harmed and where the restoration of broken relationships are needed. Realising Whānau Ora, linking agencies such as the justice system alongside health and social services and building a more cohesive approach with Whānau at the centre with a new approach such as restorative justice creates an opportunity for a sustainable whānau approach to resolve problems that exist.

Previous and ongoing Māori health initiatives

The Māori Women's Welfare League (MWWL) produced the first research in 1977 on the health of Māori women 'by Māori, for Māori' called 'Rapuora' and provided a comprehensive overview of Māori women's health in New Zealand (Murchie,

1984). This study involved 1177 interviews with Māori women based on a questionnaire that explored self-perceptions of health, recent health events, lifestyle risks, stress, chronic illness, and access to health systems. Culture-specific variables included tribal affiliations, attendance at Hui, knowledge of Māori and relationship with the tribe of origin. The results of this report raised awareness of whānau-orientated, community based care, encompassing district nursing and public health initiatives and emphasizing Māori cultural values and beliefs as part of care (Durie, 1998). This had never been done before and the MWWL continue to improve Māori health today working with a Whānau Ora focus.

Durie (1998) notes that Tipu Ora is a Rotorua based organization which arose out of concern for young Māori mothers and their children; neither for a variety of reasons were accessing appropriate health care services. Poor or non-existent antenatal care, combined with youthfulness, was evident in low Māori birth weights and high hospital admission rates in the first five years of life. Immunization uptake rates were three times as low as for non-Māori children and cot deaths occurred three times more frequently. The key to the success of this programme is the stewardship of Māori leaders with Iwi and the MWWL. This programme provides health care and a Whānau Ora focused programme that incorporates health care and health promotion at Whānau levels (Durie, 1998). The orientation towards provision for Māori health services continues, and these services focus on Whānau solutions to Māori health identified by National Cervical Screening and Immunisation programmes which still continues today.

In response to this growing Māori assertiveness and the demand to be kept informed, Government held several Hui (meetings). These marked the beginning of what is now known as the 'Decade of Māori development' (Durie, 1998). The first of these Hui, the Hui Taumata held in 1984, became the catalyst for change, recommending positive approaches to Māori development. Iwi health providers such as Tainui (Huntly), Ngāti Hine (Northland), Whakatohea (Opotiki), Papakura (Auckland) all began to create comprehensive health centre's to meet their own needs. They have in common, a commitment to integrated development-cultural, social, economic – based on tribal structures. Their distinctive feature is the inclusion of health

programmes as part of the total package rather than as an isolated medical venture. These Iwi health providers are examples of Whānau Ora development at a grass-roots level indicating their commitment to inclusive and integrated services to meet the needs of their iwi members.

Community Health Workers

Boulton, Gifford and Potaka-Osborne (2009) reported Community Health Workers (CHWs) in the New Zealand workforce based on three separate research projects and concept validation through co-authorship with a current practicing community health worker. The purpose was to determine how CHWs carried out their work and how the organization was structured to enable them to work effectively. As a consequence of seeking this information, a rich description of CHWs was produced. Findings of this research involving the role of CHWs might best be described as ‘culturally based’, requiring a deep understanding of Māori values and philosophies, to specifically medical tasks, health promotion activities, advocacy and liaison. Key challenges that needed to be resolved to further advance the position of CHWs in New Zealand include greater recognition of the unique role and the delivery of public health and primary healthcare services, linking this recognition to appropriate remuneration and ensuring that ongoing role development is met with a Māori worldview. Given the multiplicity of complex tasks and accountabilities, Whānau Ora practitioners could be an extension of the CHW, however there is limited research as yet exploring these possibilities (Boulton et al., 2009).

CHWs form an integral part of the New Zealand health workforce acting as the interface between the health sector and Māori communities. By working in a culturally distinctive manner, they help to give effect to Māori health development aspirations. Increasingly this work is carried out in a complex and demanding environments. Key challenges that need to be resolved to further advance the positions of CHW’s in New Zealand include greater recognition of the unique role they play in the delivery of public health and primary healthcare service, linking this recognition to appropriate remuneration and ensuring that ongoing role development is met within a Māori worldview (Boulton et al., 2009).

Indicators and Outcomes

Fundamental Te Ao Māori values and beliefs are critical to achieve maximum health outcomes for Māori whānau. Achieving this requires direction and support in all service developments. These values and beliefs need to be accepted as part of the healing process for whānau and ensuring that choices of treatment that are available. Supporting a Whānau Ora practitioner role to form an integral part of the Whānau Ora development may be the key challenge for all Māori health providers and communities.

Hua Oranga – A Māori Measure of Mental Health Outcome (Durie & Kingi 1997) is a cultural measure of mental health outcome, designed specifically for Māori consumers and mental health services. The measure requires the application of three separate questionnaires, one designed for the client, one for the clinician and one for the designated Whānau member. With the aid of a scoring schedule a numerical score is produced for each respondent. These scores are then compiled and divided by three. The resulting score is then used to provide an indication of an overall outcome. An outcome continuum is provided to assist with this process. This tool is designed to be a quick, easily administered measure of outcome, appropriate for routine clinical use. It may be used as a specific cultural measure of outcome or combined with other, more targeted, clinical tools (Durie & Kingi, 1997) During the course of the research for “Hua Oranga” many respondents emphasized the critical role of whānau in terms of outcome. Durie (1998) notes that the Pākehā ideal of being able to stand alone and be independent is actually an unhealthy position from a Māori perspective, where inter-dependence has been the norm. In addition, collective identity, responsibility and reciprocity are predominant components of Māori whānau relationships, as opposed to the pursuit of individualistic desires and goal (Durie, 1998).

More recently, the NHC is a response to the *Better Sooner More Convenient Primary Care Strategy*. The Coalition’s priorities are to focus around the need to implement Whānau Ora systems across the membership and Whānau Ora networks. The delivery of Whānau Ora services includes 2,500 comprehensive Whānau Ora assessments and case coordination for Māori and high needs Whānau enrolled with

Coalition members. Iwi engagement is pivotal to the delivery of Whānau Ora and will result in more informed and effective decision-making as well as stream-lined and better quality outcomes (Midlands Health Network, 2010).

Conclusion

Overcoming health inequalities has been a major priority for Government agencies in Aotearoa. Policies have been developed and designed for health and social services to improve the status of Māori health. From the first report “He Korowai Oranga – The Māori Health Strategy” in 2002 to recent reports such as the “Whānau Ora: Report of the Taskforce Whānau-Centred initiatives” in 2010 are aspirational aims consistent with a Whānau Ora philosophy. Today, the various Taranaki District Health Board evidence from their reports shows that Māori feature significantly in low-socio-economic status and have consistently poorer health outcomes in comparison with the rest of the population. TKM represents Māori health leadership in Taranaki to improve Māori health status. It seeks to attain Whānau Ora over a twenty-year time period and represents a generation of health and socio-economic advancement. The link between the Māori Models of health and Whānau Ora are a priority and need to be consistent in order incorporate a holistic interventions built around group needs rather than solely on the needs of individuals. Collective responsibility and health initiatives from MWWL and different Iwi from a grass-roots level are committed to integrated development and developing their own Whānau Ora model. Community health workers play a unique role and an opportunity to further advance their roles in the delivery of healthcare services for Māori. With indicators, outcomes, evaluations Whānau Ora and greater recognition and the extension of CHWs to become skilled Whānau Ora practitioners with appropriate training, remuneration and resources may be a pathway to addressing some of the inequalities for Māori in Taranaki and in Aotearoa.

Chapter Five Methodology

Research question and aims

The research question for this study is “*Hei aha nga whakaaro o Ngāti Ruanui mō te Whānau Ora/How does Ngāti Ruanui whānau define Whānau Ora*”. The research included Māori as participants, in particular Ngāti Ruanui iwi members in order to explore their experiences related to health and social support and how they view Whānau Ora. The aims of this project are to:

1. Understand the healthcare experiences for Māori,
2. Examine policy documents in relation to Whānau Ora to provide definitions and identify how Whānau Ora may be defined.
3. Interview key community stakeholders, Ngāti Ruanui Whānau members about their interpretation of Whānau Ora.
4. Provide an account of possible Whānau Ora interventions as described or suggested by the research participants.

In order to undertake this research a Māori-centred approach was chosen as the research is by Māori, and for Māori and guided by tikanga. Durie (2005) suggests that working between the two bodies of science and indigenous knowledge, recognises that neither alone provides a universal answer to some research questions. Health care is shaped by scientific knowledge and depends on evidence derived from scientific enquiry. In contrast indigenous knowledge is not necessarily based on a Western scientific view of the world (Edwards 2010) instead it largely depends on a set of values and observations that link people into the wider natural environment (Durie, 2005). The challenge is not to dismiss either knowledge base, nor to explain one according to the tenets of the other, but to embrace both in order to reach fresh insights that might enrich the lives of those who are touched by both systems (Durie, 2005).

Indigenous knowledge: Matauranga Māori

This research employed a Māori-centred (Cunningham 1999) qualitative methodology which aims to build indigenous knowledge. Qualitative research has been employed in this study because this methodology is best suited to the small sample of participants being studied. The choice of qualitative methodology is based on a desire to understand the individual realities of each research participant and

appreciate the diverse stories and interpretations that emerge. A qualitative approach acknowledges the multiple realities of people that exist in any given situation. All these different realities need to be taken into account, including my own personal reality, and role as a researcher, the participants, iwi relationships, supervisors and mentors.

Māori-centred research employs a Māori methodology often employed alongside western/mainstream methods and analysis (Cunningham, 1999). Māori remain central to the research but Māori and western belief systems have their own integrity, therefore utilizing the energy of two systems of knowledge in order to generate new knowledge for the benefit of all (Durie, 2005). Mātauranga Māori (indigenous knowledge) paradigm locates the researcher within a Te Ao Māori view of reality in respect to the phenomena being investigated. Roberts and Wills (1998) and Edwards (2010) suggest that all things in the universe are related, use of whakapapa in the Mātauranga Māori inquiry makes it possible to explicitly define the genealogical relationship between the researcher and the phenomenon being investigated. This may take the form of whakapapa between a botanist and the plant for research in the natural sciences, or whakapapa between the interviewer and informants in the social sciences (Edwards, 2010).

Māori are considered to be one of the most researched indigenous people in the world (Smith, 1999). Durie (1998) observes that Māori have been over-researched and generally receive little in return. In the past, Māori have experienced negative research experiences and outcomes which have resulted in mistrust and cynicism by many Māori toward research (Sporle, 2003). Inappropriate research processes and their consequent outcomes have contributed to the social marginalization of Māori by perpetuating social pathology and functional inadequacies of Māori, and offering cultural deprivation as an explanation for any gap between Māori and non-Māori (Bishop, 1994).

When considering the approach to this study I was aware of the negative experiences that Māori have experienced, and therefore that it was vital that the outcome of this

research maintains the integrity of Ngāti Ruanui iwi members by using a methodology that is respectful and valued the participants.

Indigenous knowledge is holistic in the sense that knowledge is interconnected and relational as all life is interconnected and relational (Royal, 2005). A holistic view of the world and of knowledge is not blind to parts, boundaries, borders and thresholds but rather sees these parts both as ‘whole’ themselves as well as parts of a larger whole. Indigenous knowledge can be generated anytime and can be applied to contemporary matters. For example, indigenous knowledge may be applied in diverse fields such as biotechnology, pharmacology, resource management, and understanding and addressing social issues (Royal, 2005).

Western science is based in the positivist view that researchers are objective observers and their beliefs and values did not influence data interpretation (Edwards, 2010). However, more recently emerging theoretical positions within Western science have recognized that researcher’s beliefs and values contribute to the construction of meaning throughout the research endeavour. Mātauranga Māori has an established philosophical position that requires a knowledge base grounded in Māori worldviews and built around the concept of whakapapa. The whakapapa relationship is central in the Mātauranga Māori paradigm (Edwards, 2010).

Robert and Wills (1998) state that for Māori to ‘know’ an individual, a tribe, anything animate or inanimate and even knowledge itself is to locate that entity in space and time. They succinctly describe whakapapa as a framework for an understanding of historical descent, patterns and linkages, whereby everything, animate and inanimate is connected together into a single family tree or taxonomy of the universe. Tau (2003) notes that whakapapa imposes a relationship between an iwi and the natural world. It is a metaphysical framework constructed to place oneself within the world. Tribal genealogies connect and demonstrate historic relationships between tribal groups. Common ancestry and interactions are recounted and reinforced. The interconnectedness of the whakapapa of many iwi and can trace genealogical lines from Toi who lived several hundred years ago. Furthermore, for 200 years or more there has been a steady increase in inter-tribal associations.

Matauranga Māori is not static. Distinctive tribal knowledge is increasingly complemented by Māori knowledge (Edwards, 2010).

The term Matauranga Māori encompasses all branches of Māori knowledge, past present and future. Matauranga Māori is a tool for thinking, organizing information, considering the ethics of knowledge, the appropriateness of it all and is entwined with the tikanga of learning or tikanga of knowledge. There are customary ideas, values, and notions of correctness and appropriateness associated with it. More importantly, there is a tapu (sacred) aspect of Matauranga Māori. The tapu aspect of Matauranga Māori ties it firmly into the system of beliefs and values of the Māori people (Mead, 2003). In this research the challenge is not to dismiss either knowledge base, nor to explain one according to the tenets of the other, but to embrace both in order to reach fresh insights that might enrich the lives of those who are touched by both systems (Durie, 2007).

Kaupapa Māori Research

Various definitions and examples of kaupapa Māori research approaches appear in the literature. Boulton (2006) argues that kaupapa Māori research remains an elusive goal for many Māori researchers. Irwin (1994) defines kaupapa Māori as research that is ‘culturally safe’ which involves mentorship of kaumatua (elders) which is culturally relevant and appropriate while satisfying the rigour of research, and which is undertaken by a Māori researcher, as distinct from a researcher that happens to be Māori. Smith (1999), states that kaupapa Māori research has elements of cultural safety, mentorship, relevance and rigour and is by Māori, for Māori and with Māori. According to Cunningham (1999) kaupapa Māori research calls for tino-rangātiratanga (self-determination) to control the whole process including funding, research outcomes, and evaluation. Glover (1997) emphasises the intrinsic desire within a kaupapa Māori approach to recover and reinstate Matauranga Māori while Reid (1999) notes that kaupapa Māori approaches are able to address Māori needs and fully recognise Māori culture and values. Smith (1999, p. 125) states the main objective “is about bringing to the centre and privileging indigenous values, attitudes and practices rather than disguising them with Westernised labels such as collaborative research”. Kaupapa Māori research appears to be intrinsically linked to resistance, struggle and emancipation as much as it is to cultural revitalisation, self-

determination and empowerment. It locates Māori people and Māori communities at the heart of any research process and requires Māori researchers who adopt the approach to incorporate strategies to allow the research to benefit those communities directly. In this approach, the research is not a process from the community, but will inform, support and enshroud that community during the research and long after it is completed (Boulton, 2005).

Māori Centred research

A Māori centred approach provides a framework that holds Māori central within the research process and enables ‘mainstream’ research requirements to be incorporated (Durie, 1998; Cunningham, 2000). While still promoting change and transformation, a Māori centred approach does not demand of its proponents such as a whole-hearted capture by the community (Boulton, 2005). Durie (1998, pg. 9) defines Māori centred research as focusing “primarily on Māori people, as Māori, and the research methods and practices employed to take full cognisance of Māori culture, Māori knowledge and contemporary realities.” Cunningham (2000) supports this view and claims that such an approach involves participants and researchers that are predominantly Māori, and that the aim is to collect and analyse Māori data. The methodological principles of Māori centred research are defined as:

- 1) Mutual respect, that involves recognizing and validating each system of knowledge.
- 2) Shared benefits, encouraging indigenous communities to share the benefits of research.
- 3) Human dignity, the indigenous worldviews and practices are not compromised.
- 4) Discovery, innovation and exploration using indigenous methodologies and scientific method, therefore utilizing the work from two systems of understanding in order to create new knowledge that can be used to benefit Māori.

• (Durie, 2005; Wilson, 2004)

Cunningham (2000) also differentiates Māori centred research from Kaupapa Māori research by the control that ‘mainstream’ institutions have over the research process, and by the utilization of ‘mainstream’ methodologies. When planning the best methodological approach to this research, a Māori-centred approach was considered

the most appropriate as the Ngāti Ruanui iwi members would be the central focus, transformation and change may be informed by the research findings and integral to this is the knowledge and the study of being of benefit not only for Ngāti Ruanui but potentially for all Māori and that the research process stays true to tikanga.

Durie (1997) describes three principles that are salient to a Māori-centred research: Whakapiki Tangata (*enablement or empowerment*), Whakatuia (*integration*) and Mana Māori (*Māori control*). Whakapiki tangata applies to the principles of enablement and benefit of Māori. Underpinning this concept upholds the dignity of individuals through processes that ensure confidentiality and consent and of the collective by ensuring accountability to a community through all phases of the research. Whakatuia refers to the integration of a research approach with a Māori worldview and links to culture. Underpinning whakatuia incorporates a holistic approach and importance of relationships. Mana Māori encourages tino rangatiratanga or self determination, control and tiaki (care) of the data and research. Underpinning this concept ensures that Māori have control over the participation, process and protection of information in research and is evident in this research by support of Māori supervisors, and the involvement of whānau tautoko (support) in the design of the study. This principle supports Māori involvement at all levels of the research as participants, researchers and analysts (Durie, 1998; Cunningham, 2000).

These concepts of Mana Māori, Whakapiki tangata, and Whakatuia are considered as the ‘cornerstones’ of a Māori-centred approach. These concepts of control, enablement and integration, along with principles of mutual respect, shared benefits, human dignity and discovery, is integral to this research and it aims, therefore all aspects of a Māori centred approach will be undertaken to ensure the mana (dignity) of the participants remain intact. This is adopted in this research with Ngāti Ruanui iwi members being actively involved in advising the development of the research question, and the process of meeting and working with participants, such as sharing food and establishing mutual connections with places and people (Durie, 2005; Wilson, 2004). A Māori-centred approach ensured this research was culturally responsive and appropriate, and crucial in gaining ethical approval for research for Māori (Wilson, 2004).

Ethics.

'Ethics is about values, and ethical behaviour reflects values held by people at large. For Māori, ethics is about 'tikanga' for tikanga reflects our values, our beliefs and the way we view the world' (Hudson, Milne, Reynolds, Russell, Smith, 2009 pg. 2). Ensuring that research is ethical involves key requirements such as informed consent, the maintenance of privacy and confidentiality of information, the lessening of risk to participants, the identification of benefits and or alternatives to participants (Minchiello, Sullivan, Greenwood & Axford, 2004). Moreover, the principles that are pertinent for Māori need to consider the influence of Māori history, the respect of Māori values, tikanga (customary practices) and te reo (language) (Mead, 2003; Sporle & Koea, 2004). Ethical consent for this research was obtained from the Massey University Human Ethics Committee: Southern B. – 10/69 in April 2011. (see Appendix A).

A major concern in a Māori-centred approach is that the research is ethical and further guidance was required for tika, the basis of tikanga. This ensured that processes and procedures are correct and at the end of the research all those connected to the research are enriched (Mead, 2003). The ethical framework that guided this study is taken from the seven practices provided by (Te Awekotuku 1991) essentially to a Māori specific code of conduct. The principles are Aroha ki te tangata (a respect for people) which enables people to define their own space and to meet on their own terms. This requires a mediation of power differences between researcher and research participants. Participants were able to choose where and when they would be interviewed, if they wanted whānau present, and how the information would be gathered, and what information would be used. All participants were provided with a copy of their interview and were able to amend or remove information if they wished. This was implicit in the planning of the research and the consent process, oral consent was provided for the recording of the interview and written consent (see Appendix B) was provided for participation and also included the right to withdraw at any time. The information that was gathered was also negotiated with the researcher and the participants whether they wanted to share or not. All of the participants were happy to share their korero (discussion) and a hui was held to do this.

Kanohi kitea (the seen face, to present you to people, face to face) stresses the importance of meeting people face to face so that trust and relationships can be enhanced (Te Awekotuku, 1991). Ongoing informal and formal consultation with Nga Pakeke o Ngāti Ruanui (Kaumatua/kuia roopu) community networks including my large whānau has occurred and has been a key feature in this research. At the first initial hui, endorsement and acknowledgement of this research project was positive and was approved verbally in te reo. An offer was made from the Ngāti Ruanui Organisation CEO for an opportunity for the researcher to view policies and documentation to assist in this research project. It was explained at these hui that benefits of this research may not be immediately apparent, but potential benefits may be seen as a consequence of further ongoing research and the generation of new knowledge.

Titiro, whakarongo, korero (look, listen, speak) emphasizes that the researcher should be observant through all human senses and to be open to shared thoughts. In addition, the aim is to develop an understanding of the research participants, their information and to locate a respectful place in which to speak (Te Awekotuku, 1991). Recognition of the diversities of the participants, ages and occupation, was acknowledged and maintained. Iwi affiliations, manaaki (support) of the participants and the researchers own whakapapa was recognized.

Manaaki ke te tangata (to share and host people, be generous) promotes a collaborative approach to research supportive of reciprocity. It acknowledges that learning and expertise are present between researcher and research participant, and there are expectations of caring for people (Te Awekotuku, 1991). Wilson (2004) argues that the process of dissemination of research findings should be decided during the initial consultation of the research process. My initial hui with Nga Pakeke o Ngāti Ruanui was vital in maintaining the integrity of participants and to acknowledge their positive acknowledgement and oral consent in this process. As a researcher, my ability to uphold reciprocity and participate in relevant Māori activities, and to feedback to the participants was part of an ongoing process throughout this research.

Kia tupato (be cautious) is about being politically astute, culturally safe and reflective as an insider researcher. The notion of caution is alerted to researchers to ensure they are aware of the influence of Māori and non Māori processes with Māori (Te Awekotuku, 1991). My role in this study involved a dual process of moving from an insider to an outsider. As an ‘insider’ of Ngāti Ruanui descent, living and involved with the local Māori community, I was aware of interviewing whānau members that this might generate bias. Therefore I was able to move from an ‘insider’ to an ‘outsider’, taking on a student research position with a focus on a research process (Bishop, 1994).

Kaua e takahia te mana o te tangata (do not trample over the mana of the people) asserts to the researcher the importance to consult with people before disseminating research findings and about keeping people informed about the research (Te Awekotuku, 1991). It was important to ensure that I informed my participants what my findings were before I finished this thesis. Like all research, conduct must be ethically and culturally appropriate and acceptable, and forms part of the ongoing consultation with Māori (Te Awekotuku, 1991). Feedback to participants via e-mail and kanohi te kanohi (face to face) was ongoing through this research project.

Finally, Kaua e mahaki (do not flaunt your knowledge) promotes researcher humility through the sharing of knowledge and the utilization of their status to benefit the community (Te Awekotuku, 1991). While engaging with participants over morning tea or lunch they felt more at ease and able to share information without any restraint and always emphasizing my role as a researcher was not to impose my own opinions onto the participants.

Consultation with Ngāti Ruanui Iwi members

Tikanga and researching within the Iwi

At the beginning of the project I was aware of Ngāti Ruanui tikanga and that I needed Ngāti Ruanui approval, assistance, guidance and blessing. Acknowledging the status of kaumatua and their role had a crucial influence on this process. The kaumatua status of true guardians of traditional customary roles such as kaikorero

(orator) and kaikaranga (ceremonial caller) and especially Māori women who have leadership roles in the communities and recently being called upon to take on not only their whānau marae (meeting place) duties but acting as advisory to Māori and mainstream organizations. Establishing a trust relationship with kaumatua and addressing safety issues were paramount. I have recognized the deep mistrust in Māori communities over the whole process of research and that ever increasing korero (discussion) I have heard from my own whānau “I am sick and tired of hearing about Whānau Ora” and “who is going to gain from this research” I needed to understand the commitment and negotiate a partnership with Ngāti Ruanui Iwi before I started the research.

The Chairman of Te Runanga O Ngāti Ruanui suggested that I present to Nga Pakeke o Ngāti Ruanui. In 2010 an initial formal Hui was held at Ngāti Ruanui Tahua in Hawera where a power point presentation was made to them titled “ *Hei aha nga whakaaro o Ngāti Ruanui mō te Whānau Ora - How do Ngāti Ruanui iwi members define Whānau Ora*”. I began with my background describing my role as a registered nurse working at Ngāti Ruanui Hauora in Hawera and with iwi members who have experienced illness themselves and whether limited contact with other Whānau members hinders better health outcomes. The objective of this hui was to invite Ngāti Ruanui iwi to participate in this research and to relate their stories and experiences of what Whānau Ora means to them and how this may or may not benefit their health outcomes. The response from this hui was both highly receptive and enthusiastic. Questions were asked about why I was doing the research, offers of awhi and support from kuia were made for my safety and wellbeing. At the conclusion of this hui acknowledgement of this research project was approved verbally in te reo fully supported by Nga Pakeke O Ngāti Ruanui. An emphasis was made by me at the start that this was a Masters of Philosophy (Nursing) thesis and that the recruitment of participants had not yet begun and would not until Massey University Human Ethics approval was granted. I was fortunate to have my whānau, my mentor Mere Brooks and my supervisor Dr Amohia Boulton at this presentation.

Face to face presentation with participants, whānau and iwi is a form of accountability and is crucial to the outcome of data collection. To be able to stand by your work, observe and listen rather than adopt the position as an ‘expert’ is

important, and as a researcher to remain humble and to recognize that our knowledge is only one type of knowledge (Boulton, 2005). This is relevant and reminds the researcher to be humble, remembering that we do not gain access because of our knowledge; rather, access is granted by people in those communities who are willing to participate in the project because they are related to us, or they have faith in us because we are Māori (Boulton, 2005). Mead (1996) talks about the commitment to report back to the people being part reciprocity, part accountability and notes that the final reporting will close off the activity, but not the relationship. That will endure.

As Māori participate in an ever-changing New Zealand and global societies, the role of interactions of older Māori in the contemporary context have also changed. An idealized historical view is that Māori society valued its older members who were generally looked upon to provide leadership, stability, guidance and wisdom (Durie, 1998; Edwards, 2010; Kukutai, 2006). Durie (1998) also refers to roles ascribed with older Māori are fundamental to the maintenance and development of tribal mana (strength), this is attributable to their high level cultural competence or genealogical ties.

Participant recruitment

Attendance at whānau, hapū and iwi hui (tribal meetings) outlining the research aim and potential benefits and invitations were made for potential participants to share their experiences of health care. I began to approach by e-mail and phone different potential participants and made available the information sheet and the consent forms. Issues of confidentiality and anonymity were explained when this was done. Confirmation of dates, venue and times were made for the actual interviews and eight of these interviews took place at my workplace as a preference of the participants, and one at a participant's workplace and one at home. Refreshments and kai was offered to participants, and when the transcripts were returned to them I also gave koha (petrol vouchers) to participants to acknowledge their time and support.

A total of ten Māori and Ngāti Ruanui participants, nine residing locally and one in North Taranaki, were interviewed for this research. All participants had experienced health care and were aged between 25 years and 78 years. Participants were recruited using the snowballing technique. Noy (2008) describes snowballing technique as a

sampling method which can generate a unique type of social knowledge which is emergent, political and interactional. It is also where social knowledge of an interactional quality can be fruitfully generated (Noy, 2008). This sampling method of snowballing has a number of advantages and some limitations. There is a risk that participants are known to each other and confidentiality is compromised (Gendall, Fawthorpe, 2006). The initial hui with iwi members and potential candidates who wanted to participate in this research project were advised of this through discussions at these hui. Most of the participants who participated in this research were recruited at this hui, however these participants suggested others who would be willing to take part. Through this snowballing process I was able to contact these participants through phone calls and face to face meetings. Hall (2004) argues that complete concealment of identities through the use of pseudonyms is probably impossible in a country as small as New Zealand; moreover in smaller Māori communities where everyone knows everyone else, confidentiality may not be easy to preserve. Despite this all participants were given a pseudonym. It is important to note that having some level of access to the proposed participants as whānau and iwi networks extend to include a number of participants. In Māori terms this could be termed whānaungatanga, however in methodological terms; it is known as snowballing (Millar & Sullivan, 2007).

Data Collection

An interview schedule was used to enable collection data relating directly to the research question (see Appendix C). The main areas covered were recollections of their childhood and adult life, their home place, important issues in their whānau and what interpretations of hauora and Whānau Ora. The interview schedule was developed through the review of the literature, the researcher's own experience in working with whānau, and with critical input and review from the academic and cultural supervisors.

The Interviews

Semi-structured interviews with Ngāti Ruanui iwi members were conducted with minimal broad focused questions being used to elicit the participant's perspective of Whānau Ora. Polit and Hungler (1995) suggest that semi-structured interviews are

best used when the research wants to be sure that a given set of topics is covered in the interview, so that themes across interviews can be tracked, yet it is open to allow for outlying views to be expressed. These face to face semi-structured interviews with the ten participants were carried out using open-ended questions allowing for flexibility while ensuring that key issues were covered during the research interview. These interview times varied from forty minutes to an hour and half and participants were asked if they wanted whānau present and none of them chose to do this.

At the beginning of each interview, I emphasized their choice of sharing their own information with others and that people need to respect each other's rights. Due to the small study with Ngāti Ruanui individual participants it may be inevitable and unavoidable that they may be identified, merely by relating their story, but their commitment to the betterment of Whānau Ora and this research study was confirmed orally by all participants. All participants were reminded of this so that they were mindful of any disclosure.

The first two participants were young and female. They had both been born in different towns but had come home to be near their elderly parents. They provided an insight into the importance of whānau in their lives and their experiences with health care services when dealing with a bereavement in their whānau and how one of these participants felt the distrust of the health service when her father was unwell and eventually passed away. The third participant was a male, who spoke in te reo at the beginning of the interview, was aware of my limited te reo understanding and translated his own korero (language) in English for the rest of the interview.

Four participants were kaumatua and one kuia ranging from the age of fifty to seventy-eight with in-depth discussion and had grown up with essentially traditional Māori customs. One female participant, who told her story in a lifestory structure, gave valuable feedback about how she thought the questions were very structured and did not like being interrupted. The next two participants were both fluent te reo speakers, and these interviews were translated. However, the need to access external assistance to translate te reo Māori within the data was not required as it was within my capability, as the researcher, to interpret and understand.

The data collection took place over a period 6 months. The interviews were all audio-taped and subsequently transcribed verbatim by a professional transcriber who signed a confidentiality agreement (see Appendix D). The participants were given a copy of the interview and the opportunity to give feedback or make corrections.

Data Analysis

The method of analysis chosen for this study was a hybrid approach of qualitative thematic analysis. It incorporated both data-driven inductive approach of Boyatzis (1998) and the deductive codes of approach outlined by Crabtree and Millar (1999). This approach complemented the research question by allowing the tenets of social phenomenology to be integral to the process of deductive thematic analysis while allowing for themes to emerge direct from the data using inductive coding. Boyatzis (1998), states that thematic analysis is a process for encoding qualitative information. The encoding requires an explicit code that may include a list of themes; a complex model with themes, indicators and qualifications that causally relate, or something in between these forms.

Each interview transcript was analysed separately and the interview schedule itself was used as a descriptive analytical framework to organise the data (Patton, 1990). Inductive coding of data was undertaken which involves labelling and categorising the data into key areas of interest which are identified as the data is being analysed. Through the coding process, general patterns were identified in the data which gave rise to themes as data is interpreted.

Following these reviews is a cross-case analysis (Patton 1990), undertaken where all the analyses of individual interviews were analysed together. This involved grouping together selections of data from participants organised around common issues, and identifying themes of interest with regard to each issue. Coding and analysis was carried out manually rather than using a computer-assisted analysis. Boyatzis (1998) also concludes that the coding process involved recognising (seeing) and important moment of encoding (seeing it as something) prior to the process of interpretation (Boyatzis, 1998). A good code is one that captures the qualitative richness of the phenomenon and defines a theme as a pattern in the information that at minimum

describes and organises the possible observations and at maximum interprets aspects of the phenomenon.

While much has been written about Māori methods, ways of collecting data that are appropriate and take cognisance of Māori cultural beliefs and norms, only a few contemporary Māori thinkers and researchers have attempted to characterise the elements of a “Māori analysis” (Cunningham 2000; Durie 1998; Reid 1999). It would be fair to say that as more Māori become involved in research, so our understanding of what constitutes a Māori analysis deepens (Boulton, 2005). At its simplest Māori analysis involves the use of Māori frameworks and models to analyse the data that has been collected. A Māori analysis occurs within a Māori philosophical framework and has as its ultimate goal the improvement and development of Māori. According to (Durie 1998) Māori analysis is based on frameworks relevant to Māori, and must be the fundamental goal of Māori research. It recognises that the design of the research and the interpretation of the data are not themselves mechanical tasks but are very much shaped by context values and assumptions (Durie, 1998).

Conclusion

This research project employed a Māori-centred (Cunningham 1999) qualitative methodology built on indigenous knowledge. Mātauranga Māori (indigenous knowledge) paradigm locates the researcher within a Te Ao Māori view of reality in respect to the phenomena being investigated. It was essential to the outcome of this research maintains the integrity of Ngāti Ruanui Iwi members who participated that was both respectful and valued the participants worldview. Kaupapa Māori research was outlined but it was decided that this research project would utilise an approach that enables ‘mainstream’ research requirements to be incorporated. The methodological principles were defined and ethical consent was approved and as mentioned, a Māori-centred approach provided a philosophical perspective to the study, but as a Māori researcher, further guidance was required by the principle of tika, the basis of tikanga. This ensured the processes and procedures were correct and all those that were connected to the research are enriched. A Māori specific code of conduct which guided this study was described and participant recruitment took

place. A total of ten participants, all identifying as Māori and Ngāti Ruanui were interviewed for this research project. Participants were recruited using a sampling method called the snowballing technique. Semi-structured interviews with these 10 participants were conducted with broad focused questions being used to elicit the participant's perspective of Whānau Ora. Thematic analysis was used to identify the themes for this project and subsequently the emergence of sub-themes; meanings from the participants data were formulated. A discussion of Māori analysis emerged which acknowledges its framework as being the fundamental goal of Māori research. It could be suggested that Māori analysis could be used towards research analysis for the growth, development and improvement of health and social outcomes for Māori. The next chapter discusses themes that came through the data related to Whānau Ora.

Chapter Five Findings

Introduction

This chapter presents findings from the data that identify the definitions, meanings and the core values given by the participants that are integral to Hauora and Whānau Ora. Hauora has a values based concept derived from a kaupapa Māori philosophy although it is loosely translated as health or wellbeing and has a meaning that sets it apart from the western notion of health, and is discussed further below. These two main themes have been derived from the literature and the data obtained from participants. There were also sub-themes identified in the data that were discussed in in the first chapter which were whakapapa, whenua, indigenous knowledge, colonization and inequalities/racism.

The second findings chapter, chapter six, extends the discussion of Whānau Ora, collective responsibility/whakawhānaungatanga, the politicalisation of Whānau Ora, and roles of Whānau - intergenerational/Kaumatua, tino- rangātiratanga/self-advocacy and urbanisation.

Hauora

Achieving optimal health and wellbeing involves many interlinked and complex processes for Māori. It is generally accepted that Hauora is an encompassing health concept which includes various life aspects. These include a series of values that have implications for Hauora: whakapapa, wairua, whānau, whānaungatanga, whenua, tikanga, te reo Māori, tinana, hinengaro, tapu, noa. Other aspects that could also be included here have been separated for discussion later in the findings, particularly whenua and tino-rangātiratanga which are included in the second findings chapter.

Defining the aspects of Hauora

A brief explanation is provided for each of the values identified above.

Whakapapa - Metge (1975) states that one of the functions of whakapapa is to link the relationship between past, present and the future and tie them together. According to Metge (1975) the old people refer to whakapapa as telling the story and

relationship of humankind to the environment, the elements and the flora and fauna. Whakapapa is one of the interconnected values that contribute to Hauora (Wenn, 2007).

Wairua – is the spiritual element and is linked to hauora and wellbeing. An individual can experience wairua in many different ways and is nurtured by tupuna, koro and kuia. It is the influence of life and the teachings that nurture it (Wenn, 2007).

Whānau and Whānaungatanga – Whānau is the fundamental unit of Māori society and Whānaungatanga relates to the kinship and relationships in the broader sense. These provide the personal support individuals and Whānau require in crisis and in intervention (Wenn, 2007).

Whenua – is part of the interconnected whole; refers to the land and is part of one's view of the world. Knowing your whenua gives you a sense of belonging. Whenua also refers to the placenta or afterbirth of a newborn (Wenn, 2007).

Tikanga – Marsden (1975) defines tikanga as doing what is right. It relates to Māori custom with kaupapa and base rules. These rules have been handed down from customs and traditions through many generations and are acceptable and reliable.

Tapu and noa – have a spiritual connotation. Rangihau (1975) has described four aspects of tapu all of which have relevance to hauora. He suggests that tapu provides Whānau and hapū with a means of control of its members, as a means of providing justice and managing tapu when it is overlooked or disregarded, and as a means of conserving resources and as a means of protection. Noa is provides control and balance for tapu. Wherever tapu is applied it must be counterbalanced by an alternative action which is known as noa.

Hauora - Participant's views

The participants' description of Hauora encompassed broad and diverse meanings related to wellbeing. All aspects of hauora are very important and typically reflect the wide variations within communities.

Hauora to me isn't a thing, it's just not a thing. Hauora varies whether it's about me or my family or whether it's about somebody else and theirs. Its fluid and it has to take into account everything. (Participant 8: pg 2)

Health, well-being, everything really. If you're not healthy, it could be emotional; it could be stress, depression. It could be cloud 9. Everything revolves around health. (Participant 2: pg 1)

Participants considered hauora in relation to positive or negative, to be encouraged or discouraged and to move on. This concept of hauora reflects the individual's responsibility for health and what constitutes good health by enlisting other whānau. Dealing with life's stressors can be a challenge but with the help of other whānau strengthens the ability to work through all health issues.

Hauora's about being able to work your way through negative patches to increase you feeling better about things and whether that is about you changing your attitude or call on other people to help or in another realm. It's all part of moving on and getting over that one before there's another hurdle to cross. Strengthening yourself so you can move to the next level of challenge because I don't think you can get away from these negative things, or it may not be seen as negative when I think about it. It could be seen as a challenge because it might seem negative at the time but when you've gone through it and look back, you're actually stronger for it.

(Participant 8: pg 2)

Reference was made in relation to the concepts of wairua, tinana and the combination of mental and physical understandings around health practices and being surrounded by whānau.

Whānau Hauora is about 'te taha wairua, te taha tinana, nga Whānaunga e ra tumea. The wellness of the body, the mind, the soul and of course you're surrounding Whānau. It is not just one of those things.

(Participant 6: pg 1)

Older participants reflected on the ability to translate the teachings of hauora as being their responsibility to carry on with the new generation and hauora being more than a delivery of a service.

Its understanding what the kuia taught us and understanding to carry that through with own young ones that are working in Hauora today.

(Participant 7: pg 4)

When the question of this participants definition of Hauora, he explained that he needed to use his 'Māori brain' and speak in te reo.

So my Māori brain is telling me: Koe nga to hau e pupuki mai ra e roto I a koe. Ko tera hau e pupuki mai ana he wahanga mo te tangata ko e ra o nga hoa tanga i roto i te tangata ko te wairua, ko te mauri me ro nga wahanga I roto I te tangata. E orana e ra o nga meo te tangata ka puta mai te oranga o te tangata. No reira koe titi o nga whakamarama e tae anai i o te korero. So my interpretation is more of life essence itself. From our whakapapa, from Rangi ko Papa lies the signs and the attributes of good health. So keeping the connection with our whakapapa and our historical events and stories, keeping those alive and making them relevant gives better mental, spiritual and physical wellbeing... So it's one thing knowing it. I suppose the next thing is actually practicing it.

(Participant 3: pg 1)

The concept of hauora cannot be separated from Whānau Ora as all participants see them as similar and hauora is essential for Whānau Ora.

The word Hauora: the word Hau is the family - is well - as I look at the four winds. If you look at the four winds scenario – or the hau-ora and then you look at the wha-nau ora, the family; so the four winds are capsulated in that kupu Whānau. So ko te hau rite tonu, so they are similar in the essence of the korero or the concepts.

(Participant 3: pg 3)

In some instances te reo was used to clarify the participants own thinking before speaking in English. Because of the fluidity of both Whānau Ora and hauora it was a cause of concern for them to distinguish the two concepts.

Whakapapa

Data indicated from older participants that they have an important role in the transmission of knowledge over time between whānau members and to the younger generations. This is the intergenerational passing of information of the previous achievements of tipuna to younger generations, giving them a sense of identity and connection.

To help any Whānau, you bring out their whakapapa; you bring out their whakapapa lines, their main chiefs through that whakapapa line and their achievements of their whakapapa chief to put on to the Whānau any this is what your tipuna did and this is how he dealt with problems you are having.

(Participant 5: pg 5)

You use the whakapapa tree element. I use this link on people who have been naughty and you can speak directly to them to deal with that. That's one of the tricks when you can't talk to people who are so bad and don't want to talk to anybody.

(Participant 5: pg 5)

I found out in research, is that it had changed up through the north to into Taitokorau and in that journey some of our people went off that waka(canoes) and embedded themselves in those particular iwi and evidence was pretty profound there in terms of kohatu (headstones) that were put into place to remember those who passed on. Those are the sorts of things that one was able to get a foothold in terms of helping others do their whakapapa, to do Whānaungatanga and to do the elements of the wairua with the manaaki, with the tautoko.

(Participant 10: pg 2)

Participants linked hauora whakapapa to the origins of Te Ao Māori (the Māori world) and how it ensures wellbeing in a healthy environment.

Hauora within the family derives from our whakapapa and it derives from our korero that have in Te Ao Māori. So it's not just the physical needs, it's about ensuring the mental wellbeing, your spiritual wellbeing and all those different

aspects that we can actually share with the environment. Like having a healthy environment, encourages or helps the health of the people.

(Participant 3: pg 1)

Whakapapa relates largely to human ancestry and relationships and is central to the concept of hauora. It provides information about these relationships and identity. Participants from this research identified that whakapapa is a way to link whānau who are unwell mentally and have problems with communicating. Their experiences identify the importance of whakapapa links to their tupuna and it is a value that binds people together. Celebrating the achievements of tipuna and to translate their way of helping others to today's world. They also described whakapapa as being essential in having a healthy environment.

Te Whare Tapa Wha

Durie (1998) states that Te Whare Tapa Wha (TWTW) was developed in relation to a specified health need. TWTW provides a set of interacting variables and the model likens health to the four walls of a whare (house), with each wall supporting the other three. An imbalance in one wall affects the whole resulting in ill health. This model encapsulates four interacting values:

Taha wairua – represents the spiritual dimension of health.

Taha Whānau – acknowledges the relevance of the extended Whānau to health and wellbeing.

Taha hinengaro – refers to thoughts and feelings, and how these are expressed.

Taha tinana – refers to physical or bodily health.

Out of the ten participants, four had not heard of TWTW. Participants discussed their relationship with health professionals and the health system. A feeling of alienation had arisen, not necessarily because of poor access or even inadequate care, but mainly there was a lack of shared decision making and limited recognition of Māori views which led to strained relationships (Durie 1998). This participant expressed the recognition of the TWTW model in the Western world and articulates that it is intrinsically about our ways but more to guide Pākehā.

Tapu Wha is a model that Durie put together – more to guide Pākehā to work for us. A lot of us know it, we may not articulate it in his model, but a lot of us know it intrinsically about how our ways are and our cultural beliefs are and we

do it anyway, but I believe that, this model is for Pākehā to understand the different cultural way of treating people who are unwell or have challenges in their life that they can't cope with. (Participant 8: pg 3)

Kaumātua were unsure of what TWTW was, but could articulate the concepts of hauora.

Te mauri, Te Wairua, Te Hauora, not sure about the other. (Participant 5: pg 2)
It's mainly the spiritual; element, I find that when it comes to healing people or they have gone bad or done things wrong and you're asked to bring them into the world of light and kindness to address their wairua. (Participant 5: pg 2)

Some participants were quite clear in their understanding of TWTW and also aligning this model with others. The basic principles of TWTW were easy to understand but also they expressed that there be more understanding amongst everyone about these Māori practice models.

Well, I like the Te Whare Tapa Wha model because it is basic and people can grasp the concept straight off. But on the other hand there is much more to it if you delve further into Māori practice models. (Participant 4: pg 3)

Ancestral knowledge was important and taha wairua is generally felt by Māori to be the most essential requirement for health. It implies a capacity to have faith and to be able to understand the links ancestral knowledge and taha wairua in relation to Whānau Ora.

For Whānau Ora to reach its fullest potential it has to take the "Tapa Wha" model seriously. Taha wairua, taha Whānau, taha hinengaro, and taha tinana and when I say that it is wairua that means the wairua from our ancestors. That means the ancestral knowledge base can be used to support this concept. If you are gonna use our name like Whānau Ora, you need to use the tikanga and those concepts that go with Whānau Ora. (Participant 4: pg 9)

Participant four felt that Taha Whānau, taha wairua, taha hinegaro, taha whakapapa was:

Oh um, it's absolute for me. It's because.... I know or I believe what's best for me in terms of Health you know. We've all got things to work on aye.

(Participant 4: pg 4)

And also expressed

They are essentially supportive of each other. They are integrated so that's the whole focus of the TWTW model is that it is integrated that you can't without one survive healthily without one of those values. One of those ah.....yeah.

(Participant 4: pg 8)

Taha Wairua

Out of all the dimensions of TWTW, taha wairua was the main component that the participants talked about strongly. Responses indicated that spirituality is an important dimension of overall wellbeing.

I learnt the Pākehā worldview as a young person although I was connected to Taha Māori through the meaning of wairua but didn't fully understand this. As Māori we need to nourish our Wairua more. We need to practice Māori values more because those are the things that keep us within the parameters of health lifestyles.

(Participant 4: pg 2)

There was a reference to wairua and its role in healing people from bad experiences to positive experiences.

It's mainly the spiritual element. I find that when it comes to healing people or they have gone bad or done things wrong and to bring them to the world of light and kindness is to address their wairua.

(Participant 5: pg 2)

This participant expressed the view that cultural understandings were extended to concepts such as 'old people' being described as 'taonga' and to be able to say her prayers during her time in hospital. The importance of having Whānau present when

she was having treatment and her wairua was intact when she was able to say her prayers to help her get through this procedure.

When I had cancer I went into a world which was different from anything I knew. I didn't have the old people, I only had my son and daughter and my husband with me, but one thing I remember doing in there, I was in that theatre where they were putting radiation treatment onto me, I looked up at their taonga and said a prayer in Māori to my old people. (Participant 7: pg 2)

This same participant believes that her own practice of karakia and wairua helped her in 'survival', not just the radiation treatment.

I had radiation treatment, instead of all the other stuff they use and I think myself I only survived because I believed in that culture, my own culture.

(Participant 7: pg 2)

All of these participants expressed that wairua was an essential part of their wellbeing including their whānau. They also confirmed their own self-responsibility with spiritual beliefs and spiritual balance to see them through their medical treatment. Spiritual wellness was enhanced with karakia taking a bad experience to a positive experience with the belief that it is wairua that gives people the best outcome.

Taha Tinana

Taha tinana is a more familiar health dimension (Durie, 1998), though the emphasis is different in that there is a clear separation of tapu (unsafe) and noa (safe). Certain parts of the body and the head in particular, are regarded as tapu and bodily functions such as sleeping, eating, drinking, and defecating are imbued with their own significance, reflecting various levels of importance and requiring quite different rituals. Food for example is a great leveler which removes any vestige of sacredness or distance as between people (Durie, 1998). Because cleaning the body and eating are polar opposites, separation of food from toileting functions is regarded necessary to maintain good health, a condition severely tested in hospital wards where all functions are frequently conducted in the same confined space (Durie, 1998). Tinana was expressed by all participants important for total wellness.

What is Taha tinana to a Māori and how does that affect Māori..... So when you start getting into tinana there's aspects of tapu and noa, those sorts of things you know and how and what happens when those tapu are violated? Does that affect a person? (Participant 4: pg 3)

The use of alternative means for physical health needs that needed to be addressed.

Taha tinana talks about the application of rongoa or pills and that. (Participant 6: pg 2)

You don't have to rely on the western model of being sick; it's just sometimes your body is sick of being sick. So instead of fixing for instance if someone can't sleep – instead of giving them a sleeping pill maybe you could look at why they aren't sleeping and there are issues that can help with that. (Participant 8: pg 3)

Not many of the participants discussed tinana in full detail. There was an overall concern for life experiences and social issues rather than just dealing with specific health issues.

Taha Hinengaro

Taha hinengaro serves to emphasise the interconnectedness of the thought processes contributing to wellbeing. These may include overt or covert forms of communication of feelings, the spoken word is usually redundant; for example shedding of tears to express grief, and touching or positioning yourself to another person may be used to express joy or happiness. Participants explained taha hinengaro with other concepts taha wairua, taha whānau, and taha whānau. There was no separation.

When a baby is born the cord is called the whenua and it would be returned to the whenua to show the spiritual connection for the baby. So whenua and whenua; that was the baby's whenua. That's the wairua, taha wairua, taha tinana, taha whenua and the taha hinengaro because of the thought processes that connects those things altogether. (Participant 4: pg 10)

Hinengaro – e rere kite ingoa ki te Pākehā. When we – our people see about it, kei te Hinengaro – they say it, and they say it in a way that isn't desecrating to a person. (Participant 7: pg 3)

The model of TWTW demonstrates the need for balance and synergy and illustrates the interconnectedness of all these concepts. Not one concept is more important than the other. Apart from a few of the participants who could not identify TWTW, those that did, had a clear idea that all components of TWTW make a whole. These concepts underpin the participant's health and wellbeing. It is interesting to note that a comment about the TWTW model of health was developed to inform Pākehā and that a lot of us know it intrinsically about how our ways are and cultural beliefs, but these findings revealed that some participants did not have an awareness of it.

Indigenous knowledge/Matauranga Māori

Indigenous knowledge or Matauranga Māori encompasses all branches of Māori knowledge, past, present and future (Mead, 2003). The importance of te reo aligned with English language was deemed to be important and having strong Māori knowledge in order to promote Whānau Ora applications to health services was expressed.

Matauranga Māori is a great attribute to forging strong Whānau Ora disciplines and application supply of service. The Reo is very important but so is French and so is English so Matauranga in the understanding of the Māori world view is very helpful in terms of delivering high quality of Whānau Ora to Māori but also it is a Matauranga Pākehā or Matauranga tauiwī, it is as important as well.

(Participant 6: pg 6)

Edwards, (2010) suggests that there are many terms used to describe indigenous peoples of the world, including aboriginal, native and first nation's people. An integral dimension of the mobilization and networking of indigenous peoples globally has been the efforts to promote the legitimacy and validity of their knowledge systems and indigenous knowledge. One participant described the Treaty of Waitangi and how this relates to the validity of indigenous language of Māori.

Well, that just brings me back to the treaty aye, where the law says ‘in the indigenous language, that is the right treaty.’ When they refer to the Treaty, it’s not the right Treaty; it’s the Māori treaty – that’s the right treaty. But indigenous – as you know most indigenous see it – it’s not a Māori thing we are pohara (poor). If you look at the Aborigines, if you look at American Indians they have the same as the Māori, so why are we calling it a Māori thing when it’s actually an indigenous kaupapa driven by white people.

(Participant 5: pg 7)

Healing comes from the awa (river), the maunga (mountain), de-stressing and seeing these inanimate objects as part of the participant’s family. Smith (2006) maintains that the arguments of different indigenous peoples based on spiritual relationships to the universe, to the landscape and to stones, rocks, seen and unseen have been difficult arguments for Western systems of knowledge to deal with or accept. These arguments give a partial indication of the different world views and alternative ways of coming to know, and of being, which still endure within the indigenous world. The values, attitudes, concepts and language embedded in beliefs about spirituality represent, in many cases, the clearest contrast and mark the difference between indigenous peoples and the West (Smith, 2006).

I see my family as my tipuna who aren’t here but I have these photos at home – my koro my kuia – so every time I need something I see them and talk to them. Then I go down the river and I kind of see them. I look at the maunga (mountain) and I see him as my Whānau when I want something or want to de-stress. So I see him as a maunga tupuna.

If I want to sit on the rock and put my feet in the awa (river), that’s when I see him as my Whānau- my tupuna actually. I see my father who is not here as my Whānau, my kuia who is not here is my Whānau so when I think about it, they are all part of the bigger picture.

(Participant 8: pg 2)

Participants related their own indigenous knowledge to the Treaty of Waitangi and to their whakapapa. They all acknowledged what indigenous knowledge was, the meanings and the importance of understanding these meanings. Acknowledging Te

Reo and other languages for Māori and delivering health services for Whānau who can speak Te Reo. Comparison to other indigenous nations such as the American Indians and Aborigines was articulated by participants indicating the poverty they experience and the impact on health for these indigenous people.

Whenua

Whenua can have many meanings, land and the umbilical cord of a new-born baby, and the spiritual connection this represents.

When a baby is born the cord is called the whenua and it would be returned to the whenua (land) to show the spiritual connection for the baby, so whenua and whenua, that was the baby's whenua. That's the wairua, taha wairua and taha tinana and the taha Whānau and the taha hinengaro because of the thought processes that connects all those things together.

(Participant 4: pg 10)

Participants getting kaimoana and being kaitiaki (guardians) of their own resources and going back to their own traditional models of conservation was a challenge.

What's interfering with our processes from the law systems? Why are Pākehā controlling our resources when it should be our own people controlling our resources? It should be our own to be empowered to carry out the kaitiaki process. You know these fellas go, 'oh here you be the kaitiaki, you sign the permit, you give it to them, and here they are going through your boat counting every paua – Pākehā fella. In the old days you weren't allowed to climb into anybody else's boat, let alone touch their kai. So there are too many double standards, too much ignorance and that's why we are having these problems with kaimoana. We should return back to the traditional models and that takes Whānaunga, I mean they ask themselves why isn't this working? Why are all these people getting caught? What's throwing them in jail, it's still not working.

(Participant 4: pg 10)

Furthermore this same participant questions the legal system about taking kaimoana, but also suggests that Whānau Ora could be an answer to some of these problems. Shared functions such as the gathering of food were collective activities for members

of Whānau living in close proximity to each other in past generations for Māori. However, with the change of social and economic policies, laws these characteristics have been eroded and the closeness that previously existed is no longer evident.

I question the right of the Pākehā judge to condemn Māori to prison for their own taking kai, I understand they take too much, but that's not the judge's kai. You know, we whakapapa of to all of those roofs (hauora) and we should have our own way of dealing with those things. There should be more Whānaunga or education for Māori world view perspective to help these young men understand. You know they should be sent to do something more constructive like work around the moana (ocean), do something around the moana with the kaitiaki, so they can understand where they have gone wrong. That would be more beneficial than throwing them inside and shaming them in public.

(Participant 4: pg 11)

Comments from this participant indicated the relationship with whenua and the loss of land in a global sense.

Tatau rawa ki a matou (very, very similar). So as an example we talk about 'Nga Hau e wha' or the four winds here, the Canadian First Nations people talk about the four corridors, they are the same kaupapa. Ko papatuanuku ki a putaki or the roots o matou nei putaki o matou no te ao Māori; so for Māoridom our strength and so on so forth – that has had, and that alienating effect of muru raupatu (land confiscations) has a tremendous detrimental social and health effect on as a people. So those who are not linked to the land are lost souls in many respects and is one of the biggest reasons people live in strange places like the Gold Coast and so and so forth. Our indigenous peoples... where our lands are... to a large extent unhealthy.

(Participant 6: pg 5)

Participants have expressed that whenua has different meanings for different situations. From the 'baby whenua' to resources such as seafood from the moana (sea) that Māori were accustomed to accessing to provide for their whānau. The muru raupatu (confiscations of land) had a tremendous detrimental effect on the health and wellbeing of Ngāti Ruanui uri and its descendents. Linking to the home land is an extension of Māori wellbeing. There are many whānau living outside their

tribal boundaries extending to other global countries which raises the question about how these Whānau cope when they are unwell and want to orientate back to their home.

Colonisation

The experience of colonization for the participants of this research has been of oppression, loss of land, language and cultural values. Colonial processes have imposed a range of injustices on tangata whenua (Belich 1986; Belich 1990; Smith 1999). Ongoing processes over a century and a half, undermined Māori self-determination and development, marginalising Māori as a disadvantaged and oppressed minority in their own land, visited by diverse harms in the political, economics, health and education and social spheres (Adjwani 2003 et al.; Spoonley, MacPherson, Pearson 2004). Durie (1998) states that the Tohunga Suppression Act (1907) was a statement from the Government that healthcare would be firmly based on Western concepts and methods. Participants expressed their concerns that professionally trained Māori leaders during this time such as Dr Maui Pomare and Dr Te Rangihiroa Buck were aware of current international opinion and the advantages which medical science could offer Māori. However, this forced Māori healers, such as Tohunga, underground and although their skills were not entirely lost, the transmission of their methods faltered. Participants made reference that with the loss of traditional values and concepts was the loss of te reo.

The problem is that you lose your traditional languages and values and ways of looking after yourself that have proved effective for hundreds of years and you rely on western medicines. That was the fatal flaw in the Tohunga Suppression Act 1907 and I can understand why Maui Pomare and Te Rangi Hiroa pushed for that but they couldn't see the impact it would have in years to come. The reason they pushed for the Suppression Act was because they needed to vaccinate their people against Pākehā introduced diseases however they didn't understand that the Reo wouldn't be an issue.

(Participant 4: pg 9)

The essence of understanding the Māori world view of health through te reo and a connection to the whenua (land) in relation to Whānau Ora was expressed.

They possibly thought that the Reo would be around forever but many people today have been affected because they have lost their own tikanga and understanding of Māori worldview of health and through colonisation they have been moved off their economic base which is the whenua. From the whenua in the old days, the whenua was called Te Oranga which means health. We were sustained from the whenua and now have moved into urban areas, and now they're turning back to look at Whānau Ora to help for the future.

(Participant 4: pg 9)

Colonization for participants was described as a state of confusion for some Māori being bought up in a westernized society. There is an increase in Māori health statistics and western beliefs being imposed on some Māori. The ability to speak your mind and uphold the rights of indigenous peoples was expressed. It is important to convey in this interview an increase in intensity of the participants feeling's indicating frustration, indignation and sadness in the struggle to preserve beliefs of indigenous peoples.

Māori over time have been colonized so much were are in a state of confusion for some, because we have been brought up in a world that is not ours, and mainly someone else' and we are all mucked up and we've got a whole lot of families that are in a really sad state which is why we have huge health statistics. We are an indigenous people that have been oppressed over time and not only are our cultural beliefs stood on, other beliefs have been imposed on us and because of that we are in a vulnerable state so unless you are stroppy, big-mouthed, toey, you are part of a system that tries to shut you up because we have to know our place.

(Participant 8: pg 3)

The land that was lost from generations before.

All is lost or getting lost and put onto reservations and as you know were cut in half virtually by roads going through them. Pākehā building roads through the pa's and being displaced and moved onto reservations. Taken off their lands where they hunted and lived for generations. Oh you know that story.

(Participant 5: pg 7)

There was the view that the colonization process invited alcohol and tobacco.

Again, it's a colonisation process; yeah. You see again I spoke about this, who bought alcohol and tobacco? It wasn't our ancestors; they (alcohol and tobacco) didn't come on the waka. That's the tool of colonization, if you look at indigenous peoples, 3 things, alcohol, tobacco and religion and they were used to colonize people. The alcohol and tobacco was used as a trade and it's documented here at the signing of the Treaty of Waitangi, they had alcohol there. So if you look at the American nationals – Native Americans – same they were um.....as long as you've people addicted and drunk, you can pull the carpet under their feet. (Participant 4: pg 9)

Participants considered the historical context alongside contemporary reality. They recognized the huge health statistics and the oppression over time and how Māori are a marginalised population. However they also maintained that they must be resilient and overcome this oppression challenging the systems and advocating for better health care for Whānau.

Inequalities/Racism

Participants described health in terms of where Māori are situated at the moment. This sits in line with policies and reports on Māori standards of health. Throughout these interviews it was evident that participants were fully aware of the inequalities and sense of outrage at the injustices and unfair treatment that Māori encounter.

Firstly I consider Māori at the bottom of the barrel for health.

(Participant 4: pg 2)

As well as inequalities, participants indicated the presence of racism not only in the community, but also in health service delivery.

Racism is still alive and well in New Zealand. You know people like to think it isn't but it is and you see its many shades daily. If it's not in actual service delivery it is in policy making for service delivery, it's also in attitude in central, local governments, so those are some of bigger things that impact on the

individual being able to access service. So that's why I talk about the various shades of racism which is alive and well in New Zealand.

(Participant 6: pg 4)

Furthermore, this participant expressed the view that

Racism is alive and well and we still have to fight it. (Participant 6: pg 4)

A kaumatua described growing up in an environment as a young man, where it was expected for him to do the 'dirty jobs'.

At the time the farmers around there were a bit racist, that's what I felt. I was there (on the farm) for 3 years but I had to leave because they kept putting me under the trucks with the pigs and you know all the mimi (urine) and I told them you better get someone else to do this and he said 'Oh you're the only one I can get, no one else will do it'. So I did it for a while and after that I told him I was leaving.

(Participant 9: pg 2)

In summarising hauora, all participants of this research indicated that health for them revolves around hauora. The underlying principles of hauora are fluid and not static. They maintained that hauora will only work if whānau are involved with their health care and outcomes. Themes such as whakapapa, whenua were also revealed by the older participants and it is essential that they hand down these beliefs and concepts to future generations to give them a sense of identity and connection. Some of the participants were aware of the TWTW Māori model of health and those that were not aware of this model expressed similar meanings which they stated made them well. Indigenous knowledge reinforced the practices found in Te Ao Māori (the Māori world). Participants drew attention to the fact that indigenous people of the world had similar values and concepts. They also related this to the Treaty of Waitangi and how important it is to retain these principles. Colonisation, inequalities was identified as a barrier to better health outcomes. Participants described these barriers as being unfair and unjust in their own medical and clinical care. The next section presents the data about Whānau Ora.

Whānau Ora

My interest in this research was to explore the definitions and meanings of Whānau Ora, by exploring what works for whānau, and more importantly what does not work for them in order to inform the development of policy and practice in relation to Whānau Ora. There is a paucity of literature related to cultural beliefs and practices for Māori relating to specifically Whānau Ora approaches and contact among Māori. The following findings include Ngāti Ruanui participant's experiences of healthcare, definitions and their interpretation of Whānau Ora. The main themes coming through the reading of the transcripts resolved themselves into broad categories of definitions of Whānau ora, collective responsibilities, politicisations of Whānau Ora, tino-rangātiratanga, hospitals/GPs/Community clinics and urbanisation.

Definitions of Whānau Ora

All participants were familiar with the term Whānau Ora and defined it broadly as the taonga (treasures) from their ancestors. Whānau Hauora was quoted together and agreeing with Meihana Durie.

Whānau Hauora is I think Meihana Durie got it absolutely right when he talked about 'te taha wairua te taha tinana, nga whānaungaa e ra tumea'. So for me it is the wellness of the body, the mind, the soul and of course you're surrounding Whānau. It is not just one of those things. (Participant 6: Pg 1)

To decipher the origins of the words Whānau Ora they utilised their tikanga Māori knowledge skills and understanding of te reo Māori. They initially broke the words into parts to determine the cultural significance of the word and to give it meaning. Similarities to Hauora were evident; there was no separation at times with these two concepts.

If you look at the four winds scenario – or the hau ora and then you look at the Whānau ora, the family; so the four winds is capsulated in that kupu (meaning) Whānau. So ko te Whānau ko te hau rete tonu, so they are similar in the essence or concepts. (Participant: pg 3)

Te kupu hauora is the wind ora, Māori concept of tikanga.

(Participant 7: pg 2)

The definitions of Whānau Ora included the philosophies of the Te Ao Māori world and similarities to indigenous global peoples such as First Nations (Canada), Aboriginals (Australia) and some South American countries.

More than very similar, tata rawa ki a matou – very, very similar. So we talk about ‘Nga hau e wha’ or the four winds here... the Canadians First Nations talk about the four corridors; they are the same kaupapa. They talk about tupuna – we talk about tupuna; all of those things. The pure philosophies of Whānau Ora for me shall remain as it did for my parents and their parents so koirā era (forever).

(Participant 6: pg 5)

A view from a kuia (elderly female) defined Whānau Ora by describing what it was and ‘how’ she did it.

Whānau Ora. You can take it in a different concept too. You could be amongst those people and you are part of Whānau Ora, that’s how I do it. So I would help as a kuia I would help. I have done with the nurses, going out with them, looking after my own people. Did the same thing for my own kuia, I grew up with the ‘hands of learning’ how to look after.....

(Participant 7: pg 6)

My interpretation of Whānau Ora is that healthcare would be improved if there was a perspective of introducing Māori tikanga into health needs of Māori.

(Participant 1: pg 2)

Whānau Ora continues to be defined by Māori and described within a broad context. From the origins of the ‘kupu’ (meanings) of these two words to the similarities to indigenous global peoples.

Collective responsibility/Whakawhānaungatanga

Understanding Māori values and ideals is essential to appreciate the concepts of collective responsibility. Collective responsibility is central to a Māori view of human nature and the nature of the world we live in. In a Māori worldview collective

responsibility extends beyond the Māori race, beyond the human race; it extends to all living things, it extends to the lands and the waters of the earth, it extends to Earth and Sky. Participants defined Whānau Ora as supporting one another as a collective, not only in your own whānau but in the wider community. Sometimes the concept of Whānau Ora has been applied to people who work collaboratively in order to meet specific purposes. Parents and children who attend the same Kohanga Reo, or who are part of the same cultural group often describe themselves as Whānau. Successful Whānau functioning depends on a level of cooperation and interdependence coupled with a commitment to shared objectives and a shared cultural perspective (Durie et al. 2009).

Whānau Ora is about aroha, Whānau, support, the manaaki. You have to help each other. You would have not just your own Whānau, but the wider community.

(Participant 1: pg 23)

Whānaungatanga is about using these connections, relationships and networks to secure support to meet the needs of Māori. WhakaWhānaungatanga is the consensus of the secured support to provide a positive health, social outcome. There was a commonality with these all participants expressing these views. A common perception for some participants believed that Whānau Ora included housing, education, social aspects of their health and the necessity to help out other Whānau that 'fall into the gaps'.

Whānau Ora means everything, from when you were a baby, you breast feed, going to play centre, day care, going to school, go to high school, go to University and you get a job. In that way you should know what to be expecting, otherwise if we fall into the gaps which is what people do, it's about those people out of the gaps and helping them. Whether it's helping them out with a house whether is helping them out with heating or whether it is helping them because they have cancer. You have to get right down to what they need help with.

(Participant 2: pg 4)

With regard to collective responsibility and a Whānau Ora approach, participants involved in this study identified it as meaning everything from birth and throughout their lives. They continually identified that Whānau Ora involved not only health needs but Whānau functioning depended the wider community.

Politicisation of Whānau ora

Policies have committed to health strategies to improve Māori health such as the He Korowai Oranga document (Ministry of Health 2002a) to Whānau Ora. The partner to the He Korowai document is the action plan, Whakataka (Ministry of Health 2002b) which sets out the government's expectations of the publicly funded health and health disability providers to improve Whānau ora, and to progress He Korowai Oranga. A feature of Whakataka is the recognition that traditional Māori health practices, such as rongoa (natural remedies), mirimiri (massage), and karakia (spirituality) are an integral part of the health services Māori access. This policy places Whānau Ora at the centre of public policy and challenge Māori to create environments that enable Whānau to shape and direct their own roles to achieve a healthy Whānau. There was a concern from participants that Whānau Ora must be determined and defined by Māori themselves and not politicians ensuring mana is not lost. Whānau Ora was described in a political sense that it is a 'catch phrase' at the moment. Many participants highlighted whānau who have health problems and negative outcomes and the inability for health workers to navigate through their issues to support them and empower them to make their own decisions, not just short-term but also long-term is a challenge. This was a concern expressed by participants about ensuring Whānau are guided and supported and are actively involved in deciding how their needs are met.

I think it's a catch phrase at the moment that's being misrepresented in politics and in funding which is a bit sad, because if you whittle it down to the grass roots many families are in trouble. If you're working in health, it's how you help them navigate through their stuff as advocates. You don't want to do it for them, it's how do you keep encouraging them to be stronger. Longer term – best to help them work their way through it rather than do it for them, but there are a whole lot of issues in there too.

(Participant 8: pg 4)

Initial views of Whānau Ora were expressed in a political sense.

When I think of Whānau Ora – bang- straight off I think of Tariana Turia straight away and she's always been a stalwart for that – for the – well it's been there forever to be honest but it's just awareness of the initiatives that are being taken on with the health clinics in the community around.

(Participant 3: pg 3)

There were concerns that Whānau Ora was being used in a political sense and not necessarily for health and wellness. Alcorn (2011) argues that the incidence of rheumatic fever in Māori children is more than 20 times higher than in people of European descent. Poverty plays a part in this. According to the Deprivation index (a composite of indicators including income, education and mobility), 75% of Māori people fell into the poorer half of the distribution in 2006, and 24% were in the lowest decile. The domino effect of policy change from Government with housing has a significant impact on overcrowding issues which may result in negative health outcomes for Māori.

If you are talking about Whānau Ora as being defined by politicians now, it's losing its mana being branded about like that. Now it's being misconstrued and put into politics. I think the Crown need to look at what they are doing because they can start a domino effect.

I remember I was looking at a policy change from the Crown once and made state houses market rental. Just one policy change meant that people couldn't afford to stay in state houses. They had to double up, so there was overcrowding so they could pay the rent. You get an increase of Rheumatic fever and asthma might go up. So that one policy about market rentals has a flow on effect to housing, affordability, over-crowding issues of poverty because they couldn't afford it.

(Participant 8: pg 4)

Inheriting the Government's initiatives and given these funded services will be significant in terms of whānau, hapū and iwi, there are concerns about the decision making of Whānau Ora. Ministry of Health (2002a) provides a framework for the philosophy of Whānau Ora and implementing this strategy is the responsibility of many sectors including District Health Boards and Primary Health Organizations. Participants discussed policy and decision making coming from the top down and not necessarily from Māori or a grass-roots level. A key concern was expressed that the concepts and ownership of Whānau Ora at a policy level may be of a poorer quality or even misinterpreted.

We've inherited a whole lot of muck from the top down and we get it because we are in the most vulnerable population. So we wear it, so I don't think it's from the bottom at all. I think a lot of it is recipient practices that come from many layers. I was trying to get the idea that Whānau Ora is our concept and our cultural way of being traditional but I do have to say that I have some concerns the concept of Whānau Ora being bastardized by the politics of health.

(Participant 8: p 5)

Political implications such as the suggestion that Whānau Ora will not only bring benefits to Māori but will add greatly to the nation and to the prospects of all future generations. There is an optimistic interest shown from a wide range of agencies and communities that the necessary goodwill and commitment will be forthcoming however, concerns were expressed with political changes in government.

I think Whānau Ora is a political football that can be changed at the fancy of the polls which tells me implicitly from a non-Māori point of view they don't really believe in it so they don't support it.

(Participant 6: pg 5)

This participant expressed his understanding of Whānau Ora in a traditional sense and his concerns about this relationship with politics. Once again the issue of cultural and traditional ownership is expressed and there are concerns that Whānau Ora will be translated by Government health policies.

Whānau ora is our concept and it's our cultural way traditionally but concerns about the concept of Whānau ora being transcribed by the politics of health.

(Participant 4: pg 2)

There were many instances where concerns were raised from the participants about the political commitment and the ownership of Whānau Ora. It could be suggested that the fundamental concepts of Whānau Ora are being misinterpreted this could lead to a disempowerment of whānau to achieve better health outcomes.

Roles of Whānau: Intergenerational/Kaumatua

Older Māori have a critical role in whānau and wider Māori society as carriers of culture and leaders in Māori cultural contexts. Māori society valued its older members who were generally looked up to provide leadership, stability, guidance and wisdom (Edwards, 2010). Older Māori are the carriers of culture within their iwi communities. The cultural strength of the Māori community and opportunities for the intergenerational transfer of cultural knowledge rely upon the active participation of culturally skilled older Māori (Edwards, 2010). An important aspect for the older Māori generation is to be available for their children and grandchildren. The care of mokopuna by the older participants of this study ensures that this substantial support is maintained. In order to have healthy Whānau the role of kaumatua strengthens and embraces the intergenerational transmission of cultural guidance and wisdom.

If our moko are sick long distance, we asked that we gather all together and do our karakia which was good. Mo patu te ringaringa ki runga e aia karakia meaning all hands on, just rare occasions. I tell them to do themselves with water on the phone, water being the life-source of everything and it's a sort of a baptism as well. So I see that as a healer the water, the purifier.

(Participant 5: pg 4)

Kaumatua are able to intervene when their mokopuna is in trouble. Some kaumatua are able to ensure that they are able to help mokopuna with their wairua and have positive outcomes. By utilising spiritual healing, kaumatua are able to bring them to the world of light and to address their wairua. By addressing the wairua of the mokopuna provided a clearer pathway there for them. Informing them that their

wairua has deserted them because they have done wrong and they need to bring their wairua back.

Recently one of our moko was caught off by her friends – their phones, iPods and stuff – so I said to her that she has been naughty and even said to her ‘ your wairua has deserted you because of what you have done’. Virtually I said to her that you have left piles of tutai (faeces) everywhere and you need to clean it up and bring back your wairua and so we have succeeded in doing that and she has apologized and paid for what she has stolen and she is on the right track now. (Participant 5: pg 2)

In the transmission of knowledge, kaumatua fulfil roles informally and formally, contributing to the care of mokopuna and their education needs. Being responsible for others and fulfil the function of caring is the foundation for Whānau and community cohesions a parent and grandparent. Teaching mokopuna the elements of whakapapa o tuturutanga o Taranaki, taha wairua specifically to Taranaki Māori is important.

In terms of tuturutanga (origins, birth) of Taranaki to allow one to pass on to tamariki and our mokopuna and fortunately enough we were able to put our mokopuna into the Kura Kaupapa o Ngātītaha wairua, nga tikanga katoa o Taranaki maunga (ethics of Taranaki Māori). (Participant 10: pg 2)

As a kuia, this participant noted that she had many roles.

I would help as a kuia.... Well I have done with the nurses; after my own people. (Participant 7: pg 6)

Kaumatua play a leadership role in health organizations and aligned Whānau Ora to ‘wellness’ in relation to the traditional practices of the ‘old people’.

Wellness and an awareness of how as a culture we need to be aware of how to take care of one another, in terms of seeking good advice and practices of old –

that the old people had to allow it to come back and that opportunity once again to be sitting on organizations that have the constitution, and that have the authority and the power to bring that back into place. (Participant 10: pg 2)

The capacity for kaumatua to acknowledge their limitations illustrates the reciprocal relationship that they have with their own whānau. Older people care for their children but roles can be reversed, to strengthen tangible support such as practical matters like budgeting in their households.

That's one thing with me, I wasn't very good, I knew how to subtract and work out a budget in my way and when I had my adopted son, he was very bright. He use to go to school and he had a look at my papers and he said 'gee what's this dad' and I said 'well that's my budget so I know what I have got left'. He said 'you don't do it like that', so he showed me. Well, I was blown away with that and how he made it look so easy. (Participant 9: pg 3)

The importance of kaumatua being actively involved in the intergenerational care of whanau is important. These participants demonstrate their strong alignment to the development and responsibilities to their Whānau. Whānau Ora is illustrated through these participants discussion about passing on their own knowledge of tikanga Māori and how taking care of one another brings about 'wellness' for Whānau. This is further illustrated by the last participant who was able to help his father with his budget.

Tino-rangātiratanga/Self advocacy

The Treaty of Waitangi provides a fundamental framework for Māori health. It requires the Taranaki District Health Board to establish mechanisms in place to enable Māori to contribute to decision making and participate in delivery of health and disability services. The political link between the Treaty and its guarantees of equity including the possibility of equal status with other New Zealanders is always challenged. Rangātiratanga is the ability to assert and confirm our role as mana whenua (people of the land), believing that we as Māori are the best ones to determine our own destiny. Tino-rangātiratanga is described as Māori control and self-determination. This self-determination is about Māori being better placed to

define their own realities and manage their own health. The importance of maintaining control over their own lives is a priority by many participants.

Advocacy for yourself is best as possible and part of that is my own research, my own understanding of what the health system can provide for me and my Whānau.

(Participant 4: pg 7)

Well, I am a very independent person. As far as talking about doctors and that, I also have one here that I can just buzz up and they come and see me. There is no hesitation for me to ask about my health if they can take me to Hamilton for my eyes.

(Participant 7: pg 4)

The importance of taking medications and encouraging good health was regarded as a personal responsibility.

I would be making sure that I'd be taking what I am supposed to be taking.

(Participant 9: pg 6)

This research confirms that tino-raNgātiratanga is about empowerment and self-advocacy. It is about individuals taking responsibility for each other's well-being and strengthening the Whānau. Whānau Ora is about taking leadership, encouraging good health and the skills to maintain its integrity.

Health Care Provision

All iwi now regard health a high tribal priority and most have developed health programmes delivered by their own people. Ngāti Ruanui Tahua is fortunate to have such a service with a Kohanga, Training programmes, and Social workers. This also includes a GP clinic and Community service with nurses and kaimahi. Most of these participants attend these services and others don't. Participants that attended Māori providers expressed their comparison to marae and helping people. Māori providers might also do more, because they are bound by accountabilities, not only by their professional discipline but also by taking a cultural and holistic approach as opposed to an individualistic approach to health.

Participants discussed kaupapa services in places where Whānau Ora is present.

They are a Māori Provider, they come from a Māori organization which means a marae and means our people. They fully go out of their way to ensure all our people are covered even if the nurse will go to the marae and stuff. So yes I do think Whānau Ora is based at this provider. (Participant 2: pg 4)

Participants did not expect that mainstream services would provide Whānau Ora.

Not mainstream, not at the moment because they are not fully bilingual in their focus. They are only mainstream. (Participant 4: pg 8)

Comments indicated that hospital services are dictated by clinical processes only.

Specialties in hospital services are dictated by disease processes and under that you've got the liability of doctor services who want to keep things as they are... cause it's all very well 'thank you very much' and we don't have to do anything different than treat thewhich is in opposition to how other cultures might see health. (Participant 8: pg 3)

Whānau Ora is more than the sum total of individual measures; it is primarily about the ways in which the group operates as a whole to achieve health and wellbeing for its people (Durie, 2009). This response about mainstream services was that hospital/health services don't necessarily involve whānau.

I'd say that I have gone to the Doctor or the Emergency Clinic or hospital; they have been quite helpful. I think there is a lack of involving Whānau. I think there is a perspective of what is Whānau. Who do they see is my Whānau? Most of the time they see it as being me, my next of kin and that's it. (Participant 1: pg 2)

They haven't involved Whānau. Useful if I am sick, I suppose they give me medication to help my illness but not the Whānau. Straight in and straight out. Probably 10 minutes. (Participant 2: pg 2)

Communication was an issue when Whānau had been admitted to hospital with hospital staff displaying attitudes and ignorance about tikanga for Whānau. Furthermore, (Robson & Harris, 2007) state that the rates of hospital admissions for Māori are higher than those of non-Māori for nearly every major cause for both genders and in all youngest age groups. There are different views on how to describe Māori health status. These various views debate which measures of health are appropriate, valid and meaningful; what are the underlying causes; where and how we should intervene.

I think for example, he (father) was in hospital we met with the head surgeon, he was Pākehā, he knew nothing of our tikanga or our customs or how he should be relating to us. He thought that he should not be communicating with us at all. So I had to push for that. (Participant 1: pg 3)

According to this participant the view that Whānau Ora would be a minimum requirement for any service delivery for Māori.

I think you may expect to see frontline staff actually doing graphs....pause... fundamentally of what Whānau Ora means to the individual. Given that too....also the patients that they will see...not all patients would expect to have Whānau Ora delivered to them, but the tangata whenua (people of the land) of this country would certainly in my view expect as a minimum in service delivery a operation or understanding... pause..... Whānau Ora means.

(Participant 6: pg 4)

The care received in hospitals had a significant impact on participants and generally not in a positive way. The lack of co-ordination and integration between whānau and medical staff caused additional worry. Whānau were not consulted or not involved in their care in a holistic manner.

Urbanisation

Durie (2001) suggests that urbanization has been the key contributing factor relating to increased Māori hospital rates. It could be suggested that Māori who live in urban areas do not have connection with immediate and extended whānau to help seek

medical attention due to health determinants such as access, poverty, housing and cost of medical care. As a consequence a rapid urbanization of Māori; traditional Whānau networks are broken down, placing stress on now urban based Māori (Durie, 2001). It is difficult for those whānau living in the cities to maintain their cultural identity and encompass the principles of Whānau Ora such as nurturing, caring, and compassion to meet the health needs of whānau.

Seeking, gaining and retaining employment, education in larger cities can be detrimental to the Whānau Ora philosophy of a collective role of whānau.

Ideally it's having your moko around you so you can guide them. That's truly looking after them, but if they are not here, like many urban Māori now. They really have to strive for themselves and that's a big learning curve.

(Participant 4: pg 8)

I worked in the Cheese factory and then I worked in the freezing works for a while and then said to mum (wife), "I think this is no good" here because I couldn't get enough money but there was no more jobs because they had run out so I said it might be better if we went to Wellington and we were there for 42 years and there was a lot of things happening in Wellington. I started to lose the reo, cause if you don't use it, you lose it.

(Participant 9: pg 2)

Summary

The definition of Whānau Ora is described as a broad context. The participants discussed both Hauora and Whānau Ora as intertwined and complementary concepts with overlapping rather than separate aspects. In Māori philosophy there is a greater emphasis on collective responsibility rather than individual responsibility and this was identified by these participants. There were concerns raised that with the Government policies that have been initiated for Whānau Ora they may be misconstrued or even be corrupted. Participants expressed their desire for Whānau Ora to be owned by Māori and not to be defined by politicians however, there is also the potential that Whānau Ora can be used as a health approach. The participants discussed kaumatua and kuia roles in the care of children and mokopuna. These participants were aware of their own responsibilities in the transmission of their

cultural knowledge informally and formally. This was also highlighted by teaching mokopuna whakapapa, the origins of who they are and what it means to come from Taranaki. They demonstrated their strong alignment to their responsibilities and the importance in taking care of one another to have a healthy whānau. Participants confirmed their expressions of tino-rangātiratanga as an important issue in healthy whānau. 'Doing things differently' in mainstream services was expressed as a negative concept which is in opposition to how Māori might see health. According to these participants communication also was a barrier and the lack of involving whānau when they encountered hospital admissions. These included mainstream services being unaware or ignorant of cultural practices such as tikanga.

Chapter Six Discussion of Findings

Introduction

The discussion in this chapter brings together the findings from the participant interviews and the literature presented in Chapter 3 to answer the research question. Four key themes were identified by the participants and how these definitions are similar to the main points in the literature review such as Whakapapa, Mātauranga Māori, Tino-rangātiratanga and Whānau Ora as an approach to health for Māori. The definitions identified by these participants include ‘being Māori’ and who they are (identity/whakapapa), how this translates to ‘how they live’ (Mātauranga Māori), ‘self-definition’ (tino-rangātiratanga), of Whānau Ora and how Whānau Ora is the ‘way forward’ to address past issues such as colonisation and currently issues of inequalities and racism.

Whānau Ora is ‘Being Māori’ - Whakapapa

Most of the participants identified whakapapa as key to who they are and how this relates to optimal health and wellbeing. Whakapapa is more than a genetic connection including cultural experiences, waiata (singing and music), stories from tupuna and the intergenerational handing down of traditions and rituals. The concept of identity stems from all of these cultural experiences. Durie (1998) and Moeke-Pickering (1996) argue that while there is no single exact measure of what constitutes identity, Māori identity is still being asserted today and means that the shaping of Māori identity is still occurring. The concept of identity manifests itself not only at the individual level but also at the level of societies and interactions between groups. Research on identity formation has revealed a clear link between Whānau practices and identity development. For some of the participants in this thesis to help any whānau, whakapapa is used as a tree element to link people who have been in trouble and also achievements of past chiefs and leaders who maintained their sense of identity to address their issues at that time.

You use the whakapapa tree element. I use this link on people who have been naughty you can speak directly directly to them to deal with that. That’s one of the tricks when you can’t talk to people who are so bad and don’t want to talk to people ... To help any Whānau, you bring out their whakapapa; you bring out their whakapapa lines, their main chiefs through their whakapapa line and

their achievements of their whakapapa chief to put on to the Whānau and this is what your tipuna did and this is how they dealt with problems you are having.

(Participant 5: pg 5)

Whakapapa relates largely to human ancestry and relationships and is central to the concept of Hauora and Whānau ora. Participants from this research identified that whakapapa is a way to link Whānau who are unwell and have problems with communicating. Celebrating the achievements of tipuna to translate their way of helping others in today's world was also identified. Defining Whānau Ora for these participants included all these aspects of whakapapa however it could be suggested that threats to Māori identity have been numerous. Moeke-Pickering (2006) argues that assimilative policies meant that to some extent, the ability for Māori participate and develop fully their cultural practice was dependent on the tolerance of the dominant culture. Using broad categories such as nationalism, ethnicity and race to define the reality of Māori was engendered to reduce primacy of Māori identities. Supports to Māori identity have proved that they have the capacity to survive over time and that they are resilient (Moeke-Pickering 1996). The following participant stated

Hauora within the family derives from our whakapapa and derives from our korero that we have in Te Ao Māori. So it's not just physical health, it's about ensuring the mental wellbeing, your spiritual wellbeing and all those different aspects that we can actually share with the people.

(Participant 3: pg 1)

The participants in this thesis recognised that whakapapa is identity and relates to Te Ao Māori. It is accepted that whakapapa includes and describes relationships between all things and it is a value that gives meaning to Te Ao Māori (the Māori world). Everyone and everything has whakapapa, it binds them all together and gives meaning to their world. These participants expressed the need to include Te Ao Māori and recognition of whakapapa in all aspects of health service provision for optimal health and wellbeing.

Whānau Ora is about 'How Māori live' - Mātauranga Māori and tikanga

Participants related their own Mātauranga Māori knowledge to their whakapapa. Edwards (2010) states that all things in the universe are related use of whakapapa in the Mātauranga inquiry makes it possible to explicitly define the genealogical relationship between the researcher and the phenomenon being investigated (Edwards 2010). Participants described Mātauranga Māori as a way forward for Whānau Ora.

Mātauranga Māori is a great attribute to forging strong Whānau Ora disciplines and application supply of service. (Participant 6: pg 6).

Participants described the Treaty of Waitangi and how this relates to the validity of indigenous language of Māori.

Well, that just brings me back to the treaty aye, where the law says 'in the indigenous language, that is the right treaty.' When they refer to the Treaty, it's not the right Treaty; it's the Māori treaty – that's the right treaty. But indigenous – as you know most indigenous see it – it's not a Māori thing we are pohara (poor). If you look at the Aborigines, if you look at American Indians they have the same as the Māori, so why are we calling it a Māori thing when it's actually an indigenous kaupapa driven by white people.

(Participant 5: pg 7).

The participants all acknowledged what Mātauranga Māori was, the meanings and the importance of understanding these meanings. Acknowledging te reo and other languages for Māori and delivering health services for Whānau who can speak te reo. Comparison to other indigenous nations such as the American Indians and Aborigines was articulated by participants indicating the poverty they experience and the impact on health for these indigenous people.

Whānau Ora is about ‘Self definition’ – Autonomy/Tino-rangātiratanga

Durie (1998) identifies that tino-rangātiratanga (Māori control and determination) has become part of the new Māori health movement and initiatives and are claimed by Māori as their own. The recognition of Māori interests in social policy legislation appears to arise from a concern about cultural values or disparities in Māori /non-Māori standards rather from any sense of a Treaty-based obligation or rights quite apart from equity issues. The implication of this is that, although the Government can accept the relevance of the Treaty to tribal property (as provided for in Article Two), it has not been able to accept the full implications of the Māori version of the same article with its broad definition of taonga and its promise of tino-rangātiratanga (Durie, 1998). Participants in this research expressed their own importance of maintaining control over their own lives.

Advocacy for yourself as best as possible and part of that is my own research, my own understanding of the health system can provide for me and my Whānau.

(Participant 4: pg 7)

Alcorn (2011) argues that Māori want tino-rangātiratanga as evidenced by Māori want to be able to provide health services their way by Māori, for Māori.

Whānau Ora is ‘the way forward’ to address Colonisation

Throughout the interviews it was evident that participants were fully aware of the inequalities and sense of outrage at the injustices and unfair treatment that Māori encounter;

Firstly I consider Māori at the bottom of the barrel for health

(Participant 4: pg 2)

As well as inequalities, participants indicated the presence of racism not only in the community, but also in health service delivery.

Racism is alive and well in New Zealand. You know people like to think it isn't but it is and you see its many shades daily. If it's not in actual service delivery it is in policy making for service delivery, it's also in central, local governments, so those are some of the bigger things that impact on the individual being able

to access service. So that's why I talk about the various shades of racism which is alive and well in New Zealand.

(Participant 6: pg 4)

Inequalities are barriers to better health outcomes. Māori have a constitutional right to equal health care as guaranteed under the ToW, but despite this Māori experience poor quality health when compared to Māori (Robson and Harris 2007). One narrative provided an overt act of discrimination, such as;

I was there on the farm for 3 years but I had to leave because they kept putting me under the trucks with the pigs and you know all the mimi (urine) and I told them you had better get someone else to do this and he said 'Oh you are the only one I can get, no one else will do it'. So I did it for a while and after that I told him I was leaving.

(Participant 9: pg 2)

This participant felt that he was employed only because he was Māori to do his particular job.

Raising the question about the constitutional position of Māori with the ToW is of relevance. Durie (1998) suggests that the ToW was intended to provide a partnership held by Māori and the Crown. Unfortunately, the perception of partnership upon health held by the two Treaty partners differed greatly. More than 100 years were to pass before the ToW was to be actively recognized as a means of supporting and advancing improvement in health status. In the first century of existence, no true partnership was recognized. The ToW is now the platform for forward development today. It provides an important, useful, durable and enduring leadership framework for defining and shaping sector response to eliminate inequalities and improve health outcomes for Māori.

Chapter Seven Conclusions and Recommendations

Conclusions

This chapter begins with a brief summary of the key findings which are then expanded to consider the impact that they have on current conceptualisations of Whānau Ora. The participants acknowledged that Whānau Ora is broader than health and is about wellbeing, and that wellbeing for Māori is about collective wellbeing. Many different experiences were reported that affect wellbeing so it was welcomed by the participants that there is the possibility of a way of accessing many different services that are required to address these broad issues. The participants reflected the broader contemporary shifts of whānau frequently living apart from each other but continuing relationships with the same tikanga. Participants also reflected that in any services, Māori or mainstream, whānau inclusive practices should be the norm when working for Māori health and wellbeing. Two major goals of Whānau Ora identified by the participants are to achieve progress in relation to overcoming inequality and decolonising practices.

Māori Model of Health

All participants described their lives from a Māori worldview and not necessarily from a Te Whare Tapa Wha perspective. Their interpretation of their values included tinana, hinengaro, wairua and whānau and also whenua, tino-rangātiratanga, tikanga, te reo, whānaungatanga, mauri, mana and manaakitanga. The contemporary model of TWTW identifies a set of values but clearly most participants believed that there were more than four values which gave them optimal health and wellbeing. Participants also agreed that Whānau Ora has been defined by politicians and is at risk of losing its mana. It could be suggested that the meanings and values of Whānau Ora could be further altered to fit the Crown's definition.

Inequalities

Participants indicated their full awareness of inequalities and concerns with attitudes and racism. Overcoming inequalities involves the active pursuit of justice and equality and the ability to provide the necessary tools for long-term positive change using Whānau Ora as a model of health. It could be suggested that Whānau Ora will be this new approach to create a new institution, to bring the fragmented social services for Māori into a single approach. Providers and patients will be re-orientated

to give more attention to preventive medicine and health promotion and wellbeing will be addressed holistically for Whānau rather than individuals (Alcorn 2011).

Roles and responsibilities of the Crown

As described in Chapter 3 in June 2009 Tariana Turia in her capacity as the Minister for the Community Voluntary Sector established the Taskforce on Whānau-centred initiatives to develop a new approach for the design and the delivery of government funded services and initiatives to Whānau – one that is Whānau-centred and strengths based and provides better value for the related investment made by the government. The Taskforce recognises that while government funded services are significant whānau, hapū and iwi also have a distinct and critical role to play in facilitating Whānau Ora and government agencies need to be responsive and flexible enough to align with and support whānau, hapū and iwi aspirations.

Participants agreed that the Government interpretation of Whānau Ora can be problematic because it is shaped and defined by discrete areas in health, education, housing and other social areas. It could also be suggested that Whānau Ora needs to prove itself as a viable model of health. This may not be possible if people outside of the iwi define Whānau Ora. The roles and responsibilities of the Crown must ensure these changes develop and are in collaboration with Māori organizations themselves makes it significantly challenging to describe Whānau Ora and therefore also to set a standard evaluation of it. The importance of looking at health and social policies and making sure that any changes reflect the philosophies of Whānau Ora is essential if it is to be a mainstream approach.

Outcomes

Outcomes for health services for Māori will be much improved when they are delivered in ways that meet the cultural needs of Māori. This view is substantiated by international and national research studies. These studies report comparable results that advocate a match between health consumers and the professionals they work with. Cultural and clinical competence needs to be intrinsic and available. Achieving this goal requires that health services continue to develop a sound clinical and cultural pathway that evolves as and when change is required (Tupara & Ihimaera, 2004). The aspirations of NRTT are driven by their cultural framework. The principles of manaakitanga, mana, whānaungatanga, wairuatanga, mana

whenua, tiakitanga, whakapapa and te reo as described in Chapter 3 are beliefs and values contribute to the development of their iwi with the goal of maintaining and securing a pro-active environment in all aspects of their social, cultural, economic and political life. The concepts and meaning of Whānau Ora are necessarily broad and it requires strength of character and determination and positive belief to improve the delivery of health not just for Ngāti Ruanui iwi members but for all Māori.

Whānau Ora Engagement with NRTT.

The researcher was well-known in a variety of capacities as a health professional and Uri of Ngati Ruanui. My initial engagement with NRTT and Nga Pakeke O Ngati Ruanui set the scene and enabled participants to participate in this research project. The guidance and the advice from kaumatua through various hui were well received. As an ‘insider’ who had knowledge of local networks, previous shared experiences opened the door to the establishment of trust. Wenn (2007) argues awareness of research methodologies are not notional or objective; however, objectivity is a cultural construct. Moreover, (Wenn 2007) argues that the Māori notion of acknowledging relationships and whakapapa does not preclude a reasoned assessment of knowledge and data. The data have therefore been obtained by processes that fit into a methodology proposed by the kaupapa hauora Māori research framework (Wenn, 2007). This was reassuring for me in addressing any ethical and safety issues which may have occurred. Offering a secure environment for the researcher and the participants was always a concern but with ethical and safety processes in place and regular contact with supervisors I was able to overcome these concerns.

Whānau Ora Service Provision

My engagement with the participants indicated that Whānau Ora needs to be aligned with iwi priorities and is not shaped largely by government agency drivers. A key focus needs to be on transferring knowledge and skills to whānau to enable them to better manage their own wellbeing. That is, while integration of systems is important, the key concern will be the transfer of ownership of knowledge and skills to whānau. A Whānau Ora service delivery framework will provide a conceptual basis for Ngāti Ruanui and other Māori health service providers to advance Whānau Ora within local contexts. NRTT are in the initial engagement of providing a

Whānau Ora model of health but there is the potential that they may require more resources to help with planning, policy development and workforce development.

Recommendations

From the research findings a number of recommendations have been provided, consistent with the wish for this research to contribute to transformation and change. Many of these may echo those found elsewhere about building Māori capacity in service provision such as health professionals and in capacity to undertake excellent research. Also, there are a number of recommendations to outline the important factors for consideration in service provision, iwi leadership, cultural competence and decolonisation.

Service Provision

It is recommended that a Whānau Ora approach of health service delivery is developed such as a Whānau Ora centre for iwi and by iwi. Health and social care providers can play a significant role in creating experiences and interactions with Māori that facilitate the best possible health and social outcomes. Many of the services that are currently providing health and social care would need to be better coordinated with an ultimate goal to meet needs as identified within iwi.

- Whānau Ora-centred services should provide for an integrated multi-service delivery approach and a single point of contact for whānau and a pathway to whānau wellbeing. Whānau Ora-centred practices and services, placing whānau at the centre with the necessary workforce, tools, evaluations, outcome indicators and funding will be established to deliver Whānau Ora.
- Funding should be consistent with Whānau Ora objectives and the outcome sought. Whānau will be involved from decision-making processes and actively involved early in the planning of their own health needs. A key focus will be providing for early intervention and preventative measures. Participation and building whānau capability to prevent crises, manage crisis when it does arise, should underpin whānau interventions.
- Health care providers need to undertake a process of identifying their own values, beliefs and practices in relation to Māori, and how these can impact on their practice and especially for iwi providers and the community and whānau they may be working with.

- Communication and information technology to be made available to increase whānau cohesion.

Iwi Leadership

Iwi need to support and advocate on behalf of providers to ensure that there is effective provision of services for whānau. Iwi leadership will be responsible for identifying key strategic leadership within their own territories and exercise their own high level relationships to influence decision-making for the delivery of Whānau Ora provision.

- Iwi leadership on collaboration with national leadership and coordination through regional panels established to ensure that local needs are understood and regional networks are established.
- A Whānau Ora Model of governance and management for all activities including contracting with service providers.
- Whānau Ora must be adequately resourced to achieve the objectives that need to be set in a flexible and responsive manner.
- Iwi working alongside providers and whānau to support cultural development and whakapapa connections, recognizing that whānau identity and whakapapa play a key part in Whānau Ora.

Workforce development and Cultural Competency

Formal training in whānau interventions is currently limited and is more often an ‘add on’ to other tasks. Workforce development is recommended for all when developing a Whānau Ora framework. The delivery of social and health education is currently problematic and ineffectual. Creating a learning environment where Māori can ask questions about their own health explore issues and at times go over the information they have received would be more effective. It is crucial that the environment created and the ability for Māori to obtain quality information in a form that can be both understood and used and supporting them to make informed decisions about their health to develop health-promoting behaviours. A well-prepared Māori workforce is one that has appropriate academic, professional and technical qualifications and is well attuned to Māori cultural norms. Encouraging empowerment for Māori whānau to not only to make their own decisions but the right decisions for their own health is one of the core principles of Whānau Ora.

- Workforce will be expected to be culturally and clinically competent. Strategies to build such a responsive workforce and continue the development in mainstream to work effectively with Māori.
- Development of a specific Whānau Ora practitioner/navigator/kaiawhina who have the role of being the single point of contact for Whānau with social and health needs.
- This Whānau Ora practitioner/navigator/kaiawhina role will have a wide knowledge of local services, community, marae, hapū and iwi.

De-colonisation Development

De-colonisation is a conscious exercise that examines the long and short term impacts of colonisation on all peoples. In order for Whānau Ora to be developed and maintained de-colonisation is a way forward to address the historical positioning of Māori. Workshops such as Te Hui Pumaomao (facilitated by Takawai Murphy) incorporate individual introductions, small working groups, role-play situations, and open and honest collective discussion to understand the far reaching implication of colonisation today. The issues raised were always related to the past and the present situation of Pākehā/Māori relations in Aotearoa. These workshops create opportunities to make conscious and constructive steps in understanding people of the land. Iwi providers and health and social services need to acknowledge and support these training workshops. For NRTT it is essential that anyone who is working with Māori need to move on and ensure that activities we undertake in our lives as a whānau do not further marginalise, discriminate, oppress and colonise indigenous peoples or anyone else. Re-claiming and re-identifying from colonisation and historical events is a valuable learning curve for everyone. More research on key indigenous healing such as de-colonisation will not only benefit Māori, but everyone in Aotearoa.

Research

There is a need for future research related to the implementation of Whānau Ora in different settings to understand the broad and situated approach in practice. Developing and up-skilling health research capacity and capability is also recommended, where Māori are able to undertake research with Māori about Māori.

- Iwi driven research, formal partnerships with expert researchers, Universities and within Māori community agencies and stakeholders would be beneficial.
- The establishment of research centres within Taranaki and other iwi would be a response to Whānau Ora development. This research project which has been endorsed by Ngāti Ruanui iwi members, and is an example of an iwi health provider embedded in Mātauranga Māori based on the generation of their knowledge to strengthen their own research capacity. This would inform positive Ngāti Ruanui health development and Whānau Ora for other iwi and Māori communities.
- There is a need to gather evidence to establish the credibility of Māori health providers so that Māori-based treatment and intervention options (rongoa, mirimiri) that are integrated with ‘mainstream ‘ treatment and intervention approaches can result in health gains.

Limitations of this study

A potentially limiting aspect of Māori-centred research is the dual accountability to both the University and to Māori (Cunningham, 1999; Powick, 2002). Durie (2005) explains “The challenge has been to allow Māori and western belief systems their own integrity, while developing approaches that can incorporate aspects of both and lead to innovation, greater relevance and additional opportunities” (p. 145). Māori researchers can interview their own whānau, hapū and iwi, therefore maintaining the integrity of the iwi is important. In this study the research aims were clearly outlined and a research ethic was put into practice ensuring that all participants were informed and empowered by the process.

This study concentrated on a Māori population living in South and Central Taranaki with one participant living in North Taranaki. The findings of this study cannot be generalized to all Māori, but may be useful to provide valuable insight into understanding how Māori define Whānau Ora and the shaping of Māori potential, shifting the focus from an exclusive focus on individual illness to a broader perspective around whānau wellbeing.

Appendices



MASSEY UNIVERSITY

6 April 2011

Te Moana Rolleston
40 Puriri Street
HAWERA 4640

CONFIDENTIAL

Dear Te Moana

Re: **HEC: Southern B Application – 10/69**
How does Ngati Ruanui define Whanau Ora?

Thank you for your letter dated 4 April 2011.

On behalf of the Massey University Human Ethics Committee: Southern B I am pleased to advise you that the ethics of your application are now approved. Approval is for three years. If this project has not been completed within three years from the date of this letter, reapproval must be requested.

If the nature, content, location, procedures or personnel of your approved application change, please advise the Secretary of the Committee.

Yours sincerely

Dr Nathan Matthews, Acting Chair
Massey University Human Ethics Committee: Southern B

cc: Dr Petula Brannelly
School of Health & Social Services
WELLINGTON

Prof Steve LaGrow, HoS
School of Health & Social Services
PN371

To Kaitiaki
ki Pūrehoro

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APPENDIX B



PARTICIPANT CONSENT FORM

*Hei aha nga whakaaro o Ngati Ruanui mo te Whānau ora/How does Ngāti Ruanui
Iwi define Whānau ora?*

I.....(Participant)

confirm that I have read the Information Sheet and I have had the details of the study explained to me.

My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree to participate in this study under the conditions set out in the Information sheet, and:

1. I have read and understood the information on the Study Information Sheet.
2. I have had the opportunity to discuss this study with the researcher.
3. I understand that taking part in this study is voluntary (my choice) and that I may withdraw at any time.
4. I agree to not disclose anything discussed in the interview.
5. I agree to any discussion or interview to be audio-taped and transcribed and I may ask to turn off the tape at anytime during the interview. I have been informed that I will have the opportunity to review the transcripts and make any changes that I may wish to make.
6. I have been informed that any such tapes and transcripts will be vested for safekeeping by my-self and my Supervisor Dr Petula Brannelly.
7. I understand that my participation in this study is confidential and that no material which could identify me will be used in reports of the study. There may be limits to guarantees regarding confidentiality and total anonymity cannot be entirely guaranteed regarding the small population and Whānau where the research is taking place.

8. I do/do not wish to receive a summary of this report when the final study is completed.

9. I understand that a Hui may be held for the outcomes of the study to be shared with me and my Whānau.

Participant

Signature: Date.....

Full Name

Full name of researcher

Signature Date..

Full Name

APPENDIX C



INTERVIEW SCHEDULE

Thank you for agreeing to this interview. May I have your consent to record this interview?

1. Would you like to tell me about yourself?
2. Where were you born and where did you spend your earlier years (0-10yrs)?
3. Where did you live and who was your Whānau in your earlier years (0-10yrs)?
4. Who do you regard as your Whānau at present and do they live locally or in other locations?
5. What are the elements of Hauora and what do they mean to you?
6. If your Whānau had Hauora what would it be like and how would it be different?
7. Do these elements of Hauora, eg Te Whare Tapa Wha help you keep well?
8. What is happening to you at this moment relating with your health needs?
9. If you were unwell for a long period of time, would you seek help or would you not bother for different reasons?
10. When you see a GP or a community clinic, have they been useful to you and have they involved your Whānau?
11. Has this involvement with your Whānau worked for you or not?
12. What is your definition of Whānau Ora and what does it mean to you?
13. Would you like to elaborate on your experiences of Whānau Ora?

14. Do you think the meanings of Whānau Ora have altered or changed over-time?
15. If you were to go to a hospital, GP or community clinic would you expect staff to recognize the fundamentals of Whānau Ora?
16. If they did not, what would you do?
17. If you were to go to a Māori provider, e.g. a Whānau Ora service, would you expect the staff to recognize the elements you have talked to me about?
18. What part of these elements of Whānau Ora, are important to you?
19. Is there anything else you would like to tell me about Whānau ora?

Thank you very much indeed for taking part in this research.

APPENDIX D



Massey University

COLLEGE OF HUMANITIES AND SOCIAL SCIENCES

Te Kura Pūkenga Tangata

Participant Information Sheet

How does Ngāti Ruanui Iwi define Whānau Ora?

Ko Taranaki te maunga, Tangahoe te awa, Hamua/Hapotiki te hapū

Ngāti Ruanui te iwi, Te Moana Rolleston taku ingoa.

Kia ora koutou nga Rangātira ma:

I am a postgraduate student at Massey University, and as part of the completion of my Masters Degree, I am undertaking a research project under the Supervision of Dr Petula Brannelly and Dr Amohia Boulton. My background is mental health nursing; and I am interested in exploring definitions of Whānau ora and the effects Whānau ora has on Ngāti Ruanui health outcomes from a “grass roots” level. I would like to invite Ngāti Ruanui iwi members to participate in this research project.

If you choose to participate in this research, individual interviews will be held with the support of Whānau members if required at a venue of your choice and you will be invited to relate your stories and experiences of what Whānau ora means to you and how this may or may not benefit health outcomes. These sessions will be audio-taped and should take no longer than one hour and will be conducted by myself. Written informed consent will be obtained from willing participants prior to these interviews. Once these interviews have been completed, the data will be transcribed. All personal information including names will be removed.

Confidentiality

All information obtained in this research will be treated with confidentiality. To ensure confidentiality pseudonym/codes will be used instead of real names. An Authority for the Release of Tape Transcripts form will be returned to participants. There may be limits to guarantees regarding confidentiality and total anonymity cannot be entirely guaranteed related to the small population and Whānau where the research is taking place. Access to any data during the study will be restricted to me and my Supervisor (Dr Petula Brannelly). All research information will be locked in a filing cabinet. My Supervisor and I will be the only person with access to this. On completion of the research, data will be kept at Massey University School of Health and Social Services.

Participation

Participating in this research is entirely voluntary. Participants have the right to

- decline to answer any particular question.
- withdraw from this study at any time.
- ask any questions about the study during participation.
- provide information on the understanding that their name will not be used unless permission has been given to the researcher.
- access to be given to a summary of the project findings when it is concluded.

Distribution of findings

The findings of the research will be submitted for examination and submitted as a thesis to Massey University's School of Social Services at Massey. A summary report of the findings of the research will be made available at the end of the project for all research participants if they wish to receive a copy. The research findings will be published in professional journals, and possibly at conferences. No information identifying individuals will be presented.

Further information

If you require further information or have any issue with this research please feel free to contact either:

Te Moana Rolleston

Early Intervention Alcohol and Other Drugs nurse

Ruanui Health Centre

Hawera

Email: moana @Ngāti ruanui.org

Phone: 062781310

Dr Petula Brannelly

School of Health and Social Services

Massey University Wellington

E-mail: P.M. Brannelly@Massey.ac.nz

Phone: 0800 MASSEY or 04801 5799 ext 6757

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern B, Application 10/69. If you have any concerns about the conduct of

this research, please contact Dr Nathan Mathews, Acting Chair, Massey University Human Ethics Committee: Southern B, telephone 06 350 5799 x 8729, humanethicsouthb@massey.ac.nz.

APPENDIX D



Massey University
COLLEGE OF HUMANITIES AND SOCIAL SCIENCES
Te Kura Pūkenga Tangata

Transcriber Confidentiality Agreement

Hei aha nga whakaaro o Ngati Ruanui mo te Whānau Ora/How do Ngati Ruanui Iwi members define Whānau Ora?

I have been employed by Te Moana Campbell-Knowles as a transcriber.

I agree to keep strictly confidential all information I may be privy to during my employment including the identity of those interviewed and the views expressed by interviewees. I will only discuss these matters with members of the research team during the term of my employment with this research project.

Signed

Name

Date

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