

Matariki

A Monograph Prepared by Te Mata o Te Tau
The Academy for Māori Research and Scholarship

Te Mata o Te Tau
Office of the Deputy Vice Chancellor (Māori)
Massey University
June 2008

Referencing and Contact Details

Te Mata o Te Tau Monograph Series No 2

Published in 2008 by Te Mata o Te Tau; The Academy for Māori Research and Scholarship.

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June 2008

ISSN 117 7 - 9195

Acknowledgements

Te Mata o Te Tau; The Academy for Māori Research and Scholarship, was formally established by Massey University in 2003. The Academy sits within the Office of the Deputy Vice-Chancellor (Māori) and extends across Massey University's three main campuses. We thank Casey Te Rangi and Lei Zhang for designing the cover and formatting the monograph.

About Te Mata o Te Tau

Matariki atua, ka eke mai i te rangi e roa, e whangai iho ki te mata o te tau, e roa e, hei tuku i ngā wānanga i ngā kai ki te ao mārama.

Te Mata o Te Tau; The Academy for Māori Research and Scholarship was launched in 2003 to provide a forum for fostering Māori academic advancement and creating new knowledge. The Academy is interdisciplinary and intersectoral and unites Māori scholars from several disciplines, departments, and centres of research. It has strong links with other academic and research bodies in Massey University, in New Zealand, and with indigenous scholars overseas.

The ***broad aims*** of the Academy are;

- the advancement of Māori scholarship
- the provision of a forum for Māori scholars to collaborate across academic disciplines and subject areas
- the promotion of high quality research that will contribute to new knowledge
- and positive Māori development
- the provision of leadership for Māori academics at Massey University.

The name of the Academy is linked to Matariki, the star constellation known also known as Palades, and symbolises the promise of a fruitful year, and the advancement of knowledge.

About this Monograph

Consistent with the desire to advance scholarship and promote Māori research excellence, this monograph is designed as a forum for Māori researchers and academics and provides a means through which ideas on a range of issues, connected to Māori development, can be considered.

This monograph provides another avenue for publication and which complements already existing mechanisms.

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Suggested Citation

Te Mata o Te Tau., (2008), *Matariki*, vol. 1, no. 2, Te Mata o Te Tau; The Academy for Māori Research and Scholarship, Massey University, Wellington.

This document is also available on the Te Mata o Te Tau website:
<http://temata.massey.ac.nz/publications.htm>

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INDIGENOUS HEALTH

Catalysts for Innovation

Mason Durie

This paper was first presented at the DHBRF Workshop on Innovation for health Sharing Knowledge and Building Relationships in October 2007 at Wellington

INDIGENOUS RESILIENCE

The capacity of indigenous peoples to survive and then prosper has been a characteristic of post-colonial development. Not only have the catastrophic impacts of infectious diseases, alienation from culture and customary lands, and loss of autonomy been withstood but generations later, indigenous peoples in the Pacific have endured and advanced to the extent that they are now in significantly stronger positions than they were 150 years ago.

Indigenous resilience has several dimensions but essentially encompasses individuals and groups, a capacity for positive engagement, and a level of autonomy¹. Much of the literature on resilience centres on the potential of individuals to overcome personal trauma and succeed. However, resilience is also about the achievements of collectives: families, whānau, communities, tribes, and whole populations. Success in that sense is a shared

experience which reflects an ability to adapt and a propensity for turning adversity into accomplishment.

Two broad capacities underpin indigenous success: a capacity to engage with indigenous culture, networks and resources, and a capacity to engage with global societies and communities. The duality recognises the two worlds within which indigenous peoples live and the skills needed to negotiate both. Successful engagement with the indigenous world is facilitated by spiritual and cultural competence and acceptance by communities, while engagement with global societies is eased by the acquisition of technical skills, educational qualifications, and a capacity to deal with bias and prejudice.

A third aspect of indigenous success is built around autonomy and self-management. Resilience is less likely if indigenous futures are premised on the aspirations of others. Instead indigenous success requires a capacity for indigenous approaches to governance and management that are compatible with the world views of families, tribes, and indigenous communities while at the same time being attuned to wider societal values and economies. Autonomy does not necessarily mean an independent pathway but opportunities for collaboration and co-operation on the basis of equality and shared goals.

Innovation is a fourth factor that can accelerate resilience. Clinging to the old ways without any adaptive capacity, or alternately abandoning the past as if it had no implications for the future, will not be sufficient to prepare indigenous peoples for the future. Instead innovation that can harness the energy from two dimensions, and two world views has been shown to enhance resilience and increase indigenous potential.

Two innovative approaches, separated by a century and each lasting for a period of twenty-five years, have made major

contributions to Māori standards of health and provide a basis for understanding indigenous innovation. The first period, 1882-1907 was instrumental in reversing a steady population decline that might well have led to Māori extinction, while the second, between 1982 and 2007 laid the foundations for addressing health risks in the 21st century and enabling full Māori participation in the health sector.

PERIOD ONE: 1882-1907

Reversing a steep population decline was a major accomplishment initiated by Māori leaders in the 1880s. However, the publication of an article by Archdeacon Walsh in the *Transactions of the New Zealand Institute* in 1907 seemed to cast doubt on their efforts. Despite early signs that the depopulation process had been arrested, “The Passing of the Māori” painted a grim future. “That the Māori is gradually though rapidly passing away there can be no doubt. ... Finality has now been reached, and the next census will show that the Māori population, instead of increasing has been diminishing all the time, and that if the present rate of declension continues, it must soon reach the vanishing point”².

The evidence accumulated over the preceding fifty years seemed to support the Archdeacon. In 1856 the Māori population was clearly in a state of decline. Even by 1836 there were reports that the population had been reduced by more than a quarter and by 1906 it was estimated at 45,000 – a reduction of more than 75 percent from 1806. By 1874 the *New Zealand Herald* was convinced the end was nigh: ‘That the native race is dying out in New Zealand there is, of course, no doubt. The fact cannot be disguised that the natives are gradually passing away; and even if no cause should arise to accelerate their decrease, the rate at which they are now disappearing points to their extinction in an exceedingly brief period’³.

Autonomy

However, neither the *Herald* nor Walsh had taken Māori resilience and Māori innovation into account. Determination to seek redress and gain greater autonomy, coupled with adaptation by tribal leaders, greater Māori influence in Parliament, and new professional capability proved to be a powerful formula for successful innovation. A delegation to London in 1882, led by Hirini Taiwhanga (later to become Member of Parliament for Northern Māori) sought a greater measure of autonomy for Māori and proffered the suggestion of a Māori Parliament to manage Māori affairs. Even though they received a sympathetic hearing from British officials, their efforts were not appreciated in New Zealand. But tribal leaders throughout the country were similarly concerned about loss of independence and were to join forces for a greater measure of control over their own matters. The earlier election of a Māori King (in 1858) was a clear sign of a desire for autonomy while the formation of the pan-tribal Kotahitanga movement led to the establishment of a Māori Parliament (Paremata Māori) in 1892.

At the same time, more astute Māori politicians were voted into Parliament, including James Carroll (1887), Hone Heke Ngapua (1893) and Apirana Ngata (1905). Well attuned to political processes and to Māori aspirations they became highly important conduits between legislative processes and Māori advancement. Both Carroll and Ngata were knighted and both were to attain eminence among politicians, Pakeha and Māori.

The Young Māori Party

Ngata had been part of a small but influential cohort of Māori secondary school students groomed for roles in the changing Māori world. Te Aute College in Hawkes Bay acquired a reputation as an incubator for a new type of Māori leadership based on a fervent commitment to Māori advancement and

improvement of spiritual and material conditions. As students at school some had undertaken walking tours to rural communities where they met with tribal elders to advocate health and hygiene measures taking upon themselves the task of reforming Māori communities, largely by promoting western lifestyles and standards. In 1891 an Association for the Amelioration of the Māori Race was established by the young advocates, and in 1897 many of the same group, under the guidance of Apirana Ngata formed the Te Aute Association whose special aims were to improve health, sanitation, education, work habits, and family life⁴. The Association became synonymous with the Young Māori Party.

Two of the Te Aute group, Maui Pomare and Peter Buck (Te Rangi Hiroa) were to become the first Māori medical graduates before they entered politics while Ngata, achieved distinction in law, politics, literature and land reform. Māori social, economic and cultural revival is often credited to this trio, Ngata, Pomare and Buck, and the Young Māori Party that they helped to establish. Their philosophy was greatly influenced by their inspirational principal, John Thornton; whose religious convictions and social conscience acted as a catalyst and agenda⁵.

Ngata, Pomare and Buck were in no doubt that the answer to Māori survival lay in the need to adapt to western society and to do so within the overall framework imposed by the law. Though strongly and emphatically in support of Māori language and culture they were equally passionate advocates of western democracy, education and modern health practices. They believed it was possible to retain a secure Māori identity while embracing Pākehā values and beliefs.

The appointment of Pomare as a “Medical Officer to the Māori” in the Department of Public Health in 1901 provided an

opportunity for Drs Pomare and Buck to apply the Young Māori Party philosophy to health care. Consistent with that philosophy Pomare committed his energies to Māori community development and worked to empower Māori community leaders. He had decided to make the best of the Māori Councils Act 1900 which had established Māori councils and recognised among the local councils a powerful army for health. That became his strategy, and his single most important contribution to Māori health - health could not be prescribed by the doctor; it should arise from within communities; and the leaders of health were not be doctors or nurses, but community leaders who could use their influence and wisdom to alter life-styles and living conditions. Pomare, later assisted by Buck, worked with every Māori Council assisting them identify problems and lending his medical knowledge and skills. When the task of visiting and assisting councils became impossible, he then appointed and trained a team of Māori sanitary inspectors as liaison officers. In effect, a team approach was instituted; an amalgam of medical knowledge and expertise, combined with tribal and community leadership, and supported by Government through the fledgling Department of Public Health.

Although extinction had been widely predicted, not only did Māori survive, within a century they had become more numerous than at any other time in history. Even though changes to statistical definitions of Māori make it difficult to draw exact comparisons, there is strong evidence of a substantial and sustained increase in the Māori population. In the 2006 census 565,329 New Zealanders identified as Māori with a median age of 22.7 years⁶.

Further, although accounting for some fourteen percent of the total New Zealand population in 2001, by 2051 the Māori ethnic population will almost double in size to close to a million, or twenty-two percent of the total New Zealand population. Even

more significant, by 2051 thirty-three percent of all children in the country will be Māori and the percentage of the Māori population over the age of 65 will steadily rise from three percent (1996) to 13 percent (2051) as life expectancy increases⁷.

PERIOD TWO: 1982-2007

A second period of innovation occurred a century later and began with the promotion of Māori concepts of health. When the Māori Womens Welfare League was embarking on a survey of the health of Māori women in 1982, a model of health known as Te Whare Tapa Wha anchored their study⁸. The models' appeal was based on its holistic approach to health and the recognition of spirituality as a significant contributor to good health. Until then discussions about Māori health had dwelt on the rates and consequences of disease, creating a mood of disempowerment and passivity. But by reconfiguring health in terms that made sense to Māori, it was possible for Māori communities to experience a sense of ownership and to balance medical and professional dominance with community involvement and local leadership. Te Whare Tapa Wha was presented as a four-sided house, each wall representing one aspect of health – spirituality (taha wairua), the mind (taha hinengaro), physical health (taha tinana) and family and social relationships (taha whānau).

Taha wairua remains important to Māori since it captures the notion of a special relationship with the environment, as well as a Māori cultural identity. Taha hinengaro concerns the way people think, feel and behave and recognises that Māori patterns of thought value metaphor and allusion. Taha Tinana is not only about physical illness but also fitness, mobility and freedom from pain while taha whānau focuses on the nature of interpersonal relationships, within the family but also beyond into wider society. Increasingly the model is being used as a framework for

the development of models of assessment, treatment, care, the measurement of outcomes and the formulation of health policies.

Further opportunities for adopting new approaches to health care came in 1984. Not only were major economic reforms introduced, but devolution of state-provided services followed, as well as deregulation of many industries that had previously been the province of protected groups. Driven by economic expediencies that included the removal of state subsidies from the agricultural and forestry sectors, “temporary” stress on all New Zealanders was seen as inevitable. Māori, however, carried an excessive share of the burden and within five years Māori unemployment more than doubled to over twenty percent and in some areas was higher for school leavers⁹. Nonetheless the raft of reforms positioned Māori to move towards active roles in health and education reinforced by renewed Government commitment to the Treaty of Waitangi and the inclusion of a Treaty clause in several statutes.

DECADE OF MĀORI DEVELOPMENT

New directions were spelled out at a Māori Economic Summit meeting, the Hui Taumata held in 1984. A decade of positive Māori development was prescribed premised on the themes of tribal development, economic self reliance, social equity and cultural affirmation. In keeping with the wider national economic reforms, where a diminished role for the state was being paired with a greater role for enterprise, the new call was for “Māori solutions to Māori problems”. Both the lack of confidence in the capacity of the State to offer positive solutions and a desire to capitalise on existing Māori structures and values, combined to inject a spirit of independence and enthusiasm for alternate approaches. Significantly, a sound economic base was seen as a crucial step towards achieving any real social or even cultural survival.

During 1984 a series of other important Hui were held by Māori covering education, economics, the Treaty of Waitangi and health. The Hui Whakaoranga, the first national Māori health hui in modern times, began as a recital of Māori health problems but quickly became a platform for advocating Māori led health initiatives. Inspired by the recently formed Māori Nurses Council and the few Māori communities who provided health services, Māori enthusiasm for active participation in health care blossomed. Independent Māori health providers and Māori services within conventional institutions were soon to materialise. At Tokanui Hospital for example, Whaiora was established as a Māori treatment centre within a major psychiatric hospital.

For most of the twentieth century policies for Māori were essentially premised on attaining equity with other New Zealanders and adopting the same values and world views as the majority population. It was not until 1984, and the launching of the decade of Māori development that the retention of Māori values and culture was seen as integral to socio-economic advancement.

In the new approach, there was a frank rejection of any notion of assimilation. Instead the expectation was that all Māori young people should be able to grow up as New Zealanders and as Māori. Full participation need not mean abandoning a Māori identity. Moreover there was a strong desire by Māori to develop their own economic and social systems in ways that were consistent with Māori aspirations and priorities. While the State as a provider had certain attractions, seldom was it able to recognise Māori preferences. In contrast, in the deregulated environment, large numbers of Māori health, education and social service providers emerged enabling families (whānau), communities and tribes to steer their own courses.

TRANSFORMATIONS

By the end of the 25 year period major transformations had occurred. Māori participation in education at all levels was radically altered in two respects. First, the education system recognised Māori language, knowledge, and culture as core elements of the curriculum. Second, participation rates in non-compulsory education escalated in an unprecedented manner. While participation rates are uneven, and many Māori youngsters still remain outside the reach of effective education, there has been a remarkable turnaround. The initial establishment of Māori alternatives such as Kōhanga Reo (Māori language immersion centres) in 1981 provided examples of Māori innovation and were followed by higher mainstream Māori participation rates in early childhood education, growing by over thirty percent between 1991 and 1993. By 2001 forty-five percent of all Māori children under five years of age were enrolled in early childhood services, nearly one-third in kōhanga reo¹⁰ and by 2005 around 90% of Māori children entering primary school had experienced some form of early childhood education¹¹.

For older learners there were also significant gains. Retention rates for sixteen year olds at secondary school increased from 47 percent (in 1987) to 63 percent (in 2003). Between 1983 and 2000 the percentage of Māori students who left school with no qualifications decreased from 62 percent to thirty-five percent, while at the tertiary level, between 1993 and 2004 Māori participation increased by 148 percent. By 2002 Māori had the highest rates of participation in tertiary education of any group aged at twenty-five years and over. Although the significant improvement masked the fact that Māori were still five times more likely to enrol in Government remedial training programmes and three times less likely to enrol at a University¹²,

around seven percent of the total university population in 2005 is Māori. But most of the recent tertiary education growth has occurred through accredited tribal learning centres, wānanga, which increased enrolments from 26,000 students in 2001 to 45,500 in 2002¹³.

TRANSFORMATIONS IN HEALTH CARE

Transformations in health care have paralleled gains in the education sector. Greater emphasis on health promotion, primary health care and disability support has been possible with the steady growth of a Māori health workforce within Māori communities. New interest in traditional healing, as an adjunct to primary care and as part of a comprehensive health package has also increased Māori access to services and reduced the gap between healing and treatment.

As one way of addressing the disproportionate representation of Māori in most illnesses and injuries, workforce development became a high priority for improving Māori standards of health. An important component of a workforce strategy has been the engagement of cultural advisors and Māori community health advisors to work alongside health professionals, bringing first-hand knowledge of community and a capacity to engage diffident patients. Often the combination has been highly effective though there has also been concern that the two streams of workers – cultural and clinical – have created potential for professional and cultural interventions to diverge. An integration of cultural and clinical dimensions is one of the more pressing challenges facing Māori health care.

Of critical importance, however, has been the recruitment of more Māori into the health professions. Affirmative action programmes – or programmes that have similar aims have been significant vehicles to develop a workforce that is more

representative of New Zealand's communities. In 1998 for example the University of Auckland launched *Vision 2020*, a programme designed to significantly increase Māori entry into the medical school. In 1984 there were 5 new Māori medical students but by 2004, the number of new Māori entrants had increased to 24¹⁴. Similar trends have been seen in the qualified medical workforce. From an estimated medical workforce of around 60 in 1984, there are now over 200 Māori medical practitioners across range of specialties, accounting for three percent of the total active medical workforce. In addition scholarships have been offered from a number of sources as incentives to encourage enrolment in other disciplines such as nursing, social work, clinical psychology and addictions. The number of Māori dentists for example has increased from 4 or 5 in 1984 to 44 in 2005.

But the most dramatic changes have been in the number of Māori health provider organisations. Prior to 1980 there were only three or four Māori health providers but by 2007, nearly 300 Māori health providers offered a range of services and Māori language and culture had become more or less accepted as part of the operating norm in schools, hospitals, state agencies, the media, and community centres.

HEALTH GAINS

While the impact of workforce strategies on Māori health status has not been specifically determined, there have been significant gains in Māori health, especially over the past five years. For non-Māori New Zealanders there was a steady increase in life expectancy at birth over the period from 1985-1987 to 2000-2002. For Māori there was little change for males or females during the 1980s but a dramatic improvement in the five years to 2000-2002. Between 1984 and 2002 the life expectancy increased from 65 years for Māori males to 69 years while for

Māori females it increased from 70 to 73 years. Notwithstanding the eight year gap between Māori and non-Māori, in the five years to 2000-2002, the gap reduced by 0.6 years¹⁵.

Since the 1960s disparities between Māori and non-Māori have formed the basis for appraising Māori health. Generally disparities exist for almost all disease states and for levels of severity. However there is recent evidence of a reduction in mortality disparities. Although Māori experienced the highest mortality rates in the period 1981-2004, the rate of decline in Māori mortality has increased, compared to a slowing in the European/other rate of decline. In the late 1990s and early 2000s relative inequality (mortality rate ratios) between Māori and European/other ethnic groups reduced slightly while absolute inequality (mortality rate difference) declined more notably. While much of the difference appears to be a function of socio-economic circumstances, other factors operating independently of socio-economics factors are relevant – such as racism, access to quality care, tobacco, diet and other lifestyle factors¹⁶.

CATALYSTS FOR INNOVATION

Although the two periods 1882-1907 and 1982-2007 witnessed widely different conditions and approaches to health care, it is possible to identify three themes common to each era that accelerated action and contributed to positive outcomes.

Leadership

First, transformational Māori leadership emerged. At the conclusion of the 19th century adaptive tribal leaders as well as political leaders and a new cohort of Māori professionals provided inspiration, guidance and commitment to Māori survival. Unlike an earlier generation of leaders who had literally fought to retain the old ways, the task of Ngata, Pomare and others was to guide Māori into a new environment, retaining

useful cultural values and perspectives while embracing new technologies and a new economy. Similarly, as the twentieth century closed, a Māori leadership network formed around the common goals of increased autonomy, self sufficiency, tribal redevelopment, and cultural affirmation. Their task was not about survival - by then an expanding population would assure Māori endurance for many generations to come - but about transforming society so that systems and institutions would be accessible, relevant to Māori, and able to lead to the best possible outcomes.

Transformational leadership demands a type of leadership that is essentially outward looking; integrative more than defensive; ready to cross institutional boundaries and institutions; and strategic rather than bound by a set of operational conventions. Transformational leaders promote sustainable leadership. Stand-alone charismatic leaders have less to offer changing environments than leaders who can weld together other leaders – from political, tribal, community and professional arenas and encourage a deliberate strategy of succession planning. Sustainable leadership develops leadership capacity and leadership networks where innovation, rather than standardisation, can flourish. Moreover, transformation requires a type of leadership that is distributed so that the benefits are widespread rather than localised, triggering and enabling different types of transition in society¹⁷.

Interventions at the Interface

A second theme emerging from the two periods of Māori transformation is a capacity to straddle an interface. Connecting with indigenous people means being able to live in two worlds, simultaneously. Language, cultural values, cultural protocols and indigenous associations at community, tribal and even national levels will be important vehicles for communicating and assisting indigenous clients. But equally, interventions to

promote good health need to take account of findings from science and technology, medical advancement and clinical expertise. Working between two bodies of knowledge - science and indigenous knowledge – recognises that neither indigenous knowledge nor science alone provides a universal answer. Health care is firmly premised on science and the medical model depends on evidence derived from scientific inquiry. In contrast indigenous knowledge is not fixated on science; instead it largely depends on a set of values and observations that link people into the wider natural environment. Unlike science, where explanations are constantly tested and revised, indigenous knowledge is all the more remarkable because it has endured over centuries. 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.

In contemporary health care the interface can take many forms: the interface between health and other sectors, between physical health and mental health; primary care and secondary care; wellness and disease, professional leadership and consumer perspectives; technology and human compassion; clinical skills and cultural paradigms.

Investments in Innovation

A third theme concerns investments in innovation. Typically investments in Māori health innovation have been derived from three main sources: government, health agencies, tribes and Māori communities. In 1901 the Department of Public Health invested in a ‘Medical Officer to the Māoris’, the Department of Native Affairs invested in Māori Councils and despite huge adversity Māori communities invested time and expertise. In the economic restructuring that commenced in 1984, the Ministries of Health and Māori Development similarly invested in tribal and community organisations and after the 1993 health reforms

there were substantial investments by health funding agencies in the Māori health provider organisations. Research funders have meanwhile provided major investments in innovation and the Health Research Council's innovative efforts to build Māori health research capacity as well as research at the interface between science and indigenous knowledge have been critical to strengthening Māori health capability.

The four-way investment pattern has required a series of partnerships at national, agency, local and community levels. Sometimes this has created confusion with the Crown's preferred model of negotiating with tribes, at least in respect of Treaty of Waitangi settlements, and the sectoral approach has also complicated investments that have inter-sectoral implications. Further, once established, innovative approaches to health care have often been quite quickly operationalised so that further innovation becomes compromised by a requirement to meet specified milestones.

Investments in innovation present a degree of risk to investors since the outcomes are not always clear or certain. During the period 1982-2007 a number of Māori health innovations did not survive or were criticised for not realising greater returns. While risk can be minimised by the provision of clear guidelines and specified indicators, an element of risk is part of the innovation reality. But leaving no room for innovation can also present risks especially where there is clear evidence that current practice does not meet actual need.

PRECONDITIONS FOR INNOVATION

On the basis of Māori experience during the two periods 1882-1907 and 1982-2007, it is possible to draw some conclusions about the parameters of innovation in health and health care. Three broad preconditions can be recognised.

First, innovation arises in response to a need for change. Change is indicated when current approaches fail to address existing problems in health care, either because there is inadequate access and lack of perceived relevance, or doubts about quality and safety, or multiple problems that cut across disciplinary boundaries. And when participation takes a passive form rather than creating opportunities for active involvement thereby forcing consumers into states of dependency, or when diagnosis and treatment are compromised by a cultural mismatch, innovative responses are needed.

Second, innovation is more likely to occur when the right catalysts are present. Transformative leadership is a critical catalyst. Transformative leadership integrates rather than fragments, can be sustained even when the instigators have left, and can deliver widespread benefits that trigger other societal gains. Interventions at the interface can also catalyse innovation that will not occur within segmented silos. Interfaces can be found between different bodies of knowledge, different sectors, different levels of health care, and different areas of specialisation. Investments in innovation are also necessary catalysts requiring cooperation between investors, a degree of risk taking and a willingness to explore options that will improve health care and health status.

Third, an important precondition for innovation is an enthusiasm for change. Unless the enthusiasm is shared by the sector, the community and government, it is unlikely that innovative

changes will be sustained or even commenced. In effect an innovation climate is necessary for innovation to blossom.

Arising from these considerations and from Māori experience gained over a century it is possible to represent innovation as a process that occurs within an innovation-friendly environment where communities, the sector, and government find a measure of accord, unleashing catalysts for change and ultimately producing new knowledge, enhanced sector capability, and importantly, gains in health.

¹ Mason Durie, (2007), *Indigenous Resilience: From Disease and Disadvantage to the Realisation of Potential*, in Te Mata o te Tau (Academy for Māori Research and Scholarship), *Matariki*, a Monograph, Massey University, pp. 7-26.

² Archdeacon Walsh (1907), *The Passing of the Māori*, *Transactions of the New Zealand Institute*, Wellington, pp. 154-174.

³ *New Zealand Herald* 17 August 1874.

⁴ John A. Williams, (1965), 'The Foundations of Apirana Ngata's Career 1891-1909', in J. G. A. Pocock (ed.), *The Māori and New Zealand Politics*, Blackwood and Janet Paul, Auckland, pp. 55-60.

⁵ J. B. Condliffe, (1971), *Te Rangi Hiroa the Life of Sir Peter Buck*, Whitcombe and Tombs, Christchurch, pp. 67-8.

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A DECOLONISED VIEW FROM THE MARGINS

*Mana Wāhine and Bioethics Council's Findings
into Health Related New Technologies*

Jessica Hutchings

Jessica Hutchings is currently a Health Research Council
Post-Doctoral Research Fellow based in Wellington.

INTRODUCTION

...this space of radical openness is a margin – a profound edge. Locating oneself there is difficult yet necessary. It is not a 'safe' place. One is always at risk. One needs a community of resistanc¹.

The purpose of this paper is twofold; firstly this paper provides a mana wāhine review of two reports from the Bioethics Council pertaining to emerging health related new technologies in Aotearoa/New Zealand. This paper occupies a kaupapa Māori space and engages with a mana wāhine conceptual framework² to provide a lens of relevance to examine issues relating to emerging health related new technologies. Through the mana

wāhine conceptual framework this paper raises wider issues not identified in the Bioethics Council reports but essential to a critical mana wāhine response regarding the use of new health related technologies amongst Māori populations.

The second purpose of this paper is to claim a mana wāhine and kaupapa methodological space and to privilege this transformative space from which to write about the impact of health related new technologies.

The first part of this paper overviews the key issues and recommendations for Māori as identified by the following Bioethics Councils documents;

- The Cultural, Ethical and Spiritual Dimensions of the use of Human Genes in other Organisms³
- The Cultural, Spiritual and Ethical Aspects of Xenotransplantation: Animal to Human Transplantation⁴

The second part of the paper presents critical questions not identified or adequately addressed by the Bioethics Councils documents. These questions arise from the the mana wāhine conceptual framework and relate to decolonisation, Te Tiriti o Waitangi, intellectual property rights, Papatuanuku, kaitiakitanga and decision making. The findings of this paper support other writings, presentations and discussion at various hui, forum and Waitangi Tribunal hearings around the country, which have called on the Crown to honour its Treaty relationship and to allow Māori a full decision making role in the consideration of the development and use of new technologies¹. This paper reiterates the sentiment of many other Māori voices² and gives visibility to the resistance amongst many Māori and their communities to participate in processes of engagement and

¹ See Cram, 2000 & Hutchings, 2003.

² *Ibid*

development of these new health related technologies that continue to support colonial hegemonic masculinist ideologies³.

METHODOLOGY

This paper is centred within the kaupapa Māori research paradigm which is inherently about tino rangatiratanga. Kaupapa Māori is more than an epistemology or a research method. For Ngaronoa Mereana Takino⁵;

“it is the core component of which might otherwise be thought of as divergent forms of theorising, it is a commitment to ending systems of domination and oppression and the restoration of our dignity as human beings.”

Kaupapa Māori epistemology derives from a Māori worldview and is by no means a new discourse. Fiona Cram⁶ discusses kaupapa Māori epistemology as:

an attempt to retrieve space for Māori voices and perspectives. It is about providing a framework for explaining to tauwi (non-Māori) what we (Māori) have

³ When discussing hegemonic colonial masculinist ideologies I am referring to the pursuit of particular interests to maintain domination, systems of thought that maintain the capacity of the dominant group to exercise control. This is not achieved through visible regulation or the deployment of force, but rather through a lived system of meanings and values whereby Māori accept their subordinate status as a colonised race and accept the cultural, social, and political practices of the colonial dominant elite (Johnston et al. 2000). By referring to colonial hegemonies, it can be assumed they are also masculinist, however I wish to emphasise this dimension. According to Johnston et al. (ibid: 492) masculinist knowledge “is frequently located in relation to traditions of western scientific rationality, in particular the dualisms between mind and body and between subject and object, plus the presumption that scientific knowledge can and should be objective and context free.” I re-emphasise the masculinist nature of the hegemonic colonial ideologies throughout this article to challenge the universal and exhaustive claim to knowing that colonial masculinist hegemonies presume this is implicit.

always been about. In this way kaupapa Māori is not a new initiative.

Kaupapa Māori epistemology views the right for Māori to reclaim the right to be Māori within the Aotearoa/New Zealand wider society. It is a culturally defined theoretical space⁷. Graham Smith⁸ summarises contemporary expressions of kaupapa Māori theory and epistemology as follows:

A kaupapa Māori base (Māori philosophy and principles) is local theoretical positioning related to being Māori; such a position presupposes that:

- The validity and legitimacy of Māori is taken for granted
- The survival and revival of Māori language and culture is imperative
- The struggle for autonomy over our own cultural well-being, and over our own lives is vital to Māori survival.

Essentially, kaupapa Māori are fundamental principles and philosophies capable of providing an explanation of all experience as Māori. This picture of the phenomenal world is called 'Te Ao Marama'⁹. All traditional whakapapa (genealogy and kinship ties) within the Māori world lead to Ranginui (Sky Father) and Papatuanuku (Earth Mother) who represent the physical venue within which the phenomenal world exists. However Ranginui and Papatuanuku and Te Ao Marama also represent a philosophical orientation to the world. Charles Royal¹⁰ elaborates on this view:

Matauranga Māori (Māori knowledge) was traditionally created with the view that the earth was Papatuanuku, that the sky was Ranginui and that the world in which we currently reside is called Te Ao Marama.

In addition to a kaupapa Māori approach this paper is written through the lens of mana wāhine epistemology which concerns the way Māori women define themselves and their relationship to experiences and events. Mana wāhine epistemology is a knowledge system that is created and informed by Māori women's experiences. This epistemological perspective provides space for Māori women to reclaim their experiences and make visible their voices through a framework that recognises the uha⁴ (essence) of their experience. Mana wāhine research is for Māori women and allows Māori women, their herstories and their contribution to society to be visible and valid. It challenges and analyses the social bases of gender relations and the unequal distribution of power between the oppressed and the oppressor, Māori men and Māori women, with colonisation being a central part of that oppression. A mana wāhine analysis calls for a radical shift within current power relations to enable transformative practice that challenges hegemonic colonial masculinist ideologies.

A mana wāhine epistemology places the connection between Māori women and the land originally found in the womb of Te Po and the origins of Te Ao Māori at the center. It is in the womb of Te Po where Papatuanuku, the Earth Mother, was conceived. As Robyn Kahukiwa¹¹ states, she was “born into darkness matured in darkness and in darkness became mated with the Sky”. She conceived and bore many children who lived among the world of light. The kaitiaki (guardian) role of Māori women sits in balance at the center of this epistemology creating space for Māori women to assert their kaitiaki rights⁵.

⁴ Uha describes the essence of being a Māori woman.

⁵ It is important to note that the repeated use of the term Māori women within the context of this mana wāhine epistemology does not aim to generalise or homogenize Māori women's experiences. Rather the term refers to the diverse realities held by Māori women and may also include Māori men's experiences where they lie outside of or in resistance to wider hegemonic colonial masculinist ideologies. I refer to some Māori men who have joined the struggle against hegemonic colonial masculinist ideologies and have joined Māori women working towards tino rangatiratanga.

In my view such an expression of a mana wāhine epistemology recognises:

- That Māori women hold unique positions as kaitiaki, nurturers and re-builders of indigenous knowledge and have the right to protect and control the dissemination of that knowledge.
- That Māori women have the right to create and develop new knowledge based on cultural traditions.

Both a kaupapa Māori and a mana wāhine epistemological approach occupy a powerful and radical space on the margins. The occupation of this marginal space is as much “a site of belonging as a site of struggle and resistance”¹². The privileging of bell hooks quote to open this paper served to make visible the standpoint of this paper as locating itself within this powerful and transformative space of the margins. Linda Smith¹³ explores the multilayered and multifaceted issues for Māori researchers researching in the margins, she states;

Researchers also choose to research in the margins whilst being at risk of becoming marginalised themselves in their careers and workplaces. One strategy for overcoming this predicament is to ‘embrace’ the work and commit to building a career from that place. As writers such as bell hooks and Gloria Anzaldua have already stated the margins are also sites of possibilities that are exciting and ‘on the edge’. Cultures are created and reshaped. People who are often seen by the mainstream as dangerous, unruly, disrespectful of the status quo and distrustful of established institutions are also innovative in such conditions, they are to design their own work solutions”¹⁴.

Hence this paper is located as a site of resistance to the colonial analyses on new technologies and offers a counter hegemonic perspective.

BIOETHICS COUNCIL FINDINGS IN RELATION TO CULTURAL, ETHICAL AND SPIRITUAL DIMENSIONS OF NEW HEALTH RELATED TECHNOLOGIES

“The Cultural, Ethical and Spiritual Dimensions of the Use of Human Genes in Other Organisms”¹⁵, was the first major report by the Bioethics Council to the Minister for the Environment and focused on the cultural, ethical and spiritual aspects of biotechnology. The Council undertook preparatory work to support the development of this project. Within that work the Bioethics Council’s Māori Working Group held hui with; “interested and informed Māori, and explored the possible consequences for tikanga, and matauranga Māori when thinking about the transfer of human genes to other organisms”¹⁶. In addition the Council also produced an eight page pamphlet titled, ‘Whakapapa and the Human Gene’.

Despite this Māori specific preparatory work within the Bioethics Council’s final report there are no specific Māori recommendations nor is there a detailed Māori specific critique of the cultural, ethical and spiritual dimensions of the use of human genes in other organisms. However the report does state within its key messages¹⁷ that;

“human genes are a culturally (although not scientifically) significant group, and their use in other organism does require additional ethical considerations to those required for other genetic modifications”.

Māori references and opinions are scattered throughout the document, for example under the section; ‘Cultural traditions of origin’ the report states; “some participants referred to Māori stories of creation to understand the place of various organisms, and the relationships between humans and other organisms”¹⁸.

Furthermore when the report presents the summary of views on what is special or unique about being human it states;

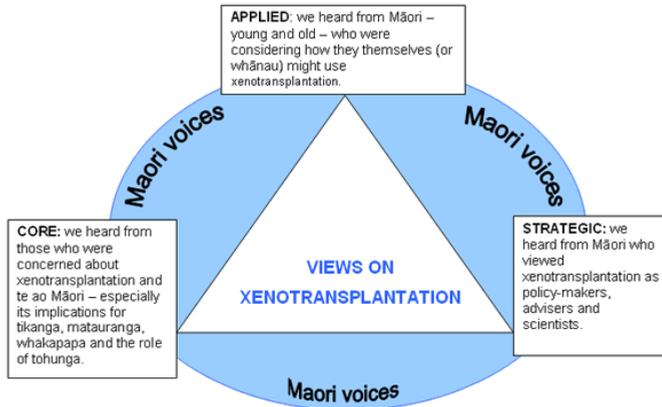
“Some referred to Māori heritage (e.g. whakapapa) as that which shapes and defines our relationships to humans and other life forms, and called for respect for wairuatanga, mauri, hinengaro, tinana. Related to this is an argument that to give special status to human genes is to perpetuate ideas of the dominance and superiority of humans that in itself denies or undermines an understanding of humans as one species among many , as sharing a common whakapapa”¹⁹.

The report also mentions the tikanga of tapu, kaitiaktianga, whakaiti and whakamana when presenting information on environmental views and humility; however there is no analysis or framing of the Treaty relationship between Crown and Māori.

The second report this paper overviews is; ‘The cultural, spiritual and ethical aspects of xenotransplantation: animal to human transplantation’²⁰.

This report is about xenotransplantation which is the transplantation of living cells, tissues or organs from one species into another, the focus of the report is on animal to human transplantation and looks at the processes involved and the related cultural, ethical and spiritual concerns²¹. This report provides more space for Māori consideration of these issues relating to xenotransplantation than the earlier report of the Council (previously overviewed) into, ‘The Cultural, Ethical and Spiritual Dimensions of the Use of Human Genes in Other Organisms’²². This report conceptually presents Māori viewpoints on xenotransplantation in the following diagram:

Figure 2.1 Māori views on Xenotransplantation²³



The figure 2.1 shows Māori views on xenotransplantation. There are three main threads coming from Māori voices:

Core - we heard from those who were concerned about xenotransplantation and te ao Māori – especially its implications for tikanga, matauranga, whakapapa and the role of tohunga.

Strategic - we heard from Māori who viewed xenotransplantation as policy-makers, advisers and scientists.

Applied - we heard from Māori – young and old – who were considering how they themselves (or whānau) might use xenotransplantation.

The report further presents examples of comments that characterised each conceptual viewpoint:

Core	‘If whakapapa links are debased through xenotransplantation then Māori culture and society are affected and will have no sense of identity and connection. Whakapapa is essential to Māori and to compromise our beliefs on whakapapa will compromise our relationship within our culture and society.’
	‘To tamper with the mauri of an animal has direct impact on the environmental ecosystem.’
Strategic	‘Māori have strong beliefs about the land and nature, and since they are tangata whenua their opinions are very valuable.’
	‘The interests and choice of the individual should be considered first before any iwi, hapū or whānau.’
Applied	‘They should consider stem cell therapy before xeno.’
	‘My two kids would take the chance in an instant [to have xenotransplantation].’
	‘I don’t believe xenografts of any kind should proceed if there is a risk to others.’

The report summarises;

“That selection of comments from Māori indicates the diversity and richness of ‘Māori views’. Caution, cultural confidence, an emphasis on tradition, an emphasis on science, a concern for the personal, a concern for the collective, a concern for the wider community – all these were found in varying strengths and combinations”²⁴.

The recommendations from the report that pertain to Māori are as follows:

Recommendation 1

Xenotransplantation (animal-to-human, animal-to-animal) be allowed to develop in New Zealand, with that development being demonstrably shaped by:

the resolution and management of safety issues by a competent authority the Treaty relationship between Crown and Māori cultural, ethical and spiritual factors that matter to New Zealanders, including a compassionate response to the suffering of people and animals; the sanctity of human life; freedom of choice; kaitiakitanga and stewardship for other life forms; and safety.

Recommendation 2

(a) The Minister for the Environment enables, including through the provision of funding, an intra-cultural dialogue process (wananga) for Māori to examine their knowledge base from which to engage with xenotransplantation and other forms of biotechnology. This would address tikanga and spiritual, ethical and cultural issues within te ao Māori, including whakapapa, karakia etc.

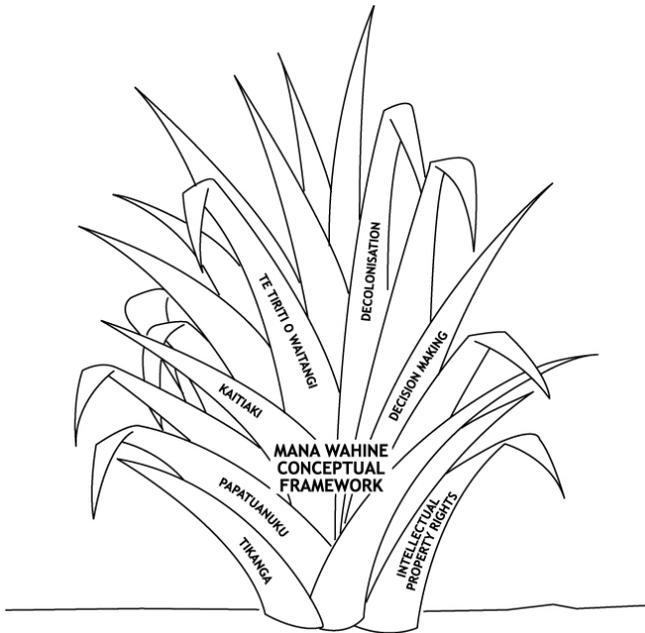
(b) Subject to tikanga, the knowledge/matauranga emerging from this intra-cultural dialogue is widely promulgated.

MANA WĀHINE FOCUSED COMMENT ON THE BIOETHICS COUNCIL'S REPORTS

The mana wāhine conceptual framework presented below in Figure 2.2 identifies the critical focus areas of; tikanga, Papatuanuku, kaitiaki, Te Tiriti o Waitangi, decolonisation, decision-making and intellectual property rights⁶.

⁶ See Hutchings, J. 2003. *Te Ukaipo te whakarururhau – Mana Wāhine and Genetic Modification. PhD Thesis. Victoria University Wellington. For further information of the mana wāhine conceptual framework.*

Figure 2.2 Mana Wāhine Conceptual Framework



The critical focus areas of the framework were identified through interviews with Māori women concerning genetic modification (GM)²⁵ and represent key mana wāhine areas of concern for consideration with regard to GM as well as other new technologies. The framework provides an opportunity to work from a mana wāhine epistemology and privileges the broader concerns expressed by Māori women holding a mana wāhine analysis with regard to new technologies. A key feature of this framework is its engagement with a decolonising analysis through the re-conceptualising of discourses from a mana wāhine epistemology. Working with mana wāhine knowledges, discourses and theories allows us as Māori women to disengage from colonial masculinist hegemonic ideologies that occupy our space and define our analysis, views and who we are. This mana wāhine conceptual framework claims a tino rangatiratanga space

and is a form of modern day resistance to the ongoing domination of racism and colonisation that pervades Crown based analyses of Māori perspectives of new technologies. The framework provides a mana wāhine space from which to comment on the Bioethics Councils reports into the cultural, ethical and spiritual dimensions of the use of human genes in other organisms and xenotransplantation.

MANA WĀHINE COMMENT INTO THE BIOETHICS COUNCILS REPORTS

A primary concern of a mana wāhine analysis is an examination of the sites of power from which critiques of new technologies emerge. An analysis of the sites of power allow us to identify who is controlling of the debate, who and/or what institution(s) have vested interested and from which paradigm are the questions of the debate being framed. Furthermore a key issue in the participation of Māori into ‘outsider’ processes is the identification of who has the control over contributed knowledges, opinions and dialogue from Māori collectives and individuals.

It is clear from the introduction sections of the both of the reports that the Bioethics Council is not the decision making body with regard to final say on the use of these health related new technologies in Aotearoa. Both of the reports were written to the Minister for the Environment who in turn takes the recommendations of the reports under consideration. This initially raises the question for me about the contribution of Māori time, energy and resource to participate in a debate where we are not engaging with the decision makers on these issues. Furthermore this raises more serious constitutional issues around why the Government continues to deny Māori and Iwi the right of direct dialogue with decisions makers over these important issues.

The report examining, ‘The Cultural, Ethical and Spiritual Dimensions of the Use of Human Genes in Other Organisms’²⁶ fails to even note the Tiriti o Waitangi relationship with regard to process and outcome in the consideration of the Māori concerns. The report on Xenotransplantation does however acknowledge the ‘special’ relationship Māori have as a Treaty partner with the Crown, but fails to clarify what it means by the term ‘special’ within the context of the Treaty relationship. When there is a lack of clarity in defining the Treaty relationship critical issues (as identified through the mana wāhine conceptual framework) such as tikanga, Papatuanuku, kaitiaki, decolonisation, decision making and intellectual property rights fail to be counted, negotiated and brought to the forefront of the debate and hence these debates continue to fail in their challenging of colonial hegemonic masculinist ideologies and perpetuate colonial norms and thinking.

Furthermore this raises questions around the appropriateness of the Crown to continue its role as both ethical monitor and investor in these technologies and calls into question the integrity of holding both of these roles when the Crown continues to have vested economic interests in the development and use of these health related technologies.

The increase space and legitimacy given to Māori views regarding xenotransplantation in the report on *The Cultural, Psiritual and ethical Aspects of Xenotransplantation: Animal to Human Transplantation*²⁷; may signal an increased awareness in the Bioethics Council’s work one year on from its previous work on the use of human genes in other organisms, or it may signal that the Council needed to be seen to take Māori issues ‘into account’ as it was charged with the responsibility of holding the first debate in Aotearoa/New Zealand on the issue of xenotransplantation. Furthermore it noted in its report on the use

of Human Genes in Other Organisms report, that many of the issues Māori raised were mirrored in the debated conducted by the Royal Commission on Genetic Modification. However in both instances this does not mean that Māori views have been upheld or that power has been shared as it should be under the Te Tiriti partnership to the extent where our views do more than occupy space but influence in terms of decision making.

The conceptual presentation by the Bioethics Council of Māori views on xenotransplantation attempts to reflect the diversity of views within our Māori communities and to provide a systematic way of explaining main groupings of Māori views. However the continuum does not extend to address critical issues such as the structural relations of power, nor does it build upon “cultural values and systems and contribute research back to communities that make a more positive difference or are transformative”²⁸. Rather the conceptual framework defines and re-presents Māori views and perspectives on xenotransplantation and continues the maintainance of hegemonic, colonial masculinist ideologies.

Engagement with the critical focus areas of the mana wāhine conceptual framework provide a space to re-orientate the debate in a way that challenges colonial hegemonic masculinist ideologies and contributes towards decolonisation. The following questions relating to the critical focus areas demonstrate how this is possible and frame questions which allow for a more relevant analysis that challenges the Crown’s domination of power and space within the discourses of health related new technologies.

Tikanga

- Is this technology congruent with our tikanga?⁷
 - Do the canons of tikanga Māori such as whakapapa and mauri approve the use of this technology?

⁷ When referring to tikanga I am also referring to the diverse tikanga amongst whānau, hapū and iwi.

Papatuanuku

- How does this technology protect the uha of Papatuanuku?
 - Is the relationship between Māori women and Papatuanuku enhanced through the use of this technology?

Kaitiaki

- As kaitiaki, do Māori women approve the use of this technology?
 - What are the key elements the mana wāhine kaitiaki role protects?

Te Tiriti o Waitangi

- Does the development and implementation of this technology endorse our Te Tiriti rights?
 - Has this technology been developed with the full participation of Māori exercising their Te Tiriti rights?
 - Is Te Tiriti o Waitangi being used as one of the decision making tools in the development of this technology?

Decolonisation

- How does this technology assist in the decolonisation of Māori?
 - How does this technology challenge hegemonic colonial masculinist ideologies?

Decision-making

- In what ways are Māori women recognised and supported as decision-making participants in the development of this technology?
 - Are mana wāhine perspectives visible and validated with regard to this technology?

Intellectual property rights

- Does this technology support Māori women protecting their cultural and intellectual property?
 - Is our biodiversity protected from commodification?

The presentation of these questions demonstrates another possible way of framing a debate around health related new technologies that challenges hegemonic colonial masculinist

ideologies and ways of working and allows for a transformative space in which to debate these new technologies.

CONCLUSION

Having participated in the area of Māori and new technologies for almost a decade it is clear to me that Māori continue to lack decision making power with regard to the development and use of these new technologies. Our views continue to be sought and the ‘cultural, ethical and spiritual issues’ continue to be documented but in terms of influencing the end use or the rapid development of these technologies Māori views almost count for nothing as we continue to be denied our Te Tiriti right to exercise our tino rangatiratanga over the development and use of these health related new technologies in Aotearoa/New Zealand.

Mana wāhine frameworks challenge hegemonic colonial masculinist ideologies as they operate from the margins, where critical conscientious and reflective analysis can take place. Our mana wāhine frameworks of analysis are not colonised by vested interests of multinationals, Māori or Pākehā public servants or colonial governments but are informed by our daily reality as Māori women to define who we are. Science is a multibillion dollar global industry which at most times lacks a community ethos and a positive relevance for indigenous peoples, it is pivotal that those of us on the margins occupy this place of resistance and continue challenging the processes and development of sciences that is antithetical to who we are.

¹ hooks, b. 1990. *Choosing the Margin as a Space of Radical Openness. Yearning Race, Gender and Cultural Politics*. South End Press, Boston. p. 149.

- 2 Hutchings, J. 2003. *Te Ukaipo te whakaruruhau – Mana Wāhine and Genetic Modification*. PhD Thesis. Victoria University Wellington.
- 3 Bioethics Council. 2004. *The Cultural ,Ethical and Spiritual Dimensions of the Use of Human Genes in Other Organisms*. Bioethics Council: Wellington.
- 4 Bioethics Council. 2005. *The Cultural, Spiritual and Ethical Aspects of Xenotransplantation: Animal to Human Transplantation (Final Report)*. Bioethics Council: Wellington.
- 5 Cram, F. 2001. Rangahau Māori: Tona Tika, Tona Pono – The Validity and Integrity of Māori Research. In Tolich, M.(ed) *Research Ethics in Aotearoa New Zealand*. Longman, Auckland, p. 40.
- 6 Cram, F., Pihama, L., and Philip Barbara, G. 2000. *Māori and Genetic Engineering*. International Research Institute for Māori and Indigenous Education, The University of Auckland. p. 41.
- 7 Pihama, L. 2001 *Tihei Mauri Ora, Honouring Our Voices*. Unpublished PhD Thesis. Auckland University, Auckland.
- 8 Smith, G. 1990. *Research Interests Related to Māori Education*. Paper Presented at the NZARE Special Interests Conference. Education Department, University of Auckland. p. 100.
- 9 Royal, C. 1998. *Te Whare Tāpere*. Unpublished PhD Thesis. Victoria University, Wellington.
- 10 Ibid. p 83.
- 11 Kahukiwa, R. 1984. *Wāhine Toa*. Viking, Auckland.
- 12 Smith, L. 2006. Researching in the Margins: Issues for Māori researchers – A Discussion Paper. *AlterNative Special Supplement - Marginalisation*. p. 6.
- 13 Ibid. pp. 4-28.
- 14 Ibid. p. 24

- ¹⁵ Bioethics Council. 2004. *The Cultural ,Ethical and Spiritual Dimensions of the Use of Human Genes in Other Organisms*. Bioethics Council: Wellington.
- ¹⁶ Ibid. p. 12.
- ¹⁷ Ibid. p. 9.
- ¹⁸ Ibid. p.19.
- ¹⁹ Ibid.
- ²⁰ Ministry for the Environment. 2005. *The Cultural, Ethical and Spiritual Aspects of Animal-to-Human Transplantation. A report on xenotransplantation by Toi te Taiao*. The Bioethics Council: Wellington.
- ²¹ Ibid.
- ²² Ministry for the Environment. 2004. *The Cultural, Ethical and Spiritual Dimensions of the Use of Human Genes in Other Organisms. A report by Toi te Taiao*. The Bioethics Council: Wellington.
- ²³ Bioethics Council. 2005. *The Cultural, Spiritual and Ethical Aspects of Xenotransplantation: Animal to Human Transplantation (Final Report)*. Bioethics Council: Wellington. p. 19.
- ²⁴ Bioethics Council. 2005. *The Cultural, Spiritual and Ethical Aspects of Xenotransplantation: Animal to Human Transplantation (Final Report)*. Bioethics Council: Wellington. p. 19.
- ²⁵ Hutchings, J. 2003. *Te Ukaipo te whakarururhau – Mana Wāhine and Genetic Modification*. PhD Thesis. Victoria University Wellington.
- ²⁶ Ministry for the Environment. 2004. *The Cultural, Ethical and Spiritual Dimensions of the Use of Human Genes in Other Organisms. A report by Toi te Taiao*. The Bioethics Council: Wellington.
- ²⁷ Bioethics Council. 2005. *The Cultural, Spiritual and Ethical Aspects of Xenotransplantation: Animal to Human Transplantation (Final Report)*. Bioethics Council: Wellington.

- ²⁸ Smith, L. 2006. Researching in the Margins: Issues for Māori researchers – A Discussion Paper. *AlterNative Special Supplement - Marginalisation*. p. 24.

MĀORI DEVELOPMENT & MĀORI ADVANCEMENT

The Dual Goals Framework

Chris Cunningham

This paper was written in 2000 at a time when the purchase agents for research, science & technology (The Health Research Council of NZ, The Foundation for Research, Science and Technology, and The Marsden Fund) were developing their purchasing policies for Māori research. While the dual goals framework was designed as a strategic framework to inform these developments, it has a broader applicability. An abridged version of this original paper is reprinted below

INTRODUCTION

Interpreting the Treaty of Waitangi is an activity which has occupied policy makers, lawyers and researchers for the best part of the last two decades, since the acknowledgement of the Treaty in legislation and the development of the Waitangi Tribunal. Yet the Treaty is not written in ways which are particularly helpful to a contemporary setting. Neither is it a document which has clear status in law or policy, or in the agendas of successive governments in New Zealand.

The Dual Goals Framework has been developed as a Treaty-consistent, but not Treaty-dependant, framework which speaks to

the related goals of Māori Development and Māori Advancement. While in many eyes these are almost synonymous terms, the following section provides definitions of these concepts which are deliberately *constructed* as outcomes to elucidate the processes required to improve these outcomes for Māori, and in Māori terms.

DEFINITIONS

The Dual Goals Framework is based on the premise that in New Zealand Māori enjoy two distinct yet related relationships with the Crown/government.

- The first of these relationships is that which exists between the Crown/government and all of its subjects or citizens, for Māori this means both as individuals and as a special population called ‘Māori’;
- The second of these relationships is unique. It is the relationship between the Crown and tangata whenua which is generally expressed as the *partnership relationship* and which exists both individually and in the form of several collectives including whānau, hapū and iwi.

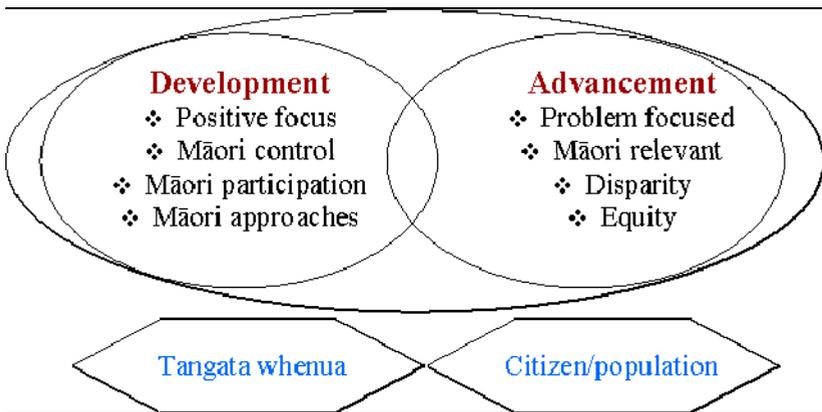
Clearly these relationships are not mutually exclusive – there is considerable overlap. It is important to note that tangata whenua are the *only* group in New Zealand to have this second explicit relationship with the Crown – explicit in the sense that it formed the basis for the signing of the Treaty of Waitangi. This distinction is important to emphasise, the relationship did not come from the Treaty but rather formed the basis for signing.

These dual relationships naturally result in the identification of two agendas. Again these agendas are not discrete but are inter-related.

The first agenda (subject or citizen) is generally conceptualised around the achievement of equity of outcome. Disparities are often raised as evidence of inequity and problems (or research questions) are thus identified.

The second agenda (tangata whenua Crown partnership) is focused on positive development for Māori based on a greater sense on Māori control and participation. This agenda also adopts Māori approaches, philosophies and methods where Māori culture, Māori language and Māori experiences are central. Māori have the substantive task of identifying priorities (or research questions) for this agenda.

The labels **Māori Advancement** for the first (equity) agenda and **Māori Development** for the second (partnership) agenda are arbitrary and are presented in the form of an analytical tool to assist analysts in their work. These words have been chosen to relate to some existing work but may convey differing meanings to different people. The words are not important but the concepts are.



Although this framework is not principally derived *from* the Treaty of Waitangi (the two are both derived from the same set

of relationships) it is consistent *with* the Treaty. The Development agenda is consistent with Article 2 of the Treaty: Rangatiratanga – Māori control over things Māori. The Advancement agenda is consistent with Article 3 of the Treaty: Citizenship – the rights and privileges of all citizens including the right to equitable outcomes. The overall ‘Dual Goals’ framework is consistent with Article 1 of the Treaty: Good Government, in the sense that good government is about progressing both agendas, and both goals, contemporaneously.

DISTINGUISHING ADVANCEMENT AND DEVELOPMENT IN A RESEARCH SETTING

The first step in this process is to identify “Māori research”. What is Māori research? Is it any research conducted by Māori? Is it any research which impacts on Māori in some way? Is it only research which will benefit Māori? The definition adopted in this paper is:

“any research which actively seeks to produce Māori knowledge outcomes”

In this context Māori knowledge outcomes include capability building – Māori human resources and Māori methodologies. Having identified Māori research, the question becomes whether the research orients towards Māori advancement or Māori development. It is important therefore to clearly understand the difference while admitting there is a crossover between the two orientations.

I have approached describing the differences and similarities between advancement and development in two ways. First a checklist provides a description of the necessary and desirable features of typical research under these categories. Second an

algorithm flowchart presents much the same information but in a logical hierarchy.

Māori Development and Māori Advancement Checklist

From a research purchaser’s perspective the first step is to identify the research purchased which actively seeks to contribute to a Māori knowledge base and thereby inform improved Māori outcomes or to produce Māori research capability outcomes. Individual projects may partially contribute or may contribute to both advancement and development.

Having identified this active Māori research, according to the model¹ the research should be allocated as either (wholly or partly) advancement or development or a mixture of the two. Research should attempt to address all of the checklist items.

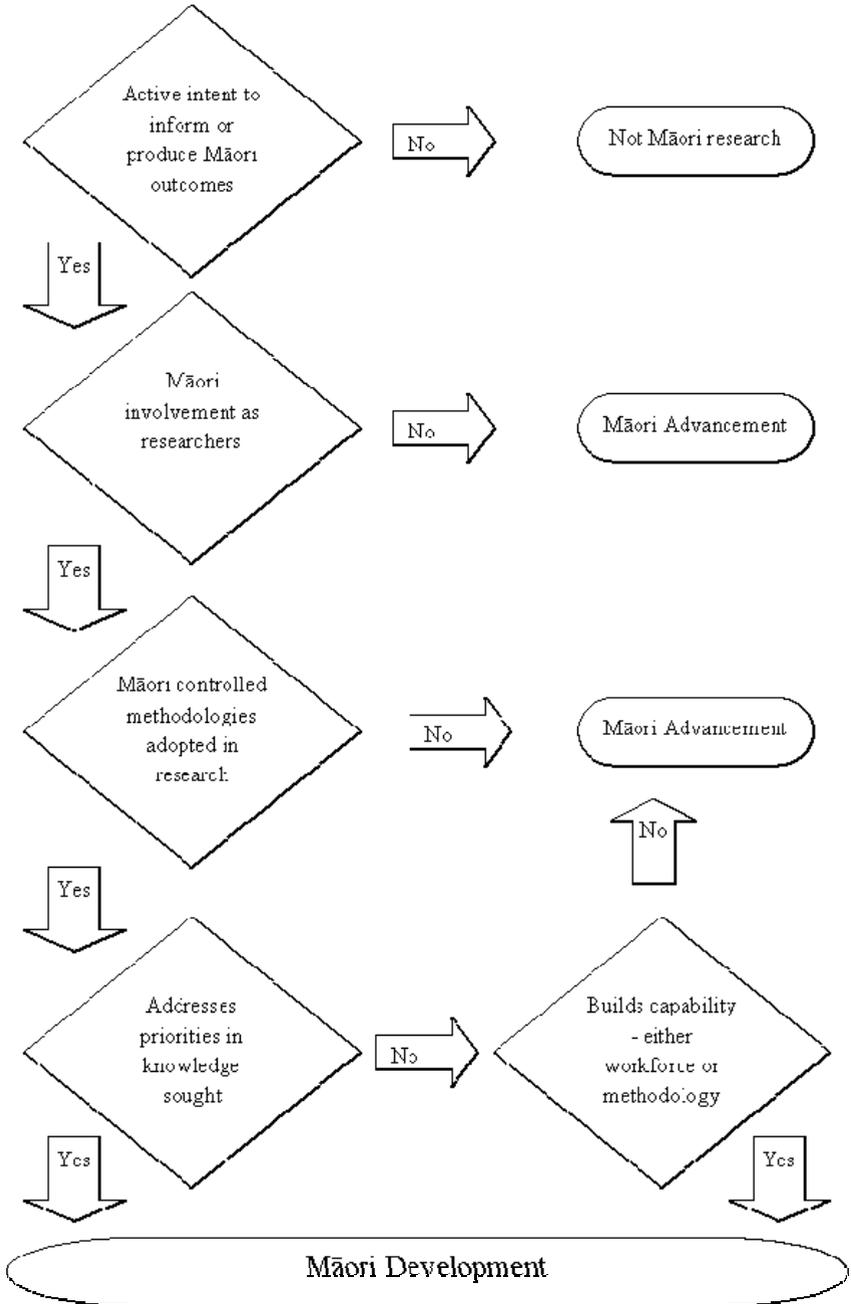
Table 3.1 Checklist - Māori Advancement and Māori Development

Checklist Items	Development	Advancement
Research intent	Active intent to produce Māori knowledge or capability outcomes or to inform Māori outcomes generally	Active intent to produce Māori knowledge or capability outcomes or to inform Māori outcomes generally
Māori involvement as researchers	High level of Māori involvement as researchers	Significant involvement of Māori – may be in advisory or kaitiaki positions
Methodology	Involves kaupapa-Māori or other Māori controlled methodologies	Involves robust methodologies
Māori involvement as participants	High degree of Māori involvement – may be involvement of Māori data or knowledge rather than people	Significant degree of Māori involvement – may be involvement of Māori data or knowledge rather than people

Checklist Items	Development	Advancement
Contribution to capacity building in Māori research	May have significant contribution to either workforce development or the development of Māori relevant methods and methodologies	May have significant contribution to Māori workforce development
Addressing priorities	May address a priority issue for Māori, or capability building, or both.	Addresses a priority issue for Māori. May contribute to capacity building.
Outcomes	Increases the Māori knowledge base and/or the capability to undertake Māori research	Increases the Māori knowledge base. May contribute to increased Māori capability.

Algorithm

The following algorithm demonstrates the process of deciding whether a project orients towards development or advancement.



Appendix 1 Worked Examples from Purchased Research Projects

Checklist Item	Best Outcomes for Māori (FRST MAU 605/810)	Harvests of Titi by Rakiura Māori (FRST RT 1801)	Female Rangatahi (HRC 99/609)	Genetic Susceptibility to stomach cancer in Māori (HRC)
Research intent	Inform Māori social outcomes	Inform Māori economic and environmental outcomes	Māori research question	Inform Māori health outcomes
Māori involvement as researchers	High	Significant	High	Significant
Methodology	Māori centred approach	Māori involvement	Māori centred approach	Māori involvement
Māori involvement as participants	Māori households	Māori kaitiaki group; Māori owned resource	Rangatahi Māori; wāhine Māori	Māori participants have some control
Contribution to capacity building in Māori research	Yes	Yes	Yes	Yes
Addressing priorities	Yes	Local priority	Yes	Yes
Outcomes	Māori knowledge	Partly Māori knowledge	Māori knowledge	Partly Māori knowledge
Māori development	Yes	Partly	Yes	Partly

It would not be sufficient for a research project though to have high Māori cultural significance to be counted, unless that significance was mirrored in the actively desired outcomes and research processes involved.

Similarly, orthodox studies of indigenous flora and fauna would not meet the standard for active Māori research.

An interesting category are those projects which are essentially mainstream in origin but which necessarily have significant Maori participation (eg stomach cancer research in a Māori whānau). Components of these projects are likely to be either development or advancement. Allocating between these categorisations will need careful analysis.

¹ Cunningham, C. W. (1998). *A Framework for Addressing Māori Knowledge in Research, Science and Technology*. Paper presented at the Te Oru Rangahau: Māori Research and Development Conference, School of Māori Studies, Massey University, Palmerston North.

A PRELIMINARY LITERATURE REVIEW OF ISSUES AND POLICIES AFFECTING THE PROVISION OF HEALTH AND SUPPORT SERVICES TO MĀORI WITH DISABILITIES IN NEW ZEALAND

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Te Pūmanawa Hauora in 2007

INTRODUCTION

Over the past six years, a new paradigm has slowly come to the forefront in the politics of disability in New Zealand. Members of the Māori community, those with disabilities, their family, community and their caregivers have created and slowly begun to implement a system of change. This system involves an overhaul of the dominant structure of disability policy and service provision. Namely, it forces the current structure to recognize and acknowledge the unique cultural needs and customs of Māori with disabilities in New Zealand.

This new paradigm has the potential to provide the impetus for indigenous peoples in other parts of the world to push for policy and services that are effective and accessible and, at the same

time, culturally appropriate. It also provides researchers with the opportunity to examine the issues that arise from discussion surrounding cultural competency and disability policy and service provision: what is the standard for cultural competency and how is it measured; which frameworks best guide policy and service implementation; and, how can governments insure that implementation reaches across sectors? This preliminary literature review (“preliminary” as certainly more documents will come to light as recent Census data and annual progress report findings are released) will examine some of the issues related to this discussion, using New Zealand as case study subject.

Authors such as Nikora, Karapu, Hickey, and Te Awekotuku¹ utilise the Ministry of Health’s definition of a person with a disability as ‘someone who has been assessed as having a physical, psychiatric, intellectual, sensory or age-related disability (or a combination of these) which is likely to continue for a minimum of six months and result in a reduction of independent function to the extent that ongoing support is required, and is not as a result of a personal injury by accident for which eligibility for cover and entitlement has been confirmed under the Accident Insurance Act of 1998.’ For the purposes of this literature review, this same definition will be used throughout the paper.

THE STATUS AND EXPERIENCE OF INDIGENOUS PEOPLES WITH DISABILITIES

Minorities as a global trend are overrepresented in population of people with disabilities². For example, within the United States the federal government recognizes some 339 American Indian Tribes and 227 native entities in Alaska. The some 2 million people counted in these groups comprise less than 1 percent (0.9%, specifically) of the U.S. population³. Despite such small

numbers, American Indians and Alaskan Natives (AI/AN) experience a disproportionate rate of disability that some estimates place as much as six times higher than any other group in the United States⁴. Current national data shows that the rate of disabilities among AI/AN populations falls somewhere between 22 and 24 percent. These numbers are further compounded by high poverty rates, geographic isolation, limited employment options, and a cultural heterogeneity that mandates an individual service approach for every tribe⁵.

Such overrepresentation often leads to this population experiencing greater inequities in terms of access to and quality of health and support services. Inequities experienced by people of color include: higher negative health disparities; disproportionately higher risks for intellectual disabilities; overrepresentation in special education classes; less satisfactory outcomes regarding education, employment, and community involvement after completing special education programs; underrepresentation in adult services; less parental satisfaction with the nature and quality of services provided; and, underrepresentation in national advocacy organizations⁶.

The status of indigenous people with disabilities (IPWD) is also compounded by the lower socio-economic standing they experience. Nikora et al.⁷ note that poverty in particular both causes and results from disability. In this way poverty and disability sustain each other, adding to the level of vulnerability and exclusion indigenous people with disabilities experience. For instance, data from national 2001 survey reveal that Māori experience higher rates of disability compared to the national rates within New Zealand. This group also experienced significantly lower levels of employment (48 percent compared to 27 percent for non-disabled Māori) and income (60 percent reported an annual income of \$15,000NZD or less)⁸. In a sense, indigenous peoples with disabilities are dual disadvantaged, as

differences in culture, ethnicity, and linguistics combined with differences in physical, mental, or emotional ability present a complexity of barriers in accessing services⁹.

These complex barriers often culminate in a health system that assumes that services framed within the dominant culture are appropriate and accessible to every person in need of services. “All people and families have their own way of perceiving problems and solutions,” comments Sharp and Siataga¹⁰, “...yet services provided within the dominant culture have done little to understand, respect, and listen to what people considered to be outside of the mainstream are saying.”

Such barriers have a direct and profoundly negative impact on the lives of indigenous peoples with disabilities. Indigenous peoples often face a health system that neglects to acknowledge their culture as members of an indigenous community or as individuals with a disability – a situation that Māori in New Zealand are now beginning to challenge. Health and social policy developed over the past decade demonstrates some level of government recognition of the unique experiences of IPWD. Legislation such as the New Zealand Disability Strategy and He Korowai Oranga attempt to address some of the issues surrounding disability and culture prevalent in both mainstream and minority communities. Questions now surround issues of the effectiveness of these policies and whether or not they can see to the particular needs of sector of the population living with a dual identity – indigenous (in this case, as Māori) and disabled. As Ratima et al.¹¹ summarizes, “The costs of disability are high; they should not include cultural alienation.”

EXISTING POLICY

Nikora et al.¹² point out that disability policy in New Zealand descends from several events and pieces of legislation that have

impacted the lives of New Zealanders with disabilities over the last three decades. These event and policy changes include the Disabled Persons Community Welfare Act of 1975, which established support services through the Department of Social Welfare for individuals whose disabilities did not result from accidents; the creation of the advocacy organization Disabled Persons Assembly in 1983, and; establishment of the Human Rights Act in 1993, which criminalized unreasonable discrimination on the basis of a person's disability. The influence of these policies and others led to the design of the following pieces of legislation that currently frame how policy, support service providers, and society at large view and treat indigenous people with disabilities in New Zealand.

The New Zealand Health Strategy

Utilizing input gathered from over 1500 people and more than 450 written submissions, the New Zealand Health Strategy (NZHS) spells out the government's goals and priorities –along with its framework for action – in its efforts to improve national health outcomes while reducing health inequities. The NZHS also aims to address issues regarding accessible and appropriate services for Māori and other issues of health service quality, such as individual rights, information management and technology, and workforce development¹³.

This document contains seven fundamental principles that must be reflected across the health sector, as well as in any policies or strategies developed in the future. It also describes five specific objectives specifically related to issues regarding Māori health development:

- Build the capacity for Māori participation in the health sector at all levels
- Enable Māori communities to identify and provide for their own health needs

- Recognize the importance of relationships between Māori and the Crown in health services, both mainstream and those provided by Māori
- Collect high-quality health information to better inform Māori policy and research and focus on health outcomes
- Foster and support Māori health workforce development¹⁴

Government officials intended the NZHS to be used in conjunction with the New Zealand Disability Strategy in order to create a comprehensive, effective framework for addressing overall health issues in New Zealand, including how other health policies and strategies are developed and carried out. However, disability, though mentioned, is a separate issue within this document. Instead, it is lumped in with a collective list of issues relating health services and outcomes. In a sector marked by competitive funding, policy, and research interests, disability-specific matters could possibly be neglected.

Still, the NZHS is not without its merits. For Māori with disabilities, this legislation provides an opportunity to identify and highlight their personal needs and experiences both as individuals with disabilities and as members of a wider Māori community. The NZHS also contributes to the creation and distribution of knowledge about disability and IPWD, potentially leading to an increase in not only improved health outcomes and service quality, but also increased community awareness of disability issues.

The New Zealand Disability Strategy

Based on a social model of disability, the overarching aim of the New Zealand Disability Strategy (NZDS) is the creation of a fully inclusive society, where people with disabilities are integrated into community life on their own terms, with recognition of and value for their abilities, diversity and interdependence, and protection of their human rights¹⁵. To this end, the NZDS includes fifteen objectives, each with its own

subsequent set of action points. Objectives 11 (Promote the participation of disabled Māori) and 12 (Promote the participation of Pacific peoples) of the NZDS specifically focus on indigenous people with disabilities. These objectives are legislatively unique: not only do they provide evidence of government recognition of the distinctive issues faced by IPWD, they also specifically describe a set of action points and goals aimed at meeting the particular needs of this section of the population of people with disabilities. They provided IPWD in New Zealand a seat in the political landscape along with a voice with which to present their concerns.

The creation of the NZDS additionally led to formation of the Office for Disability Issues (ODI) in 2002. ODI serves specific functions regarding disability policy in New Zealand, including acting as lead agency in the Strategy's implementation; serving as policy advisor on disability issues; leading the development of strategic and intersectoral policy advice, and supporting the Minister of Disability Issues¹⁶. ODI exists to oversee the implementation of the NZDS across government. But, given the somewhat expedited nature of the agency's creation, the capacity of ODI to serve its primary role is debatable, leading to questions surrounding organisational capacity, intersectoral collaboration, and transparency and accountability across government.

As comprehensive as the strategy appears at first glance, Nikora et al.¹⁷ points out that it is not without its flaws. For example, the document relies more on principles than concrete, measurable steps and goals. No baseline measures exist to accurately measure progress or failure. Similarly lacking are specific definitions and measures for goals, time lines, and sector accountability. Such ambiguity often leads to poor understanding of and problems maintaining sector accountability and responsibility, strategic planning and policy evaluation, and goal attainment.

Likewise, financial considerations, particularly the need for increased financial commitments, are not discussed. No direct reference is made to differences in entitlements and funding streams between people whose disabilities are the result of accidents and people whose disabilities are hereditary, congenital or medical, even though two separate entities oversee the distribution and financing of services between these two categories of people with disabilities (the Accident Compensation Corporation and the Ministry of Health, respectively.) Variations in funding levels have a direct impact on the quality and availability of health and disability services sought by IPWD.

Additional criticism highlights the wording in Objectives 11 and 12 of the strategy. The term “culture” is ambiguous at best, neglecting to specifically refer to Māori or Pacific culture or to the culture of disability. In addition, action points that appear in one objective are conspicuously absent from the other. For example, action point 12.3 of Objective 12 encourages discussion and consideration of disability issues in Pacific communities; a similar action does not appear in Objective 11, though Māori communities could equally benefit from such dialogues¹⁸.

The New Zealand Public Health and Disability Act

The New Zealand Public Health and Disability Act (NZPHDA) of 2000 further facilitates the government’s plan to strengthen the public health system by focusing on health and disability sector agencies and arrangements¹⁹. More specifically, the act

- establishes District Health Boards (DHBs) to take a ‘population health’ focus for their geographically defined populations

- requires the development of the New Zealand Health Strategy and the New Zealand Disability Strategy and an annual report to Parliament on the progress in implementing these strategies
- encourages co-operation and collaboration between the agencies in the sector with the aim of delivering better care and support
- strengthens local community input to decision-making about health and disability support services through electing members to DHBs.

The act established 21 DHBs. These Crown agents fund or provide services for geographically defined populations. They are also responsible for public hospitals and other related services for individuals aged 65 and over. The responsibility for assessing the needs of and planning the services for qualifying individuals with disabilities – including Māori – also lies with DHBs^{20 21}.

In effect, by focusing on the role and responsibilities of DHBs, the act provides a means for Māori to participate in decision making and delivery of health and disability services²². Like the NZHS, this offers disabled Māori an opportunity to identify their specific issues and needs. Echoing the goals and aims of the NZHS, the act also requires DHBs to improve health outcomes for Māori, to enable Māori participation and contribution to health strategy development, and to foster the capacity for Māori to participate in the health and disability sector²³.

Still, gaps remain present in the policy. For example, Nikora et al.²⁴ note that while the act requires DHBs to include a minimum of 2 Māori members in their boards and advisory committees, no requirement to include a person with a disability exists. This absence again reflects a lack of understanding of the culture of disability. It also works against the ability of disabled Māori to participate in the decision-making and service delivery processes, denying them the opportunity to contribute to strategy

development. Such oversight could lead to attempts to implement services or strategies that are not only inappropriate for Māori with disabilities, but may actually exclude them entirely.

He Korowai Oranga: The Māori Health Strategy

He Korowai Oranga (HKO) expands upon the principles and objectives of the NZDS and NZHS by providing more detail on how the government plans to achieve Māori health goals. The strategy focuses on strengthening Māori health and families in order to reach its overall aim of whānau ora or maximum health and well-being^{25 26 27}.

Recognizing that a partnership between Māori and the government and between Māori and health and disability organizations must exist in order to achieve whānau ora, HKO is laid out in two directions: (1) Māori aspirations and contributions, which supports and recognizes Māori control over their own health and well-being as well as existing strengths found in Māori communities, and; (2) Government aspirations and contributions, which acknowledges the government's commitment to reducing Māori health disparities and its aspiration to ensure accessible and appropriate services²⁸.

Within the context of these directions, HKO²⁹ outlines four pathways that describe how whānau ora will be achieved:

- Pathway One: Te Ara Tuatahi – Development of whānau, hapū, iwi, and Māori communities
- Pathway Two: Te Ara Tuarua – Māori participation in the health and disability sector
- Pathway Three: Te Ara Tuatoru – Effective health and disability services
- Pathway Four: Te Ara Tuawha – Working across sectors

Within the text of the document, it is noted that DHBs in particular have an obligation to take HKO into account in their planning and meeting their required goals and objectives for Māori health.

HKO provides an example of policy that builds upon the goals and standards established by pre-existing legislation. It discusses issues affecting the population of people with disabilities to a greater extent than the NZHS, and provides a more specific, culturally-sensitive framework for health and disability service provision than the NZPHDA. For disabled Māori, it also provides a tool that recognises their cultural identity and that works within and between the contents of the NZPHDA, the NZDS, and the NZHS all at once.

Whakatātaka: The Māori Health Action Plan

Based on feedback from Māori and service providers on the draft version of KHO, Whakatātaka describes the specific actions to be undertaken by DHBs, service providers, MOH, Māori communities, and others involved in HKO's implementation^{30 31}³². Goals, action steps, target dates and measurable outcomes are laid out in detail. The roles and responsibilities of DHBs and MOH in relation to the four pathways described in HKO are outlined. Whakatātaka also emphasises that DHBs, MOH, and other publicly-funded providers are expected to prioritize Māori health within their funding allocations.

The creation of these policies illustrates the increasing attention to the needs and issues of IPWD in New Zealand. The issues now, however, concern the implementation and impact of these policies on the lives of Māori with disabilities. Evaluations of the policy effectiveness, at this time, have yet to be conducted. Questions now surround matters of agency and department accountability, service provider development, intersectoral collaboration, and the development of specific definitions and

indicators of cultural competency. While these policies created a forum in which to discuss the issues affecting disabled Māori, attention has now turned to whether or not they can provide the mechanisms to effectively address them.

ISSUES PERTAINING TO RESEARCH WITH INDIGENOUS PEOPLES & COLLABORATIVE RESEARCH

In controlled environments and laboratory settings, the scientific method takes precedence in the research process. A community setting, however, mandates an entirely different approach. Research into topic areas such as disability policy and cultural competency require a methodology that differs from the traditional Western qualitative/quantitative models. The competent researcher must take a wide range of variables into consideration— the culture’s history with past research and society at large, project ownership, and intended use of project findings – to make the research process appropriate, effective, and successful.

Western Research v. Research with Cultural Minorities

There is an inherent difference between research “with” indigenous people versus research “on” them. It is this difference that often leaves indigenous peoples hesitant or cynical – and occasionally outright hostile – to the notion of research into their lives. Many other researchers, particularly indigenous researchers, note that the history of research concerning indigenous peoples generally involved investigations done *on* the relatively powerless *for* the relatively powerful. These negative responses to research are often compounded by the fact that indigenous peoples rarely benefit from the research being conducted^{33 34}.

Voyle and Simmons³⁵ discuss several factors that fuel this negative reaction to research, including:

- the history of colonization
- experience with government funding bodies that promise self-determination but later force compliance and restrictions through funding
- inadequate funding for indigenous peoples to run projects on their own
- previous research/ers whose projects did not result in any benefits for the community or whose results actually worsened conditions
- a perception of bureaucrats and health providers having self-serving agendas

Gibbs³⁶ offers collaborative research as new approach to research involving indigenous peoples. She defines this form of investigation as “research where the research participants and the researchers are equal partners in the research process and where all parties benefit from research.” A collaborative approach to research allows the researcher to ask questions that hold meaning from the perspective of research participants. It results in information that benefits all parties involved, as research findings are designed not only to address issues participants find meaningful, but are designed for use by participants in a manner they have determined^{37 38}.

Smith³⁹ also adds that researchers undertaking these projects must go beyond simple recognition of personal beliefs, values assumptions, and the effects had when interacting with others. Researchers working in a cross-cultural, collaborative context must ask themselves questions such as:

- Who defined the research problem?
- For whom is the study worthy and relevant? Who says so?
- What knowledge will the community gain from this study?
The researcher?

- What are some likely positive/negative outcomes from this study?
- How can the negative outcomes be eliminated?
- To whom is the researcher accountable?
- What processes are in place to support the research, the researched, and the researcher?

It is worth noting that multiple authors heavily stress the importance of communication and consultation when undertaking research with indigenous groups^{40 41 42 43 44 45}. Open communication ensures that research remains participant-driven. It also maintains an equal balance of power, ensuring that the researcher continues to work “with” participants rather than speaking “for” them⁴⁶. Consultation also helps build a more cooperative environment, and allows the researcher an opportunity to resolve potentially contentious or difficult issues regarding the research project or process early on⁴⁷.

ISSUES AFFECTING INDIGENOUS PEOPLE WITH DISABILITIES

A wide range of issues faced by IPWD exists that illustrates the need for an individually-tailored, collaborative approach to research in this area. The experiences and issues of IPWD are particularly unique, as this population maintains a dual minority identity in society. While the literature reviewed here focuses on issues affecting disabled Māori, the issues and implications have similar application to indigenous peoples with disabilities elsewhere in the world.

The Need for Cultural Competency in the Disability Sector

In order to address disparities, providers must acknowledge and understand those disparities⁴⁸. This theme is common in much of the existing literature on this issue. The recognition and comprehension of the inequities and discrimination faced by minorities, particularly minorities with disabilities, is essential to

the successful development and implementation of effective, appropriate services. This level of understanding, as⁴⁹ describe it, is “the most useful and realistic goal an organization can have with respect to understanding cultural factors and their influence on service provision.” It is this goal that can ultimately minimize the discrimination and exclusion experienced by indigenous people with disabilities⁵⁰.

Sharp and Siagata⁵¹ list a number of ways through which organizations can improve their level of cultural competency, such as:

- providing support services which reflect the families’ cultural values and beliefs;
- fostering trust-building processors (e.g. visiting families, sharing meals);
- providing cross-cultural training – increasing workers’ awareness of different cultures; seek information from ethnic community workers;
- using interpreters and utilizing bilingual workers;
- translating information so that it is easily understood;
- meeting face to face, and;
- fostering feedback and consultation with ethnic communities.

Enders⁵² adds that outcome measures should be based on consumer perception that service received resulted in something of value. It is worth noting that only a few of these recommendations can be found within the text of the previously discussed policies, again reflecting the ambiguity of some the goals of these policies and the need for more definitive indicators and measurements of achievement.

Perceptions of Disability

Ratima et al.⁵³ highlight that the way in which a person identifies him or herself can have a significant impact on the development of intervention strategies as well as the individual’s skills and

talents. The emphasis is on the individualistic nature of this identity: no two people will share the same interpretation. This variation has considerable repercussions on the development and implementation of services to indigenous peoples with disabilities. As Durie⁵⁴ observes, “Stereotypes can create misleading impressions that certain individuals will prefer certain service options or delivery modes, when their actual preferences may be elsewhere. Choice should be the aim.”

Researchers often forget that differences in individual needs, circumstances, cultural heritages, attitudes and expectations can heavily influence perception and outcomes⁵⁵. Thus, most models, though helpful when framing disability and service provision, fall short of accounting for variables of racism and minority culture status⁵⁶.

Simply put, it is impossible to make broad generalizations regarding how individual members of an indigenous community will define or perceive disability in themselves or in the community^{57 58}. Further compounding this discussion is the realization that the heterogeneity that marks the population of indigenous peoples with disabilities is often reflected in the range of definitions and concepts of disabilities. As Chaput and Claussen⁵⁹ point out, there may be no equivalent to Western concept of disability or impairment in particular indigenous communities. In their research on Māori perceptions of disability, Kingi and Bray⁶⁰ found that many Māori defined their disabilities in a variety of ways, often framing it within a context of colonization and its effects on Māori physical, mental, and spiritual development. In their research on disability support services for Māori, Ratima et al.⁶¹ noted a fellow researcher’s finding that none of the Māori with disabilities with whom he spoke used the term “disabled” at all.

These variations again highlight the broad range of how disability is viewed not only by Māori community, but by Māori with disabilities themselves. This diversity in personal identities illustrates the vital importance of the voice of disabled Māori in the development of disability policy and services to ensure the recognition of these variations. Similarly, it emphasises the need for both research and policy workers to seek out this range of issues and experiences, and to develop policies and strategies that can effectively address or be amended to effectively address them.

Māori-Based Services

Research conducted by Nikora et al.⁶² reveals that many Māori report feelings of frustration and dissatisfaction with the current health system. Their dissatisfaction is hardly surprising. Obstacles faced by Māori with disabilities are many. Māori face service barriers including poverty, physical environment, legal and institutional barriers. Attitudinal barriers may prevent Māori with disabilities from choosing to access support services; they may also lead to friends and family members experiencing discrimination due to their association with a person with a disability^{63 64}

Ratima et al.⁶⁵ and Sharp and Siataga⁶⁶ outline additional obstacles Māori face when attempting to access support services:

- few Māori staff
- dominance of non-Māori staff
- lack of cultural appropriateness of service delivery
- inadequate use of Te Reo Māori
- lack of whānau involvement
- lack of service integration
- inadequate access to information

Māori with disabilities also face difficulties resulting from institutional and criteria-based barriers more than ones based on

culture. These barriers often prevent access to and receipt of appropriate services that utilize cultural strengths and uniqueness^{67 68}. The particular nature of these barriers also illustrates the need for policy specific to the issues faced by minorities with disabilities. Current policy, such as the NZDS, specifically targets some of these barriers, such as use of Te Reo Māori and the number of Māori staff.

Though barriers may be easy to identify, their removal proves more challenging, often requiring a change not only in policy but in attitudes – namely, a revamping of the dominant model of disability⁶⁹. Additionally, changes must take place in how health providers and government agencies view Māori communities. As Voyle and Simmons note, these groups must learn to complement and reinforce, instead of trying to replace, the skills, knowledge and other resources already present within a community.

Providers also need to listen to and acknowledge the requests and preferences of those seeking their services. Māori with disabilities have reported desiring services with qualities such as encouragement of autonomy and self-determination, a rights-based rather than a charity-based approach, the inclusion of Kaupapa Māori into organizations; appropriate indicators and measures; quality information collection; client participation; caregiver/case manager participation; whānau participation; appropriate use of the Māori language; links with Māori institutions; consistency; workforce composition and sensitivity; assessment procedures; consultation, and; Māori specific factors⁷⁰.

There exists in the current literature an extensive discussion of a paradigm for the provision for culturally appropriate services to Māori with disabilities. Ratima et al.⁷¹ outline 3 cornerstones

underlying the philosophy of culturally appropriate disability support services for Māori:

- 1) Te Ha o te Tangata (Respect for clients): emphasis on client, care giver and whānau-directed service decision making and delivery; services designed to be the least disruptive and limiting to the client's lifestyle; services that encourage participation in the community and in Māori society, and; services that develop the client's skills and abilities.
- 2) Te Herenga Tangata (A community-focused approach): raise the level of awareness of needs of Māori with disabilities in Māori communities; services should provide initiative to encourage whānau participation (at with consumer determining level of whānau involvement); support service providers must form links with Māori institutions that often serve as a source of "identity, self-determination, and empowerment"⁷²
- 3) Whakapakari Māori (Workforce profiles): health service workers who are both professional and culturally capable; workforce competency that is measured in terms of cultural effectiveness; and the services that demonstrate a continual understanding of Māori perspectives.

Nikora et al.⁷³ additionally lay emphasis on a model of service delivery for Māori that recognizes:

- how households configure, live and respond to a disability and whānau member with a disability
- the nested, social and dynamic nature of households
- environmental, attitudinal and institutional barriers and facilitators
- the underlying philosophical determinants of health, attitudes, support and service delivery, and
- the living nature of disabilities (i.e., how disabling conditions intimately link to the lifespan)

While the above discussion demonstrates that frameworks regarding the service development and implementation for disabled Māori exist, questions remain as to whether or not current policy effectively utilizes this information. The cornerstones described by Ratima et al.⁷⁴ provide a starting point for the development of indicators and measurements, while the model discussed by Nikora et al.⁷⁵ could be developed into a broader strategy for service delivery for disabled Māori. These are, however, initiatives that have yet, as of the time of this review, to be undertaken at a government or service sector level.

INTERSECTORAL COLLABORATION

Multiple definition of intersectoral collaboration can be found in the current literature^{76 77}. A common feature, however, is the focus on the activities or processes in which agencies become involved when working together rather than separately. Though intersectoral collaboration is often characterized by difficulty and failed attempts, it is quickly becoming a more common fixture in the structure of government policy and programming. In fact, Farmakopoulou⁷⁸ argues that collaboration is not only an organizational necessity; it is a human one as well, as it is inherently tied into the behaviour and attitudes of the people who comprise the organizations involved.

Still, successful intersectoral collaboration has its gains. Benefits include the increase in agency capacity to address increasingly complex health and social problems; increase in the in pool of resources and in the effective use of those resources; development of networks; creation of innovative programs, policies, and strategies; reduction in the duplication and unnecessary overlap of services⁷⁹. IOG⁸⁰ also notes, with caution, that, potentially, intersectoral collaboration may positively contribute to Māori health development, as it fits well with the traditionally holistic Māori approach to health issues.

In addition to process, definitions of intersectoral collaboration emphasize the difficulty in achieving successful collaboration⁸¹. Current literature acknowledges none too often the difficulty and occasional failed attempts at interagency and even intra-agency collaboration^{82 83 84}. Barriers to effective collaboration include, but certainly are not limited to:

- differing legislative frameworks between agencies;
- the use of different terminology or differences in how key concepts are defined; lack of commitment;
- lack of communication and information sharing;
- lack of time for collaborative efforts; lack of sustained availability of key people, and;
- a lack of understanding of other agencies' policies

Ahuriri-Driscoll and Pitama⁸⁵ note that success or lack thereof of intersectoral collaboration often depends on certain variables, such as variations based on who the partners are; how the collaboration is governed; the focus of the collaboration; the types of activities pursued; and the operational level of the collaborative.

No single solution that will suit all projects facing the challenges inherent when facing inter or intra-sectoral structuring. However, as Johnson et al.⁸⁶ so diligently note, "Successful collaboration does not happen by accident." Problems should be anticipated and plans drafted ahead of time in order to effectively address them. One must keep in mind, though, that effective collaboration cannot compensate for poor quality services⁸⁷.

Common features of successful collaboration, however, do exist. Current literature on the subject^{88 89 90 91} provides a broad range of these traits, including:

- recognition that agencies share similar outcomes and a common vision;
- alignment of statements of intent;
- increase and improve accountability structures;
- use of the same “language”;
- leadership and political support;
- sufficient time;
- adequate resources;
- development of appropriate evaluation and cultural skills;
- provision of incentives or consequences for cooperative and uncooperative behaviour;
- divergent funding streams, and;
- sensitivity to the unique culture of agencies involved in collaboration.

Existing discussions regarding issues of policy have increased focus on the interaction between key actors and organizations. Given the wide and varied range of impact of disability, it is reasonable to conclude that effective policy creation and implementation requires successful collaboration across sectors. It seems that health and disability policy in particular mandates the interaction of government sectors in order to effectively address issues affecting IPWD. Intersectoral collaboration, in this context, is almost inevitable. For example, the creation of the NZDS led to the establishment of an agency designed to oversee the policy’s implementation across government. ODI’s very existence demands intersectoral collaboration in the New Zealand government. Indeed, it follows that a considerable amount of the success or failure of the policies discussed in this review depends greatly on the success or failure of government sectors to work collaboratively.

CONCLUSION

As the literature thus far has demonstrated, society is not homogenous. Service provision and disability policy, therefore,

should not be either. It is imperative that researchers, policy analysts, government officials and service providers take the time to address the unique needs of indigenous peoples with disabilities, to ensure the development of an approach to disability policy and service that is both effective and culturally appropriate. Otherwise, we merely perpetuate a dual-level of discrimination and exclusion experienced by an already vulnerable population.

The developing paradigm for the Māori in New Zealand holds the potential to change the manner in which society defines both culture and disability. As government and policy continue to change and adapt, the lasting legacy of the disability movement amongst the Māori has yet to be seen. Despite its seeming insignificance, it may turn out that the activities and developments taking place in a small island nation in the Pacific may someday impact the larger surrounding world.

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CULTURAL IDENTITY AND MENTAL HEALTH

Stephen Pomedli

Stephen Pomedli was part of the Harvard Medical School exchange programme and was hosted by Te Mata o te Tau in 2007

“The strong emotions and thoughts that come about by feelings of being trapped between two cultures are factors in anxiety disorder, depression, suicide attempt and other more serious mental illnesses”¹

“Like all cultural identities, Aboriginality is ... rooted in forms of life that exist at the confluence of historical currents and contemporary forces ... Aboriginal peoples are engaged in an ongoing process of re-articulating themselves in the modern world in ways that honour their ancestors, maintain links with crucial values, and creatively respond to the exigencies of a world simultaneously woven together by electronic media and riven apart by conflicts of culture and value”²

INTRODUCTION – CULTURAL IDENTITY AND MENTAL HEALTH

Throughout the world, indigenous peoples live within complex cultural environments, presenting an ongoing challenge for these indigenous communities to maintain their ancestral culture and

adapt it to contemporary realities. At an individual level, this challenge also involves the process of enculturation - forging an indigenous cultural identity within the context of one or several surrounding, and usually dominant, cultures. Because of the complexity of these multicultural settings with differing and often conflicting values, ideas and modes of thought represented by different cultures, navigating this intricate milieu and forming healthful and viable cultural identities can be a significant challenge. This is especially important for indigenous health as limited formation of appropriate cultural identities has been associated with psychological distress and with greater rates of mental illness among indigenous persons³.

In New Zealand, Māori have navigated this complex cultural landscape in different ways, embracing “traditional” culture or accepting western culture to varying degrees. Results from *Te Rau Hinengaro* the New Zealand Mental Health Survey⁴ show that the self-identifying Māori population shares a disproportionate burden of mental illness, in comparison to the non-Māori population. Much of this excess is explained by the youthfulness of the Māori population and some of the excess is accounted for by socio-economic disadvantage. Nonetheless even after taking account of age, sex, education and household income the prevalence of substance use disorder is about twice that for *Others* (non-Māori, non-Pacific) and there appears to be a higher prevalence of bipolar disorder. Thus, there is a need to further characterise this possible association between Māori identity and mental health and provide a framework for understanding this relationship. Issues surrounding self-identification and indigenous cultural identity will be discussed here and applied to an analysis of *Te Rau Hinengaro*.

SELF-IDENTIFICATION

Categorizing individuals as “Māori” has historically been achieved in various ways, including assessing blood quanta and applying questionable racial judgements. More recently, the definition of being Māori has come to primarily involve self-identifying as a Māori individual. Self-identification has increasingly been recognized as a critical component in assessing cultural identity as it avoids external imposition of cultural labels which can often be incorrectly assigned, and which may or may not in fact reflect the reality of the individual’s experience. Further it bestows the powers of self-definition upon the individual and the community such that cultural identity can be determined from within rather than without. As Weaver suggests in her analysis of Native American cultural identity, “[while it] makes sense that a community should define its members, it does not make sense for an external entity to define indigenous people”⁵.

Self-identification is particularly important as recent demographic surveys of the New Zealand population have shown that while 643,977 claim Māori descent a lesser number, 565,329, identify as Māori⁶. While an assessment based solely on ancestry would label these individuals as “Māori,” this would neglect the fact that there is clearly something about these individuals’ experience that distances them from aspects of their ancestral culture. This makes categorizing data from this group a delicate manoeuvre for research purposes. That is, from a mental health perspective, these individuals who do not identify with their ancestry may have patterns of health that align more closely with the non-indigenous culture with which they identify if lifestyle patterns and the greater social environment are the more critical factors influencing mental health. Conversely, it may be the case that despite not identifying as Māori, the patterns of mental illness in these individuals may align more closely with those of

their ancestral cultural group if intrinsic susceptibilities or other factors, such as cognitive vestiges of a shared history of colonialism or socio-economic disadvantage, are dominant influences on their level of health and well-being.

BICULTURAL ASSESSMENT SCALES

Utilisation of self-identification becomes more complex for other reasons as well. For example, individuals may self-identify as part of one or more cultures simultaneously: Chapple⁷ reports that in the 1996 census in New Zealand there were “250 388 New Zealanders who identified as members of another ethnic group, usually Pākehā/European, and also as Māori.” Without using cultural identity scales, such as the acculturation or bicultural assessment tools, to assess the weighting of these multiple affiliations (ie. whether one identifies more strongly as Pākehā than Māori, despite self-identifying with both cultures), it is difficult to ascertain with which group these individuals should be classified, or if they should be categorized as a separate group in order to acknowledge this dual influence. [Acculturation is usually understood to be a measure of “streamlining into dominant society” while enculturation examines the “lifelong learning process of cultural awareness and understanding”]. When dealing with those that identify with both “majority” and “minority” cultures, such as both Pākehā/European and Māori, the precedent has been to focus primarily on their “minority” identity, even though the individuals in question often may identify more strongly with the majority culture.

These assessment tools and identity scales are often applied to indigenous populations in order to categorise the diverse ways in which an individual may identify with the introduced majority culture (usually Western/European) and the antecedent indigenous minority culture. For example, Berry et al.⁸ proposed a four-category classification according to whether the

respondent identifies as part of majority culture, minority culture, both, or neither. Along similar lines, in discussing Native American ethnic identity, Garrett and Pichette⁹ employ a scale of cultural identity which locates individuals along the spectrum from “monocultural-traditional” to “bicultural-aculturated” to “monocultural-assimilated,” with so-called “danger zones” in between.

Regardless of the exact scale or system used, it is important to recognize that there are numerous ways in which each of these putative categories of differential cultural affiliations, whether on a spectrum or in more discrete categories, could have both positive and negative impacts on mental health. For example, an individual that identifies strongly with two different cultures has two complete cultural networks with which to interact and find support, and could potentially derive the respective benefits of engaging with dual sets of cultural institutions and social structures. However, there is also the potential that the world views and cultural values of these two cultures may be at odds, resulting in uncertainty and ambiguity for an individual at the interface between two cultural paradigms. This trade-off thus manifests as extensive support simultaneously present with potentially conflicting values.

When an individual identifies solely as a member of minority culture, they would tend to maintain alignment with ancestral values and remain positively connected with their family, indigenous community and cultural support base. However, this can be challenging if, because of limited engagement with majority culture, one finds it difficult to participate in necessary aspects of majority society, and are subsequently ostracized or alienated from mainstream systems or institutions (e.g. social, educational or legal institutions). This is also worrying when these individuals find it difficult to maintain their identity because of reduced access to meaningful cultural interactions,

ancestral land or language opportunities. Further, this can be further exacerbated by an uncertainty in adapting traditional patterns to the inevitable influences of majority culture, as well as the cognitive effects of implicit or explicit racism. This challenge of acculturation is often faced by immigrant populations with some studies showing increased rates of depressive and anxiety disorders in these populations¹⁰. Thus, this dichotomy centres on the support through continuation of cultural participation in opposition to the challenges of adapting minority culture to inevitable and potentially hostile external forces.

If an individual only identifies with the majority culture and is unable to identify with one's ancestral culture, this may result in a critical disconnect between the individual and their whānau, and the other related support structures of their culture. Further, it must be acknowledged that participation in majority culture also includes exposing oneself to many of the pressures and challenges of contemporary Western society that can also lead to mental health issues. On the other hand, acquiescing to the surrounding society could also provide a new support network and interactional potential to protect against mental illness. In this case then, there is the balance between the putative benefits of acculturation into majority society and weighed against the distancing from ancestral culture and the exposure to new pressures of contemporary majority society.

Finally, it is possibly that individuals, when developing within an environment of multiple cultures, may come to have little identity with either the majority or the minority culture, with an inability to interact with or synthesise salient values from either culture. While there is clearly a minimal risk for cultural clash or conflict of values in this case, there is minimal support for the individual from either structure/system; it is usually hypothesized that this state of negligible cultural identity is most

likely to be associated with increased rates of mental illness for this reason.

COMPLEXITIES OF SELF-IDENTIFICATION

Self-identification can be a complicated measure because cultural identities tend not to be static and fixed, but rather tend to be rather fluid, varying based on context and setting. Statistics New Zealand (SNZ) acknowledges that “People in New Zealand, as in other countries, may change the ways in which they identify themselves over time or they may identify themselves differently in different environments”¹¹. Some longitudinal studies have found striking variations in self-report of cultural identities over time, even when questionnaires are administered in similar circumstances: “whether an individual opts in as Māori may vary, dependent on who’s asking, the nature of the question, their self-image, societal pressures, and the expectations of those important to that individual”¹². SNZ suggests two ways in which this might occur. One type of variation, termed “ethnic mobility,” recognizes that individuals may identify with one culture in certain aspects of their lives (e.g. behaviour) or during certain activities, but identify with another culture in other ways or circumstances (values, social circles, etc.). Similarly, significant life events such as location, relationship or career changes may also impact one’s self-reported identity. Thus this fluctuation may occur in the short the long term, or both. This is further complicated by variations due to context and understanding, such that how self-identification data is collected or, the “perceived purpose of the data” may influence how one responds to questions of cultural identity. Thus it is important that this potential variability in responses, either due to ethnic mobility or context effects, be acknowledged when considering issues of internal and external validity in mental health studies which rely on self-identification.

Further, while self-identity is the current “gold standard” for measuring cultural identity, the measure can also raise certain issues when an individual self-identifies as an indigenous person but may appear to be substantially disconnected from discernible indigenous practices or, perhaps more importantly, their indigenous community. That is, if an individual has little substantive engagement with their indigenous community or aspects of the culture that have been understood to be central or defining, some debate whether their self-identification can be considered truly valid.

Pool¹³ further suggests that “those persons of Māori descent with no day-to-day link with Māori cultural life, and who are thereby excluded from the Māori population may find themselves discriminated against by other Māori whose own whanau experience has been one of continuous involvement within the Māori community life”¹⁴. Consequently, those Māori with continuous involvement may assert that “unless someone is brought up as a Māori, their beliefs, values, and responses will always be those of Pākehā, despite any self-transformation that may occur in adulthood”¹⁵. This is a significant challenge to self-identification, as it is difficult to determine whether an individual’s self-identification as part of a group can be validated if this same group cannot endorse this individual’s identity.

In response, some authors have suggested that this underscores the fundamental difference between two different levels of cultural identity: an unalienable individual or internal identity that is entirely self-determined, based on “knowledge of values and history, moral sense of obligation, and affective attachment to the group”; and an observable group or external identity, resulting from “observable social and cultural behaviours such as language, participation in ethnic functions, observance of ethnic traditions” with identity and membership defined by the group itself¹⁶. Further complicating the issue is the fact that external

factors (such as one's appearance) might similarly influence the manner in which identity is assigned or interpreted. While there necessarily is an important relationship between these two types of identity, this perspective would allow for the validity of self-identification independent of group participation, acceptance, or identity. However it still remains open to question whether this group identity is an important higher level of individual identity, such that the individual identity relies on the existence of a group identity in order to be fully actualized.

Self-identification remains the most important single measure of cultural identity, but it is necessary to recognize these ways in which it is complicated by the intricacies of dynamic and fluctuating identities, multiple cultural affiliations, and self-identification in the absence of substantive cultural participation or group endorsement. Thus, in the context of indigenous mental health, it is important to explore other potentially complementary measures relating to culture and identity in order to further investigate this complex relationship.

DIVERSE REALITIES

Previously, assessments of Māori culture have focused primarily on so-called “traditional” Māori activities and knowledge sets, collecting data based on a priori assumptions of what it meant to be Māori and engage in the Māori cultural experience. This use of assumptive measures becomes problematic when, for an example, an assessment tool of cultural identity might deem an individual to be less-than-fully Māori, despite the fact that the individual feels completely Māori and in no way compromised. This discrepancy has arisen, in part, because these types of assessments have in some ways become less applicable to the realities of modern-day Māori people, many of whom are in some ways removed from aspects of this “traditional” Māori culture, yet still maintain a sense of being fully Māori. As Durie

et al. explain, “assumptions about what constitutes a Māori cultural identity have tended to be based on “traditional” values, or at least on popular perceptions of a Māori identity. Often these have been romantic constructs ... bearing little relationship to common Māori experience”¹⁷.

Thus the trend has been to move away from this linear spectrum which tends to simplify the indigenous experience, placing it at the abutment of two sets of dichotomous cultural forces. The nascent perspective acknowledges the inherent complexity and multifactorial nature of the indigenous experience, moving towards a multidimensional model which accommodates the diversity of the various forces intrinsic to the complex cultural landscape of contemporary society: “rather than determining where someone fits on a continuum between two cultural identities or worlds, it may be more accurate to say that indigenous people live in one complex, conflictual world”^{18 19}. [Though it should be noted that not all aspects of this complex world need be conflictual.]

In New Zealand, this understanding of the breadth of indigenous experience has been extensively discussed by Durie, referring to this multiplicity of lifestyles, values and experiences as “diverse realities”: “Far from being homogenous Māori individuals have a variety of cultural characteristics and live in a number of cultural and socio-economic realities. The relevance of so-called traditional values is not the same for all Māori, nor can it be assumed that all Māori will wish to define their identity according to classical constructs.” In a similar vein, Brown²⁰ echoes this contemporary diversity when describing the experience of Australian Aboriginals, suggesting that “Indigenous Australians have a wide range of lifestyles, and social, cultural, educational, and family backgrounds. What is true of one Indigenous person or group is not necessarily true of another person’s values and lifestyle.” This perspective shift

necessitated the need for a new means of measuring Māori identity and Māori culture, as “most frameworks used to describe Māori have been of a single dimensions stressing links with traditional knowledge and skills but failing to capture the range of activities, lifestyles, and multiple affiliations which characterise Māori people in modern society.”

In response to the need for a more contemporary understanding of Māori culture and cultural identity, the Te Hoe Nuku Roa framework²¹ was developed in order to move beyond this single-dimensional perspective of the Māori experience. This framework uses longitudinal observation of Māori households to “produce a comprehensive empirical base of information that reflects the actual circumstances and aspirations of Māori at household and personal levels”²². This represents an important shift away from the use of scales and measures based on normative or idealized notions of Māori-ness towards more descriptive measures based on observations and understanding of contemporary realities, and will be critical in establishing what defines and is unique to Māori people today.

SATISFACTION AND EXPERIENTIAL MEASURES OF ACCESS, COMPETENCE AND PARTICIPATION

The Te Hoe Nuku Roa classification of Māori cultural identity moves beyond simple self-identification. Importantly, it examines this cultural self-identification in combination with the level of one’s access to and participation with Te ao Māori. According to the framework, individuals who identify as Māori may have a “secure,” “positive,” or “notional” identity based on whether they have good, limited, or no access to te ao Māori, respectively. Further, a fourth category (“compromised identity”) is utilised, representing those individuals who have good access to te reo Māori, land, and whānau but nonetheless do not self-identify as Māori. [This is similar to the categorisations utilised

by the acculturation scales discussed previously, but importantly this scale utilises a Māori-centric focus and examines Māori identity as it relates to their participation and engagement specifically with te ao Māori]. In regards to mental health, the most plausible and parsimonious hypothesis generated from this categorization would suggest that among those self-identifying as Māori, those who have least access to Māori cultural engagement and Māori cultural capital might have the highest rates of mental illness.

However, there may be reason to utilise an experientially-based measure of cultural access and participation which goes beyond that employed by the Te Hoe Nuku Roa framework. In examining the relationship between participation in cultural norms and mental health outcomes, Dressler et al.²³ have investigated what they term to be “cultural consonance,” being “the degree to which individuals, in their own beliefs and behaviours, approximate widely shared cultural models.” The authors found that low levels of cultural consonance were associated with psychological distress and poorer mental health in general, suggesting that one’s *satisfaction* with the manner in which one interacts with the cultural surround may have an important causative impact on mental health. It might therefore be hypothesized that because the individual may not have complete control over the ways in which this cultural interaction takes place, this can lead to chronic stress and feelings of helplessness and distress, due to an “inability to act on a [cultural] model ... what this means is that for some people, in some circumstances, there will be a gap between their knowledge of what is culturally prototypical and what they themselves are doing.” This cultural dissonance resulting from interactional inability can lead to chronic anxiety and stress, and have an important impact on mental health.

Therefore, rather than simply measuring an individual's degree of access to te ao Māori, knowledge of Māori culture, or their level of engagement with Māori individuals and activities, it may be most important from a mental health perspective to explore how an individual *experiences* this level of knowledge and participation. In essence, this would examine the individual's degree of satisfaction with their participation with and access to salient aspects of Māori culture. That is, it could be hypothesized that irrespective of how one identifies as Māori, it may be most important, when examining mental health outcomes, whether the individual is content with their level of cultural participation or whether they are discouraged by their limited ability to participate in aspects of their ancestral culture, due to access issues or otherwise.

For example, a contemporary self-identifying Māori individual might only have a moderate degree of te reo Māori proficiency and use the language on an occasional basis; nonetheless, this individual might be content with this level of proficiency and the frequency of their engagement with the ancestral culture in this manner. Because of this satisfaction with their cultural competence and participation they would be hypothesized to be of lower risk for mental illness among those self-identifying as Māori. However, according to other frameworks, their limited cultural contact would, based on other assessments, in fact predict the opposite, ie. that they would be at higher risk for adverse mental health events.

In contrast, another individual could have the same "moderate degree" of language proficiency, but be unsatisfied with this level of language acumen, and desire more frequent opportunities to engage with others using conversational Māori. In this case, the dissatisfaction with one's inability to participate more fully in these activities to the degree that one would desire has the potential to adversely affect mental health outcomes,

due to this lack of cultural consonance, and the related feelings of frustration, disconnection from Māori culture, and loss of control, which can ultimately lead to more serious outcomes such as anxiety and depression. This experiential type of measure may be useful in teasing out the underlying differences among individuals that, according to other measures of culture or identity, are overtly similar, yet have very disparate cultural motivations and experiences. Thus a measure such as may be able to make this potentially important discrimination between seemingly similar individuals, in order to discover the subtle interactions and causations among culture, identity and mental illness.

This sort of measure could also have other importance uses. If the putative correlation is borne out, levels of satisfaction with cultural participation would not only be a predictive and explanatory measure of mental illness, but would also act as a prescriptive means by which rates of mental illness could potentially be reduced. That is, by ensuring ready access to opportunities for cultural engagement for all Māori, especially those that feel inexorably estranged from te ao Māori, one may be able to subsequently reduce prevalence of anxiety and depressive disorders among Māori to levels more consistent with levels found in the rest of the New Zealand population.

TE RAU HINENGARO, THE NEW ZEALAND MENTAL HEALTH SURVEY

The objectives of this national survey were to estimate the prevalence of major mental disorders in the New Zealand population, as well as Māori and Pacific populations. For the Māori population, cultural markers were also collected, with the aim of analyzing them in relation to the prevalence data obtained by the survey in order to further assess on the relationship between self-identification, Māori culture, and mental health.

The Māori-centered questions in *Te Rau Hinengaro* asked about: ancestry, self-identification, knowledge of iwi, rohe, waka, and whakapapa, marae participation, whānau involvement, and te reo Māori abilities. However, there has been uncertainty as to how exactly the Māori cultural data should be examined with reference to the mental illness results. In similar situations, some investigators have chosen to pool all the measures in order to produce a single measure of “Māori-ness” (e.g. Stevenson). However, when using this specific data exclusively, this runs the risk of acknowledging only traditional measures of Māori culture as valid, and may not fully recognise the importance of the other aspects of what it means to be Māori in the 21st century. Further, a simple pooling of the measures inherently involves making numerous assumptions as to how to weigh each of the individual measures when calculating the compound measure. Therefore, there may be an advantage to examining specific sets of the cultural markers collected and examining their relation to each other, in order to arrive at measures which, within the limitations of the data collected, reflect more of the diversity of Māori identity.

In relation to mental health, the two questions collected regarding the importance of whānau to the individual and the strength of “whānau links” may be of interest, as some studies have reported supportive family structures as protective factor against mental illness²⁴. Family support has often been cited as one of the most important of these protective factors and critical for recovery, in non-specific and indigenous populations alike²⁵²⁶²⁷. In Māori populations, Pere has suggested that certain whānau support may be critical not necessarily in preventing mental illness but rather in facilitating recovery. However, this may be difficult to distinguish in the *Te Rau Hinengaro* as this is a prevalence study, and speed of recovery cannot be discerned. It is important to also note that the quality of and type of relationship that the individual has with the whānau is likely

critical to the observed effect on mental health, as deleterious relationships can be partly causative in mental illness or slow recovery. While the study does not specifically query the quality of the family relationship, the question addressing the “strength of links” may be cautiously used as a proxy for this (with the assumption being that “stronger links” indicating a more healthy and supportive relationship). Thus it may be interesting to explore the effect of family support on Māori mental health in this way, and investigate what role this factor contributes significantly to the increased burden of mental illness observed among Māori in this study. It would be hypothesized that decreased role of the whānau or weak links within the whānau itself would be predictive of poorer mental health outcomes. However it could also be that poor mental health could lead to breakdown in whānau relationships. While there is retrospective reporting of age of onset for mental health disorders in *Te Rau Hinengaro* only current involvement with whānau is reported, so that it is not possible to look at the causality which probably operates in both directions.

The other set of cultural markers collected that might provide interesting insight into the relationship between Māori culture, identity and mental health relates to language ability and use. The items in *Te Rau Hinengaro* related to language require the interviewees to self-assess their skills with day-to-day speaking, reading, writing, and speaking comprehension skills, rating them on a scale from “No more than a few words or phrases” to “very well”. In the absence of other markers commonly used to assess implicit cultural identity (peer association, music choices, media preferences, etc.), language might serve as a useful (while not perfect) proxy independent of self-report. This is because language, unlike overt behaviours or explicit knowledge, when used in thinking and speaking processes has unique cognitive access and consequently has the capacity to entirely shape one’s experiences, behaviours, perspectives and world view: as

Westermeyer and Janca explain, “lay terminology regarding subjective experiences and perceptions is strongly tied, through language, to cultural values, attitudes, norms, beliefs, and customs”²⁸ and many suggest that culture cannot truly exist without language²⁹. This is especially relevant as te reo Māori is unique to and distinct within the Māori world, and thus may be especially useful in measuring cultural identity. [Some individuals have even asserted that “If you do not speak Māori you are not Māori”^{30 31}].

Therefore, an interesting analysis of the *Te Rau Hinengaro* data might examine the relationship between Māori language abilities, using a combination of the 4 items obtained, and mental health outcomes. An option would be to look at the relationship between ability in Te Reo (for example) and the mental health of individuals that self-identify as Māori. In the absence of collected information which could better inform a measure of identity, this type of analysis would offer a unique opportunity to examine a variable of cultural interest (such as Te Reo) and to consider what possible relationship to mental health, if any, exist.

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INDIGENOUS RESPONSES TO HEALTH AND DISEASE

Principles, goals, and pathways

Mason Durie

This paper was first presented at the Thoracic Society of Australia and New Zealand Annual Conference in March 2007 at Auckland

DR HARRY WUNDERLY

The Wunderly Oration is a tribute to Dr Harry Wunderly who died in 1971 after a lifetime of devotion to the eradication of tuberculosis in Australia. His efforts inspired thousands of others and in the process generated a health movement in Australia that would lead to huge gains in the health status of the nation. In his roles as doctor, public health promoter, benefactor, mentor, educator and pioneer chest physician he energised the profession and the nation in a way that would eventually see a major breakthrough in the management of chronic disease, especially tuberculosis.

Although tuberculosis remains a global health problem, especially in developing countries, and in Eastern Europe and Asia where multi-drug resistant TB is common enough to

warrant a global response¹. the problem in Australia and New Zealand is largely contained. If tuberculosis has not been entirely eradicated then it no longer has the endemic dimensions that threatened survival in many communities during the nineteenth and twentieth centuries.

DR MAUI POMARE

Another physician who had a similarly distinguished career was Maui Pomare who graduated from the American Medical Missionary College in Chicago in 1899 becoming the first Māori medical practitioner. His contributions were not unlike those made by Dr Wunderly insofar as he sought to eradicate tuberculosis and galvanised public support for health programmes². After returning to New Zealand, Pomare was appointed to the new Department of Public Health in 1901 as Māori Medical Officer. His duties included 'visiting the natives in their villages; inquiring and investigating into their general health; the conditions of water supply; and the enlightening of the native mind by means of lectures on all points concerning sanitation and hygiene and any social questions materially affecting the welfare of the race'³.

Pomare was quick to recognise that health could not be detached from a wider environment and collaborated with community leaders for the endorsement of health and hygiene programmes. Taking advantage of the Māori Councils Act 1900 which had established Māori councils in several regions throughout the country, he worked with all the Councils assisting them to identify potential and actual problems and lending his medical knowledge and skills to create solutions. He then appointed and trained tribal leaders as Māori sanitary inspectors to monitor health status, water supplies, sanitation, and food hygiene. In his view the leaders of health were not necessarily doctors or nurses, but community leaders who could use their influence and

wisdom to alter lifestyles and effect gains in health. Their efforts contributed to the virtual eradication of diseases that ravaged Māori communities in the late nineteenth and early twentieth centuries, at least as major causes of death and disability; malnutrition and infectious diseases especially tuberculosis, typhoid, and diphtheria have largely been consigned to history.

HEALTH GAINS AND THREATS

Another measure of health gains can be found in Māori demographic transitions. In 1800 the estimated population was 200,000 but by 1894, and for a variety of reasons, it had dwindled to 42,000. However, by the turn of the century the decline had been arrested to be followed by an accelerated rate of growth so that by 2006 there were in excess of 565,329 Māori or 15% of the total New Zealand population⁴. Because the population is relatively youthful with a median age of 22.7 years, high rates of growth can be predicted to occur for four or more decades. As a result, by 2051 around one-third of all New Zealand school children will be Māori.

Gains can also be found in mortality rates and life expectancy. Infant death rates as high as 94 per 1000 live births in 1929, had reduced to 54 per 1000 by 1959 and to 18 by 1991. Similarly Māori life expectancy increased from 33 (for males) and 30 (for females) in 1903, to 66 (for males) and 71 (for females) in 1996, and to 69 (males) and 73.2 (females) by 2002.

However, although the management of disease owed much to medical interventions, it was also boosted by better understanding of the environments within which people lived – damp and overcrowded housing, inadequate diets, inter-personal contagion, distance from amenities and services, and often attitudes of resignation. Those conditions continue to constrain the lives of some communities, but Māori and Australian

Aborigines are now also confronted by a new set of social, physical, and economic environments that are also hazardous to health.

Contemporary health problems now include sudden infant death syndrome, injury, diabetes, cancer, heart disease, chronic obstructive pulmonary disease, asthma, bronchiectasis, and mental health disorders⁵. A survey of 12,992 New Zealanders, for example, containing a sample of more than 2,500 Māori participants, concluded that Māori were over-represented in most categories including depression, minor anxiety disorders, and alcohol related disorders⁶.

DISPARITIES

Although Māori health status has improved over time disparities in standards of health between Māori and non-Māori remain. Over the past two decades the disparities may even be growing. In the twenty years between 1980 and 1999 mortality rates for Māori men increased from 1.48 times higher than the non-Māori rate to 1.74 times higher, while for Māori women the disparity rose from 1.96 to 2.20. Similar trends can be observed for Pacific peoples living in New Zealand.

Ethnic disparities in life expectancy have also increased. While Māori male life expectancy increased from 64.6 years to 65.8 years in the twenty years between 1980 and 1999, non-Māori male life expectancy increased from 70.9 years to 75.7 years, a gain of 4.8 years compared to the Māori gain of only 1.2 years⁷. By 2000-2002, however, Māori life expectancy had increased even further to 69 years for males and 73.2 years for females and there were signs that the gap (*vis a vis* non-Māori) was decreasing, from 9.1% (in 1995/97) to 8.5% (by 2002)⁸.

MĀORI HEALTH RESPONSIVENESS

In a climate where there is both cause for celebration of achievements over the past century, coupled with concerns about disparities and the emergence of new epidemiological patterns, there has been active Māori participation in addressing health problems. The Māori response, at least since 1990 has evolved around a series of principles, goals and distinctive pathways.

Principles

A number of principles underlying successful engagement have been identified but three are especially important for health outcomes: indigeneity, dual competence, and human dignity.

The principle of indigeneity takes into account the determination of indigenous peoples to retain their own distinctive cultural identity, avoid assimilation and exercise a degree of autonomy. This principle goes beyond cultural recognition to claim a special place for indigenous peoples in the life of the nation. The principle of indigeneity does not mean other cultures should not also be duly recognised in health care, but it does acknowledge a unique position for indigenous peoples.

Dual competence refers to competence in both clinical and cultural dimensions. Māori as much as other New Zealanders expect that they will have access to new technologies and developments benchmarked against the best in the world. But there are also parallel expectations that health care workers will be competent at the interface between their own culture and the culture of others. Language barriers, differing codes for social interaction, variable community expectations and a willingness to involve friends or families in assessment, treatment and rehabilitation make important differences to the way care is experienced.

A third principle, human dignity, is concerned with the process of care. Health interventions that do not afford due respect for human values, cultural world views and differing health perspectives, will undermine dignity and diminish self respect. Technology and cost containment do not replace human values as the marker of quality. In an outcome-driven environment, health care must also be concerned with processes, the ways in which technology is applied, and the regard which doctors have for their patients.

Goals

As steps towards the overall aim of improved Māori health outcomes, four major goals have been identified: the promotion of healthy lifestyles, equitable health outcomes, reduced socio-economic disparities between Māori and non-Māori, and self determination and self management.

The promotion of healthy lifestyles recognises the importance of families as vehicles for healthy lifestyles and the significance of a strong cultural identity as a foundation for health. The link between cultural certainty and good health has been well described and many indigenous health programmes have been developed around strong cultural practices. Community leadership coupled with expert advice regarding sensible nutrition, sport and exercise and the avoidance of known health risks such as tobacco, alcohol and drugs, have also been influential in effecting changes, even in communities where unhealthy lifestyles were endemic. Smoking uptake rates for Māori men for example have decreased and an increase in physical activity has occurred, especially for older Māori.

The goal of achieving equitable health outcomes recognises the disparities between Māori and non-Māori in respect of most disease categories. Co-morbidities occur with higher frequency in the Māori population and can diminish the prospect of equal

outcomes because of a cumulative effect. Equitable outcomes for health also require equitable access to services and funding arrangements which are based around results rather than processes, volumes or staff establishments. In current practice, outcome measurements are relatively unsophisticated, especially as they apply to indigenous peoples. While some outcome indicators are universal, and can be applied to all populations, in areas such as mental health there is a need to adopt measures that can reflect Māori perspectives, world views and values.

A third goal is to reduce broader socio-economic inequalities for Māori. Sub-standard housing, poor educational attainment, low incomes, unemployment, and reduced access to key societal institutions, all contribute to poor health⁹. There is now considerable evidence that while access to health services is one important determinant of health status, structural causes account for much of the increasing disparities¹⁰.

Self determination and self management represent a fourth goal that contrasts sharply with policies associated with colonisation - a known health risk¹¹. But Māori communities also recognise that self management requires access to information and technology, a level of expertise, and rather than absolute independence, opportunities to establish collaborative relationships with other Māori and with other health providers.

Pathways

Seven pathways have provided springboards for action to achieve Māori health goals: Māori health paradigms, health policies, Māori leadership, Māori development, health services that are responsive to Māori, coherent development with inter-sectoral collaboration, and dedicated Māori health research.

Māori Health Paradigms

A model of health known as Te Whare Tapa Wha was introduced in 1984¹². The models' appeal was based on its

holistic approach to health and the recognition of spirituality as a significant contributor to good health. Te Whare Tapa Wha was presented as a four-sided house, each wall representing one aspect of health – spirituality (taha wairua), the mind (taha hinengaro), physical health (taha tinana) and family and social relationships (taha whānau)¹³. Similar perspectives have been described for Australian Aborigines and Torres Strait Islanders¹⁴.

Health Policies

Since 1984 successive waves of health reforms have identified Māori health as a priority area. Current health legislation, the New Zealand Public Health and Disability Act 2000, makes it clear that district health boards must address Māori health and must recognise the Treaty of Waitangi in decision-making and priority setting. The Act also requires that health disparities be decreased by “improving the health outcomes of Māori and other population groups”.

For the most part, national policies for Māori health have obligatory consequences for district health boards which are required to report against progress made towards improved health outcomes for Māori and to indicate how their funding allocations have addressed Māori health issues. District health boards have generally responded positively though have not always found it possible to provide the levels of resource sought by Māori nor to reconfigure health service compliance requirements so that they align with Māori health perspectives.

Māori Health Leadership

Since 1899 Māori leadership in the health sector has owed much to a steady stream of Māori health professionals who maintained a small but significant presence within professions and health institutions. It was not until the mid 1980s, however, that new forms of active Māori leadership re-emerged, largely as a series of Māori health initiatives. At first the initiatives revolved around community liaison and health promotion and arose

largely because of perceived gaps in arrangements for formal health care. Community health workers were well versed in Māori values, familiar with local Māori networks and sufficiently aware of health systems to advocate on behalf of consumers.

The 1993 health reforms with emphases on deregulation, devolution and contestability, provided a further opportunity for Māori health groups to tender for the delivery of services, mostly in primary health care, disability support and mental health. Quite quickly provider organisations multiplied from as few as five or six programmes in 1984 to some hundreds of registered Māori provider organisations by 2006. Their approach was typically based on Māori perspectives. Sometimes, however, they simply employed conventional methods and professional staff, to the point of becoming indistinguishable from conventional services. Contracting regimes often squeezed Māori providers to trade cultural innovation for compliance and to use measures standardised against a wider ‘norm.’

But by 2002, when primary health care organisations (PHOs) were first established, the rapid growth of Māori health care providers meant there was a vigorous Māori health care infrastructure able to bring a dimension to health care that was not available in earlier conservative practices.

Workforce Development

Māori make up around fourteen percent of the total population but only five percent of the national health workforce¹⁵. Two broad workforce strategies have been used to increase levels of participation. First, efforts to recruit more Māori into the health professions have included affirmative action programmes. Initiated at the University of Otago in 1900 when two positions were created for Māori students at Medical School, the policy has since been extended to the Auckland Medical School and other tertiary educational institutions. There are now over 200

Māori medical practitioners across range of specialties. In addition scholarships have been offered as incentives to encourage enrolment in other disciplines such as nursing, social work, clinical psychology and pharmacy.

The second workforce strategy has been to engage cultural workers or Māori community health workers to work alongside health professionals, bringing first-hand knowledge of community and a capacity to engage diffident patients. Often the combination has been highly effective though there has also been concern that the two streams of workers – cultural and clinical – have created potential for professional and cultural interventions to diverge.

Health Service Responsiveness

Although the expansion of Māori health care organisations was rapid, most Māori people remain reliant on conventional primary and secondary care services. It was important therefore that the prevailing health system could respond in ways that would improve access as well as outcomes. The nursing profession responded by endorsing cultural safety, pioneered by the late Dr Irihapeti Ramsden, as best practice with greatly increased awareness of cultural difference as a factor in health care.

At a corporate level, the requirement to comply with Treaty of Waitangi obligations resulted in greater Māori representation on boards and committees, and formal links with tribal groups and Māori community organisations. Attitudes to care were also changed by the involvement of whānau (family) who advocated for more flexible visiting arrangements in hospitals and improved facilities to accommodate relatives who wished to stay close to their sick family member.

Coherent and Integrated Development

Economic restructuring in 1984 was accompanied by new approaches to Māori policy. Positive Māori development

prescribed a shift away from state dependency and a welfare mentality to a greater emphasis on self-determination, economic self-sufficiency, social equity, and cultural reaffirmation. It was to lead to a revitalisation of Māori language, greater confidence in tribal systems of governance and management, increasing entry in the commercial world, and the establishment of distinctive Māori provider organisations for the delivery of education, social services, housing, legal services and health care. Importantly, health initiatives were seen as integral to broader social goals as well as tribal economic development. In other words, despite strong sectoral traditions in government, an inter-sectoral approach was favoured by tribes.

Māori Health Research

Efforts to recognise Māori world views in research were greatly boosted in 1993 when the Health Research Council of New Zealand funded two Māori health research units and established a Māori Health Committee to support Māori led research projects. In addition a series of scholarships and training fellowships have enabled more than twenty Māori researchers to seek advanced research qualifications. Māori health research objectives are two-fold: to increase the Māori research capacity and to encourage the development of methodologies that reflect Māori world views and intellectual traditions.

Useful clinical applications have resulted. *Hua Oranga* for example is a measure of outcome designed for users of mental health services. Based on a Māori health perspective, it assesses outcome from a holistic viewpoint and includes ratings from clinician, client and a family member¹⁶.

RESULTS

Whether the new approaches to health care for Māori can be translated into health gains is a question of considerable

importance. Media reports have often claimed that, given continuing disparities in the health standards of Māori and non-Māori, the current approaches have been unsuccessful. It is a shallow analysis that fails to take account of the wider socio-economic context within which Māori live and it implicitly places an unfair burden on the health sector as a panacea for the ills generated within wider society.

Anecdotal evidence suggests that there have been demonstrable gains in some areas such as immunisation, smoking cessation, improved Māori self management of diabetes, asthma and hypertension. Of equal importance, however, is the degree to which Māori health awareness has been raised. Active participation within the health sector by providers, consumers or advisors has been accompanied by a level of enthusiasm that augers well for positive change. Nonetheless the full impacts of the new approaches to Māori health care need to be formally assessed.

A FRAMEWORK FOR CONSIDERING MĀORI HEALTH RESPONSIVENESS

The principles, goals and pathways that have evolved over the past two decades constitute the elements of a framework for considering best health outcomes for Māori. The framework can be represented as a matrix, the horizontal axis containing the four goals and the vertical axis containing three principles and six pathways.

The Indigenous Health Outcomes Framework, (Table 1) has been constructed on the basis of Māori experience over the past two decades. The several elements in the framework have positioned Māori to move forward with greater confidence and a clearer sense of direction than was evident in 1984 when the first Māori health conference was held¹⁷. The framework has also

allowed Māori aspirations for improved health outcomes to be addressed within the context of national health policies and strategies, policies for Māori development, Māori provider organisations, and district health board priorities.

Table 6.1 Indigenous Health Responsiveness Framework

Goals →	Healthy lifestyles	Healthy lifestyles	Reduction of socio-economic disparities	Self determination & self management
Principles <ul style="list-style-type: none"> • Indigeneity • Dual competencies • Human dignity 				
Pathways <ul style="list-style-type: none"> • Māori paradigms • Health policies • Māori leadership • Workforce development • Health services • Coherent development • Research 				

WORKING AT THE INTERFACE

It is clear that advances in indigenous health status will not come from any single strategy or from the health sector alone. Instead health gains will be linked to wider aspirations and a combination of forces that seek to combine social, cultural, economic and political dimensions. The goal of achieving good health is as much about improved standards of living as it is about healthy lifestyles and it looks forward to outcomes that are relevant to being Māori and consistent with a degree of independence and self direction. Of the several pathways that lead to good health, some depend on the policies and practices within public health services and in that sense are subject to government funding priorities. But others are within the reach of Māori individuals and collectives, and will depend on Māori leadership, Māori innovation, and holistic Māori services offered within a cultural context that resonates with Māori world views and contemporary Māori realities.

Moreover, though based on science and empirical evidence, medical effectiveness may also depend on being able to inject a large measure of humanitarianism and to acquire the capacity to read the environment, including the diverse cultural environments that underpin attitudes to health and health care. The study of human pathology and responses to pathogens needs to be balanced by an appreciation of the environments within which families live and grow, the insights that emerge from human experience over time, and the cultural understandings that give meaning to health and sickness.

Living and working at the interface between medical science and other bodies of knowledge, especially indigenous knowledge, will increasingly present new challenges – as well as opportunities - for doctors in Australia and New Zealand¹⁸.

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TE PAE HUARAHI

*The Implications of Te Pae Mahutonga
for Māori Health Development*

Te Kani Kingi

This paper was first presented as a Key-note Address at the Biennial “Te Matarau” conference in November 2007 at Gisborne.

INTRODUCTION

Thank you for providing me, once again, with the opportunity to present at the biennial Te Matarau Conference. I was fortunate enough to have been given an opportunity to speak at the previous conference in New Plymouth (on the west coast) and now on the east - here in the sunny Tairāwhiti.

Unlike my previous talk which was fairly flexible in terms of content and direction - I was provided with some very clear instructions on what I should talk about today and what might possibly be of interest and use to the audience. To this end, I was asked to consider the application and implications of *Te Pae Mahutonga* – which, as many of you will know, is framework developed by Professor Mason Durie, and which describes a Māori centred approach to health promotion¹.

As a framework, the strategy draws on many established and well-considered theories on health promotion, but is unusual in that it explores these within a uniquely Māori paradigm and indeed introduces concepts and ideas about health which are not always viewed (through western eyes at least) as being relevant or important. Health promotion, quite simply, is about empowerment and providing individuals and communities with the skills and knowledge to make healthy choices - to appreciate the determinants of health and in ways which enhance their personal and collective well-being².

TE PAE MAHUTONGA

Te Pae Mahutonga draws on the imagery of the southern Cross and has six dimensions or features – Mauriora, Waiora, Toiora, Te Oranga, Ngā Manukura, and Mana Whakahaere³.

In brief *Mauriora* highlights the relationship between Māori culture, tikanga Māori, and Māori health. It places emphasis on our ability to “live as Māori” and that health – from a Māori perspective at least, must include a cultural dimension. Indeed, and if we are not provided with the opportunity to “live as Māori” then our health will be compromised or at the very least, incomplete.

Waiora considers the role of environmental protection and sustainability to health. Within this is the notion that health should not be internalised or focused on the individual, but rather includes some consideration of how we interact with our surroundings, the environment, and the various relationships and connections which occur at this level. It is based on the idea that health cannot be sustained and unless our environment is similarly robust – free from pollutants, contamination, un-natural noise and even excessive human contact.

Toiora is important to Māori health in that it reflects on the impact of lifestyles and activities which are health-averse. Smoking, poor nutrition, sedentary habits, unprotected sex, alcohol and drug abuse, and risk taking activities all negatively impact on health. The unfortunate reality, however, is that these behaviours and choices are of particular concern to Māori and often explain (to some extent) the Māori predisposition to a whole range of contemporary health concerns.

Te Oranga considers our ability to participate in society and that health cannot be sustained and unless our relationships with society, our communities, and related institutions are positive. Indeed, these types of connections are often critical to health and well-being and by providing support, encouragement, and access to key resources and services.

Ngā Manukura is about health leadership and that health promotion in particular requires guidance at multiple levels. While technical, clinical, or professional qualifications are important for health leadership they are not, in themselves, prerequisites for a leader in health. If the history of Māori health development has taught us anything it is that Māori health leaders are drawn from many fields and often possess a range of skills which, while not always formally recognised, are nevertheless critical to effective health promotion⁴. Certainly, and if health promotion is about changing attitudes and modifying behaviours, then for Māori a dynamic skill set is required. One which recognises the role of community leaders and those best able to engage our people, to encourage healthier lifestyles and to ensure that key messages are understood and embraced.

The final component of *Te Pae Mahutonga* is *Te Mana Whakahaere* or autonomy. Emphasis here is placed on the requirement for local solutions to local problems. Frameworks

or policies which are developed at distance or with little appreciation of local issues are unlikely to impact effectively or in ways which matter or are sustainable. Māori health concerns are not easily addressed nor can they be considered through a generic or overly prescriptive framework. Modifying existing theories or concepts and in order to better meet the needs of Māori is a method sometimes used to address Māori concerns. However, and while this approach is not un-helpful, it can sometimes miss the point and in that Māori do not have a single world view, nor does each region, tribe, or rohe, have identical problems or similar solutions.

Although I would suspect that the approaches to health promotion in Gisborne are similar to those in Ruatoria they are unlikely to be identical. And often it is these subtle differences in approach which matter the most.

THE IMPLICATIONS OF TE PAE MAHUTONGA

While the theory behind the development and design of *Te Pae Mahutonga* is consistent with Māori aspirations, Māori methods, and Māori ways of working - the extent to which progress towards these goals have been made is uncertain. As an ideal, *Te Pae Mahutonga* serves as a reminder of where we should head and where focus and direction is required. However (and if this is the destination) then we should at least be able to determine where we are, how far we have travelled, and how much further we have to go.

Mauriora

As already described, *Mauriora*, considers the importance of Māori culture to Māori health and Māori desires to “live as Māori”. The well-considered “Māori cultural renaissance” has been developing and evolving for more than 30 years and was initially marked by the establishment of the Waitangi Tribunal in

1975, the Whina Cooper led land march in the same year, and of course Bastion Point⁵.

The 1980s saw further developments with the establishment of the first Kohanga Reo (Pukeatua) in Wainuiomata. Te Reo Māori was recognised as an official language of New Zealand in 1987 and until very recently was the only “official” language of this country. The 1990s were significant for a number of reasons and saw Māori play a more assertive role in the recognition of Treaty rights and demands for Tino Rangatiratanga. Protests at Waitangi, Moutoa Gardens, and Treaty Settlements revealed a Māori confidence in perusing issues of justice and injustice⁶. And, while the mainstream media were not always sympathetic to aspirations of Māori there was little doubt that the so-called “Māori problem” would not go away.

The new millennium, for many, began here on the east coast and as the first major city in the world to greet the New Year. Four years later, and after a sometimes difficult gestation period, Māori television was finally born. With it, and on the back of the largest protest ever seen in this country, so was the Māori party. Sceptics initially viewed the party with a degree of antagonism and questioned the need for a political movement which was so blatantly or audaciously focused on the needs of one particular ethnic group. This despite the fact that other political parties, while in a more covert way, had for some considerable time actively promoted the interests of non-Māori.

The impression, therefore, is that Māori have had every opportunity to “live as Māori” and that the socio-political environment – the events of the past 30 or so years have in many ways facilitated this. Many non-Māori are convinced of this fact and are at some pains to point out our bilingual national anthem, Māori content on television, the new “New Year” called Matariki, and of course the excessive amount of resources which

have gone into Treaty settlements and other “Māori-focused” initiatives.

Translating these developments into tangible outcomes is, however, difficult and indeed the extent to which Māori have been able to embrace the Māori world as a consequence of these initiatives is uncertain. As a measure of cultural capacity *Te Reo Māori* perhaps provides the most reasonable measure and we would assume that a measure of our ability to live as Māori would include an assessment of our language proficiency.

A recent study on this was conducted as part of the New Zealand Psychiatric Epidemiology Study (Te Rau Hinengaro) and where Māori participants were asked about their abilities in *Te Reo Māori*⁷. The results from this are both encouraging and somewhat concerning in that while good numbers of Māori are able to speak and understand *Te Reo Māori* an equally significant number have limited or no understanding of the Māori language. The 2007 social report (released two weeks ago) also revealed a mixed picture in that while the number of Māori adults able to speak *te reo* “well” or “very well” had increased from 9% on 2001 to 14% in 2006 – it showed that more than 85% of the Māori population had a limited ability to communicate in the Māori language⁸.

Further, and that while initiatives such as *Kohanga Reo* have done much to increase the number of young Māori speakers, most Māori children do not attend *Kohanga Reo*⁹. Moreover, and although it is encouraging to see a developing interest Māori language many have raised concerns about the quality of *Te Reo Māori*, the so-called anglocisation of *Te Reo*, and that lack of capable Māori language teachers. An additional fear is that *Te Reo Māori* will become the language of ceremony – only heard on the Marae, in formal settings, during the national anthem, the

occasional All Black haka, or when a traditional welcome is called for.¹⁰

To live and to grow a language must move beyond a ceremonial function, it needs to be spoken regularly, in the home, in a variety of settings, and in order to convey any number of messages. Importantly, it must be relevant to the society within which we live.

Other measures of cultural knowledge can also be taken from our collective understanding of “things-Māori”. Again – the research shows a mixed picture in this regard. The vast majority of Māori (almost 90%) are able to name their iwi, however, fewer know their waka, and just over half are able to recite three or more generations of whakapapa¹¹.

Many authors have also been at pains to point out (quite rightly) that the Marae is fundamental to being Māori and that it provides the physical and spiritual foundation for our culture. The Marae is the only place where our culture can find true expression. Despite this, we know that about a third of Māori have not visited a Marae in the past 12 months, moreover, that more than 60% have had no more than one or two visits¹². Less well known is the reasons for these visits, though, and based on anecdotal evidence, it appears that for many Māori the Marae is no longer the cornerstone it once was nor is it a place where issues of significance to the iwi are discussed. To many, their only contact with a Marae is at a tangi, or wedding, or 21st, and for many it remains a historical and often foreign institution.

Based on what we currently know it is difficult, therefore, to determine how well we are doing in terms of *Mauriora* and our ability to “live as Māori”. Certainly, opportunities to embrace the Māori world have increased, however, these opportunities have not been taken up by all nor has there been universal

support for them. There has also been talk that while there is certainly no single Māori reality there is an emerging gap between the “Māori haves” and the “Māori have not’s”. In this regard it is becoming increasingly evident that those Māori best positioned to embrace the Māori world are typically better educated, with higher incomes, and who are better able to access Māori related opportunities. Unfortunately, and from a health perspective at least, it is not this group of Māori who are most in need¹³.

Regardless of what issues currently exist it is clear that culture must underpin any strategy for Māori health development and that while Māori and non-Māori objectives for health are often similar, they are also different. A recent survey, released just two days ago by The Nielson Company also usefully illustrates this point and how Māori view the role of culture.

In a survey of 1500 Māori, three-quarters said traditional values were really important to them, compared with under half in 2004. Māori were also significantly more positive now than they were in 2004 about the role models provided by their culture. The research found six out of 10 Māori felt their culture provided them with strong role models, up from four in 10 in 2004.

Although fluency in te reo had changed little over the past three years, the importance of the Māori language was far more widely acknowledged among both Māori and Pākehā, the survey found. Today, 82 percent of Māori recognise the importance of the development and growth of the Māori language, compared with 59 percent in 2004¹⁴.

Certainly, the value of Māori culture cannot easily be quantified but is fundamental to Māori identity and any Māori development initiative.

Waiora

Waiora (environmental protection and sustainability) is linked somewhat to *Mauriora* and certainly to live as Māori is to live in harmony with the environment and our natural surroundings. Like all indigenous people Māori have relied on the physical environment for sustenance, health, and well-being. However, this relationship exists in other ways and to the extent that our identity as a people is tied to our environment and the physical markers which tell others who we are and where we are from. Waiapu, Hikurangi, Putauaki, Taranaki, Whanganui, or Manawaru are more than just geographic markers on a map and are reflections of the people who live there and more broadly demonstrates the spiritual relationship that exists between people and the land. The significance of these types of connections cannot be understated and to the extent that while in many countries strangers are likely to ask who you are or what you do, for Māori the more usual question is where you are from.

To non-indigenous populations this relationship is difficult to describe and in that a lands value is primarily derived from its economic potential. Land confiscated from Māori therefore, and most typically, had a dual impact on the health and well-being of people. In every instance it removed an economic resource which reduced our ability to cultivate food and to draw sustenance from the land. In other ways however the impact was just as significant, as access to sacred sites was prevented, the relationship between the people and the land eroded, and the spiritual connection to our lakes, rivers, and mountains eroded.

Evidence of how Māori views on land and the environment differ from that of most non-Māori can be demonstrated in a number of ways. However, the Treaty settlements process serves as a useful example and where monies are often used to compensate Māori for lands taken. It assumes firstly that land has a monetary value and that the transfer of funds is ample

reimbursement for the lands which were taken. However, and for most tribes, financial compensation is not the purpose of negotiation and no amount of money can adequately replace what was taken. Often times, the land returned to Māori (as part of these settlements) is surplus to government requirements, has little economic potential, and in the case of at least one major settlement was unusable swampland¹⁵.

Nevertheless, and despite the quality of land returned Māori have been at pains to point out that land, not money, is required. As an aside, it should also be remembered that while much is made of Treaty settlements process and millions of dollars of compensation paid – on average, compensation is less than one half of a percent of the lands actually value. Moreover, - the funding budgeted for all historical treaty claims is less than what will be spent on a 26 kilometre stretch of road between Paekakariki and Wellington¹⁶.

Our ancient gods, deities, karakia, waiata, and purakau also stressed the fundamental relationship between Māori and the environment – as provider, nurturer, and sustainer of health. Certainly, and as Māori, our lives reflect this relationship the fact that being Māori must at the very least reflect our relationship with our natural environment.

The extent to which we now, in a contemporary setting, are able to enjoy the benefits of our environment and lands is unfortunately limited. We know that the vast majority of Māori now live in urban environments and have infrequent contact with their traditional lands¹⁷. The natural environment has been replaced by man-made structures, trees replaced by lamp-posts, and gardens by supermarkets. For many Māori the connection we once had with our land has become tenuous at best. Moreover, and while good health is often linked to the peace and tranquillity of our mountains, streams, and ngahere – too often

our daily lives are filled with congestion, the sound of traffic, sirens, roadwork's, smog, and overcrowded spaces.

Of course this is not the case for all, though is certainly the case for most and on a daily basis. An added issue is that Māori land holdings are becoming increasingly fragmented, we often know that we have land, but not exactly where or how much. Issues like this have led some to suggest that the term “Tangata Whenua” is somewhat misleading and since the numbers of tangata without whenua seems to be increasing.

Toiora

Toiora (healthy lifestyles and behaviours) is a significant Māori health issue. As a population we are frequently provided with statistics, data, and media reports which highlight the appalling state of Māori health. Whether it be diabetes, ischemic heart disease, mental illness, cancer, or any number of health concerns it would appear that we are an extremely unhealthy people and that we are somehow predisposed (though race or culture) to illness and disease¹⁸.

This view however is largely inconsistent with what (historically) we know. In fact early European reports on Māori were largely complementary – the population was strong, healthy, handsome, and vibrant. Life expectancy too was on a par with many other parts of the world (certainly Europe) and far better than in India and Asia. Indeed, indications were that we had a genetically superior make-up, which (while initially vulnerable to introduced diseases) was strong and robust¹⁹.

In a contemporary sense there is also scant evidence to support the idea that we are unhealthy by the mere fact that we are Māori. Other explanations are required including our often limited access to health care, our socio-economic position, and societal institutions which often compromise our ability to live

healthy lives. Added to this mix are lifestyle and behavioural factors (Toiora) and the way in which these too impact on our ability to live long and productive lives.

As already noted, smoking, drugs and alcohol, sedentary lifestyles, poor nutrition, and un-safe practices all make significant contributions to the poor state of Māori health and in this regard demonstrate two important points for Māori health development. First, we are no more pre-disposed to poor health than any other ethnic group, and second, our health problems are entirely preventable.

The capacity of health promotion and health education initiatives to contribute to Māori health development is therefore significant. And certainly the appeal of *Te Pae Mahutonga* stems from its ability to identify approaches and opportunities which specifically target Māori. The challenge however, is in the application and by moving our people away from unhealthy behaviours toward those which permit us to live long and healthy lives.

In this regard the role of the Māori health promoter is critical and in that behavioural change is best instigated by those most familiar with the realities of Māori communities and Māori whānau. Māori health promotion workers are better able to interact with Māori - on the marae, in their homes, at hui, or any number of social gatherings. Importantly, they have the trust of their people, the ability to engage them in meaningful ways, and to ensure that key messages are understood and healthy changes sustained²⁰.

Certainly, and while these facts are well known, greater emphasis needs to be placed on the role of Māori health workers – their understanding of local issues, their ability to initiate change, and their contribution to Māori health development.

Te Oranga

Te Oranga is about participation in society and that good health is dependent on our ability to engage and interact with everyday institutions. It has been known for some time that health and well-being is dependent on a range of factors and that the mere absence of illness is an imperfect proxy for good health. To maintain good health we must have positive and supportive relationships with our schools, our communities, government and non-government agencies, as well as the police and related institutions. Participation requires that we take an active role in the decisions which affect our lives and that we are provided with the opportunity to influence our own destiny, to set goals, and to achieve a measure of success in our chosen field, and to have some sense of control over our lives.

For too many Māori however, participation in society is low. Higher rates of Māori unemployment are the norm and are similarly matched by educational outcomes which are consistently poor across the board, but particularly for Māori boys. In recent years statistics have revealed a growing enthusiasm by Māori for tertiary education, and growth here has been impressive. However, an analysis of these statistics reveal an unbalanced picture in that Māori are often ushered into a limited range of study options, pass rates remain unacceptably low in many institutions, and the outcomes (in terms of meaningful employment) untested²¹.

Participation in society is also inconsistent with incarceration, and while Māori make-up about 15% of the national population – our prison population is almost half Māori²². The recent local body elections also revealed our limited ability to participate at a regional level as well. Despite the fact that some very good and capable Māori candidates had contested a range of positions, indications are that very few were successful. And, there is some

indication that regardless of capacity, intellect, or potential, the fact that you might have a Māori name can reduce your chances of being elected. At a national level Māori have not been overly represented in parliament and while some high profile MP's have made their presence felt, they have not always been in positions of authority. Nor can it be guaranteed that a Māori MP will in fact be sympathetic to the aspirations of Māori – in some cases the reverse has occurred.

While increased Māori participation in society is a pre-requisite for good health it is clear that we have some way to go and that for many Māori our ability to participate is compromised at an individual, institutional, societal, and political level. Although Māori aspirations for improved participation is sometimes viewed as being divisive or separatist it is clear that above all else it is simply about equity and the hope that Māori may have equal access to the full range of institutions which many other New Zealanders have enjoyed for some time.

Ngā Manukura

Health leadership is the focus of *Ngā Manukura* and is a seminal requirement for Māori health promotion. It is sometimes difficult to ratify the need for or difference between Māori and non-Māori health leadership. In fact, health leadership is a generic term and which is dependent on a capacity to advance health and well-being, to set an example for others to follow, and to create an environment which empowers others.

For Māori health leadership however, a point of difference may exist in terms of where these leaders sit and how authority is demonstrated. It has already been explained that a Māori approach to health promotion must be dynamic and holistic – operating at numerous levels and in a number of different ways. Māori health leadership is similarly dynamic, drawn from multiple sectors and professions.

Like more conventional forms of health leadership clinical and technical skill are likely to enhance leadership potential. However, and if change is a fundamental requirement of Māori health promotion, then leadership must extend further than this, to the Māori community, and to those who have the necessary skills and potential to make a positive influence on the lives of others.

This approach is not new, and in fact was used by Maui Pomare and Peter Buck some 100 years ago. At that time, the Māori population had reached an all time low and indications were that the population slide would continue until the Māori race was but a distant memory – gone the way of the moa, the huia, and piopio. For both Pomare and Buck this was an untenable prospect, though seemed likely as disease, despondency and despair was rife. Something had to be done, but without government support or a dedicated health workforce the outcome looked bleak.

In an inspired move they decided to focus their efforts on health promotion and public health initiatives and in the understanding that improvements in sanitation, nutrition, and basic living conditions could (with a bit of luck) stem the population decline. Key to this focus was a Māori workforce and in particular Māori leaders in health who would promote the virtues of healthy living.

In identifying these leaders they focused less on formal skills or training (as the government of the day would have preferred) but rather on an individual's capacity to influence others. To this end, health leaders were those who had the respect of others, who were able to engage their tribe, and who had the ability to convey key messages in meaningful and sustainable ways.²³

In a modern sense it is likely that the pre-requisites for Māori health leadership have not changed all that much and that while leaders are likely to emerge in a number of fields an emphasis on ones qualifications is probably less important than a focus on their capacity to influence and promote positive health behaviours. In this regard those most in need of health promotion might not respond to an individuals qualifications but more inclined to embrace the messages given by someone they trust, who is familiar to them, and who appreciates the daily realities of their life and culture.

Mana Whakahaere

Mana Whakahaere is the final component of *Te Pae Mahutonga* and as described calls for increased Māori control and autonomy – particularly in health, and which reflect local issues and locally led solutions. The importance of this type of approach has already been touched on and is reflective of the fact that while New Zealand is not a large country the health issues we face are often bound by socio-demographic and ethnic profiles which is unique to a particular area or region. The most recent health reforms were based on this premise and the idea that a scattering of 21 District Health Boards would ensure that local needs and priorities were met.

The Health and Disability Act 2000 facilitated the creation of the Health Boards and was of particular interest to Māori due to the Act containing references to the Treaty of Waitangi. These references caused some initial apprehension and a fear that they would somehow afford Māori special privileges or perhaps a means through which Māori would receive preferential treatment. In the end these fears have amounted to little and in fact our health status continues to lag well behind that of non-Māori.

However, the Act (and in particular the Treaty principles within it) did facilitate Māori representation on DHB boards and a greater subsequent Māori presence in local decision making processes. The Act was also unique in that it was the first piece of social policy legislation which included references to the Treaty of Waitangi²⁴.

At other levels too Māori have been keen to better express their autonomy or *Tino Rangatiratanga*. Prior to 1980 there were but a handful of Māori health providers, however, recent statistics show that there are currently more than 300. And while the focus and function of each is likely to vary, they all share a common interest in Māori and typically incorporate Māori culture as a key component of their practice. The Māori health workforce has seen similar patterns of growth. In 1984 there were 5 new Māori medical graduates, but by 2004 the number had increased by almost 400% to 24. From an estimated Māori medical workforce of around 60 in 1984 there are now over 200 Māori medical practitioners in a range of disciplines.

Additionally, scholarships have been provided from a range of sources and in order to encourage greater Māori participation in professions such as nursing, social work, clinical psychology and addictions²⁵.

The extent to which these developments have improved Māori desires for greater autonomy is unclear. Certainly, Māori services and Māori culture are now an accepted part of the health landscape (when in the past few would have seen value in any approach which did not conform to a western model). Likewise, an increase in the number of Māori health professionals, Māori health managers, and policy makers can only enhance opportunities for greater autonomy.

Yet, and despite these developments, a sense of dissatisfaction remains. Providers, while funded under the guise of a kaupapa Māori service, are often frustrated by narrowly focused contracts and which fail to recognise Māori perspectives on health, Māori models of service delivery, and the holistic nature of Māori health development. Similarly, and while many providers now have a degree of autonomy, the framework for delivery, monitoring systems, and priority setting, are not always within their sphere of control. In one sense autonomy has been achieved while at the same time limitations and constraints are also evident.

CONCLUSIONS

Te Pae Mahutonga demonstrates the relationship between Mauriora, Waiora, Toiora, Te Oranga, Ngā Manukura, and Mana Whakahaere to Māori health and Māori health promotion. The model is both a blueprint for Māori health development as well as a checklist – a means through which progress can be measured.

From the discussion thus far, it is clear that some important developments toward the objectives of *Te Pae Mahutonga* have occurred and that we should celebrate our achievements and the fact that our health waka, at least, is pointed in the right direction. As described, and over the past two decades, there has been an increasing recognition of the relationship between culture and health. Environmental concerns, while still significant, are at least being considered and as a major threat to our global sustainability. The number of Māori health providers has increased dramatically in the past 20 years and have corresponded with a burgeoning Māori health workforce.

However, and despite these gains, opportunities for further development exist. And, as Māori enter the new millennium,

steps must be taken to ensure that the gains of the past are built upon and that we are able to embrace the future with an optimistic outlook, with enthusiasm, and a renewed vigour. It is often the case that Māori health hui tend to focus on disparities and disease, the gaps which exist between Māori and non-Māori and as illustrations of where further effort is needed. There is some merit in doing so, as a catalyst for change, and as a demonstration of what is possible.

This presentation has provided some indication of what gains have been made toward the objectives of *Te Pae Mahutonga* but further reveals where gaps exist and where more progress is needed. By highlighting these issues, disparities, and related concerns, Māori have sometimes been accused of a deficit based approach to health development. However, I don't believe this to be true when clearly these issues are only used to demonstrate opportunities. That is, opportunities to develop a more robust Māori health workforce, opportunities to strengthen the relationship between culture and health, and opportunities to extend Māori health, Māori well-being, and Māori capacity. The fact that we as people have come from the brink of extinction (only a hundred years ago), to a point where we are more numerous than at any other time in our history, clearly demonstrates our capacity to recognise opportunities and to initiate change.

With these issues in mind, where do opportunities for Māori health promotion sit? Obviously, the possibilities here are countless and exist throughout *Te Pae Mahutonga* – we can certainly enhance our capacity to live as Māori, to interact with our environment, to participate in society, to control unhealthy behaviours, to lead, and to have some control over the way in which health services to Māori are delivered.

At another level however there exists a need, albeit opportunity, to further demonstrate the holistic nature of Māori health and its unique characteristics. As evidenced, Māori health is not the same as non-Māori health and reflects our relationships with our land, our culture, our environment, and our people. Māori health cannot be sustained through a silo-based approach to health delivery. And indeed, the success of Māori health services relies on their ability to imbed themselves within their communities, to become part of the social and cultural infrastructure, to negotiate links across sectors, and to provide a service which is fundamentally grounded on the needs of their people.

The opportunity also exists to place greater emphasis on the role and value of Māori health workers. And, while *Te Pae Mahutonga* is shaped by several components and numerous features, its application relies on one simple thing – and that is people. As evidenced from our past, Māori health development has relied heavily on a robust and dedicated Māori health workforce, on Māori people, and a fundamental belief in the relationship between Māori health and Māori development. And, while contemporary health workers are faced with new challenges and a modern environment – the link between the past and present is clear, through the faces of those who now lead and by the shared interest in Māori development, Māori potential, and Māori enthusiasm for the health and well-being of their people. Conferences like this provide an ideal opportunity to reflect on all these achievements, to share ideas, to examine issues, to consider possible solutions, and to plan for a positive and healthy Māori future.

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