

Copyright is owned by the Author of the thesis. Permission is given for a copy to be downloaded by an individual for the purpose of research and private study only. The thesis may not be reproduced elsewhere without the permission of the Author.

TĀNIKO:
*Public Participation,
Young Māori Women, & Whānau Health*

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

Master of Arts
in
Māori Studies

at Massey University, Palmerston North,
New Zealand.

Katarina Ani Putepute Gray

Ngāti Rangi, Ngāti Raukawa ki te Tonga, Ngāti Kauwhata,
Ngāti Rangiwēwehi

2006

ABSTRACT

Recent Māori, sexual, and primary health developments have been influenced by the principle of participation. For example, the use of a whānau-centred approach, of community development, and of Primary Health Organisations allows participation in decision-making. However, none of the abovenamed strategies adequately explain how young Māori women can participate in decision-making in one common area: Māori, sexual, primary health policy.

This thesis explores how Primary Health Organisations can work with young Māori women to promote sexual health to whānau by focusing on policymaking processes and effective participation mechanisms. Māori health development from colonial Contact to 2005 is reviewed before the broad health framework (the *New Zealand Health Strategy* and the *New Zealand Public Health and Disability Act 2000*) is defined. A critique of relevant policy, in particular *He Korowai Oranga* (2002), the *Sexual and Reproductive Health Strategy* (2001), and *The Primary Health Care Strategy* (2001), reveals scope for participation and whānau-centredness. Primary Health Organisations pose challenges to whānau sexual health promotion. However, with public participation from young Māori women, like the thesis participants, new opportunities can be realised.

The research was conducted in accordance with a Mana Wāhine-based methodology called “Tāniko”. The four parts (*Mana Wāhine*, *Te Ao Tawhito*, *Te Ao Hou*, and *Te Ao Mārama*) defined the research aim and objectives. A qualitative strategy employing semi-structured interviews with three young Māori women was followed by a confirmatory stage of content analysis utilising a deductive public participation evaluation tool: the Tāniko instrument. The instrument analysed four policymaking decisions and two mechanisms: organised peer groups and the wāhine-centred approach. The research concluded that when defining how, by whom, and to whom information is presented, organised peer groups can be utilised at the coordination and evaluation policymaking stages. The wāhine-centred approach can share or manage participation through problem definition, consultation, decision, and implementation.

HE RAU AROHA

This thesis is dedicated to the memory of my Nannies
Who passed during its writing

Te Pikonga Mahue Hughes (aka Mary Lawton)

Ngāti Raukawa ki te Tonga, Ngāti Maniapoto

1925-2003

&

Pinenga Margaret Gray (nee Yates)

Ngāti Rangiwēwehi, Ngāti Raukawa

1935-2005

Beautiful, clever, funny women
Who brought light to this world
And continue to guide from the next

Hei Tōna wā.

ACKNOWLEDGEMENTS

Tuituia te kupu ki Runga
Hei tohu Māramatanga
Horahia te aroha
Hei whakamāhana
I te ngākau mokemoke
Nō te Kuratahi tēnei
Mihi ki a Ia e...

In the first instance, I wish to express my gratitude to the three wonderful women who let me into their lives. With your stories, you provided me insight and laughter. Thank you all.

I am grateful for the support received through the Māori Education Trust (Manaaki Tauira), Massey University (Massey University Māori Masterate Scholarship), Ngaporo Waimarino Forest Trust, and Whanganui Trust. This project has been reviewed and approved by the Massey University Human Ethics Committee, Wellington Application 05/17.

I wish to acknowledge the extensive contribution of my supervisor, Ms Margaret Forster, without whom this thesis would not have been completed. Invaluable advice and support has also been provided by Dr Christine Cheyne, Mr John Waldon, and two of my best friends: Ms Megan Davies and Ms Veronica Tāwhai. Ka nui te aroha ki a koutou.

My whānau and their teachings have provided the basis for my methodology and this work. To my nannies, koros, aunties, uncles, cousins, nephews, nieces, and mokopuna: you continue to help me grow more each day. To my parents, Bob and Trixie Gray (nee Lawton), who educate me, love me, and support me in everything I do: everyday I thank God for the grounding you and my brothers, Marc and Matheu, give me. To my husband, Giles Sharp: thank you for your patience and peacefulness. Ki a Tamarongo kōrua ko Raukāhu: he mihi aroha ki a kōrua mā tō kōrua tautoko i a Māmā. Nā tō kōrua taura tēnei i puta.

TABLE OF CONTENTS

Abstract	ii
He Rau Aroha	iii
Acknowledgements	iv
List of Figures	vii

Section One: Mana Wāhine

Chapter One: Introduction

Introduction	2
Public Participation & Democratic Policymaking	4
Definitions of Whānau	10
Young Māori Women & Experiential Knowledge as Expertise	13
Conclusion	15

Chapter Two: Methodology

Introduction	19
Māori Research	19
Methodology	26
Method	31

Section Two: Te Ao Tawhito

Chapter Three: Māori Health Development

35

Chapter Four: The Broad Policy Framework

Introduction	44
The New Zealand Health Strategy	44
The New Zealand Public Health and Disability Act 2000	47
Conclusion	52

Chapter Five: He Korowai Oranga, Phase One, & the Primary Strategy	
Introduction	53
He Korowai Oranga – Māori Health Strategy	53
Sexual and Reproductive Health Strategy: Phase One	62
The Primary Health Care Strategy	64
The Whānau-centred Approach	69
Conclusion	72
<u>Section Three: Te Ao Hou</u>	
Chapter Six: PHOs, Sexual Health Promotion, & Whānau	
Introduction	74
Primary Health Organisations (PHOs)	74
PHOs & Māori	77
PHOs, Māori, & Health Promotion	79
Conclusion	83
Chapter Seven: Data	
Mana Wāhine	85
Te Ao Tawhito	86
Te Ao Hou	90
Te Ao Mārama	97
Participant Updates	104
<u>Section Four: Te Ao Mārama</u>	
Chapter Eight: Analysis & Discussion	
Introduction	106
Public Participation Evaluation	106
The Tāniko Evaluation Instrument	108
Applying The Tāniko Instrument	112
Conclusion	118
Chapter Nine: Conclusion	119
Appendix: Permission for Reproduction of Figure 1	125
Bibliography	127

LIST OF FIGURES

Figure 1	He Korowai Oranga	55
Figure 2	The Tāniko Evaluation Instrument	111

SECTION ONE
MANA WĀHINE

CHAPTER ONE

INTRODUCTION

*True political freedom is called participation.*¹

Introduction

As the opening to one person's view of whānau health policy, this introductory chapter gathers the threads, which will direct the research journey. The first section examines public participation in democratic policymaking. In the second, various definitions of the whānau are presented. The third section explores young Māori women, experiential knowledge, and sexual health. The final area provides a window to the thesis, outlining the following chapters. This introductory section presents public policy and its processes.

Policy can be defined as “positions taken and communicated by governments – ‘avowals of intent’ that recognise a problem and in general terms state what will be done about it” (Dovers, 2005, p. 12). Public policy, in particular, is defined as “a set of decisions concerning the selection of goals for the public sector and the choice of strategies for achieving these goals” (Davis & Ashton, 2001, p. 2). As outcomes, “policies are produced through multi-component and variable *policy processes* [sic] that combine government and non-government players” (Dovers, 2005, p. 12). Walters, Aydelotte, and Miller (2000) describe five stages of public policy development: problem definition, criteria identification, generation of alternatives, evaluation, and recommendation. In New Zealand, however, the theoretical public policy cycle is a nine-stage process: problem definition, policy inputs, policy analysis, policy instruments, consultation, coordination mechanisms, decision, implementation, and evaluation (State Services Commission, 1999). Whatever the process, the state-centred decisions made through these stages (such as the provision of state-sourced resources and the creation of regulations) affect both the public and private spheres.

Public policy can come in three different forms. Public policy can be “strategic”, “substantive”, or “operational” (Boston, Martin, Pallot, & Walsh, 1996, p. 122), though a degree of intersecting does occur (Martin & Salmond, 2001). Strategic public policy provides the long-term, broad direction of a particular area of government action. As it is intimately linked to the particular ideology of those in power, its appearance is infrequent (see Davis & Ashton, 2001).

¹ Vallet de Goytisolo as cited in Amaral, 2003, p. 149

An example of strategic public policy in health is *The New Zealand Health Strategy* (2000). Substantive public policy gives specific direction in a given policy area. In health, an example of substantive public policy includes the *Sexual and Reproductive Health Strategy: Phase One* (2001). Operational public policy occurs at the implementation level. The establishment and management of specific programmes (for example, the provision of chemotherapy) and allocation of resources to specific areas (for example, cleaning and rosters) are types of operational public policy. Successful implementation of public policy, whether strategic, substantive, or operational, can be targeted or tailored according to the public's need.

Targeting is the process of determining eligibility for a policy, programme, or service (Ringold, 2005). Targeting can provide a more “effective” means of fulfilling user need at a lower cost (Cabinet policy committee minutes, 2005b, p. 2). Targeted and tailored programmes operate in both “mainstream” and “parallel” institutions (Ringold, 2005, p. 44). For example, extension systems operate as targeted programmes in both mainstream schools and kura kaupapa for students who meet the high achievement eligibility criteria. Other targeted examples include disability car parks (based on particular disabilities), hotel corporate rates (based on business status), and Access funding for Primary Health Organisations² (based on deprivation and ethnicity).

According to Ringold (2005, p. 46), “few policies in New Zealand are actually targeted based on ethnicity, such that being Māori – or a member of another ethnic group – would affect an individual's eligibility to participate in the programme or access the service”. Nevertheless, in response to internal and media pressure, a review of ethnic-targeted policies and programmes was instigated in 2004. The resulting policy guides the design of “appropriate” needs-based policies and programmes, but allows “tailoring of the delivery of a programme for particular groups [when it] is likely to help reach those in need or increase the effectiveness of the programme” (State Services Commission, 2005, p. 1).

Tailoring is the adjustment of existing programmes or services to respond to the needs of a given population (Ringold, 2005). Tailoring does not affect eligibility, but allows a different mode of delivery to enhance effectiveness. Such programmes are inclusive and “self-targeted” (Ringold, 2005, p. 43). Multi-lingual literature, like the telephone book and Census forms, are examples of tailored programmes. As tailoring can be based on various premises, such as location, beneficiary participation, or subject matter, other examples include community-based health clinics and honeymoon suites (Ringold, 2005). Though each example is likely to be

² Henceforth referred to as “PHO” and “PHOs”.

preferred by a particular population group (that is, non-English speakers, community residents, or honeymooners), others are not prevented from using these services. Tailoring offers a useful distinction from “services targeted through eligibility criteria” in the design and development of public policy for Māori in general and whānau in particular (Ringold, 2005, p. 43).

Recent trends in public policy for Māori have emphasised participation, whānau-centredness, and evidence-based decision-making. Public participation requirements are apparent in policy like *The Primary Health Care Strategy* (2001). Whānau-centredness appears as a mainstay to *He Korowai Oranga – Māori Health Strategy* (2002). Evidence-based decision-making is an international trend (Ringold, 2005), which emphasises monitoring and evaluation. Since the end of the last decade, “high-quality evidence has increasingly been demanded as part of the policy process” (Lunt, 2003, p. 12). The *Sexual and Reproductive Health Strategy: Phase One* (2001) is one example of evidence-based policy. Together, these three documents present a view of whānau health policy as it relates to primary, reproductive, and sexual health. In addition, they define specific means for public participation in policymaking.

Public Participation & Democratic Policymaking

Public participation in policymaking is defined as “any of several ‘mechanisms’ intentionally instituted to involve the lay public or their representatives in administrative decision-making” (Beierle & Cayford, 2002, p. 6). As a programme of activities, it is used to both legitimate institutional norms and define new opportunities and directions. As a democratic activity, public participation engages the individual as citizen, emphasising their political right and responsibility to dialogue with the state. In addition, public participation “reflect[s] the fundamental human right of people to have a say in the things that affect them, and the related ‘principle of subsidiarity’, which stipulates that decisions should be made at the level where they have their impact” (Cheyne, O’Brien, & Belgrave, 2005, p. 133). Whatever rationale or mechanism chosen, public participation provides opportunities for the development and implementation of policy.

Public participation is a derivative of democratic citizenship. The core principle of democratic citizenship is “participatory self-government”, within which the citizen is a part of a “community with certain rights and responsibilities vis-a-vis that community” (Morgan, 2001,

p. 209). Membership benefits from a Marshallian³ perspective include civil (for example, “fair treatment by the law”), social (for example, “the right to healthcare”), and political rights (Cheyne et al., 2005, p. 62; see also Lunt, Spoonley, & Mataira, 2002). As a citizen, political rights allow the “opportunity and the means to participate in the life of the political community to which one belongs” (Cheyne et al., 2005, p. 62).

Public and citizen participation can enhance government legitimacy and policymaking processes. Primarily, effective participation helps develop a “feeling of belonging... [as] the cornerstone of the democratic state as a polity” and necessary tool for legitimising “majority decision making” (Eliassen & Monsen, 2003, p. 91). As “a combination of the perception that the general public has of its capacity to influence the decision making process, the representative aspects as well as the regime’s ability to carry out the decisions that are taken”, systems which increase participation can only benefit the “legitimacy of any political regime” (Eliassen & Monsen, 2003, p. 89). Furthermore, policymaking processes can be positively influenced by participation. Evidence suggests that the “fundamental principle of participation and voice results in greater compliance (even by those who disagree), more consistent policy and smoother and more rational implementation” (Wilson & Enright, 1994, p. 139).

The decision to enter into public participation is not an easy one, though three rationales can assist in assessing participation’s value (Beierle & Cayford, 2002). Instrumental rationales focus on participation as imperative to policymaking, emphasising trust-building, collaboration, and conflict resolution. Substantive rationales emphasise quality policymaking through participation and often involve decisions that rely on public expertise. Normative rationales are philosophical; public policymaking, as a democratic tool, requires recognition of the citizen’s participatory rights and can lead to a more civil society. It must be noted that participation is only effective if policymakers accept its nature; the public may choose to redefine the process’ focus or present a position which policymakers may disagree with. A normative rationale applied by a policymaker intent on a particular decision is doomed to failure. For public participation, in its many varied forms, to work, it must be supported by commitment to the process’ value.

Beyond elections, public participation in policy development utilises many different mechanisms. Participation can occur via direct engagement as individuals or through group processes. Process design, including scope, representation, engagement type, public influence level, and government role, all affect the chosen mechanism (Beierle & Cayford, 2002).

³ This refers to T.H. Marshall’s (1950) seminal work, *Citizenship and Social Class and Other Essays*,
Footnote continued on next page.

Beierle and Cayford (2002, p. 67) identify “information sharing and deliberation” as two primary “engagement” types. Mechanisms, which emphasise information sharing (for example, public meetings), provide a two-way route for exchanging information between policymakers and the public. They are inexpensive (in regards to both physical and time resources), but lack the capacity to deal with complex arrangements (for example, conflict resolution). Deliberative systems provide greater opportunity for discussion and group decision-making. In addition, they are “much more likely than information-sharing processes to generate successful outcomes on a wide range of social goals” (Beierle & Cayford, 2002, p. 67).

In addition to the deliberative representative model (for example, governance representation in PHOs), public engagements can include consumer and panel participation mechanisms. Cheyne, O’Brien, and Belgrave (1997) discuss consumer participation as a market-orientated form, which favours individualism, charters, and complaint procedures. A type of information-sharing, this form lacks effectiveness where providers do not require end-user knowledge for profit or credibility purposes (Considine as cited in Cheyne et al., 1997). Furthermore, its framing of the individual from a market perspective fails to acknowledge any power other than financial power, thereby limiting its application. Panels or citizen juries are a form of deliberative public participation. Kathlene and Martin (1991) researched one type of panel, the Citizen Survey Panel (or CSP). A year-long process of surveys and interviews with 147 members of the public, selected through stratified proportional sampling, resulted in a strong “integration of public and policy maker opinion” (Kathlene & Martin, 1991, p. 54). This example shows successful deliberative processes in action.

Literature has identified other public participation mechanisms. As examples, Rosener (1978, p. 461) pinpointed two individual (publications and surveys) and three group (“listen and learn sessions”, “workshops” and “advisory committee[s]”) mechanisms, whilst Montgomery (1983, p. 93) discussed one group option (“farmer committees”). Walters et al.’s (2000) exploration of two Utah participation processes provided three individual (state radio and television talkback, and internet chat sessions) and three group mechanisms (public hearings, public meetings, and working groups) as options. Furthermore, the authors identified referendums, mediation, interviews, mass-media, polls, focus groups, presentations, forums, taskforces, commissions, and bulletin boards (Walters et al., 2000). The Ministry of Health (1997a, pp. 13-14) identified a number of participation mechanisms specific to Māori audiences, including “wānanga”, hui, “roundtable”, and consultants. Whatever the mechanism chosen, participation in public policymaking affects a large number of stakeholders.

within which he identified three classes of citizenship rights: civil, political, and social.

The creation, implementation, and assessment of any public policy requires participation by a large number of stakeholders, including policymakers, administrators, and the public or individual citizens. Policymakers are often a mix of elected (for example, politicians) and appointed (for example, central and local government employees) officials. Administrators implement policy decisions and include state agencies, employees, and contracted private sector providers. The public can refer to the citizens at large or sections defined by criteria (for example, service use, age, or ethnicity). Participation by all three types throughout the policymaking process is necessary to ensure effective outcomes.

Policymakers are present across all policy process stages. Elected officials in central government form the Legislature, who “translate the public will into requests for State action” by debating and approving statutes (James as cited in Cheyne et al., 2005, p. 122). Electoral parties with sufficient votes (and strong negotiation skills in a coalition agreement) form both government and the Executive Council. At a local level, elected policymakers form city, district, and regional councils to manage infrastructure, or District Health Boards⁴ to manage population health. Non-elected officials include the Governor-General as Crown representative, who provides Royal Assent to statutes, and the Judiciary, who form and maintain common law. However, the largest group of non-elected officials is the Public Service. Baehler (2003) identifies three working areas for New Zealand policymakers: politics, management, and policy. When controversial, political involvement by elected officials may occur from the problem definition stage. However, non-controversial issues are often entirely managed by public service management or policy analysts up until final approval.

Administrators play a definitive role in the effective implementation of public policy decisions, including the creation, implementation, and assessment of subordinate policy. Though (good) public policy provides measurable outcomes, “flexible agency deliberation can and often does extend beyond specifying legislatively set ends to establishing new ends in a rationally defensible way” (Richardson, 2002, p. 214). Administrators as individuals (for example, the local council Chief Executive Officer) and as agencies (for example, the Department of Work and Income, the Public Trustee, and PHOs) have the power to diversify their delivery systems in order to fulfil public need. According to Walters et al. (2000, p. 353), the “political attractiveness of an option increases, as does the ease of its administration, if it corresponds to the values of the public”. Public participation in policymaking can assist administrators with this process.

Public participation in policymaking can benefit individual citizens as well as the public as a whole. In a representative democracy, where political power is defined by the ballot box, participation can elucidate the citizens' (with sufficient social capital) right to protection under the law (Marshall as cited in Linklater, 1998). Furthermore, the very process of participation can provide individuals new experiences and opportunities for growth. As outlined by Bachrach and Botwinick (1992, p. 29), participation in the policymaking process can "lead to revised understandings of the participants' capacities and resources". Furthermore, participation can increase individual and group power, thus, invoking "a sense of solidarity and individual well-being" (Bachrach & Botwinick, 1992, p. 30). As a community, public and citizen participation allows values to be applied in ways that directly affect community development. In particular, participation in democratic policymaking processes allows Western countries, like New Zealand, to engender the ideas of democracy, freedom, and equity.

There are a number of limitations to effective participation in democratic policymaking processes. Kathlene and Martin (1991) identified three types of barriers: citizen (including accessibility of appropriate information), policymaker (for example, how administrators value public versus technical sources), and design (who participates, the number of participants, and how policymaking integrates participation). Goal clarity (or the lack of), the value assigned to public feeling and policymakers' "self-definition of their role" (including whether they consider themselves "technical experts" or "citizen advocates") can further limit the effectiveness of public participation (Kathlene & Martin, 1991, p. 48). Knowledge of these limitations can be useful in identifying opportunities for effective public participation.

In New Zealand, opportunities for public participation in policymaking are supported through "legislative and institutional arrangements" (Cheyne et al., 2005, p. 132). For instance, the 1982 Official Information and 1987 Local Government and Meetings Acts require information accessibility and promote the principle of open government. Furthermore, Parliament's independent officers (such as the Health and Disability Services Commissioner) provide a system for investigating public sector issues. Finally, some statutory requirements, such as the DHB elections obligatory under the New Zealand Public Health and Disability Act (2000), provide legislated public participation mechanisms.

At a local level, further DHB "requirements for community participation and transparent processes are contained in legislation" (Ministry of Health, 2002b, p. 8). Like national politics, participation can occur via submissions, contact with policymakers, and selection-based

⁴ Henceforth referred to as "DHB" or "DHBs", except when a proper noun (for example, MidCentral
Footnote continued on next page.

mechanisms. “Three statutory advisory committees” (the community and public health, disability support, and hospital advisory committees) provide examples of mechanisms where participation is sought from selected sources (Ministry of Health, 2002b, p. 11). As DHBs are required to maintain Māori representation (New Zealand Public Health and Disability Act, 2000), public participation by Māori is particularly important.

As “indigenous citizens” (V. M. Tawhai, personal communication, 2006) confirmed under the Treaty of Waitangi’s Third Article⁵, Māori have a right to participate in democratic policymaking. Māori, like other indigenous citizens of “settler polities” (Havemann, 1999, p. 469) and “hegemonic state[s]” (Loomis, 2000, p. 19), have rights and responsibilities to two nations: the indigenous nation and the nation-state (see Widders & Noble, 1993). Differentiated citizenship offers the New Zealand nation-state a means for engaging with Māori as a collective. Based on substantive versus procedural equality (Cheyne et al, 2005), differentiated citizenship allows differences in citizen rights – “a much more common democratic practice than is commonly acknowledged” (Kook, 2002, p. 4). There has been debate over the benefits for the Indigenous of differentiated citizenship (including inclusive and pluralist forms), or any citizenship, of the nation-state (Cairns, 2003; Havemann, 1999; Maaka & Fleras, 2000, 2005; Widders & Noble, 1993). Nevertheless, the existing recognition of Māori citizens as holders of “indigenous rights” (for example, through the New Zealand Public Health and Disability Act 2000) makes differentiated citizenship a real possibility (Maaka & Fleras, 2005, p. 44). However, until this issue is resolved, current individual citizenship provides a means for ensuring Māori public participation.

Ensuring effective Māori public participation in general, and in health particularly, requires tailored approaches. As outlined, public participation provides a rationalised means of legitimating policymaking and offers a number of mechanisms. Furthermore, public participation presents opportunities for policymakers, administrators, and the public, including Māori. Tailored approaches to public participation “give Māori the opportunity for effective input”, establish assiduous connections “to ensure a relationship of trust and respect”, and “involve providing feedback on the ways in which views of Māori have been utilised” (Ministry of Health, 1997a, p. 16). In addition, they recognise the whānau “as the foundation

District Health Board).

⁵ The text in te reo Māori reads: “Hei wakaritenga mai hoki tenei mo te wakaetanga ki te Kawanatanga o te Kuini--Ka tiakina e te Kuini o Ingarani nga tangata maori katoa o Nu Tirani ka tukua ki a ratou nga tikanga katoa rite tahi ki ana mea ki nga tangata o Ingarani.” The text in English reads: “In consideration thereof Her Majesty the Queen of England extends to the Natives of New Zealand Her royal protection and imparts to them all the Rights and Privileges of British Subjects.”

of Māori society” and the diversity of Māori communities (Ministry of Health, 2002c, p. 1). The following section explores the meaning of whānau and provides opportunity for reflection.

Definitions of Whānau

Parents? Couples? Siblings? Friends? The process for defining the whānau is fraught with difficulties. Pre-Contact definitions located the concept within the tribal strata of waka, iwi, hapū and whānau (Barlow, 1991; Children, Young Persons and Their Families Act 1989, s.4[2]; Mental Health (Compulsory Assessment and Treatment) Act 1992, s.6[1]; Moeke-Pickering, 1996). However, more contemporary definitions perceive the whānau in one of two ways. Firstly, as a definable object or construction based on descent, cause or a mix of the two. Secondly, the whānau can be described as a collection of ideas.

Primary contemporary definitions have been centred on the whānau as a descent-based construction. Initial interpretations directly relate to the family concept. Thus, the whānau has been variably described as the family (Pere, 1984; Sinclair, 2002), the extended or wider family grouping (Bevan-Brown, 1994, p. 329; Children, Young Persons and Their Families Act, 1989, s.4[1]; Stewart-Harawira, 1995, p. xii; Te Ture Whenua Māori Act, 1993, s.13[1]), the “extended family or community” (Thomas & LaGrow, 1994, p. 87) and “a nuclear family” (Ministry of Health, 1997c, p. 4).

Metge (1995) identifies five other interpretations of the whānau concept as a descent-based organisation. All five definitions use descent as a criterion, however, only the final four definitions require the employment of a common name. The first, “a *set of siblings* [sic]”, is rarely used and was initially mentioned in early ethnographies (Metge, 1995, p. 52). The second concentrates on whakapapa⁶ by describing the whānau as “all descendants of a relatively recent named ancestor traced through both male and female links, regardless of whether they are living or whether they know or interact with each other” (Metge, 1995, p.52).

Membership of this type of whānau is based solely on descent. However, the third definition’s criteria require slightly more activity. Within this interpretation, the whānau is still a “*cognatic descent group* [sic] of limited depth”, but requires “active participation” to ensure continued membership (Metge, 1995, p. 53). The fourth identified usage moves beyond pure descent to include members who are related through marriage and adoption. Like the third version, “te pa

⁶ Genealogies.

harakeke” or the “*extended family* [sic]” requires collective activity (Metge, 1995, p. 53). The last definition extends “genealogical depth” (and, thus, population size) by its application to hapū or iwi (Metge, 1995, p. 53).

In more recent work, Metge (2001) acknowledges the “primary meaning” of whānau as “a group of kin who interact with each other for common purposes” (Metge, 2001, p. 20). However, to this initial definition, Metge links the ideas of longevity, commonality, dynamism, inclusiveness, tension and optional membership (Metge, 2001, p. 20). Ratima (1999) and others (Metge, 1995; Te Pumanawa Hauora, 1996; Te Roopu Awhina O Tokanui, 1987) continue these ideas by recognising the whānau as a dynamic entity. However, it is not the only way the whānau concept could be classified.

As a cause (or kaupapa) based construction, Metge’s (1995) five interpretations refer to specific environs. The first type of whānau is based within the compulsory school system and involves utilising the whānau as an organisational principle. By applying whānau values of “aroha, mutual support, cooperation and unity”, this type is able to ensure a positive education experience for students (Metge, 1995, p. 56). The second variant employs the whānau term within the kohanga reo⁷ environment to emphasise the two bastions of the movement: te reo Māori⁸ me ona tikanga⁹. The third form continues this theme into the bilingual and Māori language immersion systems, whilst the fourth class of whānau centres on “non-traditional marae established in urban areas, at schools and tertiary institutions and in government departments” (Metge, 1995, p. 57). The final identified version focuses on recreational groups, such as sports and kapahaka teams. Whether from an educational, governmental, or recreational environ, kaupapa-based whānau are viewed differently to their mixed criteria interpretations.

As a construction based on mixed criteria, the whānau has been defined in a number of ways. Hirini (1997), for example, makes two classifications for the whānau. The first type is based on the family concept, being “an extended family network” and “a customary Māori social structure based on common source of descent or whakapapa” (Hirini, 1997, p. 43). According to Hirini (1997, p. 43), this “whakapapa-based whānau” remains a significant Māori “social institution”, because “all Māori have connections to such whānau”. The second type of whānau is termed the “kaupapa-based whānau” (Hirini, 1997, p. 43). Hirini believes it to be a “metaphorical whānau”, identifiable as “a class of non-customary cohesive Māori interest

⁷ Māori language nest pre-school system.

⁸ The Māori language.

⁹ The various idiocultural practices.

groups without ancestral links” (Hirini, 1997, p. 43). Other authors have also employed this dual classification system.

Like others (Smith, 1995; Te Pumanawa Hauora, 1996), Durie (1997b, p. 1) has interpreted the whānau to be “more than simply an extended family network”. Firstly, the whānau can be seen as “a diffuse unit, based on common whakapapa (descent from a shared ancestor), and within which certain responsibilities and obligations are maintained” (Durie, 1997b, p. 1). Secondly, Durie acknowledges “‘non-traditional situations’ where Māori with similar interests, but no direct blood relationships, form a cohesive group” (Durie, 1997b, p. 1). However, this dual classification system is not the only method for identifying the mixed criteria whānau.

In addition to descent and kaupapa-based types, Metge (1995) identifies interpretations based on mixed criteria. Metge (1995) identifies the first three definitions as short-term relationships. Metge refers to the first interpretation as the “*elastic band* [sic]”, describing it as the expansion of the whānau’s traditional genealogical depth at times of convenience (Metge, 1995, p. 55). The second interpretation makes reference to an assembly grouped for a common, if temporary, purpose. Membership is based on common interest only. A third definition of the whānau concept involves a collection of individuals, who may or may not be kin, emerging to support a member in a time of difficulty (for example, an interview). The fourth interpretation mirrors the nuclear family, comprising of “*one or two parents and their children* [sic]” (Metge, 1995, p. 54). In comparison, the fifth version of whānau is made of clustered kindred, whose relationship is unclear. This version usually merges for support when distant from traditional communities, though it lacks the “binding power of descent” and thus “fall apart more easily” (Metge, 1995, p. 55). Membership of this type of whānau involves interaction and some type of whakapapa link.

Some authors have viewed the whānau as a collection of ideas; a concept without delineated borders, which fulfils certain functions. For example, a “*strengths-based approach* [sic]” (Adolescent Health Research Group, 2004, p. 60) to whānau acknowledges that whānau “know more about their situation than anyone” and “have dreams and aspirations for their members” (MidCentral District Health Board, 2005b, p. 8). Furthermore, whānau can “formulate their own goals and solutions”, and are inclined “to maintain solutions they create” (MidCentral District Health Board, 2005b, p. 8). The Ministry of Health (2002c) offers another ideas-based rendering defined through its employment of both role and value-based interpretations. As a role-based idea, the whānau is interpreted by the “kuia, koroua, pakeke, rangatahi and

tamariki” roles^{10 11} (Ministry of Health, 2002c, p. 1). As a value-based idea, the whānau is seen as “a principal source of strength, support, security and identity” and “recognised as the foundation of Māori society” (Ministry of Health, 2002c, p. 1).

Similarly, Stewart-Harawira (1995, p. 2) believes the whānau, as “the fundamental agency for Māori social interaction and social integration”, provides the ordinate cultural situation for “*matauranga Māori* (Māori knowledge), *mauri ora* (spiritual well-being) and *turanga Māori* (Māori identity) [sic]”. Traditionally, the whānau has been an enemy of the state through its cultural-reproductive capacity and emphasis on collectivism (Stewart-Harawira, 1995, p. 2). However, in recent times it has been useful as “an economic unit within the context of the delivery of social services”, providing the New Right with a mechanism for social control hidden behind the façade of devolution (Stewart-Harawira, 1995, p. 148). Thus, the state has sought to institutionalise the whānau concept.

With definitions based on descent, cause, or mixed criteria, and others that accept it as a collection of ideas, the whānau concept provides essential direction for state policymaking in health. As the foundation of *He Korowai Oranga – Māori Health Strategy* (2002), the whānau reflects a dynamic Māori society. However, whānau-centredness in health policy can be problematic. For example, the *Sexual and Reproductive Health Strategy: Phase One* (2001) has attempted “a whānau development approach” with limited success (Ministry of Health, 2001b, p. 12). A strengths-based whānau-centred approach, which utilises its own membership, may prove more effective (see MidCentral District Health Board, 2005b). The following section explores one group of whānau members: young Māori women.

Young Māori Women & Experiential Knowledge as Expertise

Young Māori women are kōtiro¹², taitamawāhine¹³, whaene/whaea/kōkā¹⁴, and kaumātua/kuia/pahake/pakeke¹⁵. They are older than tamariki¹⁶ and younger than rangatakapū¹⁷. They are self-defined and vaguely aged between 15 and 30 years¹⁸.

¹⁰ The original text brackets the roles after the term “whānau”. This creates a textual anomaly. It can be interpreted as either a group of five or more people who fill all of these roles, or a group of two or more people who fill at least one of these roles. I have chosen the second interpretation as it is broader and more congruent with my personal experience.

¹¹ The roles, themselves, can be seen as a collection of ideas. For example, a person can be a kuia, pakeke and tamaiti at the same time, contextually interchanging the term. Thus, the term “kuia” can be associated with, for example, the ideas of wāhine, kaumātua, tautoko, aroha and tamariki mokopuna.

¹² Daughter/s.

¹³ Adolescent woman/women.

¹⁴ Mother/s and aunt/s.

Young Māori women's participation in policymaking has two primary rationales. Firstly, the decision to enter into participatory processes fulfils a normative function through the recognition of the political rights of indigenous citizens. Secondly, the decision is substantive, providing expertise in the areas of whānau life and sexual health. This section provides evidence of this expertise.

Young Māori women's participation has a substantive rational. Young Māori women offer expertise in the areas of whānau life and sexual health. However, defining expertise is a philosophical process. In Western philosophy, ontology describes what can be known and epistemology defines how we can know it (Armstrong & Du Plessis, 1998; Davidson, 2003). Positivism is the basis of science and its epistemology emphasises objectivity (or a separation between the viewing 'subject' and the viewed 'object'). Positivists are inclined to dismiss knowledge gained through subjective means (like personal experience) as unscientific and invalid. The historical relationship between the state and positivist research has traditionally privileged objective knowledge as expertise (Smith, 1999; Trouillot, 1991). For example, Statistics New Zealand, a state agency founded on objective knowledge, provides quantitative research to support evidence-based policy. However, as Nutley, Walter, and Davies (as cited in Davidson, 2003, p. 93) indicate, there is a need for "some agreement about what counts as evidence in what circumstances".

Within the whānau, a young Māori woman's experiential knowledge allows her rights and responsibilities, which can be used as evidence. For example, as kōtiro and mokopuna¹⁹, the young woman contributes to the whānau financially, emotionally, or through housework. For some young women, contributions may extend to personal care of dependent whānau members, such as children or the infirm. Thus, a strengths-based approach reveals the young Māori woman as an expert insider on such issues as access to and protection of whānau resources. This "expert witness" can provide policymakers and administrators information on whānau structures, practices and preferences (Baehler, 2003, p. 29). Furthermore, based on her personal experience, a young Māori woman can provide evidence on issues important to her life stage, such as sexual health.

¹⁵ Grandmother/s and great-aunt/s.

¹⁶ Children.

¹⁷ Hui Taumata (2005) defines this groups as "20-40 year olds".

¹⁸ I choose to emphasise a Māori perspective of age and role. Age and role are not traditionally linked in Māori terms. A person can be 45 and still be considered a rangatahi (youth). Therefore, any specificity around age and role is avoided.

¹⁹ Grandchild/ren.

Young Māori women can claim experiential knowledge in the area of sexual health. For example, Pouwhare's (1998, p. 64) study showed "open and honest communication", "relationships based on qualities such as trust and partnership" and knowledge of options increased contraceptive usage amongst young Māori women. A "higher prevalence of STDs"²⁰ (Te Puni Kōkiri, 1994, p. 8) teenage pregnancy, and abortion (Broughton & Rimene, 1997) has ensured young Māori women are targeted by different state initiatives. Being targets of sexual health research (see Ministry of Health, 1996c, 1997c; Te Puni Kōkiri, 1994, 1995), services (for example, Te Puāwai Tapu²¹ and Te Kaha O Te Rangatahi Whānau O Tamaki Makaurau Trust²²), and promotion strategies (see Ministry of Health, 2003d), young Māori women have developed some expertise in regards to sexual health systems. As the Hui Whai Matauranga Whai Oranga (Te Puni Kōkiri, 1995, p. 26) articulated: "we know what works and what doesn't".

An ontological and epistemological position, which accepts the existence and validity of subjective knowledge gained experientially, already exists in public policy. For example, the development of monitoring frameworks has included Māori public participation and experiential knowledge (Ministry of Health, 2005a). Furthermore, the principle of subsidiarity requires policymakers and administrators to involve those who are impacted by their policies. As whānau members, young Māori women will be affected by any whānau-centred sexual health promotion. Extending both public policy philosophy and the principle of subsidiarity to embrace young Māori women will require political, bureaucratic, and administrative will. It is a public policy development to which this research is dedicated.

Conclusion

Past public policies have failed to alleviate and, in some cases, have exacerbated disparities between Māori and non-Māori. According to Cabinet policy committee minutes (2005b, p. 1), "regardless of socio-economic status, Maori... have worse health outcomes than non-Maori... (i.e. Maori in decile one have, on average, worse health outcomes than non-Maori in decile ten)".²³ For example, "about 20 Maori women a year die from cervical cancer" at a rate four times that of non-Māori (Caccioppoli & Cullen, 2005, p. 13). Part of this reproductive health problem could be due to poor service provision. In a 1998 review of 6579 patients, it was

²⁰ Sexually transmitted diseases.

²¹ A Wellington-based Kaupapa Māori sexual health service.

²² A South Auckland-based Kaupapa Māori sexual health service.

²³ Geographical areas are defined by a deprivation decile index, whereby the lowest resourced areas are deciles nine or ten and the highest one or two (Salmond & Crampton, 2002).

found that 14 percent of Māori hospital admissions were due to “poor practice by health professionals, compared with 11 percent for non-Maori” (“Inequality,” 2006). When controlling for additional factors these ethnic disparities diminish, though they do not disappear. Ringold (2005, p. 23) suggests that “the remaining effect may be due to other factors associated with ethnicity, including discrimination, exclusion, or inappropriately designed services”. Māori participation in policy development offers one opportunity for alleviating the negative effects of these factors.

Historically, Māori have participated in the development of public policy via the Treaty of Waitangi framework, elections, as state employees and “through iwi and Māori organisations” (Ringold, 2005, p. 6). Since the devolution period of the 1980s and 1990s, Māori have also been involved in the development of operational policy as state agency representatives (for example, District Health Board members), purchasers and service providers (see Kiro, 2001). According to Ringold (2005, p. 5), “questions of how policies can be best designed to meet the needs of Māori and an increasingly diverse population are very much on the front burner in New Zealand”. Since the 1990s, health policies designed to meet some of these needs have been led by whānau-centredness (Ministry of Health, 1994).

Whānau-centred policy, as the name suggests, intentionally locates the whānau at the centre of policy. With the release of *He Korowai Oranga – Māori Health Strategy* (2002), the state solidified the position of the whānau in Māori health. Though not without its challenges, whānau provides a widely applicable construct to which policy can be targeted and tailored. If the Māori Potential Framework²⁴ is applied, future policy could take a strengths-based approach and utilise whānau members (see MidCentral District Health Board, 2005b; Ringold, 2005). As whānau members, young Māori women offer expertise on sexual health, whānau life and appropriate participation timing and mechanisms. PHOs are a type of agency, which has the potential to operate as a site for Māori participation in the development of tailored operational policy for whānau health.

PHOs are state-funded agencies that would benefit from public participation. Contracted to DHBs to coordinate primary health provision in a given area, PHOs have devolved powers and responsibilities for the health of their enrolled populations. PHOs are required to “integrate Māori participation... in all levels of governance, service planning, development and implementation” (Ministry of Health, 2005c, p. 33). As a non-profit organisation of primary

²⁴ The Māori Potential Framework is a new initiative developed to guide Māori policy. Shaped like a wharenui, the Māori Potential Framework, emphasises “wellbeing”, “knowledge”, “influence” and “resources” (Te Puni Kōkiri as cited in Ringold, 2005, p. 38).

health care practitioners and providers, PHOs implement *The Primary Health Care Strategy* (2001), and implement and evaluate operational policy around issues like health promotion. Health promotion, is a relatively new responsibility and is funded “based on mortality and morbidity rates” (Cabinet policy committee minutes, 2005b, p. 2). Given current health statistics and policy, PHO operational policy should include sexual health promotion strategies tailored for whānau (Ministry of Health, 2001b, 2001d, 2002c, 2006a).

This thesis explores how PHOs can work with young Māori women to promote sexual health to whānau by focusing on policymaking processes and the best participation mechanism(s). Throughout the thesis ‘Tāniko’ provides direction.

The thesis has been divided into four sections: *Mana Wāhine*, *Te Ao Tawhito*, *Te Ao Hou*, and *Te Ao Mārama*. These sections are derived from a Tāniko methodology described in Chapter 2. The first section, *Mana Wāhine*, acknowledges Māori women’s expertise as the foundation to this research. *Mana Wāhine* describes my initial stages (first) as an uri of four very strong female lines and (second) as a researcher.

Te Ao Tawhito, the second section, provides the policy environment for the research. In Chapter Three, a historical position is taken from which Māori health development is critiqued. *The New Zealand Health Strategy* (2000), as strategic policy, and the New Zealand Public Health and Disability Act (2000) are identified in Chapter Four. Both of these policies maintain the democratic architecture of the health system. In Chapter Five, *He Korowai Oranga – Māori Health Strategy* (2002), the *Sexual and Reproductive Health Strategy: Phase One* (2001), and *The Primary Health Care Strategy* (2001) provide focus. As whānau-centred substantive policy, they provide direction in specific areas.

The third section, *Te Ao Hou*, outlines current situations. Chapter Six looks at the primary-public-Māori health relationship. In particular, it explores PHOs, their responsibilities to Māori, and health promotion. Data, in the form of analysed transcripts from semi-structured interviews, is presented in Chapter Seven. The data is the result of three young Māori women’s expertise in areas as diverse as whānau, sexual health, and organised peer groups.

Te Ao Mārama envisions new horizons in the fourth section. In Chapter Eight, the Tāniko evaluation instrument, a model for evaluating public participation by Māori women in policymaking, is applied to the data. As a result, the instrument defines how PHOs can work with young Māori women by identifying when participation would cause most affect and analysing two possible participation mechanisms: organised peer groups and the wāhine

centred approach. As the conclusion, Chapter Nine draws together the threads and offers directions for other research journeys. As a whole, the thesis aims to add to existing knowledge on Māori health development through an exploration of public participation and young Māori women.

CHAPTER TWO

METHODOLOGY

Introduction

Like other examples of Māori research, this thesis employed a particular methodology and method. According to Harding (1987, p. 3), methodology is “a theory and analysis of how research does or should proceed”. The distinction between methodology and method is made, when the latter is defined as “a technique for (or way of proceeding in) gathering evidence” (Harding, 1987, p. 2). This section aims to outline the methodology and method used to create this piece of Māori research.

Māori Research

Social research has sparked a number of traditions – from anthropology’s participant observation to the gender focus of feminist research. A review one of these traditions, Māori research, shows that its development has followed a history of colonialism and oppression. Informed by the Māori epistemology, a number of methodologies are included under the Māori research banner. As a tradition with a long and fruitful oral history, Māori research has some contemporary themes sourced cosmologically. These themes provide a binding force across methodologies, but still allow for distinctiveness to be present.

The Māori research tradition has been affected by the colonial history and ethnocentricity of imperial, non-indigenous investigators. Indeed, Smith (1999, p. 1) refers to “research” as being “inextricably linked to European imperialism and colonialism”. According to Trouillot (1991, p. 32), the “order” of research provided the “universal legitimacy of power” for the colonial West. As “a project, not a place” (Gitlin, 1989, p. 2), the West proclaimed the right to observe, deconstruct, reconstruct, and represent the indigenous “Other” (Said, 1978; Smith, 1999). Works – including “traveler’s accounts, colonial surveys, ethnographic reports and fictional utopias” – from as early as the sixteenth century were examples of ethnocentric research fed by the Enlightenment of positivism (Trouillot, 1991, p. 23). This research, and the

dichotomous relationship it established between non-indigenous researchers (the “Occident”²⁵) and the researched (the “Orient”²⁶), continue to support assimilatory practice and hegemony.

The colonisation process is continually refined through assimilatory practice, which restates the “correctness” of Western epistemology and the “incorrectness” of indigeneity (Said, 1978; Smith, 1999). The justification for such acts has been cultivated by Western researchers of the Darwinian and neo-Darwinian traditions (for example, positivism), whose philosophies and funding have been dictated by an assimilatory, paternalistic worldview. Drawn from the Western discourse of classification, representation, comparison, and evaluation (Hall, 1992), such studies are deemed “*Pākehā research* [sic]” in the New Zealand context (Mead, 1996, p. 147). Mead (1996, p. 147) defines such research beyond the boundaries of positivism, interpreting it to be:

research which brings to bear, on any study of *Māori* [sic], a cultural orientation, a set of values, a different conceptualisation of such things as time... different and competing theories of knowledge, highly specialised forms of the English language and structures of power.

Pākehā research, as a tradition, began from ‘First Contact’ with early ethnographers perpetuating the imperial pathway.

Early ethnographies on Māori helped establish the hegemony of colonial power. As early as Cook, written accounts of hierarchical social organisation amongst the “savage tribes” began to appear (Ballara, 1998, pp. 55-57). That many of these works (as in the case of John Savage in 1807) were based on interviews without aid of a common language and observations of diffuse villages, tillages, and single-family homes suggests deference to the established paradigm of the “uncivilised” (Ballara, 1998, pp. 55-57). Early officials replayed this paradigm in reports to superiors. Māori were presented as little better than animals, collective only in war (Bigges, 1821 in Ballara, 1998, p. 62) and too “incompetent to act or even deliberate in concert” (Marquis of Normanby as cited in Ballara, 1998, p. 62). The “racialised discourse that stereotyped Māori as savage” (Fleras & Spoonley, 1999, p. 68) continues to cloud the view of the Māori research tradition.

The Māori research tradition has not received wide acceptance by the mainstream research community. The “inherent racism in academia” categorises non-Western research as

²⁵ Said, 1978, p. 28

²⁶ Said, 1978, p. 28

subjective and, therefore, unreliable (Deloria, 1995, p. 49). As Deloria (1995, p. 50) points out: “the bottom line about the information possessed by non-Western peoples is that the information becomes valid when offered by a white scholar recognized by the academic establishment; in effect, the color of the skin guarantees scientific objectivity”.

Thus, the dominant culture provides Western researchers with resources (such as research funding) and a means for disseminating the “settler hegemony” to the populace (Fleras & Spoonley, 1999, p. 68). The attempt to create a separate space for Māori approaches to research has contested the universality of Western research discourse and, on a practical level, created competition for research funding (Mead, 1996). Māori approaches to research, therefore, have been viewed as a subversive essay on mainstream research by the politically (in)correct²⁷ (Durie, 1997a). This view has been rejected (see Durie, 1997a), though wayward attempts to apply Western criteria to (and, thus, the invalidation of) Māori research continue. However, these attempts have not hindered the development of this heterogenous tradition.

The Māori research tradition is multi-faceted; from indigenous perspectives of Western methodologies to oral history investigations; from Māori-centred studies to Kaupapa Māori research. Though each comes from a different standpoint, all can be located within a wider Māori epistemological setting, sometimes referred to as “Matauranga Māori” (T. Black, personal communication, 2001) or the “Kaupapa Māori framework” (Irwin, 1994, p. 25; Mead, 1996, p. 207).²⁸ A Māori worldview relies on the acceptance of a number of concepts, including: whakapapa (Barlow, 1991; Mitchell, 1972), te ao wairua (Henare, 1988; Marsden, 1992), reo (Karetu, 1993; Nepia, 1993) me ona tikanga (Henare, 1988), mana whenua, mana tangata (Durie, 1994a; Marsden, 1992), tapu and noa (Barlow, 1991; Shirres, 1997). A recognition of a shared past, present and future is presumed. Together, these epistemological elements have been used to inform “research design and process” (Irwin, 1994, p. 25).

The Māori research tradition has a long and fruitful oral history, with some contemporary themes being based on cosmological narratives. One of the first Māori research ventures was conducted by the god Tāne (sometimes referred to as Tāne-nui-a-rangi²⁹ or Tāne-Mahuta³⁰). Various authors have outlined the arduous search by Tāne for Ngā Kete Wānanga – the Three

²⁷ The notion of “political correctness” is often defined as being an aspect of the politics of diversity. However, if taken literally, the term defines correctness in accordance with the dominant political power. As Māori have not had dominant political power since the 1800s, Māori approaches to research cannot be seen as “politically correct”.

²⁸ The use of a capital letter (in this case, “K”) signifies the naming of a particular concept or object. Irwin (1994) uses the term kaupapa Māori with a lowercase “k”. In Irwin’s case, the difference may be purely ornamental (existentialist) or may define a significant difference in theoretical engagement.

²⁹ Mead, 1996, p. 183

Baskets of Knowledge – in the twelfth heaven (Buck, 1949; Mead, 1996; Shirres, 1997; Tomlins-Jahnke, 1997). Each basket contained necessary items for collective development, however, the attainment of certain aspects were restricted to those who proved their worth (Mead, 1996, p. 19). A second research project was the conception of humanity through Hine Ahu One (“the maid that emerged out of the dust”³¹). The creation of Hine Ahu One began with a search for appropriate resources, with red earth being sourced from Kurawaka (Alpers, 1964, p. 23). From this, Tāne formed the first human being and, with a breath blown into the nostrils (Alpers, 1964, p. 23), proclaimed life: “Tihei Mauri Ora!”

Both cosmological tales have themes, which can be applied to contemporary Māori research. First, both of Tane’s struggles show evidence of difficulty before triumph. Thus, it could be surmised that Māori research is about hard work. Second, the ultimate success of both ventures reveals that Māori research can be fruitful. As both endeavours resulted in positive measures for the development of humanity (knowledge and life), a third result could be inferred: Māori research should aim for higher goals beyond the immediate level.

Ironically, the employment of adapted versions of Western methodologies has, in many ways, assisted in achieving these higher goals. Though the imperial history of these methodologies, with all their negative effects, has been a source of some concern (see Smith, 1999), the adapted versions have a twofold effect. First, due to the diverse nature of Māori society (see Durie, 1997a), with some members being more comfortable with “Pākehā research” methodologies than indigenous approaches, the adoption of such processes allows their perspectives to be reflected as researchers and as participants. Second, though their colonial source means adaptation is required to align them with a Māori worldview, these methodologies have made useful additions to Māori knowledge and to positive Māori development as a whole. For example, Goodwin (1996), in her research on social support and Māori adolescent mothers, triangulated the Western phenomenological, documentary and life history methods. Unlike these methods, the oral tradition is always transmitted verbally.

Māori research, like the systems of other indigenous peoples, is based on a history of oral tradition. The oral tradition is “the teachings that have been passed down from one generation to the next over uncounted centuries” and has been a significant aspect of every culture at some stage (Deloria, 1995, p. 51). For example the great sagas of Europe and the Old Testament were all once transmitted as oral tradition (Deloria, 1995, p. 51). This tradition carried the culture of its peoples: from the spiritual (for example, cosmology) to the secular (for example,

³⁰ Walker, 1992, p. 171

names of animals); from the expansive (for example, genealogy) to the particular (for example, the place to cut a plant) (Deloria, 1995, p. 51). The wonder of the oral tradition lies in its ability to both contest the powers of the written word and to act as a vessel for “alternative histories” (Smith, 1999, p. 34), such as those held by Māori.

As Royal (1992, p. 21) points out, “Māori consider the oral tradition to be *the* historical tradition”. For example, Soutar (1994, p. 67) outlines eleven aspects of the oral history approach for those researching cross-culturally, whilst Royal (1992) provides a clear outline for Māori wanting to research their own backgrounds. A number of Māori researchers have used this method to research tribal histories, the oral resources enhancing both academic works (Hohepa, Hongi, & Sissons, 1987; Awarau as cited in Soutar, 1996; Taiapa, 1980) and those conducted within whānau. However, there are research approaches other than oral history, which may also be used to such effect.

Māori-centred research can be defined as a research approach, which intentionally locates “Māori people and Māori experience at the centre of the research activity” (Durie, 1997a, p. 9). Māori-centred research has been defined as research, which utilises “Māori research design and processes and personnel” (Cunningham, personal communication, March 20, 2001³²). However, control of the research may be mixed (Cunningham, personal communication, March 20, 2001). Durie (1997a) presents three primary principles for Māori-centred research: whakapiki tangata, whakatuia and Mana Māori. The whakapiki tangata principle refers to the “enablement... enhancement or empowerment” of Māori people participating in the research process (Durie, 1997a, p. 10). This principle highlights the need for research to be useful in the journey towards positive Māori development. The whakatuia principle focuses on integrating the “fragmented pictures” of Māori reality through contextualisation and accenting interrelated parts (Durie, 1997a, p. 10). The third principle, Mana Māori, is best defined within its slogan: “By Māori for Māori” (Durie, 1997a, p. 11). Mana Māori seeks Māori control over Māori destinies, including within the research paradigm. By utilising these three principles, Māori-centred research allows integration and movement towards a collective goal.

Kaupapa Māori research is another Māori research approach, which draws on Māori epistemology. An overriding “conceptualisation” of Mātauranga Māori (Nepe, 1991, p. 15), and a desire to develop, engage, debate, create, critique and reflect on Māori knowledge and its processes (Mead, 1996), provides a means for shared development in the Kaupapa Māori research community. Mead (1996, p. 208) believes Kaupapa Māori to be concerned with “sites

³¹ Marsden, 1992, p. 132. Please note: there are various translations.

of struggle”, chosen on the basis of their crisis status and “strategic important for *Māori* [sic]”. Therefore, from the ‘framework’ (or epistemological) perspective, Kaupapa Māori research assists in winning wider battles in the search for Māori emancipation. Glover (1997) and Pihama (1993) continue the emancipatory theme by presenting a relationship between the Kaupapa Māori and critical theories. Both theories critique existing power structures in order to undermine oppression and hegemony. However, G. H. Smith (as cited in L. T. Smith, 1999) views Kaupapa Māori theory as a localisation of critical theory, in deference to the specific needs of Māori and the perceived inadequacies of its progenitor.

Mead (1996) outlines five principles, which are used by Kaupapa Māori researchers when conducting studies among Māori and our communities. All five principles are relationship-based; the relationships between people and the relationships between people and the world. The first principle of whakapapa is integral in positioning relationships and is founded on embedded and established knowledge. The principle of te reo defines the struggle for survival – without te reo, a Māori-specific means of interacting would cease and the Māori way of life would wither. The third principle, tikanga Māori, concerns ensuring practices are “tika” or sound and, in application, should involve the observance of tapu³³ and the use of appropriate mentorship. The rangatiratanga principle is related to Treaty of Waitangi discourse, “community control, ethical practices and research reflexivity” (Mead, 1996, p. 217). The fifth principle, whānau, is an “organisational principle” (Mead, 1996, p. 220), which aims to recognise the gender and age difference within whānau, as well as the need for collaborative, supervised efforts. Together, these principles allow Kaupapa Māori research to know (mōhiotanga), learn (wānanga), understand (māramatanga) and internalise (mātauranga) the various pathways of knowledge (Stirling as cited in Salmond, 1980).

It is possible to critique the different aspects of the Māori research tradition. Apart from the obvious relationship to the Māori epistemology, similarities exist between all of the research approaches. Firstly, all the research approaches can be related to the cosmological themes introduced earlier, each showing evidence of hard work, fruitfulness and goals higher than the immediate level. Secondly, like Māori-centred research, the other approaches can be defined as “research by Māori, for Māori and with Māori” (Smith as cited in Glover, 1997, p. 2). These similarities bind the Māori research approaches together. However, the methodologies are also very distinct and operate differently in a number of ways.

³² Lecture on methodology and methodological issues, at Massey University, Palmerston North.
³³ And noa.

Firstly, apart from method-based differences (for example, documentary versus oral), most researchers³⁴ define themselves, and their research, as distinct groupings. This is important from a relativist perspective, as it emphasises the need of each group to name, define, and engage with their world in the way most appropriate to them. Secondly, where Kaupapa Māori research now draws from a growing theoretical pool, the other research types have well-established theoretical bases. In this way, each Māori research approach – whether Western-sourced, oral, Māori-centred, or Kaupapa Māori – allows expression of Māori epistemology and the development of Māori people.

Indigenous development is a “process” by which an indigenous people, such as Māori, “empowers itself to initiate [and] sustain its own betterment” (Wolfe-Keddie, 1996, p. 162). The components, which facilitate development amongst Māori, incorporate indigenous organisations, as well as problem-solving, decision-making, and knowledge systems (Warren, Adedokun, & Omolaoye, 1996). Māori knowledge systems, such as oral tradition, are used within Māori communities and are often invisible to outsiders. The reclamation of Māori sovereignty over, not only resources (see Durie, 1998; Fleras & Spoonley, 1999), but also the research process, is an essential element in development. For development to continue in a positive way, Māori must re-centre the research process and reclaim our right to create, name, and use knowledge in a meaningful way (Smith, 1999).

Māori knowledge has been ignored or appropriated by Eurocentric researchers. From the sixteenth century, indigenous peoples have been subjected to the Orientalism of the West (Said, 1978). Early Pākehā research continued this paradigm with racialised discourse continuing in academia. The recognition and development of the Māori epistemology has found space for a number of Māori research approaches, including Western-sourced methodologies, the oral tradition, Māori-centred studies, and Kaupapa Māori research. The feats of Tāne provide thematic guidance to these methodologies, which are both similar and discrete. The similarities exist in the Māori focus and the commitment to Māori advancement. As discrete methodologies, the research approaches use self-identification, size, and form of theoretical pool as distinguishing agents. Whatever the methodology employed, Māori researchers continue to fight for emancipation from the hegemony of colonial discourse.

³⁴ For example: Kaupapa Māori (Bishop, 1994; Glover, 1997; Mead, 1996) and Māori-centred (Cunningham, personal communication, March 20, 2001).

Methodology

The methodology for the research is based on a particular form of Mana Wāhine (or a Māori feminist) discourse. Irwin (1992, p. 5) was one of the first to identify the need “to develop theories of Māori feminisms”, and, thus, offered four “data bases” as possible sources for Mana Wāhine. In addition, Irwin acknowledged that there would be many theories of Māori feminism, not just one, and, thus, issues of representation must be acknowledged with the presentation of any interpretation (Irwin, 1992, p. 6). It is with this in mind that I offer this discussion and interpretation of Mana Wāhine as one Māori woman’s perspective.

Without defining the primary phrase³⁵, Mana Wāhine, as a term, can be translated in a number of ways. One possible translation is ‘Māori women’s mana’, suggesting that Māori women, as a group, possess an innate strength. Like the term, Mana Wāhine as discourse has a number of interpretations. Evans (1994, p. 54), for example, presents Mana Wāhine as “the process of self-determination by which we determine our social and cultural future and give effect to our status as tangata whenua – as Māori women”. Clea Hoskins (2000, p. 45) describes Mana Wāhine as “a positive and affirming phrase... sourced within contemporary Māori women’s discourse”. Smith (1992) conceptualises Mana Wāhine as having four strands of discourse: whānau, spiritual, state and indigenous women. Alongside other self-named Māori feminists (see Johnston & Pihama, 1994; Matahaere-Atariki, 1997), these authors interpret Mana Wāhine holistically. All the authors identify Mana Wāhine as existing within a (post)colonial framework that defines the role of Māori women and our relationship to others, including Māori men and non-Māori³⁶ (in particular Pākehā) women.

My interpretation of Mana Wāhine as discourse can be conceptualised as *Tāniko*. *Tāniko* is an “embroidered braid, border [or] tapestry” (Ryan, 1995, p. 239) made up of multiple thin threads twisted around a thicker cord to form a hand-woven pattern. Like its namesake, this *Tāniko* is but a border and does not claim to contain all answers. Similarly, this *Tāniko* can be utilised or left aside by others as they see fit. The four parts of my interpretation are *Mana Wāhine*, *Te Ao Tawhito*, *Te Ao Hou* and *Te Ao Mārama*.

Firstly, as the primary cord, this interpretation of the discourse acknowledges the mana of Māori women or *Mana Wāhine*. As the fibre around which the threads create the pattern, the *Mana Wāhine* cord recognises that all Māori women, including young Māori women, possess

³⁵ For further possible definitions of “mana”, please see Durie (1994a) or Marsden (1992).

³⁶ Non-Māori is used in this thesis to refer to all peoples who are not Māori.

an innate power inherited through gender and increased through action (Kupenga, Rata, & Nepe, 1993). This recognition is not of something new, but simply the naming of a sometimes-forgotten principle of Māori society. Like Freire (1992, p. 185), I seek to invoke “praxis” as emancipatory process. Similarly, I seek experiential knowledge as the basis for social change (Freire, 1992; Young, 2002). Indeed, I view the lived experiences of wāhine as expertise from which “a theory of action” can be created (Freire, 1992, p.185). In this research, the cord embodied respectful practice and participant-driven research. As I too am a Māori woman, the *Mana Wāhine* cord was shown in respect for me and my boundaries; ensuring I retain adequate support and guaranteeing I possess space for reflection.

The *Mana Wāhine* cord required wāhine to be viewed as social agents versus subjects and, thus, directly affected my choice of topic. When this project began in 2000, the existing sexual health research framed young Māori women as problematised (if not problematic), victims of disease and unintended pregnancy (Brander, 1991; Broughton & Rimene, 1997; Lynskey & Fergusson, 1993; McEwan, 1988; Ministry of Health, 1996c, 1997c; Te Puni Kōkiri, 1994, 1995). The Tāniko methodology was formed in 2001 as an unconscious response. Though an interest in Māori sexual health was developed in 1999, the policy focus was not defined until late 2003, with the public participation aspect appearing in 2006. The two-year gap between methodological formation and topic selection allowed the core values of the methodology to be applied intrinsically. The *Mana Wāhine* cord required a different position, where problems became experience and, thus, expertise. The foundation was taking shape.

However, *Mana Wāhine*, as the primary foundation of the thesis, was almost undermined by the research process’ obsession with objectivity. Objectivity, as suggested by its root word and suffix, is the process of making an object. Therefore, it is no wonder that positivist research, which emphasises a position of objectivity, constructs and maintains the researcher as viewer and the participant as object. Through objectification, the research process removes power and ignores mana.

As positivist objectivity is the foundation of university study in New Zealand, it is unsurprising that my research journey involved a seesaw of conflict and compromise. For example, during my first ethics application process, I was strongly advised to have no relatives as possible participants; it was deemed to lack objectivity. Indeed, the ethics process frames researcher/family member relationships as conflicts of interest. As the participant pool was Māori and my whakapapa extends to nearly all waka, I had to employ a Western definition of ‘family’ in order fulfil the requirements of my ethics approval. If I had maintained my own definition, I may have had no one to interview. It is ludicrous that, in order to receive ethical

approval, I must pretend that I believe the ‘family’ is nuclear and that I am objective. Like Fanon (1968, p. 61), “it is not possible for me to be objective”. I do not want anyone, ‘family member’ or otherwise, to ever be objectified. I, therefore, “displace” (Bhabha, 2004, p. 63)³⁷ objectivity and choose to view these wāhine as social agents with power.

Like Irwin (1992), I believe that understanding of both historical and contemporary Māori society can contribute to collective and individual growth of Māori women, as a whole, and young Māori women as a specific group. *Te Ao Tawhito*, as the historical realm, includes non-European times and spaces where non-European practices occur and occurred. For example, this thread includes the social structures (such as whānau and marae) within which traditional practices flourish. As the first thread, it requires us to look forward³⁸ to the offerings of an ancestral path. This thread warns against romanticising our past, but allows us to utilise those models and principles from which development can occur.

The Māori goddesses of Papatūānuku, Hine Moana, Hine Rau Kauri, Hine Te Iwaiwa, Hine Ahu One and Hine Titama (who became Hine Nui i te Pō)³⁹ all offer powerful role models for Māori women. In later times, Māori women – from Mahuika to Rongomaiwahine to a multitude of others – provide examples of Māori women who possess both strength and leadership skills. All of these women show young Māori women, particularly, that we have mana, that we are effective leaders, and that we are able to act independently from men. *Te Ao Tawhito* also offers examples of balanced relationship practices (for example, complementary gendered roles), a source for cultural identity, and a foundation of linguistic, social, spiritual, and economic growth. In the research, this thread was used to highlight the collective traits of the young Māori women involved. As a group, Māori women share, at the very least, gender, genealogy, and self-identification⁴⁰. The group of young Māori women participants also shared age-associated interests and the adolescent experience, providing added points of commonality.

³⁷ Bhabha (2004, p. 63) refers to judgements of stereotypes founded on old norms and engagement with their “effectivity [sic]” and “regime of truth” in order to comprehend the “productive [sic] ambivalence of the object” that is otherness. His process seeks to displace versus dismiss, allowing limits to be transgressed. I use his term similarly, with the aim of transgressing the limits from a “space of... otherness” (Bhabha, 2004, p. 63).

³⁸ Or back in European terms.

³⁹ These are by no means the only Māori goddesses, but are simply those known to me.

Like *Mana Wāhine*, *Te Ao Tawhito* affected the research topic and method. It allowed me to define a population (young Māori women) through the acceptance of commonalities. In addition, it required the recognition of existing, shared sources of traditional practice, cultural identity, and growth. As Māori health policy had begun to shift its gaze from iwi to whānau structures, the whānau became the third important axis around which the research was conducted. This whānau emphasis was reaffirmed during data collection and, thus, affected content analysis. *Te Ao Tawhito* affected the choice of method through its emphasis on Māori idiocultural practices. Though a quantitative approach could have validly expressed Mātauranga Māori, the chosen qualitative method – in-depth interviews – allowed the oral tradition to be fully expressed.

During the conduct of this research, I found my interpretation and application of *Te Ao Tawhito* to be assumptive at times. By interpreting the thread as implicitly collective and failing to recognise Māori individualism, I did not acknowledge that all societies balance social and individual needs. This led me to make some ridiculous assumptions. The greatest of these presumed that participants would share the same opinion on most things. This rejection of the subjective would not have occurred if *Te Ao Hou* had been consistently applied.

The second thread, *Te Ao Hou*, looks at the contemporary realm. In this post-contact sphere, *Mana Wāhine* recognises colonisation as the principal landscape upon which the research will be conducted, with “an analysis of colonialism [being]... a central tenet of indigenous feminism” (Smith, 1999, p. 152). To colonize is to centre the colonist, “establish control over... the indigenous people”, and “appropriate (a place or domain) for one’s own use” (Pearsall, 1999). This process continues as the state, the media, and the market maintain eurocentricity and move the colonial eye to the global stage. As a nation, we are asked to aim for international markets and, in the process, to colonise someone else. Therefore, colonisation is not interpreted as a process of simple oppression from which we can be freed. Here, colonisation is acknowledged as an ongoing discourse in every person’s life. For praxis to be realised, we must acknowledge and name the processes, which benefit and exclude us as individuals and as a society.

⁴⁰ This trait requires a Māori woman to identify herself as such and is open to criticism. Some research believes genealogy is more important than self-identification and, therefore, ascribes ethnicity even when a person does not agree. For example, the Census ascribes a statistical New Zealand Māori ethnic identity when a respondent indicates New Zealand Māori ancestry. Furthermore, it weights New Zealand Māori more heavily when ascribing primary ethnicity. This may be in contradiction to the respondent’s own belief. I believe that to label another is to whakaiti (or disrespect, humble) and whakanoa (or remove mana and/or tapu). Therefore, the labelling of another’s identity is contradictory to my belief in individual mana (see *Te Ao Hou*).

In my life, colonisation allows me benefits as an educated individual with a middle-class background⁴¹; I own my privilege (Matahaere-Atariki, 1998). In addition, colonisation positions me in such a way that self-marginalisation, through resistance, threatens my ability to act as an effective agent of social change. As colonisation will have affected each young Māori woman differently, this addition to the Tāniko seeks to acknowledge each woman's experience as distinctly important. At the micro-level, each individual embodies mana wāhine, is self-determined, and deserves respect. *Te Ao Hou* never presumes that one is able to speak for another. The inaccurate representation of Māori women's voices by the unmandated – particularly, Māori men and unmandated Māori and non-Māori women – has been detrimental (see Irwin, 1992; Matahaere-Atariki, 1997; Smith, 1999). Thus, the thread promotes processes, which allow the 'silenced' to speak. *Te Ao Hou* does not reject collectivity through clear mandating systems, but acknowledges that each 'voice' has its own 'words' to express⁴².

Te Ao Hou, as a thread, has proved to be the most difficult to manage as it accepts a position, which could be seen as hegemonic (see Gramsci, 1971). By accepting colonisation as the principal landscape, am I not limiting the power to move beyond it? I would answer this question with another: is it not the role of the oppressed to educate ourselves to move beyond the limitations instigated by our oppressors (Freire, 1992)? If we do not, because we cannot, name the power which binds us, we lose "ontological resistance" (Fanon, 1968, p. 78)⁴³.

A second issue concerns the very topic of this research. The selection of a topic, which seeks to ease the relationship between the State and young Māori women, is easily interpreted as collusive. If, as the oppressed, we engage with the power structure that disempowers us, are we not colluding with it? A simple, pragmatic approach would point to existing engagements within the confines of a social democratic nation-state. Indeed, interaction with other members of our own communities involves using state-funded utilities (for example, roads) and state-defined norms (for example, not killing people randomly). However, I prefer an approach, which favours social change from both within and outside of oppressive systems. As collusion remains a constant threat for those within, they must be provided with good supervision by those outside. Thus, the thesis topic and general approach emphasises young Māori women within the whānau unit.

⁴¹ By middle-class, I do not refer to household income, but possession of the necessary cultural capital to negotiate the education system.

⁴² This 'voice' may be presented in non-verbal ways, such as laughter or inaction (see Matahaere-Atariki, 1997).

⁴³ Fanon's (1968, p. 78) words encompass a sense of loss: "the black man has no ontological resistance in the eyes of the white man". I, too, fear subjugation through objectification and take Fanon's words as both warning and challenge.

Te Ao Mārama, the third thread, looks to our development as Māori women and the inheritance we will leave for our children. It recognises that the current hegemony, which disempowers Māori women, must be stopped at the macro-level, so as to ensure there is a hope for all of our descendants. This barrier to development is perpetuated in a number of ways, including through the (in)actions of both Māori and non-Māori people. In addition, it recognises that these same people can also be vehicles for emancipation. For progress to be realised, relationships outside the Māori women's collective must be developed and maintained.

Like Evans (1994), I believe that the answer to powerlessness is political empowerment. However, I believe this empowerment will not be realised without the localisation of political power into the relationships experienced everyday. For *Te Ao Mārama*, such localisation requires the provision of education to Māori women generally and young Māori women particularly. This education should be centred into areas which wāhine identify as important. In this research, the first aspect of *Te Ao Mārama* – external relationships – will be answered through reports to practitioners and policymakers. The second aspect – education – was addressed through the provision of education to participants as required and dictated by them throughout the research process. If I was unable to adequately provide for their needs, external relationships were prepared as means for referral.

Method

By utilising Patton's (1990, p. 197) "Design Issues and Options" table, it is possible to create a basic research design, which fulfils the research's aims. The study focussed on depth, as suggested by its "Pure Qualitative Strategy" of "Naturalistic Inquiry, Qualitative Data, and Content Analysis" (Patton, 1990, p. 190). The "analytical approach" (Patton, 1990, p. 197) was inductive. A confirmatory stage of content analysis utilised public participation evaluation as a deductive tool. The study began with documentary research, in the form of a literature review, in order to create a background.

"Observational data" (May, 1993, p. 133) was obtained through taped, semi-structured, in-depth interviews, which utilise open-ended questions. Individuals were the "units of analysis" (Patton, 1990, p. 197). The sample size was three participants. In order to increase the possible number of "information-rich cases" (Patton, 1990, p. 181), the "sampling strategy" (Patton, 1990, p. 197) for participants was combination purposeful sampling. The methods triangulated were intensity and snowball (Patton, 1990, p. 183). The logistics of gaining access

to the participants began with direct approaches. As I already knew possible participants, two participants were approached directly via intensity sampling. Snowball sampling was successfully employed to recruit one participant.

“Validity of and confidence in the findings” (Patton, 1990, p. 183) was addressed through methodological (see documentary research, interviews and sampling above) triangulation. The research used a fixed time line, with a one-year limit being used for data collection.

Ethical issues of particular importance to the research were consultation, informed consent, protection of participants, “presentation of self”, ownership, accountability, reciprocity, and positive and applicable outcomes (Patton, 1990, p. 197). In regards to consultation, pre-research consultation occurred on the parameters of the research (including aims, objectives, definitions, and methodology) with young Māori women, my whānau and tūpuna.

Informed consent was attained through the following process. Verbal and written information, alongside consent forms, was distributed to participants. Protection of participants included the right to withdraw at any time, right to not answer any question or be involved in any particular aspect of the research, right to have themselves and their words respected, and confidentiality of personal details.

In order that the words of the “involved” may be respected, oral narratives – “the material gathered in the oral history process, typically using a tape recorder” (Gluckman & Patai as cited in Selby, 1996, p. 58) – were used. So that confidentiality of details could be ensured, any distinguishable details (for example, names) were automatically suppressed, with pseudonyms used (where appropriate) and identifying comments aggregated. Confidentiality was also assured in the transcribing and storage of raw data. As both interviewer and transcriber, I was the only person to hear taped interviews. Raw data, in the form of tapes and transcribed notes in digital and paper forms, were kept in a locked cabinet. All raw data was returned to participants or destroyed at their request on completion of the research.

Presentation of the researcher in the results is another important ethical issue. The research applies reflective subjectivity, in the heuristic form. My experiences as a young Māori woman are presented alongside those of the participants. Ownership of personal statements, feelings and information are noted through “I”, “me”, “my”, and “mine”.

The participants shall retain ownership of the raw data. Accountability to the participants, my whānau, tūpuna, and te iwi Māori were actioned through ongoing reports to the relevant groups,

with the latter hopefully being serviced through the reporting process. As reciprocity was a founding ethic, I provided kai and my own perceptions at all interviews.

The resulting research shall be made available to participants. Two copies of the full research shall be submitted to the appropriate academic systems for marking. One copy shall be given to each member of the supervisory whānau. One shall be retained for personal use. Another shall be retained for presentation at a personal hui-ā-hapū. If the research reaches the required standard, one copy shall be submitted to the Massey University Library.

SECTION TWO
TE AO TAWHITO

CHAPTER THREE

MĀORI HEALTH DEVELOPMENT

Positive Māori development can be defined as a process of cultural, social, and economic advancement of Māori aspirations, whose outcomes have an effect which Māori believe is beneficial to Māori as individuals, as part of a community (such as an iwi or a hapū), and/or as a nation. Positive perspectives to Māori development require long-term planning and proactive mechanisms, instead of the “negative spending”, “bottom of the cliff” approach favoured by the state (for instance, hospitals versus health educators) (Durie, 1994a, p. 155). As Māori models for practice tend to be distinctive in their holistic nature (for example, the Whare Tapa Wha⁴⁴ and Te Wheke⁴⁵ approaches), positive Māori development relies on a co-operative format that takes into account all sectors and needs of the people. The Māori development process can be begun, applied, and completed by Māori or by other agencies, such as the government. However, as positive Māori development can be a stepping stone for Māori self-determination and non-Māori cannot always correctly assess the needs of Māori, it is important that any Māori development goals are set by Māori for Māori.

Māori health development is one branch of Māori development. In this chapter, the effects of colonialism on indigenous health introduce an historical account of Māori health development: from the population declines of the 19th century to the 2005 Māori Potential Framework. The advancement of Māori health is explored from both indigenous and Māori-specific perspectives. The incorporation of a broad view of development is justified by a commitment to integration and social change.

Indigenous health development has been affected by social change, including various types of colonisation. From the spread of disease to the spread of “cures”, domination has affected indigenous health. Kunitz (1994, p. 13) describes disease as a major influence on “the epidemiologic and demographic responses of the indigenous peoples” to colonisation, with “the health consequences of differing colonial policies... [being] particularly visible” (Kunitz, 1994, p. 18).

In the Americas, pre-contact Amerindian populations were estimated at 100 million (Aaby, 1985). However, colonial policies focussed on land and resource (for example, gold) appropriation changed this situation dramatically. By the one hundred and fiftieth (150th)

⁴⁴ Durie, 1994a.

anniversary of first contact, the population had decreased to 10 million⁴⁶, with some civilisations being wiped out entirely (Kunitz, 1994, p. 18). The primary cause of this decline was “virgin-soil epidemics”, or epidemics in countries where immunity to particular diseases did not exist and mass infection was simultaneous (Kunitz, 1994, p. 330). According to Aaby (1985, p. 335), “excessive mortality in virgin-soil epidemics greatly facilitated European expansion into the Americas and elsewhere”, with some going so far as to celebrate the occasion: “always it will be a source of thanksgiving that the destruction of the Indians of the Pacific Northwest by diseases spared the pioneer the horrors of a strong and malignant foe” (Scott, 1928, p. 161).

In New Zealand and Hawai’i, colonial policies, which favoured resource (notably land) attainment, increased production, and the mastery of the indigenous society, have had similar health consequences. Kunitz (1994, pp. 50-51) suggests that the “catastrophic population declines” experienced by the Māori and Kanaka Maoli peoples may have been due to the “destruction of subsistence agriculture... and the expropriation of land”. This resulted not only in impoverishment, and its related respiratory and intestinal diseases, but also in a loss of social and economic networks (Kunitz, 1994, p. 51). Division of a society and a loss of social support – through such mechanisms as treaties (New Zealand) and “annexation or non-legal means” (Hawai’i) (Roberts, 1997, p. 11) – has been linked to high mortality rates. New Zealand evidence has shown a link between low “Māori child-to-woman ratios” and rapid land appropriations (Kunitz, 1994, p. 51). As fertility rates were not excessively affected, it is likely that the 1850 to 1880 land expropriations caused a high child mortality rate (Kunitz, 1994, p. 51).

In the early years of colonialism, the Māori population was estimated to be between 100,000 (Cook) and 500,000 (Buck) (Durie, 1994a). Approximations made in the Treaty of Waitangi year (1840), gave a Māori-settler ration of forty to one (Dow, 1999). By the 1850s, this had equalised (Dow, 1999). This rapid decline had been detected early in the century, with an all-time low of 42,113 being recorded in 1896 (Durie, 1994a). Colonial administrators and some missionaries, aware of the situation, attempted to source solutions through the British Government, God, and secular medicine (Durie, 1994a). Like other diseases, the affects of smallpox and tuberculosis on both the Māori and European populations were met with a fatalistic attitude (Dow, 1999). Intervention was minimal, with some settlers welcoming the indigenous population’s demise. However, such a wish was not to be fulfilled without a fight.

⁴⁵ Pere, 1984.

⁴⁶ This is considered an optimistic approximate, with some research suggesting 95% decreases or a population of 5 million.

Māori have always had an efficient public health system, though at times it has not been applied. Tapu, rāhui, and noa provide the system's foundation, with movement between the states occurring according to need. Tapu restricted interactions by the majority with certain people (for example, tohunga), places (for example, urupā), activities (for example, giving birth), and objects (for example, weaponry) to protect against injury or infection. Similarly, rāhui banned activities at or with particular areas or things, to prevent injury or conserve a resource. Items marked noa were free from restriction. Cleanliness typified the Māori health system, with water being used regularly to cleanse both physical and spiritual ailments and refuse (whether human or otherwise) being separated from everyday objects and activities, especially food.

Like other cultures (see Green & Zokwe, 1996; Landy, 1977; Loudon 1976), traditional healers, or tohunga, provided guidance, diagnosis, and treatment to the sick. The cause of sickness was inevitably a breach of tapu or rāhui and it was the tohunga's task to source the breach and cure the symptoms. Tohunga used a number of methods including karakia, ritual cleansing, surgery, natural medicines and physical manipulation (massage) (Durie, 1994a). These methods were actively practiced and transferred (through whare wānanga) up until the passing of the Tohunga Suppression Act 1907. Though the Act did not destroy tohunga or their practices, the legislation did make the transfer of knowledge and skills exceedingly rare (Durie, 1994a). In many ways, the Act was just another tool of colonial domination. However, this policy represented one of the first state-endorsed battles between traditional Māori medicine and its contemporary: the Western scientific system.

By 1900, the Western scientific system had become a necessary response to the changing needs of the disrupted Māori population. Though observances of tapu and noa had not disappeared, economic and social conditions did not favour their normally prudent application. By this stage, the naturally robust Māori, who survived on an adequate (if sparse) diet, had been impoverished, disempowered, and malnourished. Elements of the colonists' lifestyle, including food, housing, and practices, had replaced the traditional Māori one. Pulled from their hilltop pa, many Māori now lived in squalid, damp conditions; "their houses were poorly constructed, with earthen floors, poorly ventilated and overcrowded" (Maclean, 1964, p. 191). According to Maclean (1964), sanitation was frequently non-existent, with drinking and cooking water often being polluted.

Pomare was one of the first "Māori medical practitioners who joined the fledgling Department of Public Health [and] attacked... risk factors such as nutrition and basic hygiene, as well as some of the underlying aspects of Māori social and economic deprivation" (Pool as cited in

Kunitz, 1994, p. 67). In his mind, “the evils of the... half-European, half-Maori ways of living” had to be expunged, largely because of their affect on Maori health (Pomare as cited in Maclean, 1964, p. 191).

Māori life expectancy in 1901 was only 35 (male) and 30 years (female) (Public Health Commission, 1995a), suggesting a high maternal mortality rate. A survey undertaken by Pomare (1908) five years later revealed a high incidence of respiratory (for example, bronchitis), digestive (for example, constipation) and miasmatic (for example, measles) disease amongst Māori. The first of these types of disease is linked to climate, poor housing, and overcrowding; the second to low quality food and hygiene; whilst the third involves a combination of factors – poor housing, overcrowding, intensive or prolonged exposure, and lack of vaccination being but four. Many miasmatic sufferers in the survey, particularly those suffering from influenza, also contracted respiratory disease in the form of pneumonia⁴⁷ (Pomare, 1908). This suggests a large number of pre-existing determinants – perhaps, as a result of long-term impoverishment. It was, therefore, fortunate that economic, in addition to physical, factors were included in Pomare’s plan.

Pomare utilised the Māori Councils Act 1900 and the resulting Councils, in his role as the first Māori Health inspector, to monitor and apply sanitation and hygiene regulations (Pomare, 1908). The Act, itself, was one of the first (and few) pieces of legislation to allow some type of Māori autonomy in regards to health issues. It allowed the establishment of Māori Councils in Proclaimed districts, with personnel consisting of up to one official and 12 elected members (Maclean, 1964). Councils were empowered to monitor and enforce “the rights, duties, and liabilities of tribes and individuals”, promote health, education and welfare, and suppress “injurious customs” (Maclean, 1964, p. 192). To that end, Councils were given the power to create and uphold by-laws. Village committees were established to assist the Councils in their duties, which, in some cases, included assuming “the functions of health committees” as outlined in the Public Health Act 1900 (Maclean, 1964, p. 192).

The passing of two pieces of legislation (the Native Land Amendment Act 1919 and the 1920 Health Act) and the establishment of the Māori Hygiene Division, of which Buck (a former health inspector) was the first Director, extended this duty (Maclean, 1964). Some progress was made up until Buck’s resignation in 1927 and the appointment (then resignation) of his replacement, Ellison. Under Director-General Watt, the Division of Māori Hygiene was

⁴⁷ Pomare (1908) does not state if he has identified patients under one or both categories, thereby creating a minor difficulty in statistical analysis.

disestablished and, through the Councils' and its demise, the determination of Māori health development centralised.

An interventionist, paternalistic approach to Māori health ensued, with the milk-in-schools project (1930s onwards), child benefits (1940s onwards) and free medical care for pregnant women (1941 onwards) assisting in uplifting the general status of Māori health. With the end of the depression, Māori economic and physical health saw a renaissance, as life expectancy rose from 46 years (both male and female) in 1936 to 54 (male) and 56 years (female) by 1951 (Public Health Commission, 1995a). Disintegration of traditional Māori networks began as Māori society drifted, then flooded, to urban areas. From 1945 to 1956, there was an approximate increase of 10% in urban Māori (Public Health Commission, 1995a). By 1956-1966, this increase had doubled (Public Health Commission, 1995a).

During the 1930 to 1970 period, Māori health became a cause advocated for and driven by Māori women. Two Māori women's organisations sprung up: the Women's Health League and the Māori Women's Welfare League. Both organisations could be defined as social movements, though each had strong links to traditional society, with many members fulfilling roles on traditional organisations. The Women's Health League was established in 1931 with support from Te Arawa (and later) Tuwharetoa, Whakatohea and Tairāwhiti (Durie, 1994a). The Health League was intensive, focussing its efforts in central and east North Island communities. In comparison, the Māori Women's Welfare League was extensive, their national emphasis being defined from their early relationship with the tribal committees founded under the Māori Social and Economic Development Act 1945 (Durie, 1994a). Both organisations have facilitated Māori health development.

In the first instance, both organisations facilitated Māori health development by providing open fora (and, therefore, participatory decision-making systems) for discussing Māori health issues. In addition, they advanced capacity development by increasing stakeholder involvement (particularly that of Māori women) and providing a mechanism for problem solving. The Health and Welfare Leagues were successful in ensuring sustainable approaches to health development, as evident in both their continued existence and the perpetuation of their greatest resources: strong Māori women and their networks. These groups have also effected social change. Both associations have raised awareness amongst the Māori population, with the Welfare League using their extensive influence to lobby politicians.

The 1960s saw the elevation of a particularly vocal indigenous social movement in New Zealand. Te Tiriti o Waitangi had begun to rise to the forefront of Māori political assertions in

the latter parts of the decade. Māori media in the form of *Te Hokioi* and *MOOHR* (Māori Organisation on Human Rights) operated as “consciousness-raising mechanism[s]” (Walker, 1990, p. 209). Ngā Tamatoa, led by the Jacksons, Peter Rikys, and Donna Awatere, used both internal (for example, Select Committee submissions on the Race Relations Bill) and external strategies to force social change in the 1970s. Māori protest action continued through the land rights movement and the 1975 Hikoī, the Bastion Point occupation in 1977/78 and the Waitangi Action Committee in the early 1980s. The latter made Te Tiriti o Waitangi its focus, protesting with the support of the Kotahitanga, the Kingitanga, and the Presbyterian and Methodist churches. The 1984 Hikoī to Waitangi became the “crescendo” to a growing “assertion of Māori political and cultural self-determination” (Kelsey, 1996, p. 179). Māori were ready to reclaim their lives and, with it, their health.

In 1977, the Māori Women’s Welfare League set-up a health research arm, which operated a survey from which *Rapuora* resulted (Durie, 1994a). This was followed in 1984 by two significant conferences: the Hui Whakaoranga in March and the Hui Taumata in October (Durie, 1994a). The Hui Whakaoranga brought together government officials, representatives from Hospital Boards, health workers, and interested individuals from the voluntary and business sector “to listen to Māori people define health in their own terms, identify their health concerns and aspirations, and share the solutions that have been developed to meet these” (Barker as cited in Department of Health 1984, p. 4).

The Hui presented and discussed Māori health perspectives, Māori-run health initiatives (including community health clinics), and future strategies (Department of Health, 1984). In addition, workshops were held to discuss Māori health over four domains (spirituality, mental and emotional well-being, whānau, and physical welfare), as well as various health programmes, including the Waahi Marae Project (Department of Health, 1984).

The Hui Taumata (or Māori Economic Summit) focussed on positive Māori development from a broad perspective. Two basic principles and six themes were identified. The principles were simply stated: “Māori control of Māori resources, and Māori objectives on Māori terms” (Mejil, 1996, p. 203). These were defined further through the themes: the Treaty of Waitangi, tino rangatiratanga, iwi development, economic self-reliance, social equity and cultural advancement (Durie, 1995a).

The fourth and fifth New Zealand Labour Party⁴⁸ Governments sparked a number of reforms, which affected all sectors of society, including Māori working in the health sector. Structural reform echoed changes in other Western nation-states, but was unique to New Zealand in the way the Labour Government pursued both social liberalisation and economic rationalisation (Cheyne et al., 1997). A separation of economic and social policy saw the former emphasised, whilst the introduction of neo-liberal ideologies produced devolution and free market programmes (Cheyne et al., 1997). Under Roger Douglas, as Minister of Finance, the application of Treasury-sourced reform packages became the priority. Many Māori organisations recognised the opportunities for development through the reforms and, by 1985, at least 18 roopu (Māori groups) were receiving state funding for the provision of health services, large and small (Durie, 1994a). However, this was not to be the only area of policy reform, which would affect Māori.

The Treaty of Waitangi, though recognised through incorporation into New Zealand's constitutional framework,⁴⁹ became the basis for a Government-instigated "policy of appeasement" (Kelsey, 1996, p. 179). According to Kelsey (1996, p. 179), this policy direction was an attempt to defuse Māori bellicosity and its "assertion of Māori political and cultural self-determination" in the 1970s and 1980s. By acting collectively, indigenous groups "threaten[ed] the social stability in many advanced countries", including New Zealand (George & Wilding, 1985, p. 133). Culpitt (1995, p. 230) writes that "so effective has been the political agitation for the satisfaction of indigenous [T]reaty rights that the sphere of racial conflict has become a prominent feature of the demands for social justice".

Through "political agitation" (Culpitt, 1995, p. 230), Māori pressure groups sought "to redress economic inequality by promoting... the principle of group entitlement" (Culpitt, 1995, p. 231). This included recognition of the Treaty partnership through both legislative (such as the State Owned Enterprises Act 1986) and non-legislative (such as *Te Urupare Rangapu*, 1988) measures. In 1986, Cabinet agreed to consider all future legislation, when presented at the policy authorisation stage, with regard to recognition of Treaty principles (Durie, 1994a, p. 102). In addition, Cabinet acceded to consultation between Māori and the public service "on all significant matters affecting the application of the Treaty" (Durie, 1994a, p. 102). This inclusion in the Cabinet manual remained untouched throughout the 1990s.

⁴⁸ Henceforth referred to in the body text as "Labour".

⁴⁹ This occurs ineffectively through the actuality of the state and its authority (Institute of Policy Studies, 2000, p. 3), statutes (for example, the Treaty of Waitangi Act 1975) and various arrangements for acknowledging the Treaty relationship, such as representative systems (Walker, 1990, p. 149).

More restructuring in the 1990s – “widely recognised... [as being] possibly the most radical of any OECD country” (Bloom, 2000, p. 183) – saw health structures redeveloped to create a competitive health system, whereby public and private health service providers would bid for state-funding. As expected, policy was developed to assist in the transition from government as provider/purchaser to a separation of the roles and an increase in private sector involvement.

In 1993, Te Puni Kōkiri (the Ministry of Māori Development) released *Te Ara Ahu Whakamua*, a discussion document proposing a number of strategic directions for Māori health. The objectives of the proposal reflected the move from state to private health provision, with Māori health initiatives being pursued as a primary means for reaching health service responsiveness for Māori (Te Puni Kōkiri, 1993). In mainstream provision, an expectation was made that the Treaty of Waitangi would be reflected “as the basis for policy advice and decision-making” (Te Puni Kōkiri, 1993, p. 30). Other Māori health goals included increasing the number and level of expertise in the Māori health workforce, the creation of networks, and the facilitation of growth in the number of Māori health initiatives. The latter goal incorporated promotion and protection of traditional Māori healing practices in its brief, ensuring the perpetuation of multiple health systems and epistemologies (Te Puni Kōkiri, 1993, p. 31-33).

By 1998, the number of Māori health providers receiving state funding had risen to 53 in the lower North Island and Nelson/Marlborough regions alone (Tu Ake Productions, 1998). In Te Tai Tokerau (Northland), managed care models were complemented with budget holding, as opportunities for greater Māori control of resources began to take affect (Waldon, 1999). However, political change was on the horizon. Again.

In 1999 and 2002, Labour formed two coalition governments; first with the Alliance Party⁵⁰, then with Jim Anderton’s Progressive Party. These elections not only showed a philosophical swing of support from the classical liberalism/libertarian tradition to modern liberalism and social democracy, but also emphasised the importance of the voting Māori population, particularly to the Labour party. It should be, therefore, no wonder that the 1999 Coalition included the Treaty of Waitangi – the basis of Crown-Māori relations – in new health policy. In the post-Orewa/Māori Party environment, Te Puni Kōkiri has developed the Māori Potential Framework as a strengths-based approach to Māori policy development (Ringold, 2005). Shaped like a whareniui, the potential of te iwi Māori, the uniqueness of our culture, and the need to invest in our largest untapped resource – our people – provides the driving principles

⁵⁰ Henceforth referred to in the body text as “Alliance”.

(Ringold, 2005). With such intention, there is no doubt that future developments in Māori health will be (at the least) interesting.

Future developments in Māori health cannot but reflect the colonial background of this country. From the 90% decline of the Amerindian populations to the 80% decline of the Māori peoples, colonisation has affected indigenous health advancement. Like other indigenous nations, Māori utilised an autochthonous public health system, which was outlawed by the colonialists. Replaced by a less effective, eurocentric system, Māori socio-economic standards dropped with poor housing, overcrowding, low quality food, and hygiene becoming frequent. As Māori adapted to the new cultural climate, the state began legislating both for (for example, the Māori Councils Act 1900) and against (for example, Tohunga Suppression Act 1907) Māori wellbeing. An interventionist approach saw a renaissance in Māori economic and physical health, with the cause finding female advocates in the form of health and welfare leagues. Vocal indigenous social movements heralded the rise of Te Tiriti o Waitangi discourse. Māori began to reclaim their lives and, with it, their health. In an environment of neo-liberal reform, research and conferences focussed policy development, whilst devolution increased the number of Māori health providers. However, the recent change in political direction presents opportunities of a different sort. How these opportunities affect sexual and reproductive health policy will reflect colonialism and its effects. Nevertheless, it is essential that this work be pursued if the negative effects of the past are to be averted.

CHAPTER FOUR

THE BROAD POLICY FRAMEWORK

Introduction

According to Davis and Ashton (2001), public policy in health involves the resourcing and organisation of public and personal health systems. This occurs through multiple, ongoing policy initiatives, which are affected and effected by public and private organisations of various persuasions – including persuasions other than health. The “drivers” of public policy in health are many, including population health status and social values (Davis & Ashton, 2001, pp. 4-5). At times, these drivers have conflicted and “trade-offs” have had to be made, the selection of that has, in itself, involved a conflict of values (Davis & Ashton, 2001, p. 5). An overview of public policy in the health can provide assistance in understanding how these values have shaped strategic, substantive, and operational policy in the health sector. This review of two major health policies – *The New Zealand Health Strategy* (2000) and the New Zealand Public Health and Disability Act (2000) – aims to provide assistance in understanding the way public and personal health systems are resourced and organised.

The New Zealand Health Strategy

The New Zealand Health Strategy (2000)⁵¹ is strategic public policy in health⁵². The NZHS outlines “health goals and targets... sector performance standards... [and] strategies” (Office of the Minister of Health, n.d., p. 2). It is, primarily, the application of “the Government’s broad objectives for health” (Office of the Minister of Health, n.d., p. 1). These objectives are a composite of the Labour and Alliance perspectives, as outlined in their respective manifestos (see Alliance Party, 2001; New Zealand Labour Party, 1999). According to Office of the Minister of Health (n.d., p. 1), the objectives are to:

- a) raise the health and independence of the population and reduce inequalities
- b) meet the health and disability support needs of local communities
- c) ensure more effective use of the available resources

⁵¹ Henceforth referred to as “the NZHS”.

⁵² For a critical analysis of the NZHS and its contribution to the refurbishment of the social democratic welfare state, see Gray (2001).

- d) increase community involvement in decision-making about health and disability support services
- e) have a non-commercial, collaborative and accountable culture in the publicly funded health sector
- f) ensure clear accountabilities

These objectives have also been further developed through the principles of the NZHS.

The NZHS contains seven long-term fundamental principles, which “the health sector will uphold – *within the money available* [sic]” (Ministry of Health, 2000, p. 2). According to the Ministry of Health (2000, p. 7 – numbering added), the principles are:

- 1) Acknowledging the special relationship between Māori and the Crown under the Treaty of Waitangi
- 2) Good health and wellbeing for all New Zealanders throughout their lives
- 3) An improvement in health status of those currently disadvantaged
- 4) Collaborative health promotion and disease and injury prevention by all sectors
- 5) Timely and equitable access for all New Zealanders to a comprehensive range of health and disability services, regardless of ability to pay
- 6) A high-performing system in which people have confidence
- 7) Active involvement of consumers and communities at all levels

Health policy drivers guide these principles. According to Davis and Ashton (2001, p. 5) health policy has (at least) 15 drivers. The discernable drivers of the NZHS are “health status”, the political climate and establishments, the “public”, user verisimilitude, social and cultural factors, and the dominant social philosophy (Davis & Ashton, 2001, p. 5). The principles and their drivers are operationalised through 16 priority objectives, “five service delivery areas”, seven quality management issues, and three implementation strategies (Ministry of Health, 2000, p. viii).

The priority objectives are short to medium-term priorities and focus on the determinants of health. The selection of these objectives above “10 goals and 61 [other] objectives” (Ministry of Health, 2000, p. vii) was based on the “degree” to which they reflect the NZHS principles and, thus, its drivers (Ministry of Health, 2000, pp. 13-14). The objectives are separated into 13 population-based aims and three focussed specifically on the reduction of inequalities. The objectives involve areas, which can be resolved by the health system alone and others, which require collaborative effort. For example, an objective on the reduction of violence allows opportunities for collaboration with other services, such as the Police. The application of these

objectives is expected to be “evolutionary rather than revolutionary” (Ministry of Health, 2000, p. 14), so that effects on other services can be minimised.

The priority service delivery areas are public and primary health, the reduction of elective surgery delay times, ameliorating the “responsiveness of mental health services”, and increasing accessibility to appropriate health care for rural communities (Ministry of Health, 2000, p. 19). The prioritising of these areas signifies that they “should be considered first if extra funding becomes available” (Ministry of Health, 2000, p. 19). The quality management issues involve “sector-wide” development, “individual rights”, a consultative and co-ordinated approach, information technology and administration, “workforce development”, and appraisal systems (Ministry of Health, 2000, pp. 25-28). The quality, performance, and efficiency of health services are to be of the highest standards, with “achievements rewarded” (Ministry of Health, 2000, p. 26). Management is expected to maintain these standards “within available resources” (Ministry of Health, 2000, p. 25). Thus, the notion of fiscal responsibility, like some other practices employed by previous governments, has been retained by the NZHS.

All aspects of the NZHS have been affected, either explicitly or implicitly, by the institutional policies and practices applied during the National and National-New Zealand First Coalition⁵³ Governments. The necessity for a system, which embodies high quality and public confidence, reflects fifteen years of the New Right. Health professionals are now subjected to “real pressures... to perform and to be accountable for their decisions” (Ashton, 2001, p. 123). Health consumers will no longer accept inefficient, ineffective service delivery. Quality health services are expected to meet high “performance” (Ministry of Health, 2000, p. 25) standards and to create “customer satisfaction” (Ministry of Health, 2000, p. 26). Though the aim of the NZHS is to improve “health outcomes”, health providers (such as DHBs) will “still be required to function in a business-like manner” (Ashton, 2001, p. 120). For example, the NZHS is quite specific on the fiscal issue: “budgets are capped and distributed through the population-based funding formula. Thus, “the health sector will need to ensure limited resources are used in the best way possible” (Ministry of Health, 2000, p. 25).

The use of contracts – now termed “funding agreements” – and performance indicators have been retained to ensure “quality standards and delivery expectations” are fulfilled and performance levels are “benchmarked” (Ministry of Health, 2000, p. 26). Chief executives, such as the officer employed by the MidCentral DHB, have had their roles adjusted, but have retained management roles (MidCentral District Health Board employee, personal

⁵³ Henceforth referred to as the “NNZF Coalition”.

communication, September, 2001). Furthermore, the retention of the language of the market, such as “consumer”, suggests a continuation of a liberal health model (Ministry of Health, 2000, p. 26).

Within the NNZF Coalition Agreement (1996, in Ashton, 2001, p. 119), a commitment to “cooperation and collaboration rather than competition” was emphasised – much like the commitment being proposed by the current Coalition Government through the NZHS. However, the NNZF Coalition’s commitment did not result in significant changes within the health sector, particularly after that Coalition’s collapse (see Ashton, 2001). The ongoing effects of this collapse have maintained the market model within the health sector. Nevertheless, this does not mean a return to centralised control is condoned.

A strong element of centralisation seems to underline the NZHS. Central control and planning is reflected in the use of “performance and/or funding agreements” between central government and DHBs (Ministry of Health, 2000, p. viii). The NZHS is very specific about the expectations of DHBs, at least in the short to medium term. Though extensive support is absolutely necessary, especially at the initial stages, the NZHS shows no method for decreasing central authority and increasing community control. A return to an interventionist state is unlikely, given the “political and economic” “transfer costs” of such a change (Myles & Quadagno, 2000, p. 3). However, unless the policymakers and local representatives ensure this “ongoing process” (Ministry of Health, 2000, p. viii) results in relative local autonomy, the result of these health reforms will be little more than a window dressing. It is hoped that the current Government will assist the NZHS in ensuring health sector reform is substantive.

The New Zealand Public Health and Disability Act 2000

The New Zealand Public Health and Disability Act 2000⁵⁴ is the structural aspect of the NZHS. As such, it was introduced to the New Zealand population as two separate ideas: the “New Zealand Public Health Services Bill” (New Zealand Labour Party, 2001, p. 1) and “Health care run democratically” (Alliance Party, 2001, p. 1). The former was presented, by Labour, as a means for ensuring “community-orientated... public hospitals”, where “co-operation rather than competition drives the health system”(New Zealand Labour Party, 2001, p. 1). The latter – a plan for replacing the Health Funding Authority (HFA) with elected “Area Health Boards” directly accountable to the Minister of Health (Alliance Party, 2001, p. 3) – was presented by

⁵⁴ Henceforth referred to in the body text as the “Act”.

the Alliance. Together, the two presentations formed the Labour-Alliance Coalition⁵⁵ policy on public health service provision.

The New Zealand Public Health and Disability Bill⁵⁶ (2000) was originally titled the “Public Health Services Bill” (Office of the Minister of Health, n.d., p. 1). The policy was broached as the means for integrating health “sector structural changes” (Office of the Minister of Health, n.d., p. 1) with the NZHS. The Bill (2000) aimed to repeal and replace the Health and Disability Services Act 1993, amend and rename the Health Reforms (Transitional Provisions) Act 1993, and include the first recognition of the Treaty of Waitangi in social policy legislation (Laugesen, August 6, 2000, p. 2). In addition, the draft proposed the establishment of “appropriate non-commercial arrangements for organisations like Pharmac” (*Parliamentary Debates*, August 17, 2000a, p. 3) and an increase in the duties of the Ministry of Health. Furthermore, it intended to replace the HFA and Hospital and Health Services with DHBs and constitute two new committees: the Health Workforce Advisory and the Mortality Review Committee (*Parliamentary Debates*, August 17, 2000a, p. 1). Such was the confidence in the intended direction that, prior to the introduction of the Bill, a DHB “establishment unit” was created “to facilitate the transition from the... [HFA] to the twenty-one DHBs” (Ministry of Health, n.d.b, p. 1).

The Bill was introduced to Parliament on 2 August 2000 (*Parliamentary Debates*, August 17, 2000a). The First Reading was held on 17 August, with the Bill being presented as a means “to restore public ownership of the health system” (*Parliamentary Debates*, August 17, 2000a, p. 1). With a centre-left bloc (Labour, Alliance, Green Party of Aotearoa New Zealand, and New Zealand First) of 71 votes, the Bill was sent to the Health Select Committee for consideration (*Parliamentary Debates*, August 17, 2000c, p. 1). The Select Committee report was returned on 14 November, with most submissions (three-quarters) being related to the (now amended) Treaty clause (*Parliamentary Debates*, November 14, 2000, p. 1). On 7 December, it was moved that the Bill be read for the third time (*Parliamentary Debates*, December 7, 2000, p. 1). The centre-left bloc ensured the Bill’s passing by 70 votes to 47 (*Parliamentary Debates*, December 7, 2000, p. 1). The Act became law, after receiving Royal Assent, on 14 December 2000 (New Zealand Public Health and Disability Act 2000).

One of the most significant outcomes of the Act has been the abolition of the “purchaser-provider split” and return of power to “democratically elected representatives on district health boards [sic]” (Ashton, 2001, p. 123). DHBs integrate the (previously separated) funder and

⁵⁵ Henceforth referred to as the “Coalition” or the “Coalition Government”.

provider roles “to improve, promote, and protect the health of [geographically] defined population” (Office of the Minister of Health, n.d., p. 4). In addition, DHBs are required “to promote the independence of people with disabilities within a defined population” (Office of the Minister of Health, n.d., p. 4). In order to fulfil these requirements, DHBs must assess, monitor, plan, fund and provide (or ensure the provision of) appropriate health services (Office of the Minister of Health, n.d., p. 4). Furthermore, DHBs must consult effectively, prudently manage resources, “uphold [high] ethical and quality standards” and “be good employers” (Office of the Minister of Health, n.d., p. 4). In this way, the Act provides DHBs with options for positive health development.

Like for DHBs, the Act provides positive options for Māori health development. For example, under part 1, section 3(1)(b), the Act gives DHBs the task of improving Māori health outcomes and reducing disparities. However, two other major options are presented. In the first instance, the policy ensures Māori participation in health. Part 3, section 23(1) of the Act requires DHBs:

- (d) to establish and maintain processes to enable Māori to participate in, and contribute to, strategies for Māori health improvement:
- (e) to continue to foster the development of Māori capacity for participating in the health and disability sector and for providing for the needs of Māori:
- (f) to provide relevant information to Māori for the purposes of paragraphs (d) and (e).

In addition, the Act requires “minimum numbers of Māori on DHBs... [and] Māori representation on advisory committees” (Bennion & Melvin, 2001, section 6)⁵⁷. In some ways, the devolution of responsibility from central government to DHBs may allow a greater opportunity for Māori influence on the policies and funds, which directly affect their health. However, it is suspected that the majority of decision-making powers will remain at the bureaucratic sphere (see Gray, 2001). Thus, as DHBs and central government collude to make a red-tape nightmare, the possibility of real progress may be nullified. It is, therefore, imperative that effective representation is utilised at the strategic and operational levels to ensure that health governance reflects Māori perspectives.

⁵⁶ Henceforth referred to as the “Bill”.

⁵⁷ This is a major change from the much stronger clauses of the original Bill. These required DHBs to have Māori representation, form and preserve “relationships with mana whenua in their districts”, and ensure opportunities for involvement by “Māori generally” (that is, Māori who are not mana whenua) (New Zealand Public Health and Disability Bill, 2000, pp. 4-5). This change occurred whilst being considered by the Health Select Committee (Bennion & Melvin, 2001).

In a second instance, the Act is a unique step towards a Treaty partnership, in that it includes a reference to the Treaty of Waitangi. Part 1, section 4 of the Act reads⁵⁸:

in order to recognise and respect the principles of the Treaty of Waitangi, and with a view to improving health outcomes for Māori, Part 3 provides for mechanisms to enable Māori to contribute to decision-making on, and to participate in the delivery of, health and disability services.

As the first social policy legislation to include a Treaty section, the Act allows the possibility of Treaty-based power structures, legislative protection of Māori rights to participate in the health sector, and the recognition of the relevance of the Treaty to social policy. The inclusion of section 4 is an exciting occasion both in regards to Māori health development and Māori development generally. The possibility of inclusion in future policies, beyond the scope of physical resources, promises to uplift the status of the Treaty and, therefore, the Māori-Crown relationship.

The inclusion of the Treaty of Waitangi section in the Act can be seen as a result of both state and society-centred forces. The state-centred approach argues that politicians are unlikely to pursue new policy initiatives if existing structures and policies do not possess the capacities (or are not adaptable) to ensure their success (Skocpol, 1992, p. 42). Many state structures and policies already exist, which (at least) acknowledge the importance of the Treaty of Waitangi and, thus, ensure the policy's success. As social policy, the Bill's Treaty clause (which became the Act's section) is "a sign, in big flashing neon, that this Labour-led government plans to pick up where the last Labour government left off in bringing the Treaty more fully to life" (Laugesen, August 6, 2000, p. 2).

In "picking up" where "the last Labour government left off" (Laugesen, August 6, 2000, p. 2), the Treaty section was the derivative of a Cabinet directive "to the Ministry of Health to report... on options for appropriate partnership arrangement with Māori" (Office of the Minister of Health, 2000, p. 1). The Treaty partnership will use "the generic partnership model" (Office of the Minister of Health, 2000, p. 8). This model provides conclusive evidence of existing state structures to support Treaty recognition in the Act.

The role of state bureaucracy and representation, as an element of the state-centred explanation, has had an influence of the Treaty of Waitangi's inclusion in the policy too. As a bureaucratic

⁵⁸ This is a major change from the much stronger clauses of the original Bill, which originally required the Act to be "interpreted in a way that is consistent with.. [Treaty] principles" (New Zealand Public Health and Disability Bill, 2000, section 5). This change occurred whilst being considered by the Health Select Committee (Bennion & Melvin, 2001).

outcome, the partnership⁵⁹ “options were developed by an inter-agency working group” of state administrators (Office of the Minister of Health, 2000, p. 2). In the representative arena, particular Government Members were open about their support of Treaty recognition from the Act’s impetus. Minister of Health, Annette King, embraced Treaty recognition and the “Crown’s partnership with Māori” as “one of the most important areas” of the Act (*Parliamentary Debates*, August 17, 2000a, p. 2). In King’s (2000, p. 1) words: “the inclusion of a Treaty of Waitangi clause [or section] in the [policy]... would have significant impact in terms of reducing disparities between Māori and other New Zealanders”.

Associate Minister of Māori Affairs, Hon Tariana Turia, was (at least) equally supportive. Turia (2000, p.1), highlighted the need for the section “to ensure that Maori can get equal access” to health services. However, her role, as a state representative, is not the only method by which the section was guaranteed inclusion.

Skocpol’s (1992, p. 42) assertion – that it is unlikely new policy initiatives will be pursued if existing structures do not possess the capacities – is also true in the reverse. Politicians will proceed with a particular policy if existing structures and policies can cope, but only if political advantage can be expected over “competitors” (Skocpol, 1992, p. 42). By including a Treaty section, the Coalition Government (and, more particularly, Labour) gains “advantages”, in the form of votes in the Māori electorates, over its “political competitors” (Skocpol, 1992, p. 42). As can be seen, a state-centred explanation of the Treaty’s inclusion could involve existing state structures and policies, the influence of particular Government Members, administrators, and the attempt by the ruling Coalition to gain political advancement.

A society-based explanation of the Treaty inclusion must focus primarily on Māori. Initial recognition of the Treaty, which provided the existing state structures for the section’s inclusion, was a direct result of Māori pressure groups. During consultation on the Treaty section, Māori representatives maintained that “the Treaty should be reflected in health legislation” (Office of Minister of Health, 2000, p. 2). In addition, Māori promoted “the political imperatives of social rights”, including protection from paternalism (Culpitt, 1995., p. 232), through “a strong preference for Māori control” (Office of Minister of Health, 2000, p. 2). In this way, Māori pressure groups have acted as a society-based force on the Act.

⁵⁹ It was understood that any communication on “partnership” between Māori and the Crown would be

Footnote continued on next page.

Conclusion

Māori have shown the capacity to be a positive society-based force in the development of a broad health policy framework. The NZHS shows this through a “special relationship between Māori and the Crown” (Ministry of Health, 2000, p. 37). However, this effect could be severely diminished if community control is not guaranteed in the long-term. Though the Act ensures the “establish[ment] and maint[enance of] processes to enable Māori to participate in, and contribute to, strategies for Māori health improvement” (Part 3, s23[1]), including “mechanisms to enable Māori to contribute to decision-making” (Part 1, s4), the focus tends to be at the delivery level. Therefore, further community (versus central) control must be developed. Until meaningful Māori public participation is guaranteed, control in broad Māori health policy will remain a contested issue.

located in the Treaty discourse (Office of the Minister of Health, 2000, p. 1).

CHAPTER FIVE
HE KOROWAI ORANGA, PHASE ONE, & THE PRIMARY STRATEGY

Introduction

Like other areas of the welfare state (for example, income support), public policy in health has become a contested issue. This is seen most strongly in recent health policy movements, which affect Māori: *He Korowai Oranga – Māori Health Strategy* (2002), the *Sexual and Reproductive Health Strategy: Phase One* (2001), and *The Primary Health Care Strategy* (2001). The first of these documents offers a whānau-centred approach, which can date its policy precedents back to the early 1990s. The second document offers a socially negotiated approach to sexuality, with a strong focus on education. The third document offers a mechanism for reducing health inequalities. Together, the three documents provide a view of Māori sexual health promotion, which affirms public participation.

He Korowai Oranga – Māori Health Strategy

The whānau-centred approach to Māori health policy is a system aimed at increasing integration and accessibility. From 1992 to 2002, the approach has utilised both personal and public health services to enhance whānau health. *He Korowai Oranga – Māori Health Strategy* (Ministry of Health, 2002c)⁶⁰ provides the next major step, though not without its challenges.

In 1992, Te Puni Kōkiri began investigating a whānau well-being strategy, with the aim of developing “an integrated, holistic approach to addressing Māori health concerns” (Te Puni Kōkiri, 1993, p. 6). The strategy aimed for effectiveness, founding itself in comprehensive, intensive and flexible interventionist principles. Project management was based on a three-year life-span, allowing time for the development, examination and provision of “policy advice on the effectiveness of an integrated, holistic approach” to Māori health (Te Puni Kōkiri, 1993, p. 6). In June 1993, two organisations, Te Runanga O Toa Rangatira and Whaioranga Trust, were contracted for three years to provide whānau-centred health services in the areas of “cot death, asthma, immunisation, drug and alcohol and family violence” (Te Puni Kōkiri, 1993, p. 6). Services were primarily health promoting, however, some asthma and immunisation

⁶⁰ Henceforth referred to as “He Korowai Oranga”.

personal health services were provided. Though intended to operationalise the whānau-centred approach, these initial attempts at a whānau-centred strategy were hampered by a lack of a commitment to the whānau concept. Guiding principles focussed on “interventions”, the “family”, and “clients” (Te Puni Kōkiri, 1993, p. 6). No conceptualisation of whānau, as end user, was provided. Evaluations were not based on whānau-centred measurable outcomes. Thus, guidelines were required to assist the development of the whānau-centred approach.

In 1995, the Ministry of Health created guidelines, which identified methods for accentuating the positive public health benefits of whānau. The document founded itself in Te Whare Tapa Wha and sought to “*promote a social and physical environment which improves and protects whānau public health [sic]*” (Public Health Commission, 1995a, p. 35). These guidelines included linking whānau and individual wellbeing, recognising diversity between whānau and the necessity for multiple “health development strategies” (Public Health Commission, 1995a, p. 26). Such strategies were to see, at least, some progress in 1998.

In 1998, the Ministry of Health released *Whaia Te Whanaungatanga: Oranga Whānau*⁶¹. Oranga Whānau accepted Metge's (1995) multiple definitions of whānau (see Chapter One), and viewed the primary functions of whānau as manaakitanga⁶², tohatohatia⁶³, pupiri taonga⁶⁴, whakamana⁶⁵ and whakatakoto tikanga⁶⁶ (Ministry of Health, 1998). As signalled by the multi-faceted definition, a whānau-centred approach that recognised diversity was favoured as a method for reducing barriers. Unfortunately, the identified key features of effective service delivery (co-ordination, resources, effective strategies, accurate information, and workforce issues) did not address whānau in any real way. Similarly, background information on whānau health was based on measurements of Māori health generally (for example, Māori demographic statistics), without offering whānau-centred measures. For example, whānau health statistics could have included group measures per the outlined functions. This difficulty in perception may have been due to the overall belief that “Māori development is synonymous with whānau development” (Ministry of Health, 1998, p. 35). Though comprehensive, Oranga Whānau seems to have offered no new directions, and may explain why a new policy document was developed.

⁶¹ Henceforth referred to as “Oranga Whānau”.

⁶² Or protection.

⁶³ Or sharing.

⁶⁴ Or guardianship.

⁶⁵ Or enablement.

⁶⁶ Or planning.

He Korowai Oranga is substantive public policy. *Whakatātaka: Māori Health Action Plan, 2002–2005* (Ministry of Health, 2002d)⁶⁷ is its operational document. Due to expire in 2012 (Cabinet policy committee minutes, 2005a), He Korowai Oranga proposes a position, which recognises the Treaty of Waitangi as foundational and supports “whānau ora” (Ministry of Health, 2002c, p.1). The policy is structured into six areas: principles, overall aim, purpose, directions, endorsements and pathways. All, but the purpose and principles, are provided in visual form via the model shown in Figure 1.

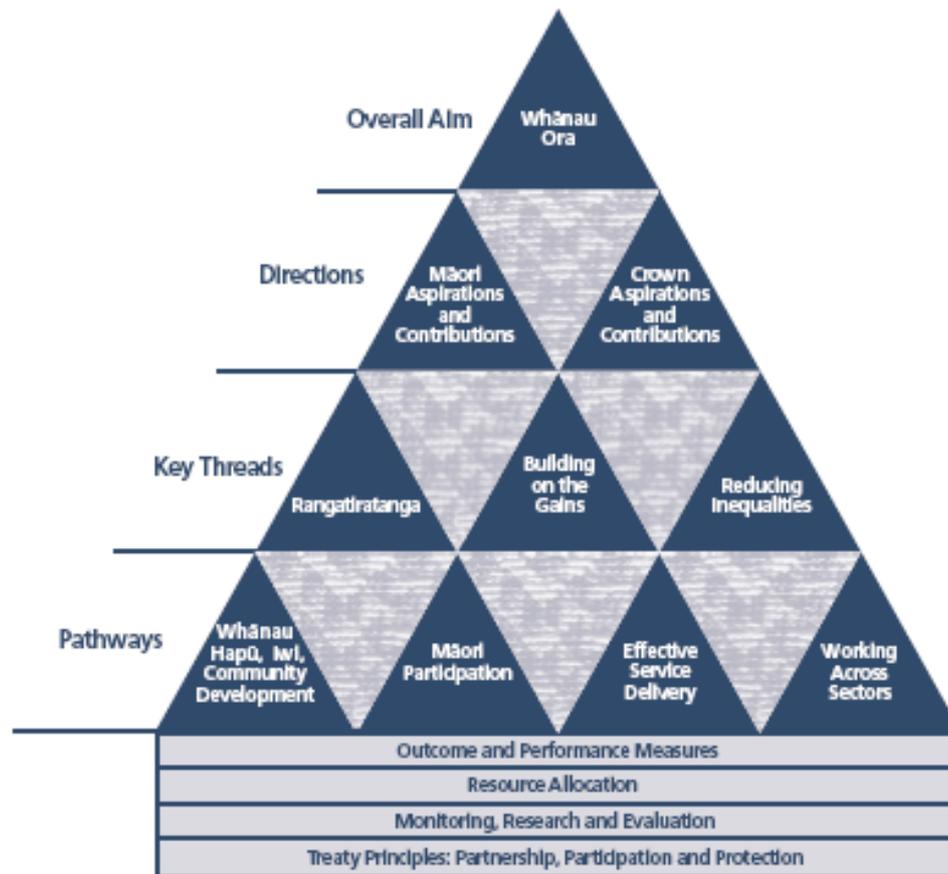


Figure 1. He Korowai Oranga. Note. From *He Korowai Oranga – Māori Health Strategy* (p. 4), by Minister of Health and Associate Minister of Health, 2002, Wellington, New Zealand: Ministry of Health. Copyright 2002 by the Ministry of Health. Reproduced with permission⁶⁸.

The principles of He Korowai Oranga are historically sourced. The 1985 Standing Committee on Māori Health recommended that the Treaty of Waitangi be accepted as primary to positive health (Durie, 1994a). Furthermore, the selection of the Royal Commission on Social Policy’s principles over others (for example, the *Principles for Crown Action on the Treaty of*

⁶⁷ Henceforth referred to as “Whakatātaka”.
⁶⁸ Permission attached as Appendix.

*Waitangi*⁶⁹) has become somewhat institutional. It is, therefore, not surprising that He Korowai Oranga accepts the principles of “Partnership, Participation and Protection” as foundational to the iwi-Crown relationship (Ministry of Health, 2002c, p. 2). Within the primary principle, Partnership, the document proposes joint strategic development between the Government, the traditional Māori structures of whānau, hapū, and iwi, and the contemporary reality that is “Māori communities” (Ministry of Health, 2002c, p. 2). Participation offers Māori involvement in all health sector areas, including “decision-making, planning, development and delivery of health and disability services” (Ministry of Health, 2002c, p. 2). The final principle, Protection, aims for substantive equality in health and the protection of tikanga Māori. Together, the three Treaty-based principles aim to support overall Māori wellbeing.

As its overall aim, He Korowai Oranga proposes “whānau ora” or “Māori families supported to achieve their maximum health and wellbeing”⁷⁰ (Ministry of Health, 2002c, p. 1). The document recognises the whānau as foundational to Māori society and defines it as “kuia, koroua, pakeke, rangatahi and tamariki”⁷¹ (Ministry of Health, 2002c, p. 1). However, the policy does not limit itself to “traditional definitions”; it recognises familial diversity and leaves the final right to define “up to each whānau and each individual” (Ministry of Health, 2002c, p. 1). From He Korowai Oranga's perspective, whānau function “as a principal source of strength, support, security, and identity”, occupying the pivotal position in ensuring Māori wellbeing (Ministry of Health, 2002c, p. 1). As such, the paper proposes outcomes, which theoretically will positively impact on individual Māori via the collective unit.

As part of its overall aim, He Korowai Oranga measures the achievement of whānau ora through three whānau-centred outcomes. In the first instance, multi-dimensional wellbeing will be experienced alongside a sense of whānau self-determination. Secondly, individual members will enjoy increased longevity and life quality. Thirdly, full participation by whānau in both “te ao Māori and wider New Zealand society” is envisioned (Ministry of Health, 2002c, p. 1). The document recognises the importance of interdependence, the “collective” as a social determinant and contextualisation (Ministry of Health, 2002c, p. 1). Together, the proposed whānau-centred results provide an integrated view of whānau health. However, this integration would be useless without a purpose.

⁶⁹ Department of Justice, 1989

⁷⁰ This is a change from the original discussion document's “whānau wellbeing and health” (Ministry of Health, 2001a, p. 2). This change has received some criticism because the new definition “has no teeth”, is “passive, victim-blaming and implies a level of unwellness” (Ministry of Health, 2005a, p. 3).

⁷¹ This is a change from the discussion document's “*kaumatua* [italics added], pakeke, rangatahi and tamariki” (Ministry of Health, 2001a, p. 5).

He Korowai Oranga has two purposes (or “kaupapa”)⁷²: the affirmation of “Māori holistic models and wellness approaches to health and disability” and the improvement of health outcomes for Māori (Ministry of Health, 2002c, p. 3). In the first instance, the document interprets support for integrated health models as affirmation of “Māori-led initiatives” and service management, suggesting the continuation of current liberal, minimal-statist models. In the second instance, it is expected that current systems (for example, DHBs) will maintain responsibility for delivering “improved health services for Māori”, thus ensuring the improvement of “Māori outcomes” (Ministry of Health, 2002c, p. 3). In addition, a “gradual reorientation” in the planning, funding, and delivery of Māori health and disability services is proposed, though a further explanation of what this means is not provided (Ministry of Health, 2002c, p. 3). More direction is provided in other sections.

He Korowai Oranga has two directions: “Māori aspirations and contributions” and “Government aspirations and contributions” (Ministry of Health, 2002c, p. v). The primary direction recognises both past contributions and future aspirations by Māori for Māori health. A focus on supporting traditional structures and recognising “other community groups in Māori society” provides further evidence of this direction (Ministry of Health, 2002c, p. 5). The secondary direction centres on the state’s desires for and augmentations to Māori wellbeing. By utilising DHBs, the Government aims to reduce health disparities and guarantee accessible services that are appropriate for Māori. Together, the two directions implicitly reflect the Partnership principle. By accepting that each Treaty partner has equal rights to and responsibilities for Māori health, the long-intended relationship will hopefully be realised. Nevertheless, this will not occur without added detail.

“Three key threads, or themes”, provide He Korowai Oranga with such added detail (Ministry of Health, 2002c, p. 7). Rangatiratanga, the first thread, “acknowledges whānau, hapū, iwi and Māori aspirations for rangatiratanga” (Ministry of Health, 2002c, p. 7). It is planned that the achievement of such an aspiration will occur via iwi participation in decision-making, Māori provider and workforce development, and Māori community capacity building. The second theme recognises past Māori health achievements and aims to build “on the[se] considerable gains” (Ministry of Health, 2002c, p. 7). The third thread continues the basic social democratic requirement for substantive equality. By focusing on “reducing inequalities”, He Korowai Oranga aims to avoid methods which increase disparities, recognise the wider social determinants, and utilise existing population health objectives (Ministry of Health, 2002c, p. 8).

⁷² This section is an addition to the original discussion document.

Though the threads and directions provide the context, it is to the four pathways and Whakatātaka that He Korowai Oranga looks for its operationalisation.

He Korowai Oranga employs Whakatātaka and the four pathways contextually in order to achieve “the aim of improved whānau ora” (Ministry of Health, 2002c, p. 9). Each pathway contains a number of objectives through which attainment is envisioned. The four pathways cover Māori development, Māori participation, health service delivery, and intersectoral methodology. Initially, Whakatātaka presents a few objectives outside of the pathways. However, the vast majority of the document is dedicated to putting the pathways into action.

Whakatātaka begins actioning He Korowai Oranga through objectives dedicated to resourcing, planning, and monitoring. The first objective aims to “increase relative investment in Māori health” (Ministry of Health, 2002d, p. 8), through the setting of national funding targets and the augmentation of “DHB funding agreements” (Ministry of Health, 2002d, p. 9). The second objective aims to increase participation by “iwi and Māori in monitoring progress against He Korowai Oranga” at both national and local levels (Ministry of Health, 2002d, p. 11). This involves the establishment of mechanisms for Māori involvement in the regulation process. The second objective is a promising (if late) addition to the participation embodiment process. However, the primary objective fails to ensure national consistency, as funding agreements, with their regional specificity, allow inconsistent service provision between DHB areas. Thus, a minimum expectation should be set for DHB investment into Māori health to reduce geographical variability, increase consistency, and support Māori health development (National Advisory Committee on Health and Disability, 2002).

The first pathway concentrates on Māori development through both traditional and contemporary structures. The pathway focuses primarily on Māori community development as a means for supporting whānau “health and wellbeing” (Ministry of Health, 2002d, p. 14). The first objective offers a community development approach, which emphasises the positive aspects of “whānau and Māori communities” (Ministry of Health, 2002d, p. 14). The action points stipulate that, firstly, the Ministry of Health will play a lead role in promoting whānau-centred service delivery models and “monitoring frameworks to support whānau ora approaches” (Ministry of Health, 2002d, p. 14). This will be marked through such mechanisms as a “whānau awards scheme”, the exploration of “an intersectoral whānau innovation fund”, and the development of a policy tool for monitoring state impact on whānau wellbeing (Ministry of Health, 2002d, p. 14). Unfortunately, the primary action point and its associated markers seem to have nothing to do with community development. Within the second action point, the Ministry of Health and DHBs aim to support Māori in the development “of their own

plans for improved whānau ora” and increase Māori participation in whānau ora initiatives (Ministry of Health, 2002d, p. 15). This involves the selection of initiatives for ongoing support versus capacity building and training opportunities. The second objective aims to build and encourage “Māori models of health and traditional healing” (Ministry of Health, 2002d, p. 15). In practice, only the traditional healing aspect is emphasised. The third objective supports social contributions by Māori who experience disabilities. These will be presented in the Māori Disability Action Plan⁷³. Together, the three objectives and their associated action points provide a vague method for supporting whānau development.

The second pathway seeks to strengthen Māori participation throughout the health sector. Critical to the success of He Korowai Oranga is investment by Māori into the project via appropriate personnel. The first objective emphasises engagement at the upper levels through “Māori participation in decision-making” (Ministry of Health, 2002d, p. 18). In action, this involves consolidated partnerships between government (in both centralised and decentralised forms) and Māori. In addition, “training opportunities” on Māori health issues will be provided to “DHB board members to ensure effective governance” (Ministry of Health, 2002d, p. 19). No indication of compulsion is presented, suggesting that knowledge of Māori health issues will remain uneven between individual board members and their DHBs. The second and third objectives concentrate on participation at ground level through Māori provider and workforce development. Here, augmentations to existing Māori provider development initiatives and the development of a Māori workforce plan are envisioned.

The third pathway focuses on personal health and health service delivery. The pathway “aims to ensure that whānau receive timely, high quality, effective, and culturally appropriate health and disability services to improve whānau ora and reduce inequalities” (Ministry of Health, 2002c, p. 19). The primary objective addresses the aim by focussing on a reduction in health disparities “through specific Māori health priorities” (Ministry of Health, 2002d, p. 24). Surprisingly, the action points provide little consideration of a consistent national approach. The Ministry of Health provides resources, training, and information, while population health objectives will be locally set via DHBs. However, national Māori health priorities have already been established (see Ministry of Health, 2000). With only minor geographical differentiation, why is one action point set aside specifically for the establishment of localised objectives? The second objective addresses mainstream service effectiveness. Initially, workforce development, performance targets and collaborative efforts were suggested as mechanisms for enhancing mainstream effectiveness (Ministry of Health, 2001a). However,

⁷³ Though this document was due in 2002, it is not available via the link on the Ministry of Health website
Footnote continued on next page.

these processes have been rejected in favour of monitoring of the Primary Health Care Strategy and ongoing reviews by DHBs. A third objective provides another example of the effects of neo-liberal ideology, through its focus on quality assurance within fixed fiscal parameters. Best practice guidelines and research are presented as the mechanisms for putting the objectives into practice. The final objective involves accurate and timely ethnic data collection in order to support, monitor and achieve the outlined aims.

The fourth pathway, “working across sectors”, focuses on the determinants of whānau wellbeing (Ministry of Health, 2002d, p. 29). According to this pathway, there are a number of prerequisites for and barriers to achievement of this goal. The prerequisites focus on accessibility to effective social services (for example, education and health providers), “a healthy environment”, “te ao Māori”, and the wider New Zealand community (Ministry of Health, 2002c, p. 25). Barriers are based on socio-economic factors, particularly “unemployment” and “unsafe working conditions with little job control”, poor housing, “crime”, large income disparities, and “unfavourable economic conditions” (Ministry of Health, 2002c, p. 25). Thus, the fourth pathway emphasises an inter-sectoral approach and requires collaboration at both central and provider levels in order to address these determinants. In addition, Māori will be assisted in the identification of “their own public or population health priorities and actions” via the Māori Public Health Action Plan and the exploration of support mechanisms (Ministry of Health, 2002d, p. 31).

As can be seen, He Korowai Oranga’s aim, directions, endorsements, and pathways vaguely emphasise the achievement of whānau wellbeing. There are a number of opportunities associated with He Korowai Oranga’s whānau-centred approach. In the first instance, the employment of the whānau approach allows for traditional Māori structures, practices, and belief systems to be applied. This collectivist (versus individualistic) method provides a culturally-relevant system for improving health, “that addresses the historical and contemporary factors which have resulted in diverse realities” (Ministry of Health, 1998, p. 48). However, some difficulties with He Korowai Oranga's proposed direction are also perceived.

There are a number of difficulties associated with He Korowai Oranga. Primarily, the policy development has been somewhat defective. Though the document refers constantly to the whānau, He Korowai Oranga actually contains very little, which could easily differentiate “whānau health” from “Māori health”. In the initial discussion document, the primary pathway provided the only whānau focus for the proposed policy through its aim “to foster whānau

and maintains “internal planning” status (Ministry of Health, 2004, Introduction).

development and health” (Ministry of Health, 2001a, p. 12). This whānau focus was removed in the final document, thus, removing any substantive whānau-centredness from He Korowai Oranga. Secondly, though the document proposes a model based on Treaty principles, He Korowai Oranga does not link the principles to any other part of the document in any visible way. Many aspects reflect the participation and partnership principles (for example, pathway two), however, this relationship is not made explicit, despite suggestions made at the submissions stage (National Advisory Committee on Health and Disability, 2002). Thirdly, the addition of “kaupapa” in the final document, though useful in providing ideological transparency, seems unusual. Logically, the purpose of policy is decided prior to its creation. As the “kaupapa” were not presented in the initial document, it could be surmised that they were created as an afterthought. Together, these three aspects create one large difficulty in the policy development area.

Another difficulty concerns the operationalisation of He Korowai Oranga. Though the policy seeks a mixed public-personal health approach, it fails to present targeted personal health plans, suggesting that He Korowai Oranga will utilise existing systems. Unfortunately, existing systems do not reflect the whānau-centredness required to ensure cohesive application. Like other Māori development strategies, whānau health development must plan across all levels – from public to personal – so that integration can be effected. Though the policy seems committed to the whānau-centred approach, it seems that much more work is yet to be done.

A final area of He Korowai Oranga, which requires work concerns Māori health leadership. A disturbing (and somewhat ironic) difficulty is the abandonment of health leadership by the state via a document supposedly instigated to provide it. He Korowai Oranga’s discussion document had a vision of whānau ora, which included non-measurable initiatives, a focus on whānau development, and an acknowledgement of the protection principle through state-centred actions. The final document abandons all in favour of the easy options: continuation of the status quo with a quick change of labels. In practice, this means more “support” and less “providing” of services essential to Māori development. It is disappointing to see a promising vision being squashed by the practices of yesteryear. Hopefully, a more cohesive focus can be developed, for whānau personal and public health, in the future.

Sexual and Reproductive Health Strategy: Phase One

Sexuality and sexual health are both personal and public health issues. As a matter of personal health, services are provided on an individual level through primary (for example, general practitioners and nurses), secondary (for example, sexual health clinics), and tertiary (for example, hospital-based gynaecologists) systems. As a matter of public health, services are provided through health promotion strategies across the system.

The *Sexual and Reproductive Health Strategy: Phase One*⁷⁴ is the substantive public policy, which directs both personal and public sexual health. It is the initial stage of a two-tier plan focussing on attaining “good sexual and reproductive health for all New Zealanders” (Ministry of Health, 2001b, p. 3). Phase One provides the general direction for the Sexual and Reproductive Health Strategy, with a planned secondary phase providing “action plans to address key issues” (Ministry of Health, 2001b, p. iii). In addition, the policy develops from earlier policy, by focussing strongly on prevention and population-based provision.

Phase One builds on three important documents: the *National Strategy on Sexual and Reproductive Health Strategy* (1996)⁷⁵ and the New Zealand Health (2000) and Disability Strategies (2001). The former has provided the sexual and reproductive health strategic focus. The latter two have provided the location of sexual and reproductive health issues within the wider health platform, alongside the mixed democratic socialist and Third Way philosophical perspective (see Gray, 2001). As such, Phase One utilises “key priority areas” – Māori, youth and Pacific peoples – to promote substantive equality, whilst maintaining accountability in the areas of public funds and efficiency (Ministry of Health, 2001b, p. 2). The key priority areas allow the strategy to utilise “a comprehensive population-based approach” to provide an integrated strategic direction (Ministry of Health, 2001b, p. 7).

In addition to the key priority areas, Phase One utilises a theoretical structure, founded on the PRECEDE-PROCEED health promotion model (Young, 2002). “**Predisposing factors** [sic]”, the first grouping, focuses on the individual and societal qualities, which provoke behaviours that affect sexual and reproductive health (Ministry of Health, 2001b, p. 7). Such factors include education, attitudes and socio-economic standing. “**Reinforcing factors** [sic]” are the

⁷⁴ Henceforth referred to as “Phase One”

⁷⁵ This document was originally entitled and is referred to in the *Sexual and Reproductive Health Strategy: Phase One* (2001) as the *National Strategy on Sexual and Reproductive Health* (1996). However, a change occurred on the Ministry of Health website between 2002 and 2006, and the listed publication is no longer available under that title. Thus, in the bibliography, this publication is listed by its new name: *Sexual and Reproductive Health Strategy* (Ministry of Health, 1996b).

results of activities, which influence the maintenance or modification of behaviour (Ministry of Health, 2001b, p. 7). Such factors include individual sexual pleasure and the reaction of partners. “**Enabling factors** [sic]” are the “environmental characteristics that facilitate healthy behaviour, and the skills and resources required to realise that behaviour” (Ministry of Health, 2001b, p. 7). Such factors include access to services and information, as well as functional skills like correct condom usage. This theoretical structure provides the basis from which Phase One creates its strategic directions.

Phase One contains four strategic directions. The first strategic direction, “societal attitudes, values and behaviour”, focuses on the impact of society on individual sexual behaviour (Ministry of Health, 2001b, p. 8). Associated objectives are primarily research-based, with explorations of prevalent views, community development, and “population group cultural norms” providing examples (Ministry of Health, 2001b, p. 8). Remaining objectives centre on training caregivers and professionals in methods for supporting healthy decision-making and fulfilling the needs of people with disabilities.

The second strategic direction, “personal knowledge, skills and behaviour”, promotes sexuality education “across the lifespan” for all (Ministry of Health, 2001b, p. 9). With the aim of “increas[ing] healthy sexual and reproductive health choices”, this direction supports the development of “personal and social skills” through education of the individual (Ministry of Health, 2001b, p. 9). It promotes early intra-familial tutelage, with sexuality training beginning during pre-school. Phase One supports continued information provision as the individual ages to reduce the incidence of sexually transmitted infections (STIs) and unintended pregnancy.

The third strategic direction, “services”, (understandably) centres on service provision (Ministry of Health, 2001b, p. 10). The direction focuses on developing the sector to ensure comprehensive, consistent and accessible service provision. Collaboration and development of the sector’s workforce are supported, alongside national standards. Access is to be addressed through appropriate planning, which emphasises multi-site, “non-judgemental”, and “responsive” service provision (Ministry of Health, 2001b, p. 10).

The fourth strategic direction, “information”, emphasises research (Ministry of Health, 2001b, p. 11). Reporting of infection information will be improved. Statistical data and “relevant research” will be used as monitoring and evaluation tools, with all data being collected in a confidential manner (Ministry of Health, 2001b, p. 11). From these four strategic directions, Phase One offers its perspective of sexuality, health, identity, and service provision to Māori.

It is possible to draw out the underlying views of sexuality, health, and identity outlined in Phase One. As intimated in the theoretical structure, Phase One tends to view sexuality from a “socially negotiated” perspective, where sexuality is strongly informed by the social environment. This perspective is seen within three of the four strategic directions, particularly under the “societal attitudes” banner (Ministry of Health, 2001b, p. 8). Space is provided for an “innate” viewpoint, whereby humans are recognised as “sexual beings” (Ministry of Health, 2001b, p. 1), however, this viewpoint does not maintain strength across the publication. As many influences lie outside the scope of the health sector, Phase One recognises the need for a “multifaceted intersectoral approach” (Ministry of Health, 2001b, p. 6). In addition, Phase One emphasises sexuality education as a public health measure. Thus, Phase One’s view of health tends to be integrated, with a preventative focus. Diverse identities appear to be accepted within Phase One. Ethnic and cultural diversity is recognised as a specific focus of service provision (Ministry of Health, 2001b, p. 10). In addition, differing sexual behaviours (for example, men who have sex with men) are supported (Ministry of Health, 2001b, p. 6). However, Phase One does not mention the needs of women who have sex with women, or the requirements of transgender/transsexual people. As such, it can be presumed that Phase One requires further development.

An area of Phase One, which requires further development, is service provision to Māori. Like He Korowai Oranga, Phase One envisages “a whānau development approach” (Ministry of Health, 2001b, p. 12). In addition, Phase One intends to echo He Korowai Oranga’s “whānau-based approach to health service delivery” (Ministry of Health, 2001b, p. 12). However, Phase One manages to confuse the intention and the actuality of He Korowai Oranga. Though He Korowai Oranga intends to be whānau-centred, the policy fails to achieve this within the service delivery pathway. None of the mechanisms stipulate systems for delivering health and disability services to whānau, and it seems unlikely that they will be provided anytime in the future. In addition, the appropriateness of such an approach must be questioned. Would whānau-centred sexual and reproductive health services really work for Māori? A public versus personal health approach may be possible; however, more research is required before any further action is taken.

The Primary Health Care Strategy

Like other Western nations, the New Zealand health system is state-defined through various policies and funding mechanisms and split into three levels of health care provision. Whereas

secondary and tertiary services are generally provided through hospitals, primary health care is normally provided in the patient's local community. There are a number of ways that primary health can be defined. In 1978, during the World Health Organization's (WHO) International Conference on Primary Health Care at Alma-Ata (USSR), the Declaration of Alma-Ata was created. Confirmed at the World Health Assembly in 1979, the Declaration defines primary health care as:

essential health care based on practical, scientifically sound, and socially acceptable methods and technology made universally accessible to individuals and families in the community by means acceptable to them and at a cost that the community and the country can afford to maintain at every stage of their development in a spirit of self-reliance and self-determination. It forms an integral part of the country's health system of which it is the central function and the main focus of the overall social and economic development of the community. It is the first level of contact of individuals, the family and the community with the national health system, bringing health care as close as possible to where people live and work and constitutes the first element of a continuing health care process. (World Health Organization [WHO], 1986)

The Australian Primary Health Care Research Institute based their interpretation of primary health care on both the Declaration and the *Primary Health Care: A Framework for Future Strategic Directions* (WHO, 2003). It includes health promotion, advocacy, community development, preventative, curative and palliative care, but essentially defines the concept as:

socially appropriate, universally accessible, scientifically sound first level care provided by a suitably trained workforce supported by integrated referral systems and in a way that gives priority to those most need, maximises community and individual self-reliance and participation and involves collaboration with other sectors. (Australian Primary Health Care Research Institute, 2005)

This definition differentiates itself by introducing the workforce as a conceptual component. The MidCentral District Health Board (2005a, p. 67) provides a similar exposition, though more closely aligned to the Declaration's version when defining primary health care as:

essential health care based on practical, scientifically sound, culturally appropriate and socially acceptable methods. It is universally accessible to people in their communities, involves community participation, is integral to, and a central function of, the country's health system, and is the first level of contact with the health system.

By combining the definitions, it could be surmised that primary health care is scientifically-sound, socially-appropriate, first-level health care, which supports community participation.

Whatever the definition, primary health care aims to improve health by working with people via a wide range of non-hospital services focused on health improvement and prevention (Ministry of Health, n.d.c). These include “health education and counselling, disease prevention and screening” services provided through general practitioners (GPs) and community health providers targeting specific conditions (for example, sexual health) (Ministry of Health, n.d.c). In New Zealand, primary health care is state-funded in accordance with the Primary Health Care Strategy.

The Primary Health Care Strategy (2001)⁷⁶ is “the blueprint for quite sweeping reforms to the primary health care system” in New Zealand (Sibthorpe, 2004, p. 1). The Primary Strategy:

provides the strategic direction for realigning primary health care and seeks to reduce both financial and non-financial barriers to accessing primary health care services over time, by providing low or reduced cost services to all New Zealanders by July 2007 and by making these services more approachable and effective for as many population groups as possible. (Cabinet policy committee minutes, 2005b, p. 1)

As substantive policy, the document reflects the NZHS, as its strategic source. The Primary Strategy’s population approach vision and key directions provide a distinctive formula for primary health care provision. The Primary Strategy is effected by DHBs via local structures called PHOs.

As operational policy, the Primary Strategy reflects its strategic source, the NZHS, as a synthesis of democratic socialism, the official Third Way (Blair & Schroeder, 1999), and the stakeholding concept (Hutton, 1999). The NZHS (and, thus, the Primary Strategy) reflects democratic socialism in its search for substantive equality in health. At both strategic and operational levels, this can be seen through an emphasis on reducing inequalities in health status for the “disadvantaged” (King, 2001, p. 8). The official Third Way, as supported by British Prime Minister Blair, is evident in the NZHS and Primary Strategy’s blending of market-type mechanisms with democratic participation. “Sanctions, and incentives, and planning and competition” (Ashton, 2001, p. 123) reflect twenty years of neo-liberal ideology, whilst the emphasis on structures, which demand citizen participation, provide a democratic vehicle.

⁷⁶ Henceforth referred to as “the Primary Strategy”.

The Primary Strategy reflects the NZHS's population health approach. Like the NZHS, the Primary Strategy focuses on the health management amongst defined populations through the delivery of personal and public health services. Similarly, though curative and palliative approaches are employed, the focus is preventative care. However, where the NZHS manages the macro-environment of primary, secondary, and tertiary health, the Primary Strategy is defined by its primary focus.

The Primary Strategy envisions participation as a foundation for the development of localised services. Specifically, the policy requires "primary health care... to involve participation by people in the communities covered" to enhance service organisation (Ministry of Health, 2001d, p. 7). The population health approach is evident in the way services are required to "focus on better health for a population, and actively work to reduce health inequalities between different groups" (Ministry of Health, 2001d, p. 6).

The Primary Strategy has "six key directions for achieving the vision and new arrangements" (Ministry of Health, 2001d, p. 6). The first direction requires PHOs to "work with local communities and enrolled populations" (Ministry of Health, 2001d, p. 6). Instead of acting responsively to individual users, providers are expected to arrange services around the needs of their enrolled populations. Community participation, particularly through "governing bodies", is required to ensure services "reflect" these needs (Ministry of Health, 2001d, p. 7). In order to link providers and their populations, a "system of voluntary enrolment" is utilised (Ministry of Health, 2001d, p. 7). Enrolment with a PHO will involve the nomination of a preferred provider to ensure continuity of care. This enrolment and nomination will not limit a user's right to "choose a different practitioner" should the need arise (for example, when seeking a second opinion or a specialist) (Ministry of Health, 2001d, p. 9). In addition, users wanting to change nominated providers do not need to provide an explanation nor do they require permission.

The second key direction of the Primary Strategy is the identification and removal of health inequalities. Health inequalities between socioeconomic and ethnic groups are evident in "higher mortality rates, in measures of the broad burden of disease and injury, and in higher rates of avoidable hospitalisation" (Ministry of Health, 2001d, p. 10). PHOs must "identify and address those groups in their populations that have poor health or are missing out on services" (Ministry of Health, 2001d, p. 10). Māori health inequalities are being addressed through Māori provider development and improvement in mainstream delivery via "culturally competent and effective" means (Ministry of Health, 2001d, p. 10).

The third key direction offers “access to comprehensive services to improve, maintain and restore people’s health” (Ministry of Health, 2001d, p. 6). Where cost is the barrier to access, improvements include increases in targeted funding. Where information is the barrier, increases in numbers and varieties (for example, different languages or formats) of communication tools are supported. Funding of these services is allocated according to “relative need... taking account of factors such as age, sex, deprivation level and ethnicity” (Ministry of Health, 2001d, p. 14).

The fourth key direction is the coordination of care across the different service areas. Collaboration between government sectors (for example, health, education, and housing) and health disciplines (for example, doctors, pharmacists, and physiotherapists) are expected to allow more “effective coordination... as primary health care becomes more comprehensive” (Ministry of Health, 2001d, p. 18). In addition, coordination between primary care and other health sectors (including secondary, public, disability support, and mental health services) will develop “local initiatives”, reduce barriers, and help maintain continuity of care (Ministry of Health, 2001d, p. 18).

The fifth key direction focuses on workforce development. At a national level, a misdistribution of primary health staff is identified. The availability of practitioners, particularly primary health care nurses, is limited. Furthermore, workforce misdistribution is a notable rural problem. In addition to consideration of the “national workforce implications of this Strategy” by the Health Workforce Advisory Committee, this direction requires the Ministry of Health to facilitate developmental approaches in the areas of primary health care nursing and rural health provision (Ministry of Health, 2001d, p. 23).

The final key direction requires continual quality improvements through the use of “accurate and useful information” (Ministry of Health, 2001d, p. 25). For example, DHBs are responsible for ensuring PHOs annually report their quality and safety compliance. In addition, the Primary Strategy requires data capturing methods on service utilisation to guide needs analyses and funding. The “accuracy and effectiveness” of the National Health Index is being improved as a “priority as we move to widespread enrolment” with privacy requirements being upheld (Ministry of Health, 2001d, p. 26). Together the six key directions aim to establish a comprehensive structure, which supports community participation, provides equitable health outcomes, and allows coordinated operation by quality providers. To achieve its population approach, vision, and key directions, PHOs have been introduced as the local structures through which the Primary Strategy operates. As organisations with participatory mechanisms, PHOs have the capacity to utilise whānau-centred approaches to Māori health.

The Whānau-centred Approach

As a consequence of their deference to He Korowai Oranga, Phase One and the Primary Strategy utilise a whānau-centred approach to Māori health. However, the whānau-centred approach contains a number of developmental challenges. This section explores the challenges of a whānau-centred approach for health policy.

In the first instance, the whānau-centred approach presumes the whānau is a universal concept. Metge (2001, p. 21) points out that it has been “at least a hundred years since the whānau was a universal feature of Māori social life”. In a reference to the Massey University Māori households’ study, Metge (2001, p. 21) points out the twenty percent of Māori who “choose to operate as ego-centric loners, emphasise family independence, or look to non-kin groups for support”. However, the presumption of universality continues, in part, because of the ideal of homogeneity. Durie (1995a, p. 1) argues that homogeneity is reflected in “the assumption... that all Māori can relate to tribal structures”. Furthermore, the writer points out that “there is no one reality nor is there any longer a single definition which will encompass the range of Māori lifestyles” (Durie, 1994a, p. 214). Though individual service users may not retain “so-called traditional [Māori] values”, define their ethnicity in accordance with “classical constructs”, or have a relationship with “hapū or iwi, or other Māori institutions”, they will self-identify as Māori (Durie, 1995a, p. 15). Furthermore, they “will reject any notion that they are “less Māori” than their peers” (Durie, 1995a, p. 15) – a presumption linked to the ‘divide and conquer’ aspect of colonial hegemony. Any assumption that all Māori can relate to traditional Māori society, including any relationship to the whānau as a concept, has the potential to deny “diverse Māori realities” (Shipley as cited in Durie, 1995a, p. 1).

A second presumption of the whānau-centred approach is that the whānau and health service delivery are compatible concepts. In some areas, there is evidence that this presumption is valid (for example, child health). However, in others (for example, sexual health) it is yet to be tested. For example, Durie (2001, p. 210) does not presume that the whānau approach is applicable to all personal health areas (including service delivery), instead focussing “whānau healing” on the mental health sector. Further research is required to ensure the appropriateness of this perspective across other personal health areas.

A third difficulty, associated with the approach, is the presumed positive connection between whānau and individual health. This premise has been previously disputed. By way of illustration, Durie (1994a, pp. 4-5) emphasises the multi-dimensional nature of health determinants, stating that “it would be misleading to imply that individual health... [is] entirely

the product of wise and balanced family care”. Furthermore “despite the commonly held view that all Māori are part of a supportive extended family network, the fact remains that whānau links are too often loose, ill-defined, unhelpful or even the cause of the problem” (Durie, 2001, p. 176). Indeed, the whānau has the ability to be a negative influence on individual health status through unsafe, laissez-faire, restricted and overwhelmed family statuses (Durie, 1994b). Similarly, the whānau has the ability to influence health status through the application of intra-whānau information restrictions. Certain health areas may be restricted by and to specific whānau members, and, thus, the collective may not be able to influence the individual's health in any meaningful way. For example, a member's sexually transmitted infection may not be discussed with the whānau or with specific members, such as children.

A fourth challenge to the whānau-centred approach concerns the limitations created by the current policy paradigm, particularly in regards to target definitions and outcome measurements. Current service targets do not allow for definition fluidity. For example, the operative whānau may be similar to the nuclear family in its day to day activities and single geographical location. However, the group may expand to a more traditional form during specific occasions and planned events, when members from far and near gather. Which form would be targeted for service provision? When a standardised definition is provided, as in the case of He Korowai Oranga's more traditional, role-centred definition, the problem is exacerbated. Will whānau, who have no operative kaumātua⁷⁷ be able to access services operating under He Korowai Oranga's definition? When fully operational, the policy will hopefully be more flexible, but difficulties in outcome measurement will remain.

Accountability, via measurable outcomes, is an accepted aspect of the policy paradigm, with current trends in outcome measurement moving towards a more standardised regime (see Ministry of Health, 2002a; Standards New Zealand, 2001). However, when evaluating services, and, thus, future funding needs, how will a standardised measurement system deal with definition fluidity or operational flexibility? It seems policymakers have taken a popular idea (whānau development), but failed to prepare for policy longevity. Skocpol (1992) asserts that it is unlikely new policy initiatives will be pursued, if existing structures do not possess the capacities. It could be equally asserted that new initiatives will not receive full support, if they do not fit within existing systems. The whānau-centred approach is proving to be one such initiative. Māori have watched pan-Māori policies be replaced with iwi initiatives, only to be subsumed by hapū mechanisms and, finally whānau development. Without serious alterations

⁷⁷ A plural form, which encompasses both koroua/koroheke/koro and kuia/kui.

to either the measurement tools or the whānau-centred approach, current policy directions will fail to be maintained.

A final challenge to the whānau approach concerns the boundaries of its application. Current whānau development theory and policy (He Korowai Oranga) have a definitive perception of health – that is, one, which is integrated and enhances welfare, versus solely preventing disease. However, given the desired outcome, what activities does it construe as promoting health? Can the chosen health promoting activities achieve welfare enhancement? And can “a demonstrable relationship between these activities” and welfare enhancement be shown (Buchanan, 1995, p. 222)? Put more simply, can the whānau development perspective choose methods which work for whānau and, then, prove it? If He Korowai Oranga is used as an example, doubt would be cast on the perspective's ability to choose methods, which work. Currently, the policy refers primarily to existing methods only: increasing Māori participation across the health sector, employment of current health services, and an intersectoral approach (Ministry of Health, 2002c). If these methods worked before, why would a new perspective be required? For effective application of the whānau-centred approach, boundaries must be pushed and creative methods applied.

Whānau-centred supporters can provide some argument supporting the continued application of this approach. Primarily, the ineffectiveness of previous Māori health policies required a creative response, which the whānau-centred approach provides. In 1991, Māori life expectancy was 68 (male) and 72.9 (female) years (Durie, 1994a). Non-Māori life expectancy was 73.4 (male) and 79.2 (female) years (Durie, 1994a)⁷⁸. In 2001, when He Korowai Oranga was introduced, Māori life expectancy was 69 (male) and 73 (female) years (Ministry of Health, 2006a). Non-Māori life expectancy was 77 (male) and 82 (female) (Ministry of Health, 2006a). Though comparisons between Māori and non-Māori health statuses have seen a fall in popularity, this is evidence of policy ineffectiveness (see Ringold, 2005). While both groups have made health gains, the gap has widened. Any new approach has to be better than what we have.

Secondly, the broad and varied definitions of whānau can provide a type of applicability unavailable to any other construct. Though multiple definitions may cause some confusion (Ministry of Health, 2005a), by defining whānau this way individuals can claim a functional relationship with at least one social group called a “whānau”. Public policy, which recognises

⁷⁸ According to the Ministry of Health (2006a, p. 29), “during the 1980s and early 1990s Māori mortality was seriously undercounted due to different ethnicity data recording on death registration forms compared with the Census”. Thus, the inequality of health outcome was even more severe than stated here.

diverse Māori realities, must provide policies and programmes tailored to an existing Māori audience. Whānau, as constructs based on descent, cause or mixed criteria, or as a collection of ideas, provide such an audience.

Though whānau can provide a negative influence on individual health, the opposite is also true. Walker (1990, p. 200) describes the importance of whānau during post-War urbanisation, as a means of cultural transmission, “mutual support” and “celebration”. Furthermore, Durie (as cited in MidCentral District Health Board, 2005b, p. 7) states that:

no matter how defined, whanau adopt behaviours that enforce mutuality, reciprocity, and shared responsibility within a Maori cultural context. More than simply a system of support, a whanau provides opportunities for identity to be strengthened and for Maori styles of communication and behaviour to be reinforced.

More recently, T. K. Kingi (personal communication, June 6, 2006⁷⁹) emphasised the whānau as the “basis for cultural interaction... [and] transmission”, as a source of advice and support, and as a medium for enhancing outcomes in the “therapeutic setting”. Though it may possess the capacity to cause harm, the whānau provides shelter in times of difficulty, a font of aroha and wisdom, and a place for Māori to call home.

Conclusion

As no explicit policy currently exists, primary-level Māori sexual health programmes should be guided by He Korowai Oranga, Phase One, and the Primary Strategy. This requires them to be whānau-centred, educative, and participatory. Indeed, the three documents provide a view of Māori sexual health promotion, which affirms public participation. He Korowai Oranga affirms participation in all health sector areas, including “decision-making, planning, development and delivery of health and disability services” (Ministry of Health, 2002c, p. 2). Though Phase One is more circumspect, it’s emphasis on community development does offer a participatory mechanism. The Primary Strategy’s requirements are more explicit, requiring participation at the governance level (Ministry of Health, 2001d, p. 7) and that “people... be part of [the] local primary health care services that improve their health, keep them well, are easy to get to and co-ordinate their ongoing care” (Ministry of Health, 2001d, p. 6). For Māori sexual health policy and programmes to work, they must involve whānau.

⁷⁹ Presentation on culture and Māori health development for Te Mata o te Tau Matariki Lecture at Te Pūtahi ā Toi, Massey University, Palmerston North.

SECTION THREE

TE AO HOU

CHAPTER SIX

PHOs, MĀORI, & HEALTH PROMOTION

Introduction

The Primary Strategy provides the blueprint for New Zealand's interpretation of primary health care. The Primary Strategy is implemented via PHOs, which have specific obligations to Māori communities, including providing opportunities for participation and promoting sexual health. PHOs have a number of health promotion mechanisms available, including some specifically designed for Māori.

Primary Health Organisations (PHOs)

PHOs are the mechanisms through which DHBs effect the Primary Strategy. Though DHBs “provide the opportunity for public participation in decision-making” (Ministry of Health, 2002b, p. v), PHOs provide, and are required to provide, an opportunity for participation at the local level. This section outlines PHOs, their opportunities, and challenges.

At a very basic level, a PHO is a non-profit organisation of primary health care practitioners (such as doctors, nurses, and health promotion workers) and providers (such as medical centres) working together to provide services that improve and maintain the wellbeing of an enrolled population. Though each PHO must include at least one general practitioner (GP) (Ministry of Health, n.d.c), membership by any practitioner or provider is voluntary. PHO decision-making must involve enrolled members and the organisation's community. PHOs were selected as the mechanism through which DHBs effect the Primary Strategy because they are believed to increase access to primary health care and, thus, create a healthier population (Ministry of Health, n.d.c). As of July 1, 2005, 79 PHOs had been established (Ministry of Health, 2005b).

PHOs are funded by DHBs for the provision of primary-level services to enrolled members. Non-PHO practitioners and providers are funded through state-sourced General Medical Subsidy (GMS) and co-payments (user fees). To receive the state-sourced funds, a GP must see in person a patient who meets certain criteria (for example, holds a Community Service Card or High User Card; aged under six years) (Crengle, 1999).

In comparison, PHOs receive capitation funding as a per patient per annum grant with the aim of reducing co-payments and, thus, increasing financial accessibility (Coster & Gribben, 1999; De Raad, 2003). Capitation funding has been utilised as a means of containing both cost and risk, whilst encouraging the population approach to primary health care (Coster and Gribben, 1999). By removing the requirement for doctor-delivered service, over-servicing can be reduced and resources re-allocated. An argument for capitation is that it, theoretically, should support the provision of high quality service, health promotion, and preventative care. By creating an environment that encourages low expenditure outputs through a healthier population, PHOs should provide these health enhancing services to reduce usage. However, should co-payments be required to maintain profit margins, any positive effects are likely to be lost.

PHOs will be funded through 'Access', 'Interim', or combination contracts until 2007. Access-funded PHOs provide lower cost or free GP visits for all enrolled members, while Interim-funded organisations provide the same services for members aged under 25 and over 64 (MidCentral District Health Board, 2005a). Under Care Plus, additional resources are available for PHOs providing services to patients who have acute health needs or suffer chronic or terminal illness (Ministry of Health, n.d.a). In addition, PHOs can access quality payments (Ministry of Health, 2003a), enrolment funding, capitation funding aimed at health provision for specific age groups and funding for supporting rural provision (Ministry of Health, 2005c).

Until July 2007, PHO funding is targeted, with deprivation and ethnicity being used as criteria for differentiating Access and Interim-funded PHOs (Cabinet policy committee minutes, 2005b). Access funding is provided to PHOs "in which at least 50 per cent of enrollees are living in deprivation deciles nine or ten areas and/or are Maori or Pacific peoples" (Cabinet policy committee minutes, 2005b, p. 1). As an example of ethnicity-based targeting, Access funding provides a "more effective targeting on health need" and reduces cost by up to \$55.5 million (Cabinet policy committee minutes, 2005b, p. 2).

PHOs receive funding based on their enrolled population. In practice, this requires the maintenance of a register of patients who have both voluntarily enrolled and been seen within a given time period. At an individual level, use of a designated provider encourages continuity of care with its numerous benefits (Ministry of Health, 2001d, p. 8). At a general level, the register allows the population-based approach to be applied to PHO service delivery.

PHOs must ensure the provision of services to enhance the health of their enrolled population. At a minimum, services must “include approaches directed towards improving and maintaining the health of the population, as well as first-line services to restore people’s health when they are unwell” (Ministry of Health, 2001d, p. viii). PHOs must provide this minimum from the establishment phase, however the requirements are limited. For example, services to both casual and enrolled users must be available at all times and, for the vast majority, within 30 minutes travelling distance during normal working hours (Ministry of Health, 2003a). However, PHOs do not have to provide all services themselves and can, unless specifically contracted, define “the extent and type of specific services that they provide” (Ministry of Health 2003a, p. 2).

PHOs have “*allocative efficiency*”⁸⁰, however, some may lack sufficient governance or technical capacity to guarantee similar outcomes as agencies with greater economies of scale (Ringold, 2005, p. 44). Nevertheless, accountability can be strengthened via either the “long-” (responsive policymakers influencing provider policy) or “short-route” (Ringold, 2005, p. 44). Short routes allow citizens “a direct influence on service providers” (Ringold, 2005, p. 44). PHO governing processes offer one such short route.

PHOs are expected to involve their communities in their governing processes. Per the Primary Strategy, PHOs must include “members of the community on their governing boards” (Ministry of Health, 2001d, p. 7). In addition, they must maintain processes which allow “community members and those who use services to influence the organisation’s decisions” (Ministry of Health, 2001d, p. 7). An evaluation of PHOs reveals that the short route is not working evenly between different PHOs. In addition to governance procedures, some PHOs have established advisory boards, whilst others are suffering “medical dominance” (Cumming et al., 2005, p. 14). For the accountability short route to work, PHOs must be willing to meet the challenges of participation.

The PHO concept in itself has a number of challenges. Of primary concern is the interpretation by some health practitioners of PHOs as simple extensions of the general practice concept. For example, the Mornington PHO is an Organised General Practice and member of the IPA Council of New Zealand (IPAC). Though a PHO, the Mornington facility maintains the general practice concept in the simplest way: it trades as the Mornington Health Centre. Furthermore, the idea of a primary health care team is abandoned. Instead, emphasis is placed on the “**twelve doctors practising** [sic] at the health centre” (Mornington Health

⁸⁰ The ability to be responsive to local requirements.

Centre, n.d.). The other major health professionals are mentioned as an aspect of “a **fully equipped nursing station** [sic]” (Mornington Health Centre, n.d.). However, this dominance of PHOs by GPs, in particular in the area of governance, reflects the experiences of the English National Health System (NHS) as an “extension” of the GPs’ “current central role in primary care” (De Raad, 2003, p. ii). It is expected that long term balance between GPs and other PHO members will be reached as other key players become more effective at instigating change.

PHOs & Māori

PHOs offer opportunities and challenges for Māori health advancement. Primarily, the principles of participation, protection, and partnership define the PHO-Māori relationship. PHOs must show responsiveness to Māori needs. Delivery and implementation of services to Māori are guided through Māori Health Plans. However, there are some barriers to the effectiveness of PHOs for Māori.

As part of the seventeenth version of the Primary Health Agreement (Ministry of Health, 2005c, p.17), PHOs must utilise the Treaty of Waitangi-derived principles of participation, protection, and partnership to guide all policies and practices, including those related to service provision. Indeed, the very “process of establishing a PHO [must]... reflect the principles of the Treaty of Waitangi” as a minimum requirement (King, 2001, p. 1). PHOs must acknowledge that access by Māori of “their choice of quality primary health care services” contributes to overall equitable health outcomes (Ministry of Health, 2005c, p. 17). Furthermore, PHOs must “integrate Māori participation... in all levels of governance, service planning, development and implementation” (Ministry of Health, 2005c, p. 33).

PHOs are required to be responsive to Māori needs. In line with He Korowai Oranga, PHOs are “expected to contribute to improvements in whānau ora, and to the reduction of Māori health inequalities” (Ministry of Health, 2003a, p. 1). As one step towards that goal, Māori PHOs have been established, however it is accepted that a fair proportion of Māori will receive services outside Māori providers. Therefore, at a minimum, mainstream PHOs are required to “organise and deliver services in ways that are culturally competent and effective” (Ministry of Health, 2001d, p.10). In addition, providers with a large Māori roll are expected to provide services tailored for Māori.

One of initial activities of a PHO is the consultation on and development of a Māori Health Plan. From the establishment point, PHOs must “endeavour to incorporate Māori

principles/tikanga into the service delivery process” (Ministry of Health, 2003a, p. 6). PHOs must implement and report on the Māori Health Plan outcomes by the end of its first year of operation including evidence of how Māori communities were involved in its development (Ministry of Health, 2003a, p. 6). Thereafter, the Māori Health Plan is reviewed annually in conjunction with Māori and reported on six-monthly.

Two barriers to the effectiveness of PHOs for Māori involve participation. In the first instance, Māori participation in PHOs can be undermined during the establishment phase if DHBs allow softening of the minimum requirements. A possible solution is the creation of “a clear, time-bound path toward meeting the requirements, with a corresponding set of realistic sanctions and rewards” (De Raad, 2003, p. 15).

Māori participation in PHOs can also be obstructed by the use of the ‘Māori Stakeholder’ concept. Māori Stakeholders are identified by the Ministry of Health as “Māori with relevant expertise... includ[ing] but not restricted to: iwi, hapū, whānau consumers, Māori communities, Māori-led PHOs, Māori providers, Māori clinicians, Māori health managers, Māori organisation[s, and] PHOs with partnership arrangements with local iwi and Māori” (De Raad, 2003, p. 12). This broad definition does not ensure that the most effective stakeholder is identified. Indeed, a non-Māori PHO could fulfil the final stakeholder role. As the current Primary Health Agreement does not qualify how Māori Stakeholders will be identified, interpretation is left to PHOs. While PHOs are allowed to define their stakeholders, Māori participation can be limited to a cursory level. For effective and meaningful participation, which at least reflect the Ministry of Health’s (1997a) own Māori communication guidelines, the Primary Health Agreement must be revised.

Further barriers to the effectiveness of PHOs for Māori are inherent in capitation funding. In the first instance, capitation gives PHOs an incentive to provide lower-cost services to enhance profit margins. This can lead to cream-skimming, under-service, and cost-shifting. Cream-skimming occurs when providers specifically aim enrolment at low-cost, low-risk groups, whilst avoiding or “shedding patients that are found to be high risk” (De Raad, 2003, p. 9). The effect is reduced expenditure and increased profit. Māori have a higher risk of poor health and, as a result, an unfortunate incentive exists for restriction of Māori numbers on PHO registers (De Raad, 2003, p. 9). This can increase the pressure on PHOs who do not cream-skim, as “high health need patients” seek enrolment (Crengle, 1999, p. 36). Cream-skimming can be minimised through needs-adjusted funding and ensuring open enrolment.

Under-servicing is a reduction in the quantity and quality of care provided to service users. This can be particularly problematic for patients with higher health requirements, such as Māori, as it limits the effectiveness of any interventions. Cost-shifting, comparatively, occurs when a PHO makes determinations that obligate service delivery by another provider (for example, hospitals), even though these services could be delivered by the PHO (Coster & Gribben, 1999; De Raad, 2003). Under-servicing and cost-shifting can be measured by DHBs by recording the number of unnecessary hospital presentations by any given PHO.

The requirement for registration with a specific PHO can be a barrier to its effectiveness for Māori. As Crengle (1999, p. 35) indicates, “high mobility is a feature of some... whānau”. Maintenance of integrated service delivery (for example, record-keeping) is severely compromised. Furthermore, cost recovery from the primary PHO by any practitioner providing service requires resource allocation (Crengle, 1999, p. 35). For PHOs to be responsive to Māori needs, further development is required.

PHOs, Māori, & Health Promotion

According to the first International Conference on Health Promotion’s Ottawa Charter, health promotion is defined as:

the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being. (WHO, 1986)

Therefore, health promotion can be seen as a holistic process, which is actioned through various health promotion approaches.

There are a number of health promotion approaches in current practice. Young (2002) explores two different approaches. The first approach focuses on health behaviour modification and is an “individual-behaviorist perspective” (Young, 2002, p. 9). One example of this theory, the Health Belief Model, is a composite of the modernist operant (Skinner, 1938) and cognitive theories, and social learning theory’s self-efficacy concept (Rosenstock, 1990). As such, this

model is individualistic, employs self-regulation, but does not reflect adequately on external social, cultural, and economic pressures. Like the individual-behaviourist approach as a whole, this model does not reflect a holistic definition of health promotion.

The second ecological approach emphasises “the interdependence between the individual and the family, community, culture, physical and social environments” (Young, 2002, p. 11). As an example, the “PRECEDE-PROCEED” model employs nine phases, centres on the participant in the first and last phases, and seeks experiential knowledge as indicators of life quality (Young, 2002, p. 13). As such, conscientisation and participation are utilised as means for attaining social change. The model defines health promotion around health education and policy development initiatives. Evident in Phase One, PRECEDE-PROCEED uses health education in its fifth phase as an “impetus for public involvement and [a] commitment to [the] social reform essential to its success in a democracy” (Green & Kreuter, 1991, p. 14). Policy is also applied in the fifth phase in order to assess and develop appropriate interventions.

Another more family-centred model, the Family Nursing Assessment (Hatrack, Lindsay, & Hills, 1994), focuses on family health promotion as “a mediating strategy between people and their environment” (Young, 2002, p. 14). This model has four components: “listening to the family”, “participatory dialogue”, “pattern recognition”, and “envisioning action and positive change” (Young, 2002, p. 15). Though professional intervention is still a focus, the model emphasises the family as expert. Health promoters do not assign change strategies; instead they are involved in the development of praxis through dialogue and critical reflection. In particular, promoters must respect and trust “the family and its members to discover and choose directions as they see it” (Young, 2002, p. 14).

A family-centred model for sexual health promotion is offered by Hisley and Clements (2004). The authors define family sexual health as “the ability of the family to foster positive sexual self-esteem of its members, to validate each member’s sexuality, and to maintain a gratifying sexual relationship between the parents” (Hisley & Clements, 2004, p. 421). As the primary social and biological reproductive unit, families “foster healthy sexuality” and psychosexual development (Hisley & Clements, 2004, p. 420). Beginning with self-examination of promoter sexual beliefs and behaviours, the approach requires health promoters to assess, diagnose, intervene appropriately, and finally conduct an evaluation (Hisley & Clements, 2004). Assessments are conducted by collecting a family sexual history from which a diagnosis can be made. Interventions can be individualistic or between the promoter and specific family members. Depending on the diagnosis, evaluations can be formative, procedural, or impact related.

Though this model offers a systematic approach to sexual health promotion, it fails to maintain integration through its deferral to common biomedical practice. For example, suggested interventions tend to focus on adult family members. This conservatism extends to the authors' definitions of gay, lesbian, and heterosexual "domestic partnerships" as "families with alternative lifestyles" (Hisley & Clements, 2004, p. 433). Furthermore, the authors insinuate – without evidence – that parental separation leads to a lack of adult supervision and, thus, risky adolescent behaviour. Though a family-centred approach to sexual health promotion is supported, this model's medical and social conservatism diminishes its capacity. Further development of a whānau-centred model may prove useful in New Zealand's health promotion context.

Health promotion in New Zealand is primarily directed by central government through the Ministry of Health and other state agencies (for example, the Police) (Wise & Signal, 2000). Health promotion services are currently provided by various contractors, including public sector (for example, hospital-based public health services), non-government and community organisations (Wise & Signal, 2000). In addition, pan-Māori (for example, Te Hotu Manawa Māori) and iwi-based (for example, Te Runanga o Raukawa) organisations provide 'for Māori, by Māori' health promotion services. Recently, PHOs were directed into the fray.

As part of the Primary Strategy's focus on reducing inequalities and, thus, the public health aspect of the Primary Health Agreement (Ministry of Health, 2005c), PHOs must promote the health of the community it serves. Current funding arrangements allow \$1.78 (GST exclusive) per enrollee for the purposes of promoting health (Ministry of Health, 2003b). As economies of scale make promotion difficult for smaller organisations, PHOs are advised to work with existing public (Ministry of Health, 2003b, 2003c) and private (Ministry of Health 2003b) providers as required. This allows opportunity for increased community participation generally and Māori participation specifically in line with Treaty of Waitangi requirements (Ministry of Health, 2003b). PHOs seeking to design effective health promotion services would benefit from an understanding of Māori definitions of, and models and mechanisms for, health promotion.

Health promotion for Māori has been defined by a number of authors. In *He Tatai i te Ara* (Ministry of Health, 1996a, p. 5), Māori health promotion is defined as "Māori having control over their health or tino rangatiratanga o te hauora, or encouraging people to determine their own good health and wellbeing". Furthermore, it is defined as "the process that assists whānau to make choices to regain and maintain tino rangatiratanga o te hauora" including "the process of social and political action for health development" (Ministry of Health, 1996a, p. 5). Māori

engagement in health promotion offers a variety of positive outcomes including the achievement of potential, the opportunity to make decisions, maximisation of options and participation in the consultative apparatus (Ministry of Health, 1996a). Kamira, Campbell, and Campbell (1999, p. 18) offer a slightly different interpretation of health promotion for Māori, believing it to be a population-based approach utilising a “range of strategies including health education”. By seeking “long term attitudinal change” and “both inter-sectoral action and multi-disciplinary execution”, Māori will have greater control over their health (Kamira et al., 1999, p. 18).

Māori models for health promotion can assist in gaining this control. In a whānau development model, health is defined from a welfare perspective (Cribb, 1995) versus specifically a disease-prevention mechanism. Whānau health promotion within this definition is ecological in nature (Young, 2002) and responsive to its environment. The second model, Te Pae Mahutonga, which is based on the Southern Cross constellation, emphasises leadership and autonomy (Durie, 1999). Initiatives which increase access to traditional Māori society, provide environmental protection, promote healthy lifestyles, and social participation are supported by this model (Durie, 1999). Both models fall within the WHO's definition of public health as “the science and art of promoting health... based on the understanding that health is a process engaging social, mental, spiritual and physical well-being” (Kickbush⁸¹ as cited in Buchanan, 1995, p. 224). Whatever the definition, health promotion for Māori requires Māori-specific strategies.

A number of authors have noted the usefulness of the marae as a Māori-specific strategy for increasing access to Māori. Simmons and Voyle (2003, p. 41) interpreted the marae as “the hub of Māori culture” and utilised one urban version to successfully promote healthy diabetic lifestyles to 436 participants. In an international review of interventions based on the WHO's Safe Communities Model, Towner and Downswell (2002) included the Waitakere Community Injury Prevention Project (WCIPP). The WCIPP's Māori component specifically incorporated holistic perspectives and was marae-based (Simmons & Voyle, 2003, p. 41). However, marae-based interventions are not the only way to promote health to Māori.

Other Māori-specific health promotion strategies utilise the social structures and activities of Māori society. For example, in order to promote healthy attitudes to alcohol and driving, Te Whānau o Waipereira's Brothers Against Drunk Driving programme employed the local gang structures and rugby league (Barnes, 2000). Similarly, Huakina Development Trust's

Whiriwhiri te Ora programme utilised the Kingitanga and traditional Tainui networks (Barnes, 2000). Through, gang, sport, political, and iwi affiliations, the promoters were able to effectively communicate the health message and promote change to individual Māori and their whānau.

Though these strategies are encouraging, examples of sexual health promotion to whānau are non-existent, partly due to a lack of sectoral direction. Currently, Māori sexual and reproductive health promotion policies emphasise rangatahi⁸² over other whānau members (Ministry of Health, 1997b, 2001b, 2003d). Indeed, resources “designed to help... Primary Health Organisations [sic] find ways of improving their populations’ uptake of effective contraception and safer sex practices.... [emphasise] young people” over any other group (Ministry of Health, 2003d, p. 1). Though this ensures younger whānau members, like young Māori women, maintain experientially-sourced expertise, it does not protect their tuakana⁸³, mātua⁸⁴ or tūpuna⁸⁵. The mean age for confirmed incidences of genital herpes (28.9 years), non-specific urethritis (29.6 years), and syphilis (36.2 years) verifies the need for extending current diagnostic, if not preventative, strategies beyond the 15 to 24 year age group (Ministry of Health, 2003d). A “collective rather than individual intervention” may assist PHOs in providing this extension (Ministry of Social Development, 2004, p. 106).

Conclusion

As the primary care sector has traditionally focused on personal health, health promotion as a public health exercise is challenging in the PHO setting (Ministry of Health, 2003c). Though specialised health promotion funding, “designed to promote health and improve access for those groups that traditionally have not fully utilised primary care” (Cabinet policy committee minutes, 2005b, p. 2), and general guidance is available (Auckland Regional Public Health Service, 2005; Ministry of Health, 2003b, 2003c), more specific direction is required. As government is yet to provide whānau-centred operational policy for sexual health, PHOs will

⁸¹ "Kickbush" is probably an incorrect reference by Buchanan or the editor, Seedhouse, to **Kickbusch**, a health promotion researcher at WHO's Copenhagen office (see Kickbusch and Badura, 1991).

⁸² The Ministry of Health (1997c) defines rangatahi as “New Zealand youths and young adults who have whakapapa and identify themselves as Māori; are aged 13-24 years; and, who, within their whānau, share the social, economic, cultural and political influences which impact on their development of a unique world view reflecting diverse Māori and iwi realities”.

⁸³ In general, this term refers to older siblings and cousins of the subject's gender, however, it operates idiomatically and may change depending on context or iwi. For example, amongst my paternal grandfather's people, the eldest child would be termed “tuakana” by younger syblings irrespective of gender.

⁸⁴ Parents, aunts and uncles.

need to utilise participatory mechanisms to inform their policymaking. The following chapter offers the subjective expertise of three young Māori women to assist in this development.

⁸⁵ Relatives of the grandparents' generation and above (for example, great-aunts and great-great-great grandfathers).

CHAPTER SEVEN

DATA

Mana Wāhine

Three participants were recruited for the study, each graciously providing their time, thoughts, and passion about issues like sexual health and whānau. The following section provides a small overview of each young Māori woman.

Ahikaa

Ahikaa is 19 and from a small rural town. Ahikaa is the third of five children: four girls and one boy. She attended boarding school before returning to her hometown college in Year 12. Since going flatting, Ahikaa has finished a course and is now “on the dole”. She respects her grandparents’ generation and understands her parents’ ethics on issues like abortion.

Ahikaa likes fun: drinking, clubbing, and sports. She values friendship, honesty, and commitment, but doesn’t believe she has “leadership skills” or is a “speechmaker”. In her opinion, young Māori women are “competitive”, “open-minded”, and “don’t really care what people think”.

Hinemoana

Hinemoana is 21 and from a large town that acts as a regional hub. She has one brother. She attended a local secondary school until Year 12 before moving towns to attend a course. She works in retail and is a single parent to a pre-school daughter, Ngaru. The two live with Hinemoana’s Mum (Waitai), who is separated from Hinemoana’s father. Hinemoana plans to return and live with Ngaru in her hometown within the next two years.

Hinemoana likes to “just have fun and laugh”, shopping, dancing, and singing. She values friendship and purposefulness, and considers herself to be “a bit of a wuss when it comes to meeting new people”. Hinemoana regularly attends church and aims for the openness she shares with her Mum in her relationship with her daughter.

Tohu

Tohu is 20 and lives in the family suburban home. In addition to her two brothers and two sisters, Tohu has had “a lot of foster brothers and sisters”. After attending a combination of boarding and co-educational schools, Tohu did some study, but is now working. She aims to enter the army as an administrator with the long-term goal of working for returned service personnel in mental health.

Tohu likes “going to family things”, shopping (“gotta love shopping”), traveling, and clubbing. She values commitment, timeliness, and respect. Tohu is very goal-orientated, does not consider herself competitive, and has high expectations of both herself and others.

Te Ao Tawhito

Young Māori women, as a cohort, share beliefs, values, and practices. These similarities underpin some of the ways they define their world. By understanding these beliefs, values, practices, and definitions, possible directions for best practice can be found. This section explores what it means to be young, Māori, woman⁸⁶, whānau members for Ahikaa, Hinemoana, and Tohu.

Being Young

Ahikaa indicated the lack of commitment sometimes displayed by youth:

You know what young people are like. They're just hoha... Pick and choose when they wanna turn up and stuff like that.

A common youth value highlighted by Ahikaa is competitiveness:

It's like young people young people are competitive. Competitive at everything. Looks and anything. The way they're dressed. You know.

Tohu believes that what may be needed is guidance:

Epecially with the young ones. Just to get them kinda like um motivated... like get into their heads what a fair idea of life is really gonna be like.... You wanna put them in real life situations.... Get them all team-building and working together and hopefully it helps them later on in life and they can look back and say, 'Y'know, shit. That did actually help me.

Being Māori

Being Māori can mean many different things, particularly when a young person is trying to establish their individual identity. Ahikaa believes the process could be eased through some intervention:

Don't have very much Māori students that did Māori like te reo Māori and kapahaka.... I reckon they should make kapahaka compulsory for every Māori student that did Māori. A Māori class.

Tohu believes being Māori involves individual responsibility. When discussing kapahaka teams, Tohu had this to say:

When I go into the army, I'm gonna join that one... Because I am Māori... That's like my contribution to the Māori sector of the army.

Being Māori Women

Ahikaa sees various differences between Pākehā and Māori. Firstly, Ahikaa believes Māori women are physically different:

We're different shapes... More hips. More wider... broad shoulders.

Secondly, presentation is differentiated:

Where the Pākehā people with [mumble] ooh makeup makeup. Where as the Māori girls they don't some don't even care.

Thirdly, Ahikaa sees a difference in attitude:

⁸⁶ The choice of 'woman' or 'women' as an identity marker is purposeful. Though 'female' may correctly recognise the physical aspects, 'woman' incorporates the identity's social construction.

Ahikaa: I reckon we're more open-minded.
Katarina: Māori girls?
Ahikaa: Yeah. Than Pākehā people... 'Cause we don't really um most don't really care what people think... About themselves. Like you could be walking down with like baggy jeans and a hoody, I wouldn't care if someone looked at me oh look at that girl.

The competitiveness common amongst youth finds a different focus amongst young Māori women:

Katarina: Do young Māori women do that with one another?
Ahikaa: Oh staunchness wise yeah... They're competitive to that. Like being staunch.

An interesting example of this was provided by Ahikaa to illustrate young Māori women's staunchness:

Like 'kay, one day me and [female friend] were walking home from course. And these Māori girls standing on the side of the corner one day. We're just walking past [mumble] ourselves and I'm just like what the [noise] looking at? You know. Just walk past and do nothing. Didn't say nothing. See that kind of competitive. Yeah. Thinking oh those are Māori girls like gotta be stauncher than them.

And the reason?

Maybe 'cause they might be jealous or something. That we've got something that they don't have.

Finally, she notes esteem issues:

Ahikaa: Low self-esteem.
Katarina: Do you think a lot of Māori girls do or just?
Ahikaa: I reckon young Māori girls do.

Whānau

'What is important to you?' When asked this question, all three participants provided the same first answer:

Ahikaa: My family.

Hinemoana: Whānau. Hard out.

Tohu: Family.

For Ahikaa, it was:

‘Cause I love them... And if they weren’t with me, I’d be all by myself. Um. Who’s gonna give me money when I have no money? Who’s gonna pick me up when I come home on the bus or something? Or buy me stuff that I need.

Hinemoana found purpose and protection within her whānau:

Just looking after my family. Um ‘specially my little bubs. Um my Mum. Um we haven’t got much of a family really... I think I’d be pretty much lost if I didn’t have my Mum... I try to do things for myself, do things independently and not have to depend on my Mum... But we have sorta opened up um a little bit um since I’ve moved back in with Mum.

For Tohu, a particularly hard year has strengthened and focussed her family:

‘Specially with everything my family’s been through this year. With my Mum being sick and that. It just like, we’ve all noticed how like how really close we are. Deep down. We’ve all really expressed it now... She nearly... we nearly lost her there. So now we all, you know, really do know how important we all are to each other.

Defining the term whānau provided interesting results. For instance, Ahikaa believes whānau includes “anyone that’s related... depending on how close... [she] felt to them”. Members of the same tribe are “extended whānau”. For Hinemoana, her whānau is her Mum, her daughter and herself. Tohu defines whānau situationally. Firstly, as her father is one of ten, the whānau extends to her grandparents’ progeny:

Like my grandmother, you know [surname] whānau from up up [small town] ways? Well that’s my whānau up there.

Secondly, Tohu recognises the whānau as the people she was raised with:

My Dad’s family is so big, we have like another whānau in itself from where I’ve been brought up.

Finally, Tohu recognises whānau members who are not related biologically:

It's just like people that have been there so much for us, we call them whānau. But blood... we're not really related.

Te Ao Hou

Every person experiences the world in a unique way. From the social (for example, groups they participate in) to the personal (for example, their sexual lives), each has a different story to tell. This section explores the stories of Ahikaa, Hinemoana, and Tohu in regards to organised peer groups, sexual health, and sexuality.

Young Māori Women and Organised Peer Groups

Organised peer groups, as the name suggests, are peer collectives whose purpose and operation are planned. Though they may include kin, organised peer groups are motivated by a given activity and include sports teams, clubs, church organisations, focus groups, and government committees. From their experiences in different organised peer groups, the participants developed an understanding of what makes a group of young people work well together. In general, effective groups utilised certain concepts well (for example, leadership and discipline) and applied them in a fashion which responded to group preferences (for example, providing food). This section provides information on young Māori women and organised peer groups.

Past Experience

All three participants have been actively involved in organised peer groups, particularly sports teams. All three played netball and touch football during secondary school. Both Ahikaa and Tohu played hockey. In addition, both Ahikaa and Hinemoana played basketball and have an interest in indoor netball. As individuals, Hinemoana plays volleyball, while Tohu has played soccer and squash. All three were also members of groups focussed on performing arts. Ahikaa and Tohu were both heavily involved in kapahaka, whilst Hinemoana was in a drama group. Each participant had different reasons for continuing their involvement. For Ahikaa, it was the activity itself:

Katarina: What made you want to keep going with.. kapahaka?

Ahikaa: After I'd finished from boarding school went to [rural town of origin], I carried on like singing. Sing.

Hinemoana found family support a strong motivating force:

My Mum was there at all my games. And you know I used to hear her on the sidelines giving it heaps and: 'Come on [Hinemoana] get up there! Don't bloody stand there! Get up there! Oh we'll pull you off if you're not going to do anything.' You know. And she used to make me get quite agro so I'd play a pretty good game.

In Tohu's case, self-development and passion provided motivation:

Katarina: What keeps you going in in a group though?

Tohu: Just new people... just keep on pushing yourself and you get there. You know, just the whole adrenaline rush of, oh my god, I actually did it!... Just the the physical part of it, I think. Just, you know, the whole thing of, 'Wow, I actually did it. I'm actually getting better at it.'

Katarina: What about kapahaka?

Tohu: S'pose, it's just a passion of it really.

Different methods of introducing participation were used, including trials:

Katarina: With touch, was it case of you you trial or was it you just did it?

Ahikaa: Oh they had a junior team and senior team. But you had to trial to get into those.

Hinemoana: [I played netball] for my school and then um there was some like um you know what do you call them? People just looking. Watching the games.... And they just: yeah, she's a bit of alright'. And then we heard there were trials on. So Mum said 'gotta go'. So I went to the trial and I got I got in.

Once membership procedures were established, groups began their activities. Consequences provided a structure for participation. Positive reinforcement (rewarding desirable behaviour) helped motivation:

Ahikaa: Breakup or something. Like you have a breakup or something.

Katarina: With your breakup did you like give out awards or anything?

Ahikaa: Yep... You get awards. Oh every week you got awards for like you know player of the day or something like that.

Surprisingly, negative reinforcement (punishing undesirable behaviour) also provided motivation:

Ahikaa: This is what I was always [mumble] basketball. We didn't turn up to practice, we didn't get to play.

Participants suggested ways for overcoming the boredom, which occurs with some repetitive organised activity:

Ahikaa: Like um we played tag or something while... We were practising. Know? Something kind of activity that is included in your thing you're doin'.

The most often-mentioned method of attracting and maintaining participation was food. Ahikaa and Tohu discussed their past experience:

Ahikaa: Yeah. Like at kapahaka, when we'd sometimes meet we'd all bring a kai and share or something...

Katarina: Did the feed work? Is that a good.

Ahikaa: Yep.

Tohu: Maybe just like a barbie after touch maybe. That's what we used to have... Like one of our friend's father's used to bring the barbie along. Used to have like a sausage sizzle and just a few drinks. Everyone used to just y'know 'lax out.

Hinemoana suggested food as a motivator when establishing a new group:

Just you know and then have a BBQ sort of. Get everyone altogether, so then they don't think 'oh, it's practice'. You know have something at the end of it, that makes them think... Food. Food.

Establishing a New Group

When establishing a new group, all three participants suggested utilising media to attract initial participation. All three mentioned notices or flyers, while Ahikaa and Hinemoana suggested newspaper advertising, and Ahikaa alone recommended radio. Word of mouth was favoured by Hinemoana and Tohu, with the latter suggesting sourcing members through existing community activities:

Other sports events. 'Cause, y'know, a majority of people, if they play one sport, they're usually, either interested or they'll be willing to learn another sport... Maybe even um some of the local schools. [mumble] Yeah like colleges... Depending on what sort of age group I was looking at in particular. Maybe like the sixth and seventh formers... Try and get them in... Learn from the older ones.

Once participation is established, positive consequences help maintain motivation. Tohu provided this comment:

I think in a way they need like incentive... Like um starting up competitions to um y'know to actually be playing for something... Start up like a tournament or something, where they've got something to work towards. And you have like um prizes. Y'know everyone loves like y'know maybe like Rebel Sport vouchers... And then just like have one big prize. Like have something for them to work towards. Then maybe um just at the end of the season, have like y'know one big get-together... y'know just something where everyone can actually like um relax and have a good talk

Participation in any group has associated responsibilities. All three participants expected commitment from group members, particularly through attendance at planned activities, such as practices. Ahikaa expected twice-weekly attendance; "once a week for like a meeting... And once for practice." Hinemoana timed her decision around the seriousness of the activity. If social, two meetings per week were considered sufficient, including one practice of up to 90 minutes. If more serious, up to three practice sessions per week were suggested, each being "maybe two hour[s]" in length with "an hour after that for a feed". In the event of a competition, Tohu would expect up to three meetings per week, each up to 120 minutes in length.

In addition to attendance at planned activities, Ahikaa required a willingness to be involved, Hinemoana wanted team members not individuals and Tohu needed to see effort. Both Hinemoana and Tohu discussed group members who did not display these characteristics:

Hinemoana: There's always some people that're pissing around and they not really wanting to be there and they're only there 'cause their mates brought them. And you know... everyone else gets their vibe and sort of 'Oh, I don't wanna do this'. And it's just makes the whole thing crap.

Tohu: Whereas there's like 20 other people there that are trying. Just because you aren't, they're all suffering from it. So, I'd rather you piss off and the rest of them concentrate on what they're doing than you stay here bloody piss around and then we'll... y'know? Be y'know failing, pretty much failing from this, I s'pose you could say. 'Cause when it does come to the competitions, they're all gonna look like crap because of that one person. I'd rather that person: laters.

Tohu suggested the noho as a culturally-specific way of team-building, information-sharing, and motivating:

Katarina: Would you do a noho for touch? Do you think stuff... like that works?
Tohu: With team-building... those are also things that you can work on with that... but I think people would come like with the whole meeting people... yeah like team-building exercises and different... I don't know. Well, you can maybe get people in just to talk to them about... Especially with the young ones. Just to get them kinda like um motivated... like get into their heads what a fair idea of life is really gonna be like... You wanna put them in real life situations... Get them all team-building and working together and hopefully it helps them later on in life and they can look back and say, 'Y'know, shit. That did actually help me.'

Concepts

Organised peer groups utilise motivating concepts with varying degrees of success. Group purpose was one concept which received comment from Ahikaa:

The reason why I didn't like kapahaka at at [secondary school 2] is 'cause we just practiced and practiced. For nothing. To do like powhiri. To do a powhiri we'd practice for like two weeks... Nah, we weren't goin' nowhere... So, there there was no like motivation for people to keep coming back to do kapahaka... If something works you attract more people to it. And they'll keep wanting to come.

Leadership and discipline are also important:

Katarina: Do you think at [secondary school 1] that the perhaps the leadership was a bit better?
Ahikaa: Yeah it was way better. There was more discipline I reckon. Way more.

For Tohu, effective leadership validated the activity and gave it meaning. She provided this

comment in reference to kapahaka:

Depending on who's teaching you the songs and what the songs are about, if you're taught them properly and they actually... inform you properly... you get like... a feel of the song... Like hakas. If you don't know what you're, you know, what you're challenging or whatever about, there's no point in bloody doing it... Some old kaumatua might come up to you, 'Oh, what was that about girl?' 'Oh, I dunno'. Just got taught at school.'

An opportunity for meaningful participation, with visible outcomes, is useful. Ahikaa believes that “if something works you attract more people to it... and they’ll keep wanting to come”. Comparatively, Hinemoana’s example shows participation as peer-directed:

Katarina: Was there like a drama club or was there a group?

Hinemoana: Oh it was just a group of my mates just sort of got together... And we’d do plays to our classes and you know. We’d just say ‘can we do a play?’ And we’d just go away and do a play and come back and. We really enjoyed it. And I enjoyed doing that sort of stuff. You know. Not always you know um planned stuff. Just like, you know. Just think ‘oh why don’t we do this and we could put a bit of that into it as well. Oh and why don’t put that in as well!’ You know sort of thing. Not have it planned like you know on script or anything.

Meaningful participation provides its own motivator. Unfortunately, the opposite is also true as Ahikaa illustrates:

We used to have a meeting sometimes... talk about talk about stuff that did... And nothing even happened when we gave our ideas and opinions and stuff like that... I stopped turning up because you’d give all your ideas and opinions about what could do to improve your kapahaka skills and stuff like that and where could we go and blah blah blah blah. And it never happened.

Affirming the value of participants to the team can provide motivation. Ahikaa believes award ceremonies provide one way for affirming member:

It gives ‘em good oh um self-esteem about themselves. Say if you’re like real dumb at sport or something then you absolutely hopeless and then you get like most improved like yay. You know. I’ll go back and keep playing... Someone’s acknowledged that your improving. And that makes ya makes ya feel better about yourself. So when people give you a compliment sometimes it can make you feel better about yourself... it gets them motivated and everyone’s like yay OK yep. I’ll do it.

Hinemoana believes verbal feedback is another important affirming mechanism:

Motivate them just like um praise them sort of thing, so that they, you know, they start thinking: ‘oh OK.’ [mumble] ‘Cause some of them may not think they’re any good or anything... When they have got a bit of... [mumble] they’ve got potential, but they don’t realise they have it. And if you

praise them and just say 'hey, keep on going! You're sweet. Come on. You know. We'll be right.'
You know, and work as a team, then you know should.

Sexual Health & Sexuality

For young Māori women, sexual health can be an uncomfortable conversation topic. Ahikaa feels that some of this could be related to the person involved:

Young Māori women know they'd be embarrassed about about going to doctors... I don't think young Māori women are really into going to talk about their sexuality or sexual health with a stranger.

Similarly, Tohu believes individual personalities can make a difference:

And you don't really wanna be on you know sharing it with the whole world. It needs to be more a yeah a personal thing... you've gotta be quite a trusting person too and you've gotta have a connection with people to talk with things like this... 'Cause this is a touchy subject y'know.

As Hinemoana puts it, the environment can make sexual health taboo:

If like just tell them that... Um there's a hui you know and we're all going to have a talk about sexual health things ra di ra. 'Cause it's sort of touchy subject. Find that a lot of people sort of go back and like 'nah, nah'.

However, amongst themselves, sex and sexuality are normal, healthy and humorous topics of conversation. As Ahikaa puts it:

'Cause it comes up in conversation generally. And if they want to know about or whatever... it's natural to talk about.

Some young Māori women talk about sex A LOT:

Katarina: Yeah... Do do your other mates talk about sex alot?

Ahikaa: Yeah [friend] does.

Katarina: Yeah.

Ahikaa: All the time. She talks about it all the time.

Te Ao Mārama

Te Ao Mārama means ‘the world of light’. It is a term I use to describe the change that occurs when we move from focussing on a problem (the darkness) and into ‘the light’ of a solution. In this section, the solutions are disjointed and complex when dealing with sexual health groups, but simple and humbling when focussed on the whānau and health promotion. However, in all cases, it is the words of Ahikaa, Hinemoana, and Tohu, which provide enlightenment. Ka awatea.

Participating in Sexual Health: Organised Peer Groups

For an organised peer group focussed on sexual health to work properly, it needs to respond to a number of factors. These factors include defining membership, attracting and maintaining participation, staffing, and frequency of group meetings. These five areas were discussed by the participants and could provide direction for agencies aiming to work with young Māori women on sexual health.

The participants believed a group focussed on sexual health needed to consider its membership. Due to the intimate nature of the discussions, Ahikaa thought membership could be limited to “cousins... and your friends”; “a group would be fine with your friends”. Two participants believed that membership has expectations. For Hinemoana, a group participant should be a “team member”. For Tohu, membership requires “commitment”, “effort”, and respect:

I s’pose just respecting... whoever’s working for them... Having a positive attitude toward it.. respecting them and going... put in the effort and go to the things you’re doing and contribute and things like that there. Instead of going there and pretending you want to have anything to do with it when really you’re like.

In return for her participation (“cause if something like this did come up, I really would be interested in it”), Tohu believes organisers need to “keep me informed”.

All three participants took some time thinking of means for attracting initial participation to a group focussed on sexual health. Hinemoana recommended flyers and word-of-mouth with television and radio advertising as alternatives. In contrast, Tohu suggested attracting participants by focusing “on where they’re gonna be”:

Y'know how they set-up like those stands kinda things like at um like the Kapahaka Nationals and like Waitangi Day... Those are always good 'cause we can always approach them... Setting out pamphlets in the mail and things like that there, I'd y'know look at them. See what they're about... I think that there's the number one thing is um just having those little stall thingies set-up at functions... Especially if you're after, as I was saying, with the young Māori women. 'Cause they're gonna be there... You need to focus on where they're gonna be... at like um secondary kapahaka nationals, people are always gonna be interested... It's not one of those y'know tryna' sell, they're not tryna' us anything... people things like um the Ratana 25th. Gonna things like that there.

The idea of attracting participation through integration in community activities was continued by Ahikaa. She suggested that the meetings themselves occur as “part of something else”:

But you're not goin' go to a sexual health clinic are you with your group of friends: 'Let's talk about sexual health.' We can do that at home... Yeah it's part of something else. Because I don't think a whole group of Māori women are come on let's go we're off to a sexual health clinic to talk about STDs... Gotta be another event to it I reckon... Maybe you could do it to like um Māori boarding schools because they always go to trips like that kinda stuff. Portray it to them like.

Maintaining participation requires positive reinforcement. Whereas Tohu suggested “seminars or something like that there”, Ahikaa suggested food and “free things”. In addition to paying participants, Hinemoana thought food might help too:

And you know maybe have a little hakari at the end of it, so then people think 'oh yeah, there's a bit of a feed at the end of it, so it's not all serious. We're all not just sitting in a room' and you know but you know... Just sitting, have a feed and talk with people afterwards and stuff like that but.

Appropriate staffing can provide another means of maintaining participation. For example, Hinemoana believes the appropriate personnel can maintain motivation:

Keep it interesting not boring. Ya' know. 'Cause a lot of things like that [mumble] you'll just say 'Oh, this nah I don't really need to be here. This is quite boring. I could hear this from anyone else' sorta thing. Um just keep it interesting and you know not always serious. Have a bit of um humour in it as well... Um yeah just sort of keep it you know bright sorta thing.

Hinemoana provided one example of prime personnel:

I always found that like English wasn't very exciting for me. I had a great English teacher and he was very um you know um... He he explained things but made it sound um... quite ya' know quite good. Like you wanted to keep listening... He was quite you know he had an interesting voice and

he made things sound um ya' know. Not boring. He kept you listening sorta thing... you need someone that um knows what they're talking about, and can do that as well.

Ahikaa thinks professional expertise can be helpful at times too, but is more cautious:

Ahikaa: I don't think young Māori women are really into going to talk about their sexuality or sexual health with a stranger... Oh well you can bring in a...

Katarina: From outside?

Ahikaa: Counsellor or someone... I reckon it's OK for somebody to come in if they're there to talk to when you go there to talk to them about it.

How frequently staff expect participants to meet can affect participation. Ahikaa believes "maybe you'd get the people coming all the time" if "it's like maybe once a month". Tohu agrees monthly meetings are preferable, though:

When it comes to things like that there, timeframe needs to be put on things. Like you don't really wanna be stuck on one thing... And if the meeting's two hours long, it goes for two hours. Doesn't go for three, y'know? 'Cause people do have other things.

Participating in Sexual Health: The Wāhine-centred Approach

PHOs have alternatives to organised peer groups if they wish to work with young Māori women to promote sexual health in general. For example, there are opportunities to participate during the development of mass-media campaigns. However, there are no referenced mechanisms for young Māori women (or wāhine in general) promoting sexual health to whānau. To this end, this section explores an alternative approach, which I have titled "the wāhine-centred approach". The three participants selected roles, defined limitations, and assessed the potential benefits and challenges. Throughout, they utilised their personal experience to inform their positions.

Each participant was asked to select a role, which they would play in the promotion of sexual health to their whānau. The roles were bystander, recipient of information, advisor, assistant and promoter. Hinemoana chose (and would recommend) the promoter role, whilst Tohu chose to be an advisor:

I think I'd be better working with someone one-on-one. Because I think when it comes to things like this... it's something quite personal... And you don't really wanna be on you know sharing it with the whole world. It needs to be more a yeah a personal thing that you can... you've gotta be

quite a trusting person too and you've gotta have a connection with people to talk with things like this.

Tohu would recommend her advisor role to other young Māori women, because:

People don't realise that the situation you've been in you may not think you know 'well shit, I'm the only one that's y'know had that problem before' or whatever. Everyone has them. You need to start talking to each other and y'know, that 's that's that's it's communication. Once you start talking, everyone's starts y'know getting deeper and deeper. That's when you starting finding out 'shit, she's had too' or y'know 'she's done that too or had that problem too'. Y'know um it's all about helping out one another. We're not going to get through life unless y'know you're communicating tryna' um you try and unless you try and um. Yeah. Advice. Is a biggie. You're not gonna get through life without good advice. You need to go to people. You can't keep all... If you keep it all bottled up, that's when things are gonna get worse. And the problem is gonna come y'know end up ten times as bad. It's better to y'know. I want other Māori women. Like say if I say was pregnant, I'd want someone to go to.

Ahikaa began with one role and then changed to another:

I said I'd be a bystander 'cause you don't have to talk about anything... But actually I gave all my opinions on how I would have run it, so that's really an ad... um an advisor.

In the end, the personal nature of advisor role fitted Ahikaa best "[bec]ause like when you're close to someone, you could probably talk to anyone about anything". She would recommend the role "to a specific group" because:

It comes up in conversation generally. And if they want to know about or whatever... it's natural to talk about.

Though each role was recommended to others, the participants were more restrictive on who would receive their information.

The intimacy of sexual health affected which whānau members the participants chose to work with. For example, Tohu would define whānau quite specifically:

Because my Dad's family is so big, we have like another whānau in itself from where I've been brought up... So I would probably focus mainly on them because they're with reach for me and I know them so well because I've been brought up with them... They'd be willing to y'know to reach out to me.

Hinemoana would work with her mother, but believes Waitai would “know bit more than I would”.

All three participants made limitations, including some that were gender-related. Some gender limitations were based on the whānau members’ personalities:

Ahikaa: My brother I don’t like talking about the stuff... He’ll just go off and walk off. Tell me to shut up. He don’t like talking about that kind of stuff.

Hinemoana: [My brother] sorta tries to change the subject if we start talking about stuff like that.

Whilst others were more general:

Katarina: Would you do it with men as well?

Ahikaa: Nah... be only to women if I was to be the advisor.

Hinemoana: Well girl yes. They know what’s up, they know what you’re talking about. ‘Cause they go... ‘cause they’re a girl themselves. But with fullas, it’s a bit different... So, some guys just don’t wanna go there. Can’t talk about it.

Perceived self-efficacy affected both gender and age limitations. In regards to gender, Tohu showed empathy in her choice:

I don’t really wanna be giving advice where I can’t really relate to the situation... if they’ve got a problem, I wouldn’t mind if they come to me. But I wouldn’t really wanna be givin’ out advice when I’m... I don’t really know how boys’ minds work... when it comes to... their sexual problems, I don’t really wanna be getting involved with that because I don’t... I feel as if I don’t have the right to to give advice when I... haven’t even been there and done ‘y’know. Myself.

In regards to age, Tohu showed humility:

‘Cause I’m only young myself, I would probably put an age ratio on it... Because I don’t really wanna be givin’ advice to people who are like 30-something. ‘Cause they’d... I’d rather go to them for advice... I’d wanna stick to like maybe like the say 16 year olds to say 25 year olds.

The final limitations were based on whānau roles. Ahikaa, for example, would advise her “cousins and sisters” (“it’s sweet... [bec]ause it’ll kind of ‘round the same age”), but not her grandparents:

No. That's a bit um too personal then... I don't know. It's a little respect line there. You know you don't... Out of the boundary about that stuff with your grandparents. I'd be like: so Nan I'll talk to about sex. [laughter] [mumble] sexual health problems.

Similarly, Ahikaa would speak to her parents' generation, but not necessarily her parents:

And maybe not with my parents. I wouldn't be like: 'no, yucky thoughts I don't wanna hear that'. See? Its hard when it comes to your family.

A number of benefits and challenges were identified by Ahikaa, Hinemoana and Tohu. Ahikaa and Tohu identified personal benefits, while Ahikaa and Hinemoana perceived opportunities for whānau. Primarily, Ahikaa believed the process presented both personal and whānau benefits:

- Katarina: So like if you were talking to say [younger sister] about it or something.
Ahikaa: And I told her to do something else and not that.
Katarina: Yeah. And then she talks back to you.
Ahikaa: About oh OK well I did this and I shouldn't have done that. Maybe next time I'll do this.
Katarina: You your getting something from that just by having...
Ahikaa: Yeah yeah. 'Cause then I know that she's you know oh whatever having safe sex or...
And then I know that she's safe or whatever.

Ahikaa expanded on the idea of personal benefit through the provision of opinions:

Well I'd advise them, you know I'd talk to them about it. It give them some advice. If they wanna take it they can take it and that's benefited from me because I've given my opinions... Sometimes other people's opinions can count. Of what you think or feel.

Like Ahikaa, Tohu saw personal benefit in this process:

I think just the whole thing of 'know them coming like being able to come to me and me actually being able to help them out would be a huge benefit. Like I'd be real um real proud of myself if I y'know I always am. Helping someone out. That's a big thing eh? Especially if um they're gonna well they'll hopefully will benefit from it. Whatever their problem is. Hopefully I can try and not so much resolve it but um try to I don't know just make it better... and hopefully they go away pretty much with a resolution... as long as they're satisfied. With the with the advice that I've given them, I'll be happy... As as long as they've kind of um got a fair idea of how they can fix the

situation that they've come to me with... Even if it's not y'know the whole thing... But they can think about it and maybe uh add to it and that's gonna fix it. Then I'll be happy.

Hinemoana saw whānau benefits via a positive effect on her relationship with daughter Ngaru:

Like just knowing how she thinks sort of thing about things... I'd like her to be able to just tell me things. Like as a friend. Not... 'Nah, I can't tell Mum that.' You know, that's how I want our relationship to be. So that she isn't scared to come and tell me things. That she's like 'Mum, what's this? And what's this when you do this?' You know not like some. I know quite a lot of families um that brush that off and: 'Oh we don't talk about that here. That's just a no-no'... I want her to not class me as a Mum pretty much. More like a sister, a big sister that we you know. 'Cause that's what I class Mum as. A big sister. I just tell her my stuff. Within reason... But most things, I'll tell her and I want [Ngaru] to do the same too. So, that she'd just be like 'Hey Mum. Um I tried this and this has happened. What what's that?'... I want her to be able to tell me not keep it to herself... But most kids, they don't always go to their Mums and stuff. They go to their friends and stuff... But I just want her to know that I'm here and that I'll help her out. And that, you know, I'm not going to judge her. And I'm not going to give her a crack, because she's done something... I'll support her and... 'Cause I know what I was like... I've gotta sorta understand, if [Ngaru] does something sort of similar.

Two participants identified challenges in the promotion of sexual health to their whānau. Hinemoana foresees some difficulties in promoting to a teenage Ngaru:

Her asking heaps of questions about things that I really don't really want to get into, but I know she needs to know. So, I'm not going to not tell her, because she's somehow she's going to find out. And I'd prefer her to hear it from me, instead of some mate or... Somebody... Challenges? Her not agreeing with me. And her thinking she knows what she... she thinks she knows everything. Little Miss Know-It-All. 'And Mum doesn't know anything'.

Tohu identified a particular challenge involved in her role as advisor:

Trust. Like if I was going to an advisor, I wouldn't want y'know them to go off blabbing to everyone else... when it all comes down to it, just having that connection with someone and really being able to trust them so that they can talk to you.

In summary, all three participants chose a female-only approach to sexual health promotion within the whānau environment. Known outcomes are an aspect of the approach, though the participants saw the intangible personal benefits as being more than satisfying. Participants

showed that it was possible to balance the health promotion programme's demands with the obligations of being a whānau member.

Participant Updates

Since the interview, each of the three participants has undergone major life changes. Shortly after the interview, Ahikaa began fulltime employment in the government sector. She maintains a long-distance romantic relationship and is about to return home to live. Hinemoana has left her job and returned to her home town, where she lives with her brother and Ngaru. She is much happier and is enjoying a whole new life. Soon after our interview, Tohu discovered she was pregnant. She and her partner have moved in together and now have a beautiful baby boy.

SECTION FOUR
TE AO MĀRAMA

CHAPTER EIGHT

ANALYSIS & DISCUSSION

Introduction

Ahikaa, Hinemoana, and Tohu offer expertise, which could be utilised through public participation. Public participation provides a rationalised means of legitimating policymaking and enhancing democracy. Ensuring satisfactory Māori public participation in health requires tailored approaches. Utilising appropriate models of public participation evaluation can identify effective timing and mechanisms for Māori public participation. The following chapter explores options and offers one such model: the Tāniko evaluation instrument.

Public Participation Evaluation

As outlined in Chapter One, public participation in policymaking is the intentional development and application of mechanisms aimed at involving the public in decision-making (Beierle & Cayford, 2002). Evaluation, in comparison, is “the process by which we examine, assess and make judgements about the relative or absolute value of an action, a process, a practice, or an investment” (Saville-Smith, 2003, p.16). Evaluation provides the policy process with impact assessments, evidence for decision-making, and a means for identifying opportunities and threats (Saville-Smith, 2003).

Public participation evaluation assesses how effectively a public participation programme attains its defined process goals, outcome goals, or a combination of both (Rosener, 1978). Public participation evaluation presumes citizenship provides political rights and responsibilities, in particular democratic participation. Furthermore, it is accepted that participatory programmes can be systematically assessed. There are a number of public participation evaluation models available.

Rosener (1978, p. 459) provides a two variable “matrix” model focussed on the “cause/effect relationship between” participation and agreed outcome goals. The first variable states whether agreement on goals has been reached between participants and programme organisers. The second variable states whether a complete or incomplete knowledge of causality is present. Designed for programmes that require measurement of an outcome, the matrix actually defines

successful participation procedurally. As the matrix is unable to measure programmes that have no agreed goals, it defines a successful programme as one with agreed goals. This is not a good example of a public participation evaluation model.

Beierle and Cayford (2002) offer a second model for evaluating what is successful public participation from an outcome goal perspective. Five social goals are identified: consolidation of “public values” into resolutions, improvement in decision quality, conflict resolution, trust-building, and public education (Beierle & Cayford, 2002, p.6). Successful participation is defined by “the extent to which public participation efforts achieve these social goals” (Beierle & Cayford, 2002, p. 7). Through its exploration of public participation in environmental decision-making, the model defines participation through context (issue type), process (mechanism type), and results. The model intentionally avoids the implementation stage, believing these decisions rely on too many additional factors (for example, funding) and timelines run beyond the participation period. This avoidance limits the model’s usefulness, especially in cases where policy relies on participation for its implementation.

Montgomery’s (1983, p. 96) research on Third World irrigation projects and social services discussion show that “the presence of local participation is not uniformly useful”. Thus, Montgomery offers a “sensitivity hypothesis” for evaluating outcome goals, particularly when the conduct of participation would be most effective (Montgomery, 1983, p. 94). The four characteristics of the hypothesis are “(1) variable effect, (2) frequency, (3) lead time, and (4) impact” (Montgomery, 1983, p. 94). The model assumes “participation will make a larger contribution to decisions involving all four characteristics than decisions which present only one of them” (Montgomery, 1983, p. 94). As his research was development and production based, Montgomery applies his hypothesis to “redistributive” social services, such as public health, in a less specific manner (Montgomery, 1983, p. 97). Public health issues, in comparison to those of other social services, “show an even greater range of sensitivity to local participation”, with some programmes needing “practically no local knowledge” and others “knowledge only available to families for their effectiveness” (Montgomery, 1983, p. 99). The model’s breadth and simplicity allow it to identify opportunities, like family-based participation, but limits its ability to identify values without additional research.

Walters et al.’s (2000, p. 351) procedural centre offers a public participation evaluation model, which focuses on binding “the purpose for participation and the nature of the issue being considered”. The Purpose-Issue Matrix, a tabulated illustration of this binding process, identifies when participation would be useful and offers “mechanisms that may be used to most effectively involve the public” (Walters et al., 2000, p. 357). The five participation purposes

are distinguished as communication “motives”: (1) discovery, (2) education, (3) measurement, (4) persuasion, and (5) legitimisation (Walters et al., 2000, p. 352). Purposes are linked to policy development stages, with earlier purposes (such as discovery) linking to earlier policy development stages (such as problem definition) (Walters et al., 2000, p. 353). Participation increases in complexity, as policy development stages are progressed (Walters et al., 2000, p. 357). In the Matrix, where a purpose intersects with the nature of a well, moderately or ill-structured issue, a recommendation is made (Walters et al., 2000, p. 357). An empty cell indicates that public participation is not recommended. A filled cell indicates public participation and a specific mechanism (or mechanisms) is recommended. Though the authors understand the main limitations of the model (“some policy problems undoubtedly will not fit neatly into these classifications”) (Walters et al., 2000, p. 357), the model’s reliance on analyst-derived purpose limits its ability to respond to diverse public needs. A New Zealand-sourced model may provide the answer.

Evaluation in New Zealand has been strongly influenced by liberal then social democratic climates intent on efficiency and transparency, with evidence-based practices like evaluation providing a necessary means (Lunt, 2003; Saville-Smith, 2003). Thus, evaluation appears as a section of New Zealand’s democratic policy cycle (State Services Commission, 1999). Though there are a number of policy evaluation approaches (for example, kaupapa Māori or positivist), purposes (for example, procedural or outcome), methods (for example, textual analysis or hui), and designs (for example, case study or experimental) (Duigan, 2003), documentary research revealed no New Zealand models for public participation evaluation in policymaking. Indeed, though Māori evaluation guidelines are available (Moewaka-Barnes, 2003; Te Puni Kōkiri, 1999; see also Cunningham, 2003), no evaluation guidelines for Māori public participation in policymaking were found. The following Tāniko instrument is one response to this need.

The Tāniko Evaluation Instrument

Participation by citizens, or in this case by whānau members, assists in making policies more consistent and smoothing implementation (Wilson & Enright, 1994). By amalgamating aspects of citizen participation evaluation with the Tāniko methodology, the Tāniko evaluation

instrument⁸⁷ has been created. This instrument can assist PHOs in determining the most effective method for working with young Māori women to promote sexual health to whānau.

The Tāniko evaluation instrument evaluates public participation by Māori women in policymaking. A “participant-orientated model”, the instrument is an amalgamation of existing public participation evaluation models and the Tāniko methodology (Davidson, 2003, p. 92). It utilises three positive aspects of public participation evaluation: the attainment of social goals (see Beierle & Cayford, 2002), deciding when participation is most effective (see Montgomery, 1983) and participation mechanism identification (see Walters et al., 2000). Like other participation evaluation models, the instrument does not compel users to adopt a particular purpose, method, or design. However, as the broad social goals of the Tāniko methodology (*Mana Wāhine*, *Te Ao Tawhito*, *Te Ao Hou* and *Te Ao Mārama*) provide the participation evaluation approach and a four-part framework for the instrument, particular methods (for example, in-depth interviews) and designs (for example, case study) may prove easier to apply than others. The instrument has two steps, which are used to identify (1) the situations where participation would be most effective and (2) the most effective participation mechanism⁸⁸. Each part of the two-step process is scored using experiential and/or evidential knowledge. Like Montgomery’s (1983) model, effectiveness will be higher where all four parts are utilised. Thus, a low aggregate score, or a failure to score in one or more parts, in step one suggests participation will be less than effective and that it is unnecessary to proceed with the second step.

At the first step, the Tāniko evaluation instrument determines the policy decisions where participation would cause the most effect. In addition, the instrument identifies the core mechanism requirements of any progressed policy decisions. *Mana Wāhine* recognises young Māori women’s innate value, in particular, their position as experts in their fields. As an effectiveness measure, this part gauges the extent to which the expertise of participants will be (or is) utilised. *Te Ao Tawhito* locates success with participants and their traditional structures, characteristically whānau. This part measures the likely impact (or existing impact) of any resulting policies on whānau. *Te Ao Hou* elucidates individual differences, such as identity, socioeconomic background, and previous policymaking experience. This part measures the effect that involvement in the participation process is likely to have (or has had) on participants. *Te Ao Mārama* employs external relationships to facilitate empowerment. It recognises and

⁸⁷ The selection of this term “instrument” is deliberate. It is not a “hypothesis” (Montgomery, 1983) as it is not intended for experimentation. It is not a “matrix” (Rosener, 1978; Walters, Aydelotte, & Miller, 2000), as multiple variables are not applied.

⁸⁸ The selection of this term “mechanism” is deliberate. Unlike Kathlene and Martin’s (1991, p.47) “techniques”, I use this term to indicate something that is used not mastered.

overcomes institutional barriers, especially those created by policymakers (see Kathlene & Martin, 1991). This part measures institutional and policy change as a result of the participation process. In practice, each of the four areas is scored to determine whether participation would be effective in the given situation. Their high score evidences the social goals, which have caused the most effect. Should a policy decision be progressed to the second step, its social goals form the core mechanism requirements.

At the second step, the Tāniko evaluation instrument identifies the most effective participation mechanism. The identified mechanism (or mechanisms) must fulfil the core mechanism requirements and allow the policy issue to be progressed through each of the five stages of development: problem definition, criteria identification, generation of alternatives, evaluation, and recommendation (Walters et al., 2000, p. 352). *Mana Wāhine* defines an effective measure as one, which allows full use of participant expertise. *Te Ao Tawhito* measures the extent to which whānau can be involved. As outlined by Kathlene and Martin (1991, p. 47), participation can be limited by institutional (for example “embedded class bias... [and] sociocultural barriers”) and design barriers (for example, “domination of citizen participation forums by unrepresentative interest groups”). Thus, *Te Ao Hou* seeks opportunity for individual as well as group participation and measures the extent to which the mechanism requires participants to reflect an ideal type. *Te Ao Mārama* tests the mechanism’s ability to facilitate education. In particular, the mechanism must ensure participants understand who benefits from different decision options, how they benefit and why. As stated by Walters et al. (p. 355), “an explanation of any limitations in the available information should be provided... as well as the impact such limitations may have on the subsequent analysis”.

As a progressive tool, the Tāniko instrument is recommended for application prior to initiation of any participation process. However, it can be applied retrospectively to evaluate procedural success. The instrument is not institutionally centred; its participant-centredness will not suit all tastes. However, the Tāniko instrument is not proposed as a definitive device, but offers a discussion point from which other evaluative equipment can be created. Figure 2 illustrates the two-step Tāniko instrument.

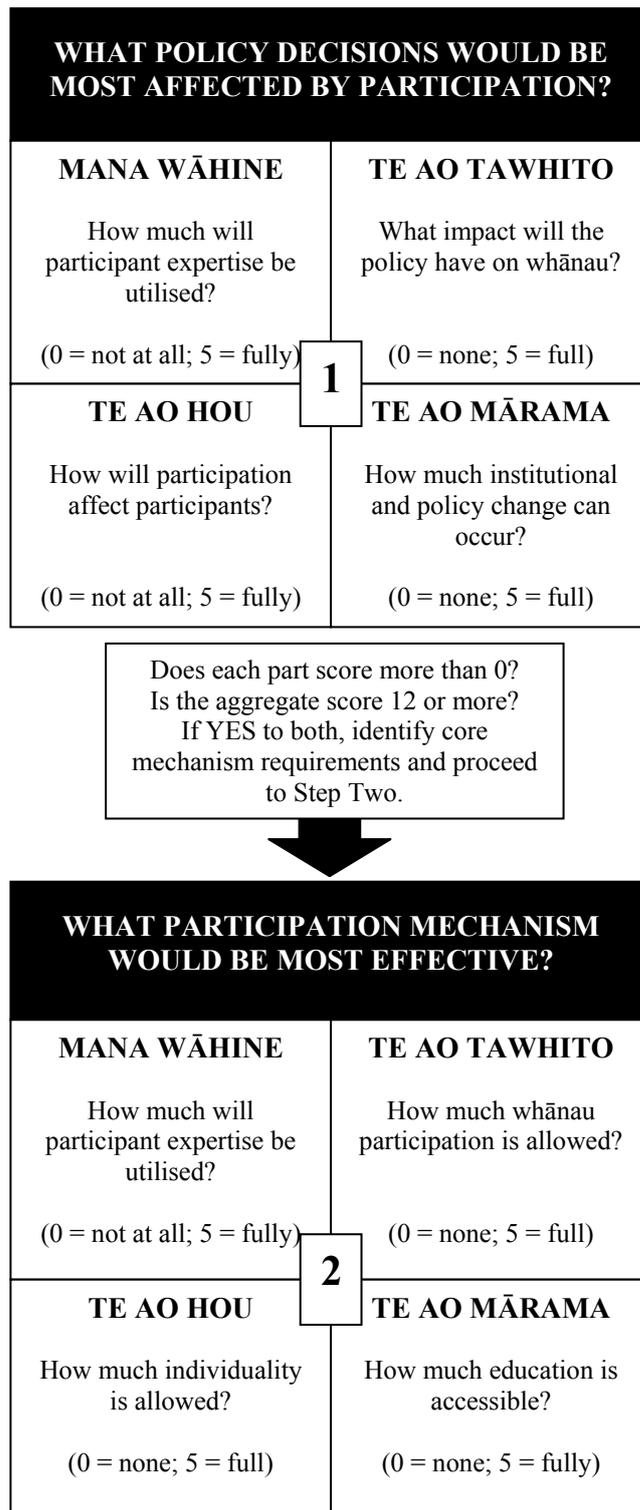


Figure 2: The Tāniko Evaluation Instrument

Applying The Tāniko Instrument

According to Walters et al. (2000, p. 354), “both the desirability of public participation and the appropriateness of participation mechanisms vary with the issue being addressed”. In this section, the Tāniko evaluation instrument is used to identify how PHOs can work with young Māori women to promote sexual health to whānau. The analysed data from Thesis Participants⁸⁹ presented in the previous chapter supports this process by providing evidential knowledge and two mechanism options: organised peer groups and the wāhine-centred approach. By applying the Tāniko instrument to four health promotion decisions, it is possible to identify both the circumstances where participation will result in effective outcomes and the best participation mechanism.

When promoting sexual health to whānau, there are four major policy decisions. The first decision determines what information will be provided to the whānau. The second decision resolves how the information will be provided. The third decision decides who will provide this information and the fourth decision concludes who will receive the information.

The First Step:

What policy decisions would be most affected by participation?

The first policy decision determines the information provided to whānau. Participation would require assessment of current resources and identification of development opportunities. *Mana Wāhine* concludes that participant expertise will be utilised somewhat (score of two), particularly when determining the variable information needs of the whānau. *Te Ao Tawhito* sees some impact (score of three) on whānau in this area. The information needs of a whānau with a large youth section (for example, Tohu’s whānau) will differ strongly to those of an aging one. *Te Ao Hou* shows lesser effect (score of two) of participation on participants; participants may feel uncomfortable or bored with an assessment of sexual health information. Given the existence of sexual health literature both from a Māori (for example, Ministry of Health, 1996c, 1997c; Te Puni Kōkiri, 1994, 1995) and biomedical (for example, Brander, 1991; Department of Health, 1990; Ministry of Health, 1996b, 1997d, 2001b) perspective, *Te Ao Mārama* indicates little likelihood (score of one) of institutional change around the decision of what information is provided to whānau. With an aggregate score of eight, this policy

⁸⁹ This term is capitalised to differentiate Ahikaa, Hinemoana, and Tohu (the “Thesis Participants”) from participants in public participation programmes.

decision would be only moderately affected by participation. Therefore, participation is not recommended when determining information resources.

The second policy decision determines how information is provided to whānau. This decision looks at whānau preferences for information presentation. For example, is the language of instruction an issue? Would they prefer the anonymity of posters at an event, the personal touch of an in-home presentation or self-directed learning through websites, pamphlets and CD-ROMs? *Mana Wāhine* concludes that participant expertise will be utilised to medium effect (score of three), particularly when assessing whānau availability (for example, timetables, personal preferences) and existing resources (for example, literacy and information technology). *Te Ao Tawhito* sees greater impact (score of four) on whānau, due to the way this decision affects accessibility. *Te Ao Hou* shows some effect (score of three); participants are likely to be affected by participation, as the desire for their expertise rises. Existing programmes aimed at promoting sexual health to Māori are evident in the public health sector and are easily applied to PHOs. *Te Ao Mārama* indicates institutional flexibility (score of three) around the decision of how information is provided to whānau. With an aggregate score of 13, this policy decision would be strongly affected by participation. Therefore, participation is recommended when determining the information presentation.

The third policy decision determines who will present this information. Like the second decision, this section looks at whānau preferences for information presentation, particularly the appropriateness of different personnel. When the reliability of information is questioned, the validity of presenter can balance (Walters et al., 2000). *Mana Wāhine* concludes that participant expertise will be utilised somewhat (score of two), particularly when assessing likely whānau responsiveness to personnel options. As accessibility will be affected by this decision, *Te Ao Tawhito* sees greater impact on whānau (score of four). *Te Ao Hou* shows average effect (score of three); participants will be affected somewhat by participation. Like the issue of how information is presented, *Te Ao Mārama* indicates institutional flexibility (score of three) around the decision of who provides information to whānau. As this is the area with greatest financial cost, PHOs may welcome less expensive suggestions. With an aggregate score of 12, this policy decision would be strongly affected by participation. Therefore, participation is recommended when determining who will present information.

The fourth policy decision determines who will receive the health promotion information. Answers in this area will be variable. Like the first decision, whānau structure will influence the final conclusion. *Mana Wāhine* concludes that participant expertise will be utilised to average effect (score of three), particularly when identifying whānau members who need

assistance. *Te Ao Tawhito* sees greater impact (score of four) as whānau are targeted. *Te Ao Hou* sees strong impact (score of four), as participants dissect, assess, and identify their whānau sexual health information needs. This procedure may cause great discomfort. As health has been “declared a fundamental human right” and effective sexual health promotion requires wide distribution, organisations need as many sexually active people as possible to receive their information (MacDonald, 2002, p.30). Therefore, *Te Ao Mārama* indicates limited flexibility (score of one) over which whānau members receive material. With an aggregate score of 12, this policy decision would be strongly affected by participation. Therefore, participation is recommended when determining who receives information.

As a result of the First Step, it has been decided that participation would not be effective in determining what sexual health information is provided to whānau. Current resources restrict institutional flexibility in *Te Ao Mārama*. Participation would be most effective in determining how, by whom, and to whom information is presented. *Te Ao Tawhito* (in particular, whānau accessibility) and *Te Ao Hou* (in particular, participant comfort levels) provide the greatest influence and are, therefore, the core mechanism requirements.

The Second Step:

What participation mechanism would be most effective?

The Tāniko evaluation instrument can assist in identifying the most effective participation mechanism. The core mechanism requirements of each progressed policy decision (how, by whom and to whom sexual health is promoted) have been demarcated by the first step. In this instance, Step One requires the mechanism to increase whānau accessibility and be aware of participant comfort levels. The analysed interview data offers two mechanisms for consideration.

The organised peer group is the first type of mechanism. In these groups, young, Māori, women participants receive and provide information to one another and to group organisers. Generally, organised peer groups can include advisory committees, panels, forums, focus and working groups, and can operate at different stages of public policy development. The Thesis Participants showed a high level of past experience in organised peer groups, though not of the public participation or sexual health subtypes. All three had been (or were currently involved in) sport and cultural groups, showing understanding of their value either as an activity (Ahikaa), enjoyment source (Hinemoana), or origin of self-development and passion (Tohu).

The wāhine-centred approach is the second type of mechanism. An inductively developed amalgamation of the three Thesis Participants perspectives, this female-only mechanism occurs within the whānau environment. In this context, participants would work with female whānau members to develop, implement and evaluate the different policy decisions. Though the personal rewards for participants are intangible, known outcomes were identified as an aspect of the approach. Thesis Participants understood the need to balance health promotion requirements with the personal responsibilities of being a whānau member. When asked to identify the important things in their lives, all three Thesis Participants named their family first. Though Ahikaa's definition was associated to emotion, Hinemoana's specific to her household, and Tohu's an "*elastic band* [sic]" (Metge, 1995, p. 55), each Thesis Participant understood the centrality of whānau in her life.

The *Mana Wāhine* site assesses the participant expertise level utilised through a given mechanism. As a mechanism for effective participation in whānau sexual health policymaking, organised peer groups enhance the utilisation of participant expertise in the areas of youth, sexual health, and the whānau as a concept. Participant expertise is utilised through appropriate process. The Thesis Participants have indicated that groups with a well-defined purpose (Ahikaa), strong leadership and discipline (Ahikaa and Tohu), meaningful outcomes (Ahikaa and Hinemoana), and member affirmation (Ahikaa and Hinemoana) were more likely to motivate and, therefore, effectively utilise their membership. Nevertheless, barriers to the groups' effectiveness in the *Mana Wāhine* section are discernable. Each Thesis Participant has been involved in a group, which has failed to utilise their membership to its full potential. For example, Ahikaa "stopped turning up because you'd give all your ideas and opinions about what could do to improve your kapahaka skills... and it never happened". Organised peer groups can utilise participant expertise, but need the many variables controlled to ensure effectiveness.

In the area of *Mana Wāhine*, the wāhine-centred approach offers an alternative to organised peer groups, if not an answer. As a mechanism for making participation work in sexual health policymaking, this approach utilises participant expertise about their whānau to assess need. Participant expertise is used in the areas of whānau roles, practices, and preferences through interactions with administrators, though the approach's strength is intra-whānau. According to Ahikaa, "when you're close to someone, you could probably talk to anyone about anything". Thus, the wāhine-centred approach provides a strong mechanism for whānau with strong emotional ties.

From *Mana Wāhine*'s perspective, the two mechanisms could complement one another by operating at different stages of the policymaking process. Organised peer groups could be used during the coordination and evaluation policy stages. Furthermore, problem definition, consultation, decision, and implementation could be shared or managed via the wāhine-centred approach. Therefore, application of these complementary mechanisms would allow participant expertise to be utilised to its fullest extent.

Te Ao Tawhito (in particular, whānau accessibility) is a core mechanism requirement, which defines how much whānau participation is allowed by the participation mechanism. In this instance, accessibility is a two-way process; the mechanism must facilitate access both by policymakers and administrators to whānau and by whānau to the policymaking process. Organised peer groups, for example, can allow whānau support from the "sidelines" (Hinemoana) and during social events, like "a sausage sizzle and just a few drinks" (Tohu). However, during the group activity, direct whānau participation is limited. Indeed, Ahikaa showed a preference for organised peer groups, which were limited to "cousins... and your friends", thereby shifting the preference from a group to a wāhine-centred approach. Organised peer groups allow whānau participation, but it is not guaranteed. In comparison, the wāhine-centred approach requires whānau participation (and, thus, enhances whānau accessibility). Therefore, from *Te Ao Tawhito*'s perspective, the wāhine-centred approach is recommended.

Te Ao Hou (in particular, participant comfort levels) is the second core mechanism requirement. This part measures the degree to which the participation mechanism allows individual (versus group) participation and expects participant conformity. Comfort, therefore, is defined as much by the mechanism's ability to allow a participant to "be themselves" as any other measure. By their very nature, organised peer groups limit individualism, though leaders may affect it to some extent. Strong leadership can allow a leader self-expression and also help ensure voices are heard. Furthermore, organised peer groups are more likely to work when participants express a willingness to be involved (Ahikaa), are "team member[s]" (Hinemoana), and show "commitment", "effort", and respect (Tohu). Thus, individuals who do not embody these traits may be considered a barrier to group achievement (Hinemoana and Tohu) and, therefore, unlikely to be attracted to or maintained in organised peer groups. It can be concluded that participants must fit somewhat of an ideal type for the mechanism to work.

The wāhine-centred approach shows comparable levels of allowable individualism, but lower expectations of participant conformity. For instance, Hinemoana sees an opportunity to allow her daughter to be her open and honest self:

I just want her to know that I'm here and that I'll help her out. And that, you know, I'm not going to judge her. And I'm not going to give her a crack, because she's done something... I'll support her and... 'Cause I know what I was like... I've gotta sorta understand, if [Ngaru] does something sort of similar...

From *Te Ao Hou*'s perspective, the wāhine-centred approach is recommended over organised peer groups as it allows similar individual participation, expects less participant conformity and, as a result, enhances participant comfort levels.

Te Ao Mārama gauges a mechanism's ability to facilitate education, including knowledge of the decision-making process. Organised peer groups assist in knowledge transference by providing a forum for different parties to meet. For example, the group format can be used to introduce administrators and participants, assess participant knowledge opportunities, and develop skills. Education is formally facilitated through the provision of appropriate resources, in particular staff. However, staff need to be "interesting... [keep] you listening sorta thing... you need someone that um knows what they're talking about, and can do that as well" (Hinemoana). The mechanism may find assuring individual empowerment difficult, as it deals with young Māori women as a group. Furthermore, organised groups withdraw whānau from the educative equation, thereby undermining the young women's primary identity source.

In comparison, a strong knowledge base on whānau issues is maintained through the wāhine-centred approach. However, the mechanism may not allow an expansion of 'the known' in participants' lives. Though the approach emphasises the collective, it may unwittingly do so at the individual's expense. Furthermore, though the Thesis Participants indicated a willingness to be part of an education process within their whānau unit, gender, personality, age, and whānau roles provide limitations.

Like *Mana Wāhine*, it may be to *Te Ao Mārama*'s favour to recommend complementary employment. Organised peer groups could be offered at the initial stages, as administrative and conscientisation vehicles. They already have one fan in Tohu: "cause if something like this did come up, I really would be interested in it". The wāhine-centred approach should be incorporated as part of the policy development process. Take-home resources and the option of administrative liaison would allow the whānau flexibility to choose their level of involvement.

As can be seen, both organised peer groups and the wāhine-centred approach provide strength to the participation process. In the former's case, participant expertise can be used at unique

policy development stages. However, organised groups fail to centre the participant in the whānau, thereby making whānau-centred decision-making difficult at best. In the wāhine-centred approach's case, participant expertise is employed well (though in different areas to organised groups) and whānau accessibility enhanced. However, gender, personality, age, and whānau roles provide limitations. Together, the two mechanisms balance one another's weaknesses. In addition, both mechanisms allow a more comprehensive approach for PHOs working with young Māori women to promote sexual health to whānau.

Conclusion

According to Ringold (2005, p. 35), "it is essential for a policy's beneficiaries to be involved in its design, implementation and monitoring". The Tāniko instrument is a two-step process for evaluating public participation by Māori women in policymaking. The first step determines the policy decisions where participation would cause the most effect. The instrument found that participation would not be useful in determining what sexual health information is provided to whānau. However, when deciding how, by whom, and to whom information is presented, public participation by young Māori women can provide appropriate levels of expertise. Furthermore, whānau accessibility and participant comfort levels were identified as core mechanism requirements.

The second step identified the most effective participation mechanism. The analysed interview data supported complementary employment of organised peer groups and the wāhine-centred approach, particularly when attempting to utilise participant expertise to its fullest extent and when making education accessible. Organised peer groups are particularly strong in the latter area, allowing formal education to be facilitated with ease. In comparison, the wāhine-centred approach provides stable whānau accessibility, expects less participant conformity, and, as a result, enhances participant comfort levels.

CHAPTER NINE

CONCLUSION

On 27 January 2004, a relatively unknown economist became one of the most influential politicians in Māori political history. Don Brash's (in)famous Orewa speech instigated a mass-media frenzy (Slack, 2004) and the 2004-2005 review of ethnic-focussed programmes and targeting (Boston, Callister, & Wolf, 2006). The review, which covered the intention, delivery and impact of targeted policies, allowed "consideration... [of] how the range of provisions for participation by Maori in statutory processes are working in practice" (Mallard, 2004, Review Scope). The resulting policy guides the design of "appropriate" needs-based policies and programmes, but allows "tailoring of the delivery of a programme for particular groups [when it] is likely to help reach those in need or increase the effectiveness of the programme" (State Services Commission, 2005, p. 1). Ethnicity is considered a "useful targeting variable" when shown to cause need or need is correlated (State Services Commission, 2005, p. 5). In addition, where it provides "an effective proxy", or "where it would be less efficient and effective to target" using other bases, ethnicity is considered acceptable (State Services Commission, 2005, p. 5). As such, cervical-screening service delivery targeted at and provided by Māori and Pasifika peoples is considered "appropriately-tailored health promotion activities and support services" (State Services Commission, 2005, p. 5). This shift in the New Zealand state's dialogue with the "indigenous citizen" provides both challenges and opportunities for development (V. M. Tawhai, personal communication, 2006).

In New Zealand, health care is state-defined through various policies and funding mechanisms. The necessity for a system, which embodies high quality and public confidence echoes even after fifteen years of the New Right. Health professionals are now subjected to accountability measures (Ashton, 2001), inefficient, ineffective service delivery is no longer accepted, and health services are expected to ensure user satisfaction (Ministry of Health, 2000). The newly-developed Māori Potential Framework, which emphasises "wellbeing", "knowledge", "influence", and "resources" (Te Puni Kōkiri, 2005 in Ringold, 2005, p. 38), has recently been invested with \$23.9 million (Cullen, 2006; *Parliamentary Debates*, May 24, 2006). Therefore, it can be expected that it will provide significant strategic direction in development of Māori health public policy.

The current overriding strategic policy is the NZHS, from which the health sector reform has been developed. The New Zealand Public Health and Disability Act 2000 is one substantive

aspect of the NZHS. Different structures, such as the Ministry of Health, Pharmac, and DHBs, were created and/or defined under the Act. The Ministry provides policy advice and administers central government funds, whilst Pharmac focuses on the regulation of medications and medical practices. DHBs, in comparison, are state-devolved entities whose aim is to administer health policy in specified geographical areas. DHBs are the operational mechanism for state health care provision in New Zealand. Though DHBs “provide the opportunity for public participation in decision-making” (Ministry of Health, 2002b, p. v), PHOs provide, and are required to provide, an opportunity for localised participation in primary health care.

The Declaration of Alma-Ata’s fourth clause of the Declaration states that “people have the right and duty to participate individually and collectively in the planning and implementation of their health care” (WHO, 1978). PHOs can provide one mechanism for allowing people to express this right and duty. Development opportunities are available during the consultation phases for *Whakatātaka tuarua: Māori health action plan 2006-2011: Discussion document* (2006). For example, the “joint work programme” to enhance mainstream service effectiveness for Māori is still under development (Ministry of Health, 2006b, p. 16). In addition, a “review of Māori access to sexual health service” will begin in 2007-2008 (Ministry of Health, 2006b, p. 16). For effective change to occur, participation in strategic developments must be made a priority by Māori in general and by whānau in particular.

As stated in He Korowai Oranga, Phase One, and the Primary Strategy, PHOs seeking to promote sexual health to Māori must take a whānau-centred approach. Evidence suggests that current methods of sexual health promotion are not working to improve whānau ora (Ministry of Health, 2003d). Literature suggests that collaboration is the most effective means for advancing health (Orme, Powell, Taylor, Harrison, & Grey, 2003). Hashagen (2003, p. 279), for example, acknowledges that “effective strategies for change often require a partnership approach” and draw “on the knowledge, skills, and resources of the community and service agencies”. Though whānau are the focus of He Korowai Oranga, the health and disability sector are not supplied with enough direction to ensure complete whānau participation. The Ministry implies support of “Māori participation at all levels of the health and disability sector” (Ministry of Health, 2006b, p. iii), but continues to provide direction only on provider capacity, workforce and governance-level participation (Ministry of Health, 2001a, 2006b). Furthermore, sexual and reproductive health promotion strategies for Māori continue to emphasise rangatahi over other whānau members (Ministry of Health, 2003d). The sector requires assistance to ensure the realisation of whānau ora.

Unfortunately, even this has stalled. As outlined by the Ministry of Health (2006b, p. 24), “the concept of whānau ora has yet to be realised because the sector has not yet given practical effect to it”. Though the Ministry considers “examples of ‘whānau ora practice’... important”, it is yet to secure any specifically aimed at whānau (Ministry of Health, 2006b, p. 24). Instead, awards made for “promot[ing] successful initiatives and celebrat[ing] models of service delivery that increase whānau health and wellbeing” focussed on “implementation and outcomes in the delivery of services to whānau, hapū, iwi, and Māori communities” in general (Ministry of Health, 2006b, p. 28). Indeed, the Ministry still promotes whānau ora as being on a “continuum of service delivery approaches that has population health (public health) at one end and individual or personal health at the other” (Ministry of Health, 2006b, p. 28). For He Korowai Oranga to have any effect, alternative processes of policymaking, participation, citizenship, democracy, and the state must be produced.

However, in the end it matters not what is produced, but by whom the decisions are made to produce it. Currently, certain sectors of society – those with enough social, cultural, and financial capital – have maintained a monopoly over the state, utilising it as a tool to produce products (for example, the military and infrastructure) they alone identify. At times, these products are complementary to the desires of the citizenry. At other times, they are at complete odds. Though democracy and its principle of subsidiarity are available, those who hold monopoly have not seen benefit in deliberative participation. Pluralism is expensive and state funds are better spent elsewhere. It is far easier to mislabel as apathy the citizens’ internalisation of the “panoptic”, autonomous state (Foucault, 2004, p. 99).

This self-disciplined subjection of the Citizen has taken many centuries of layered hegemony. “Zig-zag openings” of domination – colonialism, paternalism, the free market – have hidden “a gleam of light... [protecting] the presence of the guardian” (Foucault, 2004, p. 98). The State, “alien and separate by that distance upon which surveillance depends for its strategies of objectification, normalization and discipline” (Bhabha, 2004, p. 69), no longer watches from the tower (Foucault, 2004). But within the darkness is “a withdrawal in order to know nothing of the external world” (Bhabha, 2004, p.68)⁹⁰. Only the Other – the indigenous, the black man (Fanon, 1968), the Oriental (Said, 1978) – stands outside; they were never invited in⁹¹.

⁹⁰ Bhabha’s (2004, p. 68) discussion of dark skin and the “pleasure-value” of darkness as an object of fantasy is used here to illustrate complex escapism as a rejection of the knowledge of subjugation. Like the racist is subjugated by their racism, the citizen is subjugated by a state, which removes itself from “surveillance” and participation (Bhabha, 2004, p. 69). The darkness of not-knowing offers an escape from this reality.

⁹¹ Here, I acknowledge the multiple subjectivities present in the Other Citizen, as she is disciplined first as Other, then as Citizen. As Other, she is excluded, marginalised, and denied (Smith, 1999). As Citizen, she internalises the “Panopticon” (Foucault, 2004, p. 98). Thus, the many, interconnected ways oppression operates are emphasised (Bacchi, 2001).

Amongst New Zealand's indigenous citizenry, participation should offer an opportunity for dialogue with the state. However, democracy must be realised first. This requires that knowledge be recognised as a right of citizenship. Though open government systems exist, these do not rectify 150 years of an idiocentric state. Formal civics education can provide one means of conscientising the population (V. M. Tawhai, personal communication, 2006). Use of the subjective as power provides another. For public participation to move beyond a talkfest between a select few, the state must legislate proactive (versus passive) access. However, given the choice between a needs-based agenda, which includes in order to homogenise, and a past system, which differentiates in order to exclude, Māori may choose to stay standing outside (see Maaka & Fleras, 2005). For public participation to work for Māori, the state must acknowledge difference in order to be inclusive.

This thesis has attempted to present a method for including difference in developing whānau ora. Public participation provides one means for developing this. An alternative approach, which involves young Māori women, is offered to PHOs developing policies and programmes for whānau.

The Tāniko methodology provides a Mana Wāhine-based approach to research. Together, the four sections (*Mana Wāhine*, *Te Ao Tawhito*, *Te Ao Hou*, and *Te Ao Mārama*) acknowledge Māori women's expertise, provide a source of commonality, name current situations, and envision new horizons. The research centred on young Māori women as indigenous citizens and as experts. As the former, their right to participate was emphasised as a normative rationale. This was substantively supported by their position as experts and state policy.

The state has a mixed history in Māori health development – from colonisation to paternalism to the deregulated marketplace, the state has been anything but consistent. New policy directions, like the NZHS, offer a “special relationship between Māori and the Crown” (Ministry of Health, 2000, p. 37), however issues of community control must be addressed. The New Zealand Public Health and Disability Act 2000 offers the first legislative recognition of the Treaty of Waitangi in social policy, but the focus needs to move from the delivery to the policy development level if real gains are to be made.

He Korowai Oranga, Phase One, and the Primary Strategy provide guidance for primary-level Māori sexual health, and require a whānau-centred, educative, and participatory approach. With definitions based on descent, cause, or mixed criteria, and others, which accept it as a collection of ideas, the whānau concept provides essential direction for these three substantive policies. Though whānau-centredness can be problematic, it offers the first creative direction

in Māori health for many years. However, sexual health policy for whānau in the primary sector poses challenges.

PHOs offer one mechanism for operationalising this process, though not without their own barriers. As non-profit collectives advancing the health of their enrolled populations, PHOs are required to maintain short route participatory arrangements (Ringold, 2005). These arrangements must “integrate Māori participation... in all levels of governance, service planning, development and implementation” (Ministry of Health, 2005c, p. 33). However, there are barriers. In general, capitation funding can lead to cream-skimming, under-service, and cost-shifting. More specifically, softening of minimum requirements and the Māori Stakeholder concept can reduce the effectiveness of Māori participation. Development, therefore, is required.

Given current health statistics and policy, PHO operational policy should include sexual health promotion strategies tailored for whānau (Ministry of Health, 2001b, 2001d, 2002c, 2006a). Participation offers opportunities for both PHOs and whānau. From the problem definition stage, PHOs are able to utilise their participation requirements to fill information gaps. In return, whānau health promotion offers opportunities for conscientisation and participation in the health of Māori communities. As outlined by the family health promotion model, sexual health promotion can operate within the family environment, but whānau-specific strategies are required. With participation, sexual health promotion for whānau can be developed.

Public participation by young Māori women particularly in PHO policymaking provides opportunities for both groups. For young Māori women, participation allows personal growth and the opportunity to give. For PHOs, participation provides expertise unavailable through other means. To help develop working relationships between PHOs and young Māori women, a public participation evaluation tool was created.

In addition to providing a theoretical structure, the Tāniko methodology is the basis of this evaluation tool. As a broad “*renaissance* [sic]” device, the Tāniko evaluation instrument provides a framework for evaluating public policy participation by Māori women in policies and programmes, such as sexual health promotion to whānau (Trotman, 2003, p. 22). The instrument found that PHOs would benefit from applying two mechanisms at different stages during the policymaking process. Organised peer groups consist of young Māori women and administrators with examples including advisory committees, panels, forums, and focus and working groups. The wāhine-centred approach is a whānau-based, female-only mechanism inductively developed from the analysed interview data. When defining how, by whom, and to

whom information is presented, organised peer groups can be utilised at the coordination and evaluation stages. The wāhine-centred approach can share or manage participation through problem definition, consultation, decision, and implementation. Together, the two mechanisms offer one possibility to how PHOs can work with young Māori women to promote sexual health to whānau.

APPENDIX:
Permission for Reproduction of Figure 1

From: anna_pethig@moh.govt.nz [mailto:anna_pethig@moh.govt.nz]
Sent: Monday, 26 June 2006 10:34 a.m.
To: Gray, Katarina
Subject: Fw: query about copyright

Kia ora Katarina

Thank you for your request to reproduce an image from He Korowai Oranga - Māori Health Strategy (2002) in your thesis.

You have permission to do this, as long as you source the image to the Minister of Health and Associate Minister of Health (2002), He Korowai Oranga - Māori Health Strategy.

I wish you well with your work.

Anna Pethig
Team Leader, Publications
Communications
Government & Sector Relations
Corporate & Information Directorate
Ministry of Health
DDI: 496 2051
Mobile: 027 221 4902
Fax: 496 2010

<http://www.moh.govt.nz>
mailto:anna_pethig@moh.govt.nz

From: "Gray, Katarina" <K.Gray@massey.ac.nz>
Sent: 23/06/2006 13:04
To: <WebManager@moh.govt.nz>
cc: "Forster, Margaret" <M.E.Forster@massey.ac.nz>

Subject: query about copyright

Tena koe.

I am a postgraduate student completing my thesis on public participation, young Māori women, and whānau health. I have completed a review of He Korowai Oranga - Māori Health Strategy (2002) and would like to reproduce with permission the image on page four. Per the Copyright Statement, I formally request the written permission of the Ministry of Health to reproduce the graphic work out of this document.

As I will be submitting the thesis next week, could you please advise whether or not this permission has been granted as soon as possible? I appreciate that granting this permission requires the Ministry to undertake due process, and apologise for any undue stress caused by my request.

Thank you for your attention in regards to this matter.

Naku noa, na

Katarina A. Gray, BA, GradDipMaoriDev, PGDipArts (Dist)

Work: [omitted]

Cellular: [omitted]

Statement of confidentiality: This e-mail message and any accompanying attachments may contain information that is IN-CONFIDENCE and subject to legal privilege. If you are not the intended recipient, do not read, use, disseminate, distribute or copy this message or attachments. If you have received this message in error, please notify the sender immediately and delete this message.

This e-mail message has been scanned for Viruses and Content and cleared by the Ministry of Health's Content and Virus Filtering Gateway

Content and Virus Filtering Gateway

BIBLIOGRAPHY

- Aaby, P. (1985). Epidemics among Amerindians and Inuit: A preliminary interpretation. In J. Brosted, J. Dahl, A. Gray, H. C. Gulløv, G. Henriksen, J. Jørgensen, & I. Kleivan (Eds.), *Native Power: The quest for autonomy and nationhood of indigenous peoples* (pp. 329-339). New York: Columbia University Press.
- Abu-Lughod, L. (1991). Writing against culture. In R. G. Fox (Ed.), *Recapturing anthropology: Working in the present* (pp. 137-164). Sante Fe, NM: School of American Research Press.
- Adolescent Health Research Group. (2004). *Te ara whakapiki taitamariki: Māori specific findings of Youth2000, a national secondary school youth health survey*. Auckland, New Zealand: University of Auckland.
- Alliance Party. (2001). *Health*. Retrieved May 28, 2001, from <http://www.alliance.org.nz/policy/health.html>.
- Alpers, A. (1964). *Maori myths & tribal legends*. Auckland, New Zealand: Longman Paul.
- Amaral, C. E. P. (2003). Autonomy and subsidiarity in the emergence of a new paradigm: The European regional state of the autonomies. In S. Nagel (Ed.), *Policymaking and democracy: A multinational anthology* (pp. 133-166). Lanham, MD: Lexington Books.
- Armstrong, N., & Du Plessis, R. (1998). Shifting certainties, complex practices: Reflections on feminist research. In R. Du Plessis & L. Alice (Eds.), *Feminist thought in Aotearoa New Zealand: Connections and differences* (pp. 68-75). Auckland, New Zealand: Oxford University Press.
- Ashton, T. (2001). The influence of economic theory. In P. Davis & T. Ashton (Eds.), *Health and public policy in New Zealand* (pp. 107-126). Auckland, New Zealand: Oxford University Press.
- Auckland Regional Public Health Service (2005, August). *Guide for health promotion planning and action in PHOs*. Retrieved May 17, 2006, from

http://www.arphs.govt.nz/publications/PHO/Guide_for_HP_PlanningActions_in_PHOs.pdf.

Australian Primary Health Care Research Institute. (2005, December). Definition of primary health care. Retrieved November 23, 2005, from <http://www.anu.edu.au/aphcri/index.php>.

Bacchi, C. L. (2001). Dealing with 'difference': Beyond 'multiple subjectivities'. In P. Nursey-Bray & C. L. Bacchi (Eds.), *Left directions: is there a third way?* (pp. 110-122). Melbourne: Benchmark Publications.

Bachrach, P., & Botwinick, A. (1992). *Power and empowerment: A radical theory of participatory democracy*. Philadelphia: Temple University Press.

Baehler, K. (2003). Evaluation and the policy cycle. In N. Lunt, C. Davidson, & K. McKegg (Eds.), *Evaluating policy and practice: A New Zealand reader* (pp. 27-39). Auckland, New Zealand: Pearson Education.

Ballara, A. (1998). *Iwi: The dynamics of Maori tribal organisation from c.1769 to c.1945*. Wellington, New Zealand: Victoria University Press.

Barlow, C. (1991). *Tikanga whakaaro: Key concepts in Maori culture*. Auckland, New Zealand: Oxford University Press.

Barnes, H. M. (2000). Collaboration in community action: a successful partnership between indigenous communities and researchers. *Health Promotion International*, 15(1), 17-25.

Beierle, T. C., & Cayford, J. (2002). *Democracy in practice: Public participation in environmental decisions*. Washington, DC: RFF Press.

Bennion, T., & Melvin, G. (2001). Parliament: New Zealand Public Health and Disability Act 2000. *The Māori Law Review*, Jan. Retrieved June 22, 2006, from <http://www.bennion.co.nz/mlr/2001/jan.html#6>.

Bevan-Brown, J. (1994). Intellectual disability: A Maori perspective. In K. Ballard (Ed.), *Disability, family, whānau and society* (pp. 205-230). Palmerston North, New Zealand: Dunmore Press.

- Bhabha, H. K. (2004). Homi K. Bhabha, from 'The "other" question' (1983). In A. Easthope & K. McGown (Eds.), *A critical and cultural theory reader* (2nd ed., pp. 62-69). Buckingham, England: Open University Press.
- Bishop, R. (1994). Initiating empowering research. *New Zealand Journal Of Education Studies*, 29(1), pp. 25-43.
- Blair, T., & Schroeder, G. (1999). *The third way/die neue mitte*. London: British London Party.
- Bloom, A.L. (2000). *Health reform in Australia and New Zealand*. Melbourne, Australia: Oxford.
- Boston, J., Callister, P., & Wolf, A. (2006). *The policy implications of diversity*. Wellington, New Zealand: Institute of Policy Studies.
- Boston, J., Martin, J., Pallot, J., & Walsh, P. (1996). *Public management: The New Zealand model*. Auckland, New Zealand: Oxford University Press.
- Brander, P. (1991). *Adolescent sexual practices: A study of sexual experiences and service needs among a group of New Zealand adolescents*. Wellington, New Zealand: Department of Health.
- Broughton, J., & Rimene, C. (1997). *Hauora rangatahi: "Don't tell me, show me!"*. Dunedin, New Zealand: Te Roopu Rangahau Māori o Ngai Tahu.
- Buchanan, I. (1995). The purpose-process gap in of health promotion. In D. Seedhouse (Ed.), *Reforming health care: The philosophy and practice of international health reform* (pp. 221-227). Chichester, England: John Wiley & Sons.
- Buck, P. (1949). *The coming of the Maori*. Wellington, New Zealand: Whitcombe and Tombs.
- Cabinet policy committee minutes. (2005a, March). *Review of targeted policies and programmes: Ministry of Health: He korowai oranga: Maori health strategy* (POL Min (05) 4/5). Retrieved June 9, 2006, from http://www.ssc.govt.nz/upload/downloadable_files/Cab_Paper_He_Korowai_Oranga_-_Maori_Health_Strategy.pdf.

- Cabinet policy committee minutes. (2005b, March). *Review of targeted policies and programmes: Ministry of Health review of the primary health strategy* (POL Min (05) 4/7). Retrieved June 9, 2006, from http://www.ssc.govt.nz/upload/downloadable_files/Cab_Paper_Primary_Health_Care_Strategy.pdf.
- Cabinet policy committee minutes. (2005c, March). *Review of targeted policies and programmes: Removal of policies and programmes from the Ministerial Review Unit* (POL Min (05) 4/8). Retrieved June 19, 2006, from http://www.ssc.govt.nz/upload/downloadable_files/Cab_Minute_-_Removal_policies_and_programmes_from_MRU_process.pdf.
- Caccioppoli, P., & Cullen, R. (2005). *Maori health*. Auckland, New Zealand, Kotahitanga Community Trust.
- Cairns, A. (2003). Afterword: International dimensions of the citizen issue for indigenous peoples/nations. *Citizenship Studies*, 7(4), 497-512.
- Cervical Cancer Audit. (2004). *Cervical cancer audit report: Screening of women with cervical cancer, 2001-2002*. Retrieved June 12, 2006, from [http://www.moh.govt.nz/moh.nsf/0/341A25893948A318CC256D1100763963/\\$File/cervicalcanceraudit-report.pdf](http://www.moh.govt.nz/moh.nsf/0/341A25893948A318CC256D1100763963/$File/cervicalcanceraudit-report.pdf).
- Cheyne, C., O'Brien, M., & Belgrave, M. (1997). *Social policy in Aotearoa/New Zealand: A critical introduction*. Auckland, New Zealand: Oxford University Press.
- Cheyne, C., O'Brien, M., & Belgrave, M. (2005). *Social policy in Aotearoa/New Zealand: A critical introduction* (3rd ed.). Auckland, New Zealand: Oxford University Press.
- Children, Young Persons and Their Families Act*. (1989). Wellington, New Zealand: Government Printer.
- Clea Hoskins, T. K. (2000). In the interests of Māori women? Discourses of reclamation. In A. Jones, P. Herda, T. M. Suaali (Eds.), *Bitter sweet: Indigenous women in the Pacific* (pp. 33-48). Dunedin, New Zealand: University of Otago Press.

- Coalition Government. (1999, December 6). *Coalition agreement*. Retrieved June 12, 2006, from <http://www.executive.govt.nz/coalition/index.html>.
- Conference Advisory Group (Eds.).(2004). *1st national Māori sexual and reproductive health conference – Wainuiomata Marae, Wellington 1-2 November 2004: Conference proceedings*. Retrieved June 23, 2006, from <http://www.tpt.org.nz/downloads/ConferenceProceedings.pdf>.
- Connor, D.H. (2000). Reclamation of cultural identity for Māori women: A response to 'prisonisation'. In A. Jones, P. Herda, T. M. Suaali (Eds.), *Bitter sweet: Indigenous women in the Pacific* (pp. 125-135). Dunedin, New Zealand: University of Otago Press.
- Coroners Act*. (1988). Wellington, New Zealand: Government Printer.
- Coster, G., & Gribben, B. (1999). *Primary care models for delivering population based health outcomes: Discussion paper for the National Health Committee*. Retrieved June 23, 2006, from <http://www.nhc.govt.nz/publications/phc/phcmodels.pdf>.
- Crengle, S. (1999). *Maori primary care services*. Wellington, New Zealand: National Health Committee.
- Cribb, A. (1995). The borders of health promotion. In D. Seedhouse (Ed.), *Reforming health care: The philosophy and practice of international health reform* (pp. 199-208). Chichester, England: John Wiley & Sons.
- Culpitt, I. (1995). Biculturalism, social policy and parallel development: The New Zealand/Maori experience. In J. Dixon & R. P. Scheurell (Eds.), *Social welfare with indigenous peoples* (pp. 230-275). London: Routledge.
- Cullen, M. (2006). *Budget speech, 18 May 2006*. Retrieved June 19, 2006, from <http://www.beehive.govt.nz/ViewDocument.aspx?DocumentID=25832>.
- Cumming, J., Raymont, A., Gribben, B., Horsburgh, M., Kent, B., McDonald, J., et al. (2005, May). *Evaluation of the implementation and intermediate outcomes of the primary health care strategy – First report: Overview*. Retrieved May 17, 2006, from <http://www.vuw.ac.nz/hsrc/reports/downloads/FINAL%20Overview%2027%20May.pdf>.

- Cunningham, C. (2003). Application of the TPK guidelines for conducting evaluation research with Maori. In N. Lunt, C. Davidson, & K. McKegg (Eds.), *Evaluating policy and practice: A New Zealand reader* (pp. 142-145). Auckland, New Zealand: Pearson Education.
- Davidson, C. (2003). The mix of methods: Common research techniques used in evaluation. In N. Lunt, C. Davidson, & K. McKegg (Eds.), *Evaluating policy and practice: A New Zealand reader* (pp. 91-106). Auckland, New Zealand: Pearson Education.
- Davis, P., & Ashton, T. (2001). General introduction. In P. Davis & T. Ashton (Eds.), *Health and public policy in New Zealand* (pp. 1-20). Auckland, New Zealand: Oxford University Press.
- Deloria, V., Jr. (1995). *Red earth, white lies: Native Americans and the myth of scientific fact*. New York: Scribner.
- Department of Health. (1984). *Hui Whakaoranga, Maori health planning workshop, Hoani Waititi Marae 19-22 March 1984*. Wellington, New Zealand: Author.
- Department of Health. (1990). *Adolescent sexuality: The report of the taskforce on adolescent sexuality*. Wellington, New Zealand: Author.
- Department of Justice. (1989). *Principles for crown action on the Treaty of Waitangi*. Wellington, New Zealand: Author.
- Department of Maori Affairs. (1988). *Te urupare rangapu: Partnership response*. Wellington, New Zealand: Author.
- De Raad, J.-P. (2003). *PHOs and Māori health: implications of PHO policy for Māori health policy objectives: report to Māori Health Directorate, Ministry of Health*. Retrieved June 25, 2006, from Massey University Library database.
- Dovers, S. (2005). *Environment and sustainability policy: creation, implementation, evaluation*. Annandale, New South Wales, Australia : Federation Press.
- Dow, D. A. (1999). *Maori health and government policy 1840 – 1940*. Wellington, New Zealand: Victoria University Press and Historical Branch, Department of Internal Affairs.

- Duigan, P. (2003). Approaches and terminology in programme and policy evaluation. In N. Lunt, C. Davidson, & K. McKegg (Eds.), *Evaluating policy and practice: A New Zealand reader* (pp. 77-90). Auckland, New Zealand: Pearson Education.
- Durie, M. H. (1994a). *Whaiora: Maori health development*. Auckland, New Zealand: Oxford University Press.
- Durie, M. H. (1994b). *Whanau, family and the promotion of health*. Palmerston North, New Zealand: Department of Maori Studies, Massey University.
- Durie, M. H. (1995a). An Introduction to the Hui Whakapūmau. In Hui Whakapūmau (Eds.), *Kia pumau tonu: Proceedings of the Hui Whakapūmau Māori development conference, August 1994* (pp. 3-10). Palmerston North, New Zealand: Department of Māori Studies, Massey University.
- Durie, M. H. (1995b). *Nga matatini Maori: Diverse Maori realities*. Palmerston North, New Zealand: Department of Maori Studies, Massey University.
- Durie, M. H. (1997a). Identity, access and Maori advancement. *The indigenous future: Edited proceedings at New Zealand Educational Administration Society Research Conference*. Auckland, New Zealand: Auckland Institute of Technology.
- Durie, M. H. (1997b). Whānau whanaungatanga. In P. Te Whaiti, M. McCarthy, & A. Durie (Eds.), *Mai i Rangiatea Māori wellbeing and development* (pp. 1-24). Auckland, New Zealand: Auckland University Press.
- Durie, M. H. (1998). *Te mana, te kawanatanga: The politics of Maori self-determination*. Auckland, New Zealand: Oxford University Press.
- Durie, M. H. (1999). Te pae mahutonga: A model for Māori health promotion. *Health Promotion Forum of New Zealand Newsletter*, 49, 2-5.
- Durie, M. H. (2001). *Mauri ora: The dynamics of Maori health*. Auckland, New Zealand: Oxford University Press.

- Eliassen, K. A., & Monsen, C. B. (2003). Interest representation and legitimacy in the European Union. In S. Nagel (Ed.), *Policymaking and democracy: A multinational anthology* (pp. 89-110). Lanham, MD: Lexington Books.
- Esacove, A. (1998). A diminishing of self: Women's experiences of unwanted sexual attention. *Health Care for Women International, 19*, 181-192.
- Evans, R. (1994). The negotiation of powerlessness – Māori feminism: A perspective. *Hecate, 20*(2), 53-65.
- Fanon, F. (1968). *Black skin/white masks* (C. L. Markmann, Trans.). London: MacGibbon & Kee.
- Fitzgerald, E., Durie, M. H., Black, T., Durie, A., Christensen, I., & Taiapa, J. (1996). Whaihuia tatau: A representative sampling method for Maori populations. *He Pukenga Kōrero, 2*(1): 34-42.
- Fleras, A., & Spoonley, P. (1999). *Recalling Aotearoa: Indigenous politics and ethnic relations in New Zealand*. Melbourne, Australia: Oxford University Press.
- Freire, P. (1992). *Pedagogy of the oppressed* (M. B. Ramos, Trans.). New York: Continuum.
- Foucault, M. (2004). Michel Foucault, from Discipline and Punish (1977). In A. Easthope & K. McGown (Eds.), *A critical and cultural theory reader* (2nd ed., pp. 94-101). Buckingham, England: Open University Press.
- George, V., & Wilding, P. (1985). *Ideology and social welfare*. London: Routledge and Kegan Paul.
- Gitlin, T. (1989). Postmodernism: Roots and politics. *Dissent, 36*(1), 100-108.
- Glover, M. (1997, December). *Kaupapa Maori health research: A developing discipline*. Paper presented at Hui Whakatipu, Otara, New Zealand.
- Glover, M. (2003). Te whare tapa wha as a theoretical framework. In Health Research Council (Ed.), *Report from Hui Whakapiri – Te Papaïouru Marae, Ohinemotu, Rotorua, September 2001* (pp. 22-25). Auckland, New Zealand: Health Research Council.

- Goodwin, D. W. T. (1996). *“He tapu te whare tangata”*: Support for young Maori mothers during pregnancy, birth and motherhood. Unpublished master’s thesis, Massey University, Palmerston North, New Zealand.
- Gramsci, A. (1971). *Selections from the prison notebooks* (Q. Hoare & G. Nowell-Smith, Trans.). London: Lawrence & Wishart.
- Gray, K. A. P. (2001). Painting public policy purple: The New Zealand health strategy, social democracy and the welfare state. *Postgraduate Review*, 1, 77-106.
- Green, E. C., & Zokwe, B. (1996). Indigenous healer associations and a South African AIDS-prevention project. In D. M. Warren & P. Blunt (Eds.), *Indigenous organizations and development* (pp. 97-107). London: Intermediate Technology Publications.
- Green, L. W., & Kreuter, M. W. (1991). *Health promotion planning: An educational and environmental approach* (2nd ed.). Toronto, Ontario: Mayfield.
- Harding, S. (Ed.). (1987). *Feminism and methodology: Social science issues*. Bloomington, IN: Indiana University Press.
- Hall, S. (1992). The West and the rest: Discourse and power. In S. Hall & B. Gielben (Eds.), *Formations of modernity* (pp. 275-331). Cambridge, England: Polity Press & Open University.
- Hashagen, S. (2003). Frameworks for measuring community health and wellbeing. In J. Orme, J. Powell, P. Taylor, T. Harrison, & M. Grey (Eds.), *Public health for the 21st century: New perspectives on policy, participation and practice* (pp. 278-295). Berkshire, England: Open University Press.
- Hatrick, G., Lindsay, E., & Hills, M. (1994). Family nursing assessment: Meeting the challenge of health promotion. *Journal of Advanced Nursing*, 31, 27-34.
- Havemann, P. (1999). Indigenous peoples, the state and the challenge of differentiated citizenship: A formative conclusion. In P. Havemann (Ed.), *Indigenous peoples’ rights in Australia, Canada, & New Zealand* (pp. 468-475). Auckland, New Zealand: Oxford University Press.

- Health Promotion Forum. (1999). *Nga Kaiakatanga Hauora mo Aotearoa – Health Promotion Competencies for Aotearoa-New Zealand*. Retrieved May 17, 2006, from <http://www.hpforum.org.nz/page.php?p=28&fp=8>
- Henare, M. (1988). Nga tikanga me nga ritenga o te ao Maori: Standards and foundations of Maori society. *The April report* (Vol. 3[1], pp. 3-41). Wellington, New Zealand: Royal Commission on Social Policy.
- Hirini, P. (1997). He whakaaro mō te aria whanaungatanga: He āta rapu – Towards an understanding of whanaungatanga. *He Pukenga Kōrero*, 2(2), 43-51.
- Hisley, S. M., & Clements, C. M. (2004). Family sexuality. In P. J. Bomar (Ed.), *Promoting health in families: Applying family research and theory to nursing practice* (3rd ed., pp.420-449). Philadelphia: Saunders.
- Hohepa, P., Hongi, W., & Sissons, J. (1987). *The Puriri trees are laughing: A political history of the Nga Puhi in the inland Bay of Islands*. Auckland, New Zealand: Polynesian Society,
- Hui Taumata. (2005). *Hui tuakana*. Retrieved June 25, 2006, from <http://www.huitaumata.maori.nz/action/projects/tuakana.asp>.
- Hutton, W. (1999). *The stakeholding society: Writings on politics and economics*. Cambridge, England: Polity Press.
- Inequality in health worries ministry. (2006, June 10). *Manawatu Standard*, p. 5.
- Institute of Policy Studies. (2000). “*Building the constitution*” conference, 7-8 April 2000: *Thematic summary*. Retrieved June 12, 2000, from <http://www.vuw.ac.nz/inst-policy-studies/conf/summary.html>.
- Irwin, K. (1992). Towards theories of Maori feminism. In R. Du Plessis (Ed.), *Feminist voices: Women’s studies texts for Aotearoa/New Zealand* (pp. 1-21). Oxford: Oxford University Press.
- Irwin, K. (1994). Maori research methods and processes: An exploration. *Sites*, 28, 25-43.

- Johnston, P., & Pihama, L. (1994). The marginalisation of Māori women. *Hecate*, 20(2), 83-97.
- Kamira, R., Campbell, T., & Campbell, S. (1999). *Arotake nga rauemi hauora tamariki: A review of Māori specific child health resources*. Retrieved May 17, 2006 from <http://www.hauora.com/downloads/files/ACF8DB.pdf>.
- Karetu, T. (1993). Tōku reo tōku mana. In W. Ihimaera (Ed.), *Te ao Mārama: Regaining Aotearoa: Maori writers speak out* (Vol. 2, pp. 222-229). Auckland, New Zealand: Reed Books.
- Kathlene, L., & Martin, J. A. (1991). Enhancing citizen participation: Panel designs, perspectives, and policy formulation. *Journal of Policy Analysis and Management*, 10(1), 46-63. Retrieved May 1, 2006, from JSTOR database.
- Kearney, M. H. (2002). Defining and managing health risk: Snapshots of women's strategies across the lifespan. In L. E. Young & V. E. Hayes (Eds.), *Transforming health promotion practice: Concepts, issues, and applications* (pp. 148-161). Philadelphia: F. A. Davis.
- Kelsey, J. (1996). From flagpoles to pine trees: Tino rangatiratanga and Treaty policy today. In P. Spoonley, D. Pearson, & C. Macpherson (Eds.), *Nga patai: Racism and ethnic relations in Aotearoa/New Zealand* (pp. 177-201). Palmerston North, New Zealand: Dunmore Press.
- Khan, U. (Ed.). (1999). *Participation beyond the ballot box: European case studies in state-citizen political dialogue*. London: UCL Press.
- Kickbusch, I., & Badura, B. (Eds.). (1991). *Health promotion research: towards a new social epidemiology*. Copenhagen, Denmark: World Health Organization, Regional Office for Europe.
- King, A. (2000). *Health partnership between Maori and Crown* [2 pages]. Press release. Retrieved August 14, 2000, from <http://www.executive.govt/speech.cfm?speechalph=31962&SR=>.
- King, A. (2001). Minimum requirements for primary health organisations. Retrieved December 12, 2001, from

[http://www.moh.govt.nz/moh.nsf/f872666357c511eb4c25666d000c8888/45bfc74eca838b20cc256b040073a71b/\\$FILE/MinReqsPHO.pdf](http://www.moh.govt.nz/moh.nsf/f872666357c511eb4c25666d000c8888/45bfc74eca838b20cc256b040073a71b/$FILE/MinReqsPHO.pdf).

- Kiro, C. A. (2001). *Kimihia hauora Māori: Māori health policy and practice*. Unpublished doctoral dissertation, Massey University, Albany, New Zealand.
- Kook, R. B. (2002). *The logic of democratic exclusion: African Americans in the United States and Palestinian citizens in Israel*. Lanham, MD: Lexington Books.
- Kunitz, S. J. (1994). *Disease and social diversity: The European impact on the health of non-Europeans*. New York: Oxford University Press.
- Kupenga, V., Rata, R., & Nepe, T. (1993). Whāia te iti kahurangi: Māori women reclaiming autonomy. In W. Ihimaera (Ed.), *Te ao Mārama: Regaining Aotearoa: Maori writers speak out* (Vol. 2, pp. 304-309). Auckland, New Zealand: Reed Books.
- Landy, D. (Ed.). (1977). *Culture disease and healing: Studies in medical anthropology*. New York: Macmillan.
- Laugesen, R. (2000, August 6). Health plan adds fuel to Maori caucus fire. *Sunday Star Times*, p. A2.
- Linklater, A. (1998). Citizenship and sovereignty in the post-Westphalian European state. In D. Archibugi, D. Held, & M. Kohler (Eds.), *Re-imagining political community: Studies in cosmopolitan democracy* (pp. 113-137). Cambridge, England: Polity Press.
- Loomis, T. (2000). *The political economy of indigenous peoples and development*. Hamilton, New Zealand: Department of Development Studies, University of Waikato.
- Loudon, J. B. (Ed.). (1976). *Social anthropology and medicine*. London & New York: Academic Press.
- Lunt, N. (2003). Knowledge for policy: The emergence of evaluation research within New Zealand. In N. Lunt, C. Davidson, & K. McKegg (Eds.), *Evaluating policy and practice: A New Zealand reader* (pp. 4-15). Auckland, New Zealand: Pearson Education.

- Lunt, N., Spoonley, P., & Mataira, P. (2002). Past and present: Reflections on citizenship within New Zealand. *Social Policy & Administration*, 36(4), 346-362.
- Lynskey, M T., & Fergusson, D M. (1993). Sexual activities and contraceptive use amongst teenagers under the age of 15 years. *New Zealand Medical Journal* 106 (969), 511-514.
- Maaka, R., & Fleras, A. (2000). Engaging with indigeneity: Tino rangatiratanga in Aotearoa. In D. Ivison, P. Patton, & W. Sanders (Eds.), *Political theory and the rights of indigenous peoples* (pp.89-109). Cambridge, England: Cambridge University Press.
- Maaka, R., & Fleras, A. (2005). *The politics of indigeneity: Challenging the state in Canada and Aotearoa New Zealand*. Dunedin, New Zealand: University of Otago Press.
- MacDonald, M. A. (2002). Health promotion: Historical, philosophical, and theoretical perspectives. In L. E. Young & V. E. Hayes (Eds.), *Transforming health promotion practice: Concepts, issues, and applications* (pp. 22-45). Philadelphia: F. A. Davis.
- Maclean, F. S. (1964). *Challenge for health a history of public health in New Zealand*. Wellington, New Zealand: R E Owen, Government Printer.
- Mallard, T. (2004, March). *Terms of reference: Ministerial review unit to oversee review of targeted policy and programmes*. Retrieved May 17, 2006, from <http://www.ssc.govt.nz/display/document.asp?NavID=82&DocID=4962>.
- Marsden, M. (1992). God, man and universe: A Maori view. In M. King (Ed.), *Te ao hurihuri: Aspects of Maoritanga* (pp. 117-137). Auckland, New Zealand: Reed.
- Marshall, T. H. (1950). *Citizenship and social class and other essays*. Cambridge, England: Cambridge University Press.
- Martin, J., & Salmond, G. (2001). Policy making: The 'messy reality'. In P. Davis & T. Ashton (Eds.), *Health and public policy in New Zealand* (pp. 44-61). Auckland, New Zealand: Oxford University Press.
- Matahaere-Atariki, D. (1997). *Interrogating speech in colonial encounters: Native women and voice*. Unpublished master's thesis, Massey University, Palmerston North, New Zealand.

- Matahaere-Atariki, D. (1998). At the gates of the knowledge factory: Voice, authenticity, and the limits of representation. In R. Du Plessis & L. Alice (Eds.), *Feminist thought in Aotearoa New Zealand: Connections and differences* (pp. 68-75). Auckland, New Zealand: Oxford University Press.
- Matteson, P. (1995). *Advocating for self: Women's decisions regarding contraception*. Binghamton, NY: Haworth Press.
- May, T. (1993). *Social research: Issues, methods and process*. Buckingham, England; Philadelphia: Open University Press.
- McEwan, B. (1988). High school students' attitudes towards and use of contraceptives. *New Zealand Medical Journal* 101, 142-145.
- Mead, L. T. T. R. (1996). *Nga aho o te kakahu matauranga: The multiple layers of struggle by Maori in education*. Unpublished doctoral dissertation, University of Auckland, Auckland, New Zealand.
- Meijl, T. van. (1996). Community development among the New Zealand Maori: The Tainui case. In D. M. Warren & P. Blunt (Eds.), *Indigenous organizations and development* (pp. 193-213). London: Intermediate Technology Publications.
- Mental Health (Compulsory Assessment and Treatment) Act*. (1992). Wellington, New Zealand: Government Printer.
- Metge, J. (1995). *New growth from old: The whānau in the modern world*. Wellington, New Zealand: Victoria University Press.
- Metge, J. (2001). Family and whanau in a changing world. In S. Birks (Ed.), *Proceedings of social policy forum 2001: Child and family: Children in families as reflected in statistics, research and policy* (pp. 19-25). Palmerston North, New Zealand: Massey University.
- MidCentral District Health Board. (2005a). *District annual plan 2005-2006*. Palmerston North, New Zealand: Author.
- MidCentral District Health Board. (2005b). *Oranga pumau – Maori health strategy: Discussion document*. Palmerston North, New Zealand: Author.

- Ministry of Health. (1994). *Kia whai te maramatanga: The effectiveness of health messages for Māori*. Wellington: Author.
- Ministry of Health. (1996a). *Determining the path: Guidelines for designing Māori health educational resource – He tātai i te ara*. Wellington: Author.
- Ministry of Health. (1996b). *Sexual and reproductive health strategy*. Retrieved June 16, 2006, from <http://www.moh.govt.nz/moh.nsf/by+unid/FE8201AB853BF5AAAFCC256C32007FDA59?Open>.
- Ministry of Health. (1996c). *Rangatahi sexual wellbeing and reproductive health: A discussion document*. Wellington, New Zealand: Author.
- Ministry of Health. (1997a). *Kawe korero: Guidelines for communicating with Maori*. Retrieved June 12, 2006, from [http://www.moh.govt.nz/moh.nsf/0/89c40587c735330e4c2566780010f566/\\$FILE/kawekor.pdf](http://www.moh.govt.nz/moh.nsf/0/89c40587c735330e4c2566780010f566/$FILE/kawekor.pdf).
- Ministry of Health. (1997b, September). *Public health perspectives, I(1)*.
- Ministry of Health. (1997c). *Rangatahi sexual wellbeing and reproductive health: The public health issues*. Wellington, New Zealand: Author.
- Ministry of Health. (1997d). *Sexually transmitted diseases – prevention and control: The public health issues*. Wellington, New Zealand: Author.
- Ministry of Health. (1997e). *The wellbeing of Māori whānau : A discussion document – Whāia te whanaukataka: oraka whānau*. Wellington, New Zealand: Author.
- Ministry of Health. (1998). *The wellbeing of whānau: The public health issues – Whāia te whanaungatanga oranga whānau*. Wellington, New Zealand: Author.
- Ministry of Health. (2000). *The New Zealand health strategy*. Wellington, New Zealand: Author.

- Ministry of Health. (2001a). *He korowai oranga – Maori health strategy: discussion document*. Wellington, New Zealand: Author.
- Ministry of Health. (2001b). *Sexual and reproductive health strategy: Phase one*. Wellington, New Zealand: Author.
- Ministry of Health. (2001c). *The New Zealand disability strategy*. Wellington, New Zealand: Author.
- Ministry of Health. (2001d). *The primary health care strategy*. Wellington, New Zealand: Author.
- Ministry of Health. (2002a, March). *Publications: Transition update – A newsletter for the DHB sector on key activities in the transition to full functionality under the New Zealand Public Health and Disability Act*. Retrieved May 21, 2002, from [http://www.moh.govt.nz/moh.nsf/ea6005dc347e7bd44c2566a40079ae6f/3def09cce8cd80a3cc2569e5000b5e90/\\$FILE/Newsletter%2323.doc](http://www.moh.govt.nz/moh.nsf/ea6005dc347e7bd44c2566a40079ae6f/3def09cce8cd80a3cc2569e5000b5e90/$FILE/Newsletter%2323.doc).
- Ministry of Health. (2002b). *Doing better for New Zealanders: Better health, better participation, reduced inequalities*. Wellington, New Zealand: Author.
- Ministry of Health. (2002c). *He korowai oranga – Maori health strategy*. Wellington, New Zealand: Author.
- Ministry of Health. (2002d). *Whakatātaka: Maori health action plan, 2002-2005*. Wellington, New Zealand: Author.
- Ministry of Health. (2003a). *Establishment service specifications for essential primary health care services provided by primary health organisations*. Retrieved June 12, 2006, from [http://www.moh.govt.nz/moh.nsf/f872666357c511eb4c25666d000c8888/fe7aab9fb4171c7cc256c3e001333d4/\\$FILE/establishment-service-specifications.doc](http://www.moh.govt.nz/moh.nsf/f872666357c511eb4c25666d000c8888/fe7aab9fb4171c7cc256c3e001333d4/$FILE/establishment-service-specifications.doc).
- Ministry of Health. (2003b). *A guide to developing health promotion programmes in primary care settings – A working document*. Retrieved June 16, 2006, from [http://www.moh.govt.nz/moh.nsf/0/2e1a4681028f3a4bcc256c5200044cf3/\\$FILE/ATTKOFUV/HealthPromoGuidePHsettings.pdf](http://www.moh.govt.nz/moh.nsf/0/2e1a4681028f3a4bcc256c5200044cf3/$FILE/ATTKOFUV/HealthPromoGuidePHsettings.pdf).

Ministry of Health. (2003c). *Public health in a primary care setting*. Retrieved May 17, 2006, from [http://www.moh.govt.nz/moh.nsf/0/2e1a4681028f3a4bcc256c5200044cf3/\\$FILE/ATT9YA2Z/PublicHealthPHSetting.pdf](http://www.moh.govt.nz/moh.nsf/0/2e1a4681028f3a4bcc256c5200044cf3/$FILE/ATT9YA2Z/PublicHealthPHSetting.pdf).

Ministry of Health. (2003d). *Sexual and reproductive health: A resource book for New Zealand health care organisations*. Wellington, New Zealand: Author.

Ministry of Health. (2004). *Living with disability in New Zealand: Māori and disability*. Retrieved June 26, 2006, from <http://www.hpac.govt.nz/moh.nsf/UnidPrint/MH3517?OpenDocument>.

Ministry of Health. (2005a). *Developing a monitoring framework and strategic research agenda for he korowai oranga: Summary of submissions*. Wellington, New Zealand: Author.

Ministry of Health. (2005b). New PHOs from 1 July. *Primarily*, 15, 2.

Ministry of Health. (2005c). *Primary health organisation agreement: Version 17*. Retrieved June 16, 2006, from [http://www.moh.govt.nz/moh.nsf/0/2E1A4681028F3A4BCC256C5200044CF3/\\$File/HOContractv17Word.doc](http://www.moh.govt.nz/moh.nsf/0/2E1A4681028F3A4BCC256C5200044CF3/$File/HOContractv17Word.doc).

Ministry of Health. (2006a). *Tatau kahukura: Māori health chart book*. Wellington, New Zealand: Author.

Ministry of Health. (2006b). *Whakatātaka tuarua: Māori health action plan 2006-2011: Discussion document*. Retrieved June 16, 2006, from [http://www.moh.govt.nz/moh.nsf/pagesmh/4836/\\$File/whakatataka-tuarua-06-11.doc](http://www.moh.govt.nz/moh.nsf/pagesmh/4836/$File/whakatataka-tuarua-06-11.doc).

Ministry of Health. (n.d.a). *Primary health care strategy: Care plus*. Retrieved May 17, 2006, from http://www.moh.govt.nz/moh.nsf/wpg_Index/-Primary+Health+Care+Care+Plus

Ministry of Health. (n.d.b). *Transition update*. Retrieved June 23, 2006, from <http://www.moh.govt.nz/moh.nsf/ea6005dc347e7bd44c2566a40079ae6f/3def09cce8cd80a3cc2569e5000b5e90?OpenDocument>.

- Ministry of Health. (n.d.c). *What is primary health care?*. Retrieved May 17, 2006, from http://www.moh.govt.nz/moh.nsf/wpg_Index/About-Primary+Health+Care+Strategy+Implementation#primaryhealthcare.
- Ministry of Social Development. (2004). *New Zealand families today: A briefing for the Families Commission*. Wellington, New Zealand: Author.
- Ministry of Youth Affairs. (1996). *A guide to realising the potential for government departments and agencies: Developing and analysing government youth policies in New Zealand*. Wellington, New Zealand: Author.
- Mitchell, J. H. (1972). *Takitimu: A history of the Ngati Kahungunu people*. Wellington, New Zealand: AH & AW Reed.
- Moeke-Pickering, T. (1996). *Maori identity within whānau: a review of literature*. Retrieved June 16, 2006, from <http://wfass.waikato.ac.nz/psychology/commpsyh/publications/moeke-pickering2.shtml>.
- Moewaka-Barnes, H. (2003). Maori and evaluation: Some issues to consider. In N. Lunt, C. Davidson, & K. McKegg (Eds.), *Evaluating policy and practice: A New Zealand reader* (pp. 146-150). Auckland, New Zealand: Pearson Education.
- Montgomery, J. D. (1983). When local participation helps. *Journal of Policy Analysis and Management*, 3(1), 90-105. Retrieved May 1, 2006, from JSTOR database.
- Mornington Health Centre. (n.d.). *About us*. Retrieved November 24, 2005, from <http://www.mhc.co.nz/aboutus.html>.
- Morgan , G. (2001). Differentiated citizenship: Pancea or Pandoran Box?. In P. Havemann & G. Morgan (Eds.), *Re visioning citizenship for the 21st century conference: 22-23 February 2000, conference proceedings* (pp.208-225). Hamilton, New Zealand: Centre for New Zealand Jurisprudence, School of Law at the University of Waikato.
- Murchie, E. (1984). *Rapuora: Health and Māori women*. Wellington, New Zealand: Māori Women's Welfare League.

- Myles, J., & Quadagno, J. (2000). Envisioning a third way: The welfare state in the twenty-first century [Electronic version]. *Contemporary Sociology*, 29(1), 156-167.
- National Advisory Committee on Health and Disability. (2002). *Improving Maori health policy*. Wellington, New Zealand: Author.
- Nepe, T. (1991). *E hao nei e tenei reanga: Te toi huarewa tipuna, kaupapa Maori, an educational intervention system*. Unpublished master's thesis, University of Auckland, Auckland, New Zealand.
- Nepia, I. H. (1993). Ko taku taha rangatiratanga ko taku reo Maori. In W. Ihimaera (Ed.), *Te ao Mārama: Regaining Aotearoa: Maori writers speak out* (Vol. 2, pp. 343-344). Auckland, New Zealand: Reed Books.
- New Zealand Labour Party. (1999). *Labour on health*. Retrieved May 28, 2001, from <http://www.labour.org.nz/InfoCentre1/Policies/health.html>.
- New Zealand Public Health and Disability Act*. (2000). Wellington, New Zealand: Government Printer.
- New Zealand Public Health and Disability Bill*. (2000). Wellington, New Zealand: Government Printer.
- Office of the Minister of Health. (2000). *Sector design: Maori issues – memorandum to social policy & health committee*. Retrieved June 16, 2006, from [http://www.moh.govt.nz/moh.nsf/aa6c02e6249e7359cc256e7f0005521d/f05620b9aa0df55d4c2568b900119c54/\\$FILE/ATTBD28X/maoriss.pdf](http://www.moh.govt.nz/moh.nsf/aa6c02e6249e7359cc256e7f0005521d/f05620b9aa0df55d4c2568b900119c54/$FILE/ATTBD28X/maoriss.pdf).
- Office of the Minister of Health. (n.d.). *Health and disability sector changes and their implementation: Memorandum to cabinet business committee*. Retrieved May 28, 2001, from http://www.executive.govt.nz/minister/king/health_changes/index.html.
- Orme, J., Powell, J., Taylor, P., Harrison, T., & Grey, M. (Eds.). (2003). *Public health for the 21st century: New perspectives on policy, participation and practice*. Berkshire, England: Open University Press.

- Parliamentary debates*. (2000a, August 17). Retrieved May 28, 2001, from http://rangi.knowledge-basket.co.nz/hansard/han/text/2000/08/17_025.html. Speaker: Hon A King.
- Parliamentary debates*. (2000b, August 17). Retrieved May 28, 2001, from http://rangi.knowledge-basket.co.nz/hansard/han/text/2000/08/17_029.html>. Speaker: Hon T Turia.
- Parliamentary debates*. (2000c, August 17). Retrieved May 28, 2001, from http://rangi.knowledge-basket.co.nz/hansard/han/text/2000/08/17_038.html.
- Parliamentary debates*. (2000, November 14). Retrieved May 28, 2001, from http://rangi.knowledge-basket.co.nz/hansard/han/text/2000/11/14_003.html. Speaker: Hon A King.
- Parliamentary debates*. (2000, December 7). Retrieved May 28, 2001, from http://rangi.knowledge-basket.co.nz/hansard/han/text/2000/12/07_038.html. Speaker: C Carter.
- Parliamentary debates*. (2006, May 24). Retrieved June 19, 2006, from <http://www.clerk.parliament.govt.nz/hansard/Hansard.aspx>. Speaker: N. Mahuta.
- Patton, M. Q. (1990). *Qualitative evaluation and research methods* (2nd ed.). London: Sage Publications.
- Pearsall, J. (Ed.). (1999). *The concise Oxford dictionary* (10th ed.). New York: Oxford University Press.
- Pere, R. (1984). Te oranga o te whanau: The health of the family. In Maori Health Planning Workshop (Eds.), *Hui Whakaoranga: Maori health planning workshop, Hoani Waititi Marae, 19-22 March, 1984*. Wellington, New Zealand: Department of Health.
- Pihama, L. (1993). *Tungia te ururua, kia tupu whakaritorito te tupu o te harakeke: A critical analysis of parents as first teachers*. Unpublished master's thesis, University of Auckland, Auckland, New Zealand.

- Pomare, M. (1908). The Maori. In *Transactions of the eighth session of the Australasian medical congress*. Melbourne, Australia: J Kemp, Government Printer.
- Pouwhare, T.M.C. (1998). *'Safer sex?'* Young Maori women's experiences of sex, coercion and contraceptive use. Unpublished master's thesis, University of Auckland, Auckland, New Zealand.
- Public Health Commission. (1995a). *He matariki : A strategic plan for Maori public health: A summary*. Wellington, New Zealand: Author.
- Public Health Commission. (1995b). *Whakapiki mauri Maori health advancement*. Wellington, New Zealand: Author.
- Puketapu, B. Te T. (1994). Hokia te kopae a nga pahake: The classical Maori journey. In Hui Whakapūmau (Eds.), *Kia pumau tonu: Proceedings of the Hui Whakapūmau Māori development conference, August 1994* (pp. 161-166). Palmerston North, New Zealand: Department of Māori Studies, Massey University.
- Rada, J., Ratima, M., & Howden-Chapman, P. (1999). Evidence-based purchasing of health promotion: methodology for reviewing evidence. *Health Promotion International*, 14(2), 177-187.
- Ratima, M. T. (1999). *Mana, whānau and full and final settlement*. Unpublished master's thesis, Massey University, Palmerston North, New Zealand.
- Redfern-Vance, N., & Hutchinson, S. (1995). The process of developing personal sovereignty in women who repeatedly acquire sexually transmitted diseases. *Qualitative Health Research*, 5, 222-236.
- Richardson, H. S. (2002). *Democratic autonomy: Public reasoning about the ends of policy*. New York: Oxford University Press.
- Ringold, D. (2005). *Accounting for diversity: Policy design and Māori development in Aotearoa New Zealand*. Retrieved June 8, 2006, from the Massey University Library catalogue.

- Roberts, T. (1997). *Managed care in Hawai'i: Looking at the managed care model and the impact on indigenous people of Hawai'i and its application to Maori*. Wellington, New Zealand: Winston Churchill Memorial Trust.
- Rosener, J. B. (1978). Citizen participation: Can we measure its effectiveness? *Public Administration Review*, 38(5), 457-463. Retrieved May 15, 2006, from JSTOR database.
- Rosenstock, I. M. (1990). The health belief model: Explaining health behaviour through expectancies. In K. Glanz, F. Lewis, & B. Rimer (Eds.), *Health behaviour and health education: Theory, research and practice* (pp. 39-62). San Francisco: Jossey-Bass.
- Royal, T. A. C. (1992). *Te haurapa: An introduction to researching tribal histories and traditions*. Wellington, New Zealand: Bridget William Books.
- Royal Commission on Social Policy. (1988). *The April report – volume II future directions: Report of The royal commission on social policy te komihana a te karauna mo nga ahuatanga-a-iwi April 1988*. Wellington, New Zealand: The Royal Commission on Social Policy.
- Ryan, P. M. (1995). *The reed dictionary of modern Māori*. Auckland, New Zealand: Reed Publishing.
- Said, E. (1978). *Orientalism*. New York: Pantheon.
- Salmond, A. (1980). *Eruera: The teachings of a Maori elder*. Wellington, New Zealand: Oxford University Press.
- Salmond, C., & Crampton, P. (2002). *NZDep2001 index of deprivation*. Wellington, New Zealand: Department of Public Health, Wellington School of Medicine and Health Sciences.
- Sarantakos, S. (1993). *Social research*. Melbourne, Australia: MacMillan.
- Saville-Smith, K. (2003). Power and politics: The shaping of evaluation research in New Zealand. In N. Lunt, C. Davidson, & K. McKegg (Eds.), *Evaluating policy and practice: A New Zealand reader* (pp. 16-20). Auckland, New Zealand: Pearson Education.

- Scott, L. M. (1928). Indian diseases as aids to Pacific Northwest settlement. *Oregon Historical Quarterly*, 29, 144-161.
- Selby, R. (1996). *A study of the factors which contribute to success for Māori women in tertiary education*. Unpublished master's thesis, Massey University, Palmerston North, New Zealand.
- Sentencing Act*. (2002). Wellington, New Zealand: Government Printer.
- Shirres, M. P. (1997). *Te tangata: The human person*. Auckland, New Zealand: Accent Publications.
- Sibthorpe, B. (2004). *A system-eye view from an Australian perspective: Reflections on the IPA Council (IPAC) of New Zealand conference, Rotorua, 14-15 May 2004*. Retrieved May 17, 2006, from http://www.anu.edu.au/aphcri/Publications/Reflections%20on%20the%20IPAC%20conference_final.pdf.
- Simmons, D., & Voyle, J. A. (2003). Reaching hard-to-reach, high-risk populations: piloting a health promotion and diabetes disease prevention programme on an urban marae in New Zealand. *Health Promotion International*, 18(1), 41-50.
- Sinclair, K. (2002). *The people of the Māramatanga: Prophetic histories*. Wellington, New Zealand: Bridget Williams Books.
- Skinner, B. F. (1938). *The behaviour of organisms*. Englewood Cliffs, NJ: Appleton-Century-Crofts.
- Skocpol, T. (1992). *Protecting soldiers and mothers: The political origins of social policy in the United States*. Cambridge, MA: The Belknap Press of Harvard University Press.
- Slack, D. (2004). *Bullshit, backlash & bleeding hearts: A confused person's guide to the great race row*. Auckland, New Zealand: Penguin.
- Smith, G. H. (1990). *The issue of research and Maori*. Auckland, New Zealand: Research Unit for Maori Education, University of Auckland.

- Smith, G. H. (1995). Whakaoho whānau ohangā: The economics of whānau as an innovative intervention into Māori cultural and educational crises. *He Pukenga Kōrero*, 1(1), 18-36.
- Smith, L. T. (1992). Māori women: discourse, projects and mana wāhine. In S. Middleton & A. Jones (Eds.), *Women and education in Aotearoa 2* (pp. 33-51). Wellington, New Zealand: Bridget Williams Books.
- Smith, L. T. (1999). *Decolonizing methodologies: Research and indigenous peoples*. London & Dunedin, New Zealand: Zed Books & University of Otago Press.
- Soutar, M. (1994). Oral research in Maori communities: Some considerations. *Proceedings of the Australian Society of Archivists Conference, Townsville, Australia, 9-11 May*. Dickson, ACT, Australia: Australian Society of Archivists.
- Soutar, M. (1996). A framework for analysing written iwi histories. *He Pukenga Kōrero, Koanga*, 2(1), 43-57.
- Standards New Zealand. (2001). *NZS 8134:2001 – Health and disability sector standards*. Retrieved June 12, 2006, from [http://www.standards.co.nz/web-shop/?action=viewSearchProduct&mod=catalog &pid= 8134:2001\(NZS\)](http://www.standards.co.nz/web-shop/?action=viewSearchProduct&mod=catalog &pid= 8134:2001(NZS)).
- Starzomski, R. C. (2002). Listening to multiple voices: Public participation in health care decision making. In L. E. Young & V. E. Hayes (Eds.), *Transforming health promotion practice: Concepts, issues, and applications* (pp. 71-86). Philadelphia: F. A. Davis.
- State Services Commission. (1999). *Essential ingredients: Improving the quality of policy advice*. Retrieved June 19, 2006, from http://www.ssc.govt.nz/upload/downloadable_files/Occ_Paper_No9.pdf.
- State Services Commission. (2005). *Guidance for designing needs based policies and programmes*. Retrieved May 17, 2006, from http://www.ssc.govt.nz/upload/downloadable_files/guidance-designing-needs-based-programmes.pdf.
- Stewart-Harawira, M. (1995). *Whakatupuranga ngaro ki te whei ao ki te ao marama: The impact of colonisation on Maori whanau*. Unpublished master's thesis, University of Auckland, Auckland, New Zealand.

- Taiapa, J. T. T. (1980). *Kinship and descent in Hicks Bay: A study of the effects of changing community life on child rearing patterns in a small rural community*. Unpublished master's thesis, Massey University, Palmerston North, New Zealand.
- Te Awekotuku, N. (1991). *He tikanga whakaaro: Research ethics in the Maori community: A discussion paper*. Wellington, New Zealand: Ministry of Maori Affairs.
- Te Hoe Nuku Roa Research Team. (1999). *Māori profiles research project: Te Hoe Nuku Roa source document: baseline history*. Palmerston North, New Zealand: Te Pūtahi ā Toi Massey University.
- Te Pumanawa Hauora. (1996). *Oranga whānau: Maori health and wellbeing, and whānau: A report*. Palmerston North, New Zealand: Massey University, Department of Māori Studies.
- Te Puni Kōkiri. (1993). *Strategic direction for Māori health: A discussion document – Te ara ahu whakamua*. Wellington, New Zealand: Author.
- Te Puni Kōkiri. (1994). *Mate ketoketo/arai kore: A report about HIV/AIDS and Maori*. Wellington, New Zealand: Author.
- Te Puni Kōkiri. (1995). *Hui whai matauranga whai oranga: Report of the hui on Maori reproductive health and HIV/AIDS*. Wellington, New Zealand: Author.
- Te Puni Kōkiri. (1997). *Tou mana hauoranga: Three case studies of Maori health programmes*. Wellington, New Zealand: Author.
- Te Puni Kōkiri. (1999). *Evaluation for Māori – Guidelines for government agencies*. Wellington, New Zealand: Author.
- Te Puni Kōkiri. (2000). *Progress towards closing social and economic gaps between Maori and non-Maori: a report to the Minister of Maori Affairs*. Wellington, New Zealand: Author.
- Te Puni Kōkiri & Ministry of Women's Affairs. (1999). *Maori women in focus: "Titiro hangai, ka marama"*. Wellington, New Zealand: Te Puni Kōkiri.

- Te Roopu Awhina o Tokanui. (1987). Cultural perspectives in psychiatric nursing: A Maori viewpoint. *Nursing Praxis in New Zealand*, 2(3), 2-11.
- Te Ture Whenua Maori Act 1993 (Maori Land Act 1993)*. (1993). Wellington, New Zealand: Government Printer.
- Thomas, T., & LaGrow, S. J. (1994). Whanau workers: Providing services for the indigenous people of New Zealand. *Journal of Visual Impairment & Blindness*, 88(1), 86-90.
- Tomlins-Jahnke, H. (1997). *Whaia te iti kahurangi: Contemporary perspectives of Māori women educators*. Unpublished master's thesis, Massey University, Palmerston North, New Zealand.
- Towner, E., & Dowsell, T. (2002). Community-based child injury prevention interventions: what works? *Health Promotion International*, 17(3), 273-284.
- Trouillot, M.-R. (1991). Anthropology and the savage slot: The poetics and politics of otherness. In R.G. Fox (Ed.), *Recapturing anthropology: Working in the present* (pp. 17-44). Sante Fe, New Mexico: School of American Research Press.
- Trotman, I. (2003). Evaluation in New Zealand: A founder's reflection. In N. Lunt, C. Davidson, & K. McKegg (Eds.), *Evaluating policy and practice: A New Zealand reader* (pp. 21-26). Auckland, New Zealand: Pearson Education.
- Tu Ake Productions. (1998). *Te hauora Maori*. Wellington, New Zealand: Health Funding Authority.
- Turia, T. (2000). *Treaty clause – health bill*. Retrieved June 16, 2006, from <http://www.beehive.govt.nz/ViewDocument.aspx?DocumentID=8871>.
- Vuori, H. (1984). Primary health care in Europe – problems and solutions. *Community Medicine*, 6, 221-231.
- Waldon, J. A. (1999). The role of budget holding in the provision of public health services for Maori. In Te Pumanawa Hauora (Eds.), *Proceedings of te oru rangahau: Maori research and development conference – School of Maori Studies Massey University 7-9*

- July, 1998 (2nd ed., pp. 183-185). Palmerston North, New Zealand: Te Pūtahi a Toi, Massey University.
- Walker, R. (1990). *Ka whawhai tonu matou: Struggle without end*. Auckland, New Zealand: Penguin.
- Walker, R. (1992). The relevance of Maori myth and tradition. In M. King (Ed.), *Te ao hurihuri: Aspects of Maoritanga* (pp. 170-182). Auckland, New Zealand: Reed Books.
- Walters, L. C., Aydelotte, J., & Miller, J. (2000). Putting more public in policy analysis. *Public Administration Review*, 60(4), 349-359. Retrieved May 15, 2006, from JSTOR database.
- Warren, D. M., Adedokun, R., & Omolaoye, A. (1996). Indigenous organizations and development: The case of Ara, Nigeria. In D. M. Warren & P. Blunt (Eds.), *Indigenous organizations and development* (pp. 43-49). London: Intermediate Technology Publications.
- Webster, S. (1989). Maori studies and the expert definition of Maori culture: A critical history. *Sites*, 18, 35-56.
- White, N., & Ladley, A. (2005). Claims to Treaty and other rights : exploring the terms of Crown-Maori negotiations. *Policy Quarterly*, 1(2), 3-9.
- Widders, T., & Noble, G. (1993). On the Dreaming track to the republic: Indigenous people and the ambivalence of citizenship. In G. Hage & L. Johnson (Eds.), *Republicanism, citizenship, community* (pp. 95-112). Nepean, New South Wales, Australia: Research Centre in Intercommunal Studies, University of Western Sydney.
- Wilson, M. G. and Enright, A. (1994). New Zealand's work-force policy: Reflections on fairness in the 1990s. In A. Sharp (Ed.), *Leap into the dark: The changing role of the state in New Zealand since 1984* (pp. 125-145). Auckland, New Zealand: Auckland University Press.
- Wise, M., & Signal, L. (2000). Health promotion development in Australia and New Zealand. *Health Promotion International* 15(3), 237-248.

- Wolfe-Keddie, J. (1996). Aboriginal agenda or agency agenda? Community-development planning projects in Australia. In D. M. Warren & P. Blunt (Eds.), *Indigenous organizations and development* (pp. 159-183). London: Intermediate Technology Publications.
- Workman, K. (1994). Youth and family: Walking in more than two worlds. In International Association of Adolescent Health (Eds.), *International association of adolescent health first Pacific Rim conference : Auckland, New Zealand, 6-9 November 1994 : youth and the family : conference proceedings*. Christchurch, New Zealand: Youth Health New Zealand, N.Z. Association for Adolescent Health and Development.
- World Health Organization. (1986). *Ottawa charter for health promotion*. Retrieved May 17, 2006, from <http://www.ldb.org/iuhpe/ottawa.htm>.
- World Health Organization. (2003). *Primary health care: A framework for future strategic directions*. Retrieved May 17, 2006, from http://www.who.int/entity/chronic_conditions/primary_health_care/en/phc_report_oct03.pdf.
- Young, L. E. (2002). Transforming health promotion practice: Moving toward holistic care. In L. E. Young & V. E. Hayes (Eds.), *Transforming health promotion practice: Concepts, issues, and applications* (pp. 3-21). Philadelphia: F. A. Davis.