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**Ngā Kairaranga Oranga**  
**The Weavers of Health and Wellbeing:**  
**A grounded theory study**

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

Doctor of Philosophy  
in  
Nursing

At Massey University,  
New Zealand.

Denise Lucy Wilson  
2004

## Abstract

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*Ngā Kairaranga Oranga – The Weavers of Health and Wellbeing* is a theory about the health and wellbeing of Māori women. Health data about Māori women indicate that their health status is less than that of the non-Māori population despite the right to experience equality in health outcomes. Māori women's health and wellbeing influences the nature of their health outcomes, varies across their lifetime. 'What is happening for Māori women, their health and interactions with 'mainstream' health services?' is the question that guided the research with Māori women. A grounded theory informed by a Māori centred approach was developed that utilised Mason Durie's Māori-centred concepts of mana Māori (control), whakapiki tangata (enablement) and whakatuia (integration), and integrated Glaserian grounded theory to guide the collection and analysis of the data. Twenty-three women who identified as Māori within the Te Arawa rohe, and who were between the ages of 18 and 80 years were formally interviewed as either a group, pairs or individuals, with a further 15 informally interviewed during the process of theoretical sampling. Semi-structured interviews and field notes were used to collect the data, and the processes of constant comparative analysis, theoretical sampling and saturation were used to generate a middle-range substantive Māori centred grounded theory. Three core categories were identified relating to the health and wellbeing of Māori women: (a) *Mana Māori*, which describes what is important for their health and wellbeing; (b) *The Way It Is*, which outlines the resigned acceptance they have of their reality and life circumstances, and the barriers and challenges that are encountered; and (c) *Engaging with Health Services*, which describes what they require from 'mainstream' health services to improve the access and use of these services. The basic social psychological process of 'weaving health and wellbeing' integrates these core categories. The interpretations Māori women have of health and wellbeing, and health-related actions are explained by the theory generated. This substantive grounded theory provides a model to guide the education and practice of health care providers working within 'mainstream' health services.

## Preface

---

Whakataka te hau ki te uru  
Whakataka te hau ki te tonga  
Kia makinakina ki uta  
Kia matarata ki tai  
Kia hi ake ana te atakura  
He tio, he huka, he hauhu  
Tihei mauri ora!

Ko Tainui te waka  
Ko Karioi te maunga  
Ko Whaingaroa te moana  
Ko Tainui te iwi  
Ko Ngati Tahinga te hapū  
Ko Denise Wilson ahau

Tēnā koutou, tēnā koutou, tēnā koutou, katoa  
Ngā mihi nui ki te koutou katoa.

Before I begin, I want to acknowledge our tupuna, wāhine Māori (especially those who have dedicated their lives to improving the health and wellbeing of Māori), and our mokopuna, and the contribution that they make, or have made, to the health and the wellbeing of whānau, hapū, iwi and Māori communities.

In undertaking research for a PhD degree, it was important to me that I would produce something that could make a contribution to improving the health of Māori, and more specifically Māori women. The impetus for this research arose out of my role as a

registered nurse, the concerns about the appropriateness of some health services delivered to Māori, and my observations of community and acute 'mainstream' health services. These concerns and observations raised many questions about the effectiveness of the interactions between health providers and Māori women. Fundamentally I wanted to know, 'What is happening for Māori women using 'mainstream' health services?' Despite the growth in Māori focused health services, Māori will continue to require 'mainstream' health services. The delivery of appropriate and acceptable services, therefore, is crucial to improving the health outcomes of Māori.

*Ngā Kairaranga Oranga – The Weavers of Health and Wellbeing* is about the strengths that these women have, and use on a daily basis, to maintain the health and wellbeing of themselves and their whānau. These strengths often go unnoticed by health care providers, yet they are a vital part of improving the health outcomes of wāhine Māori. The foundation on which the research and this thesis are based recognises that wāhine Māori are the holders of knowledge about health and wellbeing within their cultural context and life circumstances. They are the kaitiaki of whānau ora...

Ko te mana o wāhine Māori  
Ko rātou te whare tangata  
Te kairaranga oranga.  
Ko te kaitiaki o whānau ora  
Tihei mauri ora!

The integrity of Māori women  
Who are the bearers of life,  
The weavers of health and wellbeing.  
The guardians of whānau health & wellbeing.

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---

E hara taku toa, I te toa takitahi  
Katahi o taku toa, he toa takitini

*Mine is not the strength of one alone; it is the strength of many.*

I have to acknowledge first, the Māori women who participated in this research, and who willingly shared their whakaaro about their health and wellbeing. Without their participation this thesis would not have occurred, and I am both humbled and privileged to have had the opportunity to listen to the insight and wisdom these women shared. It is with sincere hope that the outcome of this study has done their whakaaro the justice that it deserves, and that the findings will benefit them. *Kia kaha, kia manawanui, kaha aroha wāhine mā.*

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## Glossary

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### A

Aroha – love  
Atua – gods

### H

Hapū – wider, extended family  
Harakeke – flax  
He korowai oranga – the cloak of wellness  
Hinengaro – mind, intellect  
Hui – gathering, meeting

### I

Iwi – tribe

### K

Kai - food  
Kaitiaki – guardian  
Kanohi kitea – known face  
Karakia – prayer, incantation  
Kaumatua - elder  
Kaupapa – strategy or a theme  
Kawa – protocol  
Kawanatanga - governorship  
Kete – basket  
Kete taonga – important basket of knowledge  
Koha - gift  
Kohanga reo – preschool Māori language nests  
Kōrerō – talk, speak  
Kowhaiwhai – scroll painting on rafters

### M

Mahikai – preparing food  
Maketu – illness of a spiritual origin with physical manifestations  
Mākū – wet, damp  
Makutu – indirect punishment inflicted by someone  
Mana – prestige  
Manaaki – caring for others  
Mātauranga – information, knowledge, education  
Mate Māori – sickness, death or an unconscious problem with a spiritual origin  
Ma te wā – perception of time  
Matua – parent or main stem of flax  
Mirimiri - massage  
Mokopuna – grandchildren

## **N**

Noa – common, free from tapu

## **P**

Pākehā – non-Māori, European, Caucasian

Papatuanuku – the earth mother

Poutama – step pattern on tukutuku (ornamental) panels

## **R**

Ranganui – the sky father

Rangatiratanga – sovereignty, supremacy

Raranga – weaving of kete

Rito – central shoot of the harakeke (flax)

Rohe – region, area

Rongoā – traditional Māori ‘medicine’

## **T**

Tane – male

Taonga – treasure, property

Tamariki – children

Tangata whenua – people of the land

Tangi – mourning for those who have passed away (died)

Tapu – sacred, forbidden

Tātou tātou – sharing of property

Teina-tuakana – younger-older

Te ao Māori – the world of Māori

Te ao Pākehā – the world of Pākehā

Te kore – void or nothing

Te reo – Māori language

Te whare tangata – house of learning

Tikanga - custom

Tinana – physical body

Tino rangatiratanga – self-determination, control

Tohunga – traditional Māori healer, expert

Tua haere – people living away from area or whānau

Tupuna - ancestors

## **W**

Wahine – woman

Wāhine – women

Wairua - spirit

Wairuatanga - spirituality

Wananga – learning, series of discussion

Whakamā – embarrassment, shame, shyness

Whakapapa – genealogy

Whakawhanaungatanga – process of establishing relationships and connections

Whakataukī - proverb

Whānau – family, extended family

Whanaungatanga – relationships, connections, networks

Whānau ora – family health and wellbeing

Whenua – land, placenta

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# CHAPTER 1

## Introduction

---

*Hutia te rito  
Hutia te rito o te harakeke  
Kei hea te komako e ko  
Ki mai ki ahau*

*He aha te mea nui  
He aha te mea nui o te ao  
Maku e ki atu  
He tangata, he tangata, He tangata hei*

If the centre of the shoot of the flax is pulled out,  
Where will the bellbird sing?  
If you were to ask me what is the most important thing in the world? I would reply,  
It is the people, it is the people, it is the people.

(Whakatauki/waiata from Te Rarawa)

The entitlement to optimal health and wellbeing is a right of all members of society. Despite this right, disparities in health status exist among the various groups within our communities. While the causation of disparities is complex, many causes often lie outside the control of individuals. Māori women are one group who experience poorer health status when compared to most other groups within New Zealand. The multidimensional nature of health and wellbeing involves spiritual, psychological, socio-cultural, and physical dimensions - it is more than being physically well or healthy. Importantly, optimal health and wellbeing requires each of the dimensions to be in

balance, and a person may, at times, require the support of health care providers for its maintenance.

The health and wellbeing of women is significant for society, as they are the bearers of life, and the traditional protectors of the health and wellbeing of families. Māori women, like other women, rely on being well and healthy so they can undertake the various roles that they have within their whānau and communities. This thesis articulates what is important for Māori women and their health and wellbeing, and identifies the challenges and barriers of achieving optimal health and wellbeing, including their interactions with health care providers. Contrasting views of health can create difficulties for the access and use of 'mainstream' health services, such as the biomedical view that prevails in 'mainstream health services' and the health beliefs and practices of Māori women (Dickson, 2000; Sibthorpe, Anderson & Cunningham, 2001). 'Mainstream' health care providers who do not recognise or understand the worldviews and health needs of Māori women have the potential to compromise their health outcomes. This can lead to a common view by health care providers that the admission and readmission of Māori women are generally the result of some failure on behalf of Māori women themselves. Such views are of concern as there seems little or no recognition that the health services Māori women receive may be less than optimal and might not meet their needs (Durie, 1998a; Reid, Robson & Jones, 2000).

Māori women should experience the same level of health and wellbeing as other New Zealand citizens. Yet, health researchers frequently indicate that many Māori women die younger than other women in New Zealand (Aroturuki me te Arotakenga, 1997; Ajwani et al., 2003) and that many Māori women experience less than optimal health (Ajwani et al., 2003; Durie, 1998a; Māori Health Group, 1997; Public Health Consultancy Group, 2001). My observations of Māori women who were acutely ill in hospital, and reflection on encounters between Māori women and health care providers within the primary and secondary health settings provided the impetus for this thesis. The more I reflected upon the differing perspectives of health care providers and those of Māori women, the more questions I asked. As I considered the nature and quality of health outcomes, and the apparent health priorities determined by the Ministry of

Health, and health care providers, I began to question what Māori women thought about their health and their interactions with health services. I also contemplated if the needs of Māori women were not being recognised or addressed (Ajwani et al., 2003; Durie, 1998a; Reid et al., 2000), how effective health services were. Uncovering what is happening for Māori women, their health and wellbeing, and their interactions with 'mainstream' health services can inform the practice of health care providers, and thereby increase opportunities to improve health outcomes.

This chapter provides an introduction and an overview of the research I undertook with Māori women. It begins with a brief outline of the research and is followed by an exploration of the right Māori women have to optimal health and wellbeing. The disparity in worldviews that Māori women encounter when they interact with health services is then discussed, followed by an examination of the benefits the research has for Māori women. To conclude, an overview of the structure of the thesis itself is provided.

## **Research Overview**

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Most health care providers working within 'mainstream' health services are highly likely to come into contact with Māori women at some point of their careers. Health care providers who have an insight and understanding about the thoughts Māori women have about their health are in a powerful position to effectively support Māori women to achieve both optimal health and wellbeing, and to experience positive interactions with health services.

For the purposes of this thesis, 'mainstream' health services refers to those publicly and privately funded services that provide personal, public and population health services within New Zealand. These health services are primary, secondary or tertiary health

services, and are found in a variety of settings that include both community-based and hospital-based services. Many Māori women will at some stage of their lives need to access a 'mainstream health service'. While I recognise that Māori health providers (that is, 'by Māori for Māori' health services) are accessed by many Māori, they provide services within a Māori paradigm and are generally located within the primary health sector with some providing a limited range of services, and therefore fall outside the focus of this study.

This research utilises grounded theory to explain Māori women's health and their interactions with health services. Semi-structured interviews undertaken with Māori women participants and other data sources (such as literature and informal interviews) were used to explore Māori women's interpretations of their health and health experiences. The question used to guide the research was, *what is happening for Māori women, their health, and their interactions with 'mainstream' health services?* The intention of this research is to make an empirical and theoretical contribution to improve the understanding of health care providers about Māori women's health and wellbeing. Thus, the aims of this research are to:

1. Ascertain the interpretation Māori women have of health and how this influences their health behaviours.
2. Determine the interactions Māori women have with health services.
3. Generate a substantive grounded theory, informed by a Māori centred framework, about Māori women's health and wellbeing.
4. Use an appropriate Māori-centred research methodology.

Initially, I intended this thesis to be located within, and make a contribution to, the discipline of nursing. However, as the interviews and the data analysis proceeded it became evident that the Māori women participating see their health experience broadly and do not necessarily differentiate between the various groups of health workers or

health professionals. Thus, throughout this thesis I make reference to health care providers, which refers to all those working within 'mainstream' health services.

The use of a culturally appropriate and acceptable research methodology was an important consideration when embarking on this research project. A Māori centred approach was used to inform the explication of Glaserian grounded theory method to generate knowledge about Māori women within the health context. Such an approach kept the Māori women central to the research process, and the grounded theory method enabled the discovery of what was important for the participants to emerge from the information that they shared. A deliberate decision was made to focus this research on Māori women as a social group, although Glaser (1999) warned that gender and culture should earn their way into a grounded theory. Theory that can inform the practice of health care providers about how Māori women interpret health and health experiences, and their subsequent actions can make a contribution to the body of knowledge that focuses on the health experiences of Māori women. Given the focus on Māori women, the grounded theory generated was confined to the level of a substantive theory rather than a formal grounded theory.

## **A Right to Optimal Health & Wellbeing**

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Māori inhabited New Zealand for over 1,000 years (Orange, 1987) prior to becoming a 'settler' society, with settlers arriving from other countries and cultures (Bell, 1999; Pearson, 1990; Spoonley, 1994). Māori share a similar history and experiences with other indigenous groups who were settled, colonised and subsequently rendered a minority group that resulted in the political power residing with the majority group (Durie, 2004). Prior to this settlement by others Māori were a healthy people who were socio-economically robust (Ballara, 1998), but post-settlement suffered large population losses, along with the loss of land, language and cultural practices due to colonisation

and policies of assimilation and integration. As the indigenous people of New Zealand, Māori survived what Berger (1987) describes as 'genocidal colonisation' and 'land dispossession'. While defining indigeneity can provoke debate about who is 'indigenous', the United Nations (1982, cited in Berger, 1987) define indigenous people as descendants of the existing inhabitants of the land at the time of the arrival of settlers. Indigeneity is also defined by a unique worldview held by indigenous people globally (Berger, 1987). Evident in an indigenous worldview is the symbiotic relationship indigenous people have with the land, which also provides a sense of identity and spirituality, and at one time ensured their economic viability (Berger, 1987). Globally, indigenous experiences of colonisation resulting in minority status have had a negative impact on health status (Wilson, 2003).

Health is a basic human right. The World Health Organisation (WHO) (2004) maintains, "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being..." In 1978 New Zealand signed the World Health Organisation's *Declaration of Alma-Ata* on primary health care, and agreed that health was a human right in its fullest sense. This declaration stated:

...health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal...

The World Health Organisation also deems that inequalities in health status, such as those experienced by Māori, are unacceptable (WHO, 1978). Acer (2002) maintains that no country has fully implemented human rights for women, and traditions and cultural practices are major barriers. Human rights for women are inalienable, indivisible and interrelated according to Acer (2002) in making a reference to the United Nations Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW).

With regard to health, the current New Zealand Health Strategy (King, 2000) provides the focus for health policy and service delivery that aims to reduce the disparities that

exist in health status. To this end, King (2002) identifies the need to address the health inequalities experienced by Māori as a 'major priority', and recognises the Treaty of Waitangi and the Government's role in meeting its obligations as a Treaty partner.

The Treaty of Waitangi ('the Treaty') is a relevant document for Māori and non-Māori, and is referred to in a variety of health-related legislation and social policies. The Treaty is an agreement between Māori and the 'Crown' that outlines an arrangement for the Queen of England's governorship, with the purpose to protect the rights and interests of Māori (see Appendix 1 – Māori Version). While Article One of the Treaty ceded kawanatanga (governorship) to the 'Crown', Article Two guaranteed Māori tino rangatiratanga (the right to self-determination) over their lands, villages and taonga (everything they hold as a treasure). Health is considered a taonga by most Māori, although 'Crown' representatives have debated the relevance of this point with regard to the Treaty. The right to health under Article Two is tenuous (Durie, 1998a). However, Article Three guarantees the protection of Māori, and the same citizen rights as British citizens under the governorship of the 'Crown'. It is Article Three that establishes the right for Māori to experience the same health status as other New Zealand citizens. The Māori version of the Treaty also contains a controversial 'Fourth Article' that relates to the protection of beliefs and customs of those who were living in New Zealand that does not exist in the English version of the Treaty. The Fourth Article was prompted by the Catholic Bishop Pompallier in order to protect the Roman Catholic Church's interests in New Zealand. While Article Four was not driven by Māori, the protection of the beliefs and customs of Māori remain implicit.

The Royal Commission on Social Policy (1988) identified three principles that underpin the Treaty of Waitangi to assist in the application of the Treaty – partnership, protection and participation. The Royal Commission on Social Policy (1998) warns that these principles should not be applied in isolation from the Treaty and other principles that have been identified. Certainly, the principles of partnership, protection and participation are congruent with Article Two of the Treaty and the rights of Māori to self-determination over their land, villages and taonga, while having the same citizen rights as all other citizens. Up until the 1980s it is questionable that the terms of the Treaty

had been honoured and consequently the interests and the rights of Māori were not protected as intended (Bramley et al., 2004; Durie, 2004; King, 2003; Reid, Robson & Jones, 2000; Walker, 1996). This is evident in the various assimilation and integration policies, supported by a variety of legislation, which resulted in the loss of cultural beliefs and practices, including te reo Māori. While the role and place of the Treaty in contemporary New Zealand society is a constant source of debate and controversy that ranges from its lack of relevance to its underpinning all legislation, the Crown and its agents (such as publicly funded health services and providers) have an obligation to meet its terms.

Health status is a complex concept influenced by multiple factors, yet under the terms of the Treaty of Waitangi the health interests of Māori have not been protected. Moves have been made, however, by the Crown to address this wrong. He Korowai Oranga - the Māori Health Strategy (King & Turia, 2002), is underpinned by the principles of the Treaty of Waitangi, and outlines the requirements by which District Health Boards function. At the consumer level, the engagement of Māori women in partnerships regarding their health concerns, and providing the opportunities to participate in decision making and planning, is variable to say the least. The same can be said about the protection of their beliefs and practices.

There can be no argument that Māori women have multiple rights under various Codes and Acts with regard to their health and wellbeing. The right to optimal health and wellbeing is a basic human right that extends beyond the Treaty of Waitangi and is also enshrined in New Zealand's Health and Disability Commissioner Act 1994 and the Health and Disability Services Consumers' Code of Rights 1996. The application of the Treaty of Waitangi and its principles provides a framework to improve the access and use of health services by Māori women. Certainly the active engagement of Māori women in their health experience, in terms of partnership, participation, and protection, must have beneficial effects on their health status.

## Disparities in Māori Women's Health

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The epidemiological evidence tells us that the health status of Māori is of major concern (Ajwani et al, 2003; Durie, 1998a; Reid et al., 2000; Ministry of Health, 2000; 2001a; 2002b). The statistics pertaining to Māori health generally paint a negative picture and tend to offer deficit explanations. The *Decades of Disparity* report (Ajwani et al., 2003), released during the writing of this thesis, shows that improvement in the status of Māori health over time has occurred. However, the gaps between the health status of Māori and non-Māori/non-Pacific are widening (Ajwani et al., 2003). The media response to the release of the *Decades of Disparities* report tended to lay the blame for Māori health status with Māori themselves (see for example, Editor, 2003; Laws, 2003). These responses were without any consideration of the socio-economic and structural influences on health status. In contrast, Blakely and Robson (2003) refute media and generalised explanations as 'knee-jerk' and 'simplistic' that ignores the evidence about socio-economic deprivation being a prime determinant of health status. It is known that Māori generally under-utilise primary health care services, and over-utilise secondary health services (Reid, et al., 2000). Similarly, as found during this research, Māori women delay access to health services due to factors such as resource constraints and putting others ahead of themselves<sup>1</sup>.

Rotorua (within the region where this research was undertaken) has been constructed as a fun and exciting place with its appealing façade, geographical wonderment and up-market accommodation. Said (2000, p.181) refers to how geographical spaces are invented and constructed - a type of 'imaginative geography'. However, the 'tourist' portrayal of Rotorua hides the 'real' Rotorua, which is a place with low socioeconomic status, high unemployment and crime rates, and the tourist dollar that does not appear to filter through to the general population. All of these factors contribute to socio-

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<sup>1</sup> The epidemiological evidence about the health status of Māori women is detailed in Chapter 2.

economic deprivation that impacts upon health status. This is the reality for many of those who live there (Public Health Consultancy, 2001). Despite the adversities that have been encountered, Māori possess strengths that have enabled their survival, yet the general approach to Māori health issues appears to focus on their deficits and negative aspects (Reid et al., 2000).

Little research exists that concentrates specifically on Māori women and their health experience beyond epidemiological research. In 1984 Murchie surveyed 1177 Māori women and described their health experiences and perceptions. Murchie's (1984) research focused on the needs of Māori women, and she recommended that more data about the health needs of Māori women be collected so they can be better understood. While this was a major piece of research it is now 20 years old. It contains valuable information but more recent information is required given the socio-economic changes that have occurred since then, and in response to the economic and health reforms of the 1990s.

The Ministry of Health requires District Health Boards to have greater community involvement in their planning and decision making activities. However, the determination of health priorities and the delivery of health services are not necessarily inclusive of the needs of various population groups living in New Zealand, as they are derived from government priorities and policies based on the burden of disease (King, 2000). While the rhetoric around consultation indicates that it is inclusive of various groups within communities, this is debatable. For example, evident in North Health's (the Northland Area Health Board) (1996) research with Māori women about health issues is a pre-determined list of health priorities. Such an approach could be considered a privileging of the dominant group's view of health over the Māori women's views of health. Of more use to North Health would be a list of health priorities for Māori women as described by Māori women.

North Health (1996) produced a discussion document with the dual aim of identifying the health priorities of Māori women in the North Health region, yet presented predetermined health priorities. The findings of this report, therefore, are not

necessarily the priorities of the Māori women within this region. This form of 'consultative research' appears to be tokenism, as the agendas of the organisation were being promulgated while the Māori women did not appear to have an unbiased opportunity to identify their own health priorities.

Norris et al. (1989, cited in Kilgour, 1990) evaluated women's health centres, and although Māori were participants, the specific health priorities and service needs of Māori women were not identified. Other researchers, such as Durie et al. (1997) and the Public Health Advisory Group (1997) have examined the health and wellbeing of Māori kaumatua and Māori whānau (respectively) and recommend that more research and better health information about Māori is required in consultation with Māori.

## **Competing Worldviews**

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The biomedical model is an influential force within 'mainstream' health services. It dominates the way health and illness is viewed that then influences the planning and delivery of health services. Yet, it has a mechanistic view of the body that lends itself to reductionism in an attempt to explain ill health. This perspective is predicated on Cartesian mind-body dualism, and objective scientific observation (Ryan, Carryer & Patterson, 2003; Wass, 1994; White, 1999). The dominant positioning of medicine within the health system gives rise to the belief that health professionals are wiser than the people they serve – a 'we know best' approach (Willis, 1994).

The biomedical model has a tendency to view people as passive participants in their health-illness experiences, a position that people are often socialised to reinforce (Ryan et al., 2003). White (1999) believes that medical knowledge has subordinated women's

experience. In New Zealand, the findings of the Commission of Inquiry into the Treatment of Cervical Cancer at National Women's Hospital and into Other Related Matters (Cartwright, 1988, see also Coney, 1988) illustrate how women's health was compromised by medical dominance, where medical consultants used their power to determine the fate of many women's lives and health without their knowledge or input. Ryan et al. (2003, p.21) point out that lay health beliefs are a "...complex blend of traditional, alternative and biomedical views of health, illness and disease". Indeed lay health beliefs can vary across time and groups. Alternative perspectives to those held by 'mainstream' health services can give rise to a disparity in worldviews when Māori women enter them.

The following are examples of the breakdowns in health experiences that can occur (observed in my practice). A Māori elderly woman returned to hospital acutely ill amidst a 'diagnosis' of non-compliance. She had a number of co-morbidities – diabetes, heart failure, asthma, and less than optimal kidney function – most in an uncontrolled state. During a doctor's round I observed the consultant and his registrar debating the conditions this woman presented with, each trying to speak louder than the other. They were standing on either side of the lower half of her bed, while she was lying in bed with the covers pulled up to her chin – her eyes were wide, and reflecting confusion. Her medical conditions were 'out of control', and the doctors and nurses involved in her case referred to her negatively and accused her of being 'non-compliant'. As the doctors moved onto the next patient, I laid my hand on her hand and asked if she understood what was going on. She shook her head. I returned later to talk to her and learned that she was taking her 'cocktail' of medications at 8.00 am every morning as she had been told to make sure she had them everyday. She did not understand that she needed to take her medications at different times throughout the day, and more importantly, why. When I discussed my findings with the nurses I was told emphatically that 'she had been told!' I then asked if they had checked that this woman had understood the information that they had given her. The nurses told me that because they had delivered the information prior to her discharge home (on previous admissions), she should have known and it was, therefore, her non-compliance that

was the issue. What was anecdotally evident, was a difference in approach to those patients who were obviously Māori and those who were not.

In another incident, I was faced with patient complaints about the large number of whānau members a Māori woman had with her. This woman was acutely admitted the evening before. Prior to her admission the staff was aware that a number of her whānau would be accompanying her. The staff decided to put her into a six bedded cubicle with five Pākehā women. Some of these women had been transferred from another hospital and were not happy about being there. One of the complaints received stated that '50 whānau members' were present (a physical impossibility) and that they were eating 'KFC' (Kentucky Fried Chicken). When I investigated the complaint, all the women were unhappy and antagonistic toward the Māori woman. The staff were also 'blaming' the woman and her whānau for the situation, without recognising that they could have decided to position her in another, less crowded unit.

Both of these incidents illustrate worldviews that are at variance. First, an elderly Māori woman who is faced with doctors that clearly did not see the need to involve her by providing information or engaging her in decision making, and the nursing staff who had judged her as non-compliant without determining her understanding of the situation and what the underlying issues were. The woman was too whakamā (ashamed and embarrassed) to let her needs be known. In the second instance, there was an apparent 'misuse' of the nurse's power, together with a lack of understanding about the role of whānau support and how to work with the patient and her whānau.

Evidence exists that the needs of Māori are not being met by health services (Reid, et al., 2000). Ajwani et al. (2003) highlight the inequalities that exist in hospital admission data, morbidity and mortality. This supports the differential access to health services outlined by Reid et al. (2000), where Māori under utilise primary health care services, over utilise secondary health services, and have less access to life saving tertiary interventions (Bramley et al., 2004; Tukituitanga & Bindman, 2002). The outcome is a lower life expectancy at birth when compared to other ethnic groups in New Zealand (Ministry of Health, 2002b). The worldviews of Māori women and health services

appear to be at variance, and is evident in communication breakdowns that ultimately affect the mana, health and wellbeing of Māori women. Competing worldviews create unease. For example, Māori women have an understanding of health that is wholistic and culturally, socially and individually determined. It is a view that contrasts with the biomedical model that prevails in 'mainstream' health services, and does not align well to a focus on ill health and reducing people to patients and diagnostic labels. The tensions that may exist with competing worldviews are further compounded by the complex integration of a variety of professional and personal worldviews that health care providers also bring to their work.

Māori people continue to call for culturally appropriate health services (Durie, 1998a; Hand, 1998; Reid et al., 2000), indicating their cultural and broader health needs are not being met. This research with Māori women about their health and interactions with health services will provide a perspective on Māori women's health that may assist in reducing the negative impacts of tensions through a lack of understanding about different worldviews.

## **Benefits of Addressing Māori Women's Health Needs**

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The current New Zealand health system is a predominantly publicly funded community oriented health and disability service (Ministry of Health, 2003). The Minister of Health has overall responsibility for the health sector through the Ministry of Health, with health and disability services being delivered through District Health Boards (which are Crown entities), and Private and Non-Government Organisation (NGO) providers. The government determines the provision of publicly funded health services based on the strategic direction for health and the priorities, goals and health outcomes are identified for funding. The current overarching strategy is the New Zealand Health Strategy (King,

2000). The New Zealand Health Strategy is the ‘umbrella’ strategy for a number of other strategies, such as He Korowai Oranga (the Māori Health Strategy), which aims at not only reducing the inequalities in health status that exist between Māori and non-Māori, but to achieve whānau ora – families health and wellbeing (King & Turia, 2002).

He Korowai Oranga (King & Turia, 2002), links to other strategies, such as the New Zealand Primary Healthcare Strategy (King, 2001) and Te Puāwaitanga Māori (Ministry of Health, 2002a). Whānau ora (family health and wellbeing) is the overall aim of He Korowai Oranga (King & Turia, 2002) and reflects the aspirations of Māori. While the Crown’s objective is to reduce the inequalities Māori experience in health status, this objective alone will not necessarily achieve the aspirations of Māori for whānau ora.

Improvements in the health and health experiences of Māori women is key to meeting the aim of whānau ora, particularly as women hold key roles within their whānau, and are the bearers of future generations. Improving the health status of Māori women within their whānau must be beneficial for not only Māori women, but also for health services, and New Zealand society. The costs associated with morbidity and mortality burden taxpayers through the health budget, and also communities, whānau, and individuals. At an individual level, optimal health enables a fully functioning person to effectively enjoy life and undertake meaningful and productive roles. This thesis provides an explanation about how Māori women view health and the nature of the interactions they have with health care providers, which can enhance the understanding health care providers have about Māori women and their health and wellbeing.

## **The Thesis Layout**

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I have divided this thesis, *Ngā Kairaranga Oranga – The Weavers of Health and Wellbeing*, into two parts. Part One outlines the background information for this

research; Part Two provides the grounded theory informed by a Māori centred approach generated as a result of this research, and the implications for health service development. The justification for this research is presented in Chapter 2 *Māori Women's Health and Wellbeing*. This chapter begins with an exploration of the historical and contemporary influences on the health status of Māori, and includes an analysis of the validity of the ethnicity data used to inform health service planning and decision making. The demographic profile of Māori women living in New Zealand and more specifically those living within the Lakes and Bay of Plenty regions is then described. Chapter 3 *Health Priorities and Policy Development* explores broader issues, such as the relationship of the Treaty of Waitangi to the health status of Māori women and the development of health priorities and policy development are also reviewed.

The need for an appropriate research methodology that is credible within both the worlds of Māori and academia is explored in Chapter 4 *Constructing an Appropriate Research Methodology*. This exploration reviews the experience of Māori with research, along with the legitimacy of mātauranga Māori as a way of knowing within the context of colonisation, capitalism and technological change. The emergence of 'Māori' methodologies, such as an indigenous science, kaupapa Māori research and Māori centred approaches are analysed, and provide a context for the use of grounded theory in Chapter 5 *A Māori Centred Approach to Grounded Theory*. This chapter describes how a Māori centred approach to research informed the use of Glaserian grounded theory. The research design for this research is discussed and illustrates the implementation of grounded theory informed by a Māori centred approach.

Part II provides a theory about Māori women's health and wellbeing. The underlying premises and parameters for the following data chapters are discussed in Chapter 6 *Ngā Kairaranga Oranga – The Weavers of Health and Wellbeing*. This introduction to Part II of the thesis maps out the data chapters that are presented as the core categories, explained in the following three chapters. A further chapter explains the basic social psychological process of weaving health and wellbeing.

Chapter 7 *Mana Wāhine* outlines the first core category pertaining to what is important for the health and wellbeing of Māori women – it describes their shared worldview that is at variance with ‘mainstream’ health service. The personal and health service barriers that influence the achievement of positive health outcomes are outlined in Chapter 8 *The Way It Is – Resigned Acceptance*, the second core category. The final core category that relates to the nature of the relationships and sense of trust that are vital to enable the access and use of health services by Māori women is explained in Chapter 9 *Engaging with Health Services*.

Chapter 10 *The Weaving of Health and Wellbeing* explains the process of weaving that brings together the dimensions identified with each of the core categories that are necessary for the health and wellbeing of Māori women. The nature and quality of the weaving is determined by how well the health and wellbeing needs of Māori women are met, the barriers that they encounter, and their requirements of health services and health care providers.

The final chapter, Chapter 11 *Implications for Health Service Development* discusses the significance of key aspects of *Ngā Kairaranga Oranga – The Weavers of Health and Wellbeing* for health service development, health care providers, and for curriculum development.

## **Conclusion**

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Despite health being individually defined, shared meanings of concepts such as health can be determined with the use of grounded theory research methodology informed by a Māori centred approach. The generation of knowledge about how the Māori women participating in this research understand health and their interactions with health care providers provides insight into their knowledge and experience. The theoretical

descriptions and explanations that result from this research provide the components of a theory about the health and wellbeing of Māori women that can be used to inform practice and to educate health care providers.

The evidence provides a picture of increasing disparities in the health status of Māori women when compared to their non-Māori counterparts. Health is a complex phenomenon influenced by socio-economic determinants that are beyond the immediate control of individuals and health care providers, although there are some areas that 'mainstream' health care providers can address. The provision of culturally appropriate and acceptable health services to meet the needs of Māori women is one example. This requires having information that can inform the practice of health care providers.

There is a need for research that will make a contribution to the body of health knowledge that benefits Māori women and their health. Māori women have the right to experience optimal health and wellbeing, yet generally the health status of Māori women is poor when compared to other groups of women. Information leading to improved understanding about Māori women's health and their health interactions has the potential to equip health care providers to better support Māori women. The next chapter reviews the health information and literature to justify the need for this research.

## PART I

### CHAPTER 2

## Māori Women's Health and Wellbeing

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Health status data indicate that Māori women experience higher rates of some illnesses and disease processes than their non-Māori counterparts, and that they are more likely to die younger (Ajwani et al., 2003). Poor health status has been a concern for Māori people and consecutive New Zealand governments, and is currently identified as a health priority (King, 2000). Improvements have occurred in Māori health status and in their life expectancy over the past two decades. However, the indications arising from the New Zealand Census-Mortality Study<sup>1</sup>, and the subsequent *Decades of Disparity* report (Ajwani et al., 2003), are that the gaps in 'survival chances' for Māori are increasing when compared to non-Māori non-Pacific ethnic groups:

The key finding is that mortality rates declined steadily over the observation period [1980 – 1999] for both genders and at all ages for the non-Māori non-Pacific ethnic group, whichever definition of ethnicity is used. By contrast, both Māori and Pacific ethnic groups showed little change (Ajwani et al., 2003, p.ix)

Significant disparities continue to exist between the health status indicators of both Māori and Pacific peoples and non-Māori non-Pacific peoples. Historically the articulations by various governments of their commitment to honour the Treaty of Waitangi and to address the disparities that exist for Māori health through health policy have been variable. The past involvement of Māori in the identification of health priorities and in the development of health services has been a 'politically

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<sup>1</sup> The New Zealand Census-Mortality Study compared the New Zealand Census data (where individuals self-report ethnicity) with the mortality data (where others may determine a person's ethnicity) and found that Māori and Pacific deaths were undercounted. The mortality data was then adjusted for the undercounting.

correct' rhetoric that has generally not been fully inclusive of Māori consumers of health services. The current Labour-led Government (1999 to the present) has made a commitment to meet its obligations under the Treaty of Waitangi and to improve involvement of Māori in the planning and delivery of services (King, 2000). For example, District Health Boards are required to include Māori participation in the planning of local and regional health services (Public Health Consultancy Group, 2001).

The identification of Māori women's health priorities and needs are of value in guiding effective policy development and service delivery, especially as Māori women are referred to as the kaitiaki of the health of the whānau and hapū - a role that may also extend to wider whānau, hapū, iwi or Māori communities. Thus, the delivery of appropriate, acceptable and effective health services is essential in order to achieve sustainable improvements in the health status of Māori women, and to maintain their health and wellbeing.

This chapter positions the need for the research undertaken for this thesis, particularly the understandings Māori women have of their health and wellbeing, and their interactions with 'mainstream' health services. Reference will be made to both Māori women living in New Zealand and more specifically to those living in the Bay of Plenty and Lakes region – the area that relates to this research. The health status of Māori women and the influences on health status will be examined. An outline of the demographic profile of Māori women living within New Zealand, and the Bay of Plenty and Lakes region, will follow this.

## **Historical Influences on Māori**

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The health of Māori has been affected, both directly and indirectly, by a number of historical circumstances. Orange (1987) claims estimates of the Māori population in 1840 ranged from 90,000 to 200,000. However, epidemics and infectious diseases, such as tuberculosis, respiratory diseases and typhoid fever, introduced with settler

contact drastically reduced the Māori population in 1896 to 42,000 (Hunn, 1961), along with war-related deaths (Ballara, 1998). The Māori population continued to decline until 1926, when it slowly rose from 4.5 percent to 6 percent of the total New Zealand population in 1960. Despite this increase, Hunn (1961, p.7) highlighted the seriousness of the health status of Māori:

Before this turn of the tide in Māori fortunes, they were in such a sorry plight that the most elementary public health measures of housing, sanitation and water supply could not fail to produce spectacular benefits.

Land lost through confiscation and many sales of a dubious nature severed vital spiritual connections Māori had with the land (Ballara, 1998). Despite the signing of the Treaty of Waitangi in 1840 that afforded Māori the right to tino rangatiratanga and protection, these rights were denied through various legislative and policy mechanisms (Durie, 1998b, Walker, 1990). The links Māori have to the land establishes the importance of Māori women within Māori society as te whare tangata (the house of humankind) (Mikaere, 1994). Indeed, evidence in stories indicates that some Māori women held equal status with men in early Māori society, prior to colonisation (Ballara, 1998).

Various social and economic influences that arose out of the processes of colonisation, capitalism, patriarchy, and intermarriage contributed to change in the social structure of Māori and their whānau. Māori struggled to retain their 'traditional' knowledge, language, and way of life as policies of integration and assimilation aimed to create a homogenous society (Durie, 1998b; Walker, 1990). These struggles included retaining their beliefs and practices related to health and wellbeing. Hunn (1961) claimed there was an absence of written policy regarding Māori, although he noted that when questions were asked, the 'official policy' was assimilation. A broad number of legal definitions of 'Māori' existed, and while Hunn (1961) recognised the need to reconcile these differences, he expressed a concern that the increasing eligibility of Māori to the 'privileges of special legislation' needed to be restricted. In the following years since Hunn wrote about restriction, the narrow legal definition for Māori achieved this. Many eligible to claim Māori identity through whakapapa were denied their Māori identity legally (Durie, 1998a; Walker, 2001).

Post war economic development resulted in great numbers of Māori moving to urban areas for employment. However, the availability of housing in urban areas was insufficient to keep up with the high numbers of Māori undertaking the urban migration (Hunn, 1961). This prompted concerns about the lack of preparation Māori received for urban migration including their welfare. An editorial in the New Zealand Herald on 23 May 1960 connected the broader socio-economic influences to health, stating: “Poor housing leads to poor health, poor family life, poor education and poor moral conduct” (cited in Hunn, 1961, p.61). Urbanisation resulted in Māori not only relocating, but also changing the structure and function of the whānau as members moved away from their tribal lands (Pearson, 1994; Spoonley, 1994).

The whānau reflects a way of living and organisation that extends beyond the physical location of its members, and represents the fabric of Māori society. It has, however, been subject to negative influences that have resulted in a loss of its nurturing role for some whānau (Durie, 1998a; 2001a). Anecdotally there is a tendency to ‘romanticise’ the whānau by some as having caring and curative roles without reference to the historical and contemporary socio-economic context within which it is situated. Such romanticism can lead to assumptions being made (Wilson & Roberts, 2005) and place unrealistic expectations on the capacity of the whānau to respond optimally (Durie, 2001).

The whakapapa that historically provided important bonds and links (and still does in contemporary society) were lost for many Māori. As Māori were (and still) function in a collective rather than individualistic manner, dislocation from hapū and iwi, together with changes in the whānau structure and functioning had detrimental effects on many Māori (Durie, 1998a; 2001). These effects, along with inter-marriage with Pākehā, have contributed to the diversity that exists within the Māori population of contemporary New Zealand society.

Māori have endured numerous changes post-European contact – disease and death, land loss, urbanisation, inter-marriage, acculturation, assimilation policies, and re-defining who they were as Māori by others, to name a few. Ballara (1998) maintains the ‘fatal impact’ theory regarding the negative effects of European contact on Māori is irrelevant, as Māori pragmatically and innovatively responded and adapted to the changes that resulted from European contact. Yet,

contemporary writers maintain colonisation has affected the health, spiritual and socio-economic wellbeing for Māori (Ajwani et al., 2003; Durie, 1998a; Robson & Reid, 2002). The continuing inequalities in health status would indicate that Māori have not adapted as well as Ballara (1998) claims. Howden-Chapman and Cram (1998, p.55) maintain:

While those whānau that retained their land and mana have been relatively advantaged, many more whānau were displaced and have struggled to regain both the economic resources and cultural support essential to promote their health. Undeniably, many Māori were and still are faced with the challenge of having to walk in two worlds – that is, te ao Māori and te ao Pākehā.

The process of colonisation resulted in the loss of Māori women's status within the whānau and Māori society, as 'traditional' cultural beliefs and practices were replaced with the Victorian beliefs and values of the missionaries and the settlers (Mikaere, 1994). The important roles Māori women played in traditional Māori societies are present in the waiata, haka, whakatauki, and mōteatea passed down through the generations (Mikaere, 1994). As a consequence of colonisation, women were viewed as belonging to men first, as their fathers then as their husbands (Figes, 1986), as evident in English law (Mikaere, 1994). The outcome was that Māori women were also relegated to that of possessions and chattels within the whānau, and consequently rendered as both passive and invisible members of society.

## **Contemporary Influences on Māori**

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While historical influences and colonisation processes have impacted upon the health and wellbeing of Māori, so too have contemporary life circumstances. The nature of the life circumstances for Māori whānau and its members affects their ability to take advantage of opportunities that may come their way. Socio-economic

deprivation impacts on the ability of Māori women to access and utilise the health services they may need. For example, education influences the ability to attract employment, which in turn dictates income level. Income together with employment influences social mobility and the opportunities for the next generation. Many Māori women are in either part-time or unpaid work (Statistics NZ, 2002e), thus seriously hindering their ability for upward socio-economic mobility.

Contemporary Māori experience social issues that appear to be generational in nature, such as unemployment, family violence, and mental health issues (Durie, 2001). They also experience institutional racism that is reflected in the under-utilisation of primary care services and over-utilisation of secondary health services (Reid et al., 2000). One of the manifestations of institutional racism, according to Jones (2000; 2001), is differential access to appropriate and quality resources and health services that is maintained by contemporary structures and processes. For example, Māori undergo less expensive procedures such as heart surgery than non-Māori (Bramley, et al., 2004; Tukituitanga & Bindman, 2002). Institutional racism also supports personally mediated racism (such as prejudice and discrimination) and internalised racism (which reflects systems of privilege and societal values) (Jones, 2000; 2001).

Whānau structures have changed (Durie, 2001) in response to societal and technological 'progress' evident in contemporary society. This has meant that some Māori may experience less support and minimal (if any) access to the extended family (Durie, 2001). Added to this are the demands upon Māori as they preserve and rebuild cultural beliefs and practices, and for some, being reacquainted with their Māori culture (Royal, 2002). Education and factors that influence the access and use of health services such as access to resources, fears, and negative experiences, impact on the development of health promoting knowledge and behaviours. Yet, all these impact on health and wellbeing (Ministry of Health, 2000). Resources to maintain health and a healthy lifestyle are scarce for many and influence the ability to access and use health services when required (Reid et al., 2000).

## **Impact of Ethnicity on Health Status**

Undeniably those of Māori ethnicity have a poorer health status than of non-Māori ethnicity including Pacific peoples<sup>2</sup> (Ajwani et al., 2003). Health status is evident in the 'gaps', disparities, or inequalities that exist in hospital admission data, and morbidity and mortality data (Ajwani et al., 2003; Reid et al., 2000). While the quality of the data enables the identification of trends it is influenced by its accuracy, consistency across data sets, completeness, and continuity over time (Robson & Reid, 2002). Measuring the exact extent of poor health status, especially for Māori, is affected by the quality of the data, especially with regard to the accuracy of ethnicity data and its apparent under-reporting (Ajwani et al., 2003).

Walker (2001) maintains that while ethnicity has social, biological and ancestral links, membership to an ethnic group is an individual decision – a decision that is not necessarily congruent with how others view an individual's group membership. Added to the complexity of ethnicity is its dynamic nature as a person's self-identified ethnicity may change in response to various experiences, and the perceived relevance of ethnicity at any point in time. When an 'outsider' names a person's ethnicity on the basis of group similarities, Walker (2001) contends that vital differences, such as geographic, cultural, linguistic and political backgrounds are obscured. Robson and Reid (2002) maintain Māori have a 'sovereign' right as indigenous people to individually and collectively name their identities. The contemporary notion of multiple ethnicity is also complex as it does not necessarily identify the preferred, complementary, or conflicting aspects of an individual's ethnicity (Walker, 2001).

Disparities in the health status data suggest that the interests of Māori have not been protected. Ethnic disparities are indicative that 'one-size-fits-all' health services are both inappropriate and ineffective for diverse ethnic groups (Blakely, Robson & Woodward, 2002). Accurate health-related data is important in monitoring societal progress toward equity (Blakely et al., 2002). However, the inaccuracies that exist in the ethnicity data within health records, along with the use of a variety of ethnicity

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<sup>2</sup> It is noted that Pacific ethnicity data also has similar flaws as Māori ethnicity data (Ajwani et al., 2003)

definitions and changes in the Census ethnicity questions are problematic and make measuring trends and health outcomes accurately difficult. Many interpretations of health, education and employment data have framed Māori as failures and 'deficient' (Robson & Reid, 2002). Such interpretations are compounded when comparisons are made with dominant Pākehā groups and cultural norms, continually portraying Māori in the deficit. The persistence of utilising data to identify deficits is counterproductive. Research with Māori women that moves beyond description to production of outcomes that will be beneficial to their health and wellbeing is thus required.

## **Ethnicity Data – How Accurate Is It?**

Prior to embarking further it is essential to discuss the limitations that exist regarding the available data for Māori. Examples of flaws in the health data that relate to Māori are the:

1. Manner in which ethnicity data is collected.
2. Number of changes that have occurred in how the Māori population ethnicity has been defined since the Treaty, and in the Census questionnaire since the 1980s (Table 2.1).
3. Identification of Māori ancestry versus Māori ethnicity.
4. Use of differing definitions for ethnicity (when data sets are compared over time).

Durie (1998a) maintains that the post-Treaty distinction between full-blooded Māori and half-caste Māori was erroneous as, among other things, it neglects those 'half-castes' living as Europeans. Defining ethnic categories on the basis of Euro-centric views of race does not align with the various ways that Māori define themselves. Robson and Reid (2002) argue that Crown influences on identity are a cause for debate, especially in relation to who has the authority to name and claim Māori identity.

A number of authors, such as Durie (1998a), the Ministry of Health (2001a), and Robson and Reid (2002), articulate the problematic manner in which ethnicity data has been collected, and in many cases not collected. Judgements about a person's ethnicity, based solely on their appearance, have been made in the past by those who collect ethnicity data, and if doubts existed ethnicity was recorded inaccurately as European/Pākehā/New Zealander (dependent on the title at the time) (Durie, 1998a). This practice is illustrated by Durie (1998a, p.125):

...hospital clerical staff completed most statistical forms and sometimes made up their own minds rather than asking patients or relatives. As a result they tended to under-report Māori.

Durie (1998a) and the Māori Health Group (1999) maintain making judgments about ethnicity based on a person's appearance is unacceptable and contributes to the inaccurate collection of health information and statistics. Te Puni Kokiri (1993) also contend that in general the existence of variations in policies for admission to hospitals, referral to consultants and the level of services available, further compound the questionable accuracy of the health information available.

Identification as Māori has moved the issue from a matter of 'race' to one of 'ethnicity'. Hunn's (1961) report highlighted the need to reconcile the variation in the definitions of Māori that ranged from those of full Māori descent to those that were more exclusive, defining a Māori as a half-caste. Durie (1998a) discusses how the definition of 'Māori' has changed over time in response to legislative changes that have resulted in increasing numbers for those who self-identify as Māori. The changing definitions of 'Māori' by Statistics New Zealand, results in shifting benchmarks (Table 2.1) that makes the comparison of ethnicity data between years difficult and problematic.

The changing definition for Māori ethnicity is further compounded by the use of differing definitions between various government departments and organisations. The definition of who could officially be considered Māori was changed in September 1995 to those who self-identified as Māori. Previously the official definition of Māori was narrowly defined, requiring more than 50 percent of Māori ancestry or 'blood'. Descendants with complex inter-ethnic whakapapa were

required to ‘add up the pieces’ of their Māori heritage, and were excluded from being officially identified as Māori if their Māori component did not reach the 50 percent threshold – a denial of their genetic make-up and/or upbringing (Durie, 1998a; Walker, 2001). This approach to ethnic identity resulted in many Māori being excluded from the data collected. The ethnicity question in the 1996 Census was broadened to include the self-identification of multiple ethnicity. The selection of multiple ethnicity has resulted in Māori ethnicity data currently categorised and described as either sole or ‘prioritised’ (that is, Māori ethnicity is routinely prioritised above any other ethnicity that may be identified) (Ajwani et al., 2003). Since 1986, there has been increasing numbers of people who are officially claiming Māori ancestry and Māori ethnicity.

**Table 2.1**

*Changing Definitions of Māori Ethnicity for Census Data Collection*

<b>Census Year</b>	<b>Definition of Māori Ethnicity Utilised</b>
<b>1981</b>	Biological definition with 50 percent or more Māori ‘blood’ – less than 50 percent Māori blood were considered European
<b>1986</b>	Self-identification used to determine ethnic identity – the term ‘race’ was no longer used
<b>1991</b>	New Zealand Māori became one option of nine ethnic group choices. A question relating to Māori ancestry was introduced, along with another question asking about main and up to three other tribal affiliations.
<b>1996</b>	Self-identification of: (a) Māori ancestry, and/or (b) Māori ethnicity, including iwi affiliation This Census enabled multiple ethnic affiliation, with the selection of up to 3 ethnic affiliations, including Māori.
<b>2001</b>	As 1996

Note source of data is from Durie (1998a) and Reid (1999a).

Defining Māori ethnicity as 'sole' or 'prioritised' also makes it difficult to compare data over any period of time, especially in assessing the progress in the reduction of inequalities in health status. The 'prioritised' group automatically prioritises Māori ethnicity, however, there is no indication that those identifying as Māori prioritise their Māori ethnicity over any other ethnicity identified. In the analysis of data using 'sole' and 'prioritised' criteria, there appears to be greater disparities in the health status associated with 'sole' identity compared to 'prioritised' identity (Ajwani et al., 2003). Added to the ethnicity milieu is the identification of Māori ancestry versus ethnic identification with Māori and/or an iwi group. The 2001 Census data, for example, identified that 18 percent of New Zealand residents were of Māori ancestry, yet 14.3 percent identified as being of Māori ethnicity (Statistics NZ, 2002a). Thus, 3.7 percent of those with Māori ancestry are likely to be unaccounted in the health ethnicity data.

The manner in which the Census is counted with regard to Māori is the subject of criticism and political agendas. The Dominion (Editor, 2002, 30 March) reported the concern that the counting of Māori as 'prioritised', when multiple ethnicities have been identified, doubled the entitlement of Māori for services such as health and social welfare. The problem with this discourse is that it neglects the health issues that may have an ethnicity or genetic connection.

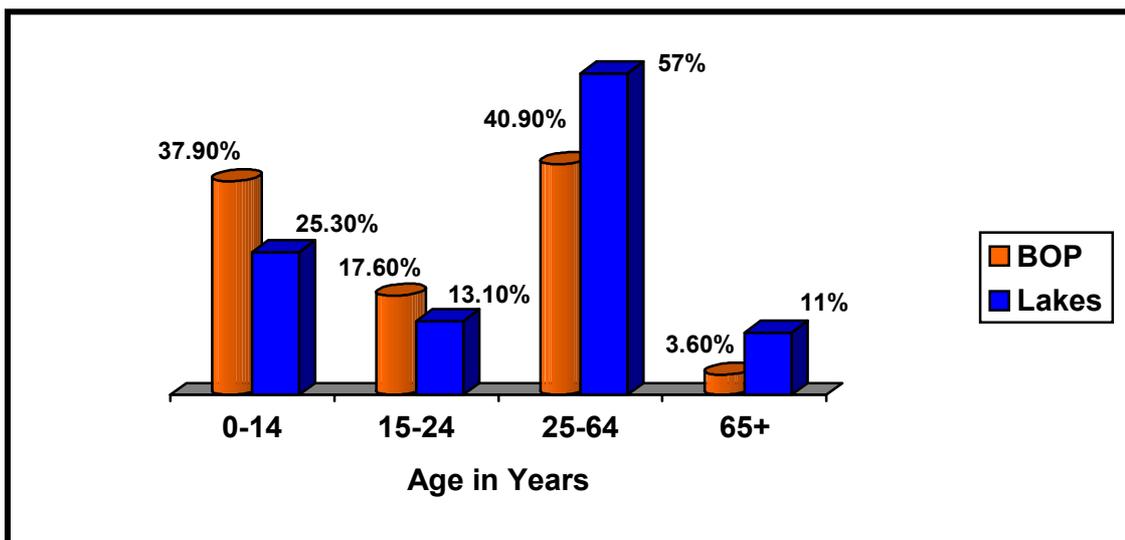
It can be concluded that the Māori ethnicity data available within New Zealand are neither valid nor reliable. Inaccuracies, are related to changing ethnicity definitions, inaccurate collection of ethnicity data, and a gap between those who claim Māori ancestry but not ethnic affiliation. These are limitations that support the fact that Māori statistical data are under-reported. In relation to this, Durie (1998a) highlights concerns that exist regarding the collection and collation of information, which form the basis for conclusions about health status. The problematic nature of Māori ethnicity data must be kept in mind when interpreting the data or acting upon demographic and health status conclusions.

## **The Health Status of Māori Women**

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The health status of Māori women is of concern both nationally and locally to the Lakes region (Public Health Consultancy, 2001). The 1990-1994 morbidity data for Māori women within the Lakes region identified high rates of lung cancer, diabetes mellitus, ischaemic heart disease, breast cancer, cerebral vascular disease, and a higher than the national average teenage pregnancy rate (Health & Disability Analysis Unit, 1996; Health & Disability Analysis Unit, 1997; Māori Health Group, 1999; Public Health Consultancy, 2001). The number of newly diagnosed patients within the Lakes region with gonorrhoea is twice the national average, and while ethnicity data was not available, it could also be assumed that it is a health issue for Māori due to the percentage of Māori that live within the region (Māori Health Group, 1999).

In addition to the conditions already mentioned, Māori women also experience high mortality rates as a result of asthma, chronic obstructive pulmonary disease and associated conditions, pneumonia and influenza. The death rate of Māori within the Lakes region is 1400 per 100,000 population with higher age-standard hospital discharge rates (Health & Disability Analysis Unit, 1997). High morbidity amongst Māori inevitably leads to higher premature mortality rates for those between 25-65 years old. This greater risk of premature death is noteworthy as the age structure of Māori women living in the Lakes region in the 1996 Census data identified a higher proportion of Māori women were between the age of 25 to 64 years (Figure 2.1). Mortality and morbidity statistics and hospital admission data constitute the major source of information determining health status and service planning. Yet, Te Puni Kōkiri (1993) maintain that hospital admission rates are under-reported by up to 30 percent and that most Māori people spend very little time in hospital (if at all) - a factor neither described nor quantified.



**Figure 2.1.** Age Structure of Māori Women within the Bay of Plenty and the Lakes Region. Note source of data is from 1996 Census Data.

The health status of Māori pertains to more than disease processes based on epidemiological evidence as indicated in the Ministry of Health’s (2001a) priorities of Māori health. It is the complex outcome of a number of historical and contemporary influences that have ultimately impacted on Māori health and wellbeing. Inequalities exist despite Māori being afforded protection under the Treaty of Waitangi. In order to understand about Māori women’s health it is necessary to explore the historical and contemporary influences on the health status of Māori.

## Demographic Profile

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Health status is about more than illness and disease processes. It is also influenced by socio-economic and political determinants. Demographic data that includes socio-economic determinants provides an overarching picture of Māori women within New Zealand. Since embarking on this study, the 2001 Census has taken place. Every effort has been made to utilise the current Census data, however, it is noted that it has not undergone the depth of analysis that has been undertaken on

the 1996 Census data, particularly as it relates to Māori women and their health. Therefore, a mixture of data has been used in places to better illustrate the discussion points. For example, the Ministry of Māori Development's (1999) document (based primarily on the 1996 Census data) presents a comprehensive picture of Māori women within New Zealand. As it represents the most comprehensive data about Māori women in New Zealand, information from the 1996 Census, and the data specific to the region where the study was undertaken, is presented in conjunction with the available 2001 Census data.

Māori women comprise over 14 percent of all New Zealand women<sup>3</sup> and 7 percent of the total New Zealand population<sup>4</sup> (Ministry of Māori Development, 1999). The Ministry of Māori Development (1999) predicts that the population of Māori women will rise, and that within the next 50 years Māori women will make up 21 percent of the population of New Zealand women and 11 percent of the total population. Māori women currently outnumber Māori men – that is, for every 100 Māori women there are 95.7 Māori men (Statistics NZ, 2002a). At birth Māori women also have a higher life expectancy than Māori men by 3.7 years, but it is less than New Zealand women in general by 8.1 years (Ministry of Health, 2002b).

Ninety nine percent of Māori are born within New Zealand (Statistics NZ, 2002b). Ninety percent of those identifying Māori ethnicity live in the North Island according to the 2001 Census (Statistics NZ, 2002a), and 60 percent of those live in the upper North Island. Regionally Māori make up 28 percent of Northland; 11 percent of Auckland; 20 percent of Waikato; and 28 percent of Bay of Plenty populations (Statistics NZ, 2002a). Geographically, 58 percent of Māori women are situated in the northern half of the North Island, with 25 percent of all Māori women living in the Waikato and the Bay of Plenty regions, and another 25 percent living in the Auckland region (Ministry of Māori Development, 1999). Despite most Māori living within the urban areas, 65 percent of Māori women are more likely to live in provincial cities and towns, smaller urban centres and rural areas, outside the five largest urban centres.

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<sup>3</sup> 'New Zealand female' refers to females over the age of 15-years resident in New Zealand.

<sup>4</sup> 'New Zealand population' refers to those resident in New Zealand who are broadly categorised as European, Māori, Pacific Peoples, Asians and 'Other' ethnic groups. Under these broad ethnic categories, individuals identify more specifically their ethnic identity.

Māori are described by Statistics NZ (2002c) as a 'youthful' population. Thirty-seven percent of Māori are under the age of 15 years (considerably higher than the national average of 23 percent) (Statistics NZ, 2002d). However, only 3.3 percent of Māori are 65 years or older (Statistics NZ, 2002a), compared to the national average of 12 percent (Ministry of Health, 2002b). Despite the 'youthful' nature of the Māori population, the median age increased during the period of 1991 to 2001 by 2 years from 20 years to 21.9 years. This is considerably younger than those identifying as European, where the median is 36.8 years. The population of those over the age of 65 years has also increased over the last decade from 1:40 in 1991 to 1:30 in 2001 (Statistics NZ, 2001a).

## **Whānau Composition**

The family and household composition of Māori has changed over the past 40 years, along with a decline in the fertility rate of Māori women in the last 30 years. Māori women generally have their children in their mid-teens and early twenties. The 2003 demographic data shows the median age of Māori mothers is 26.2 years, four years younger than the median age for the total population (Statistics NZ, 2003a). The fertility rate of Māori women, however, remains higher than non-Māori with childbearing rates of those between 15-19 years four times higher (Statistics NZ, 2003a). These factors account for the predicted increase in the Māori population, along with the increases in those identifying as Māori. The Ministry of Māori Development (1999) claims that Māori women experience higher numbers of unplanned pregnancies and higher abortion rates, which they suggest is a reflection of unequal access to, and use of contraception. The 2003 abortion rate for Māori women was 245 per 1000 known pregnancies, and for under 20-year old Māori women, this rate increases to 331 per 1000 known pregnancies (Statistics NZ, 2003a)

The 2001 Census (Statistics NZ, 2002a) identified 21 percent of Māori women are sole parents, considerably higher than the 10 percent national average for all women. The Te Hoe Nuku Roa study (Stevenson et al., 2001) surveyed a cohort of 'contemporary' Māori about their geographic, economic, cultural and social circumstances. This study also confirms that Māori women were over-represented as sole persons, sole parents, childless couples, or shared households. While 21

percent of Māori women are in one-parent families, 60 percent of Māori children are raised in two-parent families according to the Ministry of Māori Development (1999). Undoubtedly, Māori women play a substantial role in caring for children, with 50 percent of Māori women caring for a child (not necessarily their own child) in their own household within the 4-week period prior to the 2001 Census.

The structure of the family unit in New Zealand as a whole has undergone a transformation from the extended family structure to a variety of diverse compositions. The 2001 Census (Statistics NZ, 2001c) identified three main family types:

1. Couples with children, comprising 42 percent;
2. Couple-only families, comprising 39 percent; and
3. One-parent with children, comprising 19 percent.

Sixty percent of families have children.

Thirty five percent of Māori families are one parent with children, which is considerably higher than the average for the total population. However, the family types identified above are narrow and do not necessarily reflect how Māori may define whānau. Whānau is a broader concept (King & Turia, 2002) than the main family types identified in the 2001 Census and may include grandparents, aunts, uncles and cousins in its day-to-day functioning. Māori children have greater ethnic diversity than Māori adults do, with 24 percent of Māori children identifying as Māori in the 2001 Census (Statistics NZ, 2002d) and 59 percent of Māori babies belonging to one or more ethnic groups (Statistics NZ, 2003 a). Despite the diversity that exists in contemporary New Zealand society and families, extended family households are still common. In fact, Māori women tend to live in households of two or more generations (Ministry of Māori Development, 1999).

## Education

The early childbearing pattern of Māori women impacts on the ability to undertake both post-compulsory education and training opportunities and paid employment. A lack of access to early childcare services and the level of success they experienced at secondary school compound this. Consequently, more Māori women enter post-compulsory education and training after 34 years of age (Ministry of Māori Development, 1999). Education, training, and employment are all factors that impact on the economic positioning of Māori families and will be discussed in more detail later in this section.

Kohanga Reo<sup>5</sup> is the largest provider of early childhood education for Māori children. According to the Ministry of Māori Development (1999), Māori girls are reported to do better than Māori boys during the middle primary school years, however at the secondary school level this difference narrows.

Greater numbers of Māori are staying beyond the compulsory school leaving age of 16 years, and are leaving with qualifications that enable an increasing number to attend tertiary education. Young Māori women however, are more likely than young Māori men to stay at school past the compulsory school leaving age of 15 years (Statistics NZ, 2003b). In 1996, 40.6 percent of young Māori women leaving school accessed some form of post-compulsory education and training. On entering the realm of tertiary education, however, only 9 percent of young Māori women leaving school enrolled at university, with Training Opportunities Programmes (commonly known as TOPs) or Polytechnics the preferred venue of tertiary education.

The National Māori Language Survey (1995, cited in Ministry of Māori Development, 1999) is also of note. The 1995 survey identified that 59 percent of Māori adults were able to speak Te Reo Māori. However, only 8 percent were considered highly fluent speakers. These tended to be men despite 55 percent of the speakers being Māori women. The 2001 Census (Statistics NZ, 2002a), however, revealed that only 25 percent of Māori speak Te Reo Māori, with nearly half being under the age of 25 years.

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<sup>5</sup> Kohanga Reo – Preschool ‘language nests’ that utilise te reo Māori and tikanga

## **Income and Employment**

The opportunities for employment, and the type of employment, affect the income that can be earned by Māori women. Māori women are less likely to be employed full-time than their non-Māori women counterparts (Statistics NZ, 2002e). The majority of Māori women are in either part-time employment, unemployed or not in the workforce at all. Women were twice as likely as men to be in unpaid work (Statistics NZ, 2002b), with Māori women featuring highly in unpaid work or activities (Ministry of Māori Development, 1999). Fifty-five percent of Māori women were engaged in unpaid activities, such as household work, caring for others, volunteer work and attending study or school (Statistics NZ, 2002b).

The entry of Māori women into the workforce is dependent upon a number of factors, such as qualifications, geographical location and availability of jobs, possessing the perceived 'desirable' attributes, childbearing patterns and the family commitments they may have. These factors often present multiple barriers to gaining employment, and there can be no doubt that low-paid part-time employment and unpaid work impacts upon the socio-economic status of Māori women.

In 1996, the personal median annual income for Māori women was only \$11,200 (Ministry of Māori Development, 1999), but the 2001 Census (Statistics NZ, 2002a) indicated that the median annual income had increased to \$13,200. The median annual income for Māori women, however, is \$5,400 less than that for Māori men and \$5,300 less than the median annual income for all New Zealand residents (Statistics NZ, 2002a). This further supports the contention presented earlier that Māori women are more likely to be unemployed, in part-time employment or engaged in unpaid activities, and reliant on alternative sources of income for their economic survival. While the median annual income for Māori women is increasing, the gap between Māori women and Māori men, and women who are of European ethnicity continues to widen (see Table 2.2) (Statistics NZ, 2002b).

**Table 2.2**

*Gap in Median Annual Income of Māori Women compared to European Women and Māori Men*

	Census Year		
	1991	1996	2001
Māori women	\$10000	\$11200	\$13200
European Women	\$11500	\$13000	\$15100
<b>GAP</b>	<b>\$1500</b>	<b>\$1800</b>	<b>\$1900</b>
Māori Men	\$13000	\$16100	\$18600
<b>GAP</b>	<b>\$3000</b>	<b>\$4900</b>	<b>\$5400</b>

Note source of data is from the 2001 Census data (Statistics NZ, 2002b).

Many Māori women (54.5 percent) derive their personal income from government-funded income support, such as the unemployment and the domestic purposes benefits (Statistics NZ, 2002b). The Ministry of Māori Development (1999) report that within the 12 month period preceding the 1996 Census 1 in 2 Māori women derived their personal income from government income support – a trend that continues with the 2001 Census. This is higher than 3 in 8 Māori adults who received a government benefit during the preceding 12 months of the 2001 Census (Statistics NZ, 2002a). For many Māori women the reality is that income support may be their only source of income. In addition to this, 5.9 percent of Māori women receive New Zealand Superannuation, a factor probably influenced by only 3.3 percent of Māori living beyond 65-years (Statistics NZ, 2002a). Of the women between 15 to 85 years (and over), 7.3 percent have no source of income. This is a particular issue for those Māori women aged between 15-19 years, as they account for 4.2 percent who have no source of income, compared with 0.4 percent of Māori women over the age of 65 years receiving no income.

## **Deprivation Index**

The link between life expectancy and the effects of socio-economic and ethnic inequalities is one measure of health status (Crampton & Davis, 1998; Ministry of Health, 2001b). A correlation between poor health status (measured by life expectancy, mortality, and hospitalisation rates) and deprivation also exists. Such

an approach recognises the complex connection of health status to a combination of factors that include:

1. Individually related influences.
2. Social and community environments.
3. Living and working conditions.
4. Gender and culture.
5. General socioeconomic and environmental influences (Ministry of Health, 2002b).

The NZDep96 is a deprivation index that measures socioeconomic inequalities. Deprivation is measured using the Census data for small geographical areas (defined by Statistics New Zealand) called 'meshblocks' that contain a median of 90 people. The deprivation index measures deprivation using a combination of measures (see Table 2.3) on a scale of 1 to 10, with 1 being the least deprived and 10 being the most deprived (Ministry of Health, 2001b).

**Table 2.3**

*Measurements of Deprivation used in NZDep96*

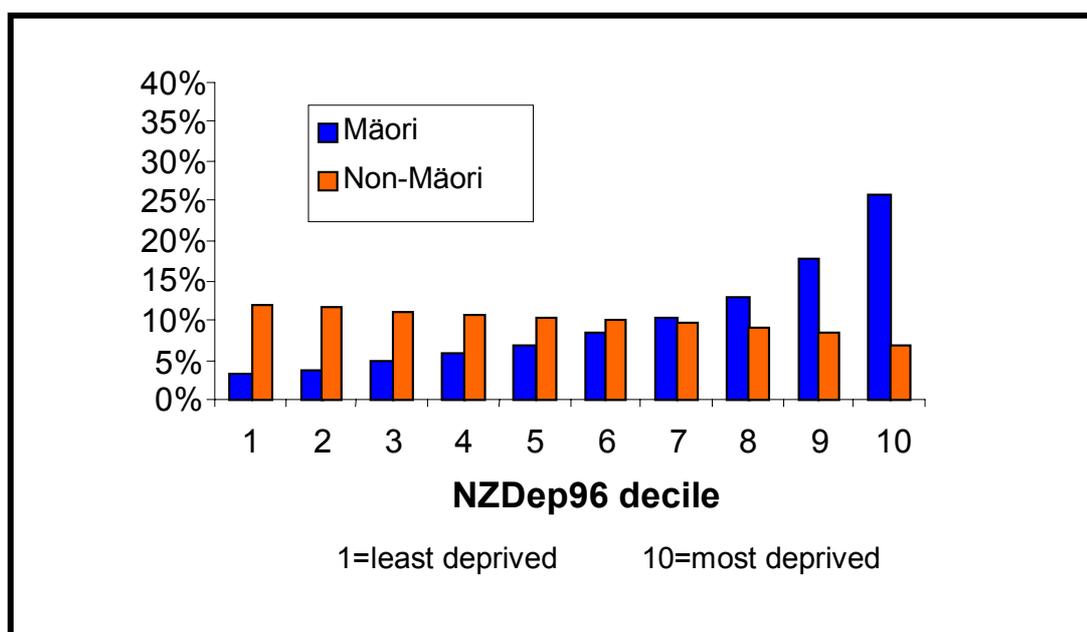
Deprivation Measure	Variable
	(calculated on people living within each small area or meshblock)
Communication	No access to a telephone
Income	Aged 18-59 years receiving a means-tested benefit
Employment	Aged 18-59 years unemployed
Income	Living in households with equivalised income below an income threshold
Transport	No access to a car
Support	Aged <60 years living in a single parent family
Qualifications	Aged 18-59 years without any qualifications
Owned home	Not living in own home
Living space	Living in households below equivalised bedroom occupancy threshold

Note table adapted from Crampton, Salmond, & Kirkpatrick (2000).

Māori are located within the deciles that reflect the most deprivation - generally within deciles 7-10 (Figure 2.2). The level of deprivation experienced by Māori is linked to health status as it affects their ability to access and utilise health services due to the limited resources available to them. The Lakes Region presents a picture of greater deprivation than the national picture, with 60 percent of the Lake's Māori population located in deciles 9-10 (Public Health Consultancy, 2001). It can be concluded from this information that Māori living within the Lakes Region are more likely to reside in the areas of most deprivation.

### **Māori Women Living in the Lakes Region**

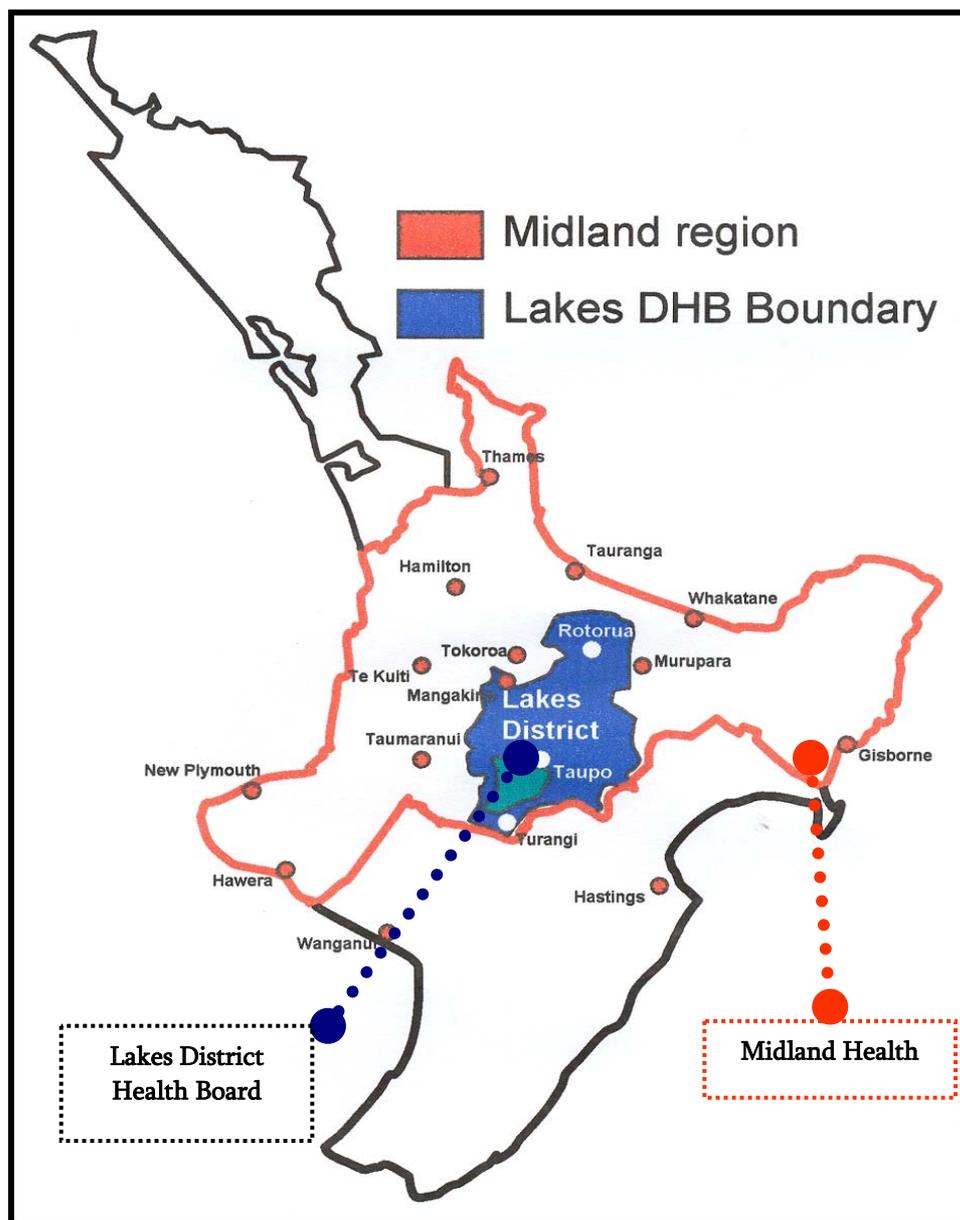
Women identifying as Māori, and who resided within the Te Arawa rohe were invited to participate in this study. The Te Arawa rohe extends from Maketu on the East Coast of the Bay of Plenty to Tongariro, and from Ruatāhuna across to the Mamaku. Health-related data for the people within this region can be found with reference to the Lakes area, the wider Bay of Plenty or Midland Health (Health & Disability Analysis Unit, 1996; Health & Disability Analysis Unit, 1997; Māori Health Group, 1999; Ministry of Māori Development, 1999; Public Health Consultancy, 2001).



**Figure 2.2.** NZ Dep 96 distribution for Māori and non-Māori. Note source of data is from Ministry of Health (2001a)



was also part of the wider Midland Health region that included Waikato, Bay of Plenty, Tairāwhiti, and Taranaki Health and Hospital Services (see Figure 2.4).

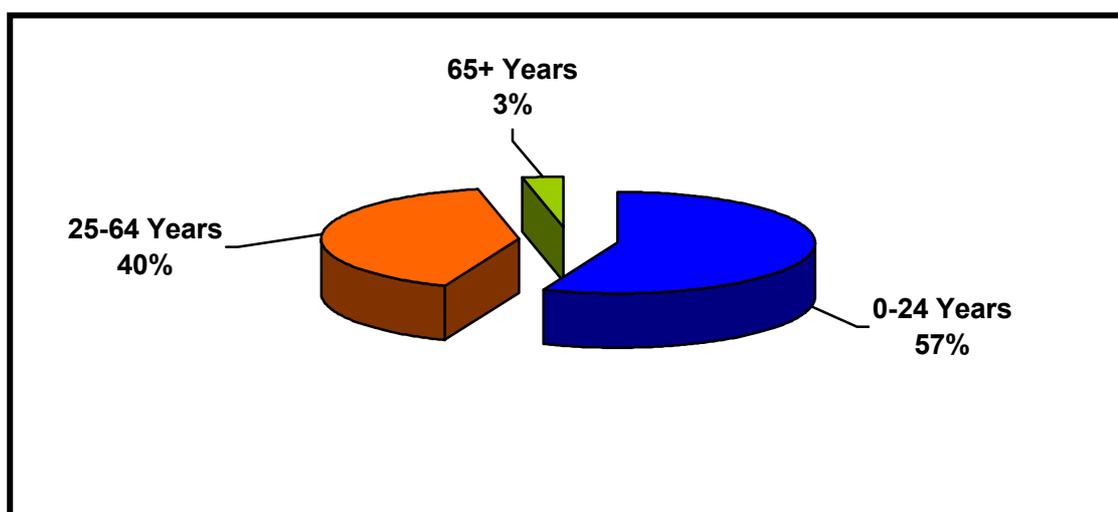


**Figure 2.4.** Regions relevant to this study – Lakes District Health Board (DHB); and Midland Health. Note reproduced from (Cooney & Smith, 2003) with permission from C. Cooney, CEO Lakes DHB.

Māori comprise 21 percent of the Midland Health population (Health & Disability Analysis Unit, 1997) and make up 35 percent (35,240) of the total population (100,040) within the Bay of Plenty region, which includes the Western Bay of Plenty, the Lakes region and Eastern Bay of Plenty. This is more than twice the proportion

of the population of Māori in New Zealand as a whole. The majority of the Māori population within the Bay of Plenty region (96 percent) (Māori Health Group, 1999), and in the Lakes region (96.3 percent) (Public Health Consultancy, 2001) are under 65 years of age. Figure 2.5 shows the Māori ethnicity age structure in the Rotorua and Taupo districts, which is representative of the Lakes regions.

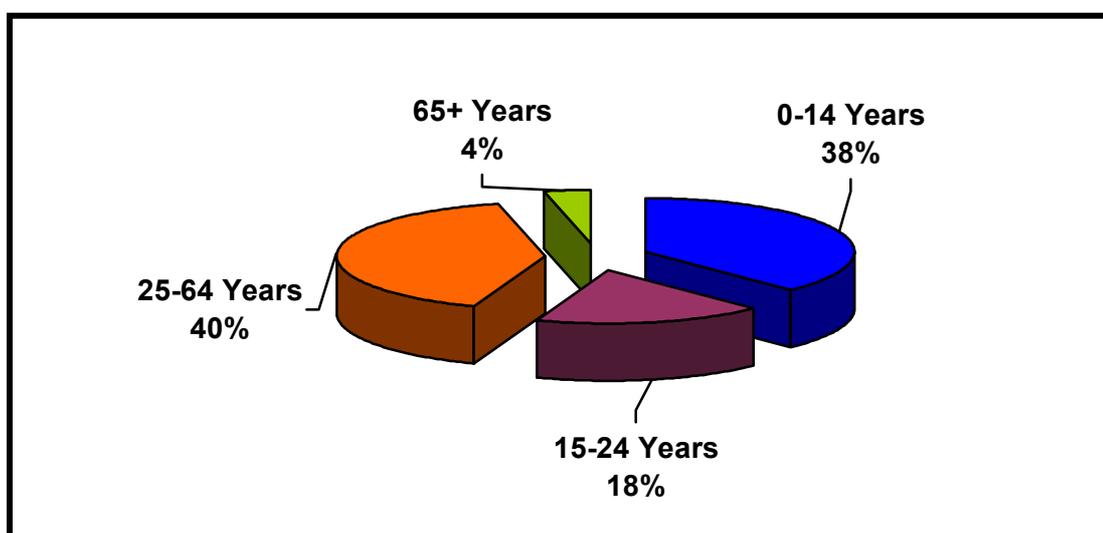
The birth rate for Māori women within the Bay of Plenty is 2.31 births per women and is higher when compared to the national average of 1.96 births per women. The life expectancy for Māori women within the Bay of Plenty region is 72.1 years compared to 72.9 years for Māori women nationally, which is approximately 11 years less than the life expectancy for non-Māori women (83.6 years) living in the Bay of Plenty (Māori Health Group, 1999). Māori experience higher premature mortality both within the Midland Health region and nationally (Health & Disability Analysis Unit, 1997). Thus, Māori women living in the Bay of Plenty are more likely to die before the age of 65 years when the mortality by age data is examined (Figure 2.6).



**Figure 2.5.** Māori ethnicity age structure within the Lakes DHB region. Note the source of the data is from the Public Health Consultancy Group (2001).

Within the Lakes region, Māori women (17,910) currently make up 35.5 percent of the total population of women (50,420). Of the total population living in the Lakes region, Māori women comprise 18 percent and Māori men 17 percent (Public Health

Consultancy, 2001). In terms of morbidity within the Lakes region, Māori have a shortened life expectancy, higher premature mortality rate and are more likely to experience serious health problems (Aroturuki me te Arotakenga, 1997; Durie, 1998a; National Health Committee, 1998; Public Health Consultancy, 2001). The low proportion of Māori over the age of 65 years is indicative of poor health outcomes and health status. Essentially Māori experience the illnesses that are normally associated with the elderly, such as diabetes, cancer, and cardiovascular disease at an earlier age. Their reality is a high likelihood of death as a result of these often age-related diseases before reaching 65 years of age.



**Figure 2.6.** Mortality by age for Māori women within the Bay of Plenty. Note the source of the data is from the Health & Disability Analysis unit (1997).

## Conclusion

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There is no doubt that Māori women are likely to experience socio-economic disadvantage, and therefore are at risk of experiencing serious health problems and premature death. The Te Arawa rohe (where this study has been undertaken) has a

high Māori population who experience poor health status along with socio-economic disadvantage. These factors influence their ability to access and use health services fully.

The geographical location of Māori women, their economic and employment status, and general experience of deprivation, all impact upon their ability to access and utilise education and employment opportunities and services such as health and welfare. The work on the NZDep96 undertaken by Robson and Reid (2002) illustrates how health status is linked to factors such as economic, education and employment status. The importance of understanding the link between the health status of Māori women and their access and use of health services is highlighted by the Ministry of Māori Development (1999, p.1) who concludes that:

The challenge of mainstream agencies is to recognise that the needs, experiences and interests of Māori women are different...

## CHAPTER 3

# Health Priorities and Policy Development

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The persistent identification of Māori health as a priority highlights various approaches used to address Māori health issues. Cunningham and Durie (1999, p.240) reinforce this, stating:

It was telling, if not an unexpected, commentary on progress to realize that Māori health was still a priority a decade later in 1994, and still was in the late 1990s.

Māori are high users of health services primarily for serious illnesses (Durie, 1998b; Reid, 1999; Triggs, Johnstone, O'Connor & Wong, 1995). However, Māori utilisation of primary services is low (Triggs et al., 1995). The National Health Committee (NHC) (1998) claims that differences in mortality and morbidity can be attributed to the utilisation and effectiveness of health services, although they did not explore this claim further. The locus of poor health status is complex and situated within a context of social, economic, cultural and historical issues, along with lifestyle practices that are known to contribute to serious health problems (such as high smoking and alcohol consumption, and poor diet and exercise). It is against this demographic background that the question about what is happening with Māori women and the determination of their health priorities and services is raised.

Health policy in relation to Māori health is politically and economically driven and thus, is characterised by inconsistency and fragmentation. Dow (1999) describes health policy as 'ad hoc' and 'piecemeal' resulting in no single policy or set of standards in his analysis of Māori health and policy between 1840 to 1940. Major restructuring of the New Zealand health system has been underpinned by the political ideology at the time, and resulted in the rationalisation and redefinition of health services. Health service delivery within New Zealand is undeniably constrained by its relatively small size, an aging population, and a limited gross

national product. This reality will continue to influence the allocation of resources necessary to correct inequitable health status for Māori unless equity issues are positively addressed. While health policy and its implementation are crucial factors in the status of Māori health, it is not the purpose of this chapter to conduct an in-depth analysis of these. Instead a brief exploration of health policy over the last decade will be undertaken, commencing with a view of health as a business. The development of policy for health and health service delivery, and the need for greater involvement of Māori women will be argued. A review of the available research regarding Māori women and their interactions with 'mainstream' health services will be reviewed.

## **A Business Model of Health**

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The pivotal role of health policy is to set and determine the direction of health services and their delivery, and to influence the access and use of health services. New Zealand health services today are influenced by the neo-liberal health policy introduced in the 1990s by a right-wing National government that resulted in major health reforms. The prescriptive and normative approach of neo-liberal health policy, however, did not account for the complex and unpredictable nature of health. Viewing health as a 'business' created difficulties for those working within the health system and those using it, as resource allocation could not be controlled and service delivery became compartmentalised (Tenbensen & Gauld, 2001).

Still evident in the current health environment are the remnants of those major health reforms. A feature of these reforms was the introduction of the purchaser-provider split. The National government established hospitals as Crown Health Enterprises, and later as Hospital and Health Services with a Health Funding Authority as the contractor of health services. Essentially the provision of health and disability services became contestable, and was purchased by Regional Health Authorities according to a schedule of services. Under this approach, health services were rationalised, with some services ceasing to be publicly funded and others having strict criteria applied to them.

Primary health care has a key role in improving the health status of Māori through early detection, health promotion and the prevention of ill health. Despite a developing primary health system during the mid-1980s to early 1990s the health reforms of the 1990s focused predominantly on the purchase of secondary and tertiary services. The Health Funding Authority (HFA) (1998a), however, did release a discussion document that outlined a national strategy that aimed to improve the quality of primary health services. A key feature of this document was the move to enrolment of populations. The need for Māori to have confidence in primary health services was articulated, along with the need for services to operate with the principles of the Treaty of Waitangi. While the intent of the HFA was to review the role of general practice, it essentially reflected the status quo, with a continued focus on 'general practitioners'. The HFA (1998a) did not clearly address the issues for Māori related to transient populations and those people who did not have a consistent general practitioner/practice. Despite the HFAs (1998a) reference to the principles of the Treaty of Waitangi, the performance measurements proposed made no reference to Māori, although it was stated that health services would be required to demonstrate quality and cultural appropriateness.

The development of health policy in the late 1990s acknowledged the 'special relationship' between Māori and the Crown and articulated a commitment to improving the health outcomes for Māori so they could achieve the same health status as other New Zealanders (Creech, 1999). It was planned to achieve this through responsive services and greater involvement of Māori in their delivery. The purchase-provider model enabled Māori groups to successfully contest for health services contracts, and groups were contracted to deliver 'by Māori for Māori' health services. Despite anecdotal evidence that indicates the efficacy of many Māori health services, Cunningham and Durie (1999) argue that Māori control over health service delivery does not necessarily guarantee improved health status. They claim that the politically driven agendas and motives of these groups to achieve autonomy, self-determination, and resource allocation differ from the agendas of the consumers.

The reality of health services, at least in the eyes of consumers, is more pedestrian: relief from pain and suffering, care and prevention of further illness (Cunningham & Durie, 1999, 248).

The National Government's 1999 medium-term goals (Creech, 1999) targeted the reduction of long-standing disparities in health status through greater Māori participation, improved responsiveness by mainstream services and health professionals, and recognised the role of appropriate services, and cultural and social factors. Māori providers are measured on their integration with other community and iwi programmes, pivotal in the wholistic and intersectorial manner that Māori generally view health. But such a view contrasts with, and is frustrated by, the 'silo' way in which government departments essentially operate, with little, if any, integration between the sectors (Cunningham & Durie, 1999). He Taura Tieke (Ministry of Health, 1995) is a tool that aimed to measure both mainstream and Māori provider effectiveness of technical and clinical competence, structural and systemic responsiveness and consumer satisfaction in the delivery of services to Māori.

Cunningham and Durie (1999) refer to Māori health policy as 'pseudo' policy that constitutes guidelines rather than formal policy. Undoubtedly anomalies are evident. For example, *Whāia te Ora mō te Iwi* (Department of Health, 1993) documents the need for Māori participation in the purchase and delivery of services, but excludes any reference to Māori inclusion in the determination of those services. Also, the *Roadside to Bedside* policy that Creech (1999) maintained would improve 'reasonable' access to services resulted in the obstruction of access by Māori to emergency departments for health services considered to be 'non-urgent'. Yet, historically they had accessed these services in some areas.

The National Government's 1999 objectives and expectations of Hospital and Health Services regarding services delivered to Māori have been outlined by Creech and English (1999). These expectations were in accordance with section 11 of the Health and Disability Act 1999 that required the provision of a range of health and disability services to improve health outcomes, and to enhance the health status of the people that the Hospital and Health Service served. Paradoxically, however, Hospital and Health Services were also expected to function in a 'business-like' and fiscally efficient manner, covering all costs including capital costs. Māori, like others,

were dependent upon the Health Funding Authority purchasing decisions that determined their access to health services. While the Health Funding Authority and the Hospital and Health Services were ‘encouraged’ to seek appropriate Māori advice at Board and management levels to ensure ‘customer satisfaction’, the principles that underpinned the prioritisation of services were contradictory (see Table 3.1). For example, for Māori, the principles of health equity and need were potentially polarised by the principle of cost-effectiveness.

**Table 3.1**

*Health Funding Authority’s Criteria for Prioritisation and Decision Making*

<b>Prioritisation is based upon the service:</b>
<ul style="list-style-type: none"> <li>• Effectiveness</li> <li>• Cost-effectiveness</li> <li>• Demonstration of equity</li> <li>• Acceptability of the service to the consumer group</li> <li>• Achievement of health gain for Māori</li> </ul>
<b>Decision-making is based upon:</b>
<ul style="list-style-type: none"> <li>• Explicit processes</li> <li>• Consistent set of values used to guide decisions</li> <li>• Evidence</li> </ul>

Note the source of the data is from the Health Funding Authority (1998c).

The 1990s health reforms met with public outcry about a declining public health system. Ashton’s (1999) analysis of performance indicators supported the public perception that the health reforms did not achieve their objectives. The ‘business’ approach to health service delivery did bring about improved accountability, better health information, and a decrease in *per capita* spending from Vote: Health (Ashton, 1999). However, the reference to the Treaty and the improvement of Māori health status tended to lack substance and appeared to have a rhetorical quality about it. The intention to improve access to health care services in reality impacted negatively as Māori were under-utilising primary health care services, but presenting

to secondary health services with greater acuity and complexity. Reid's (1999, p.62) statement illustrates the lack of effectiveness of health policy for Māori, specifically with regard to the improvement of health status:

...Māori development remains a central theme, even in the face of ongoing marginalisation.

The end of the 1990s saw a change in government from National to Labour and with it another change in the direction of health policy that moved away from a 'business' model of health to a community and population-health focus

## **A Strategy for Health**

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When it was elected in 1999, the Labour-led Government instituted another major restructuring of the health system enacted under the New Zealand Public Health and Disability Act 2000. This change aimed to increase local community and Māori participation in the planning and delivery of health services. Health policy changed from a neo-liberal approach to a participatory one. A participatory approach to health policy aims to have more direct input from the public and is based upon democratic principles. However, Tenbensen and Gauld (2001) maintain that such an approach is more subject to public opinion and electoral politics. The response by the Labour Government to the recent criticisms by Dr Brash<sup>1</sup> (leader of the opposition National Party) of its policy that claim Māori receive special treatment, supports Tenbensen and Gauld's (2001) assertion that a participatory approach is sensitive to public opinion and electoral politics.

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<sup>1</sup> Don Brash criticised Labour Government's stance on the Treaty of Waitangi and policies that he maintains 'advantage' Māori. The policy released by Brash unleashed underlying negative responses by the public toward Māori resulting in a decline in support for the Labour Government.

The Labour-led Government articulated a clear intention to ‘close the gaps’ evident in the health status of Māori compared to non-Māori. The Minister of Health, the Hon. Annette King (King, 2000, p.iii) stated an intention to have:

A health system that makes a real contribution to reducing inequalities between the health status of Māori and Pacific peoples, and other New Zealanders.

The rationale provided for yet another change in the philosophy and the structure of the New Zealand health system included:

1. Structural reasons, such as the commercial focus of health being a barrier to a robust health system, loss of trust in the health system, and the need for a government driven inter-sectorial approach to the health needs of people.
2. Health status issues, such as the reality that some New Zealanders live in less than acceptable social circumstances; the reduction in the health status of New Zealanders internationally, particularly Māori (that have the poorest health status of any group in New Zealand); and the need to reduce the disparities that exist in the health of various groups.
3. Planning and delivery approaches that need to include greater involvement of community and consumers, along with a population health focus.

This change in direction has led to the development of a comprehensive and strategic approach to improving the health of New Zealanders, including a specific focus on Māori that reflects the Labour Government’s intention to honour its obligations as a Treaty partner (King, 2000). The current New Zealand Health Strategy (King, 2000) outlines the government’s priority areas along with clearly defined principles, goals, and objectives. It also articulates the ‘special relationship’ between Māori and the Crown, and the need to ensure accessible and appropriate services for Māori. The health strategy includes the development and implementation of specified ‘sub-strategies’ including the Primary Health Care Strategy (King, 2000) and *He Korowai Oranga* - the Māori health strategy (King & Turia, 2002).

## Health Priorities and Māori

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Priorities for health and health services originate from the various policies that reflect the Government's (at the time) direction. The Health Funding Authority's (1998b) policy statement on Māori Health formed the basis for the prioritisation of health and disability support services prior to the move to District Health Boards (Health Funding Authority, 1998c). While providers of health services were required to be more accountable for the services purchased by the Health Funding Authority during this era, it is less apparent that the needs and aspirations of Māori were seriously taken into account during the prioritisation process. This is despite Aroturuki me te Arotakenga's (1997) findings (discussed later in this section) and the Health Funding Authority's (1998c) criteria for prioritisation outlined in Table 3.1. During this era, effectiveness in the delivery of health services resulted in health services being both reduced and redefined amidst public outcry. When the priorities and needs of Māori were considered, the Health Funding Authority (1998c) based the purchasing of services on evidence-based clinical guidelines. When clinical guidelines (based on the western biomedical model and evidence based medicine) form the sole basis for purchasing decisions of health services, it could be questioned if such a stance invalidates the principles for the prioritisation of health services as noted in Table 3.1, particularly around equity, health gain, and acceptability. A definitive answer to this question at the commencement of this study was difficult to ascertain.

Ministry of Health officials provide the government with advice about the formulation of health policies based on ascertaining 'evidence' (such as, statistical data and research that is usually quantitative), along with advice from Ministry appointed reference groups whose advice may or may not be used<sup>2</sup>. However, the 'evidence' used often does not yield information regarding health-related consumer perceptions, experience, reactions, and processes they use. As already mentioned, the current overarching policy that outlines the health priorities for New Zealand is the New Zealand Health Strategy (King, 2000). Most of the data on which decisions are made to determine these health priorities appears to be determined by the statistical analysis of morbidity, mortality and hospital admission data (Ministry of

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<sup>2</sup> My personal experience on various sector reference groups has been that the Ministry of Health does not always act on the 'expert' advice it is provided with.

Health, 2001a). Thus, biomedical diagnoses, risky lifestyle practices and membership of 'at risk' population groups form the basis of the health priorities.

A review of the Ministry of Health by Aroturuki me te Arotakenga (1997) found its response to Māori health needs was inadequate, including fulfilling its role to improve health outcomes for Māori. Aroturuki me te Arotakenga (1997) claims the focus on morbidity and mortality data neglects the influence of other factors on health status. This review highlighted the Ministry of Health's inadequacy to effectively identify and implement health policy to effect a positive change in Māori health status. Durie (1998a, p.139) went further to say that health policy "...fails to answer the question about Māori aspirations and perspectives". Sustainable policy, according to Henare (1999) must be based upon the 'authentic' values and needs of Māori as the recipients of government developed policy.

Given the inaccuracy in the collection of health data (discussed earlier) that pertains to Māori, and the lack of Māori perspectives in the formation of health priorities, it is debatable that some policies are totally relevant to the needs of Māori. Durie (1998a) maintains that the way in which data is collected for analysis contributes to the formation of 'sickness profiles', and does not account for differing views of health. This is a problematic stance, as it also does not allow for the diversity that exists amongst Māori, and for Māori with a wholistic worldview (Aroturuki me te Arotakenga, 1997; Cunningham & Kiro, 2001; Durie, 1998a; Henare, 1999). Tau Henare, Minister of Māori Affairs during 1998/99 (Māori Health Commission, 1998, p.5) sums up the issues for Māori, claiming that "...government initiatives are often the ambulance-at-the-bottom-of-the-cliff type policies".

Health policy is shaped by dominant ideologies and political agendas (Cunningham & Kiro, 2001). Yet, the imposition of a dominant biomedical view of health does not necessarily allow for the incorporation of what Māori consider important in the achievement of improved health outcomes and health status. Cunningham and Kiro (2001) point out that health is a 'subset' of hauora (a Māori concept of health and wellbeing) that also includes tikanga and te reo Māori. Indeed, the distribution of resources by Government departments appears to assume that Māori have secure identities and traditional iwi links despite urban Māori challenging such a view. In its defence, the current Labour-led Government has undertaken an extensive

consultation process in the development of *He Korowai Oranga*. This strategy representing the Crown partnership with Māori as a Treaty partner, has resulted in Māori aspirations for whānau ora being the overall aim, and has incorporated the Crown's goal to reduce inequalities in Māori health.

## **Endeavours to Reduce Inequalities**

The 'ambulance at the bottom of the cliff' approach to health service delivery in New Zealand (that consumes the majority of the health budget) has not reduced the morbidity and mortality rates that are associated with lifestyle and that can be considered essentially avoidable - especially for Māori. Primary health care is an important component of the New Zealand Health Strategy. The National Health Committee (2000), in its advice to the government, stresses the importance of 'investing' in primary health care to prevent the increasing morbidity and early mortality of various population groups. Disease focused outcomes are a barrier to the development of innovative solutions that improve the overall health and wellbeing of people (National Health Committee, 2000). However, almost no reference to Māori is evident in the National Health Committee's (2000) report.

Primary health care generally has a well-health approach. It moves beyond dwelling on poor health status and the treatment of ill health, and away from 'deficit' and 'negative' notions that have tended to inform health service planning and delivery for Māori. The Primary Health Care Strategy (King, 2001) is a long-term strategy that links to the principles, goals and objectives of the New Zealand Health Strategy. This strategy supports Māori to have greater control over their own health and to build upon the strengths that they already possess. It stresses the use of population health approaches and reinforces the requirement of District Health Boards to involve local people in the planning and delivery of services that best meet the needs of their community. However, Barnett and Barnett (2004) question that the change in health policy to increase access and use of primary health services by those in need will be realised due to problems with funding and a tension that exists between the old and new models for the delivery of primary health care.

A feature of this strategy is its emphasis on interdisciplinary approaches in the delivery of health services. However, to date this has not been a smooth path, as

the various health professional groups appear challenged and seemingly threatened. In some cases this has led to 'patch protection' in the development of services in the primary health sector that aim to contribute to the achievement of the New Zealand Health Strategy (King, 2000) goals and objectives, but differ from those currently offered. The introspective and self-preserving behaviours by various health professional groups neglects their obligation to deliver services that meet health needs and achieve health gain. Such behaviour does little to promote Māori development and advancement that Cunningham and Kiro (2001) maintain is an integral part of Māori health policy.

The development of *He Korowai Oranga - Māori Health Strategy* (King & Turia, 2002) was informed by Māori and by contributions from the public, various health groups and other interested parties. *He Korowai Oranga* links to the New Zealand Health Strategy, the Primary Health Care Strategy and to *Te Puāwaitanga* (the Māori mental health framework) (Ministry of Health, 2002a). It is considered a 'living' strategy that reflects the aspirations of Māori for whānau ora, and the Crown's commitment to the Treaty of Waitangi (as previously mentioned) as a Treaty partner to work with Māori to improve Māori health and reduce the inequalities that exist. This strategy clearly articulates the responsibility that those in the public health sector have to whānau health status, and in promoting policies that both 'enable' and address systemic barriers. Certainly, the strategy's kaupapa affirms Māori approaches, such as wholistic models of health and wellbeing, and builds upon the strengths and resources of whānau to improve health outcomes. The partner document to *He Korowai Oranga* (King & Turia, 2002) is the action plan, *Whakatātaka* (Ministry of Health, 2002b), which sets out the government's expectations of the responsibility publicly funded health and disability providers have to improve whānau ora, and to progress *He Korowai Oranga*. A feature of *Whakatātaka* is the recognition that traditional Māori health practices, such as rongoā, mirimiri and karakia, are an integral part of the health services Māori access.

*Te Puāwaitanga* (Ministry of Health, 2002a), the strategic framework for Māori mental health has a kaupapa based upon concepts of te ao Māori. It recognises that the mental illness profile for Māori differs from non-Māori – that is, Māori

present late, with higher acuity, with over a third of Māori presenting via law enforcement and welfare services.

The health strategies mentioned above are being implemented at the time of writing this thesis, and it is therefore, too early to evaluate their efficacy in improving the health outcomes for Māori. They do, however, appear to make a concerted effort to address Māori health issues in a more substantive manner than the rhetoric of previous health policy. The pathway to date, however, has met with obstacles. For example, the Government's stance on 'closing the gaps' and a greater emphasis on its Treaty obligations met with intense opposition from all opposition political parties and various sectors of the public, who believe that Māori were not entitled to the resources necessary to achieve policy goals. This has resulted in a dilution of the Treaty obligations originally intended by the Labour-led Government in the New Zealand Public Health and Disability legislation, and a softening in the language describing health status, from gaps to inequalities. Such moves minimise the reality of the 'gap' in health status that Māori experience, and confuse the need for equity with equality.

## **Māori Women and Health Priorities**

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Finding published research in relation to Māori women's health was not easy. None of the literature reviewed addressed the identification of health priorities and health service needs *by* Māori women, as health care consumers. The only empirical research related to Māori women, cited by Curry (1995) in a bibliography on women's health research, is Murchie's (1984) study into the health of Māori women.

*Rapuora* (Murchie, 1984) was a significant piece of research that described Māori women's health experiences and perceptions. 1177 women were surveyed in either English or te reo Māori using a whānau-based methodology, and guided by tikanga Māori. Murchie (1984, p.81) explains that the purpose of *Rapuora* was to "...prepare a blueprint for the improved health of *Te Wāhine Māori, Te Whānau me*

*Te Iwi.*” The value of this research is its focus on the health needs of Māori women, something that had not been previously undertaken. Murchie (1984) recommends the collection of additional information using Māori women to collect the data to effectively address the health needs of Māori women.

A report entitled *Oranga Kaumatua*, outlines research undertaken by Durie et al. (1997) that explores the health and well being of kaumatua for the purpose of assisting planners and policy makers in the development of policies. This study explored issues affecting kaumatua (defined for this study as Māori men and women aged 60 years and over), although it was recognised that the majority of Māori are less than 60 years of age. Higher standards of health were found amongst kaumatua who participated in marae and cultural activities, owned their own homes, and had higher incomes. Barriers for kaumatua using ‘mainstream’ health services included perceived inappropriate services and the absence of a ‘friendly’ approach. While 397 kaumatua were interviewed, the study’s findings are limited by the inclusion of those kaumatua with traditional profiles, while those who were ill, in hospital, or in residential care were excluded. Durie et al. (1997) recommends more information and consultation with Māori is required for the development and purchase of services. Some of the findings were represented in gender groups, however, the study did not look specifically at Māori women.

Norris et al. (1989, cited in Kilgour, 1990) evaluated women’s health centres in New Zealand using a multi-method approach to the data collection. Three health centres were included in the research. This study found that well women’s centres that focused on preventative health were accessible for Māori women, particularly when Māori women were involved in the co-ordination of the centres. The Māori women working in these centres undertook a diverse range of work when compared to the Pākehā coordinators, with a lot of their work being undertaken within the community. Again, this research does not address Māori women’s health priorities or health service needs specifically.

In 1996 the North Health Regional Health Authority produced a document with a dual aim: to inform Māori women about the role of North Health, and to seek feedback about health services for Māori women (North Health, 1996). While Māori women were questioned about the health priorities presented by North Health, it

was evident that there was a clear focus on the services to be purchased by North Health. The discussion was supported by statistical information that compared the morbidity and mortality data of Māori women and non-Māori women. Thus, the consultation strategy about the Māori women's health priorities and service needs was based on priorities previously determined by North Health, rather than Māori women themselves.

The Public Health Group (1997) advising the Director-General of Health examined the wellbeing of Māori whānau that culminated in yet another discussion document. The Public Health Group questioned the use of health services by Māori. They claim that the disparities evident in Māori receiving medical and surgical interventions were unexplained. The Public Health Group (1997, p. 85) state that while health risks were known, "...there is not enough information on whether Māori access appropriate health services to reduce those risks". This group clearly outlines the need for better health information, and for further research to be undertaken.

## **Conclusion**

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Health policy that relates to Māori reflects the political and economic ideology and agendas of the government at that time. Prior to the 1990s policy regarding Māori health has been inconsistent and fragmented. Since the 1990s the New Zealand health system has undergone major reforms, beginning with a business model of health. During this era the National-led government viewed health as a 'business', resulting in the purchase of health services by a funding arm for delivery by service providers. This change brought about the opportunity for Māori to contest for funding to deliver Māori-focused services. While this approach to the planning and delivery of health services brought about a rationalisation of services, in some areas it hindered the access to health services by Māori. This was despite the National-led government's rhetoric about having greater participation by Māori in the planning of services and to be more responsive to their health needs. The 1999 Labour-led

Government instituted further changes that were underpinned by greater community involvement in the planning and delivery of services, and a focus on improving personal and population health. The New Zealand Health Strategy (2000) identified reducing the inequalities in the health status experienced by Māori as one of its goals. Subsequently, He Korowai Oranga (King & Turia, (2002) and Te Whakatātaka (Ministry of Health, 2002b) were developed based on the joint aspirations of Māori and the Crown to achieve an overall aim of whānau ora. This recent health policy, while aiming to improve Māori health is responsive to political and public opinion.

Given the health status of many Māori women and the role of kaitiaki they hold in the maintenance of whānau health, the identification of Māori women's health needs is of importance in the development and delivery of health services. The delivery of appropriate and acceptable health services is essential to achieve a sustainable improvement in health status for Māori. Limited research undertaken with Māori women is available and reflects the need for further research. Given this, this study addressed this lack of research and will focus on the Māori women's perception of health, and the interactions they have with 'mainstream' health services and health care providers.

Any research with Māori needs to be undertaken within a framework that is not only acceptable, but that also protects the integrity of the worldviews of Māori participants during the planning, data collection, and data analysis stages. Thus, the development of an appropriate methodology for this study, along with appropriate data collection and methods of analysis needed to be established. The following chapter outlines the rationale for a Māori-centred methodology to guide the implementation of this research.

## **CHAPTER 4**

### **Constructing an Appropriate Methodology**

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The identification of an appropriate methodology to inform the research design and meet the needs of the research question posed was an important part in the preparation for this research. It was also important to select a methodology that would result in a process that (a) respects the cultural values, beliefs and practices of Māori women; (b) acknowledges that the worldviews of Māori women may differ from the worldviews that inform ‘mainstream’ research methodologies, and thus influence the way in which the data is analysed; and (c) acknowledges the historical and contemporary influences on, and experiences of, Māori with research, and the potential impact that this research may have. Within the context of these issues I felt that it was important to select an appropriate methodology that would both protect the interests of Māori women and also meet the needs of the research aims and questions.

This chapter provides the background and rationale for a Māori centred approach to inform grounded theory, explained in the following chapter. To begin, the historical and contemporary experiences of Māori and research are discussed, contextualising the need for an approach that is beneficial to Māori women. The legitimacy of mātauranga Māori as a knowledge base within the context of contemporary ‘mainstream’ research will be explored, and the effects of colonisation, capitalism and technology are considered. This is followed by a brief critique of the applicability of other methodologies for this research, such as feminism. The chapter culminates with an analysis of the emergence of ‘Māori’ methodologies that provide the foundation for the development of grounded theory informed by a Māori centred approach.

## Research and Māori

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In the past Māori have experienced negative research experiences and outcomes, which has resulted in mistrust and cynicism by many Māori toward research (Sporle, 2003). The unethical, insensitive and inappropriate behaviours of some researchers, according to Sporle (2003) has 'poisoned' the ground. Inappropriate research processes and their consequent outcomes contribute to the social marginalisation of Māori by perpetuating the social pathology and functional inadequacies of Māori, and offering 'cultural' deprivation as an explanation for any 'gap' between Māori and non-Māori statistics (Bishop, 1994). The reinforcement of negative stereotypes and deficit explanations has overlooked the strengths and positive aspects that many Māori individuals and groups possess. Those past research experiences have been anything but beneficial or positive. The emergence of Māori methodologies, such as kaupapa Māori and Māori centred approaches, redresses the legacy of 'mainstream' research methodologies that have threaten the cultural and social integrity of Māori. Although multiple research methodologies have their place (Durie, 1998b), it is important that the cultural foundations of Māori are an integral and valued part of the entire research process no matter what research methodology is selected.

Achieving relevance for everyone is a point of tension when mass data is being collected from a number of diverse sources. While some research outcomes have resulted in gains for Māori (for example, increased health funding), historically Māori and their knowledge have been both devalued and demeaned within the dominant research culture. An example of this would be the tendency to use dominant cultural indicators to measure Māori, with little or no recognition that their cultural beliefs and practices may alter the outcomes. Māori have also been 'over-researched' and generally received little in return according to Durie (1996). However, Broughton and Lawrence (1993) refutes this claim as there is insufficient information and research about Māori in order to successfully plan strategies to effect changes in health status. Māori have rightly questioned the benefits of being involved in research activities. In fact Glover (1997) maintains that research has not only perpetuated myths about Māori, but also has problematised and pathologised

Māori. Dissatisfaction by Māori with dominant research methodologies, inappropriate researcher behaviour, a lack of control throughout the research processes, and the manner in which findings are interpreted, have all contributed to the resurgence of mātauranga Māori and the emergence of methodologies, such as kaupapa Māori (Glover, 1997). Durie (1996), Smith (1996) and Walker (1997) all stress the value of Māori engaging in research activities. These developments attempt to address issues Māori have with research, and aim to ensure that research processes are relevant, appropriate, and acceptable.

It could be argued that the historical experiences of Māori with research are not entirely methodologically driven and amount to the dubious ethical practices and/or a lack of cultural insight of those undertaking the research (Bishop, 1996; Bishop & Glynn, 1992; Glover, 1997; 1999; Walker, 1979). The undertaking of research that benefits the researcher with little or no involvement of Māori in its planning, is a recipe for disharmony. This is compounded when detached objectivity is demanded by some research methodologies, which require impartiality with Māori people and communities. Such approaches can be at variance with the cultural processes and practices that Māori feel comfortable with. The interpretation of research findings through a dominant cultural lens involves not only methodological issues, but also processes that threaten the cultural integrity and mana of those Māori involved, and at times Māori, in general (Bishop, 1996; Bishop & Glynn, 1992; Glover, 1997; Irwin, 1994; Smith, 1999).

Walker's (1998) critique of science, and Bishop's (1994) critique of methodologies thought to be 'Māori-friendly' (for example, critical theory) both raise questions regarding the control, initiation, design, participation, researcher(s), findings and benefits of research. Irwin (1994), Smith (1996) and Te Momo (2003) maintain any research with Māori should be informed and underpinned by Māori tikanga and kawa, and be culturally appropriate and acceptable to both the research participants and the wider Māori community. These views aim to reposition Māori knowledge and processes as credible within the research community and set up an ideal for the planning and implementation of research endeavours. Such an ideal places demands on Māori to be involved with a limited number of researchers who possess the necessary research knowledge and skills. It also overlooks Māori who do

successfully use 'mainstream' methods to research about Māori and Māori phenomena.

The involvement of Māori within the research process endeavours to meet the needs and aspirations of Māori, and preserves the integrity of their beliefs and practices. This cannot be guaranteed, however, as there is limited research knowledge and skills amongst some Māori communities. Key Māori are often already burdened with multiple demands on their knowledge and expertise of 'things' Māori, which can create tensions for both Māori and those undertaking research with Māori. The need to contest for resources within the dominant research culture also creates a barrier. However, the identification of these barriers by Māori and the Health Research Council (HRC) (1998) have contributed to the formation of collaborative alliances, and changes in policy and funding to enable Māori to develop research expertise.

Having an appropriate methodology to guide this research was vital to produce outcomes that would benefit Māori women. Central to an appropriate methodology is respecting and valuing the cultural integrity of Māori women. In recognition of the mistrust that many Māori may have of 'academics' and research, the development of a methodology that varies from 'mainstream' research approaches, and that maintains rigour and trustworthiness, was important for building the necessary trust with the Māori women participating.

## **The Legitimacy of Mātauranga Māori**

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The knowledge embedded within Māori culture is inextricably woven with 'being' in the world. The predominately ontological basis of mātauranga Māori is deeply situated within a wholistic and humanitarian paradigm that is transmitted from generation to generation via whakapapa (Bishop, 1994), and is evident in the interrelationships of whanaungatanga (Pere, 1991). A well-known whakatauki emphasises the importance of this humanistic approach to the world:

*He aha te mea nui, o te ao?*

*Maki e ki atu*

*He tangata, he tangata, he tangata.*

What is the most important things in the world?

It is people, it is people, it is people

The approach Māori have regarding knowledge and its transmission starkly contrasts the differences between mātauranga Māori and some dominant 'western' research approaches. Because oral traditions, as legitimate ways of knowing, are difficult to consistently quantify and observe, they invariably come under scrutiny. Some of the scientific approaches to knowledge development, such as the positivist paradigm, do not appear to grapple with 'other' ways of knowing well and as such relegate them to the position of 'other' (Smith, 1999). As this research focuses on Māori women, this section explores mātauranga Māori and the effects colonisation, capitalism, and technology has had on its legitimacy and on Māori women.

Mātauranga Māori is knowledge steeped in a spiritual basis and in whakapapa. It operates within sanctions that ensures it is protected, used appropriately, transmitted accurately (usually via karakia, waiata and customs) and is restricted to designated individuals and groups within the iwi and hapū. The sanctions around the transmission of mātauranga Māori demonstrate that it is considered a taonga. Therefore, the acquisition of knowledge within traditional Māori culture was (and still is to a degree) controlled. Knowledge was (and still is by some Māori) imparted only to those considered "worthy" and ready to receive it, and contrasts with the freely available, universal approach used toward knowledge in the 'western' world. The social structures and communication networks of hapū and iwi did not facilitate a universal approach to knowledge. In some respects, the control that surrounds mātauranga Māori has contributed to the loss of some traditional knowledge that has occurred since colonisation began. The changes in Māori social structures and functioning, particularly with urbanisation, meant that those entitled to the knowledge have not necessarily received it. Royal (1992, p.21) supports this view, stating "...many elders have gone to the grave without passing on their knowledge".

Māori are not a homogenous group of people, and Smith (1996, p.211) stresses that a "...*Pan-Māori*" approach to all things Māori was an identity imposed externally upon all *Māori* people". Diversity existed amongst Māori prior to colonisation, with each hapū and iwi holding varying beliefs and practices (Dickison, 1994; Durie, 1995; Smith, 1996). The degree of diversity that exists within contemporary Māori society has been further compounded by factors such as demographics, education, socio-economic positioning, language, cultural identity, and inter-marriage (Durie, 2001). This increasing diversity amongst contemporary Māori creates apparent paradoxes and contradictions, and makes absolutes difficult to establish regarding knowledge and research methods. Indeed, any research methodology needs to account for this diversity.

The dominant research conventions influence the standards against which all research is measured and influence the validity and legitimacy of knowledge. *Mātauranga Māori* (or Māori knowledge) has struggled to be recognised as a legitimate way of knowing within the dominant New Zealand western culture. The scarcity of research methodologies perceived to be appropriate and acceptable to Māori (Bishop, 1994; Irwin, 1994; Smith, 1996) is evidence of the struggle for the recognition of *mātauranga Māori*.

Despite the influences of colonisation, capitalism, and technology some Māori knowledge has been retained over time and continues to evolve and develop, while some has been lost. Deloria (1995) claims the transmission of knowledge through the oral traditions of indigenous people passed on anecdotal material that explains the physical world experience and important historical events. The knowledge transmitted allows for variation through the expression of multiple viewpoints. Yet Deloria (1995) also claims that this knowledge was neither fragmented nor invalidated, reflecting the precision that exists in the art of oral traditions and storytelling. The accuracy of this mode of transmission can be debated, however, as it can be prone to embellishment, romanticism, and gate keeping by the transmitter. Royal (1992) maintains that oral traditions rely on the recall of memories. Memories are prone to inaccuracies as accuracy diminishes with time (Myers, 1993). Royal (1992) also claims that some Māori have been known to 'invent' facts to satisfy Pākehā curiosity. These weaknesses make the development

of rigorous methods in oral traditions open for criticism regarding the accuracy of knowledge contained within them. Those in a dominant and superior cultural position challenged the accuracy of oral traditions based upon their worldview of knowledge development and norms. The modes of knowing and knowledge development that came with colonisation has resulted in Maori knowledge being devalued and demeaned, especially as it does not stand up to the scrutiny of some 'mainstream' research methodologies (Durie, 1996, Walker, 1997).

The subject of colonisation within New Zealand is one that evokes emotive responses. For the purposes of this discussion the impact of colonisation will be confined to providing a contextual background for this research. Prior to colonisation, Māori were far from a homogenous group, possessing a rich and diverse tapestry of knowledge (Ballara, 1998; Durie, 1998a). The processes of colonisation functioned as a wedge, driven (amongst other things) by colonial legislation, educational and social agendas, and Christianity. Rousseau's initial romanticised view of Maori as the 'noble savage' was short-lived when the practices and customs of Māori were paradoxically viewed as barbaric and uncivilized savages (Lovegrove, 1972; Smith, 1996). Colonisation effectively destroyed the cultural beliefs and practices of many Māori, with the aim that Māori would conform as acceptable colonial subjects (Durie, 1998a; 1998b; Smith, 1999; Walker, 1990). In an attempt to conform, many Maori also discarded their cultural practices (at least in public) to become like Pākehā (Ihimaera, 1998; Moir, 1994)<sup>1</sup>. The socio-economic positioning and health status of Māori today is, in part, an outcome of the colonisation agenda, and along with capitalism and technological advances has had detrimental effects on Māori despite the gains that it also brought. Whether the negative outcome of the processes of colonisation was part of an intended political agenda is debatable.

A variety of processes forced Māori to change the way they functioned in society:

1. Legislation introduced the concept of the individual (as opposed to the collective functioning of Māori) ownership of land, such as the Native Land Acts 1862 and

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<sup>1</sup> Anecdotal stories also exist in various forms, but especially transmitted orally about growing up by older Māori, depict how they were dressed like Pakeha, were punished in schools for speaking *te reo Maori* and having to adopt Christian beliefs and practice in an attempt to gain acceptance by Pakeha.

1865, and prohibited cultural practices, such as healing by Tōhunga through the Tōhunga Suppression Act 1907 (Durie, 1998).

2. Education reinforced changes in social functioning through the prohibition of language and cultural practices (Durie, 1998; Hokowhitu, 2004; Lovegrove, 1972).
3. Christianity replaced the perceived 'pagan' spiritual beliefs of Māori (Lovegrove, 1972).

William Fox, a missionary, believed indigenous cultures impeded progress, and that indigenous people needed to be rescued from savagery. Fox (1851 cited in Lovegrove, 1972) considered colonisation was inevitable and beneficial to the 'civilised' people settling in New Zealand. Given attitudes similar to this, Lovegrove (1972, p.30) maintained the mythological basis of Māori beliefs were measured against biblical standards, and stated:

Many aspects of traditional tribal life underwent marked changes. The pervasive laws of the tapu were subverted by Christianity, the powers of the chiefs were weakened by an administrative system which did little to fashion acceptable alternatives to the institution they had eliminated, and tribal mana had been disgraced by military defeat and made virtually meaningless by the introduction of new values and standard of conduct.

Mohanram (1999, p.201) contends that the identity of indigenous people was ascribed additional meanings with colonisation:

Indigenous identity has two meanings, two identities inscribed in the body simultaneously – that which is from its occluded history and that which was constructed with the onset of colonialism. Indigenous identity is always a negotiation between these two identities.

Knowledge and identity are linked, and the loss of traditional knowledge has created identity issues for some Māori (Ihimaera, 1998; Moir, 1994). However, reclaiming traditional knowledge and ways of knowing is a problematic notion given the changes that have impacted upon Māori society. Some traditional knowledge has

been lost to generations that have passed and some knowledge has been redefined in response to social and technological changes. It is fair to say, however, that Māori are re-defining their cultural knowledge and the terms of its accessibility, and not necessarily constraining Māori development to some point of tradition in the past (Royal, 2002). The social structures of Māori have also been challenged over time by inter-marriage, urbanisation, and the education agendas of assimilation and integration (Durie, 1998b). The outcome has also contributed to the extensive diversity amongst Māori that ranges from those who have had the opportunity to experience a traditional cultural upbringing and are strong in their identity as Maori, to those who have been totally dislocated from hapu-iwi links and struggle with their identity as Māori (Durie et al., 1997).

While cultures and traditions may change in response to social changes the transmission of core cultural values and beliefs remains evident. The colonisation processes that Māori experienced have resulted in a systematic denial and destruction of traditional Maori culture, language and the valid development of its knowledge (Durie, 1998a; 1998b; Smith, 1999; Walker, 1990). Foucault (1972), however, believes that knowledge relating to a culture does not get lost despite the endurance of time and describes this phenomenon as 'cultural archive'. Knowledge, Foucault (1972) maintains, is preserved within discourse that is transformed and exists within multiple realities. While mātauranga Māori achieves legitimacy in some quarters, it struggles to do so in others. The knowledge and skills of tohunga, for example, are now being accepted in some 'mainstream' health services, but their legitimacy as a health science remains questionable and unexplainable. I continually observe the superior positioning of biomedicine and the claim that double-blind randomised controlled trials are the 'gold standard' of biomedical knowledge, a notion supported by Sackett, Straus, Scott, Richardson, Rosenberg and Haynes (1997). Other forms of knowledge, such as that arising out of the interpretive paradigm, are at best tolerated but not necessarily accepted (Walker, 2000).

## Why Not Other Methodologies?

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On several occasions I have been both questioned and challenged by colleagues about my decision to not utilise research methodologies or approaches such as critical theory, feminism, post-structuralist feminism, post-colonialism and post-modernism. While I do not wish to dwell on this challenge too long, I feel that it is important that I address it for those who have not had the opportunity to participate in these discussions. First, it was vitally important that the outcome of this research maintained the integrity of the Māori women participating in this research and their contribution did not become yet another construction of Māori knowledge within a 'mainstream' research framework. Second, I was also very aware of the growing critique of 'mainstream' research methodologies being applied to Māori, particularly mainstream researcher's failure to acknowledge and include aspects of their worldview and the life experiences of Māori. Thus, adopting a methodology and approach that was both respectful and valued the participants, and their worldview, was vital.

'Mainstream' research methodologies can present challenges when applied without critique within the Māori setting. Understandably 'mainstream' research methodologies have originated from western worldviews. To be true to the philosophical basis of a research methodology, therefore, results in a dominant worldview inevitably being imposed upon Māori. Cunningham (1998) maintains Māori knowledge must have equal status, and not be referred to in the context of 'other'. Any research undertaken from a dominant cultural perspective with Māori risks not acknowledging their worldview, with the research outcomes being at best an interpretation of Māori through a dominant worldview. No longer is this acceptable, and it is important for this research to ensure that the knowledge generated is based in the interpretation of the Māori women participating. While the methodology used in any research project is determined by the questions and aims posed, the methodology selected must also be able to appropriately explain the group being researched.

The use of quantitative approaches provides a useful macro view of health issues. For example, quantitative approaches enable large amounts of health data to be analysed to support the justification of policy directions and increased funding. However, quantitative analyses may also paradoxically disadvantage Māori (Smith, 1999). For example, Durie (1992) criticizes research that is comparative in nature for its exposure of 'gaps' that reinforces negative attitudes and prejudices against Māori, such as seen in the analysis of epidemiological data. Such a view can be described by 'cultural deficit theories', where the dominant cultural interpretation does not account for the cultural and economic differences that exist between Māori and non-Māori (Hokowhitu, 2004). As a result the differences in social and educational measures, along with health status and health outcomes, are attributed to the inadequacies and failures of Māori. Indeed, such comparisons tend to place Māori consistently in a deficit position that is of little benefit to resolving such a position. Durie (1996) argues that this type of 'comparative' research has failed to recognise ongoing underlying inequalities, it can be used to justify resources to address inequalities and inequities.

While quantitative research can provide the 'big picture'; qualitative research offers the opportunity to generate information directly from the participant's perspectives, such as Māori women. The philosophical perspective of the methodology used to interpret the information gathered may, however, distort the worldviews and perspectives of the participants. This has been a criticism of research with Māori (Bishop, 1996; Durie, 1997; Pihama, 1993; Smith, 1999) where the interpretations and explanations of Māori behaviour and phenomena have been undertaken through a 'western' perspective. Jahnke (1997) and Smith (1999) go further and maintain that methodologies such as feminism and critical theory are underpinned by "...western patriarchal assumptions" (Jahnke, 1997, p. 97). For example, critical theory and feminism offer an analysis and explanation about how gender and power issues impact on marginalised groups, but fail to deliver effective resolutions due to the structurally and socially embedded nature of the issues that affect these groups. Bishop (1994) claims the cultural context in the analysis of critical theory and action research is influenced by the researcher's 'outsider' stance and the 'western' interpretation placed on the research findings.

The value of feminism for research with Māori women is debatable. Feminism is a philosophical perspective that has diverse viewpoints. Pihama's (1993), and Smith

and Taki's (1993) critique of feminism locates it clearly within the realm of white women. Both Pihama (1993), and Smith and Taki (1993) maintain that feminism ignores Māori women's spirituality, their wholistic worldview, complex whānau relationships, and their differing roles and responsibilities. They also maintain that it fails to critique the involvement of white women in past and ongoing colonising processes. Pihama (1993) contends the centrality of gender is problematic for Māori women as 'white women's feminism' generalises and makes the position of all women universal – a position supported by Moreton-Robinson (2000) who discusses similar concerns regarding the Aboriginal women of Australia and feminist approaches. This debate is complex, however, the adoption of universal stances regarding women risks overlooking the positioning of Māori women in two worlds – that is te ao Māori and te ao Pākehā; and the diverse positions, roles, responsibilities and accountabilities they hold within these worlds.

The positioning of Māori women in two worlds is culturally defined and subject to change. Feminism has a dualistic relationship with patriarchy that essentially relegates women to the subordinate and focuses on the subsequent gender and power imbalances that reinforce this position (Pihama, 1993). The superior-inferior positioning of women with men does not necessarily exist for many Māori women, who anecdotally stress that in the world of Māori both men and women have mutually complementary and supportive roles and relationships within their whānau and communities. The degree to which outsiders can observe these roles and relationships as complementary and supportive varies and is dependent upon the frame of reference used to evaluate such observations.

Some Māori women, however, such as those working within Women's Refuge, support the use of a feminist perspective to inform their work, and find the gender-power analysis useful. For these Māori women, feminism is an appropriate philosophy. In order to uncover what is important for Māori women, having an appropriate research methodology is vital, especially when relationships are complexly underpinned by gender and power issues (such as those between 'colonisers' and the 'colonised', and between feminism and patriarchy) remain evident in contemporary society. Colonising processes still exist for Māori in Aotearoa/New Zealand (Pihama, 1993; Smith, 1999), evident when dominant groups influence decision making for Māori, and the relative disadvantage continues

to be experienced by Māori on many fronts (Durie, 1998b). While I feel that the methodologies discussed above have value, in terms of making a difference or creating positive change they raise the question, 'So what?'

Stokes (1985) criticises academic based research with Māori due to its lack of benefit for Māori, its reinforcement of negative stereotypes, and being devoid of Māori values. Being mindful of the perceived limitations of 'mainstream' research methodologies assist to minimise them and ensure the interests or the needs of Māori are upheld. Inclusion of Māori perspectives is one way to minimise distortions and inaccuracies in the research outcomes. This can be achieved by researcher participation in relevant Māori activities, with the aim to produce beneficial research for Māori (Durie, 1995).

Durie (1995) also maintains the researcher's ability to 'translate' the concerns of Māori to outsiders is important, as is legitimating the experiences of Māori women according to Smith (1999). Principles applicable for undertaking research with Māori should be developed and applied from the inception of the research through to its dissemination and beyond. For example, the principles of reciprocity and accountability should underpin the dissemination of research findings and are considered an important process when undertaking research with Māori. The process for the dissemination of research findings should be decided during the initial consultation regarding the research process. Thus, feedback should aim to utilise a variety of media, both written and oral, and be disseminated widely within the worlds of both Māori and Pākehā. The principles for underpinning the research undertaken in this thesis will be discussed further in Chapter 5.

## **Emergence of 'Māori' Methodologies**

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In an effort to address dissatisfactions with 'mainstream' research methodologies, alternative approaches to research are emerging that focus on the interests of Māori

(Bishop, 1996; Durie, 1997; Smith, 1999). The discussion and debate around these developments are useful and expose the concerns that some Māori have about research on 'them'. The approaches proposed appear to focus predominately on relationship building with the Māori communities being researched, and the recognition and inclusion of appropriate cultural beliefs and practices. They provide a philosophical approach rather than the actual 'nuts and bolts' of undertaking research. This section will analyse some Māori methodological developments in relation to their potential use for this research.

## **Notions of an Indigenous Science**

The 'accepted' scientific approach is, "[a] logical, orderly and objective means of generating and testing ideas" (Beanland, Schneider, Lo Biondo-Wood & Haber, 1999, p. 587). The scientific approach is premised on empirical observations used to generate objective evidence that is gathered through systematic investigation, and that formulates knowledge through the processes of inductive or deductive reasoning for the production of generalisable knowledge. The knowledge systems of indigenous cultures are dynamic and have survived the adversities of time. Yet, these knowledge systems are devalued by the political and cultural systems that dominate indigenous communities. In an attempt to achieve an acceptance and credibility of indigenous knowledge within established scientific paradigms, Colorado (1996), and Suzuki and Knudston (1992), pose the notion of an 'indigenous science'. Indigenous knowledge systems and 'western' science both aim to discover or explain a sense of order within the physical universe. However, they differ in the approach each takes.

Notions of an indigenous science (that has an ecological and wholistic foundation) are posed as a method by which indigenous knowledge may gain credibility and respect within the wider scientific community (Colorado, 1996; Suzuki & Knudston, 1992). The 'western' scientific approach differs to indigenous knowledge forms in that it tends not to allow for subjective observations or multiple truths that can be applied in a variety of contexts. The oral traditions associated with indigenous

knowledge forms make it difficult to observe and verify them, despite the seemingly 'accurate' transmission of knowledge from generation to generation. The traditional transmission of mātauranga Māori, for example, is selective and generally not readily accessible to everyone so that tribal knowledge could be protected (Durie, 1998a). Indeed, Māori knowledge is tribal specific. Thus, it could be considered that the notion of an indigenous science is potentially problematic as it (a) enables 'untruths' to exist with no way of verifying them, (b) is difficult to question and be subjected to scrutiny by 'outsiders' due to its mode of generation, (c) makes indigenous knowledge forms something it is not, that is a 'science', and (d) negates the multiple and diverse knowledge forms that exist among indigenous groups in the search for generalisable knowledge.

Colorado (1996) presents indigenous science as a possibility of bridging the gap with western knowledge. However, Deloria (1995) maintains that methodological problems exist when integrating non-western traditions, and/or knowledge, within the western scientific perspectives. For example, racism and stereotypical views can create bias when undertaking research. The comparison of indigenous science with western science, and its methodologies, in an attempt to achieve 'mainstream' credibility makes it something it is clearly not. Such a comparison is like 'comparing apples with oranges' - a view supported by both Kramer (1996) and Smith (1996). The notion of an indigenous science achieving credibility is fraught with difficulty when placed within the dominant scientific paradigm. Despite indigenous knowledge systems possessing systems of rigour, and surviving time, the methods of knowledge production struggle to meet 'western' scientific criteria, such as observable validity and replicable reliability.

Indigenous knowledge is acknowledged within the 'mainstream', but is usually referred to in nostalgic, romanticised or culturally inferior terms (Lovegrove, 1972; Smith, 1996). In fact, Deloria (1995) goes so far as to maintain that science accepts non-western traditions only to the point that it supports existing and approved orthodox doctrines – those that do not support scientific doctrines are rejected. As mentioned earlier, the validity and credibility of indigenous knowledge is questioned within a world where the scientific paradigm reigns and is generally accepted as the primary source of all knowledge. The western scientific paradigm historically and ideologically dominates and excludes competing knowledge systems. It effectively

excludes Māori from, and creates structural barriers for participation in, 'mainstream' research endeavours, either directly or indirectly (Colorado, 1996; Deloria, 1995).

Scientific methods objectively observe and measure in a predominately reductionist manner in an attempt to understand and rationally explain phenomena. Indigenous science, however, views the world as a totality, which is wholistic, dynamic, multi-sensory, and not confined by boundaries. It generates knowledge grounded in observation and oral traditions, with a spiritual dimension often evident. Suzuki and Knudston (1992, p.20) defend the rigour of indigenous knowledge systems, and claim:

Modern science looks out upon the same universe through very different lens. Through an often laborious process of debate and discussion, the *community* [sic] of scientists itself agrees for a time upon an interpretation of some aspect of the world – a new, more intellectually satisfying paradigm, or model, of reality, the latest in a long, lurching succession of ever-provisional scientific "truths".

Suzuki and Knudston (1992) contend indigenous knowledge systems are highly sophisticated, are of practical value, grounded in observation, and have withstood the test of time. They also possess spiritual and mythological elements that science has long divorced itself from (Dickison, 1994; Kramer, 1996). Despite Suzuki and Knudston's contention, the 'all-encompassing' approach of indigenous science relies on methods that are difficult to verify and clearly establish rigour.

Dickison (1994) posed the question 'why indigenous science?' but did not articulate his argument well in response to this pertinent question. He did, however, highlight the difference between science and mātauranga, and concludes that they do not do the same thing, and parallels the legitimisation of mātauranga by western science to its colonisation. Kramer (1996) supports Dickison's stance and stresses that conformity to the dominant scientific discourse risks the loss of the spiritual and mythological elements of mātauranga.

The notions of an indigenous science are not well developed and are subject to potential credibility issues, and is therefore, not beneficial for use in this research. Yet, the solely empirical and reductionist basis of knowledge production has not

produced comprehensive and relevant knowledge systems either, and has resulted in a growing dissatisfaction by some professions, such as nursing. Observable and measurable methods, the hallmarks of empiricism used in quantitative research methodologies, do not necessarily account for individual experiences and diversity. The Māori women participating in this research are culturally positioned, and protecting the cultural integrity of the knowledge shared is an important.

## **Kaupapa Māori Research**

Qualitative research methods have been utilised and make a growing contribution to the body of knowledge in the health arena that complements knowledge generated through quantitative methods. Proposing alternative research methods, such as kaupapa Māori, also attracts questions. Indeed, some Māori ask, 'what does kaupapa Māori research mean?' There is no simple or definitive answer other than it is a 'by Māori, for Māori, with Māori' approach to research informed by Māori tikanga and kawa. Just as Māori possess diversity in their worldview, they also have diverse methods and approaches in the generation of knowledge. In this sense kaupapa Māori research is not dissimilar to the dominant research methods.

The basis of any kaupapa Māori research must, according to Smith (1990, cited in Smith, 1996) be related to 'being' Maori, and Maori philosophies and principles. Thus, it must validate and legitimise Maori language and culture as any credible research should value the worldview and practices of its participants. Defining of kaupapa Māori research is made extremely difficult however, as the requirements differ when researching different groups of Māori. Barlow (1991) and Bishop (1996) both highlight the importance of whakapapa being fundamental to the organisation of knowledge from both a creation and a developmental perspective. Whakapapa is the concept that relates and links all elements of 'being' (human and otherwise) together, and establishes the connection between the present and ancestral and historical relationships (Barlow, 1991; Henare, 1988; Salmond, 1997; Smith, 1999; Suzuki & Knudston, 1992). Henare (1988) also describes in detail the importance of mana Maori and its interrelated links with concepts such as tapu, utu, mauriora, tika, aroha, rangatiratanga, hauora, waiora, and kotahitanga. These principles can be applied to research undertaken with Māori, which reflects an ontological position to minimise any disrespect of the mana of the Māori participating. As previously noted,

Smith (1996), however, warns against taking an externally imposed 'pan-Maori' approach and stresses the need to respect the whakapapa of each Maori community.

When it comes to deciding who is the researcher, Cunningham (2000) concurs with Smith (1996) that Māori should research Māori when undertaking kaupapa Māori research, especially as it is steeped in Māori philosophy and ontology. Smith (1999) acknowledges that the involvement of non-Māori researchers in kaupapa Māori research is complex, and states:

When undertaking research, either across cultures or within a minority culture, it is critical that researchers recognize the power dynamic which is embedded in the relationship with their subjects (p.176).

However, Bishop (1994) differs, believing that non-Māori researchers have an obligation as a Treaty of Waitangi partner to nurture Māori research. Smith (1996) also advises against adopting a normative approach and maintains that researchers must recognise their own whakapapa, and engage with it reflexively to expose any issues and biases they may bring to the research project. Reflexivity is something that is advocated, among others, by feminist writers such as Wuest and Merritt-Gray (2001).

The initiation of any research project using a kaupapa Māori research methodology must include the participation of Maori in the preparatory stages, particularly those from the community under study. From the inception of a research project, key Māori groups and kaumatua should guide the process. This ensures that research goals are mutually agreed upon, and the aspirations and needs of a particular group of Māori can be realised. It also minimises the chances of researchers 'doing to' groups, such as Māori. Durie (1995, p.19) asserts:

If indigenisation of Maori research is to mean anything at all, then the research done must arise out of the aspirations and needs of the Maori people.

The principle of rangatiratanga relates to Māori possessing absolute control over their life, cultural wellbeing, and includes research. According to Smith (1996), rangatiratanga is framed within the Treaty of Waitangi discourses. Thus,

consultation and collaboration must occur throughout the entire research process to ensure that Māori maintain control over their cultural integrity. This also involves the right of veto and withdrawal from any study within the terms of the research partnership (Durie, 1992).

Māori are noted for their oral tradition – a tradition that conveys their worldviews that are embedded within te reo Māori. Smith (1996) describes language as the window to Māori ways of knowing and interacting within the world and must be considered in any research undertaken with Māori. Indeed there are some socio-cultural practices, such as pōwhiri that are conveyed only in te reo Māori, or concepts that are not able to be translated. Thus, when planning any research design te reo Māori must be an important consideration, despite many Māori not speaking the Māori language. This is vital when interpreting research data that contains te reo Māori, and in its dissemination.

Links with the Māori community being researched is vital to assist with gaining access to the 'right' people and the participants. The establishment of contact and credibility is essential according to Stokes (1995), and can be achieved by participation in community affairs in order to become known. The principle of he kanohi kitea, the 'known face' is an important step for any research project with Māori (Bishop, 1994; Irwin, 1994). He kanohi kitea assists in establishing trust, which is fundamental to undertaking research with Māori. A 'by Māori for Māori' approach does not preclude gaining credibility within a Māori community, as both Māori and non-Māori researchers need to establish their credibility. In the absence of being known within a Māori community, the researcher needs to engage the assistance of intermediaries who are known and have established credibility within the Māori community where the research will be undertaken in order to enter it.

Models, such as Pere's (1991) 'Te Wheke' and Durie's (1998a) 'Te Whare Tapa Wha', portray the wholistic worldview and interrelated relationships that make up what it is to be Māori. However, such models tend to have local rather than universal acceptability. The limited range of established Māori methodologies currently means that western methodologies may be legitimately used, a notion endorsed by the Te Ora Rangahau Conference (Durie, 1998b). The notion that research with Māori should be solely 'by Māori, for Māori, with Māori' is debatable

(Glover, 1997), and is a position that is often politically motivated rather than entirely research oriented. Cunningham (2000), Durie (1997), and Walker (1990) all provide a reality check when tempted to adopt a seemingly 'purist' position – a reminder that the need for 'mainstream' research support exists as few Māori have the skills to embark upon an exclusively Māori approach. Irwin (1994), however, points out the interests of Māori must be central to any research process undertaken, including the development of research knowledge and skills with Māori. The lack of consensus regarding a clear definition of kaupapa Māori research reflects the diversity that exists within Māori, but makes it difficult to establish a firm foundation on which to develop this research. In fact, it could be argued that kaupapa Māori research offers a philosophical, rather than a methodological, position that is not dissimilar to some 'western' interpretive research methods such as phenomenology and even grounded theory.

## **Māori-Centred Approach**

Any research with Māori must be credible in two worlds – the world of Māori and the 'mainstream' research world. While kaupapa Māori research may achieve credibility with Māori this is not necessarily guaranteed, and as it is predominantly a philosophical approach that informs the research process, methodological credibility within the 'mainstream' research community cannot be assured. The potential impact of negative research on Māori, and the cultural issues that arise highlights the importance of Māori participation in all stages of a research project and the need to keep Māori central throughout the process, to minimise such occurrences. Anecdotally many Māori want quality research to be undertaken, and if it is to be beneficial in any way it must attain credibility. Research approaches, however, conducted within a Māori worldview, with Māori being central to the process, are supported by writers, such as Durie (1992), Durie (1996), Glover (1997), Smith (1996, 1999), and Te Momo (2003).

A Māori-centred approach provides a framework that holds Māori central within the research process and enables 'mainstream' research requirements to be incorporated (Durie, 1997). As the Māori research methods available are limited, Cunningham (2000) and Durie (1998b) maintain 'mainstream' research methods can be used. A Māori-centred approach provides both a philosophical basis and a

methodological structure for process to involve Māori in the development and explication of research, enabling complementary methods, such as grounded theory (a western research method), to be used.

A collaborative approach to research with Māori based upon the Treaty of Waitangi is recommended by the Health Research Council of New Zealand (HRC) (Health Research Council, 1998). The HRC further describes the consultation process to identify how Māori will benefit, a notion supported by Bishop (1994), Cunningham (2000), Durie (1992) and Stokes (1985). The development of an appropriate research design involves establishing a meaningful partnership and strategies to resolve any contentious issues that may arise. Smith (1996) contends this initial process optimises the chances that the research undertaken is culturally appropriate and acceptable, gains the confidence of the participants, and enables access to the community. Partnerships with Māori ensures that any issues pertaining to intellectual property, access to data, accountability, authorship, information storage, and the allocation of funding can be addressed, according to the HRC (1998). Essentially collaboration with Māori leadership aims to clarify the aspirations of Māori, terms of the research and the methodology to be utilised (Durie, 1995). The work of the HRC highlights the essential processes and concepts necessary, and could be considered Māori centred.

Durie (1997, p.9) proposes a Māori-centred approach to research that "...focuses primarily on Maori people, as Maori, and the research methods and practises employed take full cognisance of Maori culture, Maori knowledge and contemporary realities". Keeping the Māori community and participants central throughout the research process requires (a) their research and wider societal rights to be respected and upheld, (b) the research aims and processes to be beneficial, and (c) the incorporation of the Māori worldview of the community and participants that governs their beliefs and daily practices. A Māori-centred approach to research ensures that Maori are at the centre of the research and that the research contributes to the gains of Māori and to the advancement of positive Māori development. It enables the use of 'mainstream' research methods for the collection, analysis and interpretation of data (Cunningham, 2000). Such an approach is inclusive of Māori epistemology and ontology as well as factors such as the diversity, which exists within Māori. Māori centred research advocates the

development of research expertise where research expertise amongst Māori is lacking, justifying the involvement of non-Māori.

A Māori centred approach will be adopted for this research that builds on the work of Cunningham (2000), Durie (1997) and the HRC (1998). The underlying principles of a Māori centred approach that enabled the use of 'mainstream' research approaches was an important consideration in selecting an appropriate methodology for this research. It keeps the participants central.

## **Conclusion**

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Traditionally Māori possessed a predominantly ontological system of knowledge, known as mātauranga Māori. This knowledge was generally transmitted using oral traditions via medium such as waiata, whakapapa, wananga, and the use of story telling. Mātauranga Māori is a knowledge system that has a spiritual basis and accepts multiple realities and diversities. The processes of colonisation, capitalism, and technological change, however, subjugated Māori ways of being and knowing while western scientific methods became dominant. Western science also brought objective, detached researchers and methods to research Māori. Yet, while this way of knowledge development is seen as credible by the dominant research culture, it does not necessarily portray Māori in a positive light.

Dissatisfaction with 'mainstream' research methodologies, particularly in view of the continual negative portrayal of Māori, has contributed to the emergence of 'Māori' methodologies. While the ideologies of indigenous science and kaupapa Māori research provide an important contribution to the research arena, these approaches have their limitations. The development of a Māori-centred approach informed and underpinned by Māori philosophies and principles optimises the opportunity to exercise rangatiratanga (control) and maintain cultural integrity. The next chapter will outline grounded theory informed by a Māori centred approach, and its explication within the research design.

## CHAPTER 5

### A Māori Centred Approach to Grounded Theory

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This research contributes a meaningful and theoretical explanation about Māori women's health and their interaction with health services. Having established the importance of a 'Māori centred' approach in the previous chapter, accounting for the selection of an appropriate research method that would not only answer the research question, but would also provide optimal processes and 'tools' for the collection and analysis of data was important. A Māori centred approach provides an epistemology and ontology to inform the research process. However, it cannot be considered a research method *per se*. Thus, a Māori centred approach was used to inform the use of Glaserian grounded theory in this research.

Prior to discussing the validity of using grounded theory with a Māori centred approach, both will be discussed separately. An exploration of the philosophical and practical foundations of a Māori centred approach first, and then grounded theory will be undertaken. The methodological development of grounded theory and the subsequent 'methodological split' will be analysed in order to justify the selection of Glaserian grounded theory to inform this research. Highlighting the points of congruence and tension between a Māori centred approach and Glaserian grounded theory will provide a platform to discuss the wisdom of a grounded theory using a Māori centred approach. The latter part of this chapter will explain the research design and its implementation, illustrating the use of a grounded theory using a Māori centred approach.

## **A Māori Centred Approach to Research**

A Māori centred approach was used to guide the research process within a grounded theory framework. Durie (1997, p.9) defines Māori centred research as focusing:

...primarily on Māori people, as Māori, and the research methods and practises employed to take full cognisance of Māori culture, Māori knowledge and contemporary realities.

Cunningham (2000) supports this view and claims that such an approach involves participants and researchers that are predominately Māori, and research that collects and analyses Māori data. Cunningham (2000) also differentiates Māori centred research from Kaupapa Māori research by the control that 'mainstream' institutions have over the research process, and by the utilisation of 'mainstream' methodologies. These features are evident in this research, with ultimate control residing with two 'mainstream' ethics committees and the university. As Māori specific methodologies are in various stages of development and many requiring validation, grounded theory was selected as the most appropriate method for this research to guide the collection of data and its analysis.

The outcome of a Māori centred approach to research is the production of Māori knowledge, and specifically in relation to this research, knowledge about Māori women's health and their interactions with health services. The values and philosophies that underpin a Māori analysis, Cunningham (2000) maintains, differ from those of the 'mainstream'. A 'Māori analysis' places the experience of Māori central to the theoretical base and accepts the existence of 'Māori' research processes. In order to keep Māori central throughout the research process, I have developed a Māori centred model (Figure 5.1) to inform the process. This model will be explained in the next section. The development of this model was prompted by the need to clearly identify those Māori values, philosophies and requirements that needed to be kept central, whilst simultaneously taking into consideration 'mainstream' research requirements.

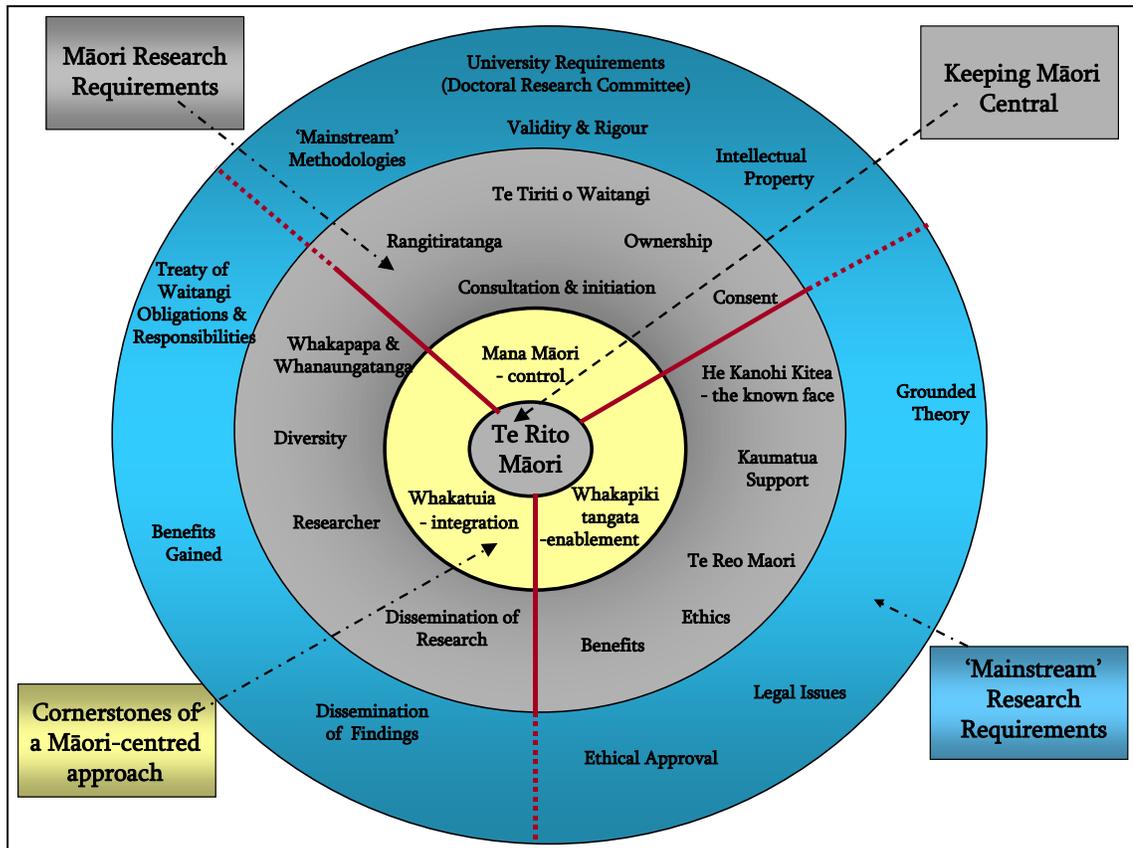
A Māori centred approach to research is informed by a number of assumptions:

1. Research activities should be beneficial to those being researched.
2. Such an approach recognises both the wholistic view many Māori hold that is integrated into their lives, and the multiple and complex interactions they experience within their lives.
3. Māori must have control over the research in order to protect their interests. Durie (1997) refers to these respectively as whakapiki tangata (enablement), whakatuia (integration), and mana Māori (control).

These assumptions provide a basis for the development of the research design and its implementation. It could be argued that some of these assumptions are inherent for research with any group and I acknowledge this. However, I also believe that it is important to emphasise these assumptions when undertaking research specifically with Māori - as discussed in the previous chapter, it cannot be taken for granted that these assumptions are necessarily observed.

A Māori centred approach to research has its limitations, as with any research approach. The dual accountability to both 'mainstream' and Māori is a constraining feature (Cunningham, 2000). The demand of fulfilling dual expectations that may be at variance is an example of how being accountable to both 'mainstream' and Māori can be both challenging and a point of tension. Cunningham (2000) contends that a 'Māori analysis' has its own biases. It is fair to say that any analysis of research undertaken from a specific perspective has its own biases and is potentially a limiting feature. This research does not seek a single universal truth or to make generalisations to explain Māori women's health and interactions with health services. Rather it aims to produce a substantive grounded theory that will benefit Māori women by improving the understanding health care providers have of how Māori women interpret their health and their interaction with health services. Further, the diversity that exists among Māori makes the generation of a universal explanation unrealistic, whereas a grounded theory will highlight the processes that are used in relation to their health and interactions with

health services. Despite the diversity that exists, a key notion in the Māori centred approach used in this research is keeping Māori women participants central. What ultimately is generated is a perspective that may have relevance to many, an outcome to be expected when working with diverse groups or populations.



**Figure 5.1.** A Māori centred approach to research within a mainstream research environment.

## The Māori Centred Model Explained

Durie's (1997) principles of mana Māori (control), whakapiki tangata (enablement) and whakatuia (integration) were adapted to form the cornerstones of the model. This model also depicts the principles and relationships that arise out of dual accountabilities to meet both Māori (HRC, 1998) and mainstream research requirements.

Mana Māori (control) recognises the rights of Māori under Te Tiriti o Waitangi to both rangatiratanga and protection. The principles of partnership, participation and protection articulated by the Royal Commission on Social Policy (1988) provided a framework on which to engage with Māori, and involve Māori in the development and implementation of this research. Rangatiratanga, guaranteed under The Treaty of Waitangi, provides the basis for control by Māori over the development of the research and participation in the selection of appropriate methods that were utilised to ensure the research would be beneficial. This was achieved through consultation and the involvement of Māori women so the outcomes of the research align with their aspirations. The control Māori women had in this research is implicit in the planning of the research and the consent process to participate and included the standard right to withdraw at any time. The information that the participants shared over the course of the research remained in the ownership of the Māori participating, if they so wished. The way that this information was gathered and analysed was negotiated with the participants.

Whakapiki tangata (enablement) aims to optimise the benefits of the research for Māori women and minimise the chances of exploitation of those participating in any way. Kaumatua (or kuia) support and guidance aims to prevent any actions that may result in compromising the cultural integrity of those participating. Together with kaumatua support, he kanohi kitea (the known face) involves becoming known and involved in community affairs in order to establish the necessary contacts and credibility to undertake the research. Intermediaries, however, may need to be used who have he kanohi kitea in order to gain the necessary access. As culture is embedded in language, participants had the opportunity to express themselves in te reo Māori. Therefore, it is necessary when preparing for research with Māori to have available the necessary resources for interpretation of the information shared in te reo Māori so that its integrity is safeguarded. Like all research the conduct must be ethically and culturally appropriate and acceptable, and forms part of the ongoing consultation with Māori. The negative experiences Māori had historically with research (discussed in Chapter 4) need to be remembered to avoid repeating similar experiences and potential

harm. Finally, the benefits of the research for Māori must be tangible and acceptable to the participants.

Whakatuia (integration) acknowledges Māori worldviews and the complex interactions they engage in on an everyday basis. Fundamental to whakatuia is the need to respect the whakapapa and whanaungatanga of the participants and the Māori community involved. The researcher's whakapapa must also be recognised, and any issues or biases that may impact upon the research or the participants exposed through a process of reflexive engagement. Recognition of the diversity that Māori possesses within its membership and the dynamic nature of culture needs to be integrated into the research. This was achieved by the participant's varied backgrounds in terms of their ages, experiences, educational levels, income, and most importantly their iwi affiliations. Thus, research should reflect this diversity unless a single homogenous sub-group is being studied.

'Mainstream' research requirements must also be considered, and as this model focuses on keeping Māori central these are located on the periphery, including obtaining the appropriate ethical approval and addressing any legal issues that may exist. Fundamental to undertaking research with Māori is establishing the obligations and responsibilities that must be met under the Treaty of Waitangi. The principles of partnership, participation and protection provide a useful framework for undertaking research with Māori. It is also recognised that undertaking any research with Māori will have consequential benefits for the researcher that must be declared to the Māori community and participants involved. For example, obtaining a PhD has associated benefits that arise from the completion of this research. As this research is part of a doctoral degree, the university requirements of doctoral research must also be met.

The use of 'mainstream' research methods such as grounded theory, needs to ensure that Māori have control during the process (Cunningham, 2000; Durie, 1997). The research must also have formal ethical approval and any legal issues considered,

including intellectual property, which were negotiated with Māori<sup>1</sup> at the beginning of the research process and discussed in more detail later in this chapter. Any framework that is at variance with the cultural values and beliefs of Māori should not be imposed on the participants or during the analysis of the data, without the consequences being made evident. Therefore, in developing this research the methodology and method were negotiated and discussed fully with Māori to ensure that these were both acceptable and appropriate. Equally important is that the research outcomes are credible through the rigorous application of the research method, and the trustworthiness of the findings. The findings of the research, particularly that resulting from a PhD, will be disseminated amongst the 'mainstream' research community via media such as publications and conferences. This must be done in a manner that aims to benefit Māori and uphold their mana by being respectful and presenting the findings in a manner that can be used to the advancement of the health of Māori women.

In this section the key components that need to be incorporated into the development of grounded theory informed by a Māori centred approach have been identified. Prior to discussing how a Māori centred approach can be used to inform grounded theory, grounded theory and its philosophical underpinnings will be explored. This will provide the necessary background to explore the development of grounded theory informed by a Māori centred approach.

## **Grounded Theory**

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Barney Glaser and Anselm Strauss proposed grounded theory as a social science research method in their book *The Discovery of Grounded Theory* (Glaser & Strauss, 1967). They maintained that the interpretation and meaning of social phenomena could

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<sup>1</sup> Discussions with 'Māori' refer to the consultation process undertaken with some Māori women, and people from groups such as Te Mana Hauora o Te Arawa, Te Puni Kōkiri and Lakeland Health's Te Whakaruruhau.

be discovered and explained. The systematic process of constant comparative analysis facilitates the discovery of social phenomena and processes that are of concern for the participant group. The end result is a theory that has inductively emerged out of conceptualisation of the data collected from the participant group under study. The inductive approach to the generation of theory differs from other social research methods that may utilise inductive research methods to verify a proposed theory or hypothesis (Glaser & Strauss, 1967). To this end, Glaser and Strauss (1967, p.4) claim that “[g]rounded theory can help to forestall the opportunistic use of theories that have dubious fit and working capacity”. The inductive approach utilised by grounded theory makes it suitable for using a Māori centred approach, primarily because it allows what is important for the participants to emerge from the data. Grounded theory, as a method was considered congruent with the aims of this research, and the production of a theoretical explanation that is both meaningful and useful.

Grounded theory is philosophically underpinned by symbolic interactionism (Benoliel, 1996; Chenitz & Swanson, 1986; Corbin & Strauss, 1990; Crotty, 1998; Glaser, 1998; Glaser & Strauss, 1967). As this research seeks to understand and explain the social reality of Māori women with regard to their health and interactions with health services, symbolic interactionism an appropriate philosophical position. Crooks (2001) contends that grounded theory is ideal for exploring the worldviews, social relationships and health behaviours of women to gain insight and understanding. Prior to exploring the method of grounded theory, the philosophical underpinning of symbolic interactionism will be discussed.

## **Symbolic Interactionism**

George Herbert Mead, laid the foundations for the development of symbolic interactionism. Mead (1934) rejected the behaviourist notion that consideration should be given to behaviour that could only be directly observed. Such an approach, he believed, did not facilitate gaining an understanding of the mind and its role in human behaviour. Influenced by the philosophy of pragmatism, Mead believed that humans interpret and define the situations they are involved in, rather than merely ‘respond’ or

'react' to a situation. The work of Charles Darwin in relation to the 'natural' world was also influential, leading Mead to concur from a social perspective that humans are active participants in their environment and their own evolution. Such action implies dynamic rather than static processes of interpretation of social phenomenon (Charon, 1998; Mead, 1934).

Philosophically, symbolic interactionism is an interpretive perspective that is epistemologically grounded in constructionism. Crotty (1998, p.42) claims constructionism is the:

...view that all knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context.

Symbolic interactionism focuses on the social construction of 'acting' individuals (Blumer, 1969; Bowers, 1988). Group action is then the collective alignment of the shared meanings and actions of a group of individuals (Blumer, 1969). Symbolic interactionism, according to Blumer (1969), is based upon the assumptions that (a) humans act on the basis of meaning, (b) meaning arises from interacting with others socially, and (c) meanings are an interpretation of the social interaction by the individual with themselves and with others.

Meaning is derived from the interaction individuals have with symbols and objects, which they interpret within the context that they occur, and with consideration of previous interactions. The meaning derived from the process of interaction results in the construction of meaning (Blumer, 1969). Thus, individuals and groups are not merely responsive to situations, but interpret and make meaning of the situation that in turn constructs the action they subsequently undertake. The main concern of symbolic interactionism is the discovery of the 'realities' of individuals, the nature of their encounters with objects and symbols, and the subsequent interpretation and processes used (Bowers, 1988).

From a symbolic interactionist perspective, health can be considered a phenomenon that Māori women interpret and define, ascribe meaning, and act upon within the context of a variety of settings. Bowers (1988) notes that individuals react differently toward objects (including phenomena such as health), and subsequently interpret them differently. However, Blumer (1969) contends that the collective alignment of an individual's interpretations of a symbol or an object can result in a shared meaning of it, despite varying interpretations by individuals.

Given the social construction of meaning and action, the role of culture can also be considered from a symbolic interactionist perspective. Berger and Luckman (1966) and Charon (1998) both contend culture is a socially constructed concept. Culture, like various symbols, objects, situations and events, is subject to change and a process of definition, and cannot be considered static. It does, however, constitute a shared perspective based upon shared meanings and understandings of symbols and objects in order to define a reality and interpretation of the world, which then influences the actions of individuals. Individuals experience multiple group membership that provides multiple reference points. However, Charon (1998) points out that it is culture rather than membership of a group or groups that influence the development of meaning and action.

## **Relevance of Symbolic Interactionism to this Study**

Blumer (1969) describes symbolic interactionism as providing a 'down-to-earth' approach to the scientific research into human interaction and action. Crotty (1998) holds there is a need to understand how groups view phenomena or problems, the meanings they have, and the actions or course of action they undertake. For this research, the philosophical perspective of symbolic interactionism could move the experience of health beyond description to discovering the interpretation or meaning of health that guides the actions of individuals, such as Māori women. Having an insight into how Māori women attribute meaning to their health and interactions with health services can thus provide guidance to the health sector on how to improve access and use of health services by Māori women.

The meaning that individuals acquire about their social world emerges from their interactions with others and the subsequent actions they undertake as they internalise their subjective and objective reality (Berger & Luckman, 1966). Berger and Luckman (1966) refer to this process as socialisation and claim that it always occurs within the contexts of particular social structures. While socialisation and the internalisation of objective and subjective realities usually occurs within a primary social-structural context, Berger and Luckman (1966) claim that secondary socialisation with other realities may be internalised but are not necessarily identified with. This point is relevant for Māori women who undergo a primary socialisation within their social group and a secondary socialisation with a social world governed by the dominant structures and processes. This necessitates many Māori women to live in two different social-structural contexts (one with a collective orientation, and one with an individual orientation) which, therefore, provides the context for their interactions and the meaning they derive from these.

MacDonald (2001) debates a criticism posed by Denzin (1992) and Layder (1989) that the focus of symbolic interactionism on microanalysis contributes to an 'astructural bias'. However, despite Denzin's (1992) criticism, he does conclude that symbolic interactionists also consider influences of social structures and systems on behaviour. This criticism, MacDonald (2001) argues, neglects the influences of social organisations and structures on health behaviours. Both Glaser and Strauss (1967) and Blumer (1969) indicate their primary concern is on the interactions and actions of individuals rather than on social structures or systems. However, the later work of Glaser (1978) recognises the role of social structure in his discussion about basic social processes and the differentiation between basic social structural processes and basic social psychological processes. In fact, grounded theory studies undertaken by Hayes-Bautista (1996), Mullen (1975) and Skodol Wilson (1974) published by Glaser and Kaplan (1996) identified social-structural influences for the social groups they studied.

Charon (1998) maintains social structures include the designation, power, authority and roles that individual members of social groups hold, along with the rules that govern their functioning. MacDonald (2001) does accept that the predominate focus of nursing has shifted from the individual to increasing consideration of the influences that social

structures and agencies have on the health behaviours of individuals. Indeed, the Ministry of Health (2000) recognises the structural influences on both health status and health outcomes for groups such as Māori who experience socio-economic deprivation.

Symbolic interactionism is a philosophical perspective not a research method. One research method that has evolved out of symbolic interactionism and that is oriented toward the discovery and explanation of fundamental patterns that occur in social life is grounded theory. The theoretical knowledge generated by research using this approach is 'grounded' in the realities of the participants and what is important for them – that is, the findings emerge from the data collected. Thus, I argue that grounded theory informed by symbolic interactionism is highly relevant for discovering and explaining what is happening for Māori women's health and their interactions with health services, while holding the perspectives of Māori women central to the generation of any explanation. Prior to discussing the notion of a grounded theory informed by a Māori centred approach, an overview of grounded theory will now be covered.

## **An Overview of the Grounded Theory Method**

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Glaser's and Strauss' combined backgrounds and knowledge in both the quantitative and qualitative paradigms contributed to the development of grounded theory (Glaser & Strauss, 1967). But grounded theory does not solely belong in either the quantitative or the qualitative paradigms. It is a method that attempts to 'close the gap' between empirical research and theory. It was Glaser and Strauss' (1967) expectation that closing of this gap would be achieved through the inductive generation of theory from data originating from reality. The result is a theoretical explanation that is not only meaningful, but that works when applied to real-life situations.

The simultaneous collection and analysis of data is a feature of grounded theory, together with its use of constant comparative analysis. Constant comparative analysis involves the continual analysis of the data for its similarities and differences. Data is coded, categorised and conceptualised during the process of analysis. This process is recorded using memos. Theoretical sampling techniques enable emergent codes or categories to be explored and developed, using data not only from participants but a variety of sources, such as literature. The data gathered is subjected to constant comparative analysis until the codes, concepts and categories generated become saturated (Glaser & Strauss, 1967; Glaser, 1978, 1992, 1998).

As stated, the conceptualisation or abstraction of ideas about the codes, categories and their relationships is documented using memos. These provide a trail of the development of emerging concepts and links between them. This conceptualisation lifts the emerging theory above the raw data. As theoretical codes emerge from the conceptualisation of the coded data they bring together multiple perspectives to reveal patterns and processes of action and interaction (Glaser & Strauss, 1967; Glaser, 1978, 1992, 1998). Theoretical coding enables the identification of categories, their properties and the context within which they occur and their relationship to each other to form a substantive theory. A substantive theory explains the interpretation of, and the actions undertaken in response to situations that are of concern to the participant group under study.

Grounded theory has evolved and developed since Glaser and Strauss' (1967) initial work. The most notable development has been the 'split' between Glaser and Strauss that resulted in a divergence from 'classical' grounded theory. This divergence in perspective and method is worthy of consideration because it prefaces the selection of Glaserian grounded theory to use with a Māori centred approach.

## **Methodological Split**

The split between Glaser and Strauss resulted in their debating the issue of 'emergence' versus 'forcing' of data (Benoliel, 1996; Corbin & Strauss, 1990; Glaser, 1992). Babchuk (1997) describes the debate between Glaser and Strauss as an

epistemological and methodological 'chasm', while Annells (1996) maintains it is an ontological split between the critical realist ontology of Glaser, and the relativist ontology of Strauss and Corbin. Glaser (1992) criticises Strauss' developments with his student Juliet Corbin, as he believes that 'forcing' the data during its analysis compromises the theoretical codes being grounded in reality.

Glaser (1992) maintains the researcher needs to have patience and trust that categories reflective of the reality from which the data came would emerge. The notion of 'forcing' the data is a vital point for this research in that Corbin and Strauss' (1990) approach focuses on a pre-determined problem or phenomenon the researcher aims to develop, rather than generating an inductive grounded theory from what is of concern to the participant group. Their approach is based on the development and testing of questions and hypotheses about a social process, and involves the formulation of conditions, consequences and contexts (Annells, 1997). Glaser (1992) and Schreiber (2001) maintain this process 'forces' the data by the use of a specified coding paradigm that may or may not be relevant, rather than letting the problems or areas of interest emerge. Indeed the process of 'pre-determination' by the researcher appears to be the antithesis of enabling problems or phenomena of concern to the participants 'emerge' from the data.

Annells (1997), however, argues that Glaser's stance about Corbin and Strauss' (1990) approach stems from what she termed as his 'academic distance' that compromises his ability to keep up with contemporary qualitative inquiry debates. However, Glaser's (1992) concern appears to stem from the aberration of the grounded theory methodology that notably departs from its original tenets. Corbin and Strauss (1996) also underpin their version of grounded theory with continual permutation of action<sup>2</sup> - a departure from symbolic interactionism. Essentially Corbin and Strauss' (1990) approach could be considered as a movement of grounded theory from being an inductive to a deductive mode of inquiry.

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<sup>2</sup> Strauss' theory of continual permutation of action focuses on action that can undergo a macro-level social analysis. Strauss maintains that the causes related to the consequences of action are influenced by a set of conditions (Corbin & Strauss, 1996).

The risk of misrepresenting the 'voice' of the participant group under study exists when pre-determined ideas and questions are utilised to direct the collection and analysis of data. This risk heightens when Corbin and Strauss' (1990) developments have eroded the central tenet of the grounded theory method proposed by Glaser and Strauss (1967) that relates to the emergence of what was of concern for the participant group, not the researcher. Annells (1997) suggests that Corbin and Strauss' responses are inadequate to the concerns raised about their method creating a 'crises of representation or misrepresentation' of the 'other' voice.

The conceptualisation of the data in this research needs to be both grounded in, and reflective of, the reality of the Māori women in the study. The ability to reflect the reality of the Māori women could be achieved through 'emergence' but not through pre-determined notions and the 'forcing' of data. 'Emergence' safeguards the research outcomes by maintaining the essence and intent with which the data is shared by the women participating. Undoubtedly, Corbin and Strauss' (1990) method, which allows the imposition of pre-determined ideas and questions, renders it unsuitable for exposing what is of concern for Māori women and their health, and interactions with health services that is the focus of the research question. Instead the most appropriate method selected is the Glaserian method.

Glaserian grounded theory has its roots in the classic grounded theory originally proposed by Glaser and Strauss (1967). Glaser (1978, 1992, 1995, 1998, 1999, 2001) has continued to expand on Glaser and Strauss' (1967) original work. His work has served to clarify, refine and develop grounded theory. Wilson and Hutchinson (1996), and Baker, Wuest and Stern (1992) stress the need to specify the grounded theory approach that will be used to avoid 'muddling' or 'slurring' methods, which risks compromising the integrity of a grounded theory. Such muddling also risks eroding the original tenets of grounded theory. Undoubtedly the methods used to analyse data will influence how the data is both viewed and interpreted (Becker, 1993).

## **Glaserian Grounded Theory**

Glaser's (1978) work reinforces, advances and elaborates the original Glaser and Strauss (1967) version of grounded theory. In doing so, he stresses the need for the researcher to have trust that what is important and relevant to the substantive area under inquiry will emerge from the data. This approach enables what is of importance to the participant group to emerge without preconceived ideas being imposed and data forced to fit predetermined structures (Glaser, 1992). 'Emergence' can be considered a hallmark of Glaserian grounded theory. 'Classical' and Glaserian grounded theory are both underpinned by the philosophy of symbolic interactionism, with the intention to generate an inductive grounded theory that focuses on a substantive area of inquiry. The basic problem or concern for participants is addressed by the social and/or psychological processes that become apparent through the systematic process of constant comparative analysis, coding, memoing, and categorising already described.

The 'evidentiary proof' required by some methods, according to Glaser (1999), does not make the research superior. Glaser (1999) further contends that cultural diversity results in a 'cultural disaffection' with some research methods due to their lack of relevance for many cultural groups. Indeed there is considerable evidence (as outlined in Chapter 2) and subsequent rhetoric, about the 'poor' health status of Māori. The rhetoric has elements of victim blaming and negative stereotyping that positions Māori women negatively on a continuum of 'good health' versus 'poor health'. Rhetoric that labels and victim blaming does little to improve the health status of Māori women, or any group. It tends to focus entirely on the deficits individuals or groups may (or may not) have, and on the disease or illness process. Such rhetoric does little to expose and build upon the strengths they may possess, and does little to identify what is important for enhancing health.

A further hallmark of Glaserian grounded theory is the conceptual rather than the descriptive nature of the research outcomes. Becker (1993) points out, a common

'pitfall' of grounded theory research is the production of description about whatever is going on within the substantive area under study. Glaser (1978) stresses that grounded theory must provide a theoretical explanation of the phenomenon under study (Glaser, 1978, 1998, 2001). As well as producing a theory that rises above description, the conceptualisation of the data and establishment of the relationships between the concepts generated must explain what is going on within the substantive area under study.

It can be rightly argued that both the emergence and conceptualisation of the data are inherent components of Glaser and Strauss's (1967) classical version of grounded theory. This is not denied. However, it is evident in Glaser's (1992, 1995, 1998, 1999, 2001) writing since the split with Strauss, that he goes to great lengths to explicate the process, and develop both emergence of the data and conceptualisation.

## **Methodological Rigour**

What matters to the participant group, and what explains the ideas, meanings and actions they engage in (rather than the persons in the research) should be evident in rigorous grounded theory. Rigour is established when the grounded theory meets the criteria of fit, relevance, work and modifiability (Glaser, 1978). In summary, a substantive grounded theory must:

1. Be systematically generated from the data, so the basic social psychological process explains the actions and response of the participants within the substantive area under study, and integrates the categories generated.
2. Have both fit and relevance.
3. Work to explain, predict and interpret the substantive area researched, with the categories clearly contributing to the explanation, prediction and interpretation.

Because of the subjective nature in which qualitative grounded theory is generated, Chiovitti and Piran (2003) maintain the standards of rigour are (a) credibility (the

research methods reflect the participant's meaning, and the researcher's views and insights), (b) auditability (the selection of participants, and the identification of questions and criteria to guide the analysis of data), and (c) fittingness (that identifies the scope of the research, and how the literature relates to each category). Glaser (1998, p. 133) maintains "...well constructed grounded theory concepts 'sell' well to those to whom it makes sense, and usually 'quick sense...'", referring to this as 'conceptual grab' (Glaser, 1998).

## **Grounded Theory and a Māori Centred Approach**

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A grounded theory using a Māori centred approach aims to generate knowledge based on the perspective of Māori participants. Neither a Māori centred approach nor symbolic interactionism, which informs grounded theory, deny the use of diverse research methods or the contribution they can make to the generation of knowledge (Benzies & Allen, 2001; Cunningham, 2000; Durie, 1997). I contend that the use of a Māori centred approach and grounded theory together is not only possible, but these two are mutually beneficial for undertaking research with Māori.

It is feasible to merge differing philosophies to inform the research method. Both Cunningham (2000) and Durie (1997) support the notion of diversity of method and the use of 'mainstream' research methodologies with a Māori centred approach to research. Feminist grounded theory illustrates the merging together of symbolic interactionism with feminist theory. For example, Wuest (1995) argues that the feminist philosophy that underpins research can function to improve the position of women within the research relationship. Grounded theory is in a process of evolution and is conducive to feminist research, according to Keddy, Sims and Stern (1996), although they recommend retaining the language of grounded theory. Indeed, Dignam (cited in

Giddings & Wood, 2000) maintains that methods evolve, and therefore, it is important that the method being used is clearly expressed.

A grounded theory using a Māori centred approach optimises the power of any theoretical explanation having 'conceptual grab', and benefits the group that participants belong to. Simply, the research method needs to work in order to provide a significant explanation of the phenomena identified within the research. Undoubtedly, Māori women are sources of knowledge who can articulate what is significant for them as individuals. Keeping the Māori participants central, and utilising processes that are both appropriate and acceptable, increases the likelihood that what is significant for the participant group emerges. If participants have both comfort and trust with the process and methods used, it is reasonable to conclude that they are likely to share what is important for them more openly. The researcher controlling the analysis and conceptualisation of the data, however, is a potential limiting factor. The researcher's position of marginality (Bowers, 1988), however, and the process for assessing methodological rigour should optimise the theoretical explanation having fit, relevance and workability (Glaser, 1978).

Given that a Māori centred approach cannot be considered a research method, it can still provide a philosophy to guide the implementation of a research method, such as grounded theory. In fact, the inductive nature of the generation of a grounded theory is ideally placed to merge with a Māori centred approach. What it does is provide the structure to manage the data without imposing any particular lens on it (Benzies & Allen, 2001). The emerging theory is driven by the data, not a theoretical framework, and thereby moderates the criticism of some Māori researchers (such as Smith, 1999) that the lens used for the interpretation of the data is either inappropriate or unacceptable.

A grounded theory using a Māori centred approach is able to incorporate the diversity that exists within participant groups. It is unrealistic to expect a homogenous group of research participants, even among Māori women. Māori women come from a myriad of backgrounds and experiences that result in their interpretations and meanings of phenomena that have both similarities and differences. The reality is that diversity

exists within cultural groups, yet shared interpretations and meanings about symbols and objects are evident. Constant comparative analysis is able to expose the shared interpretations and meanings held by the group (Wuest, 1995). In discussing feminist grounded theory, Wuest (1995) reinforces the need for research to account for the multiple diversities and pluralities that exist within various groups.

Culture, from the perspective of symbolic interactionism, provides a frame of reference acquired through the processes of socialisation, abstraction and generalisation of sets of shared rules (Charon, 1998), and thus influences the way individuals within groups interpret and act on phenomena. This research focuses on participants who belong to a specific gender and cultural group – a position that may be criticised from a grounded theory perspective. Glaser (1999, pp. 839-840) explains that:

Grounded theory tells us what is going on, tells us how to account for the participant's main concerns and reveals access variables that allow for incremental change. Grounded theory is *what is* [sic], not what should, could or ought to be.

While the participants in this research belong to a specific gender and cultural group, I entered the research with no preconceived notion about what would emerge from the data. The intention of this research was to make a contribution to the body of knowledge about Māori women and their health – an area that was lacking. Glaser (2001) rightfully suggests that the core variable that emerges in a grounded theory should transcend 'time, place and people', so that a neutral and generalised grounded theory is produced that can be used to explain processes used to resolve a specific group's problem(s), such as Māori women. If issues pertaining to gender or culture exist, and are of significance for the research participants, they will emerge from the data during the processes of coding, categorisation, constant comparative analysis and conceptualisation. To this end, gender and culture must 'earn' their way into a grounded theory (Glaser, 2001).

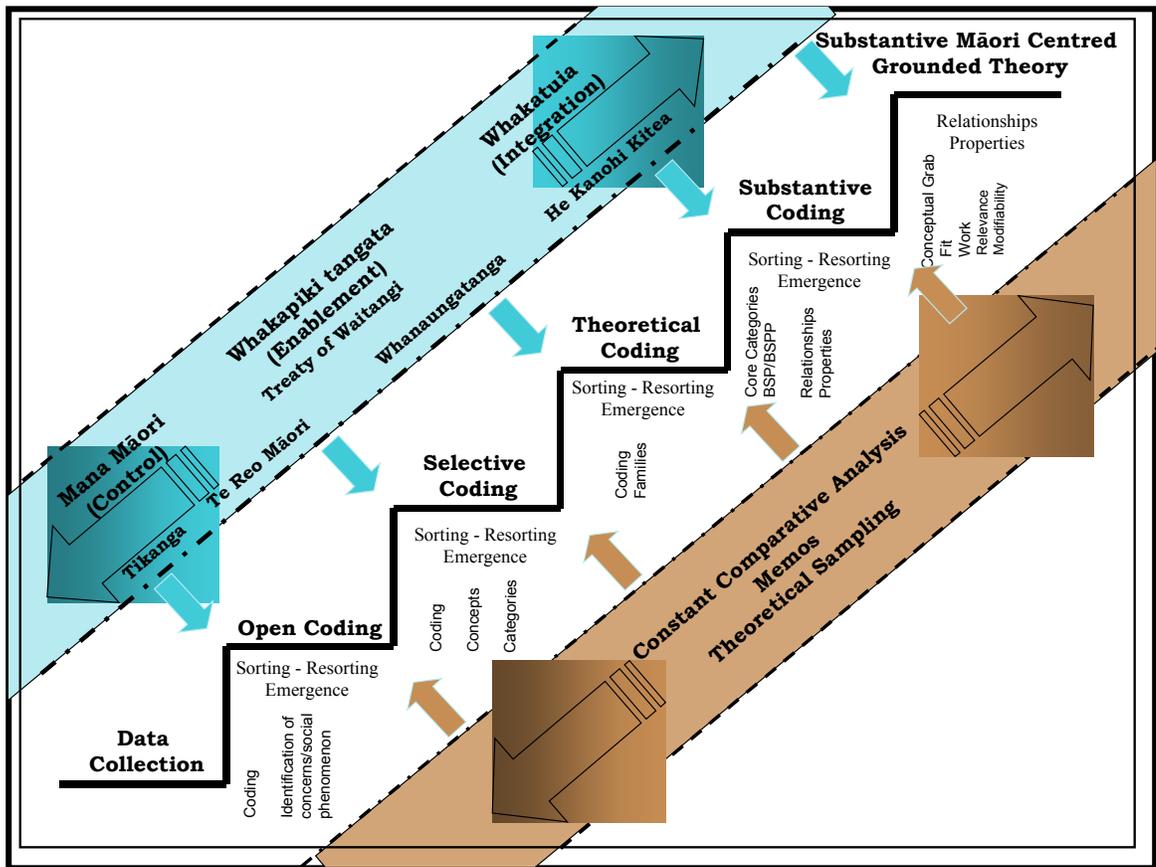
Grounded theory has been used to study specific gender and cultural groups. For example, Wuest (1995) claimed that the use of a feminist philosophy with grounded theory supports the reduction of objectification and exploration in the research

relationship. Dickson and Kim's (2003) grounded theory study on Korean American women's experiences of osteoarthritic pain was argued on the basis of a need for culturally specific knowledge about this group of women. They maintained that culture influenced their perceptions, responses (including health-seeking behaviours) and health beliefs. Glaser (1993; 1994; 1995) and Glaser and Kaplan (1996) have published cultural and gender focused studies, such as (a) Hayes-Bautista's (1996) study on changing ethnic identity where he sampled Chicano health professional students; (b) Kearney, Murphy and Rosenbaum's (1974) study on mothers who were on crack cocaine; and (c) West and Glaser's (1988) study on older women undertaking college education. Thus, it appears that grounded theory method can be explicated for sub-groups, such as gender and culture. Researching Māori women using grounded theory informed by a Māori centred approach enables the generation of a new perspective on Māori women's health without imposing preconceived ideas about the meanings and actions they have about health, a notion supported by Stern (1980).

## **Research Design**

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Undoubtedly an understanding of what is happening for Māori women and their health from their perspective can make a contribution to the improvement of the delivery of health services to Māori women. Yet, as established in Chapter 2, research that investigates the relationship that Māori women have with their health and with health services is scarce. This section will outline the explication of grounded theory informed by a Māori centred approach, and will begin with the research aims and question followed by a discussion on the management of the research with regard to maintaining a Māori centred focus. The sampling strategies, criteria and consent issues used in the selection of the participants are then discussed. The data collection and analysis strategies will then be explained, including the establishment of research rigour. This section will conclude with a discussion on how the remaining ethical considerations pertaining to the research were addressed.



**Figure 5.2.** The process for the generation of a substantive grounded theory using a Māori centred approach.

The process of grounded theory informed by a Māori centred approach can be graphically depicted using the poutama (Figure 5.2), which is a step pattern found in tukutuku panels in whareniui. The poutama is used by Māori to describe the process of learning, where it takes time for activities to be understood. Processes, such as titiro, whakarongo, and kōrerō are undertaken during the plateau phase of the poutama to enable understanding. Once learning has occurred, the learner ascends to the next step (Tangere, 1997). Likewise, grounded theory using a Māori centred approach begins with the collection of data and through the processes of constant comparative analysis, theoretical sampling, memoing, and saturation, the data is coded, sorted and resorted during the plateau phase. Similar to the process of learning, the development of the grounded theory using a Māori centred approach ascends in steps from open to theoretical to substantive coding, until a substantive theory has emerged. The nature of

the steps enables previous data and analysis to be revisited and revised by descending and then re-ascending the steps. Throughout this process Māori centred principles and processes constantly guide and inform the collection and analysis of the data.

The Māori centred model informs the management of the development and implementation of the research design. It highlights the need to keep Māori central throughout the research process, along with key factors that need to be observed to ensure the credibility of the research. Therefore, from the consultation that was undertaken early in the research process, to development of the research question, to the selection of participants, to the collection of data, Māori women and relevant groups were involved. Glaserian grounded theory provides a method that is compatible with the research question and aims, and was appealing, as it would let what was of concern for the participants to emerge without imposing a 'western' lens or any lens on the analysis of the data. Grounded theory guided the data collection and analysis, and the conceptualisation of the codes, concepts and categories in the construction of the theory about Māori women's health and their interaction with health services. Interestingly, the participants talked about Māori concepts in reference to 'their world', however, it was noted that as they talked about their health in relation to 'mainstream' health services reference to Māori concepts became minimal. The use of a Māori centred approach to inform grounded theory enables a 'Māori' emergence from the data, and to this end the grounded theory generated reflects the interpretations and meanings of the Māori women participating. Keeping the Māori centred process in mind, the next section outlines how the research process was managed.

## **Management of the Research Process**

The research process used needed to be in accordance with the Treaty of Waitangi (Health Research Council, 1998), as this study focused on Māori women. Thus, the Royal Commission on Social Policy's (1988) principles of partnership, participation and protection were used. First, in terms of partnership and participation, a consultation process was undertaken with some Māori women, and with groups such as Te Mana

Hauora o Te Arawa, Te Puni Kōkiri and Lakeland Health's<sup>3</sup> Te Whakaruruhau. Initially, I made myself known – where I was from, who I was, what I was doing, what I hoped to do after discussions with them, and who needed to be involved. Using this process I negotiated with these groups the research aims, its processes, and the procedures that would be used.

The consultation process was aided by working with two Māori women who undertook an important and valuable role in the development of the research question and methodology, and in accessing the appropriate persons or groups to consult with. These women also played a valuable role as intermediaries later in the access and selection of participants (discussed further in the *Participants* section). Working with the Māori women and the Māori groups mentioned above ensured that the research process was both appropriate and acceptable for Māori, and protected their cultural integrity. Their participation also facilitated the development of their knowledge about research processes, which was an important element related to the principle of partnership and the concept of reciprocity.

The process of consultation and negotiation also aimed to ensure that Māori women would be able to participate in a manner that was acceptable to them, and that upheld and protected their beliefs and interests. The maintenance of a partnership approach with the two Māori women intermediaries, and participants facilitated my being able to be sensitive to their needs and wants throughout the process. A partnership approach also enabled them to have some degree of control over their participation. For example, some women indicated they wanted to be interviewed individually, in pairs, or in one instance, as a group.

It was negotiated that the ownership (and the implicit intellectual property) of the information shared during the interviews in the form of field notes, remained the property of the respective women and would be available to be returned to them if they so requested. It was also negotiated at the time of consent to participate in this

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<sup>3</sup> At the time of writing this thesis, Lakeland Health has since been restructured with the Labour-led Governments 2000 health reforms, and is now know as Lakes District Health Board (DHB)

research that the original information shared would be analysed along with information supplied by other Māori women, and that this analysis would be jointly shared between myself as the researcher and the University in the form of intellectual property. It was explained that once the analysis that involved comparing each set of information was undertaken and developed withdrawal of the information from the study would be difficult. None of the participants withdrew from the study or requested their field notes. It was also negotiated that in the first instance that the findings of this study would be disseminated to the Māori women in this research, if they so wished, at its completion. This would then be followed by meetings or hui with the groups supporting this study – that is, Te Mana Hauora o Te Arawa, Te Puni Kokiri and Lakes DHB Te Whakaruruhau. Written copies of the study's findings will be provided for the women and the groups attending the proposed meetings or hui – that is, they will be disseminated in both oral and written forms.

## **Research Question and Aims**

Māori women have a role in the health and development for not only themselves, but also their immediate whānau, and are often involved in the health and development of their wider whānau, hapū, iwi and community. Having an insight and understanding about how Māori women construct their understandings about health and their health behaviour is beneficial in informing the delivery of effective health services, especially as health is a socially and culturally determined concept. Thus, as mentioned in Chapter 1, this research aimed to:

1. Ascertain the interpretation Māori women have of health and how this influences their health behaviours.
2. Determine the interactions Māori women have with health services.
3. Generate a substantive grounded theory, informed by a Māori centred framework, about Māori women's health and wellbeing.
4. Use an appropriate Māori-centred research methodology.

The research question asked was:

*What is happening for Māori women, their health, and their interactions with 'mainstream' health services?*

In order to develop and implement the research design there were various processes that needed to be undertaken to satisfy the requirements of Māori. The next section outlines the management of the key processes that were undertaken.

## **Participants**

Twenty-three women finally participated who resided in the Te Arawa rohe at the time of the research (plus approximately 15 others that were informally approached during the theoretical sampling phases). The participants identified with a number of North Island iwi, including Te Arawa, Ngati Pikiāo, Ngati Whakaue, Tūwharetoa, Ngati Awa, Tuhoe, Tainui, Ngati Porou, Raukawa and Ngā Puhī. The participants varied in the degree of access to cultural activities that they experienced, such as participation on the marae, and access to, and fluency in understanding and speaking, te reo Māori. For example, some were fluent in te reo Māori, others were able to understand the language but not speak it, and some did not have the language at all.

They ranged in age from 24 to 61 years. The majority of the women had children and were living in a variety of relationships, that is permanent, non- permanent, or they were on their own. Most lived in homes with more than one family or generation. The level of education also varied with the women, with some leaving school without a qualification to those who had undertaken some tertiary level of study. Many of the women were in paid work, although most were employed part-time, and some were not employed receiving income support. Not all of the women participating had access to telephones or private transport. When the participants were unwell they generally consulted either a doctor or a Māori health provider.

While all the participants identified as Māori, as a participant group they were diverse in their iwi affiliations, cultural experiences, age, and education, employment and socio-economic backgrounds. This demographic diversity also contributes to diversity in their beliefs, understandings and philosophical perspectives. The process of constant comparative analysis exposed the common patterns and differences in the participant's understandings and experiences of health and their interactions with health services, and enabled the verification of codes, concepts and categories as they emerged (Glaser, 1998). This will be further elaborated in the data analysis section of this chapter.

## **Sampling Strategy**

The purposeful sample was acquired by a network sampling strategy. Purposeful sampling was used to identify the group being researched, and to ensure that the participants met the criteria for inclusion in the study (Polit & Hungler, 1991). Potential participants were required to meet each of the following criteria to be eligible for inclusion in this research. That is, they needed to be:

1. A woman, who
2. Identified as Māori, and
3. Aged between 15 to 80 years.

Katzer, Crook and Crouch (1982, p.212) define purposeful sampling as a "...non-random sampling technique in which researchers use their knowledge of a *population* [sic] to select a *sample* [sic] for a given purpose." This form of sampling is used when the participant group is specifically defined and the needs of the research dictate, as in this research (Morse, 1991; Polit & Hungler, 1997). Purposeful sampling is also compatible with theoretical sampling, which guided the collection of more data from Māori women about an emerging code, concept or category, and for verifying their emergence, until they are saturated (Glaser, 1992). Theoretical sampling occurred

throughout the coding processes and in the development of the substantive grounded theory.

Network sampling strategy complements purposeful and theoretical sampling by taking advantage of social networks in order to access participants – it can be considered a form of convenience sampling (Burns & Grove, 1993; Polit & Hungler 1991; Morse, 1991). Two intermediaries were used for the selection of participants, a decision made during the consultation with Māori when the research was being developed. The intermediaries came from the Te Arawa rohe where the research was conducted and were actively involved in the Māori community. These women approached a number of individuals and community groups who met the inclusion criteria for the research. The role they played involved undertaking the initial approach and negotiation regarding participation in the study. This approach proved to be immensely effective and valuable, as the intermediaries also organised the interviews and ensured the participants were available for the interview.

The intermediaries used network sampling, which was based on the premise that these intermediaries were able to differentiate between ‘insiders’ and ‘outsiders’. The intermediaries, as Māori women themselves, were familiar with the criteria for selection and the process of theoretical sampling, and interacted actively within the community of Māori women under research to recruit participants for this research. These women were thus deemed qualified to recommend who would have the information required for the purposes of the research, a strategy suggested by Morse (1991). The intermediaries developed familiarity with the selection criteria as I worked with them. Theoretical sampling was undertaken as codes, concepts and categories were generated and more information was required for their saturation, or verification about what was emerging was needed. For example, the notion of *te whare tangata* arose in early interviews and was discussed at length by a group of participants. *Te whare tangata* was then theoretically sampled in subsequent interviews and its physical and spiritual significance for the Māori women was ascertained. Table 5.3 (see later in this chapter) shows an example of comparative analysis that arose out of the theoretical sampling of an emerging code on *te whare tangata*.

The Māori concept of he kanohi kitea (a feature of the Māori centred approach outlined in Figures 5.1 and 5.2) to access participants was aided by network sampling. He kanohi kitea requires having contact within the community, being known and having an established credibility amongst the members of the community (Stokes, 1985). Stokes (1985, p.11) stressed the importance of establishing credibility through the 'known face' and stated:

The man or woman who travels alone will be cold and lonely. The one who travels with a group will have their warmth and support on the journey. The researcher in tune with the people will be supported by their aroha.

Polit and Hungler (1991) note the risk of bias in the sampling strategy and participant selection process. The bias in this research was recognised in the development of the research design, however, the intention was to elicit the perspectives of Māori women in order to generate one explanation. That is, it was not intended to produce an explanation that can be generalised or claimed to be the 'perspective' of all Māori women. Indeed the use of theoretical sampling means that both purposeful and network sampling are appropriate and necessary strategies in the development of a grounded theory.

## **Consent**

Historically Māori have an oral tradition, and it was acknowledged that prospective participants might be te reo Māori speakers and prefer to receive and discuss information relevant to the study in te reo Māori. To ensure that prospective participants had a choice, the Participant Information Sheet (Appendix 2) and the Consent Form (Appendix 3) were translated and made available with te reo Māori on one side, and English on the other side. The majority of participants chose to use the English version, although the presence of a te reo Māori version was noted and appreciated by most participants.

Prior to commencing the interviews, the process of whanaungatanga was used (see Figure 5.2). I introduced myself and stated where I was from (including my iwi and hapū affiliations, and my professional affiliations), and what I was doing (outlining the

aims of the study). I also expressed my appreciation for their agreement to participate in the study. This process facilitates the establishment of mutual connections and relationships – family, friends or acquaintances. Following this process the terms of the study were outlined.

The Participant Information Sheet (Appendix 2) and the Consent Form (Appendix 3) were reviewed with the participants, and any questions a participant asked were answered. It was stressed that the women could withdraw from the study at any stage without any consequence. One woman that had been selected to participate felt too *whakamā* and was reluctant to participate. In this case I reiterated that it was perfectly all right for her to choose not to be involved in the study if she did not feel comfortable. She chose not to participate.

Consent was obtained either in written or oral form. One group indicated that their presence was sufficient consent and they raised questions around the appropriateness of formal written consent within what they perceived as a Māori-centred approach. This raised an interesting discussion as some participants viewed written consent as a 'western research issue' and not necessarily their issue as Māori women. They firmly believed their presence was an indication of their consent. The 'rules' set down about consent within the broader ethical context aims to protect the research participants and the university. Some of the participants (within the context of their worldview and beliefs and practices) maintained the requirement for written consent was a patriarchal approach of 'we know best' dictated by 'dominant' groups, such as the Health Research Council or the university ethics committees. The research had been designed (and ethical approval obtained) so consent to participate in this research could be provided by either individual written or verbal consent, or by Kaumatua consent, dependent upon what was the most appropriate and acceptable form of consent for each of the Māori women. This provided the Māori women both choice and control over how they wanted to express their consent to participate. The Māori women in this study provided either written or verbal consent.

## Data Collection

Data collection is the first step of the poutama model that depicts the process used to generate a grounded theory (see Figure 5.2). The data was collected from the participants using semi-structured interviews with both groups and individuals, dependent upon their wishes. The collection of data in grounded theory allows methods such as interviews with, and observations of, participants and also includes a variety of other sources (Glaser, 1996, 1998; Schreiber, 2001). The interviews were structured in a way that the participants are able to recount their reality without my agenda and structure, as a researcher, becoming a barrier (Schreiber, 2001). Therefore, semi-structured interviews were conducted with minimal broad focused questions being used in order to elicit the participant's perspective.

Three broad questions (Figure 5.3) based on the research questions and aims were used in relation to the research question to initiate discussion with the participants. By providing a broad framework that related directly to the research questions and aims, these questions were designed to engage the participants, ensure the research aims were addressed, reduce ambiguity, and minimise researcher bias (Wilson, 1997). This approach allowed relevant issues arising to be explored and areas identified for theoretical sampling. Schreiber (2001) supports the use of semi-structured interviews, as she maintains that structure impedes the participants sharing their reality, affecting the data quality.

**Initiating questions used for the interviews:**

- Tell me what health means to you.
- What are the things that are important for your health?
- Tell me about your interaction with health services and the people working in them.

**Figure 5.3.** Initiating questions used for the semi-structured interviews.

I had initially decided that the interviews would be audio taped when planning the research design, primarily for the purposes of clarification and verification when the information was being analysed. The participants, however, indicated a preference for the information to be recorded by detailed written notes, as a recording of the interviews as they felt more comfortable to talk without our conversation being recorded. In accordance with the Māori centred approach (Figure 5.1), the participants were able to exercise this control, and their decisions were respected. My previous experience in taking detailed notes of conversations and meetings in the various professional roles that I have held prepared me to make a written recording of the interviews in the form of field notes. After the interviews the field notes were then typed up ready for coding.

Glaser (1998), in fact, recommends avoiding the taping and transcribing of interviews, as it is time consuming, creates delays in theoretical sampling (due to the transcription process), and does not necessarily capture all the information, such as non-verbal language (Glaser 1996; 1998). This position reassured me that not taping the interviews was acceptable for grounded theory. Schreiber (2001) concurs with Glaser that taping is not imperative, and maintains that information that is pertinent to the study can then be attended to and explored. Previous research experience (Wilson, 1997) where the tape recorder failed and I had to rely on field notes, gave me some confidence that the essence of what the women had to say could be captured. A criticism of using only field notes is that the researcher may forget or miss data and may be selective. Glaser (1998, p.110) however, refutes this and states:

The mind is a sponge. It does not forget anything. The problem is to call up data by association, which generating grounded theory does automatically by coding, conceptualizing, analyzing and theoretical sampling. What is missed will be remembered when relevant.

I found that it was not so much an issue of 'missing' data or becoming 'selective', but the process of simultaneous analysis and conceptualisation brought data that was seemingly irrelevant at one time into relevance. This emerging data could then be followed up with theoretical sampling.

The detailed notes I took to capture the information the Māori women shared in their interviews, together with my reflections and thoughts recorded immediately after each interview formed the field notes for this research (Schreiber, 2001). This allowed vital information, such as observations, to be captured, which is important according to Glaser (1996; 1998) and Schreiber (2001). The dependability of the information recorded was confirmed with the women during the interviews using the processes of rephrasing, clarification, and summarising. I also explored with the participants whether they wanted to change anything or add any further information to reflect their thoughts. In the group interviewed, the participants listed their key concerns on a board, and checked this against what I had recorded. The use of field notes to also record observations after the interviews combined with the discussion recorded during the interview – a ‘meaningful mix’ according to Glaser (1998).

Global and generalised statements and comments are evident in the content of the field notes, reflecting the collective orientation of the Māori women, which contrasts with an individualistic orientation. For example, rather than talking about themselves they make reference to ‘Māori women’. Māori women anecdotally do not tend to ‘promote’ themselves as individuals but position themselves collectively among others. Therefore, when reading the data examples in the findings chapters, it should be noted that these are not representative of my taking an interpretive leap when reference is made to ‘Māori women’.

Having a method of data collection that did not require the interviews to be audiotaped fitted with the Māori centred approach whereby the participants could have some control over the process. In planning the research the potential for assistance with translation was recognised and planned for. However, the need to access external assistance to translate te reo Māori within the data was not required as it was within my capability, as the researcher, to interpret and understand.

## **Theoretical Sampling**

As the data collection was occurring, its analysis was being undertaken (Glaser & Strauss, 1967). The focused collection of data occurred using the process of theoretical sampling, which involved the further exploration of the emerging codes, concepts and categories for exploration, clarification, verification, and saturation (Glaser, 1998). For example, a group of women interviewed expressed their concern about the apparent loss of knowledge pertaining to te whare tangata, especially with young women. In response to the importance that the participants placed on this apparently important spiritual concept I decided to undertake theoretical sampling. With this in mind, other participants, informally focused interviews, and the literature were also theoretically sampled. I sought to establish if this was a concern for Māori women participating (see Table 5.3 for an example of the theoretical sampling that led to comparative analysis between two different interviews), and found that they had differing perspectives although similarities existed.

Up until the stage of data collection, the literature was used to justify the need for this research. It was only after the concepts, properties and categories had emerged that the literature was consulted, ensuring the emerging grounded theory was free from the 'claims' of the literature (Glaser 1998). At this stage the data was then compared to the literature that was directly relevant to the emerging concepts, properties and categories, as Glaser (1998, p. 89) refers to this as "...simply more data." The literature was sampled, for example, with regard to the concept of tapu in relation to the emerging concerns around the loss of te whare tangata. Thus, theoretical sampling involved the research participants, as well as a variety of other data sources, such as informal interviews and discussions, literature, other research, and popular media. Schreiber (2001, p.66) supports such an approach, commenting that:

...good grounded theories are built on a variety of data sources and perspectives on the topic, but the choice of data source is determined and directed by the emerging theory.

As mentioned earlier, everything in grounded theory can be considered data (Glaser, 1978, 1998; Schreiber, 2001). Thus, the use of the literature in writing up the findings

chapters reflects the theoretical sampling that occurred after the categories, concepts and properties had emerged, that supports the theory, rather than as debating or drawing conclusions about the findings. Glaser (1998, p. 67) maintains the literature is "...woven into the theory as more data for constant comparison." The literature, has been therefore, used for comparison and to refine concepts, properties and categories, rather than arguing an assertion in the findings.

## **Data Analysis**

The analysis of data occurs together with its collection. This required my needing to be sensitive to the data by remaining open to what was emerging, and minimising the influence of pre-determined ideas, propositions and biases. Bowers (1988) refers to this as holding a position of marginality that encourages sensitivity and an ability to 'see' objects in the participant's world. While Glaser (1978) maintains that a naive approach needs to be taken when using grounded theory, this is not always feasible. For example, the researcher may have prior experiences and undertaken reading around the area in the development and formation of the research project. Indeed, as a Māori woman, a registered nurse, and someone who had an interest in Māori health, I came with prior experiences and exposure to the literature. Schreiber (2001) argues that few researchers approach a study without a familiarity with the area, and that it is unrealistic to 'unlearn' what is already known. She believes that some knowledge of the substantive area under study can be advantageous for theoretical sampling and theoretical sensitivity.

The risk during the analysis of the data is imposing preconceived ideas onto the data. Schreiber (2001) recommends the use of reflexive memos to document these and put them aside. Reflexivity recognises that the researcher is part of the social world they study, and requires researchers to honestly examine their assumptions, behaviours, and motives that may impact upon the research (Ahern, 1999; Bowers, 1988; Schreiber, 2001). Ahern (1999) and Bowers (1988) also recommend the researcher temporarily 'bracketing' their own perspectives, assumptions and biases that may impact on the data in order to minimise imposing unidentified preconceived ideas onto the interpretation of the data. In order to expose my assumptions, I began the research with a 'free writing' exercise where I unreservedly and honestly wrote my thoughts and

feelings down into a journal, that I kept throughout the research process. This journal also became a place where I documented my thoughts, feelings, and assumptions down, and assisted me to minimise and identify any area of bias that may have been entering the analysis of the data by making them conscious (Tolich & Davidson, 2003).

## Open Coding

During the analysis of the data I was guided by the methods of Glaserian grounded theory. The data initially underwent a process of open coding where I assigned labels or codes to the data as it presented in order to generate codes (see Table 5.1 for an example). Constant comparative analysis is used throughout the process and begins with open coding to generate codes, concepts and categories that are verified and refined as they emerge and until they became saturated (Glaser, 1978). This involves codes being sorted, re-sorted and then refined as concepts and categories, as their properties begin to emerge. Open coding is confined to the substantive area under study to promote the relevance, fit and work of emerging categories.

**Table 5.1**

*Generating Codes*

Excerpt from Data	Open Coding
<p><b>Ref #:</b>            The spiritual part plays an important part as get older. It is about being at peace.            Contact with whanau is nurturing and a source of great comfort. It is also about connecting with the pa.</p>	<p><b>Spiritual Part</b>  <b>Important</b>  <b>Being at peace</b>  <b>Contact with whanau and pa</b>  <b>Nurturing</b>  <b>Source of comfort</b></p>

Hayes-Bautista (1996, p.9) stresses that concept generation must reflect the reality of the participants if they are to be meaningful. Thus, the naming of codes, concepts and categories undergo modification as the data is subjected to constant comparative analysis and subsequent refinement. Glaser (1998, 2001) recommends the use of '*in vivo*' codes, that is, the participant's words, where possible. This ensures codes accurately reflect what the participants are saying and clearly links the emerging codes, concepts and categories to the data.

## **Memos**

Writing memos assisted in the process of capturing the meaning and the development of the ideas that were emerging, and the conceptualisation of the data and development of the categories, concepts and properties, (Glaser, 1998). They were used to track the process of abstracting the ideas that arose from the codes, concepts and their relationships. An example of a memo about the use of language is outlined below in Figure 5.4.

Despite Glaser's (1978, p. 83) assertion that the "...*prime rule* [sic] is to *stop and memo* [sic] no matter what", I found this to be a constant challenge, the greatest of which was the inability to write-up memos immediately. My making rapid conceptual movements during the process of thinking compounded this. Thus, I used a variety of forms of memos, including diagrams, drawings and notes, along with more substantive pieces of writing, developing what Glaser (1978) refers to as a 'memo fund'. Glaser (1998) asserts that memos can be unstructured, lack visibility, and are private. Indeed, memos assist in the analysis of data by providing greater focus and in identifying any gaps that may exist. Not only do they trace the development of the theory, but they also assist in the process of theoretical sampling (Glaser, 1998).

**Excerpt from Memos - 11/12/00:**

The language used by health professionals is perceived to be 'professional' and subsequently a barrier as the women are often unable to understand. (e.g. ref: HO1, IO3, IO4, IO8) Language was also viewed as being used as a 'scare tactic' and complicated (e.g. ref: HO1, IO3, IO6). It is evident that they want more of a user-friendly approach when language is used, as this is very important (e.g. ref: IO3, IO4, IO8)...Comprehension is again vital requiring health professionals to listen with their "ears and hearts". (HO1) Obviously when these women are unable to verbalise their difficulty in understanding, they also note that their body language is being ignored. Explanations may need to be reinforced if there is a lack of understanding. (IO3, IO4, IO6, IO8) These women are not lacking in intelligence, but are receiving messages from health professionals who do not recognise that for others, their area of practice is totally foreign. This is often due to their expertise and the 'normalisation' of the language they use.

**Figure 5.4.** *Theoretical memo on the uses and consequences of language.*

## Selective and Theoretical Coding

The next two steps on the poutama (see Figure 5.2 earlier) where coding moves beyond open coding to selective and theoretical coding. The aim was to limit the coding to only those variables that relate to the core variable or basic social (psychological) process (Glaser, 1978). Further data collection through theoretical sampling and its analysis was guided by the emerging core variable. Categories and dimensions generated from the data through a process of sorting, assisted with achieving the 'best fit' and meaning to reflect the data.

The process of constant comparative analysis of data and the emerging codes, concepts and categories compared the similarities and differences in the data. I used the questions outlined in Figure 5.5, posed by Glaser (1978), to guide the coding and categorising of the data. An example of the comparative analysis can be seen in Table 5.2, where I compared the data from two interviews about the emerging code of *te whare tangata*. I used theoretical sampling to explore this concept along with going to the literature. The data underwent a process of constant comparative analysis, sorting and resorting, that eventually culminated in the generation of the property *influencing te whare tangata* under the concept of *Nurturing Wairua* (see Chapter 7 for more details).

**Questions guiding the constant comparative analysis:**

- What is this data a study of?
- What category does this indicate?
- What is happening in the data?
- What are the processes at work?

**Figure 5.5.** Questions used to assist the process of constant comparative analysis. Note questions adapted from Glaser (1978).

Initially the coding of the data enabled me to organise it so that I could then sort it into something more meaningful and coherent. The poutama model (Figure 5.2) depicts the process involved of sorting and resorting the data and emerging codes into categories, concepts, properties, and identifying the concern for Māori women. Thus, as the stairway pattern of the poutama indicates, I was able to ascend, descend and re-ascend the poutama in order to recheck and verify the emerging codes, concepts, categories and properties, aided by constant comparative analysis, memoing, and theoretical sampling.

**Table 5.2**

*An Example of Comparative Analysis*

Excerpts From Field Notes INTERVIEW ONE	Coding	Excerpt From Field Notes INTERVIEW TWO	Comparative Coding
<p><b>Ref #: HO1</b> Many young 'Mums' no longer consider their bodies tapu, yet there is a need for them to look after their bodies. Tapu means they control people entering and leaving their bodies, but some young women just let men in and out of their bodies – this results in high pregnancy rates and sexually transmitted diseases. Increased pregnancy rate could be attributed to this lack of knowledge. Young Māori women need to look after their bodies. 'girl' having had sexual relations with 70 men. If this young woman had knowledge about the spiritual significance of te whare tangata and the consequences of tapu for keeping herself safe, she wouldn't let so many 'people in and out' .</p>	<p>No longer consider bodies tapu</p> <p>Need to look after</p> <p>Role of tapu Control</p> <p>Association with increased pregnancy Women bearers of future generations</p> <p>Practical aspects of spiritual concept</p> <p>Need to look after bodies</p> <p>Knowledge of spiritual significance of te whare tangata and tapu</p> <p>Keeping self safe</p>	<p><b>Ref #: IO1</b> According to embalmers, women were returning from post-mortems without their reproductive organs. This stops the spiritual flow and the returning to Papatuanuku. There is a distress that occurs when the spiritual flow with Papatuanuku was disrupted ...when upon their death women are returned to Papatuanuku. This is a cause of distress for some Māori women not knowing that the reproductive organs are the physical expression of te whare tangata and they will not be returned. There is a real need for more women to be educated about te whare tangata as it also has practical applications. Te whare tangata's spiritual underpinnings provide practical direction for keeping oneself well. For example, abstaining from casual sex reduces the incidence of the body being invaded by 'foreign things'. The loss of knowledge about te whare tangata and the availability of contraceptives, however, has enabled young women to engage in casual sex.</p>	<p>Importance of women's reproductive organs Spiritual flow between women &amp; Papatuanuku</p> <p>Distress when spiritual flow is disrupted</p> <p>Reproductive organs are a physical expression of te whare tangata</p> <p>Need for education</p> <p>Spiritual underpinnings provide practical direction for keeping well</p> <p>Reduces invasion by foreign things</p> <p>Contributed to casual sex</p>

'In vivo' codes were predominately employed to name the concepts, properties, and categories, and used the language of the participants (see Table 5.3 for examples). For example, the core category *The Way It Is* is an *in vivo* code based on the words of several participants when they described their resigned acceptance of their life situation. This phrase reflected their acceptance of their life situation. Some 'sociological constructs' (Glaser, 1978) that reflected the meaning of the data and its conceptualisation were used (see Table 5.3 for examples). *Forming Effective Relationships* is an example of a sociological construct used that describes the need for the Māori women in the study to establish effective relationships with those working within health services in order to optimise their health outcomes.

**Table 5.3**

*'In vivo' Codes and Sociological Constructs Used*

'In vivo' Codes	Sociological Constructs
<p><b>Categories:</b></p> <ul style="list-style-type: none"> <li>• Mana Wāhine</li> <li>• The Way It Is</li> </ul> <p><b>Concepts:</b></p> <ul style="list-style-type: none"> <li>• Connecting through whānau</li> <li>• Using mātauranga</li> <li>• Putting others ahead of self</li> <li>• Acting on fear and past experiences</li> <li>• Connecting with an appropriate service</li> <li>• Forming effective relationships</li> </ul> <p><b>Properties:</b></p> <p>All the properties identified, except the <i>Influence of te whare tangata</i>, are 'in vivo' codes</p>	<p><b>Categories:</b></p> <ul style="list-style-type: none"> <li>• Engaging with Health Services</li> </ul> <p><b>Concepts:</b></p> <ul style="list-style-type: none"> <li>• Nurturing wairua</li> <li>• Undertaking self-care activities</li> <li>• Impeding access to services</li> <li>• Accessing health services</li> </ul> <p><b>Properties:</b></p> <ul style="list-style-type: none"> <li>• Influence of te whare tangata</li> </ul>

Coding families guide theoretical coding and highlight the interacting patterns that exist between two or more variables. For example, the interactive coding family guided theoretical coding in this research. The interactive coding family (Glaser, 1978) fits with

the process of weaving as it focuses on interdependence and covariance, and illustrates how the separate recounts about the health and wellbeing Māori women can be woven together in a way that is unique to each Māori woman. The focus was not on how the process started or ended, but on its interactive nature. Glaser (1998, p.163) insists that theoretical codes "...are emergent and weave the fractured story turned into concepts back to an organized whole theory". Weaving of health and wellbeing is pivotal to the substantive grounded theory generated as a result of this research.

### **Substantive Coding**

Theoretical codes locate the interrelationships of the substantive codes, yet differ from substantive codes that focus on the categories and their properties of the substantive area under study. The emerging patterns and processes that reflected the multiple interpretations of the Māori women became evident (Glaser & Strauss, 1967; Glaser, 1978; 1992; 1998). These were then sorted and resorted into substantive codes once the core categories, concepts and properties, and their relationships had been identified. The core categories that emerged related to (1) what was important for the health and wellbeing of these Māori women, (2) the barriers encountered, and (3) the interactions the women have with 'mainstream' health services. Table 5.4 provides an example that illustrates the various levels of coding that were generated from the data that related to self-care, condensing it into properties and concepts.

The process of memoing and theoretical sampling resulted in the identification of the basic social process, which aided in the substantive and theoretical coding. A basic social process (BSP) is a type of core category or variable that emerges from the data (Glaser, 1978, 1996). It is a process that "...occurs over time and involves change over time...[that]...give the feeling of process, change and movement over time" (Glaser, 1978, p.97). The social process that emerged was the basic social psychological process (BSPP) of weaving. While the participants did not specifically refer to 'weaving', this appeared to be the process that was happening. It became evident through the process of constant comparative analysis that each Māori woman 'wove' together unique dimensions.

**Table 5.3**

*Condensing Codes from Data into Properties and Concepts*

LEVEL ONE CODES	LEVEL TWO PROPERTIES	LEVEL THREE CONCEPTS
Giving up smoking to prevent ill-health Reducing stress to keep healthy Identifying activities to maintain health of self and others Being conscious of activities that promote health Knowing getting older and Māori die early Being older and wiser Caring for self when not well ‘Lost arts’ – gardening, budgeting, cooking Taking vitamins and minerals Using rongoā Eating healthy foods within budget Having proper meal times within budget Changing diet over years Laughing – ‘often forgotten’ Nutrition Exercise Linking tinana and <i>wairua</i> Responding early to signs Early diagnosis ‘Listening’ to body Delaying getting attention Recognising the need to address health issues Knowing about long waiting lists when need to be seen quickly Resisting using antibiotics and orthodox medicines Having support networks Keeping stimulated Doing physical activity Being lazy and not feeling fit Having a balanced lifestyle Doing fun and relaxation –spiritually well	<b>PROPERTY: INSIGHT &amp; KNOWLEDGE</b>	<b>UNDERTAKING SELF-CARE ACTIVITIES</b>
	Knowing and understanding Age and wisdom Listening to body Reducing stress	
	<b>PROPERTY: WORKING WITHIN AVAILABLE RESOURCES</b>	
	Limiting finances Restricted by whānau budgets	
	<b>PROPERTY: KEEPING WELL &amp; HEALTHY</b>	<b>PROPERTIES</b>
	Undertaking preventive practices Avoiding risk behaviours Undergoing preventive diagnostic processes	Insight & Knowledge Working with Available Resources
	<b>PROPERTY: HEALTHY LIFESTYLES</b>	Keeping Well & Healthy Healthy Lifestyles
	Reviewing lifestyle practices Acknowledging spiritual dimensions	

Figure 5.5 is an example of a theoretical memo that illustrates the emergence of weaving as a process that draws and weaves together the core categories, concepts and properties to offer an explanation about Māori women’s health and wellbeing and their interaction with health services. The outcome of the process of weaving is either degrees of optimal, or less than optimal, health and wellbeing. While similarities existed, the content of the dimensions differed and the way in which they were combined influenced the outcome of their health and wellbeing. Glaser (1978;1998) and Schreiber

(2001) contend that the participants may not recognise the BSPP until it is made obvious. According to Glaser (1978) the BSPP is a type of BSP that accounts for the variation in behaviour within the area of concern for the participants. Indeed, the emergence of 'weaving' as a BSPP explains how the Māori women uniquely bring together multiple dimensions that influence their health and wellbeing.

**Excerpt from Theoretical Memos - 25/10/01:**

When reflecting on the data, the women appear to weave together the 'dimensions' that are important for their health and wellbeing. A wholistic perspective informs this weaving whereby the weaving encompasses the 'whole'. Weaving of the 'dimensions' (like fibres) creates a continuity of these 'dimensions' into a whole. It appears that all the important or vital components for health and wellbeing are intertwined and influence each other. The interwoven nature of these dimensions creates a degree of strength necessary for the endurance of their health and wellbeing. Each incidence of weaving undertaken by an individual woman is unique, as the dimensions are woven together in different ways and forms. The manner in which the dimensions develop is representative of the uniqueness of each dimension.

Strength - Continuity - Endurance

**Figure 5.5.** Memo on the weaving health and wellbeing

Basic Social Processes (or Basic Social Psychological Processes) are a type of core category that relates to processes used by the participants to resolve a social problem or phenomenon of concern. These capture change over time and are labeled as a gerund, such as 'weaving' to embody the actions of participants (Glaser, 1998; Glaser & Kaplan, 1996) and provide a new understanding of phenomena. Although Basic Social Processes may or may not be recognisable to the participants due to their immersion

within their experiences and interactions, they do recognise the process once it is made visible (Glaser, 1978, 1998; Schreiber, 2001).

## **Theory Construction**

This substantive theory relates directly to the substantive area being researched – that is, the health and wellbeing of Māori women. As previously alluded to earlier in this chapter, I made a decision not to go further and generate a formal theory that could be applied generically, as doing so would make invisible the concerns of Māori women regarding their health and interactions with health services. Substantive grounded theory is a middle-range theory developed from a substantive area of inquiry (Glaser, 1978; 1998), such as Māori women's health. Glaser (1978), and Glaser and Strauss (1967) refer to middle-range theory as being located between everyday working hypotheses and grand theories. The focus of this research on Māori women and their health precludes the development of a formal grounded theory, which would lift the grounded theory generated beyond the substantive area of inquiry. That is, on Māori women and their health, thus negating the purpose of this research. Substantive grounded theory differs from formal grounded theory in that the former arises from the substantive area of inquiry and the latter is a conceptualisation of the area of inquiry (Glaser & Strauss, 1967).

Identifying features of a substantive grounded theory are that it has 'fit' in the real world; it works by predicting and explaining the substantive area of inquiry; it is relevant to those in the area of inquiry; and it is easily modifiable to different contexts (Glaser, 1978). Certainly, the theoretical sampling and discussions with Māori women that occurred as the grounded theory emerged, indicated that the emerging theory was one that they could identify with. Schreiber (2001, p.78) describes the qualities of grounded theory as:

The theory should be abstract – often a metaphor – but must be immediately recognizable to participants, must fit the data, and must compellingly illuminate the action and interaction of the phenomenon of study.

The grounded theory that emerges is the result of the process of constant comparative analysis and sorting and resorting until the categories and concepts are saturated, and the relationships are established. The following section outlines the features of fit, relevance, work and modifiability.

## **Establishing Research Rigour**

The criteria of fit, relevance, work and modifiability (Glaser, 1978) were used to measure the rigour of the research and its process. The BSPP and the theory of Māori women's health and wellbeing were systematically generated from the data using the processes explained in the previous section. The data in this research underwent a systematic process of coding, categorising, sorting, resorting, and conceptualisation. The resultant grounded theory offers one explanation about Māori women's health behaviour that originates out of their perspective and understanding, and provides a platform for prediction.

Fit relates to how well the categories are indicative of the data. An example of how fit was established involved the review of the data that I undertook in response to a challenge by my supervisors that the BSPP was *connecting and relating* rather than *weaving*. This review of the data occurred at what I thought was the completion of the theoretical constructs. The data, its analysis and the conceptualisation of the categories and their relationships were reviewed. *Connecting and relating* did not 'feel right' based on my knowledge of, and work with, the data and its analysis. The review I undertook involved revisiting the data, the codes, concepts, properties and categories. It validated the BSPP as *weaving*, as the concerns of the Māori women about their health and wellbeing extended beyond connecting and relating with others, but included their own interpretation and actions. This review resulted in further refinement and clarification of aspects that had led my supervisors to challenge the BSPP that had emerged.

The interviews with Māori women participating in this research about their health and their interactions with health services were the main source of data in the generation of

the grounded theory. Thus, it can be concluded that this grounded theory is relevant to the concerns of Māori women who participated in this research.

While the grounded theory generated may have relevance it must also work (Glaser, 1978) to explain, predict and interpret the substantive area under research – that is, Māori women's health and their interaction with health services. The grounded theory offered about the weaving of Māori women's health and wellbeing has what Glaser and Strauss (1967) refer to as 'work'. Informal theoretical sampling with the Māori women as part of the theoretical development and verification confirmed that this theory has both meaningful relevance and conceptual 'grab'. For example, one woman was clear about the relevance of the developing theory to her life situation. In support of the relevance of the emerging theory, particularly about engagement with health services, she talked about being a 'Māori woman':

*It is about putting yourself at the 'end of the line' when you need to get health care. When you access health services you feel that you are 'not treated as a human'. You do things to keep well and healthy, along with the things you should be doing when you are sick – but you cannot afford the prescriptions and then the doctor 'growls' at you. Health and wellbeing is '...what is real for me. It is the ordinary things that determine health' (Field Notes VT 12/06/02).*

Another woman commented:

*Your observations are truly accurate and I am blown away by what I consider to be deeply insightful comments...I just wanted to share how moved I've been reading your paper!! (E-mail correspondence JM 16/05/04).*

Modifiability ensures that the grounded theory is a dynamic theory. The grounded theory generated is responsive to the societal and environmental changes that impact on Māori women, although the BSPP of weaving will remain without variation. If relevance is to be maintained, the theory generated is subject to potential modification, such as the theoretical propositions offered.

## **Ethical Considerations**

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While ethical considerations are important for all research, they are identified components of Māori centred grounded theory. Ethical consent for this research was obtained from both the Bay of Plenty Ethics Committee and the Massey University Human Ethics Committee. The work of Durie (1988c), Durie (1998d), Te Awekoutuku (1991) and the Health Research Council (1998) informed the development of the ethical aspects of this research. It was important to consider the potential and actual cultural and ethical issues associated with this research prior to its commencement so strategies could be developed to eliminate or minimise these impacting upon the participants and the quality of the research. Aside from the issues of access, consent and consultation already discussed in this chapter, protection of the participants and the benefits associated with this research also required ethical consideration.

The potential for the participants to feel exploited or coerced was recognised and considered throughout the planning and implementation of the research process used. However, it was not anticipated that there would be any physical or psychological risks or side effects to the participants, or any third parties, as a result of being involved in this research. These risks were minimised through consultation and the involvement of the intermediaries in accessing the participants. Participants were also informed of their rights when they agreed to participate in the research, in both writing (Appendices 2 & 3), and verbally prior to the commencement of interviews. Participants' questions and requests for further information were encouraged and attended to.

It was also recognised that participants could incur travel costs associated with their participation. The ethical approval gained included the provision of koha as a contribution toward travel costs. The concept of koha is part of Māori tradition and is offered in recognition of the socio-economic status of many Māori women and the demands to often contribute information without any reimbursement, despite the

incurment of costs. I also provided coffee and food as a form of koha in recognition of the time the participants gave to participate in this research.

Identification of the benefits arising from this research for the Māori women participating, and myself as a researcher needed to be explicit. It was anticipated that those participating could use the information generated to influence those agencies responsible for the development of policy and the delivery of health services. Information about what is important for the health of Māori women and their needs related to health services has the potential to make a significant contribution to policy development, and in the planning of service delivery. Any improvement in health services potentially benefits not only Māori women, but also other New Zealand citizens.

There can be no doubt that I will derive benefits and opportunities as a result of undertaking this research. Not only will I gain a qualification that will be of immense importance to me, but the nature of a PhD study requires the presentation of the knowledge generated and various aspects of the research through a variety of media, including publications and conferences. The potential and actual benefits that I gain by undertaking this research were disclosed to the participants, and I clearly stated in the Participant Information Sheet (Appendix 2) that I "...intend to use this study to write a thesis to complete a Doctor of Philosophy degree (or PhD)".

## **Conclusion**

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A grounded theory using a Māori centred approach was developed and used for this research. Such an approach kept Māori values, philosophies and processes central throughout the research process and guided the explication of Glaserian grounded theory throughout this research. A grounded theory using a Māori centred approach

would produce Māori knowledge in a manner that respected cultural beliefs and processes, and it also ensured that what was of concern for Māori women, their health and their interactions with 'mainstream' health services formed the basis of the research outcomes. The Māori centred model (Figure 5.1) developed was used to inform and direct the research process. This model acknowledges the rights of Māori women under the Treaty of Waitangi and incorporates the cultural aspects that need to be considered when undertaking this research. 'Mainstream' research requirements that needed to be met were also recognised, such as the university requirements for doctoral research.

Glaserian grounded theory was informed by a Māori centred approach as its philosophical underpinnings, along with its focus on the emergence of what is of concern for the participants. The tenets of symbolic interactionism that informed Glaserian grounded theory provided an appropriate foundation to realise the aims of this research. Described as a 'down-to-earth' approach (Blumer, 1969), a grounded theory approach focuses on a substantive area of inquiry and the development of grounded theory using a Māori centred approach enabled Māori women to remain central throughout the process.

The shared meanings that Māori women ascribe to their health and interactions with health services, and their subsequent actions were discovered through the use of a grounded theory using a Māori centred approach. All the women who participated in the study were aged between 24 and 61 years, and identified as Māori. These women participated through the use of intermediaries based on the concept of *kanohi kitea*. The data was collected using semi-structured interviews and recorded in field notes along with observations. These were coded and re-coded, sorted, resorted and then categorised. The data also included a variety of other sources that were simultaneously collected and analysed. Initially a process of open coding was used, followed by selective coding and theoretical coding. The process of coding also assisted in directing the theoretical sampling to explore and saturate the emerging concepts and categories. The basic social psychological process formed the core variable around which a middle-range substantive grounded theory using a Māori centred approach was constructed. The theory generated explains the interpretation and meaning of health

and wellbeing of Māori women, and provides an understanding of the health-related behaviours.

Prior to commencing the research, the cultural and ethical issues related to the research and the participants were identified and strategies were negotiated, guided by the Māori centred model described in this chapter. For example, issues relating to the benefits for both the researcher and the participants, and access and protection issues were explicated. The research rigour was established for the study, using the grounded theory hallmarks of 'grab', fit and relevance, work and modifiability.

Part One of this thesis has provided the background to this study, its justification, methodology and method. It also describes the background to the processes used for the collection and analysis of the data that resulted in the development of the theoretical explanation of how Māori women weave their health and wellbeing. Part Two of this thesis focuses on the analysis of the data that resulted in the generation of a substantive grounded theory using a Māori centred approach. Part Two begins with an introduction of the theory (*Ngā Kairaranga Whakaoranga – The Weavers of Health and Wellbeing*) and outlines its underlying premises. This is followed by three chapters that explain each of the three core categories – *Mana Wāhine*, *The Way It Is*, and *Engaging with Health Services* respectively. These core categories are the key components of the theory developed. Chapter 10 explains the basic social psychological process – that is, the *weaving of health and wellbeing* - around which this theory has been developed.

# Nga Kairaranga Oranga



*Ko te mana o wāhine Māori, Ko rātou te whare tangata,  
Te kairaranga oranga. Ko te kaitiaki o whānau ora,  
Tihei mauri ora!*

The integrity of Māori women, who are the bearers of life, the weavers of health and wellbeing. The guardians of whānau health & wellbeing.

## The Weavers of Health & Wellbeing

## **Ngā Kairaranga Oranga**

### **-The Weavers of Health and Wellbeing -**

The green double-ended koru symbolises the nurturing relationship a Māori woman has with her mokopuna, tamariki, whānau and community.

The green signifies growth, with the deepening shade of green indicating increasing maturity and wisdom.

The blue border symbolises the wairua that encompasses each Māori woman, while the red background represents the connection Māori women have with Papatuanuku (who was fashioned from red clay) and the whenua as te whare tangata (the bearers of life).

The orange kete represents the wisdom, knowledge and skills that a Māori woman possesses, and that informs her health and wellbeing.

The raranga (weaving) brings the woman, her wairua, and her links with the whenua and Papatuanuku, her wisdom, knowledge and skills together, thereby weaving her health and wellbeing.

**Illustrated by Moniqué Gilbert**

## **CHAPTER 6**

# **Ngā Kairaranga Oranga The Weavers of Health and Wellbeing**

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This thesis contributes a theoretical explanation about what is important for Māori women with regard to their health and wellbeing, and provides an insight into what compromises their health. Health and wellbeing for Māori women are complex constructs, located in how they see themselves, what they believe is important for themselves, their past experiences, their perceptions of ‘mainstream’ health services, and the social roles Māori women have. A grounded theory informed by a Māori centred approach is presented in the following four chapters, and provides a model that employs the metaphor of weaving. Weaving helps to explain the perspectives Māori women have regarding their health and wellbeing, and how this impacts on their ability to engage effectively with ‘mainstream’ health services.

In this section I provide a brief overview of the theory, *Ngā Kairaranga Oranga – The Weavers of Health and Wellbeing*. This will be followed by the discussion of the parameters and context for reading about the core categories in Chapter 7 *Mana Wāhine*, Chapter 8 *The Way It Is – Resigned Acceptance*, Chapter 9 *Engaging with Health Services*, and the basic social psychological process in Chapter 10 *The Weaving of Health and Wellbeing*.

### **Overview of the Theory Presented**

A substantive grounded theory has been presented as a model that describes and explains how Māori women interpret their health and wellbeing. This model has emerged primarily from the perspectives of the Māori women participating in this research, along with other data sources that were used during the process of theoretical sampling. As outlined in Chapter 5, theoretical sampling was used to verify and saturate the emerging categories, concepts and their properties. *In vivo* codes have been used, where possible, to name these categories, concepts and properties (see

Table 5.2). The *in vivo* codes used reflect the perspectives of Māori women, and connect the conceptualisation of the data (or theoretical abstraction) to the data itself.

The theoretical explanation of the health and wellbeing of Māori women presented in this thesis comprises three core categories and a basic social psychological process of weaving, around which the model is constructed (Table 6.1). This model describes: (a) what is important for the health and wellbeing of Māori women, (b) the barriers Māori women encounter, and (3) what Māori women need when they engage with 'mainstream' health services and health care providers in order to achieve optimal health status. The metaphor of weaving describes the integration of multiple dimensions that contribute to the health and wellbeing of Māori women. The nature and quality of the process of weaving these dimensions together influences both present and future states of health and wellbeing. While each Māori woman constructs her dimensions and weaving in different ways, all do so within the context of a cultural and social environment. Thus, the health and wellbeing of each Māori woman is unique.

This model comprises three core categories that are each described in the following three chapters. The first core category, *Mana Wāhine* (Chapter 7), outlines the shared understanding Māori women have about health and wellbeing, and how it is culturally, spiritually and socially constructed. It reflects those aspects that are important for Māori women to keep both well and healthy. *The Way It Is – Resigned Acceptance* (Chapter 8), is the second core category that describes the resigned acceptance Māori women have of their life circumstances and the constraints they experience when accessing and using health services. This resigned acceptance is linked to their acceptance of those factors that are beyond their individual control. The final core category, *Engaging with Health Services* (Chapter 9) describes the nature and quality of the interactions Māori women experience or require when they access and use 'mainstream' health services. When the perspectives of health and wellbeing that are held by the Māori women and the health care providers are not aligned, the nature and the quality of the health outcomes are compromised. The positive engagement with 'mainstream' health care providers is, therefore, crucial. *The Weaving of Health and Wellbeing* (Chapter 10) explains the weaving of health and wellbeing, and the relationship between the various components of this grounded theory informed by a Māori centred approach.

**Table 6.1**

*Ngā Kairaranga Oranga : A Theory on the Weaving of Health & Wellbeing by Māori Women*

The Weaving of Health & Wellbeing	Core Categories	Focus	Concepts	Properties	Theoretical Propositions & Outcomes
	<b>Mana Wāhine</b>	What is important for Māori women's health & wellbeing	<b>Connecting Through Whānau</b>	<ul style="list-style-type: none"> <li>• Sense of identity</li> <li>• Whanaungatanga</li> <li>• Having many roles</li> <li>• Changes in whānau</li> </ul>	Maintaining mana & integrity of self  Influencing health & wellbeing
			<b>Nurturing Wairua</b>	<ul style="list-style-type: none"> <li>• Being spiritual</li> <li>• Importance of whakapapa</li> <li>• Influence of te whare tangata</li> </ul>	
			<b>Using Mātauranga</b>	<ul style="list-style-type: none"> <li>• Knowing &amp; understanding</li> <li>• Seeing things holistically</li> <li>• Focusing on outcomes</li> <li>• Comfort with things Māori</li> </ul>	
	<b>Undertaking Self-Care Activities</b>		<ul style="list-style-type: none"> <li>• Insight &amp; knowledge</li> <li>• Working within available resources</li> <li>• Keeping well and healthy</li> <li>• Healthy lifestyles</li> </ul>		
<b>The Way It Is</b>	The challenges and barriers to achieving positive health	<b>Putting Others Ahead of Self</b>	<ul style="list-style-type: none"> <li>• Putting whānau first</li> <li>• Prioritising finances</li> <li>• Accepting the situation</li> </ul>	Accessing & use of health services is hindered  Preventing positive health outcomes	
		<b>Acting on Fear &amp; Past Experiences</b>	<ul style="list-style-type: none"> <li>• Childhood experiences</li> <li>• Whānau dying in hospitals</li> <li>• Negative contact with health care professionals</li> </ul>		
		<b>Impeding Access to Services</b>	<ul style="list-style-type: none"> <li>• Limited by resources</li> <li>• Accessing resources</li> <li>• Lack of a user-friendly approach</li> <li>• Complex systems</li> </ul>		
<b>Engaging with Health Services</b>	What Māori women need when they interact with health services	<b>Accessing Health Services</b>	<ul style="list-style-type: none"> <li>• Being able to choose</li> <li>• Reception encountered</li> <li>• Influencing the service</li> </ul>	Connecting and relating  Enabling access & use of health services	
		<b>Connecting with an Appropriate Service</b>	<ul style="list-style-type: none"> <li>• Acknowledging beliefs &amp; worldview</li> <li>• Availability of support &amp; advocacy</li> <li>• Choice of healing approaches</li> </ul>		
		<b>Forming Effective Relationships</b>	<ul style="list-style-type: none"> <li>• Comfort with a Māori focus</li> <li>• Having trust &amp; credibility</li> <li>• Understanding the language used</li> </ul>		

## **Parameters for Consideration**

Writing the conceptualisation of the data provided challenges in how it should be presented, and I am aware that a danger exists for misinterpretation in some areas. The parameters of the approach that I have taken in presenting this theory of health and wellbeing are described, as follows.

Each of the data chapters has been structured to begin with a whakatauki that reflects the essence of the contents of the respective chapter. The whakatauki represent more than those words that are written, and are intended to provide a broad direction and guidance for the readers. I have used whakatauki that reflect the Māori women's comments, and to set the context for each chapter. They also signify a change in focus that occurs. Some 'overlaps' may appear in the data chapters because of the wholistic view of health held by the Māori women participating. Where apparent overlaps do occur, it needs to be stressed that this is not repetition but addressing a different emphasis of a code, concept or category.

I recognise that the constructs and issues discussed within this theory may hold both relevance and resonance for women in general (and possibly in some instances for men). Indeed, Glaser (1978; 1998) makes reference to the fact that grounded theories should have 'fit and relevance' to wider social groups. However, as discussed in Chapter 5 *A Māori Centred Approach to Grounded Theory*, I have purposefully confined this theory of health and wellbeing to Māori women. Māori women are a population group that are often marginalised, and subsequently rendered relatively invisible and without voice regarding their health and wellbeing within the health setting. My justification for focusing solely on Māori women relates purely to making a research contribution that will benefit Māori women, and their health and wellbeing needs.

This grounded theory informed by a Māori centred approach demonstrates how Māori women manage their health and wellbeing, within their life circumstances and the resources they have available to them, and will add to the body of knowledge about

health and wellbeing issues in New Zealand. The theoretical explanation about Māori women's health and wellbeing presented may or may not, hold 'fit and relevance' to all Māori women, and will depend upon their worldview and social experiences. The conceptualisation of the shared meaning of health and wellbeing for Māori women may also conflict with those who hold negative or deficit beliefs about Māori women that result in victim blaming attitudes and behaviours.

Readers are cautioned against 'romanticising' aspects of this theory of health and wellbeing, such as the importance of whānau and links with creation stories used to illustrate points. The Māori women in this research make links to aspects of Māori creation stories, and these have been used to illustrate and provide meaning to components of the theory presented. However, as I have tried to explain, great diversity exists amongst Māori women, and there will be some Māori women where this is not their reality. For all of these Māori women the concept of whānau was important to them, as reflected in the core category *Mana Wāhine*. I do, however, recognise that the whānau is not always the safe, nurturing environment for some Māori, and care must be taken not to overstate the whānau as a panacea for all things. However, as this grounded theory has originated from the data generated from interviews with Māori women in this research it reflects commonalities in their collective realities.

Examples from the field notes are used to link the abstracted concepts and ideas under discussion back to the data. These can be identified as indented paragraphs written in italics, and coded (for example, *I-02*) to the interviews that were undertaken. Where memos have been used, these are located within 'text boxes'.

I have used the term 'health care provider' to refer to the people involved in the delivery of health services, whereas my initial intention was to use the term 'health professionals'. It became apparent when analysing the data that the term 'health professional' was restrictive and exclusive, and did not reflect the Māori women's experience. People associated with the delivery of health services who did not have 'professional' status are not included when the term 'health professional' is used. Therefore, the term 'health care provider' is used in preference as it is inclusive and

incorporates people, such as reception staff, who also play a vital role in the access and use of health services.

The following chapter, *Mana Wāhine*, is the core category that describes the components of health and wellbeing that are important for Māori women. This chapter provides insight into the worldview held by Māori women, and links to the way they ascribe meaning to their health and wellbeing.

## CHAPTER 7

### Mana Wāhine

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*Ko te tapu o te whare tangata*

*Me te ahu atua*

*O na tama ariki*

Let us hold to the sacredness of our bearers of life, let us make it safe for the future leaders and let us assist them to aspire to their individual greatness<sup>1</sup>

The health and wellbeing of Māori women is culturally and spiritually located, and occurs within a socio-political and economic context. An individual's notion of health and wellbeing reflects their beliefs and practices, and to some extent their health needs. The efficacy of health services for Māori women may be influenced by the degree that a health service is aligned to their beliefs, practices, life circumstances and health needs.

Health policy reflects identified health priorities, and forms the basis for the delivery of health services that are determined at a macro or government level. These are usually based upon epidemiological information, and are frequently identified as medical diagnoses, associated lifestyle activities, and behaviours considered a health risk. Health providers (such as hospitals, non-government organisations (NGOs), Primary Health Organisations (PHOs), and Māori providers) are then contracted by District Health Boards and the Ministry of Health to provide targeted services.

It is a population health focus, rather than a personal health focus, which determines health priorities and service delivery that aims to achieve maximum 'health return' for the resources invested. Thus, the health needs of Māori women as a group may not

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<sup>1</sup> Tau Huirama with the Māori Advisory Committee created this whakatauaākī for use in the Ministry of Health Family Violence (2002) Project to stress the importance of women and their children in society.

be fully recognised or included in planning an intervention or treatment plan, potentially compromising its efficacy. Concerns exist that 'mainstream' health services are not being accessed by Māori, and where they are being accessed they are not making an appreciable difference (Reid et al., 2000; Tukituitonga & Bindman, 2002; Triggs et al., 1995). Therefore, identifying what is important for Māori women from their perspective, and its inclusion in the delivery, planning and implementation of a health service, must be beneficial to meeting their health needs.

Mana Wāhine is the first of the three core categories that describes what is important for the health and wellbeing of the Māori women participating in this research. Mana is an inherent part of a Māori woman's being. It is illustrated in the creation stories of Māori humankind that reflect the important role women have in the wellbeing and continuance of humankind and whānau-hapū-iwi. Consequently, mana has been bestowed upon every Māori woman, reflecting the valued role they play in their world. Each woman takes an individual course of action to maintain her mana and integrity<sup>2</sup> of self, which ultimately influences her health and wellbeing.

My analysis of the shared voices of the Māori women in this research suggests that the core category *Mana Wāhine* comprises the following concepts: *Connecting through Whānau*, *Nurturing Wairua*, *Using Mātauranga*, *Undertaking Self-Care Activities* (Figure 7.1). Each Māori woman's health is unique and dependent upon the strength and the nature of these concepts that are integrated to shape each Māori woman. The construction of mana and self focuses on what is important for the maintenance of each Māori woman's mana and integrity of self. In this chapter, I will first outline the theoretical proposition of *maintaining mana and integrity of self* with an outcome of *influencing health and wellbeing*, and I will then explore each of the concepts that comprise *Mana Wāhine*.

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<sup>2</sup> Integrity – In this chapter I use the word integrity to refer to a Māori woman's sense of wholeness or completeness.

## Maintaining Mana & Integrity of Self

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Mana originates from a variety of sources. It is a source of status and authority that is associated with feelings of worthiness and value, by the person themselves, or as determined by others. Spiritually, mana is derived from the power of the atua (gods) and the kawai tupuna (spiritual ancestors) that cannot be overruled or destroyed (Henare, 1998; Ministry of Justice, 2001). Mana derived from the atua is accorded to everything in the universe (Pere, 1991). It is closely linked to the concept of tapu, which places restrictions and prohibitions upon human conduct. Humans themselves are not a source of mana, but have mana bestowed upon them at birth.

*Ahakoā he iti, he pounamu*

Be it ever so small, it is as precious as the jade

(Pere, 1991, p.14)

Papatuanuku's<sup>3</sup> productive and nurturing power is a power that Māori women inherently possess. Indeed, the Māori women in this research take their caring and nurturing roles within their whānau seriously, especially the care of children, marae and visitors (Barlow, 1991).

Pere (1991) maintains that mana is a quality beyond translation from the Māori language, as it has multiple forms and includes a variety of factors that control, influence and bind a person. Like identity, the mana of contemporary Māori has taken on a variety of meanings (Barlow, 1991). Mana relates to the prestige, spiritual authority, and power that influences a person's or group's ability to perform and conduct themselves; or is attached to natural resources, whakapapa and inanimate objects (Pere, 1991). While individuals and groups may possess the power and authority of

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<sup>3</sup> Papatuanuku is the spiritual mother of the environment, living creatures and humankind, and is often referred to as the Earth Mother.

mana, it has boundaries. Stepping outside these boundaries is considered an abuse of that power and authority (Marsden, 1992). For example, a person's mana may be lessened if they misused their position of leadership. In this instance, the person may have the authority and power to lead and undertake associated tasks, but have misused their power by going beyond the boundaries of their leadership or by treating others poorly. In such situations those who have been entrusted the authority and power to lead impose a loss or lessening of mana.

Individuals also derive mana through other sources and by different pathways<sup>4</sup>. The possession of mana is dynamic, subject to fluctuation, loss and restoration. It is derived and strengthened through displays of superior ability, skills and knowledge. It can be lost if a person abuses their talents and skills, and misuses power or leadership. Protection from the loss of mana is not only an individual's responsibility, but also the responsibility of the whānau to protect individual members from situations leading to the loss of mana. The mana held by a person or group, such as Māori women, is significant in influencing life situations and experiences (Ministry of Justice, 2001). For example, failure to recover from illness may be seen as a reflection of the state of a person's mana. Henare (1988, p.18) states:

In the Māori world, virtually every activity, ceremonial or otherwise, has a link with the maintenance of and enhancement of mana. It is central to the integrity of the person and the group. Many everyday measures, threaded into the fabric of existence, are designed, consciously or otherwise, as maintenance of mana.

Fundamental to the core category *Mana Wāhine* is the theoretical proposition of *maintaining mana and integrity of self*. How well this is achieved influences the health and wellbeing of individual Māori women (Figure 7.1). This theoretical proposition is based upon the perceptions that the Māori women in this research had about what is necessary and important for the maintenance of their health and wellbeing. Yet, the maintenance of their mana and integrity may be compromised when they encounter situations, such as 'mainstream' health services, where their worldview is at variance

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<sup>4</sup> Informal interview with Darrin Haimona (lecturer in Māori studies) on 11 November 2002.

and not aligned to those health care providers they interact with. The degree to which Māori women can exert their individual control within 'mainstream' health services becomes weakened as indicated by the following participant's recount:

*Health services are so different and there is a need to have knowledge about them...It is important to be able to contribute to own wellbeing. There is a need to be able to influence the way a service is delivered, but unable to change the way they do things (I-03).*

Having an understanding of the worldview of Māori women can reduce the degree of compromise they may experience. When Māori women are in unfamiliar surroundings, or when they are in situations where they experience beliefs and practices of others contrary to their own, their frames of reference retreat into the background. In such situations maintaining the integrity of their mana and sense of self can become difficult.

The maintenance of Māori women's mana can be compromised within the 'mainstream' health setting as illustrated by one participant.

*Being treated with respect and making sure Māori women understand is so important. It is devastating when Māori women are not treated with respect – it affects both their mana and wellbeing (I-06).*

As discussed earlier, mana is a significant aspect in the life and positioning of a Māori woman and their sense of self. The notion of self is also developed and grounded within the cultural and other social groups Māori women belong to, and is closely linked to their mana. However, encountering situations where they are not treated with respect and dignity can be a reflection of the lack of value others place on them, and ignoring their importance. The Māori women in this research also located themselves within an wholistic perspective that allows them to assess their feelings of wholeness and completeness. From this perspective, their health is more than physical wellbeing, including spiritual, social, intellectual and emotional forms. Thus, it emerged from the data that when Māori women interact with 'mainstream' health services, it is important

for them to feel respected, and for their perspective to be considered, in order to protect their mana and integrity.

*Health services are so different. It is, therefore, important to be able to identify with people that are helpful and not condescending, and who recognise the need for Māori women to contribute to their own perspective (I-03).*

Identity is an integral part of the notion of self, and extends beyond ethnic identity to cultural identity, which influences a person's everyday beliefs and practices. However, despite the unique positioning of Māori women in the world they are generally banded together under a single identity. There is no single cultural identity for Māori, as Māori are situated within an increasingly multicultural society in contemporary New Zealand. The participants referred to the importance of whakapapa with regard to their identity, a notion that is supported by Jackson (2003), yet many contemporary Māori are attempting to re-establish their cultural links, and some desire to reclaim traditional beliefs and practices. Given the dynamic and evolving nature of culture reclaiming 'traditional' aspects of culture could be considered idealistic. Royal (2002, p.14) explains:

We Māori remain gripped by the pressures of cultural survival and our deep thirst for knowledge of our ancestors from both an existential desire to be 'Māori' and fear of the loss of Māoritanga.

All the Māori women in this research identified as Māori (a condition of inclusion in this research) but had a variety of experiences and backgrounds that influenced their identity. This created a paradox of difference and commonalities. Some Māori women referred to 'cultural loss' in their lives, where they have not had the opportunity to access aspects of their 'Māori' culture, a concept that can be further understood by referring to the works of Ihimaera, (1998) and Moir (1994). This contributes to the diversity and uniqueness of each Māori woman.

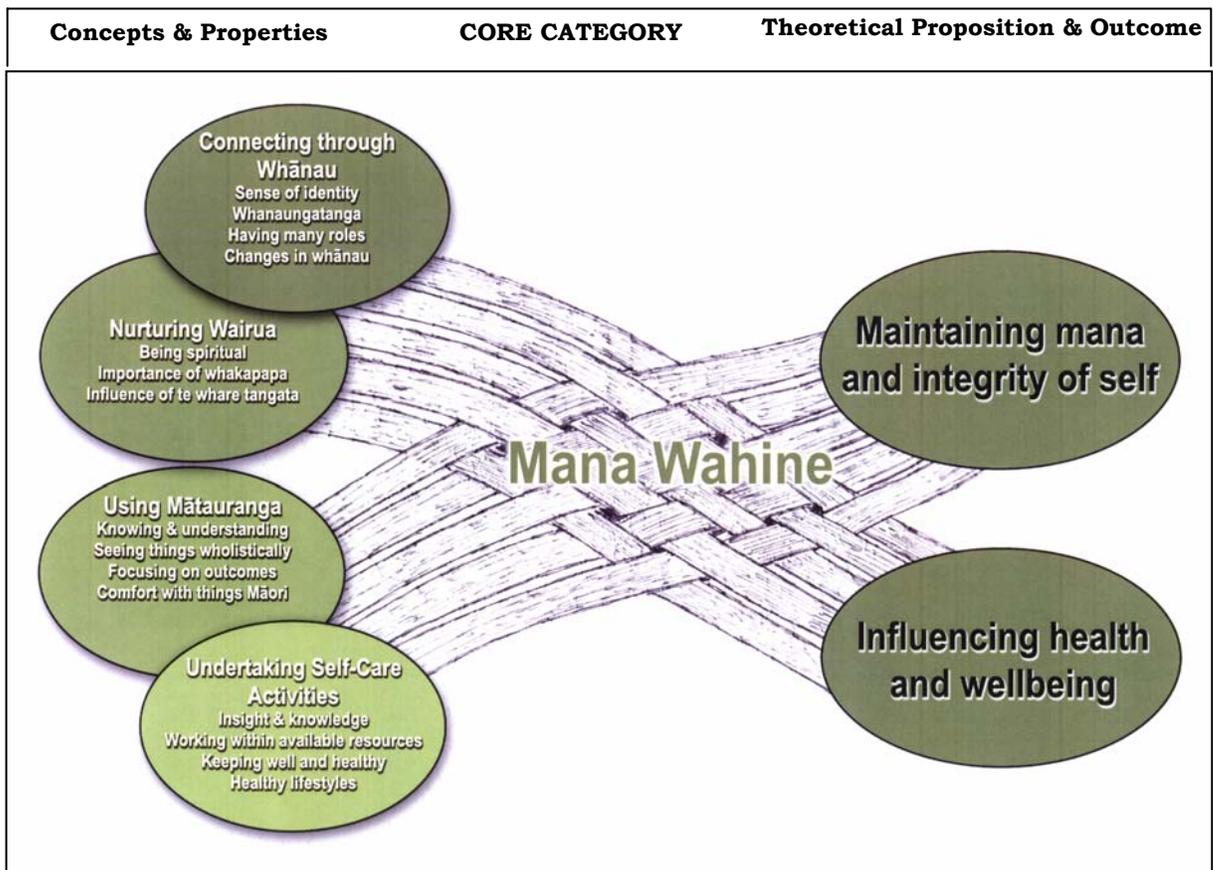
Like the above findings about the diversity among the Māori women, Durie (199a) concurs that diverse cultural identity is evident amongst contemporary Māori. Te Hoe

Nuku Roa (Durie, 1998a) is a longitudinal study of 700 Māori households that is studying a variety of aspects of the lives of its Māori participants over a 10-15 year period. The study defines cultural identity as a combination of ethnic identity, cultural knowledge, access to and participation in te ao Māori, and the use of Māori language. Four main identities have been determined (based on the above markers); definite self-identification, positive identity, notional identity, and compromised identity. It could be argued that situating the cultural identity of a person into one of these four identities masks the extent and the variability of the diversity that does exist. Te Hoe Nuku Roa, does however, highlight the diversity that exists amongst contemporary Māori and accentuates the importance of not making assumptions about Māori that enter health services, which is congruent with the theoretical proposition of *maintaining mana and integrity of self*.

Health is defined by individuals within a social and cultural context and is evident in the participant's understanding of health and wellbeing. Thus, the wholistic definitions of health and wellbeing held by the Māori women participating can, and generally do, differ from those working within health services, or those generated out of a biomedical context. It has been theorised from the data that Māori women view their health and wellbeing within a wholistic context, which incorporates multiple dimensions and facets that are important in their lives. Medical diagnoses were sometimes alluded to during the interviews; however, I noted that this was only done within the context of illustrating how something was important to them. For example, some women had reviewed the nature of their diet, while retaining their cultural practices related to food. The explanation for this action was to avoid developing diabetes. This example illustrates how Māori women focus their health and wellbeing on health-promoting behaviours, not on biomedical diagnoses.

The core category *Mana Wāhine* describes the complexity of what the Māori women consider is important for their health and wellbeing (Figure 7.1). That is, the *connecting through whānau* and the role Māori women have within whānau, *nurturing wairua* (spirituality), *using mātauranga* (knowledge and understanding), and the *undertaking of self-care activities*. These concepts are interdependent and the weaving of each together in a complex manner contributes to the integrity of mana and self, which is

unique for each woman. Factors influencing the uniqueness of each woman's mana and self include their cultural identity, experiences, life circumstances and resources (described in more detail in the following sections).



**Figure 7.1.** Core category - Mana Wāhine.

Identification as a Māori woman, and participating in te ao Māori necessitates walking in two worlds according to the women in this research. Contemporary Māori women have been forced to develop their identity within a variety of contexts: Māori-Pākehā, and/or rural-urban, and/or te reo-non-te reo worlds. At the same time, Māori women have developed their identities within a context of stereotypical views, 'popular' construction of Māori, and in the context of the pan-Māori label. Some Māori have also experienced what could be described as 'cultural loss', where the outcomes of assimilation practices,

intermarriage and urbanisation have resulted in an absence of te reo Māori and 'traditional' cultural approaches. Ihimaera's (1998) and Moir's (1994) work supports the sense of loss some Māori experience in response to not having had access to the 'traditional' cultural beliefs and practices relevant to their Māori ancestry. The world of contemporary Māori is one of extreme difference and contrast that may also extend to the structure and function of the whānau. Some Māori women describe growing up with racism, stigma and a sense of not belonging – a painful experience where identities were often imposed upon them or they were forced to make choices about their identity, including their Māori identity. Māori women may, therefore, establish their cultural identity anywhere along a continuum that ranges from traditional Māori cultural beliefs and practices to Pākehā cultural beliefs and practices, depending upon their socialisation and experiences.

It is within this context that the Māori women find it difficult to maintain their mana and integrity of self when they interact within 'mainstream' health services. The following excerpt illustrates how the participants struggled to have their needs met.

*These people [health providers] do not have an understanding of the needs of Māori women, and Māori in general, and were often seen to not be interested in trying...there was no wholistic consideration given to Māori, which reflected their [Māori women] worldview...This lack of consideration was exacerbated by a lack of monitoring by Māori, especially...health professionals who did not have an understanding or insight (H-O1).*

Assumptions made by health care providers about who Māori women are, and what is important for them, should be avoided in order to facilitate them being able to maintain their integrity of self. *Mana Wāhine* provides an explanation of the shared meanings Māori women have with regard to what is important for their health and wellbeing.

## Connecting Through Whānau

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Contact with whānau is important for the Māori women in this research, and contributes to their sense of identity. Whānau connections provide an awareness of where an individual comes from, who they are and their sense of wholeness as a person. The nature of the relationship Māori women have to their whānau is important, together with the pivotal roles they undertake within the whānau.

An eternal circle reflects an inability to separate the present generation from the past and future generations in the whānau. The whānau brings together the past, present and future – I ngā ra o mua (past days are in front of us). The future generations of whānau are just as important as the present and past generations, and provide a sense of joyful anticipation and hope.

*Each generation gets more special. Seeing a new generation was a blessing (I-06).*

For the Māori women in this research, the whānau is a source of identity, connection, functioning and change. The following properties, *sense of identity, whanaungatanga, having many roles, changes in whānau*, describe the components that highlight the importance for Māori women to have the opportunities to connect with their whānau while in 'mainstream' health settings.

### Sense of Identity

The whānau provides Māori women with a sense of identity, and a grounding and closeness, which they find nurturing and comforting – it makes them feel complete. Paraha (cited in Moir, 1994) maintains that identity is related to Māori women's 'landscapes' – be they personal, physical, spiritual or related to whakapapa. The ability to connect and bond with whānau is an important source of support and impacts on a Māori woman's sense of spirituality, health and wellbeing, illustrated by the following extract from the data:

*Whānau is about relationships and enjoying each other's company. Having contact with whānau nurtures, comforts and helps the spirit. It is a source of inner strength. Whānau is who a person is (I-05).*

The whānau is a source of inner strength that contributes to feeling whole and complete. When the whānau is absent during times of need the Māori women in this research had the feeling that something was missing within them. This situation subsequently compromises the ability for them to fully experience optimum health and wellbeing.

*Tuahaere experience hardships being away from their own family and away from their supports [both actual and spiritual] – there is something that is missing and a sense of not being complete (I-02).*

*Whanau is important... especially when everyone is around, but it is pleasant when some are around (I-08).*

Whānau means to give birth. For Māori society, the whānau is the basic social unit and comprises groups of individuals and families who descend from a relatively recent and common ancestor. Its primary function is procreation and the nurturing of children and whānau members (Ministry of Justice, 2001), and the Māori women in this research highlighted the importance of this role. While whakapapa defines the individual, kin groups and the relationships between them, the whānau may also extend to other close relationships based on friendships. The extended nature of whānau enables others to receive care and affection from many people in addition to their parents.

The Māori women in this research have a collective orientation that is they see themselves as part of a larger group (that is, whanau) rather than seeing themselves as discrete individuals. This is supported by McCarthy's (1997) contention that the collective nature of whānau conflicts with the ideology of individualism, and that while its structure and nature change over time, core values and practices such as obligation, reciprocity, group responsibility, aroha and manaakitanga remain. There is a structure

of internal authority, with direction and guidance being provided by koroua and kuia. The whānau is a place of belonging and of socialisation where the aged are held in high esteem for their wisdom and the contributions they have made, for example, to raising children. This concept can be further understood by the works of Henare (1988) and the Ministry of Justice (2001).

Despite the diversity, the contrast and the pain for some Māori growing up in two worlds (Ihimaera, 1998; Moir, 1994), the whānau is signified as a place of warmth and sharing in which Māori grow and develop.

*The whānau helps by being present and provides feelings of satisfaction and completeness (I-08).*

*Whānau is a source of inner comfort (I-05).*

The whānau is a place of socialisation where the values of humility, respect, contributing, sharing, reciprocity, loyalty and solidarity are learnt. It is where a group identity reigns over an individualistic one. The Māori women in this research also noted special relationships with siblings (who often have shared experiences while growing up) and with mokopuna (who are seen as living examples of tupuna, themselves, their children and who will carry the whānau on into the future). It is the connections through whakapapa that spiritually link individuals and whānau to the atua, the tupuna, whenua and people that brings together the past, present and future in a seemingly 'timeless' manner. That is, where the present is simultaneously inextricably linked to both the past and the future.

The establishment of links and connections is important in feeling secure within an environment and in the further establishment of relationships. The participants identified this connection as being particularly important for their sense of wellbeing when either the women themselves, or a member of their whānau, engaged with a 'mainstream' health service for any length of time.

*Family comes first. Health and wellbeing is important for undertaking various roles in the family, but if someone else in the family is not well then this affects a Māori woman, and may affect her health (I-06).*

Having access to whānau and friends is important, and this access has an influence on a woman's wairua and the maintenance of her wellbeing. The ability to establish connections with others both within and outside of the whānau is considered very important for the Māori women, and occurs through the process of whanaungatanga.

## **Whanaungatanga**

Whanaungatanga refers to the relationships and networks that Māori women have. The establishment of connections and networks is through a process called whakawhanaungatanga. This process determines the links and connections that a woman may have either directly or indirectly to others, and includes establishing connections with health care providers.

Whanaungatanga can be accessed through the whakapapa of whānau and friends. Whakapapa, among other things, enables an understanding of where one has come from and where one has been, and importantly connects all Māori and living things. Many Māori women are able to whakapapa back to a common point in creation – for some Te Kore and the creation of the universe, and for others to a common whānau member (or friend).

The importance of these connections and relationships cannot be underestimated with many of the participants experiencing 'stress' when they were unable to connect with whānau and other Māori when in 'mainstream' health settings.

*It is important for those Māori who are not well to have their whānau around them and their kite taonga with them. They contribute to their spiritual wellbeing (I-04).*

This is not unlike the research into the stress response of women by Taylor et al. (2000), where they found that women ‘tend and befriend’, a notion that reinforces the importance of relationships and networks. For many years it was commonly believed that both men and women respond to stress with a fight or flight response (Author unknown, 2002; Taylor et al., 2000). The research of Taylor et al. (2000), however, found that when stressed women spend more time tending to children, physiologically releasing both endorphins (released by the brain and relieve pain) and oxytocin (a female reproductive hormone that induces relaxation and reduces anxiety). They also found that the tendency for women to ‘befriend’ other women (amongst the social networks they have) also produces the same release of endorphins and oxytocin.

*A sense of health and wellness is heightened by being able to access whānau and friends when there is a need or want to connect with them. Whānau and friends are important (I-03).*

*Whānau supports and the land are important and being away from them can affect your spiritual wellbeing and how stressed someone feels (I-02).*

*Whanaungatanga* may also involve the informal establishment of common ‘landscapes’ and connections to a common person or whānau. This is not unlike Paraha’s (cited in Moir, 1994) notion of identity that is related to connections with ‘landscapes’ and demonstrates the relationship between a sense of identity and *whanaungatanga*. Socialisation to the Pākehā world, however, may contribute to feelings of inadequacy, experienced by some Māori women in this research, as they are either unable to establish connections or converse in te reo Māori. Like the findings in this research (see Chapter 9), Paraha (cited in Moir, 1994) contends feelings of inadequacy can contribute to Māori women fading into the background, especially when unsubstantiated judgments are made by others about their ability to know ‘things’ Māori and speak te reo Māori. Their actual needs are then not identified.

## Having Many Roles

Māori women are socialized into *Having many roles* and it is an integral part of their being. When substantive changes to their role, or the inability to undertake roles and obligations occurs, it is highly likely to create stress for Māori women, especially when hospitalised or incapacitated in any way. Depending upon the intensity and duration of the stress experienced, short or long term effects on health and wellbeing may result. Sarafino (1998, p. 70) defines stress as:

...the condition that results when person-environment *transaction* lead the individual to *perceive a discrepancy* – whether real or not – between the *demands* of a situation and the *resources* of the person's biological, psychological or social systems.

While humans need a level of stress for optimal stimulation, it is a well-known fact that ongoing and cumulative stress taxes a person's resources and is highly likely to compromise their health and wellbeing (Sarafino, 1998). Holmes and Rahe's (1967) Social Readjustment Rating Scale (SRRS) provides a useful illustration of how various life events culminate and can impact on the health of an individual. The SRRS, however, does have limitations that need to be considered, as it can be ambiguous and does not necessarily account for the individual meaning of the various life events. It also does not distinguish between favourable and unfavourable events (Sarafino, 1998). Despite Holme and Rahe's (1967) work being dated and having limitations, it is applicable to this research as it tangibly demonstrates the cumulative effects that stress can have on the health and wellbeing of a person.

Compromises to health and wellbeing that are stress-induced may be in the form of short-term illnesses or chronic conditions. Sarafino (1998) maintains that social support is vital in reducing the effects of stress on health and states, "Friendship is to people what sunshine is to flowers" (p.100). This, and the work of Taylor et al. (2000), highlights the importance of support from whānau and friends, especially in relation to the stress that may arise from changes in roles.

As mentioned previously, many Māori women undertake assigned roles within their whānau and have roles within the wider community. This is no different for the women participating in this research. The ability of Māori women to participate in whānau activities (such as attendance at hui, involvement in mahikai and tangi) is of the utmost importance to their sense of wellbeing and its maintenance. The Māori women in this research take these roles and their associated obligations seriously, especially whānau obligations. The inability of Māori women to fulfill these roles and obligations is perceived to impact on their health and wellbeing. The changing roles that some Māori women experience were also noted to impact on health and wellbeing.

*Becoming the sole income earner impacts on the relationships with a partner. Not only do women have to emotionally support their partner, but they also experience worry and stresses themselves. Despite being resigned to the situation that is the way it is, women in such situations need to cope with keeping themselves well and healthy to do everything they have to, but this creates a fear of taking any risks (I-05).*

Changes in the structure and function of whānau may mean the support that was available for Māori women within the whānau is not necessarily available to all contemporary Māori women.

## **Changes in Whānau**

*Changes in whānau* highlights the whānau being confronted with societal changes, despite it being an integral component of Māori life and culture. Changes in the structure and function of the whānau influences how Māori women meet their obligations, and reinforces the importance of whānau as a source of support. Impacts on lifestyle and relationships within the whānau and the wider community are occurring, as society has become more urban, materialistic and technological. The following data illustrates this:

*Māori are engaging in a different lifestyle – it is cheaper to buy rather than to make, something Māori appear to be buying into materialism more. Thus, the needs of whānau have changed, together with the changes in the structure of the whānau (I-05).*

Access to extended whānau is reduced due to changes in society. Therefore, the available support networks are less for some Māori women. The strengths of the extended whānau, such as the support system inherent within the structure and its function are at risk of either being lost, or are no longer evident due to the various demands that exist within contemporary society.

*The elderly used to care for the mokopuna and were valued for the nurturing role they played with tamariki. But now the elderly grandparents are going into Rest Homes because of the need for everyone to work. Younger grandparents are still in the workforce and are unable to fulfill this caring and nurturing role (I-05).*

The importance of whānau is exceedingly strong. However, it is important for health care providers to acknowledge the diversity that exists amongst Māori, and the structures of the whānau. Whānau is a broad concept and Māori women do not generally differentiate the whānau into Māori and non-Māori – generally all are considered whānau. Thus, the notion of feeling complete is dependent upon a number of factors, especially the degree of contact that can be maintained with whānau, whether living in close proximity or a distance away. Whānau support and presence contributes to Māori women feeling complete and possessing a sense of satisfaction. Recognition of the importance of whānau support and its facilitation can make a positive difference to the wellbeing of Māori women. While whānau is important to the Māori women in this research for their health and wellbeing, their wairua (spirituality) also contributes to their sense of wellbeing. Having a strong sense of wairua, for example, minimises (rather than compensates for) the impact of being distanced from whānau.

## Nurturing Wairua

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The concept of spirituality is private to Māori women, and not open to scrutiny by others. Wairua, or the spiritual dimension, is an extremely important part of Māori women's health and wellbeing. Wairua contributes to their feeling complete and directs the way in which they approach each day and its activities. Wairuatanga (spirituality) is an internalised dimension, which is embedded in both the temporal and transcendent worlds of Māori. It reflects a person's intimate relationship with the gods and the universe (Henare, 1988). Wairua is greater than religion, and while for some Māori women in this research formal religion plays a vital role in their lives, for others it does not. Spirituality, for many traditional Māori, differs from accepted contemporary Judeo-Christian based religions in that it encompasses multiple 'gods', the environment and all living things. Tupuna also play an important part in a Māori woman's sense of wairua.

Fundamental to understanding wairuatanga is the integration of the physical realm with the spiritual realm that contributes to a wholistic worldview – a worldview held by many Māori. A wholistic worldview contrasts with dominant concepts evident within the biomedical model and the health system that utilise reductionistic, mechanistic and systemic approaches. Such approaches are closed and exclusive – a view that many Māori have difficulty engaging with, as aspects of their world become compartmentalised. The Māori women in this research are profoundly influenced by a sense of wairua (as will be illustrated in the following sections), and therefore, the centrality of wairuatanga in the maintenance of their health and wellbeing is significant. *Nurturing Wairua*, therefore, is a vital concept of health and wellbeing and is composed of the properties *being spiritual*, *the importance of whakapapa* and *the influence of te whare tangata*.

## Being Spiritual

*Being spiritual* is generated from the need to feed or nurture the wairua or the spirit. Each Māori woman in this research had her own way of determining how her wairua is nurtured and the activities that must be undertaken to do so. A wholistic approach and recognition of the diversity that exists amongst Māori women underpin *Nurturing Wairua*. For many, wairua is intrinsically linked to the presence of whānau, and participation in whānau activities. While religion is important in undertaking spiritual activities for some, for others it is important to karakia or acknowledges tupuna within a traditional context.

*For many Māori women their spiritual side is important. Being spiritual does not necessarily mean praying to God, but may also include praying to tupuna and family. Spirituality gives a better understanding of where one comes from. Religion, however, is a minor part and differs from the spiritual side that is about people – tupuna, people who have ‘gone before’ and the whole family (I-06).*

Other participants' sense of spirituality contrasted, however.

*Being able to recite karakia, whether they be ancient, traditional or contemporary (I-07).*

*Don't always pray to God, but to Tupuna for guidance (I-06).*

*It is about prayer and gratitude and thanking God (I-01).*

*Wairua is about a lot of prayer and meditation (I-08).*

*It is about being at peace, connecting with nature and whānau (I-05).*

It is important to understand that each Māori woman needs to undertake spiritual activities that are appropriate and relevant to nurturing her wairua. *Nurturing wairua* involves a variety of actions that include participation in whānau activities, relaxation, self-development, doing things that make a difference, meditation, activities within the home, and attendance at tangi.

*Nurturing wairua was about being spiritually at peace and plays an increasingly important role as one got older. The maintenance of one's spiritual being not only includes factors such as reading, gardening, being outside with nature, being at home, self-development, independence and being able to make a difference – it also includes enjoying the company and relationship with tane and mokopuna. Contact with whānau members also nurtures one's wairua and is a source of 'great' comfort. Nurturing wairua is 'grounding' (I-05).*

Wairua is about being at peace with oneself and affects health as it is seen to attract both wellness and goodness. It is a place from which the Māori women operate on a daily basis, and sets the pace for their functioning.

Spiritual wellbeing influences the degree of activity Māori women engage in and manifests itself in many forms. When a Māori woman's spiritual wellbeing is compromised in some way or it is not nurtured, it may manifest as physical ill health or sickness. Māori women may interpret such a manifestation as mate Māori and recognise the need to restore and nurture their wairua.

*Often people are not sick, but are spiritually affected by mate Māori. For example, someone with a diagnosis of schizophrenia may attract a spirit of a 'like mind' and manifest behaviours similar to the spirit. But the spirit energy is such that it requires a traditional healer to reduce the spirit's strength so the person can resist it (I-04).*

This is similar to the concept of mate Māori that Durie (2001a) describes as a spiritually induced illness requiring intervention from a tohunga. Mate Māori is usually an infringement of tapu or makutu (an indirect punishment inflicted by someone). Murchie's (1984) study about Māori women's health also revealed that one in five of the participants would seek assistance from a traditional healer for mate Māori, although not all could define what mate Māori was. Thus, 'sickness' resulting from a compromised wairua was noted to be one view of illness, but one not necessarily shared by all Māori women or by health care providers. The concept of mate Māori, however, provides insight into why some Māori women may view the nurturing and

sustaining of their wairua as important to avoid the possibility of ill-health. It also illustrates the importance of finding out the beliefs and practices of Māori women who enter 'mainstream' health services, so 'spiritual healing' can form a legitimate part of their plan of care.

## **Importance of Whakapapa**

The *importance of whakapapa* reinforces the notion of Māori women knowing where they have come from, and that they will contribute to the future growth of the whānau. Whakapapa is integral to *connecting through whānau* and *being spiritual*. Tupuna, the immediate and extended whānau, and mokopuna (believed to be representations of the future continuance of the whānau) are all reflected in a Māori woman's whakapapa. These are vital spiritual links for Māori women. The Māori women in this research referred to their spiritual links – for some they extended as far back as the creation of the universe, and humankind through the birth of Papatuanuku. These links are contained within various Māori creation stories, and form part of their whakapapa.

*It is important that upon death or the loss of tissue or body parts that these are returned to Papatuanuku from where humankind began. The process of returning to Papatuanuku vital in the maintenance of a positive spiritual flow (I-01).*

It is this spiritual link that connects many Māori to their ancestors, the living, the future and their mana as women (who are integral to the continuance of humankind). It was recognised by the participants, however, that some Māori women do not have access to such a rich and extensive whakapapa, and may or may not feel fulfilled spiritually.

*Being able to connect with the tribal land is so important for one's wairua, yet there are people who do not know where they are from (I-02).*

Identification with tribal lands is important, and Pere (1991) supports this highlighting that the natural place for connecting with one's wairua is Papatuanuku. The works of both Ihimaera (1998) and Moir (1994) contain examples that support the notion that some Māori whose knowledge of whakapapa is tenuous or absent, feel they have something missing. The manner in which Māori women make their spiritual connection, however, is individual and dependent upon the unique beliefs and practices that they may hold.

## **Influences of Te Whare Tangata**

*Mai I te timatanga o te ao  
Ko Papatuānuku te whaea whenua –  
Ko Hine-Ahu-One te ira tangata, tuatahi, he wahine  
Ko te wahine te whare tapu o te tangata  
I rere ai te toko ka puta ko koe rā  
Ngā whakatupuranga katoa o te ao tangata rā e!*

From the beginning of time was Papatuanuku, the earth mother  
Then came Hine-Ahu-One, the first human created, a woman,  
Her womb became the sacred house of man from when flowed blood when you,  
Man, and all generations of mankind were born! (Source unknown)

The influence of te whare tangata supports *Nurturing Wairua*, and also has practical implications according to some of the Māori women participating in this research. Te whare tangata means the 'house of humankind'. Te whare tangata links women to Papatuanuku as bearers of future generations, and Papatuanuku connects women spiritually and metaphorically to the land through the whenua (placenta or earth). Following the birth of a child the whenua is returned to the earth (Papatuanuku) – an action that creates an important spiritual flow for some women.

*There is a distress that occurs when the spiritual flow with Papatuanuku was disrupted.  
It was disturbing that embalmers report that some women return from post mortems*

*without their reproductive organs. This disrupts the spiritual flow, when upon their death women are returned to Papatuanuku. This is a cause of distress for some Māori women, knowing that the reproductive organs are the physical expression of te whare tangata and they will not be returned to Papatuanuku (I-01).*

In addition to its spiritual dimension, te whare tangata also has practical applications, as is evident above. The concepts of tapu and noa provide practical knowledge and guidance with regard to Māori women keeping their bodies healthy and well. The head, genitalia and heart are tapu, and people themselves become tapu during different times and situations (see Durie, 1998a for further understanding of these concepts). The role of tapu is one of guidance, assisting women to control their bodies. Thus, the control and restrictions placed on their bodies at various times have a wellness and 'preventive' focus. Yet, some of the women in this research indicate the loss of knowledge about te whare tangata has had a negative effect on the health and wellbeing of Māori women.

*Te whare tangata's spiritual underpinnings provide practical direction for keeping oneself well. For example, abstaining from casual sex reduces the incidence of the body being invaded by 'foreign things'. The loss of knowledge about te whare tangata and the availability of the contraceptive, however, has enabled young women to engage in casual sex through a loss of control and sanctity over their bodies is evident. There is a real need for more women to be educated about te whare tangata as it also has practical applications. (I-01).*

Noa, on the other hand, refers to those aspects that are without the restrictions or controls imposed by tapu, depending upon the circumstances. The state of noa dynamically complements the state of tapu that serves to achieve balance (Durie, 1998a).

The diversity that exists amongst Māori women again results in varying perceptions and connotations about the meaning of te whare tangata and how it can be applied in daily life. Many young Māori women have not been brought up with the knowledge and understanding of te whare tangata. This is due to the cultural loss that occurred in response to the processes of colonisation and the subsequent policies of assimilation and integration. These were evident in the 20<sup>th</sup> Century and prevented Māori from

engaging in cultural practices. Some of the Māori women in this research expressed concern that the loss of this knowledge is reflected in the promiscuity that exists, and the high pregnancy rates.

*Many young 'Mums' no longer consider their bodies tapu, yet there is a need for them to look after their bodies. Tapu means they control people entering and leaving their bodies, but some young women just let men in and out of their bodies - this results in high pregnancy rates and sexually transmitted diseases (H-01).*

*Nurturing Wairua* is one aspect that is important in the maintenance of Māori women's health and wellbeing that relates to spiritual wellbeing. This is closely woven with *Connecting with Whānau*, which highlights the essential role of whānau and friends for involvement and support - these concepts are integral in the development of Mana wāhine. *Using mātauranga* is the next concept that is part of core category *Mana Wāhine*.

## **Using Mātauranga**

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The concept *Using Mātauranga* relates to the knowledge, wisdom and skills Māori women use in the maintenance of their health and wellbeing. The maintenance of health and wellbeing is dependent upon Māori women having and using both knowledge and skills to inform the promotion of health and prevent illness and disease of not only themselves, but also their whānau. The wisdom gained with age and experience provides the insight and motivation to make changes in their health behaviours and lifestyles as needed. While mātauranga relates to Māori information and knowledge, the Māori women in this research use a combination of traditional and contemporary Māori knowledge, and contemporary 'mainstream' knowledge. *Using*

*Mātauranga* comprises the properties *knowing and understanding, seeing things wholistically, focusing on outcomes, and comfort with things Māori.*

## **Knowing and Understanding**

The property *Knowing and understanding* can be compared to a kete taonga that Māori women carry with them through their lives. It forms the foundation of the self-care activities they undertake in order to maintain their health and wellbeing. Health and wellbeing, in part, results from the complex interplay of *mātauranga* and the environmental context within which Māori women live. The Māori women in this research recognise there is a connection between *mātauranga* and the power that they have to influence and control their health and wellbeing. Having the necessary knowledge that is useable influences the choices and decisions these women were able to make regarding their health and wellbeing. In order to make informed decisions, these women need to be able to understand health-related knowledge. *Knowing and understanding* is developed over time and is used in conjunction with the wisdom Māori women gain with age, and through life experience.

*The need to lead a balanced lifestyle is recognised as one gets older, and results in taking more notice of what one's body is saying, and how one is feeling. This recognition leads to the engagement of activities that can optimise life and wellbeing (I-04).*

Knowledge and wisdom gained over time provides the insight to optimise health and wellbeing, and the impetus to change lifestyle patterns and minimise engaging in 'risk' behaviours.

## **Viewing Things Wholistically**

All the Māori women participating in this research use their knowledge within a wholistic perspective. *Viewing things wholistically* involves a knowledge base that Māori women

in this research consider is broader and deeper than the approach taken by the health system.

*Health means wellbeing – physical, spiritual, emotional and mental health. It is about tending to all these aspects – maintaining physical health through various activities, maintaining support networks for emotional wellbeing, keeping the mind stimulated and engaging in spiritual activities. It also includes responding to physical signs early and undertaking preventive practices (I-01).*

This wholistic view is the nucleus of their life and wellbeing – a view that Māori women maintain resists reductionism and compartmentalisation.

*Problems are just ‘picked off’ by health professionals and are never looked at wholistically. Focusing on a single aspect of a health problem does not necessarily get to the core of the problem. This approach is to the detriment of Māori women (I-01).*

This contrasts with the biomedical approach they predominantly encounter that is either exclusively physical or exclusively psychological in its focus. Such an approach reduces the health experiences of Māori women to narrow compartments, and influences the mode in which they receive information. According to most of the Māori women in this research this approach was to their detriment, and to the detriment of a Māori way of life.

The property *Focusing on outcomes* can optimise the way in which mātauranga is used. Yet, the Māori women in this research expressed their frustration with health services that do not focus on the health outcome. From the perspective of the participants, ‘mainstream’ health services are perceived as ‘reductionist’, ‘compartmentalised’ and ‘problem-focused’<sup>5</sup>, although it is useful to note that these are not necessarily exclusive of an outcomes focus.

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<sup>5</sup> These are the words the participants used to describe the approach ‘mainstream’ health services were seen to take.

## **Focusing on Outcomes**

*The focus is not on the cause of the issues, but on the 'ambulance at the bottom of the hill'. An outcome focus would enable a flexible approach to achieve a desired outcome (I-02).*

The use of an outcome focus<sup>6</sup> to resolve health issues enables issues to be viewed in their totality. Such an approach would ensure that all pertinent factors and the associated variables related to a health issue that a Māori woman experiences can be incorporated into interventions aimed at achieving that outcome. Adopting an outcome focus also acknowledges that there are different pathways to achieve an outcome, thereby promoting an individualised approach to health services rather than a universal approach. The Māori women in this research believe that such an approach is better able to meet their needs.

An outcome-focused approach supports the nurturing of, and maintains the integrity of, a woman's wairua by being inclusive of those aspects that are important for health and wellbeing. It also enables the use of pathways that are both culturally appropriate and acceptable. The Māori women in this research recognised that some outcomes may not be immediate and, therefore, the short-term measurement of outcomes may be inappropriate. For example, when prevention and health promotion outcomes are planned, the achievement of the desired outcomes may not always be seen for two or more generations. Thus, interventions implemented may change outcomes for future generations but not necessarily in the present generation.

## **Comfort with Things Māori**

The ability to participate in te ao Māori for some Māori women is very important, although for some this may not have the same significance or importance. The

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<sup>6</sup> An outcome focus identifies the outcome that is to be achieved and recognises key factors and the best approach to realise that outcome. Such an approach contrasts with a problem-focus that narrowly concentrates on the problem and tends to exclude aspects that may influence the outcome.

property *Comfort with things Māori* situates *Using Mātauranga* within the Māori world and leads to feelings of comfort. For example, some Māori women maintained that ‘gathering’ and hui engender a feeling of fulfillment and being alive.

*Hui and tangi are times when everyone can get together. It enables time to sit around and kōrerō and laugh. Hui and tangi engender feelings of being alive and complete (I-07).*

Within the ‘mainstream’ health setting, *comfort with things Māori* may include the use of signage that includes te reo Māori and Māori images, such as kowhaiwhai. Whakatauki were also seen as providing a source of direction and guidance in a manner some Māori woman are familiar with – a potentially effective medium for important messages.

*Whakatauki help guide the actions and thoughts of Māori. The whakatauki...E hara tōku toa I te toa takatahi, E ngari kō tōku I te toa takatini – my strength comes not from myself alone, but from the strength of all the people...highlights the benefits of working together to achieve outcomes (I-01).*

Using ‘things’ Māori conveys to Māori women that a health service has considered their interests as Māori. *Comfort with things Māori* can serve to improve access, but needs to extend beyond signage and images, to the formation of meaningful and respectful relationships.

*It is comforting to see and hear things Māori when you enter a health service...it conveys the sense that the people will respect and look after Māori (I-02).*

For example, the provision of opportunities for whakawhanaungatanga acknowledges and respects the importance for Māori women to establish connections and networks – an action that makes them feel comfortable. *Comfort with things Māori* also includes the use of wananga as an effective pedagogy for Māori women to learn about health and wellbeing issues. Wananga also provide the opportunity for connection, support, and simply being with other Māori women.

The concept *Using Mātauranga* describes the mechanisms by which Māori women can acquire and utilise knowledge, wisdom and skills. It contextualises their learning within a Māori worldview that is wholistic and outcomes focused, and is an approach they believe ‘mainstream’ health services could adopt to enhance their ability to acquire health-related knowledge using an outcomes focus. This then provides health information within a context that they feel they can identify with, and then can use in a more meaningful way. The knowledge and skills that Māori women acquire over time provide the foundations for the concept *Undertaking Self-Care Activities*.

## **Undertaking Self-Care Activities**

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The concept *Undertaking Self-Care Activities* involves the integration of lifestyle, wisdom, resources, and preventive practices that are undertaken to optimise the experience of health and wellbeing. The self-care activities that Māori women engage in focus, to some extent, on keeping well and healthy to prevent ill-health and disease, and extend to engaging in alternative (and natural) remedies, such as rongoā. All the Māori women in this research are able to clearly explain the activities they undertook to care for themselves with the ultimate aim of maintaining their mana, nurturing their wairua, using information and to keep well and healthy. These Māori women are all able to clearly articulate what constitutes a healthy lifestyle, and about what they need to do to maintain their health and wellbeing. This was evident in the recount of the self-care activities they engaged in. For example, they knew about what comprises good nutrition and the need for exercise. These activities also include early diagnosis as an essential part of preventive action. *Undertaking Self-Care Activities* comprises the properties *insight and knowledge, working with available resources, keeping well and healthy, and healthy lifestyles*.

## **Insight and Knowledge**

*Insight and knowledge* is the property that relates to the knowledge and understanding Māori women have about maintaining their health and preventing ill-health. As age and wisdom (and the increasing threat of ill health) increases, so does the importance of self-care. The Māori women in this research report both age and wisdom enables them to focus on themselves and recognise factors that impact upon their health and wellbeing.

*Engaging in self-care activities, helps the maintenance of health and wellbeing, for example, responding to early physical signs of illness with natural remedies and rongoā, and nurturing spiritual wellbeing with regular prayer and gratitude. Creating support networks helps with emotional wellbeing and stops one from getting 'down'. Keeping stimulated by being involved in diverse activities, such as Māori health and reading books also helps. (I-01).*

*Insight and knowledge* enhances the ability of Māori women to 'listen' to their bodies and respond to the need to stay healthy and well. For example, the recognition that financial worry causes pressure or tension resulting in a stress response provides the impetus to undertake stress reduction activities.

*It is important to take note of what one's body is saying or feeling. If the head is 'heavy' it is an indication that a lot of mental work has been done so there is a need to relax and have some fun (I-04).*

While having *insight and knowledge* about self-care was evident, the ability to undertake self-care activities is dependent upon the resources these women have available to them.

## **Working within Available Resources**

The ability to undertake self-care activities, and the quality of these activities, is moderated by the resources Māori women have available to them. *Working within available resources* is the property that places parameters around the ability of Māori women to undertake self-care activities. Having sufficient financial resources is a major determinant in being able to undertake self-care activities, and to also access health services. As a consequence, many of the Māori women in this research meet their health and wellbeing needs outside the health system, accessing health services as a last resort.

*A lack of resources is a real barrier in having good health. Resources cost a lot of money and are difficult to access most of the time. It means having to find alternatives that may not be the best to use (H-01).*

Despite the knowledge Māori women have about what they need to do to keep healthy, the financial resources available to them limit the extent that they can act on this knowledge. For example, they know that diet and nutrition is important, however, 'healthy' foods are expensive. Limited whānau budgets means Māori women are forced to buy foods that they know have less nutritional value. Accessing other resources that support health and wellbeing may be dependent upon having the financial means. Given the restrictions on resources, undertaking preventive practices for the maintenance of health and wellbeing becomes important.

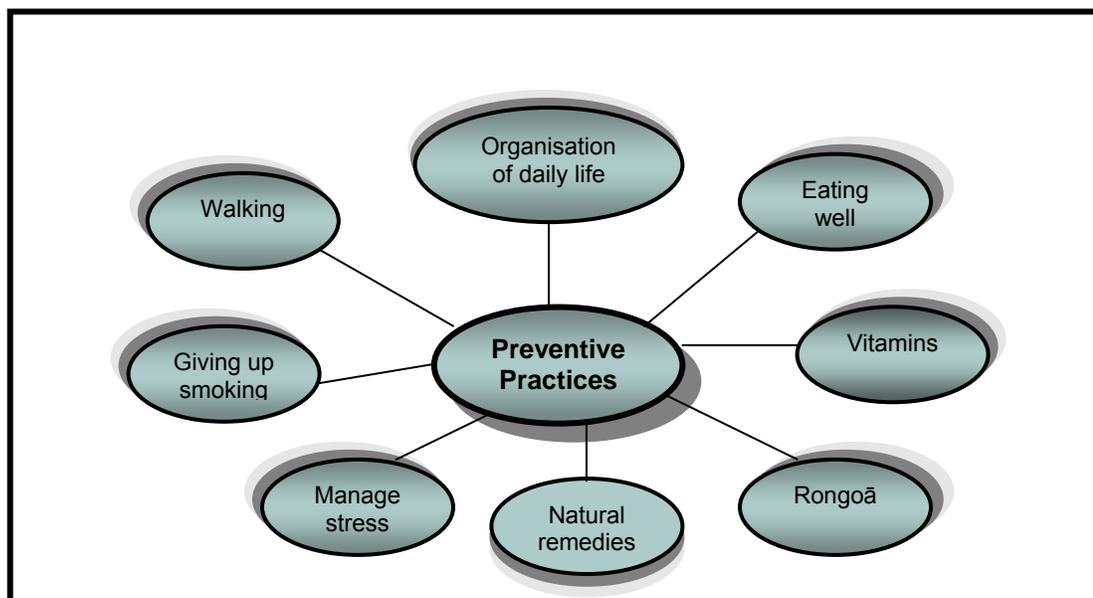
## **Keeping Well and Healthy**

Māori women actively engage in preventive practices in order to maintain and/or achieve optimal health. The need to undertake preventive practices becomes imperative when factors such as limited resources exist, and with the awareness of increasing risks of ill-health with age. The property *Keeping well and healthy* highlights how Māori women maintain their health through engaging in a variety of preventive

practices. Yet, the extent and quality of preventive practices is also determined by factors such as financial ability and the subsequent availability of resources. Underlying *keeping well and healthy* is the recognition by Māori women that various lifestyle behaviours can compromise health and wellbeing, and the notion that taking preventive actions will enhance health and wellbeing.

*Health means everything and if one is not well then you cannot function properly. There is not enough money as well, so you watch your diet, walk everyday and see the doctor if something is wrong (I-06).*

*Keeping well and healthy* also includes the avoidance of risk taking behaviours and engaging in preventive diagnostic procedures (such as cervical smears and mammograms). The Māori women in this research recognise the role that prevention, early detection and intervention play optimising health and wellbeing. They were also aware of the role that health care providers have in this area of health and wellbeing. The preventive practices engaged in (Figure 7.2) are diverse in nature, and Māori women select those that are relevant to their needs and are achievable within their resources. The most frequent practices engaged by the participants in this research were exercise, eating well, rongoā and giving up smoking.



**Figure 7.2.** Example of preventive practices.

Just as the Māori women in this research engage in preventive practices, they also reviewed their lifestyle, especially as they got older. The property *Healthy lifestyles* outlines the changes that the Māori women made in response to the review of their lifestyle.

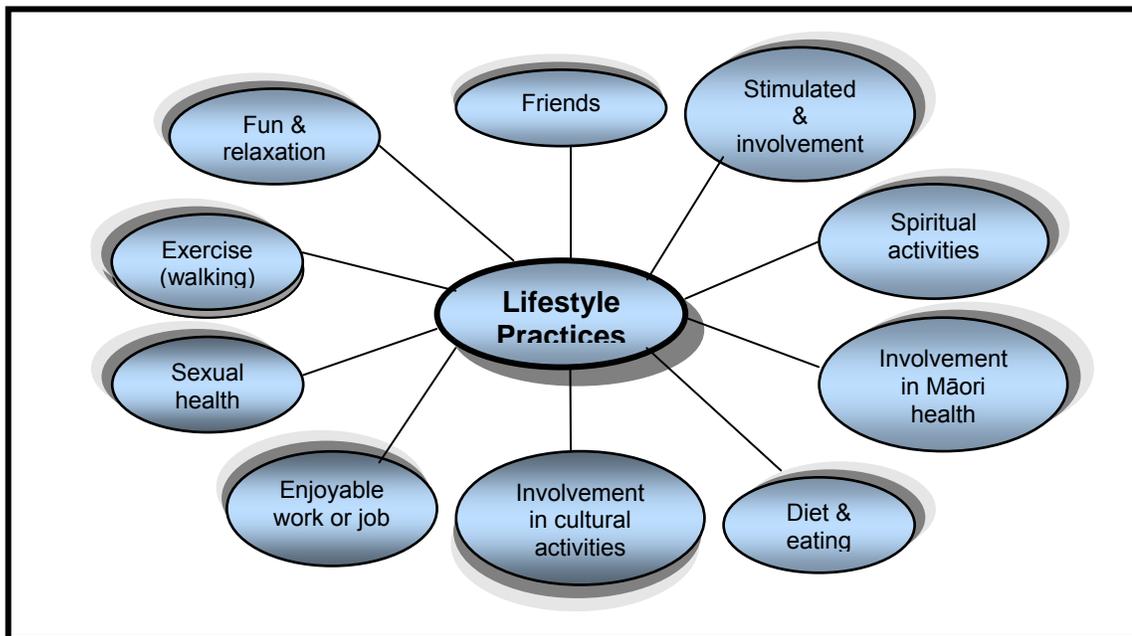
## **Healthy Lifestyles**

The property *Healthy lifestyles* is closely connected to *keeping well and healthy* and extends into the area of wellbeing that when woven with health contributes to the total feeling of health and wellbeing. A distinctive feature of *healthy lifestyles* is the changes that Māori women make in their lives with age. The changes in lifestyle undertaken by Māori women are in response to a number of factors, but primarily are a response to their need to be role models, and their fear of getting older and not coping. This provides the impetus for the women to focus on caring for themselves. One way this is achieved is through maintaining a healthy lifestyle.

*It is important to have a balance in life, and use knowledge about keeping healthy to undertake relaxing activities such as reading, being involved in cultural activities, talking with friends, eating low fat foods, not smoking, drinking lots of water and walking regularly (I-04).*

A defining feature of *healthy lifestyles* is a strong spiritual dimension that becomes an increasingly important feature of their health and wellbeing as Māori women. In addition to this, Māori women review their lifestyle practices according to their needs and resources. The lifestyle practices (Figure 7.3) engaged in are broader than preventive health practices and encompass activities that enhance their sense of wellbeing. Many of these practices require little in the way of resources and are thus, attainable for most Māori women. However, the degree and extent that some lifestyle practices can be engaged in is dependent upon the resources available.

The concept *Undertaking Self-Care Activities* illustrates the importance of health and wellbeing to the Māori women in this research. Māori women are aware of what is required to keep them both well and healthy. They employ a number of strategies to achieve this, such as knowledge, wisdom and a variety of health-related practices and activities. However, the effectiveness of these strategies is compromised by the nature and extent of the resources available to Māori women to support such strategies.



**Figure 7.3.** Example of lifestyle practices.

## Conclusion

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The core category *Mana Wāhine* is concerned with *maintaining the mana and integrity of self* of each Māori woman, and influences their health and wellbeing. It represents the complex integration of the concepts *Connecting Through Whānau*, *Nurturing Wairua*, *Using Mātauranga* and *Undertaking Self-Care Activities* and their associated

properties (see Figure 7.1). Each woman's *mana* and integrity of self is influenced by the diversity that exists within the Māori population, by her experiences, life circumstances, and available resources. The complexity of the weaving of *Mana Wāhine* reflects the complex and interdependent nature of their concepts and how they are integrated.

Māori women engage in activities and practices to maintain their health and wellbeing. The depth and nature of the components of the core category *Mana Wāhine* contributes to the quality of their health. The following scenarios are presented to illustrate two possible outcomes as examples. A Māori woman who has strong whānau connections, a healthy wairua, who has a strong knowledge and understanding of health and wellbeing (and of herself), and who undertakes self-care activities is more likely to positively influence her health and wellbeing. This contrasts with a Māori woman who may be disconnected from her whānau, is spiritually troubled, and does not have sufficient resources available to engage in self-care activities. The outcome of this woman's health and wellbeing is likely to be compromised.

*Connecting through Whānau* reflects the importance of a Māori woman's sense of identity and the connections and roles they have within the whānau. *Nurturing Wairua* relates to the importance of wairua in the maintenance of Māori women's mana and integrity of self. *Using Mātauranga* involves the use of knowledge, wisdom and skills that a Māori woman possesses to maintain her health and wellbeing, and to inform the self-care and preventive practices she undertakes. *Undertaking Self-Care Activities* describes how Māori women integrate their wisdom, available resources, preventive practices and lifestyle to optimise their health and wellbeing. These concepts are complexly integrated to form a matrix that highlights the interdependence and integration of the dimensions.

The core category *Mana Wāhine* represents the shared meanings Māori women have about their health and wellbeing. It emphasises those dimensions that these women collectively maintain is important for their health and wellbeing. Despite all the Māori women in this research engaging in activities with the aim of enhancing their health, the achievement of health and wellbeing is moderated by the second category *The Way It*

*Is.* The core category *The Way It Is*, indicates a resigned acceptance that Māori women have regarding their life circumstances and the nature of health services they interact with, that hinders the access and use of those health services. Where the access and use of health services is compromised in anyway the achievement of positive health outcomes is prevented. *The Way It Is* is discussed in the following chapter.

## CHAPTER 8

### The Way It Is - Resigned Acceptance

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*E taea hoki te aha te pā horo?*

What can be done about a pā that has been defeated?

*Mana Wāhine*, the second core category, highlights the knowledge and insight that Māori women use to inform a variety of self-care practices, with the aim to maintain their health and wellbeing. Yet, the efficacy of the self-care practices in terms of improving health status and outcomes that are undertaken by Māori women is not necessarily reflected in the health status data. It could be construed from the health status data (Ajwani et al., 2003; Ministry of Health, 2001b, 2002c; Reid, et al., 2000) that Māori women could benefit from greater self-care, particularly in relation to lifestyle related illnesses. As mentioned in Chapter 2, health care providers may label Māori women as ‘non-compliant’ or ‘negligent’ with regard to their health care, particularly if they present late in the course of an illness. Such labelling constitutes negative stereotyping, where those with the power to label view those that belong to a particular group as possessing similar traits and characteristics (Myer, 1993). Negative stereotyping can be considered racist, and is less than helpful when attempting to improve the health status of groups, such as Māori women.

Despite the apparent commitment that the Māori women demonstrate in this research to engage in a variety of health-promoting practices within the resources they have available, they delayed seeking professional assistance when faced with a health issue or illness. This behaviour contradicts their belief about undertaking self-care activities, and manifests when they present to health services late in the course of ill health, with advanced health problems. Presenting late to health services is a phenomenon that

health care providers are aware of (Reid et al., 2000). *The Way It Is* is the second core category that refers to the resigned acceptance that Māori women have about their life circumstances, and of experiences that potentiate delays in the access and use of health services. It comprises factors that occur in varying degrees, dependent upon the individual women. *The Way It Is* describes the apparent paradoxical nature of the efforts that the women in this research make to maintain their health and wellbeing, and contributes to the non-achievement of positive health outcomes.

The Māori women in this research endeavour to move beyond 'poor health status'. However, they encounter 'mainstream' health services that focus on poor health status not recognising the positive health behaviours that Māori women do undertake. This situation enables victim blaming to persist that Māori women are powerless to change, making evident a paradox between self-care behaviours they do undertake and health status data. A further paradox also emerges whereby Māori women experience a degree of control in relation to health promoting behaviours within their personal lives, but when they interact with 'mainstream' health services they have little or no control over their health experience. Māori women purposefully and rationally function in the best possible way within their resources, with the knowledge that these resources need to be prioritised and apportioned accordingly.

The core category *The Way It Is* weaves with the core category *Mana Wāhine* and highlights a barrier to the access and use of health services. The contradiction that exists between self-care and the delay in accessing services when needed, prevents the achievement of positive health outcomes. *The Way It Is* comprises the concepts *Putting Others Ahead Of Self*, *Acting On Fear And Past Experiences*; and *Impeding Access To Services*. In this chapter I will discuss the theoretical proposition underlying the core category *The Way It Is*, and describe these concepts and explain their influence on health outcomes.

## **Hindering Access to and Use of Health Services**

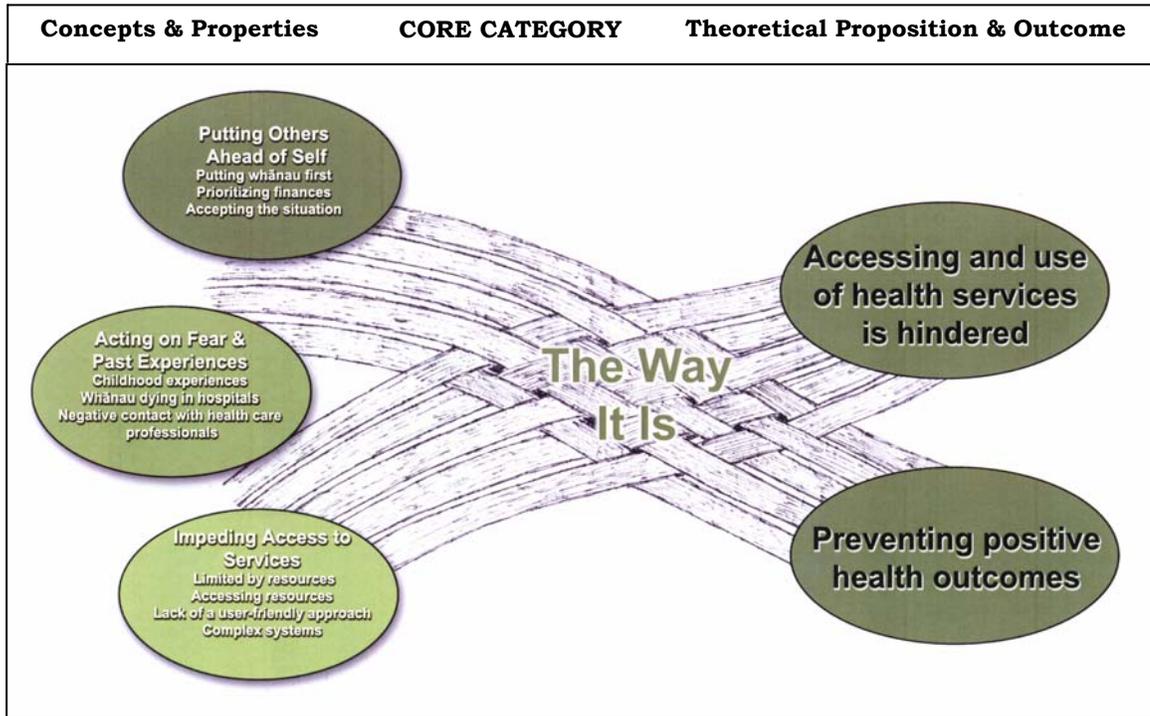
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*Hindering the access to, and use of, health services*, preventing the attainment of positive health outcomes is the theoretical proposition underpinning the core category *The Way It Is* (Figure 8.1). The attainment of optimal health and wellbeing by the Māori women in this research is constrained by personal factors (such as competing priorities) and the resources they have available, as well as issues in accessing health services. Maintaining mana and integrity of self is influenced by health and wellbeing. Thus, the benefit of carefully considered and executed self-care activities to keep well and healthy are potentially limited. The ability of Māori women to maintain health and wellbeing is frequently compromised.

Delays in accessing health services sometime extend to avoiding health services altogether when professional attention for personal health issues and illness is clearly indicated. This behaviour is also supported by the evidence provided by Reid et al. (2000) supports the existence of delays in the access and use of health services apparent in the second core category *The Way It Is*.

A paradox occurs when Māori women actively undertake health-promoting and self-care behaviours, yet do not access and use health services (which are both health-promoting and self-care behaviours in their own right). Delays in the timely access to, and use of, health services when indicated or required may be hindered for a variety of reasons – such as, socialization to put others first, fear, negative past experiences of health services and other factors that impede access to services. Soldow's (2001, p. 41) discussion about the concept of paradox within the marketing context, highlights the difficulty for those experiencing a paradox to correct it:

...the person who is in the one-down position and has received the paradoxical message is not allowed to discuss the untenability of his [sic] position to the sender of the message. He [sic] is therefore not able to destroy the paradox.



**Figure 8.1.** Core category - The Way It Is.

The Māori women in this research could be described as being in an untenable position. They understand the importance of ‘self-care’ in maintaining health and wellbeing, and are aware of the messages sent by health care providers about taking responsibility for their own health. Yet, they are unable to remove the paradox evident in their health-seeking behaviour where they undertake self-care activities with the aim to keep themselves well and healthy, yet they delay accessing or using health services, a position that is neither defiance nor ignorance. Their behaviour is driven by a position that goes unrecognised or unquestioned by many health care providers. It is not simply saying one thing and doing another – it occurs within a complex social context that is influenced by a number of factors, such as whanau priorities, a lack of financial

resources, fear and past experiences, barriers encountered when accessing and using services, and simply accepting their life circumstances as they are.

I would argue, based on the data, that Māori women are acutely aware of their life situations and make every attempt to take care of themselves in an attempt to prevent infirmity or death.

*Seeing a lot of friends the same age die means it is about maintaining a healthy lifestyle to live longer and see mokopuna grow up. This involves managing stress and being spiritually at peace, among other things (I-05).*

*It is about being well – mind, body and whole body – so the whānau and people you come in contact with can be served. So you walk everyday, watch your diet, stop smoking, and try to go to the doctor when something is wrong (I-06).*

This is not unlike Morris and Peng's (1994) research into the attribution patterns of individualist and collectivist cultures, found that people in cultures that have a collective focus (as opposed to an individualistic focus) are more likely to explain behaviour in terms of social obligations and situational constraints. These findings are not dissimilar to the findings in this research whereby the Māori women, in part, attribute their delays in seeking health care to their social commitments and the various restrictions within their lives.

The Māori women in this research do appear, however, to demonstrate resilience, where despite less than optimal life circumstances they have accepted them and successfully function with the available resources. Deveson (2003, p. 231) claims resilient people "...stop trying to control the uncontrollable". The concept of resilience offers a positive way of viewing how people manage adverse situations, particularly how they successfully cope with these situations. These Māori women are resourceful and approach their health in a 'positive' manner. The whānau and social connections they have are an important part of their lives, and also in their health and wellbeing. Certainly, the wholistic context within which the Māori women participating in this research view their health and wellbeing is broad and encompassing and includes

whānau. Thus, Māori women's views contrast with the reductionist, symptom approach taken by the dominant biomedical view of health and wellbeing.

The strength of the core category *The Way It Is* and its potential impact on health and wellbeing is dependent upon the integration of the concepts *Putting Others Ahead Of Self*, *Acting On Fear And Past Experiences*; and *Impeding Access To Services*. *The Way It Is*, is influenced by the:

1. Degree of socialisation Māori women have undergone with regard to putting others first.
2. Psychological ability or willingness to prioritise, and tend to one's own needs in a timely manner.
3. Nature and quality of health related experiences generated, and the intensity of any resultant fear.
4. Ability to access the necessary resources to maintain health and wellbeing, be they financial, physical, and/or interpersonal.
5. Ability to manoeuvre through seemingly complex systems and processes.

The reality is that the delays that occur in accessing health services affect health outcomes. *The Way It Is*, is influenced by a complex interweaving of Māori women's socialisation to put others first, their health service experiences (whether personal or vicarious), the availability of resources, and the ability to access resources. In the following sections I will describe the concepts that comprise the core category *The Way It Is*.

## Putting Others Ahead of Self

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*Putting Others Ahead of Self* highlights how Māori women see themselves in relation to those about them, and is often underpinned by their socialisation. *Putting Others Ahead of Self* provides insight into why Māori women delay accessing health services despite the measures they take to care for themselves, and involves the intricate integration of the properties *putting whānau first*, *prioritising finances*, and *accepting the situation*.

### Putting Whānau First

*Putting whānau first* explains how Māori women assign the prioritisation of their personal health care needs below the health needs of others, particularly whānau members. As mentioned in Chapter 5, the whānau is an integral part of Māori women's being and their health belief system. Māori women view their role as kaitiaki (guardians) of the whānau and the whānau's health with the utmost importance that results in the welfare and needs of whānau members taking priority. The Public Health Group (1997, p.43) supports this stance, and contends "...Māori women carry the major burden of responsibility for maintaining the health and welfare of the whānau". The Māori women in this research reported being socialised to tend to the needs of the whānau and others they come in contact with before tending to their own needs.

*It is the norm for Māori women not to put themselves forward. This is the result of two reasons: children and fear. So they put off doing anything if they have something wrong with their health (I-05).*

*There is not enough money to go around so going to the doctor is not an option. Children or husbands always come first and this is the way it is (I-06).*

The health and wellbeing of whānau plays a central part in the lives of Māori women – a role that they are committed to and take seriously, but a role that is potentially to the detriment of their own health and wellbeing. The commitment Māori women have to the health and wellbeing of whānau is another paradox that is likely to jeopardise their own health and wellbeing. The outcome is similar to the previous paradoxes already identified; that is, the delay in access and use of health services, and the loss of control over their health experience when they engage with ‘mainstream’ health services.

## **Prioritising Finances**

The property *Prioritising finances* refers to the financial status of Māori women and their ability to access the necessary financial resources when required. Limited financial resources means that finances must be prioritised, and the needs of children, partners and other whānau members are put first. Thus, *prioritising finances* is dependent upon Māori women having the necessary financial resources. All the Māori women in this research mentioned that a degree of financial independence was the key determinant in their ability to maintain their health and wellbeing.

Finances are a cause of worry, and insufficient financial resources are a continual stress for Māori women that impact on their health and wellbeing.

*The worry of ‘making ends meets’ and putting off going to the doctor for health issues – so going to the doctor is ‘put on the back burner’. Simply put, ‘the daughter goes before the mother’ (I-05).*

*‘Money is inadequate’ – as a result Māori women did not go to the Doctor, they take the ‘kids’ first or their husband. It was observed, however, that many women do not have gardens or are unable to cook and these may help to make money to go even further (I-06).*

Financial concerns for the Māori women in this research are a reality, and are supported by the analysis of the 1996 Census data for Māori women undertaken by the

Ministry of Māori Development (1999). In terms of family income, one in two Māori women received government income support (a 'benefit') in the 12-month period prior to the 1996 Census, and 45 percent of Māori women lived in households with an annual income of \$30,000 before tax. According to the 2001 Census, the median personal income for Māori women was \$13,200 (Statistics NZ, 2002b). The 1996 Census indicates that 78 percent of Māori women had an annual income of less than \$20,000 and only 3 percent had an annual income of more than \$40,000. The Ministry of Māori Development (1999) also noted that Māori women were more likely to undertake unpaid work.

Recently, Grigg and Macrae (2000) reported that Māori women between the ages of 25-44 years are more likely than any other group of the population to run out of food due to a lack of money. They attributed this to their low-income levels. This group of Māori women were also more likely to be sole parents relying on income support. Despite the evidence, with regard to the socio-economic realities of Māori women, the negative stereotypes held about Māori women by some members of society result in victim blaming. One common belief<sup>1</sup> relates to those receiving income support as being well off, and any inability to function within the financial support provided by the State is attributed to poor management of money. For example, the belief that women on limited incomes 'waste' their money on videos. Yet, the reality is that the cost of taking the whānau to the movies is prohibitive, however, entertainment with a video may be attainable. Other examples relate to money spent on smoking and drinking alcohol. Yet, these activities are possibly the only relaxation and escape from the reality of their life. Such beliefs do not necessarily account for the reality that income support provides for day-to-day living only. Accessing health services may mean that money is taken from one area (for example, food, rent, power and telephone) to pay for the health service and the associated costs involved in accessing and using it.

*Prioritising finances* becomes a major determinant in the ability of these Māori women to access health services. Brown (1999, p.259) points out:

You can have the highest-quality, shiniest, best-configured health care system in the world, but you haven't accomplished anything if people can't get into that system.

Most of the Māori women in this research did not have the financial means to access the private health system, and are dependent upon the public health system. They lack choice in selecting a health service and rely on a seemingly compromised public health system. For some, a health issue or illness may be advanced by the time assistance has been sought for it, thus creating even greater pressure. A participant simply stated:

*Finances are attached to health (I-08).*

Financial resources also influence the ability of Māori women to adhere to, or comply with, medical regimes. I have observed a tendency for some health care providers to attribute incidents of 'non-adherence' or 'non-compliance' to the women themselves. For example, an elderly Māori woman (mentioned in Chapter 1) was quickly labeled as 'non-compliant' when she was acutely admitted to hospital with unstable long-term health conditions. However, this woman did not understand her drug regime and her level of understanding about her drugs was never validated by the health care providers involved. Sarafino (1998, p.290) supports the notion of labelling patients, and contends that health care providers "...tend to place most of the 'blame' on the patients – their 'uncooperative' personalities, inability to understand the advice or difficult life situations". The reality is that health care providers often do not explore the socio-economic impact that a prescribed regime may have on a person's ability to undertake it. Both health care providers and patients have the potential to influence adherence (Sarafino, 1998).

## **Accepting the Situation**

The paradox in the self-care behaviours, displayed by the Māori women in this research, could be considered self-sabotage. When explaining why some people

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<sup>1</sup> This belief becomes apparent in conversations about those on income support, and over the years is evident in media responses when those receiving income support comment on its inadequacy.

'undercut' themselves on the edge of success, Wareham (1998) maintains that self-sabotage arises out of anxiety and guilt about not being worthy, with those who self-sabotage usually having been raised in insecure and unhappy homes. Most of the literature sourced pertaining to the outcomes of self-sabotage appears to be related to performance within work situations and career achievement. Its applicability to the health care context therefore is questionable and should be viewed cautiously.

The Māori women in this research do not support Wareham's (1998) profile regarding self-sabotage. Wareham's (1998) contention that anxiety and guilt behaviours are located in a sense of unworthiness has tenuous validity for the women in this research. While some Māori women may have self-esteem issues they generally do not see themselves as unworthy, evident in their engagement in self care activities discussed earlier. The anxiety they experience is generally generated by fear and negative experiences, rather than the need to self-sabotage, although it is agreed this may lead to a degree of self-sabotage in some women, either consciously or unconsciously, by engaging in cognitive and/or behavioural avoidance tactics. This will be discussed further in the next section of this chapter, *acting on fear and past experiences*.

The strong sense of obligation to meet the priorities and needs of whānau members leads to property *accepting the situation*. This acceptance of their way of life involves being aware of the risks associated with delays in seeking health advice for health issues or illness.

*As a sole income earner for the family there is the worry and stress of making ends meet, together with the need to cope with keeping healthy. It is about being resigned to the situation being 'the way it is'. As a consequence there is a degree of being scared, and thus, avoid taking risks that may negatively impact on health and wellbeing (I-05).*

The Māori women in this research report being socialised not to complain and, therefore, only spoke up if something was very wrong. This behaviour also influences the timely access to health services when they are required.

*There is a belief that Māori women shouldn't be sick. This belief is instilled in Māori women and so they do not complain, only when there is something really wrong. This belief and the associated silence delays being seen by health care providers in a timely manner (I-06).*

These behaviours, based in socialisation and obligations to meet expectations associated with cultural beliefs and practices, go unchallenged by the Māori women and reflect *accepting the situation*. The resigned acceptance of *The Way It Is* is a complex outcome of various social and cultural norms and expectations to put others first, and thus are accepted without question.

## **Acting on Fear and Past Experiences**

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The process by which fear is experienced by Māori about health services, especially hospitals, may also occur vicariously through discussions with other Māori. Fear may be generated during childhood and is often reinforced by experiences of health services (either directly or indirectly) as Māori women get older. Sarafino (1998) provides further understanding about fear, which is a common emotional reaction comprising phobias and anxiety, and has both psychological and physical reactions of varying intensities (Sarafino, 1998).

The fear and past negative experiences generated through the Māori women's child and adult health-related experiences may induce an avoidance response to escape an aversive stimuli. Avoidance responses may be cognitive where the Māori women may be physically present, but psychologically disconnected; or physical where these women physically avoid any health-related situation that is perceived to be aversive. Hadjistavropoulos, Craig and Hadjistavropoulos (1998) studied the responses of health-anxious and non-health anxious individuals when exposed to health information. The participants in this comparative study were assigned to either a health-anxious or non-

health anxious group, on the basis of their pre-determined health anxiety scores, and completed varying diagnostic feedback tasks. They found that health-related anxiety led to cognitive and behavioural avoidance. The Māori women in this research recount the fear and anxiety they experience regarding health services, and a tendency to engage in avoidance behaviours, if able to. By reducing the presence of an aversive stimulus through avoidance, the avoidance response is reinforced and the fear is maintained (Carlson, Buskit & Martin, 1997).

Knight and Eleenbein (1996) researched the relationship of death anxiety/fear to health beliefs and behaviours. They found that women with a high death anxiety/fear were more likely to ask questions of health care providers, but had 'poorer' health care and were less likely to take personal responsibility for their own health care. However, this differs from the findings in this research in respect of the Māori women asking questions of health care providers. I will discuss this notion further in the next chapter where the characteristics and behaviours of health care providers are a barrier to asking questions.

Integrated with the fear Māori women may have are the negative interactions they may have had with health services and health care providers. The concept *Acting on fear and past experiences* comprises the properties of *childhood experiences, whānau dying in hospitals, and negative contact with health care professionals*.

## **Childhood Experiences**

The property *Childhood experiences* relate to the generation of fear and anxiety during childhood when adults used hospitals or doctors as a form of punishment, or to elicit behavioural compliance. The fear of hospitals or doctors is comparable to the religious tactics of instilling a 'fear of God'.

*Health services were used as a 'fear' tactic or punishment – similar to the 'fear of God', for example. As children, some Māori women were told that 'you would go into hospital and never come out'. Despite the intellectual messages that this is not necessarily so,*

*the childhood fears resurface and contribute to Māori women not accessing health services (I-05).*

The fear nurtured in childhood is further reinforced by adult experiences.

*A fear of going into hospital still remains together with the belief that you were never going to come out. The reality was this participant's parent's generation did go into hospital and died – this had a strong influence on them as children (I-05).*

Sarafino (1998) concluded that fear-generating experiences need not be concrete or tangible in nature as the imagination is a powerful and effective tool that is able to produce long-term reactions based in childhood fears – a factor that appears to be evident in the Māori women's accounts of their interactions with health services. Sarafino (1998) describes this, stating: "The things children fear tend to become *less* concrete or tangible and *more* [sic] abstract and social as they get older". This fear generated during childhood is further compounded by *whānau dying in hospital*.

## **Whānau Dying in Hospital**

*The reality of knowing that someone died in a room or bed produces anxiety and panic attacks – it is the knowledge about people who have died (I-05).*

*Whānau dying in hospital* explains in part the fear that exists with some Māori women, and situates that fear in reality. Such fears may produce anxiety and panic attacks when engaging with health services. Many of the Māori women in this research were able to recount instances of whānau members and friends dying in hospital – 'they go to hospital and never come out again'. It begins for many of these Māori women when their parents' generation 'went to hospital to die'. These fears are reinforced further with the knowledge and realities about the health status of Māori and the relatively young

age that many Māori die. A kōrerō with a kaumatua<sup>2</sup> reinforces the notion that some Māori have an expectation that they will die in the 40-50 year age group – an expectation that influences the perceptions held about illness, ill health and hospitals, and reinforces the perception that death is inevitable. The emotions associated with a fear of hospitals overpower any rational messages that could negate that fear, including the knowledge that risks are minimised by early use of health services.

Hadjistavropoulos et al. (1998) maintain that health-related anxiety originates from critical incidents that initiated what they referred to as, ‘dysfunctional’ health-related beliefs that contribute to the experience of anxiety. Anxiety is generally not pleasant, as the recipient experiences varying degrees of panic, feelings of apprehension and dread, difficulty in concentrating, irritability, sleep disturbances and physiological reactions such as restlessness, fatigue, an increased heart rate, sweaty palms, tightness in stomach, and muscle tension (Carlson et al., 1997). Vandervoot’s (1995) research into the relationship between depression, anxiety and hostility to physical health, found anxiety was significantly related to physical symptoms and somatic health problems. Thus, the presence of health-related anxiety can also negatively impact on health and wellbeing.

## **Negative Contact with Health Care Professionals**

The nature of the experiences that Māori women may have with health services and health care providers is significant in how they subsequently act, or not act, toward health issues or illness.

*Hospitals are great places for not telling things. The staff speak around you and not at you. They give the impression that if you don’t have a professional qualification then you are not told anything – it is seen to be condescending (I-03).*

The property *Negative contact with health professionals* highlights the avoidance of, or reticence to seek professional health advice and health services when required as a

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<sup>2</sup> Kōrerō with Roger Chase, Kaumatua from Ngāti Tūwharetoa - 11 June 1999

result of negative experiences. The negative experiences with health services or health care providers are multi-factorial. They may be a result of:

1. Attitudes and behaviours of those working in health services.
2. Language that is used and not understood.
3. Not understanding what is happening.
4. The nature of the clinical environment of a health service, such as the smells of methylated spirits and the equipment used.

Veljaca and Rapee (1998) also found that highly anxious people are better at detecting what they refer to as 'negative audience behaviours'. Social phobias result from any situation where a person feels they are under scrutiny by others and fears any humiliation or embarrassment that may arise from such scrutiny (American Psychiatric Association, 1994).

*The language or the explanations cannot always be understood, but nothing is said because of what health care providers may think (I-05).*

*The timely access to health services is compounded by answering the paperwork correctly, or not understanding things. But complaining is not considered because of a fear of what else may happen (I-06).*

It was evident that the Māori women in this research were motivated to avoid any humiliation or embarrassment from health care providers who were negative and engaged in judgmental behaviours, thereby preventing positive health outcomes.

## Impeding Access to Services

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The core category *The Way It Is* extends to the ability of the Māori women in this research to access and effectively utilise resources and health services. The ability to effectively access and use the appropriate resources and services influences the nature and quality of health outcomes. It is difficult to challenge this notion. However, *Impeding Access to Services* weaves with the concepts *Putting Others Ahead of Self* and *Acting on Fear and Past Experiences* to hinder the use of both resources and services. The concept *Impeding Access to Services* comprises the properties *limited by resources, accessing resources, lack of a user-friendly approach and complex systems*.

### Limited by Resources

*Limited by resources* is that property that refers to self-care activities being limited by the financial resources available. The ability to access financial resources is a major determinant of the amount and quality of the resources the Māori women in this research have available to themselves and their whānau. A group of participants maintain:

*Socio-economic status and the accessibility to funding are a barrier to achieving health and wellbeing (H-01).*

The challenge of having to budget limited money impacts on the quality of self-care activities undertaken. For example, the amount of money available influences the quality of food choices (such as the ability to buy more fruit and vegetables) despite having strategies to help money 'go further', resolving insufficient financial resources.

*There is a real need for young women to learn the art of budgeting, cooking and growing gardens, and education about what is available. But more money is needed, 'but...how are they going to do it?' (I-06).*

Interrupting cycles, such as the one alluded to above, where education is required to learn new skills to free financial resources and change, is not as easy as it sounds. Skills also require time to develop and time is also a limited resource for a variety of reasons, such as meeting the demands of whānau and other roles Māori women may have. Such strategies as mentioned above generally require additional resources (including financial resources), and accessing them is problematic. *Limited by resources* is closely linked to *accessing resources*.

## **Accessing Resources**

The reality of physically getting to health services cannot be taken for granted. The geographical location of health services and the costs involved in private or public transport (if they are available), the payment for the services, and the interventions prescribed creates difficulties for many Māori women accessing health services. It is not uncommon to hear that some Māori women with sick children take one child to the doctor and share the antibiotics with the others who are sick. This is not because these women are being neglectful, but they are maximising the resources they do have to seek help for their sick children.

Even where geographical distance may appear to be small, a Māori mother with no transport, and children, may find the problems with access to health services insurmountable. Nor can it be assumed that Māori women have access to a telephone. The Māori Health Group's (1999) review of resources for Māori within the Bay of Plenty and within New Zealand (Table 8.1), shows that of the Māori living within the Bay of Plenty, approximately 1/5 had no car, 1/5 had no phone, and 1/3 of households had children under 5-years of age. Māori living in the Bay of Plenty had slightly less access to these resources when compared to data for all Māori within New Zealand. Māori do have a relatively high number of one-parent families with children, comprising 35.4 percent of Māori 'families' compared to 14.5 percent of European's respondents (Statistics NZ, 2002b).

**Table 8.1**

*Resources of Māori Living in the Bay of Plenty and New Zealand*

	No Car	No Telephone	Household with children under 5-years
<b>Māori in Bay of Plenty</b>	19%	22%	30.6%
<b>Māori in New Zealand</b>	18%	17%	29.3%

Note source of information is from the Māori Health Group (1999).

The impact of one-parent families with children on health and the ability to access the necessary resources cannot be underestimated. O'Donovan, McMillan and Worth (2004) surveyed 244 female Domestic Purposes Beneficiaries (DPB)<sup>3</sup> with children over the age of six years to determine the barriers for DPB recipients gaining paid employment. They found that there were greater unmet health needs of the children of these women (when compared to national data) due to cost, transportation and appointment time issues. One third of the DPB recipients surveyed also had health issues that prevented them from seeking employment, which could potentially increase their income.

The property *Accessing resources* can also include factors such as the language used by health care providers, literacy and comprehension levels. The following data illustrates the difficulty comprehending letters that have been sent out by health services.

*While English is spoken, it is difficult to absorb the written words when reading letters that are sent by health services (I-08).*

<sup>3</sup> The Domestic Purposes Benefit is the income support available to one-parent families with children who are not employed.

*Health care providers use language that people can't understand, and they don't follow-up with explanations (I-05).*

Writing is the main medium health services use to communicate with its consumers. This assumes that all recipients can read and understand the contents of letters or information pamphlets. Sometimes the language used is unintelligible to the recipients and includes jargon. It does not account for the varying literacy levels of Māori women and that 47.2 percent of Māori women leave secondary school without a qualification (Ministry of Māori Development, 1999). The ability to understand any information received, and the manner in which it is conveyed, is vital for Māori women to gain access to, and use, the appropriate services. Understanding information is compromised when explanations lack clarity, inappropriate language (particularly health-related jargon is used), and there is an absence of symbols and pictures (that aid understanding).

## **Lack of a User-Friendly Approach**

*It is nice to see someone who is pleasant, who smiles and is caring when you first go into a health service (I-08).*

The approach and attitude Māori women encounter when they do access health services influences the quality of their interactions, and the likelihood of them returning in the future. *Lack of a user-friendly approach* is the property that contributes to core category *The Way It Is* by acting as a disincentive to access health services. The reception received and the attitudes of those encountered are vital to the outcome of any health service interaction.

*The negative attitude and approach of people in health services does not consider the needs of Māori women and acts as a barrier to accessing the services (H-01).*

The Māori women referred to a 'user-friendly' approach that includes the language health care providers use. The language used, especially biomedical or health-related jargon, creates barriers to understanding. Māori women perceive the use of such

language labels women (especially biomedical or psychiatric diagnoses), and at times is also interpreted as a scare tactic to elicit compliance. The data illustrate the difficulty Māori women have with the approaches taken and the language used. One woman said:

*Responding to the health promotion messages about cervical cancer and the need to have regular smears, one participant recounted her experience. She was told that her cervical smear was 'clear' and she didn't need to have another one for another 4-years. However, 18-months later following a review of the files she was told her first smear was Stage 2 cervical cancer. On reflection the woman claimed the language that was used in terms of her treatment was a 'scare tactic' on reflection. She felt she was coerced into decisions about treatment and it left her with a lot of regrets when she complied with the single treatment option she was given (H-01).*

*The participant group of participants discussed that labels were assigned for medical diagnoses and vital in getting the necessary support. However, labels and the language health professionals used compartmentalised and de-personalised Māori women and did not enable them to be viewed as spiritual beings – an important component of Māori women's health and wellbeing. The language of labels was difficult to understand and was isolating (H-01).*

Conflicting worldviews exist. However, the Māori women in this research believe the dominant biomedical worldview is seen to prevail. This leaves Māori women with little or no option to have their own beliefs and practices incorporated into any health planning. The lack of a user-friendly approach does nothing to reduce the perceived complexity of the systems and processes that Māori women also encounter in health services.

## **Complex Systems**

The property *Complex systems* create barriers when accessing health services. Indeed, evidence reinforces that generally Māori are not accessing a variety of primary, secondary and tertiary health services (Bramley et al., 2004; Crampton, Salmond &

Kirkpatrick, 2000; Tukuitonga & Bindman, 2002). Informal accounts also exist about Māori not being offered opportunities to 'fast track' into the public health system by seeing consultants privately. Gaining access to health services and health care providers may involve convoluted processes. This is compounded by 'appropriate' referral systems that must be used, and reports of lengthy waiting times. A booking system exists to assess and prioritise those needing secondary health services, although interventions are not necessarily guaranteed, especially when conservative management of health conditions may be adopted. Booking systems and health service prioritisation strategies do not necessarily address the impact on quality of life and functioning that Māori women may experience.

*When a Māori woman has put off seeking help for her own health, her needs may need to be addressed more quickly – for example with a lump in the breast. Despite the booking system it was longer than six weeks before a friend was seen and diagnosed with cancer (I-05).*

Simply 'showing up' to many health services is considered inappropriate, however, the window of opportunity to engage a Māori woman with the health services that she requires may be lost as she is forced to use seemingly complex systems. One example of this was the change in the purchase and delivery of health services during the late 1990s that resulted in the delivery of services being restricted to only those contracted. Consequently, for those Māori without a general practitioner, access to hospital Emergency Departments when ill became impossible. It should be noted that Emergency Departments were never intended to be the primary care agents, however, historically Māori did use them and were able to use them. With the changes in health services, Māori not meeting the criteria for emergency services are turned away as Emergency Departments are no longer contracted to deliver sub-acute health services<sup>4</sup>. The only options are health services that charge a fee, such as Primary Health Organisations (PHOs), general practitioners, or after hour's clinics.

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<sup>4</sup> The *Roadside to Bedside* policy (Creech, 1999) was ironically designed to improve access to health services, but has inadvertently made access for Māori problematic.

Changes in health policy regarding health service access aim to increase the efficiency and effectiveness of health services. However, such changes do not necessarily account for impact a change in service delivery can make. The above example regarding accessing health services through Emergency Departments demonstrates such a change that on the one hand aims to increase access to, and the efficiency of, emergency services, but on the other hand, reduces access for one sector of the community.

Emergency services have been used by Māori who did not have a regular General Practitioner (GP), yet when they delay accessing health services there may become a time when there is no option but to seek assistance, despite the fear of hospitals. The reasons for not having a regular GP are varied and may include the transient nature of some Māori whānau, and not having sufficient financial resources to access a GP. The use of a health service that charges a fee (such as a GP), albeit publicly funded in part through Primary Health Organisations or the General Medical Services Subsidy (GMS), may not be a realistic option. This adds to the complexity of health services. Yet, the risk of a sub-acute health problem becoming a serious acute health problem necessitating an emergency admission to hospital is a reality for Māori women. Malcolm's (1996) research into the use and expenditure on primary medical care by Māori and low income New Zealanders found that financial and other barriers contributed to poor access and use of primary health services, and was a significant factor in the high use of hospital services. The relevance of health policy to the access and use of health services by Māori women will be discussed further in Chapter 11.

When systems, and their associated processes, are perceived to be complex there is a greater likelihood that difficulties will be experienced in accessing an appropriate service when required. The Māori women in this research experienced a sense of powerlessness to influence the delivery of services.

*It's difficult to work things out. Everything is complex, but the nurses are rushed, the doctors are too sterile, and the forms are complicated. Māori women get so muddled. A place is also needed to go and talk that is not in the corridor (I-08).*

These women attribute their inability to influence health service delivery and decision-making to the 'distance' they, as consumers, were from health service decision-makers. Politically driven health reforms and the consequent changing nature of the health service delivery system also compounds problematic access. Improved access to health services by Māori women is dependent upon the quality of information they have about the various health services and resources available. This is an important factor as health and wellbeing is enhanced by the timely and appropriate access of health services.

## ***The Way It Is and Health Outcomes***

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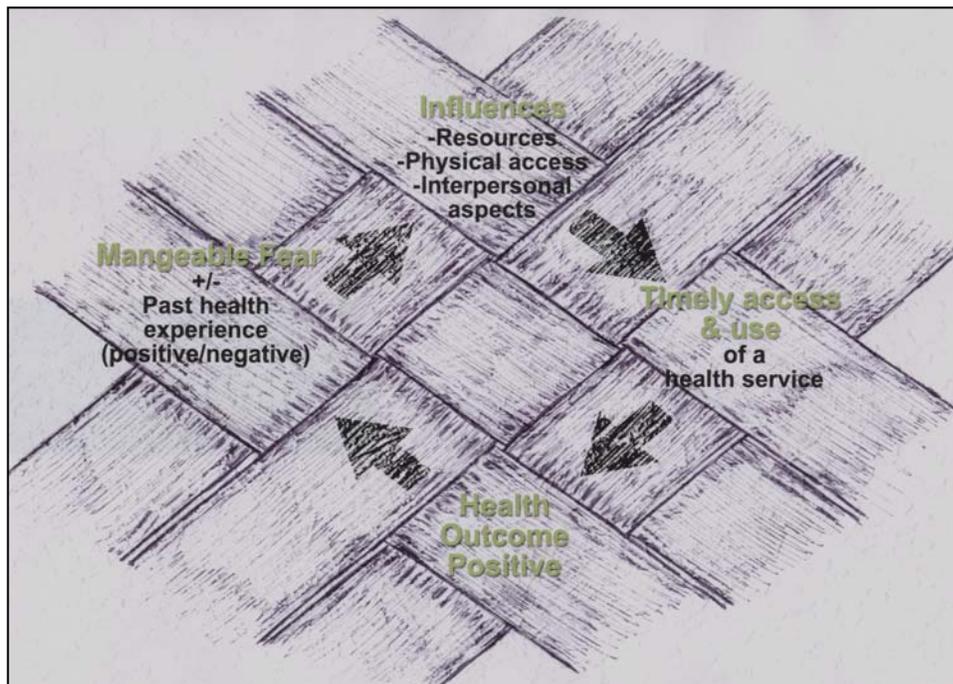
As Māori women construct their health and wellbeing in very different ways, they also have different health outcomes. *The Way It Is* explains the influencing factors that contribute to a paradox of self-care – that is, despite many Māori women undertaking self-care and preventive practices, influences such as putting others ahead of oneself, acting on fear and past experiences and impeded access to health services, hinder the access and use of health services. Therefore, access and use of health services by Māori women depends upon:

1. Her perception that she can tend to her health and wellbeing needs in relation to others around her.
2. How she responds to any fears she may have.
3. Her past health experiences.

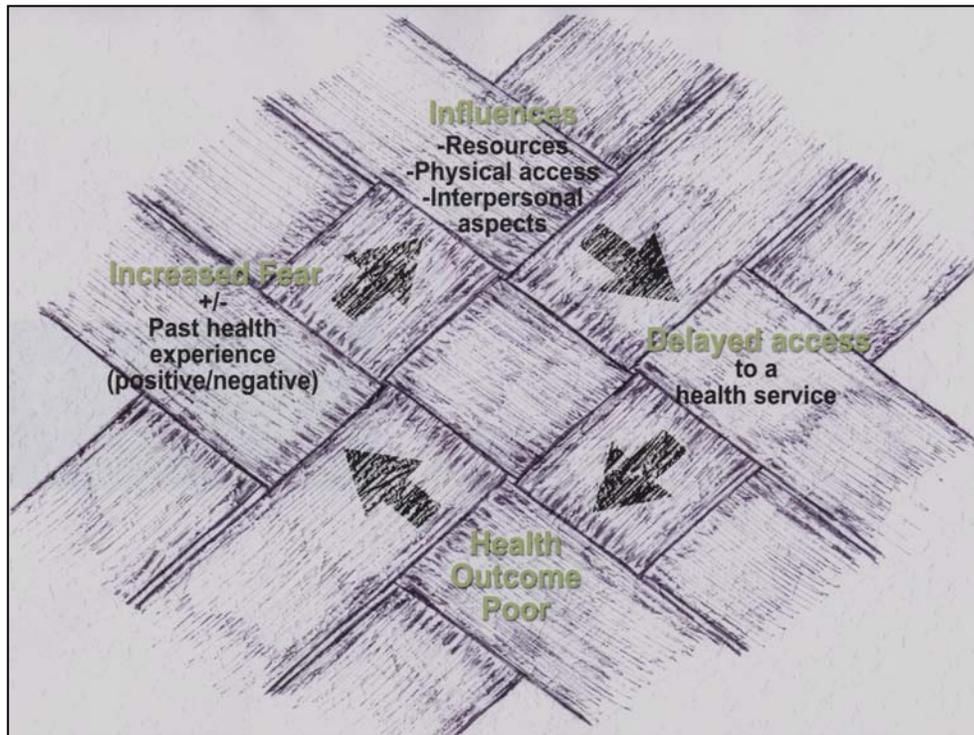
4. The factors that would prevent her from accessing and using health services.

For some women, a cycle may evolve that becomes difficult to break. Such cycles need to be interrupted in order for health outcomes to be improved.

The cycles presented in Figures 8.2 and 8.3, result in health outcomes that can be placed at either end of a continuum. The health outcomes of Māori women, however, do not fall simplistically into one of two end points. Their outcomes may be placed anywhere along such a continuum dependent upon the combination of factors they experience. For example, some Māori women may have minimal fear and positive past health experiences, but do not have sufficient resources to access a health service. The outcome for this group of women is highly likely to be delayed access.



**Figure 8.2.** Cycle of *The Way It Is* – positive outcome.



**Figure 8.3.** Cycle of *The Way It Is* – poor outcome.

Another influence that may affect access, use of services, and health outcomes is the interpersonal aspects when engaging with a ‘mainstream’ health service. When a Māori woman does access a health service, the nature of the reception and interaction she has with health care providers may influence the outcome. For example, encountering a negative reception, or not being able to understand the language used or what is happening will only exacerbate any fear or anxiety a Māori woman may already have. Despite the rhetoric about health care providers facilitating access to health services, a gap often exists between the health services available and the health needs of people, such as Māori women (Gulzar, 1997).

## Conclusion

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*The Way It Is* is the core category concerned with the paradox that occurs with the activities that Māori women in this research carried out. It explains the resigned acceptance Māori women have of their life circumstances, claiming that it is “the way it is”. Socialisation, personal experiences and the availability of, and access to, resources and health services may limit the ability to undertake self-care activities. When access and use of health services is hindered by these factors, the achievement of positive health outcomes is compromised. The complex nature and weaving of the concepts *Putting Others Ahead of Self*, *Acting on Fears and Past Experiences*, and *Impeding Access to Services* operates to prevent or compromise the achievement of positive health outcomes.

*Putting Others Ahead of Self* is the concept that highlights the socio-cultural and financial reasons Māori women have to put the health needs of others (especially their children and other whānau members) ahead of their own. It describes why many Māori women accept this situation as ‘the way it is’. The concept *Acting on Fear and Past Experiences* discusses the fear and anxiety that may be generated in childhood, and is then reinforced by negative personal or vicarious experiences with health services or health care providers during the growing and adult years.

*Impeding Access to Services* is the concept that relates to the constraints that Māori women have that hinders access to the necessary physical or financial resources. In turn these constraints determine the ability of Māori women to access and use health services. Interpersonal aspects, such as the lack of a user-friendly approach or having to navigate through complex systems, processes or language create further challenges when needing to access and use health services.

The contradiction that occurs between the self-care activities undertaken, in core category *Mana Wāhine*, and the access and use of health services being hindered, in core category *The Way It Is*, may be moderated by the Māori women anticipating how

health services and health care providers will respect and meet their needs. In the next chapter, *Engaging with Health Services*, I will explain what the Māori women need to positively influence their access and use of health services. *Engaging with Health Services* is the third core category that discusses the nature of the relationships Māori women require when they interact with health care providers.

## CHAPTER 9

### Engaging with Health Services

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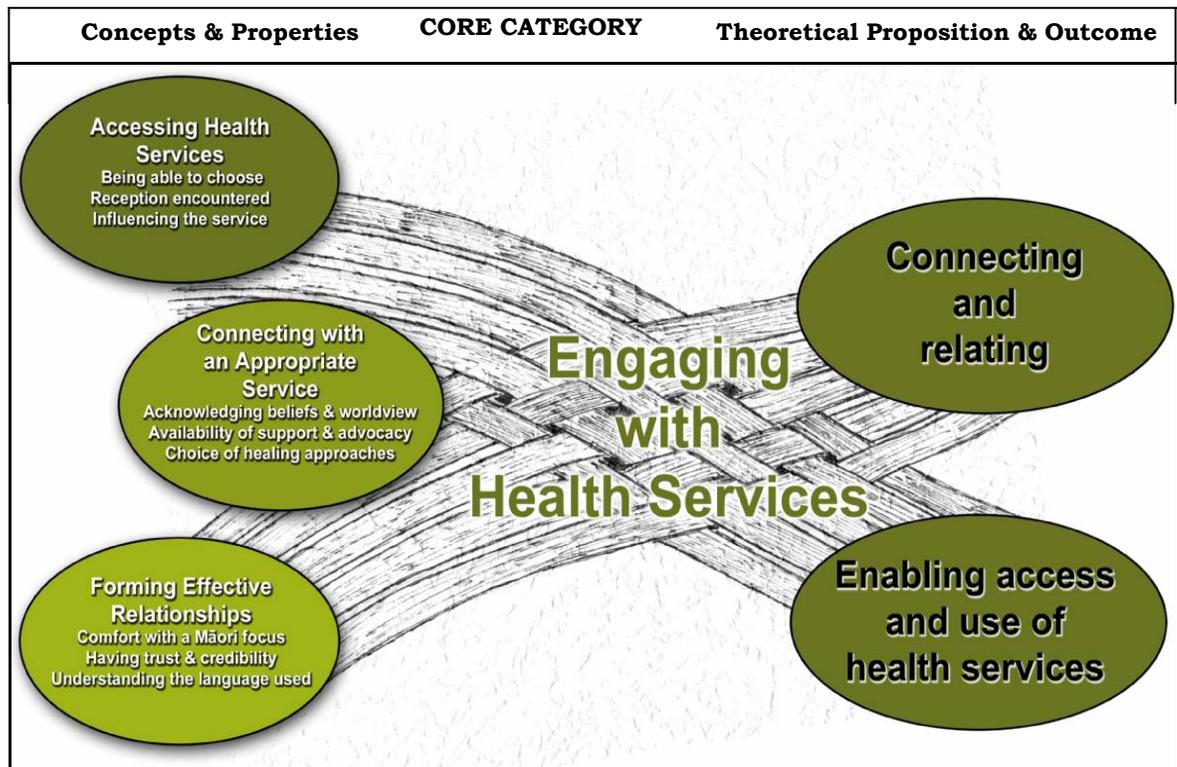
*E tau hikoi I runga oku whāriki  
E tau noho I toku whare  
E hau kina ai toku tatau toku matapihi*

Your steps on my whariki (mat), Your respect for my home  
Opens my doors and windows (Barnes, 2000)

An important factor in achieving health and wellbeing outcomes is Māori women having their health and wellbeing needs met by ‘mainstream’ health services. Having a sense of connection and relationship facilitates anticipation that health care providers will meet their needs, and increases the likelihood that the health service will be both accessed and used. It facilitates trust in a health service that functions on beliefs and practices that are at variance with those of the Māori women in this research and determines the degree to which they accessed and used that health service. Establishing effective connections depends on the nature of the relationship formed with health care providers.

I have discussed what is important for the health and wellbeing of Māori women in the first core category *Mana Wāhine*, and explained how the challenges faced and the degree that these can compromise the achievement of positive health outcomes weaves together with the second core category *The Way It Is*. A third core category, *Engaging with Health Services*, outlines the needs Māori women have when they engage with health services in order to establish the trust required to access and use those services. The nature of the relationships formed by Māori women with health care providers facilitates the access, and ongoing use of, appropriate health services. *Engaging with Health Services* comprises the concepts of *Accessing Health Services*,

*Connecting with an Appropriate Service and Forming Effective Relationships* (Figure 9.1). In this chapter I begin by outlining the theoretical proposition, *connecting and relating*, that underlies *Engaging with Health Services*, and then explain each of the concepts that support *Engaging with Health Services*.



**Figure 9.1.** Core category – *Engaging with Health Services*.

## Connecting and Relating

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Māori women go about meeting their own health and wellbeing needs within the constraints of their life circumstances and resources. However, when they are

dependent upon the involvement of others to meet these needs, trust is required. *Connecting and relating* is the theoretical proposition that underpins *Engaging with Health Services* that enables access and use of health services (Figure 9.1). The health and wellbeing needs of individual Māori women extend beyond purely physical health or illness issues. As explained in the core category *Mana Wāhine*, Māori women view health from a wholistic perspective that includes not only their physical dimension but also encompasses spiritual, intellectual, social and cultural dimensions. Therefore, the integrity of the health and wellbeing of Māori women is dependent upon their needs being met in their entirety. The needs associated with health and wellbeing are complex and interrelated, yet must be in balance to achieve positive health and wellbeing, defined by Māori women. Health and wellbeing needs are based on what is important for each Māori woman – needs that may differ from what is deemed to be important by health care providers.

The inadequate responsiveness by ‘mainstream’ health services determined by the participants has been established by Blakely and Pearce (2002), Durie (1998a), Gray (1994) Reid et al. (2000), Sporle, Pearce and Davis (2002) who all allude to the poor health status and mortality data being a reflection of the health needs of Māori not being met. Māori women, like all health consumers, have to place a degree of trust in health care providers who are privy to information, and who perform procedures that others would not. However, for Māori women this notion of trust is not implicit. They indicated a need to establish a meaningful relationship with their health care provider and feel that health care providers are non-judgmental and genuine in their approach.

Thus, the basis of an effective relationship between a Māori woman and a health care provider evolves from being able to effectively connect and relate to health care providers. Such a relationship must ensure that the personal integrity and dignity of a Māori woman is safe during any encounter.

*The formation of relationships is important and is based upon continuity of health care providers. From continuity trust is developed (I-05).*

*Trust is vital, but it needed to be built up over 2-3 visits. A woman's real story takes time to be shared (I-04).*

When the ability to connect and relate is compromised or non-existent, the access and use of health services is likely to be at risk. Indeed, the various properties of connecting and relating are woven through the concepts *Accessing Health Services*, *Connecting with an Appropriate Service*, and *Forming Effective Relationships* within the core category *Engaging with Health Services*.

## **Accessing Health Services**

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The ability to have choice regarding the health service or the health care provider is important to Māori women. Equally important is the reception and attitudes of the health care providers when Māori women make contact with a service. For the Māori women in this research, being able to determine and have some control over their health experience relates directly to ensuring that their individual health and wellbeing needs are met – needs that may be broader than what a health care provider determines or is contracted for. *Accessing Health Services* is the concept that explains those aspects that are vital for *being able to choose*, *reception encountered*, and *influencing the service*.

## **Being Able to Choose**

*Being able to choose* is the property that accentuates the importance of having choice over the health service and the health care providers that may be required. In order to exercise choice, Māori women require information about health services, their availability and how to access them.

*There is a need for information that outlines the service provided, including how to be referred. Health services need to let everyone know what the boundaries are (I-04).*

An important determinant for the Māori women in this research when connecting with a health service is the quality of a service. 'Customer satisfaction' and the effectiveness of a service are perceived to be vital components of a quality service. What constitutes a quality service is determined and monitored by the Māori women themselves in an informal manner.

*The measure of a quality service includes customer satisfaction, a service's accessibility and cost. A quality service, also has a personal approach, is effective, and has good follow-up processes (I-02).*

While the Māori women in this research explain what constitutes a quality service, they also accepted that the health services they have utilised are limited.

*Quality services are those services that are supportive of what Māori women believe in. However, it is recognised that the nature of the services were set and already developed (I-05).*

Māori women also know what they want from a health service and health care providers, but often what they want contrasts with their experience.

*What is needed is courtesy and a willingness by health care providers to listen. But the attitudes of health care providers are 'bad'. Health care providers do not listen (even when they are told something is wrong) and respond in a manner that gives the impression that nothing can be done – so Māori women simply go away (I-01).*

Choosing the right person and the right service is important when the health issue or illness is of an intimate nature. While the health care provider does not necessarily have to be Māori, the ability to engage in gender-specific services when required is important.

*Some women need a health care provider who is a woman. Many women have been abused either physically or sexually and this may be identified during a health interaction (I-04).*

*It is devastating and culturally inappropriate for an elderly woman to be assessed by a young male doctor who is the same age as her mokopuna (I-05).*

*Being able to choose a health service or a health care provider, however, is constrained by financial limitations. It is the private health system that enables choice of health care providers and timely access. While the financial constraint referred to by the participants in this research occurs at the micro (or personal) level, it also occurs at the macro level. That is, the allocation of health funding does not generally meet the health needs of individual Māori. Funding for public health services is limited, and therefore, its allocation tends to be based upon the utilitarian principle of 'the greatest good for the greatest number' (National Health Committee, 1997). Understandably, this form of allocation generally does not allow for meeting individual needs. The Māori women in this research did not have access to the private health system, and were dependent upon the public health system for the health services they may require.*

## **Reception Encountered**

The experience of a respectful service is certainly one that Māori women, like all consumers of health and disability services, have a right to. This is a right that is enshrined in legislation and the Health and Disability of Consumers' Code of Rights 1996. The reception Māori women encounter not only influences their current interactions with a health service, but also future interactions.

*There is a necessity to get the attention that is needed – a pleasant person who asks questions in a nice way and not in a rushed or unfriendly manner...they [health care providers] need to be human beings as some are not very nice...then going back is avoided (I-08).*

The psychology literature supports the notion that first impressions are lasting, and form the basis of judgments regarding whether people, such as health care providers, can be trusted (Myers, 1993).

*Reception encountered* relates to the nature of the contact Māori women have with a health service or a health care provider. The interaction that occurs at the first point of contact determines the nature of the relationship established with a health service or a health care provider.

*Māori use whanaungatanga to establish connections and relationships. It is important – it engages in a Māori reality (I-02).*

Yet, the Māori women in this research have a heightened sensitivity to the attitudes and behaviours of health care providers that they consider are not genuine, are judgmental and/or unfriendly.

*It is important to be greeted in a nice unhurried way, by people who are willing to be welcoming. But some people are not very nice and are 'sterile', and this is unsettling (I-08).*

Once a negative or unfriendly attitude or behaviour is detected, these women become guarded, anxious, and approach the relationship with health care providers with apprehension. For the Māori women in this research, the reception they wanted on contact with a health service was one that was user-friendly, helpful and respectful.

*The reception that Māori women encountered was important – it was about being acknowledged and treated respectfully. It was important to know what is going on and to be assured that the health service is where it is needed to be (I-03).*

*Public Health Nurses and District Nurses focus on whānau health and relationships are developed. It worked 'really well' as Māori families knew the nurse and trust was present. It is about connecting and relating (02).*

Helpful, welcoming people who are perceived as being 'user-friendly' is important. It provides an assurance that a 'good' service is likely to be provided.

## **Influencing the Service**

The need to be able to influence health services (against a background of publicised failures within 'mainstream' health services, particularly in the area of women's health) was expressed by the Māori women in this research. They wanted the option of self-determination as health consumers, the property *influencing the service* affects the potential to make decisions and choices about personal health and wellbeing that are appropriate to their needs and within the limits of available resources. Having the ability to influence the service also increases the likelihood of a positive outcome.

*There is a need to feel able to contribute to your own health and wellbeing. This means needing to know about what was going on, and needing the information so that decisions could be made on how to use it. But...first, Māori women needed to know that the information does exist (I-03).*

The Māori women in this research cited the New Zealand inquiries into the cervical cancer screening at National Women's Hospital and Gisborne as examples that have resulted in the credibility of health services decreasing.

*Māori women are told that they need to have cervical smears but they [the health services] don't get it right. It affects the belief that the health service is going to look after Māori women (H-01).*

Added to this, health services have traditionally delivered services based on an approach that has primarily focused on the physical dimensions of illness. Some participants believe that political agendas also drive the delivery of services, which has been perceived as detrimental to the 'way of life', and to the health and wellbeing of most of the Māori women in this research. Thus, a lack of confidence or trust is engendered that affects connecting and relating.

Knowing there is an ability to influence a service increases the likelihood of accessing and using health services.

*Need to be allowed to say and do whatever is wanted so everyone is on the same level and that it matters – its about being able to put it out there...like in wananga (I-07).*

Durie (1998a) contends one of the aims of self-determination is to affirm Māori identity, which can also contribute to the reduction of disparities. Self-determination enables the opportunity for individuals to reach their maximum potential in a way that they feel comfortable with. McClelland (1989) supports the link between a sense of control and an improvement in health and health status. Coyle's (1999) research into dissatisfied users of health services highlighted the tendency for consumers to blame and hold others responsible for poor quality care, yet were conversely more likely to accept it. However, they are then less likely to access those health services again, and are more likely to seek alternative practices that meet their health needs. Coyle's (1999) findings are similar to those in this research where Māori women would avoid returning (see discussion in Chapter 8).

Coyle's (1999) work is a reminder to health care providers that while there may be silence about less than acceptable health services, the poor quality services are noticed and acted upon. Complaining about unacceptable or inappropriate health service delivery is not a preferred approach for many Māori women.

*Complaining is not an option as things may get worse (I-06).*

The Māori women in this research indicated a reticence to complain despite the fact that a complaint process exists within the New Zealand health system (Health & Disability Consumers' Code of Rights 1996 (Health & Disability Commissioner, n.d.)). Complaints are believed to negatively influence the delivery of a health service that may be received in the future.

The concept *Accessing Health Services* relates to Māori women connecting with a health service. *Connecting with an Appropriate Service* enhances access when the approach utilised by a health service or health care providers can be reconciled with the beliefs and worldviews of Māori women enabling them to relate to health care providers.

## **Connecting with an Appropriate Service**

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The concept *Connecting with an Appropriate Service* moves *Connecting and relating* beyond the level of interpersonal relationships. This concept is about the alignment or non-alignment of the approach utilised by health services and health care providers with Māori women and their beliefs and worldview. *Connecting with an Appropriate Service* weaves together the properties *acknowledging beliefs and worldview, availability of support and advocacy, and choice of healing approaches*.

## **Acknowledging Beliefs and Worldview**

The property *Acknowledging beliefs and worldview* involves recognising different pathways that can be taken to achieve an intended outcome. This concept is analogous with road maps where different pathways can be taken to get to the same destination. Taking a different pathway that respects and incorporates the beliefs and worldviews of Māori women optimises the outcomes of interactions with health care providers. Such an approach enables the wairua of the women to be recognised - an important aspect for Māori women.

*The following whakataukī was used to illustrate how groups can be more effective in having an outcome focus. Groups were also seen as a cost-effective approach.*

*E hara taku toa, I te toa taki tahi*

*Katahi ko taku toa, he toa takitini*

Mine is not the strength of one alone, it is the strength of many

*This whakataukī provides guidance that is located within a wholistic view, rather than a compartmentalised view (I-02).*

The differing beliefs and worldviews of Māori women and health care providers create a tension when accessing and using health services. The Māori women in this research, as previously mentioned, have beliefs and worldviews that are both wholistic and outcome focused, contrasting with the compartmentalised and reductionist approach of most 'mainstream' health services. A service that attempts to meet the diverse needs of its consumers is more likely to yield positive health outcomes.

An understanding of the historical and socio-political context for Māori is essential in understanding how Māori have become increasingly diverse over time. Recognition of diversity is central to the property *acknowledging beliefs and worldviews*. This is also supported by Paraha (cited in Moir, 1994, p.9) who highlights the importance of recognising the diversity that exists among worldviews so the identity of Māori women can be made visible, and makes the observation that:

At the bottom of each social pile I met indigenous women, marginalised by a colonising power, who were fighting for their identity.

The diverse experiences and influences Māori are exposed to, reinforce the need for health care providers to accept that adopting a universal approach to service delivery is neither acceptable nor appropriate.

*Not all Māori women have been taught the 'old ways' and Māori culture had been suppressed, but it was knowing you were Māori – it was who one was. '...So we flounder and find some things hard to learn' (I-04).*

Consistently, the Māori women in this research encounter health services and health care providers that are problem-focused, and who employ an approach that compartmentalises issues or problems and may result in a desired outcome not being

achieved. Compartmentalisation prevents pertinent health issues or problems being viewed as a 'whole', and therefore risks them not being recognised or explored.

*Problems are never looked at wholistically, they are 'picked off' and compartmentalised (I-02).*

*Wholism encompasses everything that 'touches' a person – it is difficult to separate things out (I-07).*

Certainly the tenets of wholism are based upon the notion that the whole is greater than the sum of the parts. 'Parts', such as diagnoses, however, aid the identification of the likely cause of health problems that enables treatment in the most effective manner. Health care providers do need to be mindful that the moment the whole is compartmentalised, or only a part is examined, the whole ceases to exist and vital components may be overlooked.

Adopting a narrow focus that neglects the wider aspects that impact on health and wellbeing increases the likelihood of victim blaming or deficit explanations when health care provider determined outcomes are not achieved. In such instances the responsibility for compromised health focuses on individual Māori women and their whānau. Yet, health care providers may have overlooked vital factors beyond the immediate control of these women, but necessary to achieve positive health outcomes.

*One participant stressed that there needs to be a flexible approach together with a wider scope of who and how a service is provided to achieve the right person and right service. In other words there needs to be flexibility to do things outside of the traditional way in which health services are provided (I-02).*

The 1990s was an era where health services were market driven; focused on meeting financial 'bottom-lines', bringing about changes in the health system, and subsequently in the delivery of health services. This approach resulted in the contracting of services for specifically defined health services. It was noted by some of the Māori women in this research that differences in the provision of 'appropriate' services had occurred

over the recent years. The ability of health care providers to meet health and wellbeing needs is compromised, particularly spiritual needs.

*Nurses used to do 'things', but they do not do these now. The 'things' such as old values and practices, which contribute to spiritual wellbeing (I-04).*

Certainly, the health reforms brought about a reconfiguration of primary health services, such as Public Health Nurses who delivered well child and family services, and played an extensive role in the primary health of Māori. Public Health Nurses generally had long-term relationships with families and the community. The mutual familiarity and respect that was developed with Public Health Nurses has been lost in many areas.

Universal approaches to health care delivery are based upon the notion that all Māori (and possibly all health care consumers) have the same health needs, and therefore, can be generally approached in similar ways. This is not as simplistic as it sounds and I do recognise that there are instances where those using health services are not always treated the same, especially when aberrations in health status, such as acute events, occur. When health care providers elect to adopt a universal approach to the delivery of health services the tendency is to require the consumers of these services to fit into what is provided. Such approaches cannot be considered consumer-focused, nor are they able to meet the needs of consumers in anything but a random manner. One participant indicated that on reflection:

*The needs of Māori women were not easily met by health care providers and this lay with the way in which services were purchased. It appeared that as long as a health service met the criteria set down by the purchasers it did not appear to matter how it was delivered, from the perspective of those receiving the service (I-02).*

The concept of cultural safety requires health care providers to recognise the beliefs and practices of health consumers, and incorporate these into intervention and treatment plans (Nursing Council of NZ, 2001; Ramsden, 2002). However, culturally based health needs are often overlooked. *Acknowledging beliefs and worldviews* is essential if health services and health care providers are to address the needs of Māori

women in the delivery of health services. This would lessen the negative impact of reductionist and compartmentalising approaches on the health and wellbeing of Māori women that they believe is prevalent in 'mainstream' health services. It would also facilitate the inclusion of a *choice of healing approaches* into treatment options that will be discussed later in this section.

## **Availability of Support and Advocacy**

*Availability of support and advocacy* is the property that outlines optimising the quality of the interaction and connection with a health care provider. It relates to the need by Māori women for support and advocacy to enhance the outcomes of their health experiences.

*It is nice to have a Māori person in a health service to welcome Māori, especially the elders. Different information may be shared that may not otherwise be shared with health care providers, by being able to talk to 'our people' (I-08).*

Accessing and using health services is an experience that produces anxiety for the Māori women, as it generally lies outside of their 'comfort zone'. This is influenced by past experiences and fear of accessing and using health services and health care providers. This anxiety intensifies when insufficient information relating to the experience is provided, and the language used by health care providers is not understood, including that used in written information and forms.

Access to advocacy and support assists Māori women to respond to questions, share necessary information, and interpret any information. An advocate is able to provide assistance with explanations, and where necessary ensure that a Māori woman has enough time to think about her response and to communicate it accurately. The role of an advocate may be particularly important for Māori women who do not have any immediate support available.

*Some Māori women do need an advocate or assistance. Sometimes health care providers ask questions that require a lot of thought, and Māori women do not always have an immediate answer to the questions asked. But they are pressured to answer (I-08).*

An advocate can also assist with the completion of any 'paperwork' that may be difficult to understand. The forms and letters sent out by health services can be complicated and difficult to understand. The need to complete forms accurately creates anxiety. The 'paperwork', therefore, can act as a deterrent to accessing and using services.

*Paperwork and the fear of answering it wrongly hinders seeking help with health issues. Some Māori women saved forms that arrive in the mail so whānau members can help to complete them. Māori women need an advocate to help with these things (I-06).*

The value of an advocate to assist Māori women in their interactions with health care providers cannot be underestimated. Health care providers need to be aware that at times Māori women may not have answers to the questions they ask or be able to respond quickly, especially when pressured. Ignoring this, and insisting on responses, may yield inaccurate information, and ultimately impede the development of a sense of trust and respect for the health care provider(s).

*Māori women need an advocate – someone who can assist them in an informed and clear manner when they are involved in a health problem (I-05).*

The use of an advocate who is able to support, and in some situations speak on behalf of a Māori women may improve the quality of the information shared. An advocate can also assist Māori women to select the most appropriate healing approaches.

## **Choice of Healing Approaches**

*Choice of healing approaches* is the property that highlights the need for the availability of a range of traditional Māori healing approaches to healing within 'mainstream' health

services, such as the ability to have access to kaumatua and tohunga. The Māori women in this research prefer to seek the expertise and guidance of kaumatua and tohunga for health-related issues, where possible. The reason for this is based on the difference between kaumatua and tohunga and 'mainstream' health care providers.

*Rongoā Māori involves tikanga and karakia, and the consultation with tohunga. There are specific processes around the use of rongoā that need to be observed that are steeped in wairua (H-01).*

*Tohunga and kaumatua are able to connect and relate to Māori. They are supportive and provide spiritual guidance (I-07).*

Kaumatua and tohunga are perceived to be both positive and supportive, use language that can be easily understood, and the environment in which Māori women meet with kaumatua or tohunga is 'comfortable'.

Traditionally kaumatua and tohunga were trusted and respected members of Māori society who provided both spiritual and emotional support, along with expertise and guidance. The value of tohunga lies in their recognised and accepted expertise and their ability to engender a sense of faith and to strengthen mind and agility – attributes that are considered very important (Moon, 2003). Durie (1998a) supports the importance of traditional healing methods used by tohunga that focus on the spiritual and symptomatic aspects of a health issue or problem. Traditionally healing methods draw eclectically upon "...spiritual, psychic, physical and ecological levels" (Durie, 1998a, p.17). Common activities utilised include karakia, incantations and rituals, natural medicines, massage, water and surgical interventions.

*The tohunga is important and is an expert in an area of life. They are powerful and the conveyer of knowledge and wisdom that brings together both tinana and hinengaro [that is, bringing the physical dimensions with the mind] (I-07).*

Rongoā provides an alternative to, or complements, biomedicine and contemporary drug therapy, but is an approach that is often not recognised or accepted by 'mainstream' health care providers. However, rongoā has an important place in the

maintenance or attainment of the health and wellbeing of Māori women. A number of the women in this research report using rongoā as a self-care activity in the maintenance of their health and wellbeing. Many reported using rongoā prior to approaching a mainstream health care provider for any health issue or problem. *Choice of healing approaches* may also include the role of taonga, such as a specific and special piece of pounamu that is of spiritual significance.

*Whānau may have a healing taonga that has spiritual significance and can be used to bless someone who is not well. It was important being able to use a healing taonga for any whānau member who is not well (I-06).*

The utilisation of groups and wananga provides one way Māori can learn health-related knowledge and skills. Wananga has the potential to increase the effectiveness of learning activities (including, the cost-effectiveness of the learning process). Hemara (2000) contends that while a diversity of opinion exists around the traditional concept of te whare wananga, contemporary approaches to Māori learning, however, can be used to maximise learning. Contemporary approaches to wananga focus on the relevance of the learning, the frequency of interactions between the teacher and learner, working together, and the exchanging of ideas. The group learning that prevails in wananga, however, does not preclude individualised learning. Learning can also be optimised by utilising intergenerational involvement (such as that evident in the teina-tuakana model<sup>1</sup>) and mixed media.

*Getting rid of the clinical setting with its stethoscopes and smell of methylated spirits would allow Māori to say or ask whatever they want. In a wananga everyone is on the same level and is able to utilise the knowledge of the wananga (I-07).*

*Choice of healing approaches* also extends to the choice of the environment where healing and learning occurs. For many Māori women, the experience of whakamā results in what appears to be a reticence to participate. Whether whakamā originates from shyness, embarrassment, shame or a loss of mana, its presence is likely to reduce

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<sup>1</sup> teina-tuakana model – this model utilises a learning process based upon the partnership of the young and the old, whereby the older person shares their knowledge and wisdom.

the effectiveness of any interactions with health care providers. The thought of the loss of dignity compounds whakamā, making any health or learning experience more difficult. It is, therefore, desirable (where possible) for Māori women to have the option to choose where such experiences take place, such as the privacy of their home or within the familiarity of their own cultural milieu.

*The hardest thing to do is lose one's dignity. If this was going to happen it was best to do it at home and within one's own culture. The whānau may need support for this to happen, for example, assistance from the health service with equipment and how to use it (I-05).*

The appropriateness of health services and health care providers is vital for Māori women *Engaging with Health Services* and their ongoing interaction, especially for any long-term health issue or problem. Continued access and use of health services is dependent upon, and optimised by, the following concept *Forming Effective Relationships*. The establishment of an effective relationship with a health service or a health care provider is a powerful indicator of the nature of future access and use of health services.

## **Forming Effective Relationships**

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The formation of effective relationships is vital in the attainment of positive health outcomes and maximises the impact health services may have through the processes of relating. An effective relationship established with health care providers, who are genuine and familiar, involves and empowers Māori women in a meaningful manner in their health care. The aim of an effective relationship is to establish and attain mutually negotiated health goals and outcomes. However, the attitude and behaviour of a health care provider can either nurture or destroy a sense of trust and credibility that is vital for the formation of such relationships. The concept *Forming Effective Relationships*

weaves with the concepts *Accessing Health Services and Connecting with an Appropriate Service*. It builds upon the relationship formed at the first point of access with a health service and health care providers, and weaves together the properties *comfort with a Māori focus, having trust and credibility, and understanding the language used*.

## **Comfort with a Māori Focus**

A Māori focus conveyed by a health service or health care provider attempts to create an environment that acknowledges and respects Māori, and indicates an intention to make the service comfortable for Māori patients and their whānau. This intention is increased by the overt presence of ‘things’ Māori, such as signage in te reo Māori, images and artwork, and seeing a Māori face on entering a service. *Comfort with a Māori focus* is a vital property of *Forming Effective Relationships*.

*It is a sense of comfort when things Māori are seen. It may be a Māori image, signs in te reo. What it does is that it gives a feeling that there is respect for Māori (I-06).*

*It is important for a Māori person to be in the health service. Sometimes there are Māori women who did not know what is happening, and who feel lost (I-08).*

Having the choice and the ability to participate in te ao Māori and its associated activities such as karakia prior to surgery is also important. The ability to participate in te ao Māori contributes to a sense of being ‘alive’. Other such activities may include, for example, the use of Māori language and images, having access to familiar kai, or attending hui or tangi.

*It is important to be involved in tangi. The role of tangi is important in maintaining health as it releases what can be described as ‘external stuff’. It is about needing to do what feels right (I-07).*

Providing choice to participate in the activities of te ao Māori requires health services and health care providers to be flexible and willing to include important beliefs and practices of Māori women into the provision of their service, and the planning of care. Being able to elect to participate in activities associated with te ao Māori can have a positive effect on a Māori woman's wairua.

*Being able to karakia and do things that are about nurturing wairua. Māori women need to have time and space to do these things (I-07).*

As wairua is an important part of a Māori woman's health and wellbeing, having the flexibility to incorporate such activities into intervention and treatment plans can be just as vital as the administration of other prescribed treatments.

Access to whānau, friends and/or support networks when needed or wanted is important in the maintenance of wellbeing for many Māori women. The networks that are established through whanaungatanga are also important, especially where the numbers of Māori within a geographical area are not high. The connections or links that Māori make with one another, also may include the natural forces and living things within the world. Such connections may be evident in Māori creation stories that link all Māori through whakapapa - back to Ranginui (the Sky Father) and Papatuanuku (the Earth Mother), and ultimately to Io (the Supreme God).

*It is about connecting to not only health professionals but to whānau. Connecting starts with the atua, the gods, and tupuna, ancestors, and Papatuanuku. It is who Māori are (I-07).*

*The presence of whānau is helpful and supportive – they provide a feeling of both satisfaction and completeness (I-08).*

The concept of kanohi kitea (the known face) provides a sense of connection and a source of reassurance for Māori women when accessing and using health services. It can also facilitate the establishment of effective relationships with health care providers. Kanohi kitea is established through the identification of familiar faces and the continuity

of relationships with health care providers who deliver health services. Continuity creates a sense of familiarity and knowledge of what can be expected for Māori women, and importantly the opportunity to develop a sense of trust and integrity in relationships.

The use of process is important for some Māori, particularly for those whose life has been grounded in a tradition of tikanga and kawa. Having a clear understanding of what is available, the processes involved in accessing and using services, plus a sense of constancy and stability is an important component of process and facilitates access and use of health services. Knowing what is available in terms of assessment, scans, and tests, and how these can be accessed, and having timely feedback about any investigations that may have been undertaken contributes to understanding the processes involved. Two participants noted that:

*Getting the results of a mammogram instantly had positive effects. There is nothing worse than having to wait for results. It is much better getting the results straight away, especially if there is a family history of breast cancer (I-05).*

Health care providers having some insight and knowledge about how to ascertain what is culturally appropriate can minimise barriers to the access and use of health services.

*Culturally appropriate care is so important for elderly Māori women. It could be devastating for elderly Māori women to be assessed by someone who is the same age as their mokopuna. Privately with whānau (but generally not with the health care provider) elderly Māori women may also question the experience young health care providers have to touch them or the appropriateness of young male doctors assessing them – these are seen as barriers (I-05).*

The property *Comfort with a Māori focus* influences the feelings that the Māori women in this research experienced when accessing and using a health service. Health services that overtly incorporate aspects of a Māori world can convey a willingness to welcome Māori, and signify a respect for what is important for the Māori women using the service.

## Having Trust and Credibility

Trust and credibility is the basis of effective services and is closely connected to *kanohi kitea* and genuine attitudes. Health care providers engendering trust and credibility are another important component of *Forming Effective Relationships*. Trust develops and evolves over a period of time and with a number of interactions. Health care providers do not gain trust and credibility automatically. The Māori women in this research believe that there are a number of factors that are vital ingredients in the property *having trust and credibility*. These include genuine attitudes, respect, time, and positive and productive interactions.

*Having trust and credibility* begins with health care providers recognising that time is required to develop sufficient trust and respect and to facilitate the sharing of necessary information. For the Māori women in this research, this included not only the need to be listened to carefully, but also to have their privacy and dignity respected at all times. Vital to Māori women sharing their health and life stories is providing sufficient time that enables them to think about the questions asked and to respond.

*Being listened to is important. It shows health professionals care (I-05).*

*It is important that health care providers are 'people who are pleasant and not too sterile'. Health care providers need to be human, as some were not very nice. It was also important to be able to go to a private place to talk and fill in forms – not in corridors or shared rooms, as this contributes to being muddled and unable to express oneself (I-08).*

The reception Māori women first encounter with health care providers lays the foundation for the subsequent interactions with a health service and health care providers. The conveyance of genuine attitudes by health care providers is another essential component in the development of effective relationships, and trust and credibility (Northouse & Northouse, 1985). The Māori women in this research all recounted an acute sensitivity toward attitudes that are interpreted as either genuine or not, and which influence the use of a health service. A sense of genuineness may be

determined by a pleasant smile, the conveyance of a caring non-judgemental approach, together with the sense of not being rushed.

*It is important to see someone who is pleasant, who smiles and is caring when Māori women first go into a health service. It is nice to get the attention you should have – someone pleasant who asks questions in a nice, unhurried way (I-08).*

The development of an effective relationship is an affirmation for Māori women that someone will listen to what they are saying, and that their needs are likely to be met.

While all the Māori women in this research indicate a need for health care providers to have genuine attitudes, their reality was frequently different. They had all encountered health care providers with negative attitudes that created instant barriers. Such attitudes resulted in a lack of faith or trust that their needs would be met.

*The attitudes of health care providers are bad. They do not listen and when health care providers are told when something is wrong, they often respond by saying nothing can be done. The manner of health care providers conveys their attitudes – that is, abruptness, tone of voice and body language (I-01).*

Encountering the negative attitudes of health care providers influences the willingness of Māori women to share information.

*Hospitals were seen as great places for 'not telling things'. Health care providers speak around Māori women and not to them. These actions are perceived to put Māori women down. Consequently, Māori women do not share information with health care providers because they would not understand their beliefs (I-03).*

Tension and anxiety when health care providers do not allow time (time to think, time to process information or questions, and time to respond to questions and information that arise during any interaction) was experienced by all the women in this research. Sensitivity to the needs of Māori women is crucial, as they do not typically put themselves forward – a product of their socialisation and feelings of whakamā. Some Māori women may appear to psychologically disassociate in response to rushed

interactions, or when health care providers convey attitudes and behaviours that they are too busy. Thus, they may not voluntarily return to the health service again. The degree of sensitivity and willingness to be supportive conveyed by health care providers toward Māori women and their beliefs and practices, signals that they may be sensitive to their needs.

*Sensitivity to needs and culture can make the difference for Māori women. For example, health care providers who recognise the importance of whānau support, which can be a source of inner strength (I-05).*

The agendas of health services and health care providers may have an impact on the ability of Māori women to form an effective relationship.

*It was noted that while women's centres are recognised as being accessible, they also have political agendas that was not necessarily about meeting the needs of Māori women. This is reinforced when the service provided did not have a Māori component to it (I-05).*

The fact that many health care providers are women was not necessarily seen to be advantageous by some of the Māori women in this research, due to the personal agendas that some may have.

*It was also noted that while there are currently more women doctors they were not perceived as very approachable. Some women health care providers, including some advocates and other health care providers, had their own agendas that were imposed onto Māori women. It is important for health care providers to understand the worldview and beliefs of Māori women (I-05).*

*Having trust and credibility forms the foundation for an effective relationship a Māori woman may have with a health care provider. Understanding the language used is another important feature of an effective relationship.*

## Understanding the Language Used

Fundamentally, interactions between Māori women and health care providers must utilise language that is transmitted in a respectful and inclusive manner and that can be easily understood. The nature of the language used by health care providers can also act as a barrier to eliciting accurate information when planning and implementing treatment or interventions. The property *Understanding the language used* effects the formation of effective relationships.

Language appears in a variety of information such as letters, forms and pamphlets, and is often provided on the assumption that recipients have the necessary literacy<sup>2</sup> to understand the content. Appropriate language needs to be used so interactions with health services or health care providers are meaningful. When language cannot be easily comprehended it isolates and marginalises Māori women, and ultimately compromises the achievement of positive health outcomes.

*Health care providers need to explain information in a way that can be understood. Māori women need to be able to ask questions so they can understand – they need to be able to ‘check out’ the information. It is all about knowledge and power (I-04).*

Having the opportunity to follow-up explanations is important for Māori women. Follow-up explanations enable clarification to be sought and specific areas explored further, but it requires time and a ‘no rush’ approach. Health care providers need to be proactive, taking the initiative to ensure first, the language that they use is understood, and then to check the interpretation a Māori woman has of the information they have delivered. Reliance on Māori women to initiate and seek clarification potentially risks situations where the information delivered is not understood, as generally they are shy and do not put themselves forward willingly.

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<sup>2</sup> This reference to literacy does not necessarily mean illiteracy, but recognises varying degrees of literacy, and degrees of health literacy an individual Māori woman may have.

*It is important when Māori women are receiving explanations that time is made for this process and that any explanation is clear and uses language that they can understand. Explanations need to be delivered in a manner that is sensitive to the needs of a Māori woman. It is also important for health care providers to understand that there may need to be follow-up explanations, as some women do not always understand, especially when emotions they may be experiencing at the time clouds their thinking (I-05).*

Processing and interpreting the information that uses medical or health jargon requires time and further explanation. Failing to allow time may result in a variety of strategies being used by Māori women to enable a response. Strategies that may be employed include nodding the head in agreement; making up a response (that did not necessarily resemble their experience) so a response is made and humiliation is avoided; not undertaking any treatment or interventions (because they did not understand); or leaving, not to return.

*Sometimes a Māori woman is not able to express herself due to a combination of factors – her state of health, fearing the unknown and having been socialised not to complain if unwell. The ability to express oneself is further compounded by paperwork and not being given the time to respond appropriately (I-06).*

Comprehension is crucial to being able to make effective use of health information and to being able to adapt it to the individual life situations of each Māori women. But it is one of several components necessary for the formation of an effective relationship.

## **Optimising Engagement with Health Services**

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Like the previous two core categories, *Engaging with Health Services* weaves together its concepts and their respective properties – that is, *accessing services, connecting with an appropriate service, and forming effective relationships. Connecting and*

*relating* is grounded in the nature of the relationship a Māori woman establishes with a health service and its health care providers. Being able to connect and relate influences the access and use of health services by Māori women who make a judgment about the level of trust and credibility that health care providers can be afforded, based in part on whether they will meet their health needs. It is important that health care providers view the needs of Māori women from a perspective that incorporates what is important for their health and wellbeing (as outlined in the core category *Mana Wāhine*), rather than focusing solely on the presenting health issue or problem they present with. The core category *Engaging with Health Services*, together with the core category *The Way It Is*, explains how Māori women act in ways that do not always align with their self-care behaviours, or the expectations of health services - ways that are not always beneficial for their health and wellbeing.

Connecting and relating may vary at differing levels of the service, and includes accessing a service, the ability to choose a service or health care provider, the reception encountered, the support and advocacy available and being able to have a sense of control throughout the experience. Once a service has been accessed, the establishment of an effective relationship is essential. The familiarity of faces, attitudes and behaviours of health care providers; the degree of trust and credibility engendered by health care providers; and the ability to understand what is happening all influence the formation of relationships. The appropriateness of a service is increased by achieving greater alignment of the approaches used by a health service and its health care providers with the beliefs and worldviews of Māori women. This involves recognising the diversity that exists amongst Māori women, together with a genuine respect of the beliefs and worldviews and the provision of choice, such as healing approaches that complement 'mainstream' health approaches. These strategies convey that a service has a 'Māori-friendly' focus and is likely to appropriately meet the needs of Māori women.

## Conclusion

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*Engaging with Health Services* is the core category concerned with the access and use of health services by Māori women that influences their health and wellbeing outcomes. The Māori women in this research identified various factors that influence their ability to engage with a health service and its health care providers. *Engaging with Health Services* is about the ability to connect and relate in a meaningful manner with a health service and its health care providers. It is underpinned by the theoretical notion, *connecting and relating*, which results in *enabling access and use of health services*. The process of connecting and relating begins with the initial encounter Māori women have with a health service and its health care providers.

The concept *Accessing Services* begins with Māori women being able to have choice regarding the service and the health care providers they need. Due to the socio-economic status of many Māori women, *being able to choose* is limited, especially as private health care is generally not an option. The property *reception encountered* during the first and ongoing contacts Māori women have an impact on how they will connect and relate with the health care providers. Indeed all the Māori women in this research provide examples of how *connecting and relating* starts with the perception of how 'welcoming' and genuine the health care providers are. *Influencing the service* is also important and may include, for example, complementing 'mainstream' health care with traditional Māori approaches to healing, such as the use of a tohunga or rongoā.

The concept *Connecting with an Appropriate Service* relates to the congruence of the beliefs and worldview of the health service with those of Māori women. An appropriate service is one that recognises the diversity and socio-political influences that exist amongst Māori women. Fitting Māori women into a service that offers a standard universal approach for all consumers increases the likelihood that vital information will not be recognised or considered. The property *Acknowledging beliefs and worldview*, and a subsequent understanding of what is important for a Māori woman and her health and wellbeing is essential. The incorporation of beliefs and worldviews into an

intervention plan may influence the achievement of a positive outcome. The *availability of support and advocacy*, especially if an advocate is Māori, provides a sense of reassurance and support. The Māori women in this research maintain that the *availability of support and advocacy* increases the ability of Māori women to both relate to health care providers and to communicate their health experience and health needs. The properties *choice of healing approaches* and *acknowledging beliefs and worldview* are also closely woven together enabling Māori women to integrate the healing approaches that may be spiritually based into a 'mainstream' intervention.

*Forming Effective Relationships* is a concept that explains the relationships Māori women need to develop with health care providers. The property *comfort with a Māori focus* may include the presence of Māori images, or being greeted by a Māori person for example. *Connecting and relating* is about the quality of a relationship health care providers develop with each Māori woman, and the recognition that a quality relationship evolves over time. Such a relationship respects, and is sensitive to, her needs. The perception that Māori women have about the attitudes of health care providers being genuine is crucial in the development of trust and whether health care providers can credibly meet their needs. The ability to comprehend both what is happening and the health-related activities that a Māori woman may need to undertake relates to the property *understanding the language used*. Adherence to health regimes is optimised when the relevance and rationale for processes, procedures and health promoting activities is understood, and an effort is made by health care providers to ascertain the understanding a Māori women has.

*Mana Wāhine* is the core category that provides a picture of what Māori women consider is important for their health and wellbeing. It weaves together with the core categories *The Way It Is* and *Engaging with Health Services* to provide an explanation around the access and use of health services. The weaving of these three core categories influence the health and wellbeing outcomes for the Māori women. In the next chapter the basic social psychological process of weaving explains how these three categories are integrated, forming a theory of health and wellbeing for Māori women.

## CHAPTER 10

### **The Weaving of Health and Wellbeing**

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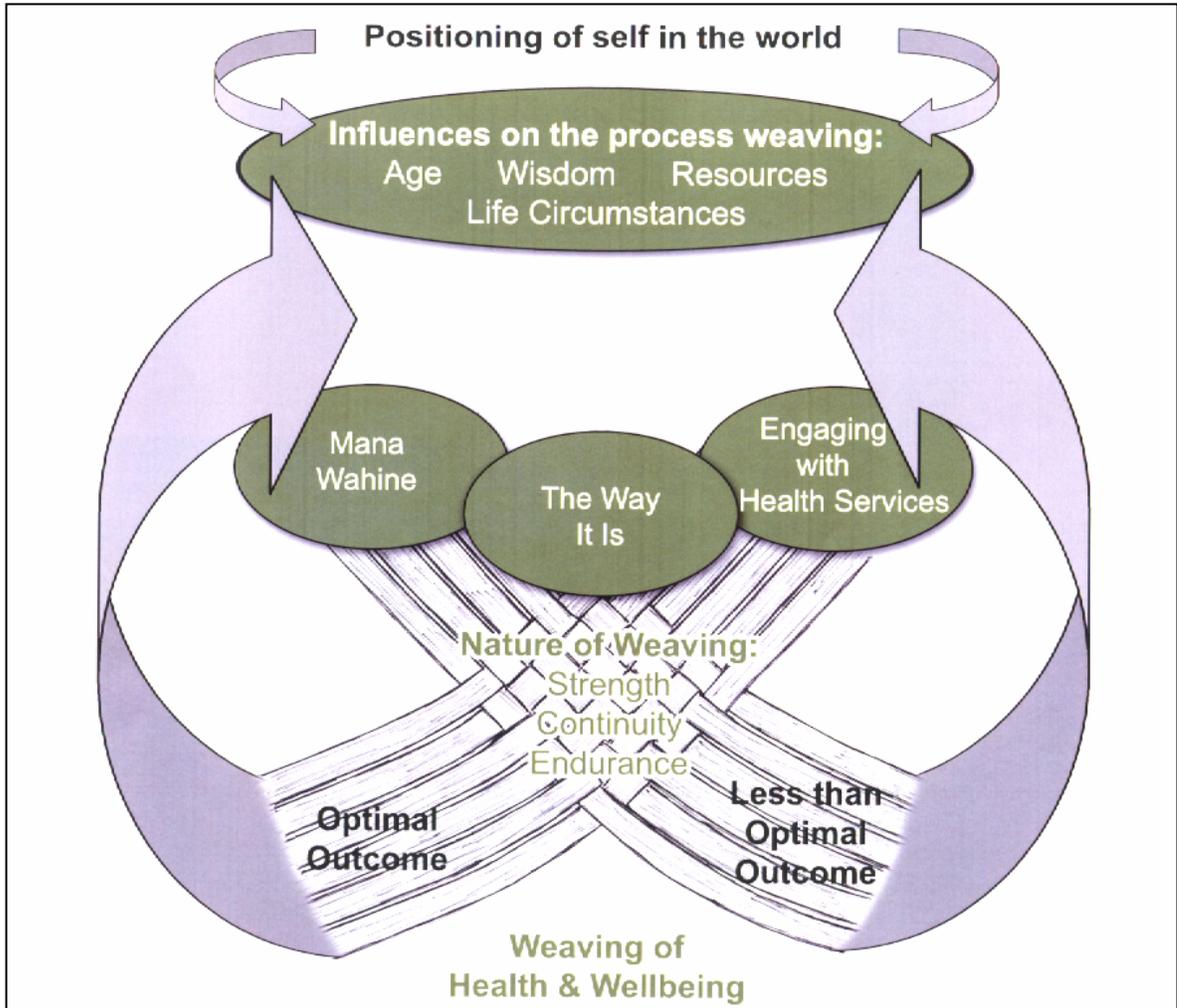
He rereke ta tenei  
He rereke ta tena

It is different for this one  
It is different for that one  
(Puketapu-Hetet, 2000, p.5)

Health and wellbeing is a complex integration of multiple interdependent and interrelated dimensions. Some dimensions, such as socio-economic determinants of health status, genetic influences, and the quality of health services are outside of the immediate control of the Māori women or health services; others are within their sphere of influence. The process of weaving health and wellbeing was conceptualised from the data using a grounded theory informed by a Māori centred approach to explain the integration of these dimensions, and highlights those areas that are within the sphere of control by either Māori women themselves, or by health care providers. This substantive grounded theory is presented as a model of weaving health and wellbeing (Figure 10.1) that integrates the core categories described in the preceding three chapters around the basic social psychological process of weaving (briefly outlined in the introduction to Part II of this thesis).

I have used the metaphor of *weaving* to describe the process that Māori women use to integrate the multiple dimensions that have emerged from the data. This metaphor is one recognised by the Māori women theoretically sampled, and also fits the data. Schreiber (2001) maintains that a metaphor, such as weaving, illustrates the phenomenon arising from the study and must not only be apparent to the participants, but also clearly relate to the data. The dimensions described within the concepts and properties associated with the health and wellbeing of Māori women integrate to form the core categories *Mana Wāhine*, *The Way It Is*, and *Engaging with Health Services*. The weaving of health and wellbeing brings together the important requirements, challenges and barriers that compromise optimal health and wellbeing, and the health service needs of Māori women. The process of weaving is influenced by how Māori women position themselves in the world, and its quality and nature. This model of health and wellbeing aims to provide some insight into the complexity of Māori women's health and wellbeing.

In this chapter I present the basic social psychological process of *weaving health and wellbeing*, and argue its relevance in providing an understanding of how Māori women construct their health and wellbeing. In order to do this, I will begin by outlining the relevance of a model about health and wellbeing for Māori women, followed by an explanation of the basic social psychological process of weaving health and wellbeing. The contextual influences and components of the weaving of health and wellbeing are then explicated. The model is derived from the data on the women's understandings of health and wellbeing and interactions with health services. Metaphorical explanations and the use of analogy are common within Māoridom to convey meaning, therefore, I will conclude this chapter by using the weaving of a kete to illustrate how Māori women weave their health and wellbeing.



*Figure 10.1.* The weaving of health and wellbeing.

## **A Grounded Theory of Māori Women's Health and Wellbeing**

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As mentioned earlier in this thesis, when I began this research it was with a nursing focus. However, as the collection and analysis of data proceeded it became evident

that the participants did not necessarily focus on any particular health care provider group, such as nurses. This is indeed the nature of grounded theory, whereby the emerging concerns of the participant group may not be what was predicted or anticipated. Thus, this grounded theory informed by a Māori centred approach focuses on the health and wellbeing of Māori women, and their interactions with 'mainstream' health care providers in general.

The model about the weaving of the health and wellbeing of Māori women presented in this chapter is a substantive grounded theory informed by a Māori centred approach that has emerged from the analysis of the data. Arising out of this is a process-oriented model around the metaphor of *weaving health and wellbeing*. It provides a framework to understand the construction, interpretation and meaning Māori women have about their health and wellbeing, and insight into the health actions that Māori women undertake.

The functional components of any theory include the person, act, other and environment according to Meleis (1991), referred to as commonplaces by Stevens Barnum (1990). While I have elected to explain the model that I present (Figure 10.1) according to its structure, components and the relationships between the components, the functional components of the person, act, other and environment as they relate to this grounded theory will be defined first.

The *person* pertains to Māori women who have a multidimensional experience of health and wellbeing. Māori women interpret the concept of health and wellbeing for themselves within a wholistic context. At some point in their lifetime they may need to access and use 'mainstream' health services, and interact with health care providers within these services.

The *act* relates to how the multiple dimensions of the health and wellbeing of Māori women are integrated through a process of weaving them together. It involves the weaving of what is important for the women themselves, the challenges and barriers they encounter, and their interactions with 'mainstream' health services. Some of the challenges and barriers experienced may arise from competing worldviews that Māori women encounter when they interact with 'mainstream' health services. Each woman's health and wellbeing outcomes are influenced by the nature and quality of the weaving.

The *other* refers to the 'mainstream' health services and health care providers whose interactions and/or input can directly or indirectly influence the health and wellbeing of Māori women. Health care providers who interact directly with Māori women are generally those involved in the delivery of health services, whereas those indirectly involved may include policy makers, and those involved in educating health care providers for service delivery. By recognising the worldview of health care providers, and the impact this can have on Māori women, health care providers are better positioned to incorporate the worldview of Māori women into the planning and intervention activities and thereby positively influence the outcome of their interactions.

The *environment* includes both the socio-cultural and political environments that Māori women live in, as well as the environment of 'mainstream' health services. Each environment is influenced by the worldview that prevails, but is at variance with, and not necessarily aligned to the worldview of Māori women. The nature of the health environment has the potential to influence the health and wellbeing of Māori women. In the following section, I will discuss the process of the weaving of health and wellbeing.

## The Weaving of Health and Wellbeing

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The Māori women in this research do not view the various dimensions of their health and wellbeing in isolation or independently. They consciously and unconsciously, combine multiple dimensions in ways that are simultaneously independent, but also integrate with other dimensions. Each Māori woman weaves her health and wellbeing in a unique way that is reflective of her life circumstances and the diversity that makes it different from other Māori women. The process of *weaving health and wellbeing* is underpinned by the following assumptions:

1. Weaving is both a conscious and an unconscious process.
2. All women have the potential to improve the quality of their health and wellbeing.
3. The nature of the weaving of health and wellbeing is dependent upon the resources that are available to inform, and to assist the process.
4. Health and wellbeing is dependent upon the individual's experience, and the nature of the outcome of the weaving.

The process of weaving health and wellbeing is influenced by a number of factors and experiences that result in varying outcomes for health and wellbeing. The depth and quality of the dimensions important for each Māori woman, along with the nature of the process of weaving influences the outcome of the weaving of health and wellbeing, and is an indicator of her health status.

The weaving of health and wellbeing is a dynamic life-long process that is neither a linear nor a finite process. It is a continual process whereby the nature and quality of the weaving varies, for example, at one point in time it may be strong and enduring, but at other times less so and prone to breaking down. Thus, the status of health and wellbeing varies for an individual Māori woman across her lifespan, and between Māori women, when for example, past weaving of health and wellbeing may fray and unravel due to the quality of the weaving at that time, affecting current health and wellbeing. An example of this could be a past episode of rheumatic fever resulting in the need for a heart valve replacement during middle adulthood.

## **Positioning of Self in the World**

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The way in which each Māori woman is positioned within the world with regard to her socio-cultural reality, wholistic worldview and her uniqueness has an overall influence on the nature and quality of the weaving of health and wellbeing (Figure 10.1). The weaving of health and wellbeing occurs within a context of how the world is viewed and is underpinned by the values and beliefs that influence the health of individual women. Māori women in this research all indicate that their worldview is at variance with the dominant biomedical view evident within the 'mainstream' health system. Thus, how they position themselves within the world provides an indication of what is important to them, and needs to be recognised and incorporated into their health experiences.

The socio-cultural context that Māori women are positioned within has both commonalities with other Māori women and individual differences. This notion has been

explored in more detail in the first core category, *Mana Wāhine*. Engaging with 'mainstream' health services generally requires Māori women to move into a socio-cultural context that is different to their own. This is evident within the core category *The Way It Is*, where Māori women are strongly influenced by factors within their own culture and become exposed to, and influenced by, different ways of functioning as they engage with 'mainstream' health care providers. *Engaging with Health Services*, the third core category, describes what Māori women require to lessen the impact of worldviews and practices that are different from their own when they engage with 'mainstream' health services. In this section, *Positioning of Self in the World*, I describe the key components related to how a Māori woman positions herself in the world, and discuss how this influences the process of weaving health and wellbeing.

## **Socio-Cultural Reality**

All Māori women have a socio-cultural reality that is reflective of their life circumstances, and is determined by their socio-economic circumstances and cultural background. Socio-economic circumstances are influenced by a number of factors. The education a Māori woman has undertaken influences the type of employment she can attain. Whether employment is unpaid, part-time or full-time impacts on the level of income that a Māori woman can access. Income influences the ability to access quality housing, transport, telephone, and food; all factors that contribute to the socio-economic determinants of health (Ministry of Health, 2000).

The socio-cultural reality of Māori women impacts upon not only their health status, but also on their ability to access and use health services. Māori women do not share the same cultural background and have varying degrees of access to their whakapapa, cultural activities and te reo Māori. Identification as Māori does not guarantee that Māori women have full access and involvement in marae activities and are able to

speaking te reo Māori, for example. It has been established that great variation exists amongst the cultural identity of Māori.

## **Wholistic Worldview**

As already mentioned the Māori women in this research recounted how they viewed the world from a wholistic perspective – a view of the world they did not question. A wholistic worldview focuses on the whole and encompasses multiple dimensions, such as tinana (physical), wairua (spiritual), hinengaro (mind), whānau (family), whakapapa (genealogy), and tupuna (ancestors).

A variety of models illustrate the wholistic worldviews that exist amongst Māori, and represent relationships between various dimensions they depict. Examples of these models include Durie's (1998a) Te Whare Tapa Wha, Pere's (1991) Te Wheke and Jones (2000) Five Cornerstones of Healing. These are only a small example of the 'wholistic' models that exist, and that can vary from region to region. What is common is that the Māori women talked about 'wholes'. The models referred to above, all depict the interconnected and interdependent nature of relationships that include the spiritual world, the environment and humankind past (ancestors), present and future (mokopuna). Durie (2001a, p.171/2) reinforces this:

...Māori gain understanding not so much from being able to recognise each single component part as from an appreciation of the whole, and the relationships that occur between phenomena and structures.

The perceived reductionist approach of 'mainstream' health services and health care providers posed difficulties for the Māori women in this research. These difficulties manifest themselves in the non-alignment of the worldviews of Māori women and health care providers. Māori women believe a reductionist approach results in a problem focus

that compartmentalises their health and wellbeing issues, which may extend beyond physical or mental presentations. Such an approach becomes problematic, when attention focuses exclusively on one aspect of their health and wellbeing is at the expense of other issues that a Māori woman may consider important, and effects the overall presenting issue. Not incorporating a wholistic perspective into a Māori woman's health experience ultimately impacts on her health and wellbeing. For example, many of the Māori women in this research see spirituality as vital to their health and wellbeing, but this is generally overlooked when they enter health services.

Despite the comments that exist that Māori health perspectives are romantic, impractical, and contribute to Māori not accessing health care (Durie, 1998a), the recognition of a Māori worldview is important. The wholistic nature of Māori worldviews that influences their health perspectives holds many similarities to other indigenous worldviews and health perspectives (Suzuki & Knudston, 1992). A wholistic worldview provides a window for identifying the important issues from the perspective of a Māori woman; how knowledge is acquired and understood; important relationships and connections; and what beliefs guide everyday living and practices. When undertaking assessments and planning interventions, for example, socio-cultural issues and socio-economic status can be linked to the ability to undertake prescribed treatments and interventions, and can be invariably linked to health status and mortality (Ajwani et al., 2003; Ministry of Health, 2002c; Reid et al., 2000).

## **Diversity in Contemporary Society**

The diversity that exists amongst contemporary Māori is closely linked to their identity as Māori women. Māori women are diverse, unique individuals. The historical and contemporary experiences Māori have had contribute to their diverse socio-cultural realities. Indeed, the variety of upbringings, experiences and backgrounds of the Māori women in this research are reflective of the diversity that exists amongst contemporary

Māori. While some have had traditional Māori upbringings and speak te reo Māori; others have not had the exposure to traditional beliefs and practices. What they generally do have in common is their self-identification as Māori, a wholistic worldview, and the comfort of being part of a collective (rather than solely as individuals).

Diversity is complex and reflective of the differences that exist between iwi and hapū, and also those differences resulting from the impact of the processes of colonisation, capitalism, patriarchy, and socio-economic status. Ihimaera (1998) and other authors like Moir (1994) illustrate the diverse experiences that influence Māori growing up in Aotearoa/New Zealand. Aitken (quoted in Moir, 1994, p.58) explains the dual influences on her whānau growing up:

Our lives revolved mainly around the Pākehā way of life. Although that was the way of life for us, our Māori feelings in our hearts were very strong and still are.

There is a tendency amongst some health care providers to view Māori as having homogenous cultural practices and beliefs. A universal approach to health care is based upon the notion that all Māori have the same health needs, and therefore, their health care can generally be approached in the same way. While the adoption of a universal approach may be appropriate and acceptable in instances where there is a crisis or emergency, such an approach is not appropriate when the situation requires longer-term interventions and strategies. Such an approach does not account for individual needs in proposed treatment and intervention plans, thus potentially influencing the outcome of the interventions.

Universal approaches are usually adopted in the health sector under the guise of individualised care. Waters and Easton's (1999) study found that nurses made little effort to get to know patients and elicit their views on their health issues, supporting the notion that a universal approach is often adopted. Waters and Easton's (1999) findings

also support my observations within the clinical setting, and the discourse among health care providers within the New Zealand health setting. Individualised care that incorporates the beliefs and practice of Māori women tends to be an exception rather than routine practice.

I do note here, that the reality of health care is not as simplistic as it sounds. I recognise that those using health services, at times, need to be 'treated' the same, especially when acute aberrations in health status occurs, such as a 'heart attack' or a diabetic coma. There is a tendency to require consumers of these services to fit into what is provided when health care providers adopt a universal approach that objectifies individuals as 'the same'. Such an approach cannot be considered consumer-focused, nor is it able to meet the needs of consumers in anything but a random manner.

*Health care providers do not easily meet the needs of Māori women. The problem of meeting their needs lies with the way in which services were purchased (I-02).*

Health services and health care providers need to recognise and incorporate the diversity that exists within the Māori population into the services they provide. An understanding of the historical and socio-political context for Māori women provides insight into how they have become increasingly diverse over time. Adopting a universal approach to service delivery while expedient is neither acceptable nor appropriate. The following data illustrates the potential difficulty with health care provider practice based upon assumptions:

*Despite being Māori, not all Māori women have had access to Māori culture and traditional ways of doing things. Yet, at times there is an assumption that some Māori women have this knowledge, such as speaking te reo Māori, when they don't (I-04).*

How a woman positions herself in the world, in terms of her wholistic perspective and uniqueness, holds the key to establishing what is important for her health and wellbeing.

## **Influences on Health and Wellbeing**

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Various factors, such as age, wisdom, life circumstances, resources, and 'western' influences, can also have an overarching impact on the nature and quality of the weaving of health and wellbeing (Figure 10.1). The *weaving of health and wellbeing* is not linear or finite and is, therefore, affected by these factors that may vary over time and with circumstances. Thus, the continuous weaving of health and wellbeing throughout a woman's lifespan may vary depending upon the impact of various factors any particular point in time.

### **Age**

Advancing age results in Māori women reflecting upon their mortality, and the risks of acquiring a preventable illness or disease that affects their quality of life. This reflection occurs at some point in time when a heightened awareness that life is limited occurs.

*We see a lot of friends the same age die (I-05).*

*There is the realisation that health means everything, being able to contribute to the family and to work. So you look after yourself better, and go to the doctor if something is wrong (I-06).*

The concerns about health and wellbeing that the Māori women in this research have are based in the reality that on average they have shorter lives than non-Māori (Ajwani et al., 2003; Pomare et al., 1995). They are also aware that they have a higher risk associated with some illnesses or diseases such as respiratory disease, renal disease and diabetes that impact on quality of life, and increase the risk of premature mortality (Te Puni Kokiri, 1995; PHC 1993/94); and that disparities in health status are also associated with lifestyle, such as nutrition, exercise and alcohol and tobacco use.

The reflection on health and wellbeing that occurs as Māori women move toward mid-life and beyond can be considered a normal developmental expectation. When Māori women reflect upon their life they will generally do so with consideration of the roles they have, within the context of the collective whānau and social groups, and by viewing the world in a spiritual and wholistic manner. Macfarlane (2000) and Penetito (2000) both offer Māori perspectives on human development, adding to most human development theories that offer an ethnocentric view. Macfarlane (2000) maintains that Māori development is underpinned by a wholistic worldview, the values of wairua, manaaki (caring for others), whanaungatanga, and the concepts of tātou tātou (sharing of property) and ma te wā (perception of time). Penetito (2000) stresses that Māori have a collective (or group) rather than individualistic orientation for society and socialisation, such a view contrasts with many developmental theories that focus on the individual while excluding acceptable behaviour and achievements within a group context.

The impetus to review lifestyle and health practices are the result of heightened awareness and undertaking a process of reflection by Māori women - the aim being to extend one's lifespan. Changes in lifestyle and self-care activities are also prompted by a Māori woman's strong need to undertake the social roles and responsibilities associated with their whānau, hapū, iwi. The motivation to change lifestyle and

practices for health and wellbeing, and increase the quality of self-care activities originates from the need to avoid incapacity and infirmity.

## **Wisdom**

With increasing age and experience comes a wisdom that serves to inform a Māori woman's perspective on health and wellbeing, and the associated lifestyle beliefs and practices. Wisdom is a way of thinking that is based upon insight, experience, feelings, relationships and language (Bird & Drewery, 2000). According to Bird and Drewery (2000), wisdom evolves through mid-life and continues to develop throughout the remainder of a person's lifespan. Wisdom is the accumulation of knowledge and experience that is acquired over a lifetime, and that has undergone a process of reflection.

Māori women's wisdom may be strengthened by the use of whakataukī (a source of wisdom from tupuna and kaumatua themselves) that provides guidance and direction in daily life. As Māori become recognised within their whānau-hapū-iwi as 'elders' they are afforded a place of respect, and their wisdom is generally not questioned – a stance that is evident throughout history (Bird & Drewery, 2000). The ability of Māori women to analyse issues that arise in their life increases with their wisdom. This wisdom can then be used to review alternative approaches to managing their health and wellbeing that may influence its outcome.

## **Life Circumstances**

Life circumstances, which include socio-economic status, educational background and employment, provide the context within which Māori women weave their health and wellbeing in their everyday life. Indeed, a correlation has been established between

health status and social deprivation (Reid et al., 2000), supporting the notion that life circumstances influence the quality of the weaving of health and wellbeing.

The context of a Māori woman's life circumstances impacts on her ability to be effective in her efforts to achieve optimal health and wellbeing.

*Being a sole income earner leads to becoming resigned that this is 'the way it is' (I-05).*

*There is not the accessibility to funding, so this becomes a barrier and Māori women are forced to make up their own resources (H-01).*

Social position determines access to sufficient and quality resources to support the process of weaving health and wellbeing. Life circumstances are also influential in Māori women being able to both access and understand 'mainstream' health services. To this end, life circumstances also influence how Māori women prioritise their health and wellbeing needs amongst the needs of other whānau members. The needs of others, especially children and partners, are generally put ahead of those of the women themselves, and determine when they access and use health services.

## **Resources**

While resources are referred to in the preceding chapters in relation to the core categories, they are also a pivotal influencing factor on the weaving of health and wellbeing. The reality for many Māori women is that they do not have ready access to sufficient physical<sup>1</sup> and financial resources, which affects their ability to attain the resources necessary to access and use health services.

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<sup>1</sup> Physical resources include telephones, private or public transport, and the payment of expenses related to health services like pharmaceutical and relevant appliance costs.

*Money is required to help keep you well and healthy (I-07).*

*Need money, but there is a lack of it so it needs to be used for others first (I-06).*

Resources are not only confined to physical or financial resources. They extend to the capability of individuals and groups of Māori women to understand health-related experiences. When Māori women do not understand what is happening with their health and consequently do not 'adhere' to any interventions, they become the objects of victim-blaming and deficit explanations. Nutbeam (2000) suggests that health education that focuses solely on the transmission of information does not account for the social and economic circumstances of individuals and does not achieve outcomes such as changes in behaviour. Health literacy, according to Nutbeam (2000) is more than just transmitting information. It is about improving the access that people have to health information and their ability to effectively use it, vital for increasing their autonomy and empowerment. Health literacy should have both personal (that is, decreased morbidity, disability and avoidable mortality) and social (quality of life, functional independence and equity) benefits.

## **'Western' Influences**

Most of the Māori women in this research articulate how '*western influences*' impact on their health and wellbeing, especially evident in 'mainstream' health services.

*Western ways of seeing people does not include seeing them as 'spiritual', so spiritual needs are not considered (H-01).*

*The medical approach focuses on the physical part of people. This way of doing things is to the 'detriment' of a Māori way of living (I-03).*

*Problems are 'compartmentalised' and 'picked off'. They are never looked at holistically (I-02).*

*Its like trying to put western society and Māori together – it doesn't work (I-01).*

*The attitudes of health professionals and their way of seeing the world are different from Māori attitudes and their wholistic view of the world (H0-1).*

The philosophy of 'mainstream' health services is influenced by the dominant biomedical model, which Māori women perceive is both reductionist and compartmentalised compared to the worldview they hold. Māori health providers, by contrast, have a worldview that these women felt were more aligned to theirs.

The 'western' influences on Māori women's health and wellbeing have a place of importance, in relation to this research. Many Māori women feel they are forced to deal with competing worldviews when accessing 'mainstream' health services, resulting in their beliefs and practices being relegated as inferior or totally ignored. In such cases Māori women are then forced to make choices about the maintenance of their health and wellbeing, for example, seeking traditional Māori healing treatments outside of 'mainstream' health services (such as tohunga or rongoā), often without informing 'mainstream' health care providers. The rendering of their beliefs and practices as inferior impacts on their spiritual wellbeing – especially as their values, beliefs and practices are challenged and denied as valid. Another example is the normograms that are based upon populations of 'European' descent, such as the height/weight charts. Despite the knowledge that those of Polynesian descent have a larger body structure, weight is still measured against a 'norm' determined for the dominant ethnic grouping – the result is that many Māori will fall outside the 'norm', and are then perceived negatively.

The Māori women in this research believe that if their beliefs and practices were accepted by 'mainstream' health care providers they could co-exist alongside 'western' biomedical beliefs and practices – but it requires a process of listening and negotiation by all parties. Until a process of listening and negotiation takes place, 'western' influences will impact on the health and wellbeing of some Māori women.

## **Properties of Health and Wellbeing**

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The shared understanding that the Māori women in this research have about health and wellbeing is based upon the following properties. Health and wellbeing:

1. Is considered a wholistic concept that involves multiple dimensions that includes physical, spiritual, emotional, mental, social, whānau, and environmental dimensions.
2. Is individually defined and are mutually dependent concepts that occur within a wholistic framework, and are central to life, and to being.
3. Refers to the complex interrelationship and balance involved in maintaining the health and wellness of the physical, spiritual, emotional, mental, social, whānau dimensions, and environmental dimensions.
4. Is achieved through a variety of health promoting self-care and lifestyle activities that nurture the above dimensions.

5. Involves a balanced lifestyle that includes fun and relaxation.

Essentially, health and wellbeing is implicitly a wholistic concept that relates to more than physical or mental wellbeing.

*Health means wellbeing – physical, spiritual, emotional and mental health (I-01).*

*Health is total wellbeing and encompasses everything that touches a person including socio-economic circumstances, environment, and accessibility to services and support systems (I-02).*

*Health is about wellness and being able to fulfil whānau obligations. It includes the essential things for living – it's wholistic (I-03).*

*Health is being well and includes the mind, body and whole being like te wheke<sup>2</sup> [the octopus]. It's about being able to serve family and others first (I-06).*

*Health is to have wellbeing and to live naturally in a wholistic way. It is about recognising a person's potential (I-07).*

An alteration in any aspect of a Māori woman's health and wellbeing can effect her ability to function optimally. These properties link to the three core categories (Figure 10.1) *Mana Wāhine, The Way It Is, and Engaging with Health Services*.

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<sup>2</sup> Te wheke, the octopus, is used by some Māori to symbolically represent the multiple dimensions and their interrelationships associated with health and wellbeing. It is based upon the work of Rose Pere (1991).

## **Mana Wāhine**

*Mana Wāhine* is the core category that describes the dimensions that are important for Māori women, and their health and wellbeing in the concepts *connecting through whānau*; *nurturing wairua*; *using mātauranga*; and *undertaking self-care activities*. These concepts, and their properties, weave together to form *the* core category *Wāhine*, a reflection of the mana and integrity of each Māori woman. Māori women exercise control over those aspects of their health and wellbeing within their capacity and resources in order to maintain their mana, integrity, and health and wellbeing. There are, however, other aspects that they have little or no control over. The ability for women to have control over their health and wellbeing is compromised when they enter 'mainstream' health environments and are confronted with worldviews and ways of doing things that are at variance with their own. Maintaining *mana and integrity of self* is the theoretical proposition that underpins *Mana Wāhine* that influences their health and wellbeing.

## **The Way It Is**

*The Way It Is* is the second core category that explains the resigned acceptance Māori women have for their life circumstances, and the challenges and barriers that they encounter. Resigned acceptance by Māori women relates to both themselves, and to health services that do not meet their health and wellbeing needs. It accounts for the apparent paradox of self-care that occurs when Māori women actively engage in self-care activities (described in Chapter 5). However, the barriers that they encounter compromise the outcomes of the activities they undertake. The theoretical proposition that underpins *The Way It Is*, relates to the access and use of health services being hindered in some way, impeding the achievement of positive health outcomes. The concepts of *putting others ahead of self*, *acting on fear and past experiences*, and *impeding access to services*, and their properties describe how the life circumstances,

challenges and barriers Māori women experience influence their health outcomes. The impact upon health outcomes varies from Māori woman to Māori woman, dependent upon the degree of their acceptance of their life situation, challenges and the barriers they experience.

## **Engaging with Health Services**

*Engaging with Health Services* is the final core category that describes what Māori women need from 'mainstream' health services and health care providers when they interact with them. *Connecting and relating*, is the theoretical proposition that underpins *Engaging with Health Services* that enables the access and use of relevant health services. The concepts *influencing access to services*, *connecting with an appropriate service* and *forming effective relationships*, and their properties, weave together to determine the nature of engagement a Māori woman has with a health service, and its health care providers. The ability of Māori women to develop positive relationships with health care providers influences their access and use of a health service. Information, feelings of comfort and interpersonal relationships are key features of effective relationships, but these can be offset by the hypersensitivity of Māori women to the attitudes of health care providers.

## **The Nature of the Weaving of Health and Wellbeing**

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The theoretical constructs of strength, endurance and continuity are used to explain the variation that may occur in the health and wellbeing of a Māori woman across her

lifetime, and also between Māori women. Each incidence of weaving is unique, with the nature, and the outcome, of the process of weaving indicative of its qualities of strength, continuity and endurance.

## **Strength**

*He iti, he iti kahikātoa*

Though little, it is still a mānuka tree

Strength is determined by the nature of the weaving; the closer the weave, the stronger the health and wellbeing of a Māori woman. Strength enables the weaving of health and wellbeing to withstand the challenges that face Māori women in maintaining their health and wellbeing, although it can vary over time. A lack of strength in the weaving of health and wellbeing may have either an immediate or delayed effect on health status.

## **Continuity**

*Engari tēnā, te tūtanga tē unuhia*

It is better that its joints are never pulled apart

Continuity refers to the ongoing nature of the weaving of health and wellbeing that simultaneously integrates the past and the future into the present. The timeless notion of continuity also incorporates a wholistic perspective that draws together all the relevant aspects and dimensions in the process of weaving. The notion of continuity in the weaving of health and wellbeing incorporates the influences and information from

the past, while at the same time influences and determines current and future health and wellbeing.

## **Endurance**

*Mate atu he tētē kura, whakaeke mai he tētē kura*

A fern frond dies, but another frond rises to take its place

Endurance relates to the durability of the weaving, and is dependent on how the health and wellbeing of a Māori woman is maintained. The endurance of the weaving of health and wellbeing continues to influence not only the Māori women themselves, but also their future generations. The transmission of (a) genetic data, (b) knowledge and information about maintaining optimal health and wellbeing, and (c) quality health care, all influence the endurance of the weaving of health and wellbeing.

Together the qualities of strength, continuity and endurance in the weaving of health and wellbeing assist in maintaining the integrity of a Māori woman's health and wellbeing. As health and wellbeing occurs, the integrity of its whole is always at risk of compromise or threat. For example, if a dimension is weakened or compromised in any way, the whole risks falling apart – that is, a period of ill health, poor nutrition, or spiritual distress may result in less than optimal health and wellbeing, affecting general health and wellbeing.

## **Outcome of the Weaving of Health and Wellbeing**

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The unique and dynamic nature of health and wellbeing means its outcomes may change as time proceeds. The outcome of the weaving of health and wellbeing is

dependent upon multiple factors; how a Māori woman positions herself in the world, the influences of age, wisdom, resources and life circumstances, the nature of each of the main concepts associated with the health and wellbeing of Māori women, and the nature of the weaving of health and wellbeing. The strength, continuity and endurance of the weaving is indicative of its quality, and consequently the health and wellbeing of each Māori woman. Health and wellbeing can be located on a continuum that ranges from optimal to less than optimal health and wellbeing (Figure 10.2).

The following data demonstrates examples of both optimal and less than optimal outcomes of weaving health and wellbeing. First optimal outcomes:

*It is important to be able to participate in whānau activities and feel that the environment is stable and consistent (I-03).*

*Being able to lead a balanced lifestyle and taking note of what the body is 'saying' and feeling. It is about having fun, having an enjoyable job, relaxing, spending time with friends, and being involved in cultural activities (I-04).*

*Maintaining a healthy lifestyle helps with living longer and means seeing the mokopuna [grandchildren] grow up (I-05).*

*Being able to do things without feeling 'draggy' or sick (I-08).*

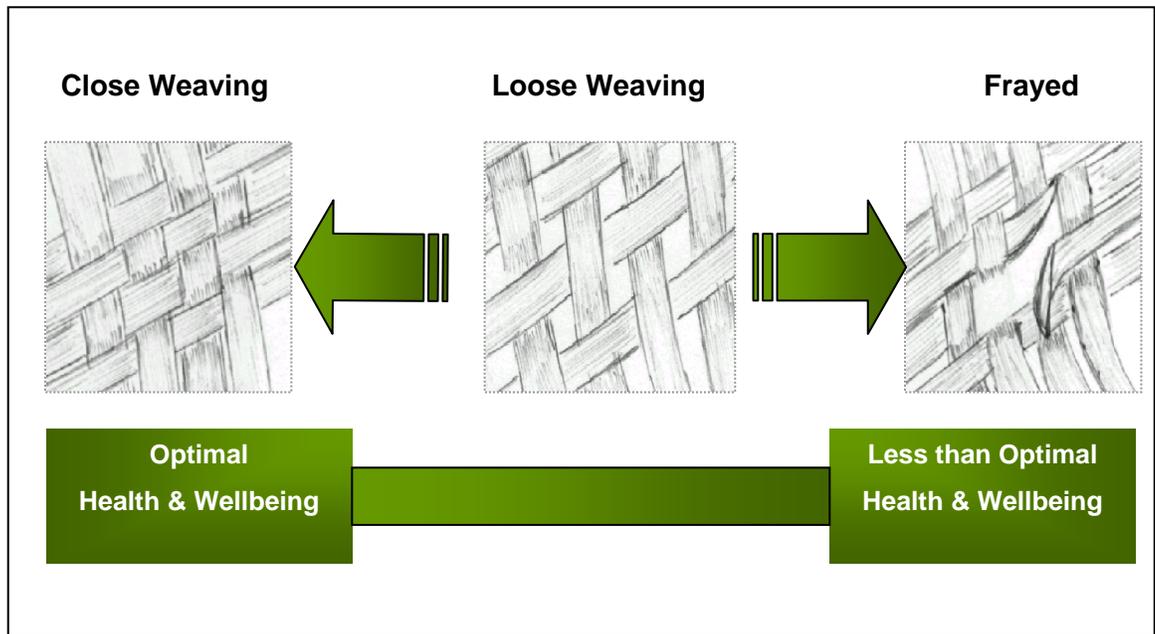
Next, less than optimal outcomes:

*Being spiritually unwell – mate Māori - not being sick, but it reduces your energy and strength (I-03)*

*Putting off going to the doctor for a health issue as the daughter needs to go first, and there is not enough money (I-05).*

*If one is not well you don't function properly (I-06).*

*If a person hasn't got their health then everything else falls down (I-04).*



**Figure 10.2.** Health and wellbeing continuum.

Optimal health and wellbeing is based on a number of factors, including the integrity of a Māori woman's mana and sense of self being preserved, and the barriers and challenges that may compromise self-care are kept to a minimum. Interactions with health care providers that are mutually productive and are based upon information and language that can be understood and easily used, support the practices of Māori women that aim to maintain health and wellbeing.

Conversely, less than optimal health and wellbeing can occur when a Māori woman's mana and sense of self are compromised to any extent. Overcoming barriers and challenges may require resources that are limited or non-existent, and are generally difficult to resolve. Contact with health services and health care providers may also be problematic and further tax resources Māori women may have. Any information that could assist in the maintenance of health and wellbeing is either not well understood or conflicts with the beliefs and practices of the Māori woman.

No matter what the outcome of the weaving of health and wellbeing is at any given point in time, the process of its weaving continues. High quality weaving of health and wellbeing may serve to support a Māori woman through a period where her health and wellbeing may be compromised. Likewise, a period of poor quality 'weaving' of health and wellbeing may result in neither the strength nor the endurance standing the test of time, and potentially results in ill health during a period where she was optimally well and healthy.

## **Weaving of a Kete**

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*Hutia te rito*

*Hutia te rito o te harakeke*

*Kei hea te komako e ko*

*Ki mai ki ahau*

*He aha te mea nui*

*He aha te mea nui o te ao*

*Maku e ki atu*

*He tangata, he tangata, He tangata hei*

If the centre of the shoot of the flax is pulled out,  
Where will the bellbird sing?  
If you were to ask me what is the most important thing in the world? I would reply,  
It is the people, it is the people, it is the people.

(Whakatauki and waiata from Te Rarawa)



**Figure 10.3.** Harakeke (flax) plant

The process of weaving of a kete (Figure 10.4) can be used to illustrate the process of the weaving of health and wellbeing for the Māori women in this research. Io (the Supreme Being) gifted three kete of knowledge to humankind, and thus the kete is symbolic of a vessel carrying both knowledge and wisdom (Ministry of Justice, 2001). For Māori, weaving (like health and wellbeing) is not simply the bringing together of materials to form a pattern. Weaving is a reflection of the spiritual values, beliefs and wisdom held by Māori women, and the product is symbolic and contains meanings for both the creator and the user of the weaving. The fibres reflect the symbolism and meaning that have been woven together into patterns (both old and contemporary). The form of weaving used in the weaving of kete is called raranga. According to Puketapu-Hetet (2000), raranga survived the processes of colonisation, like Māori women, that resulted in many cultural practices and artefacts of Māori being lost. Raranga is symbolic of the:

1. Intense unity and togetherness held by many Māori.
2. Weaving together of people, their families, and iwi into a society.
3. Spiritual weaving together all living forms into a solitary inseparable whole (Himona, 2001).

Harakeke is the material used for raranga. It is a living form, and according to Māori creation stories is linked to human beings. Tane Mahuta, the god of the forest, is a descendent of Papatuanuku (the Earth Mother) and Ranginui (the Sky Father)<sup>3</sup>. The descendants of Tane Mahuta include plant life, such as harakeke. A large number of varieties of harakeke exist, each with its own qualities and strengths (Puketapu-Hetet,

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<sup>3</sup> Papatuanuku & Ranganui are the parents of the gods and all living things according to the various creation stories of Māori.

2000). The diversity of harakeke can be compared to the variety that exists amongst Māori women, with each having their own qualities and strengths that have both similarities and differences when compared with other Māori women. The process of weaving enables the life force of harakeke to live in another form – such as the kete.



**Figure 10.4.** *Kete (basket).*

The formation of the harakeke is used by Māori to represent people – the rito (central shoot) is the young shoot in its centre and is embraced by the leaves on either side of the rito. The outer leaves are known as the matua (parent or main stem) or awahi (embracing) rito. The harakeke can be used to illustrate how a Māori woman is

embraced on either side by elders, whānau and friends. These parts of the harakeke should never be cut, as to do so risks its survival.

The time the harakeke is gathered is important as it may affect its quality. The concept of tapu governs the timing for gathering harakeke for weaving. For example, gather it in the rain and the fibres will be wet, in the frost the fibres are brittle, and in the wind the fibres are difficult to remove (Puketapu-Hetet, 2000). Like the harakeke there are times when a Māori woman is stronger and experiences optimum health and wellbeing than at other times. The mākū (wet or damp) is the moist, sticky fibrous material inside the harakeke leaves that holds the fabric of the harakeke together – it resembles whakapapa (genealogy), which holds the fabric of humanity together. Any unused trimmings gathered are returned to Papatuanuku as mulch that rots and enriches the soil and feeds the plants. Māori women also, however, need to be enriched and ‘fed’ to ensure their health and wellbeing is maintained.

Health and wellbeing is a central concern for Māori women, especially in ensuring they are able to undertake their varied and diverse roles. Like harakeke, the process of weaving also has a life force, and is as much a spiritual process as it is a manual skill according to Puketapu-Hetet (2000). The process of weaving a kete is used as a metaphor to describe how the Māori women in this research weave their health and wellbeing.

Māori women are weavers of health and wellbeing, pulling together the various dimensions that are important in the achievement or maintenance of their health and wellbeing. They combine these dimensions in a manner that allows each dimension to be simultaneously independent, also both connecting and relating to other dimensions. The kete (Figure 10.4) is complete and represents a whole, yet the opening of the kete allows ‘things’ to move in and out of it. These ‘things’ may influence and impact upon the quality of the weaving of health and wellbeing. While the actual process of the

weaving brings multiple dimensions together and enables their interaction, like Māori women, each kete possesses its own uniqueness and individuality, and is reflective of the diversity that exists.

## **Conclusion**

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The health and wellbeing of the Māori women in this research is resolved by the basic social psychological process of weaving health and wellbeing - a process that bears similarities to the weaving of a kete. As a kete utilises the fibres of harakeke for its construction, Māori women utilise the core categories *Mana Wāhine*, *The Way It Is*, and *Engaging with Health Services* to weave together their health and wellbeing. Māori women are influenced by their position in the world and by their age, wisdom, resources and life circumstances, like the harakeke is influenced by factors that affect the quality of its fibres.

The nature and process of weaving health and wellbeing is diverse among Māori women, with some weaving their health and wellbeing in a complex and intricate manner, and others weaving a simplistic pattern of health and wellbeing. This is similar to the production of a kete, with some having complex and intricate designs that will stand the test of time, while others have a loose weave that is less durable. It is the nature of the weaving that gives it its strength, continuity and endurance. The weaving of health and wellbeing is a continuous process over the lifespan of a Māori woman. The outcome of the weaving of health and wellbeing is subject to change at given points in time and can be situated on a continuum of being either optimal or less than optimal (Figure 10.2). Changes in health and wellbeing are dependent upon the influences that impact upon the process of weaving health and wellbeing.

The next chapter discusses the implications for health service delivery of the model and the core categories presented in the last four chapters. I acknowledge that health services and health care providers cannot 'fix' the health status issues of Māori women on their own. However, their actions and interactions can have a profound influence and optimise the health and wellbeing outcomes of these women. Chapter 11 discusses the implications of this work, and considers the model's usefulness in both the practice and education settings.

# CHAPTER 11

## Implications for Practice and Service Development

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*Ko koe ki tena*

*Ko ahau ki tenei*

*Kiwai o te kete*

You have that handle of the basket, I have this handle of the basket  
Let us together uphold the mana of the weaving

Being able to connect and relate to health care providers and health services is key to Māori women having a positive health experience. This research is applicable to health care providers in general, and I intend to discuss its implications for health care providers and their practice in this chapter. The interaction between a Māori woman and her health care providers can be considered a dynamic 'social' experience. A mutual point of interest, such as a particular health issue, and the subsequent interactions and dialogue that may occur, forms the basis of the relationships Māori women develop with health care providers. Such relationships vary in duration and are dependent upon the nature of the health issues presenting. It is of benefit to Māori women that health care providers have an understanding of what is important for them, their health and wellbeing, the challenges and barriers that they encounter, and their 'mainstream' health service needs. The ability of health care providers to instill a sense of trust in Māori women is essential to maximising the benefits of any interaction they may have with a 'mainstream' health care provider.

*Ngā Kairaranga Oranga – The Weavers of Health and Wellbeing* provides a grounded theory presented as a model to explain the weaving of Māori women's health and wellbeing, grounded in the perspectives of the Māori women in this research. This model relates, in part, to the access and use of health services. The preparation of health care providers must ultimately benefit those Māori women who access and use 'mainstream' health services. An adequately prepared 'mainstream' health workforce is more likely to positively influence the health status of Māori women, and Māori in general.

Health care providers can play a significant role in creating experiences and interactions with Māori women that facilitate the best possible health outcomes. It is noted, however, that the complexity of the determinants of health and wellbeing mean that neither 'mainstream' health care providers nor Māori women themselves, can be held entirely responsible for their health outcomes. The environment created, and the ability of Māori women to obtain quality information in a form that can be both understood and used, are crucial in supporting them to make informed decisions about their health, and to develop health-promoting behaviours.

This thesis offers a perspective on what is important for the health and wellbeing of Māori women, and what they require from 'mainstream' health services. *Ngā Kairaranga Oranga – The Weavers of Health and Wellbeing* highlights the non-alignment of some of the needs of Māori women with the actual health services that are available for them. I acknowledge that the access and use of health services is determined by a complex interplay of a number of socioeconomic and relationship issues, and that some of the 'needs' of Māori women may lie outside the scope of 'mainstream' health service delivery. This research does, however, provide some illumination on how 'mainstream' health services and their health care providers could adjust their practice in order to improve the health outcomes of the Māori women accessing these services.

Māori women need to be involved in a meaningful way in the development of health policy and in the planning of health service delivery. Māori women survive, despite adverse socioeconomic circumstances, and do so by capitalising on the strengths that

they have. They could benefit by the provision of genuine opportunities to influence the development of health policy and service delivery that targets them and their whānau. Such involvement could assist a health service to be better aligned to the aspirations and development needs Māori women have in relation to their health and wellbeing.

*He Korowai Oranga* (King & Turia, 2002) focuses on achieving Māori aspirations for whānau ora - a concern also shown by the Māori women in this research. As many Māori women undertake a key role in whānau health and wellbeing, it is vital that the health status of Māori women is improved and sustained. *Ngā Kairaranga Oranga – The Weavers of Health and Wellbeing* could be used to inform the implementation of *He Korowai Oranga* (King & Turia, 2002) and *Whakatātaka* (Ministry of Health, 2002b), and the policies that exist within the current ‘mainstream’ health system that aim to improve both the responsiveness to Māori, and the delivery of culturally appropriate health services. As Māori health is a priority at a national level, as outlined in the New Zealand Health Strategy (King, 2000) this research could also inform the activities aimed at achieving the Health Strategy’s goals and obligations, and those of *He Korowai Oranga – the Māori Health Strategy* (King & Turia, 2002) and *Whakatātaka – the Māori Health Action Plan* (Ministry of Health, 2002b).

This chapter considers the grounded theory informed by a Māori centred approach generated, *Ngā Kairaranga Oranga – The Weavers of Health and Wellbeing*, and discusses its implications for practice and education within the ‘mainstream’ health setting. To begin, I will review the aims of this research, and reflect on how they have been met. The importance of developing the practice of health care providers working with Māori women will then be explored. Practice implications will be discussed under the following headings: (a) promoting trust in the health service, (b) maintaining mana and integrity of Māori women, (c) facilitating access and use of health services, and (d) building upon existing strengths. The model of weaving Māori women’s health and wellbeing, and its implications, will be outlined for the practice settings, and curricula within education settings. Suggestions for further research will be discussed, and the thesis will be summarised prior to completing this chapter.

## A Review of the Aims

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The following aims for this research have been outlined in both Chapter 1 *Introduction*, and Chapter 4 *A Māori Centred Approach to Grounded Theory*:

1. Ascertain the interpretation Māori women have of health and how this influences their health behaviours.
2. Determine the interactions Māori women have with health services.
3. Generate a substantive grounded theory, informed by a Māori centred framework, about Māori women's health and wellbeing.
4. Use an appropriate Māori-centred research methodology.

To achieve these aims this research sought the perspectives of Māori women about their health and wellbeing, including their understandings, actions, and interactions with 'mainstream' health services. This was achieved through the process of inductive comparative analysis using a grounded theory informed by a Māori centred approach developed for this research. The key questions used to obtain this information were: *Tell me what health means to you?; What are the things that are important for your health?; Tell me about your interaction with health services and the people working in them.* The responses of Māori women, additional data, and the theoretical sampling (used to explore areas that emerged during the collection and analysis of data) were used to develop the model *Ngā Kairaranga Oranga – The Weavers of Health and Wellbeing*.

*Ngā Kairaranga Oranga – The Weavers of Health and Wellbeing* describes the interpretation the Māori women in this research have about health and wellbeing, and how their interpretation influences their health behaviours and interactions with

'mainstream' health services. These are described in the core categories *Mana Wāhine* (Chapter 7) and *The Way It Is – Resigned Acceptance* (Chapter 8). *Engaging with Health Services* (Chapter 9) describes the interactions Māori women have with health services and health care providers, and also what they require to improve their access and use of a health service. *The Weaving of Health and Wellbeing* (Chapter 10) explains how the process of weaving health and wellbeing pulls the multiple dimensions involved together. This research is relevant to the development of the practice of 'mainstream' health care providers, particularly as research from the perspective of Māori women regarding their health is minimal outside of epidemiological evidence. *Ngā Kairaranga Oranga – The Weavers of Health and Wellbeing* provides a model that can be used to gain insight into Māori women's health and wellbeing.

## **Promoting Connecting and Relating**

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*Building trust allows the real story to be told (I-04).*

The lack of credibility in a health service and the practice of health care providers may contribute to Māori women avoiding access and use of health services. The majority of Māori women in this research exercise control over their health and wellbeing until such time as they are required to access and use 'mainstream' health services. Examples of positive interactions with health services and health care providers in this research, however, were minimal and were outweighed by the Māori women's need to feel that they had some control and autonomy over planning and decision making. Having some control promotes connecting and relating.

Māori women need to be able to have trust that a service will respect who they are and 'look' after their health needs in the best possible way. Yet, the Māori women in this

research are acutely aware of the 'failures' of the public health system. Exposure to health service deficits contributes to a sense of mistrust in health services, compounding any mistrust that may already exist from previous experiences. The attitudes and behaviours of health care providers that display a lack of respect and are 'judgmental' also compromise the credibility of a service and its providers.

The ability to establish a positive relationship with a health care provider assists the confidence Māori women have that they are in a supportive environment, and that they could participate in decision-making about their health. Noone's (2002) concept analysis on client decision making clearly locates it within the domains of both the client (such as Māori women) and the health care provider. Noone (2002) maintains that personal and environmental contextual factors, as well as client preference need to be established as these factors influence client's decision-making about their health management.

Underpinning a sense of control is the concept of tino rangatiratanga (Durie, 1997). Tino rangatiratanga is a stated right under Article Two of the Treaty of Waitangi, which pertains to the right of Māori to exercise their autonomy, and to determine what is best for them. Given the notion that Māori women are knowledgeable about their own life circumstances, they are optimally positioned to make a meaningful contribution in the determination of the best approaches when intervention and treatment plans are developed. The ability to retain some control and contribute to health planning supports the maintenance of the mana and integrity of Māori women, which acts as a 'reference point' for success in life and influences how a Māori woman may function (Ministry of Justice, 2001).

## **Health Care Provider Practice and Māori Women**

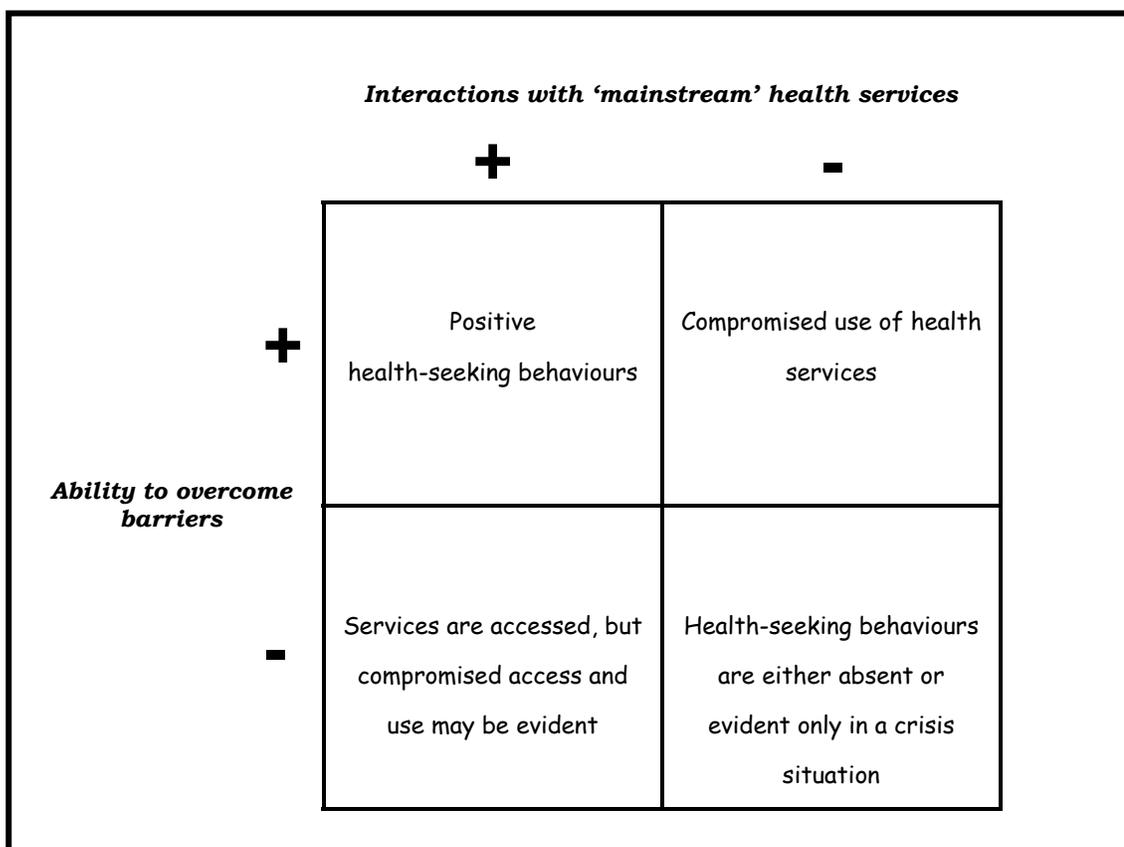
*Continuity and trust are important in a relationship with a health care provider (I-05).*

Working effectively with Māori women can positively influence their health outcomes, and the development of health-promoting behaviours. Effective practice is grounded in

the assessment, diagnostic, planning and evaluative activities of health care providers. Māori women are highly likely to come into contact with a health care provider at some point in their lifetime. It is, therefore, important that health care providers are able to determine and act upon the health needs of Māori women, as Māori women perceive them.

Having an understanding of how the health and wellbeing of Māori women is complexly woven together, and the important factors involved in their health and wellbeing, assists in the delivery of a health service that aims to promote positive health outcomes. However, the focus should not rest solely with the Māori women themselves, but should involve the examination and development of the attitudes and behaviours that drive the practice of health care providers, a notion that aligns with the requirements for culturally safe practice (Nursing Council, 2002).

Positive health-seeking behaviours are an important step toward Māori women accessing a health service, and interacting with its health care providers. Figure 11.1 illustrates the influence that positive and negative interactions can have, moderated by the ability of Māori women to overcome the barriers they may experience when accessing and using health services. The model, *Ngā Kairaranga Oranga – The Weavers of Health and Wellbeing*, supports the desire of Māori women to have their worldviews acknowledged and incorporated into their health experience, to be respected, and to experience genuine, non-judgmental attitudes of health care providers.



**Figure 11.1.** Health-seeking behaviours of Māori women.

Cultural safety focuses on the recipient's experience of the care they receive from health care providers, and their subsequent determination of how safe they felt during that experience. In preparation to deliver a culturally safe service, health care providers are required to examine their own cultural beliefs and practices, the power they have, and how these may impact on clients with different cultural beliefs and practices, such as Māori women. Personal and professional beliefs, attitudes, and practices are often not recognised, and unless a conscious effort is made to acknowledge these, their influence can have a profound effect on others (Ramsden, 1990; 2002). The 2002 guidelines for cultural safety (Nursing Council, 2002) highlight the relationship of cultural safety with the implementation of the Treaty of Waitangi and the improvement of the health status of Māori. While the need for cultural safety to be an important part of the

education and practice of health care providers has been reinforced by the women in this research, the model *Ngā Kairaranga Oranga – The Weavers of Health and Wellbeing* moves beyond cultural safety, and indicates additional areas for practice development to meet the needs of Māori women.

## **Efficacy of Health Care Providers**

### *The attitudes of health care providers are bad (I-01)*

The efficacy of health care providers is a reflection of their perceived credibility, and has a powerful influence on the health outcomes of Māori women accessing and using health services. Just as the beliefs and stereotypes held by health care providers can influence the nature of the relationships established with Māori women, so can their attitudes and behaviours. Positive health experiences can emerge from meaningful partnerships established between health care providers and consumers, according to the Māori women in this research. Health care providers bring health and illness expertise to such partnerships, while Māori women bring the knowledge about their health beliefs and practices, and life circumstances. The nature of such partnerships influence the efficacy of health care providers working with Māori women, and the information that they may contribute can be used in the planning and decision making activities. Christensen (1990) proposes the notion of the client as 'expert', and believes this concept is crucial to the nursing partnership. Acknowledging the expertise of Māori women is vital in establishing health care provider credibility and trust.

Conversely, not acknowledging the expertise and the view of health and wellbeing that Māori women have about their life circumstances ignores the importance of involving them in planning and decision-making activities. Health care providers may mistakenly assume that Māori women are not knowledgeable about their health, or are negligent for not seeking assistance earlier when they do eventually access an appropriate service. Some Māori women may delay accessing services, however, it does not justify health care providers making assumptions that are not verified. Such assumptions that reinforce negative explanations about the apparent lack of health-seeking behaviours

by Māori women are unhelpful. When planned health outcomes are not realised, labels such as 'non-compliance', 'non-adherence' and 'non-attendance' are frequently used, and are often supported by negative stereotypes and deficit explanations. Dickson (2000, p.188) highlights this, stating:

People's participation in health is too often interpreted as compliance with programs rather than as a strategy for increasing relevancy and reducing inequalities.

Approaches such as these are inappropriate, insensitive and 'blame' on Māori women. As already discussed, when the outcomes of health experiences fall short of those expected by health care providers, the onus is generally placed on Māori, an experience reinforced by the Māori women in this research. This stance, however, neglects the role that health care providers have in achieving positive health outcomes for Māori. If improvements are to be made in the health status of Māori women, health care providers must continue to engage in a process of reflection on their practice that aims to increase their effectiveness.

The concept of compliance in relation to the health and wellbeing of Māori women is problematic. "Compliance with the wishes of health professionals..." (Wass, 1994, p.42) ignores the life circumstances of Māori women that influence their ability to undertake prescribed treatment regimes. Importantly this view of compliance is the antithesis of partnership and empowerment (Wass, 1994) with consequences that Evangelista (1999) contends include conformity, dependence, a lack of control and obedience, with the power residing with the health care provider. While stating this, I do acknowledge the complexity of the situation, particularly with regard to the 'health' knowledge that health care providers possess, and the ongoing difficulties with resources that provide challenges to doing things differently. Evangelista (1999, p.10) recommends:

There is a need to see patients as individuals who construct and give meaning to their encounters with professionals, and who actively evaluate treatments prescribed and advice given.

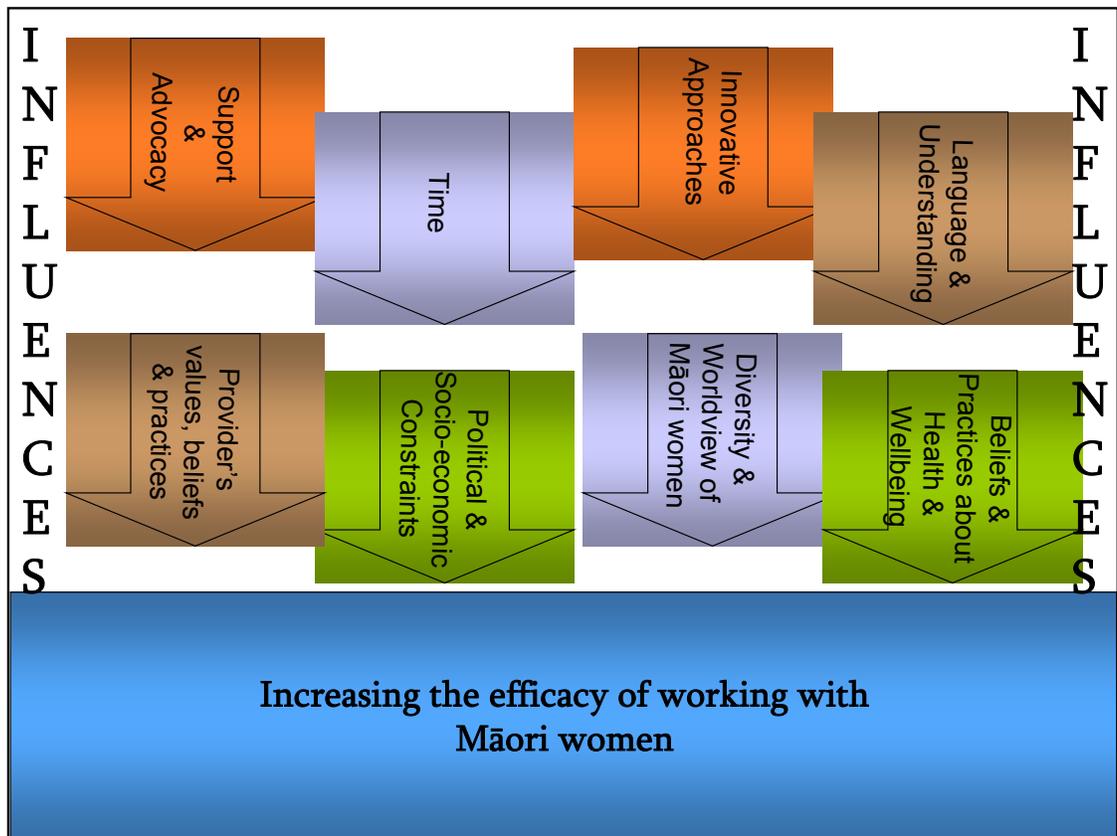
However, there are some Māori women who may not want to be actively involved in the decision making and planning of their health experience, but many do. Decisions made by others for Māori women do little to foster independence and positive self-care behaviours. Health care providers, who have an analysis of the wider political and socio-economic issues that negatively impact on Māori health status (and that are generally beyond the control of Māori themselves), can avoid the use of negative labels and stereotypes that work to the detriment of Māori women. The persistence of those health care providers who adopt approaches based upon misunderstandings and unsubstantiated judgements contribute to Māori women having a lack of trust in health care providers.

The core categories *Mana Wāhine* (Chapter 7), *The Way It Is – Resigned Acceptance* (Chapter 8), and *Engaging with Health Services* (Chapter 9) indicate that there are a number of activities health care providers can utilise to increase the efficacy of their practice as illustrated in Figure 11.2. These activities can be organised under the following areas:

1. *Provider's Values, Beliefs and Practices*: Health care providers are recommended to undertake a process of identifying their own values, beliefs and practices, and how these can impact on their practice (Ramsden, 1990; 2002), and more specifically on Māori women they may be working with.
2. *Political and Socio-Economic Constraints*: Health care providers should have a sound knowledge of their communities in order to utilise the health information and data (that many health services have for reporting and monitoring purposes), supported by an analysis of the political and socio-economic determinants on health. This assists to identify the constraints Māori women may experience when they access and use 'mainstream' health services.
3. *Diversity and the Worldview of Māori Women*: It is important for health care providers to recognise that Māori women are not a homogenous group, but can be diverse in their backgrounds, life circumstances, and in their health beliefs and practices. It is also helpful to understand that Māori women may have health beliefs

and practices that have been acquired through intergenerational transmission, and that are at variance with the dominant biomedical worldview that prevails in 'mainstream' health services. This can explain why some things perceived to be important for a health care provider do not necessarily hold the same level of importance for a Māori woman. It also reinforces the need to avoid making inaccurate or inappropriate assumptions about Māori women.

4. *Beliefs and Practices about Health and Wellbeing:* It is important to Māori women that health care providers establish what is important to them for their health and wellbeing. These priorities can then be incorporated into assessment, intervention and treatment processes. This process should also include the identification of the health goals that each Māori woman has for their health experience.



**Figure 11.2.** Strategies to increase the credibility and efficacy of health care providers.

5. *Language and Understanding:* Health care providers should determine the level of understanding a Māori woman has about the instructions and information that she receives as this is crucial to effectively undertake prescribed treatments and interventions. This includes the use of a variety of modes to communicate information (such as verbal, written, diagrams, videos) that facilitates understanding. Making assumptions that a Māori woman understands what a health care provider has said risks instructions not being carried out, or vital information not being understood. It should be noted that language and understanding is an educational issue, rather than an ethnicity issue.
  
6. *Innovative Approaches:* Health care providers need to possess sufficient practice flexibility to incorporate the needs of each Māori woman into the planning of their intervention and treatment plans. For example, the continued inclusion of traditional Māori approaches to maintaining health and wellbeing, such as karakia or mirimiri. This also requires a willingness by health care providers to adopt innovative approaches where they do not exist, so that interventions or treatments are achievable within the resources of individual Māori women.
  
7. *Time:* Sufficient time needs to be afforded to Māori women so they can answer questions and to absorb information. Health care providers who convey non-verbally that they do not have enough time, or who push for an immediate answer, may find that important information is not shared or is missed. This will be an ongoing concern for some areas where staffing and resource issues exist, however, sometimes putting off something may result in extra time having to be spent at some point in the future.

The collection of adequate assessment data is vital in planning appropriate interventions (Weber & Kelly, 2003). The adage that 'time spent now saves time later' is valid here. Rushing Māori women through procedures, interactions or teaching sessions is highly likely to result in the women not understanding key information and, therefore, compromising their ability to optimally manage their

health. Māori women may also find it difficult to comprehend messages, and be reticent to ask questions. Health care providers who rush or use language that is difficult to understand do little to engender a sense of trust, as they appear to be too busy to be genuinely interested in the Māori women they work with.

8. *Support and Advocacy*: Enabling Māori women to have someone to support them through their health service experience, and to act as an advocate, also increases the efficacy of health care providers. Māori women may feel whakamā, anxious and/or pressured by health care providers who unknowingly 'rush' them, as described in the property *availability of support and advocacy* (Chapter 7). As a result they are unable to answer questions asked of them or may answer them wrongly just to provide an answer.

## **Individualising Interactions**

*It is the cultural component that makes it different for Māori women (I-05).*

As Māori women are a diverse group, positive health outcomes are contingent upon an individualised approach. When working with Māori women it is useful to note that the use of the word individualised is used within a collective context. That is, while an individual Māori woman may be the focus of the attention of a health care provider, her identity and possibly health issues may well be within a collective whānau or hapū context. As previously mentioned, a universal 'one-size-fits-all' approach that treats 'all' patients the 'same' negates an individualised approach. It is, therefore, important that health care providers establish their interactions with Māori women based upon the premise that they are a diverse group.

Individualising interactions involves the recognition that for Māori the concept of hauora is wholistic and spiritual in its foundation, an approach Māori prefer (Cunningham & Durie, 1999).. This contrasts with the western view of health that generally takes a narrower perspective. Individualising interactions also includes incorporating socioeconomic and life circumstances into planning intervention and treatment plans.

One does not have to look far within the health arena for situations that support the need to consider these aspects as well as physical health needs. For example, consideration of the affordability and acceptability when planning treatment and interventions. When socio-economic and life circumstances are considered in situations such as this example, alternative arrangements may be made by respectfully working with the woman.

## **Facilitating Engagement**

*What is needed is courtesy and a willingness by health care providers  
to listen (I-05)*

The facilitation of a positive relationship by health care providers with Māori women is vital in the establishment of trust and credibility, of both the service and its providers. Browne and Fiske (2001) undertook in-depth interviews with 14 Canadian First Nations women about their encounters with mainstream health services, and the factors that influenced these encounters. The interviews were analysed using interpretive thematic analysis, informed by critical and feminist ethnographic approaches. They found that mainstream health care delivery reflected the social encounters that marginalise these women. While the findings are limited to the First Nations women studied, Browne and Fiske's (2001) findings support those in this research with regard to Māori women having their cultural identity respected, and being involved in decision making that develops trust and credibility. These are important features in the development of positive and long-term relationships with Māori women.

The establishment of a relationship between a Māori woman and a health care provider is dependent on the quality of the initial contact she has with a health service, and continues with subsequent interactions that may include other health care providers. Thus, the use of a friendly and genuine approach when meeting a Māori woman is important to make her feel both comfortable and safe. Often feelings of whakamā (shyness, embarrassment, or shame) may result in a Māori woman approaching her

health experience tentatively. As previously mentioned, the establishment of a positive and effective relationship with a health care provider is influenced by the health care provider's attitude. Having a familiar face can assist with establishing a sense of comfort a Māori woman experiences. Continuity of care can also help establish positive and effective relationships.

The process of whakawhanaungatanga can be usefully applied in forming a relationship with Māori women as it reflects an understanding of the importance of connections for Māori women. While whakawhanaungatanga generally establishes the connection Māori have within whānau, hapū and iwi, it may also be extended to include reciprocal relationships where they exist (Ministry of Justice, 2001). It is also a process that can be used in the formation of the relationship between a health care provider and a Māori woman prior to addressing her health care needs. The use of this process conveys respect towards a Māori woman, and indicates an intention to keep her interests central to the relationship.

The core element *Engaging with Health Services* (Chapter 9) highlights undeniably, how the practices of health care providers may influence the development of relationships with Māori women. The body language that health care providers exhibit assists Māori women to detect whether a health care provider is genuine in his or her approach. The majority of communication is conveyed non-verbally (Myers, 1993; Pease, 1985) predominately through body language. Health care providers can promote the quality of their interactions by undertaking a process of reflection on their attitudes and behaviours toward Māori women.

Māori continue to call for culturally appropriate services, (Durie, 1998d; Reid et al., 2000) and maintain that the issues underlying the health status of Māori are indicative of culturally unacceptable and inappropriate services, among other factors. Indeed, a growing body of literature (Bophal, 2001; Browne & Fiske, 2001; Eliason, 1999; Jones, 1999; Karlsen & Nazroo, 2002; Kirchheimer, 2003; McKenzie, 2003; Reid et al., 2000) clearly indicates that there is a detrimental connection between disparities in health status and racism (both institutional and personal), and its discriminating practices. Bophal (2001, p.1504) maintains that:

Racism is the most disturbing of the potential explanations for...[health] inequalities.

There is a need for health care providers to undertake a process of self-reflection on their attitudes and behaviours as racism is communicated through attitudes, behaviours and language, and may negatively impact on Māori women.

The core element *The Way It Is – Resigned Acceptance* (Chapter 8) describes the negative experiences Māori women have when health care providers behave in a manner that is neither appropriate nor acceptable. It appears that the societal and health discourse on racism has moved into the background, yet institutional and personal racism could provide one explanation for less than desirable behaviours exhibited by health care providers (Jones, 2001). The failure to address personal and institutional racism that exists within a health service perpetuates the complicity of health care providers in maintaining societal, institutional and health care racism, which writers such as Karlsen & Nazroo (2002), Kirchheimer (2003), and McKenzie (2003) propose is a public health issue. Such behaviours are also shrouded in political correctness, and are evident in the language used that lessens the reality that 'others' may experience. Political correctness makes contentious issues more palatable for those using it. Recently one Māori woman described to me that health care providers 'get what they give' – she was talking about the negative attitudes and behaviours of health care providers that result in a reticence by many Māori to engage in relationships with them. Not acknowledging and addressing the negative effects of racism on Māori women can be considered a failure in the duty to care and does little to facilitate the engagement of Māori women in health services.

Papps (2002) maintains that cultural safety education aims to address racism by increasing insight into stereotyped beliefs and assumptions held about Māori seeking health services, and the impact these have on the delivery of services. In reality, the efficacy of cultural safety in practice is questionable (Ramsden, 2002), despite the aims of cultural safety education (Ramsden, 1990; 2003) to improve the effectiveness of health care providers working with Māori. It is the recipient of the service that determines whether the service they receive is in fact culturally safe, yet health care

providers frequently judge their own, and their peers', practice as safe. The recipients of the care provided by such health care providers, however, may be left with differing perceptions, and a feeling of dissatisfaction.

## **Maintaining the Mana and Integrity of Māori Women**

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*We need to be listened to because of our beliefs about wairua (I-04)*

The Māori women in this research reported the loss of who they are and what is important to them when they enter 'mainstream' health services. It is important that Māori women can enter a 'mainstream' health service and retain their mana and their sense of integrity. The core category, *Mana Wāhine* (Chapter 7), describes what is important for Māori women's health and wellbeing. The core categories *The Way It Is - Resigned Acceptance* (Chapter 8) and *Engaging with Health Services* (Chapter 9), however, identify important components to be considered for their health and wellbeing – components that are generally not recognised or included in their 'mainstream' health experience. Māori women, like all women and men, need to have their sense of self kept intact when they enter environments (such as a 'mainstream' health service) that differ in a number of ways from their everyday environment. They should be able to expect, at a minimum, that they can be respected as a person, and thus, for whom they are.

An integrated approach to health service delivery must account for the multiple dimensions, and the variety of complex interactions, that Māori women may experience when they 'walk' in two worlds. These dimensions and interactions extend beyond a presenting physical ailment. A wholistic worldview, notions of wellbeing, cultural beliefs and practices, socio-economic status, concepts of past and present, and the collective nature of Māori society are all equally important and need to be considered.

The integration of Māori worldviews, beliefs and practices into 'mainstream' health services could potentially improve service delivery. Total integration, however, risks the beliefs and practices of Māori women becoming invisible if they become too integrated – a subtle form of assimilation. What then occurs is an approach based on treating everyone the same – an approach that is evident and prevails in many health services. Such approaches are based on the notion of equality, but equality does not necessarily address equity issues that some groups experience. Equity requires the use of alternative approaches in order to achieve the same health outcomes as others. Equity is about responding to the unique needs of Māori women. For the Māori women in this research, greater credibility is gained by meaningfully incorporating 'things' Māori into health services.

Some 'mainstream' health funders, such as Lakes District Health Board, have gone to lengths to work with local Māori to identify and establish Māori services that aim to keep Māori and their health needs visible. However, there is variability between 'mainstream' health services with regard to their responsiveness to Māori health needs, and satisfaction of those Māori using them (CPAC, 2002; Health Reform 2001 Research Team, 2003). The Health Reforms 2001 Research Team (2003) three-year evaluative study undertaken from 2001 to 2004 on the implementation of the 2001 Health Reforms, found that health services were predominately delivered using an 'individualistic pakeha' model, and that 'mainstream' health care providers needed to review the services delivered to Māori. Reasons for the lack of 'visibility' of Māori needs within 'mainstream' health services may include a lack of time, resources, knowledge of cultural beliefs and practices, and/or the lack of recognition of the diversity amongst Māori. Undoubtedly, the biomedical model that dominates the health system is influential in decision-making at all levels of health service delivery. Dickson (2000, p.188) identifies that those who hold the 'power' generally make decisions for those who are members of marginalised groups.

The identity of Māori women is embedded in their worldview. 'Mainstream' health care providers can minimise the impact of a mismatch in the worldviews by exploring key aspects that are important to Māori women (described in Chapter 7 *Mana Wāhine*). Determining what health and wellbeing means to a Māori woman, and the essential

beliefs and practices that need to be observed is a start to address any mismatch in worldview that exists. This can then be followed by an exploration of how the whānau is a source of identity, connection, support, familiarity, and strength, and how these need to be incorporated into the health experience of Māori women. This exploration is important as assumptions made about a Māori woman (that have not been validated) risks her needs not being identified or met. Determining what is important for the wairua of a Māori woman, for example, and the practical aspects to achieve this enables its incorporation into her health experience, where appropriate. An exploration of life circumstances and the self-care activities already established (which will be discussed later in this chapter) can also provide a basis for planning and decision making. When it is not practical or possible to incorporate important practices, this should be discussed with the Māori women and alternatives negotiated. Honest and direct communication with rationale is preferable to singularly dismissing of the needs of Māori women.

## **Converging Worldviews**

*There is no wholistic consideration, so spiritual needs are not considered (H-01)*

Māori women are no strangers to walking in two worlds (Ihimaera, 1998), but this does not mean that their personal worldview should be automatically subjugated when they move from the world of Māori to the world of Pākehā. Often when their health beliefs and practices contradict those of 'mainstream' health services, poor health outcomes are often attributed to some deficit in the Māori woman. Such explanations are short-sighted and one-sided as systemic deficits related to the delivery of services are not addressed, as seen in the media response to the release of the *Decades of Disparity* report (Ajwani et al., 2003), where Māori were 'blamed' for their health status. Sibthorpe, Anderson and Cunningham (2001) stress the problematic nature of the domination of one worldview over others, especially when the role of culture in the development of health practice and behaviours is not considered.

Māori women using 'mainstream' health services should expect that their cultural beliefs and practices will be respected, at a minimum. When this expectation is not met, the experience within health services can be both unpleasant and difficult. The Māori women in this research reported feeling that their beliefs and practices were frequently devalued by 'mainstream' health care providers, and these were generally not included as part of their health care experience. The importance of considering the role of cultural beliefs and practices in the health experiences of those using health services is not a new idea.

Identifying the nature of the relationship a Māori woman has with her whānau, how her wairua needs to be 'nurtured', the nature of her knowledge and understanding of health and wellbeing, and the self-care activities they undertake, can all provide insight into the cultural beliefs and practices of Māori women. *Mana Wāhine* (Chapter 7) provides a guide to the areas that are important for Māori women to be integrated into the health services delivered.

## **Incorporating Knowledge and Healing Practices**

*Rongoā can go hand-in-hand with western medicine, but it needs to be recognised (I-01)*

The importance of Māori knowledge and healing practices to the maintenance of health and wellbeing of Māori women is discussed in Chapter 7 *Mana Wāhine*. The Māori women in this research all engage in some form of traditional Māori healing outside of 'mainstream' health services, whether it is, for example, rongoā, mirimiri, karakia or consultation with a tohunga. These practices are underpinned by the spiritual beliefs of the Māori women. The incorporation of wairua into healing practices is important to many Māori women. Traditional Māori knowledge and healing practices used by Māori women are examples of how worldview can be incorporated into intervention plans. However, these have often been invalidated by the dominant biomedical approach to health care. Despite a renaissance of Māori knowledge and healing practices, like many 'alternative' healing practices, they remain on the margins within most 'mainstream' health services and lack the 'evidence' to support their use. Those Māori women using

them, however, do not view such practices as ‘alternative’, but as legitimate approaches that work. Traditional Māori healing practices within ‘mainstream’ health services necessitates a diverse workforce. *He Korowai Oranga* (King & Turia, 2002) and the Health Workforce Advisory Committee (HWAC) (2003) both reflect the need for Māori workforce capacity building to better meet the needs of Māori. However the percentage of Māori in the health workforce is well below the proportion of Māori in the population (HWAC, 2003).

The basis, on which clinical judgements and decisions are made, further marginalises Māori knowledge and healing practices within ‘mainstream’ health services. The effectiveness of traditional healing practices is not measured in the formal ‘mainstream’ sense. That is, these healing practices have not been subjected to randomised control trials (commonly known as RCTs) that are considered the ‘gold standard’ in the hierarchy of evidence (Sackett, Straus, Scott Richardson, Rosenberg & Haynes, 1997). As a consequence, ‘mainstream’ health care providers often discount such healing approaches. Yet, the Māori women in this research believe that healing practices could complement interventions used in ‘mainstream’ health services. Tapsell (2004) concurs with this notion, particularly around *tohunga* and traditional healing practice being able to complement the work of ‘mainstream’ health care providers. *Tohunga*, for example, can provide important healing support for the spiritual dimensions of health and wellbeing.

Māori health providers report positive health outcomes by delivering health services that are more aligned with the needs of Māori using these services (Hand, 1998). However, there is a need to gather ‘evidence’ to establish the credibility of Māori health providers. The use of traditional healing practices in conjunction with ‘mainstream’ interventions is an area that is currently being researched. The information in relation to the outcomes of such practices, and the establishment of the reliability and safety of traditional healing practices, such as *rongoā*, can only be beneficial.

There are multiple ways of looking at the world, each way is neither more appropriate nor inappropriate – they are different. Determining the beliefs and practices and healing practices that Māori women already use, or want to use, is the initial step to

incorporating these into their intervention and treatment plans. There needs to be dialogue, respect of the beliefs and practices, and a willingness to include practices that are at variance to those promoted by the 'mainstream' health services.

## **Facilitating Access and Use of Health Services**

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*They speak around you, not to you (I-03)*

Māori women encounter aspects that are directly related to health services that might compromise their access and use of a health service. Given the context of delayed access and use of health services previously discussed, a 'window of opportunity' exists for health care providers to make a positive difference in the health and wellbeing of Māori women. Taking advantage of any 'window of opportunity' involves optimising the access and use of a health service. Yet, Māori women view health services as complex systems with complex processes, and thus they find it difficult to determine how to effectively access and use a service. Health services, and health care providers, can reduce the complexity of the systems and processes by providing information in a manner that can be easily understood on how to access the service, along with the processes that can be expected.

## **Creating a Conducive Environment**

*It is important to see someone who is pleasant, who smiles and is caring... (I-08)*

The nature of a health service's environment is influential in the health experience of Māori women. The Māori women in this research were hypersensitive to the type of reception that they received, and to the nature of the ongoing interactions they had with health care providers. From the first point of contact through to follow-up health

experiences, Māori women undertake a surveillance of the process, the attitudes and the behaviours of health care providers, and the outcomes of their health experience. The attitudes and the behaviours of health care providers are then interpreted to be either positive or negative, and influential in determining the degree of engagement a Māori woman would have with a health service and its providers. Creating an environment that conveys support and understanding for Māori women, and their life circumstances, is fundamental in establishing productive working relationships.

A environment that is conducive may reduce any anxiety that Māori women may experience, particularly if they suspect that they may have something seriously wrong with their health. Past and current experiences with health services (either directly or vicariously through friends and whānau members) influences the degree of trust Māori women may have in a health service and its providers in the future. Understanding the impact that various experiences Māori women have had with health services can assist in the provision of a supportive environment. The Māori women in this research expressed a fear of health services that originated from a number of sources and may have originated in both their child and adult experiences, as described in core category *The Way It Is – Resigned Acceptance* (Chapter 8). These women stressed the importance of the initial interaction with a health care provider to allay anxiety and any discomfort they may experience.

Negative encounters with health care providers also contribute to the anxiety Māori women may experience in relation to a health service. The more negative the experience, the more anxious and vulnerable a Māori woman may feel, which can impact on the quality of the interaction they have with the health care provider. While some Māori women may avoid accessing a health service, some will tolerate negative experiences out of necessity. However, any future follow-up or return visits may be delayed or avoided as a consequence – a phenomenon supported by Coyle's (1999) grounded theory study about dissatisfied users of health services in the United Kingdom. While it could be debated that Coyle's (1999) study is a thematic descriptive study rather than grounded theory, this study does provide insight into the experiences of dissatisfied users of health services.

In the current health environment some health care providers appear to have a preoccupation about understaffing, busy and complex workloads, and in some cases non-supportive collegial relationships. An excessive focus on these concerns, however, can compromise a 'consumer focus' – the consumer is often absent in their discourse. While these concerns are real considerations for health care providers, failure to keep Māori women (and other consumers of health services) central to the purpose of their work puts the health outcomes of Māori women at risk. Undeniably, the health and wellbeing of people and their communities should be the central concern of health care providers. Health care providers must address these issues so a genuinely conducive and receptive environment is created for Māori women.

The creation of a conducive environment also involves creating an aesthetically 'friendly' environment. Such an environment may contain Māori images and artwork, such as artwork on the walls, and signage using te reo Māori. Together with a friendly and welcoming atmosphere it conveys a message of respect and a willingness to be 'Māori-friendly'. This is complemented by the use of information that is jargon-free and uses language that can be understood by Māori women, and presented in a variety of mediums such as visual, oral or written forms. Health services, however, must be mindful that the production of a 'Māori-friendly' environment is genuine and does not resonate political correctness or tokenism. Māori women easily detect superficial 'window dressing', and an absence of a genuine effort to create a conducive environment may have the opposite effect than is desired.

## **Informed Choice**

### *Need to know what is available (I-06)*

Having sufficient information is essential to make informed choices and therefore, for Māori women to have some control over a health experience. Informed choice is a legislated right for consumers of New Zealand health services under the Health and Disability Commissioners Consumers' Code of Rights 1996 (Health & Disability Commissioner, n.d.). Despite this right, the Māori women in this research indicate that

often their health experience occurred with little opportunity for them to exercise any choice. They often did not fully understand what was happening and for various reasons felt unable to ask questions and seek further clarification. Indeed Right Six of the Health and Disability Consumers' Code of Rights 1996 articulates the requirement for health care providers to deliver sufficient information, in a respectful manner and using language that can be understood.

Consumers of New Zealand health services have the right to complain when their rights have been breached in anyway. Māori women however, report an unwillingness to complain for fear that it may be detrimental to their future health experiences. Instead they appear to endure the experience with a reluctance to return to either the health service or health care provider. A lack of complaints regarding insufficient information in a form that can be understood is no indication that the health care providers have fulfilled the requirements of Right Six well. Thus, health care providers need to be aware of the barriers that exist, as outlined in the core element *The Way It Is – Resigned Acceptance* (Chapter 8) and *Engaging with Health Services* (Chapter 9) that results in Māori women not understanding the information delivered to them.

The provision of choice that includes diagnostic, treatment and intervention options is also a right of health consumers. A variety of services and healing approaches need to be delivered to Māori women, including alternatives that are appropriate, acceptable, affordable and accessible. Māori women are then able to select the best option that is appropriate to their life circumstances and within their available resources, without having to feel embarrassed because these factors prevent some approaches being adopted. To meet legislated and professional obligations, health care providers need to be innovative, knowledgeable and familiar with the resources available within their community, and how referrals and contacts can be made (Wilson & Roberts, in press).

In order for Māori women to absorb the information and choices provided, they need to be given time and an opportunity to seek clarification. This process may be aided by Māori women being able to have either a support person to advocate on their behalf or by health care providers genuinely inviting questions and providing options. The value of an advocate is that this person can act as a moderator requesting further time,

clarification or information that enables a Māori woman to understand the information that she has received.

## **Building on Existing Strengths**

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*Stop telling us what is wrong...tell us how to stop getting sick! (I-05)*

The contradictory self-care behaviours of Māori women evident in this research, together with the context of poor health status, can erroneously be associated with victim-type behaviour. It raises the question, are Māori women victims or survivors? Victim behaviours are closely linked with a sense of helplessness and hopelessness. Individuals who believe that they do not have the ability to control what happens to them are likely to adopt a passive approach when addressing health issues. It is highly likely that they have an external locus of control, and possess a poor sense of self-control and low confidence to actively address health issues. Survivor behaviour, however, stems from an individual's belief that they have some degree of control (that is, an internal locus of control) over their life situation and actively engage in activities aimed at optimising their health and wellbeing (Bennett, Norman, Moore, Murphy & Tudor-Smith, 2002). Indeed, the Māori women in this research not only valued their health, but also actively engaged in health promoting behaviours within their sphere of control.

The attitudes and behaviours of Māori women evident in core category *The Way It Is* could also be considered fatalistic, as they appear to accept without question what life delivers them. Visser (2002) asserts that we define boundaries that constantly reminds us that 'that's all there is'. Within the context of social determination and the roles women have, Visser (2002, p.42) states, "[t]hat what happens is fated, and hoping and striving for change is a waste of time". It is possible to move beyond the limits imposed

by fatalistic beliefs by having an understanding of situations that provide the potential to move beyond such limits (Visser, 2002). This reinforces the importance of Māori women having sufficient knowledge on which to function.

The Māori women in this research do not refer to themselves as victims, despite informal references to Māori women being 'victims' of their circumstances or demonstrating 'victim mentalities', .Survivor-victim theorising about the health behaviours of Māori women and its subsequent labeling is of little benefit. The Māori women in this research demonstrate an acceptance of their life circumstances and what they have to work with. While Māori are frequently reminded how 'bad' their health is, the Māori women in this research recounted a keen interest and concern about keeping themselves well and healthy, underpinned by their knowledge and wisdom about what contributes to the maintenance of their health and wellness. They actively engage in purposeful self-care activities with the aim of keeping well and healthy so they can undertake the various roles they have.

Resilience offers a constructive way of viewing how adversity is managed, integrity is maintained, and wisdom is developed. By focusing on how Māori women successfully manage their health and wellbeing within the context of the adversity they may experience, facilitates the identification of the strengths they possess (as opposed to their deficits) (Mackay, 2003). Resilience facilitates successful adaptation and functioning to challenging situations (Cooper, 2004; Guttuso, 2003). It also provides a form of protection from the adversities of life and enables such situations to be approached with a sense of realistic hope and resourcefulness, supported by the social connections individuals have (Cooper, 2004; Deveson, 2003; Guttuso, 2003).

Engaging in health-promoting behaviour is in everyone's best interest, however, optimising health status is one of many goals a person may have (Roberts, Towell & Golding, 2001). Whether there is a conflict of interest between the attainment of better health and the other goals a person may have, is rarely questioned by health care providers. Whether "...health should occupy a prime position amongst the numerous competing motivations in life is certainly open to question" is an idea put forward by Roberts, Towel and Golding (2001, p.140).

Māori women enter 'mainstream' health services with existing knowledge, health promoting behaviours and other various strengths. The Māori women in this research engage in a range of positive health behaviours driven by their acute awareness of their health status and have a genuine desire to prevent ill health and disease processes. The aim of these practices and activities is to maintain their health and wellbeing, and prevent ill health. Yet, they encounter a health system that is predominately illness focused, difficult to access, and health care providers who often do not recognise the positive health behaviours they come with. These Māori women want health services to adopt a health promotion, disease prevention approach as they wanted to know how to stop getting ill, and in some cases how to manage disease processes effectively. This desire is consistent with the developments in primary health care within the health sector.

Despite the negativity that surrounds the health status of Māori, Māori women demonstrate resilience amidst various adversities. In order to survive these women have developed strategies and strengths – yet, these are often neither identified nor acknowledged by 'mainstream' health care providers. Health promotion activities need to build upon that existing knowledge and the strengths Māori women have. Approaching education activities in a way that acknowledges and values the strengths that Māori women do have, increases the likelihood that they will positively engage with health care providers and education sessions will be effective.

The development of health-promoting behaviours is an important factor in the maintenance of health and wellbeing. There is truth in the saying that 'knowledge is power'. Māori women require useable knowledge to support the development of health-promoting behaviours. The risk of minimising or neglecting activities that promote health or prevent illness may occur by focusing solely on addressing a health-related problem or illness. Dickson (2000, p.188) criticises the seemingly contradictory nature of the beliefs and practices within 'mainstream' health services:

In principle, the health sector recognizes that social participation, self-determination, self-reliance and empowerment enhance health and well-being, and these phenomena are the

cornerstones of primary health care, community development, and health promotion. In practice more rhetoric is heard than reform or transformation is seen.

Holding individuals totally responsible for their health status amounts to victim blaming and labeling, according to Wass (1994). It is easy to 'talk' about what should happen, the challenge is moving this 'talk' into the arena of meaningful 'action'.

The delivery of education by 'dumping' information and expecting Māori women to absorb and understand it is problematic and ineffectual. It may be more effective to create a learning environment where a Māori woman can ask questions, explore issues, and at times have the opportunity to go over information that they have received. The efficacy of any health education hinges on understanding the information delivered. Therefore, the delivery of health education may be more effective in a group format, for example, health promotion activities delivered collectively to whānau and hapū in some cases. Often health issues, such as diabetes, that affect a Māori woman may also affect other whānau and hapū members. Tangaere (1997) describes frameworks such as poutama<sup>1</sup> and tuakana/teina<sup>2</sup> as approaches that may be used for learning by Māori. It may also be beneficial that a Māori woman has a support person present during an education session, if agreed to, who is able to act as an advocate and assist in asking questions or explaining information in a form that can be understood.

Language is also vital and has a key role in identifying and communicating information. Health jargon is generally normalised by health care providers, and is subsequently used unconsciously with people who do not understand such jargon. The language used in teaching sessions must be at a level that each Māori woman is able to understand, and the use of health-related jargon avoided where possible. This can assist in establishing an atmosphere where a Māori woman feels that she is able to ask questions without fear of ridicule or humiliation. The way in which vital health

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<sup>1</sup> Poutama is a stepping pattern seen on the tukutuku panels in the whare tupuna and is used as a framework for learning. The plateau is a period where understanding is achieved through processes, such as titiro (look), whakarongo (listen), and kōrerō (speak). Once learning and understanding has been acquired, the learner ascends to the next step (Tangaere, 1997).

<sup>2</sup> Tuakana/teina is the mutual learning and support that occurs between older and younger people.

information is communicated can either facilitate improved health and wellbeing, or it can become a barrier.

It could be argued that what I have described here are simply accepted principles for the education of adults. This research reveals that from the perspective of the Māori women in this research, many health care providers do often not use such principles. Yet, as already mentioned, health care providers often hold individuals solely responsible for their health status without the recognition that they may have been recipients of incomprehensible information. This includes the delivery of health-related information. Undoubtedly, anecdote exists about the 'difficult' or 'different' patient within the health setting who ends up being labeled if they are perceived to 'demand' too much information, or they resist conforming to the expectations of health care providers. What cannot be denied is that knowledge and understanding assists in their self-care and health promoting behaviours.

## **A Model for Practice**

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*Ngā Kairaranga Oranga – The Weavers of Health and Wellbeing* provides a model for practice. As previously mentioned, this model describes factors that influence the health and wellbeing of Māori women, what is important for their health and wellbeing, the barriers and challenges to achieving health and wellbeing, and what they need when they interact with 'mainstream' health services. The basic social psychological process of *weaving health and wellbeing* is useful in understanding how Māori women 'weave' together the multiple and complex dimensions of their health and wellbeing. *Ngā Kairaranga Oranga – The Weavers of Health and Wellbeing* can be used to guide practice, and provides a framework for assessment activities and how to optimise interactions with Māori women. The following questions (Table 11.1), based upon

issues discussed earlier in this chapter, are suggested as areas that could be investigated and acted upon when working with Māori women. Some of these questions are directed toward the health care providers themselves, and provide a prompt for reflection on individual and service beliefs, attitudes and practices.

**Table 11.1**

*Questions For Investigation and Action*

<b>Question</b>	<b>Category</b>	<b>Concept</b>	<b>Theoretical Proposition</b>
<b>Maintaining the Mana &amp; Integrity of Māori Women</b>			
How are the beliefs & practices (worldview) of Māori women determined?	<b>Mana Wāhine</b>	Theoretical proposition	Maintaining mana and integrity of self
How are the principles of partnership, participation and protection implemented when working with Māori women?	<b>Engaging with Health Services</b>	Theoretical proposition	Connecting and relating
What opportunities are afforded to a Māori woman to undertake cultural practices that are important for her wellbeing?	<b>Engaging with Health Services</b>	Forming effective relationships	Connecting and relating
How are the relevant life circumstances of a Māori woman determined and incorporated into the assessment and intervention plans?	<b>Engaging with Health Services</b>	Connecting with an appropriate service	Connecting and relating
How are barriers to the (a) access, and (b) use of a health service determined?	<b>The Way It Is</b>	Impeding access to services	Accessing and use of health services is hindered
What barriers can health care providers contribute to minimising or removing?	<b>The Way It Is</b>	Impeding access to services	Accessing and use of health services is hindered
<b>Promoting Connecting &amp; Relating</b>			
What are the beliefs that I, as a health care provider personally hold with regard to Māori women and their health?	<b>Engaging with Health Services</b>	Theoretical proposition	Connecting and relating
How do these beliefs potentially/actually impact on the Māori women I work with?	<b>Engaging with Health Services</b>	Theoretical Proposition	Connecting and relating
What knowledge or practice frameworks do I use to work 'with' Māori women?	<b>Engaging with Health Services</b>	Connecting with an appropriate service	Connecting and relating
What knowledge and skills do I require to develop my practice for working with Māori women?	<b>Engaging with Health Services</b>	Theoretical Proposition	Connecting and relating
Are the attitudes and behaviours toward Māori women genuine and non-judgmental?	<b>Engaging with Health Services</b>	Reception encountered	Connecting and relating
Does the health service have policies and processes that aim to improve the delivery of services to Māori, and include the implementation of beliefs and practices of Māori?	<b>Engaging with Health Services</b>	Connecting with an appropriate service	Connecting and relating
Are Māori frameworks of health and services	<b>Engaging</b>	Comfort with	Connecting and relating

evident in the delivery of the health service?	with Health Services	'things' Māori	
<b>Facilitating Access and Use of the Service</b>			
What mode of communication is used to contact Māori women about appointments, admissions, etc? Are there more effective ways that could be used?	Engaging with Health Services	Forming effective relationships	Connecting and relating
Is the language used, 'user-friendly' and contain minimal or no jargon?	Engaging with Health Services	Forming effective relationships	Connecting and relating
<b>Question</b>	<b>Category</b>	<b>Concept</b>	<b>Theoretical Proposition</b>
How are Māori women greeted and welcomed to the service?	Engaging with Health Services	Accessing health services	Connecting and relating
What Māori images, language, etc are present in the physical environment of the health service?	Engaging with Health Services	Comfort with 'things' Māori	Connecting and relating
What choices do Māori women have about how and when they access and use the service? How are these choices communicated to Māori women?	Engaging with Health Services	Having choice	Connecting and relating
<b>Building on Existing Strengths</b>			
What existing knowledge does a Māori women have about her current health status?	Mana Wāhine	Using mātauranga	Maintaining mana and integrity of self
What are the self-care and health promoting behaviours that this Māori woman undertakes?	Mana Wāhine	Undertaking self-care behaviours	Maintaining mana and integrity of self
Has this Māori woman undertaken any recent changes in lifestyle or self-care activities?	Mana Wāhine	Undertaking self-care behaviours	Maintaining mana and integrity of self
What support systems does this Māori woman have? How are these accessed?	Mana Wāhine	Connecting with whānau	Maintaining mana and integrity of self
What additional knowledge and skills does this Māori woman require to support her self-care activities?	Mana Wāhine	Using mātauranga	Maintaining mana and integrity of self
<b>Converging Worldviews</b>			
How are the beliefs and practices of Māori women incorporated into treatment and intervention plans?	Mana Wāhine	Theoretical proposition	Maintaining mana and integrity of self
How are the desired outcomes of Māori women identified? What support is required to achieve the outcomes for each Māori woman?	Engaging with Health Services	Forming effective relationships	Connecting and relating
What mechanisms are in place to include the whānau of Māori women in their health experiences, if they so wish?	Mana Wāhine	Connecting with whānau	Maintaining mana and integrity of self

These questions (Table 11.1) can guide assessment activities and action in practice. The measurement of whether practice is both culturally appropriate and acceptable, however, is another issue. The recipient of care, not health care providers, makes the determination of whether their practice is culturally safe. Within the current health environment the competency of health care providers to deliver safe and appropriate

health services is in the foreground, especially with the imminent implementation of the Health Practitioners Competency Assurance Act 2003.

The notion of cultural competence is not clearly defined, although competency in the delivery of culturally specific information is frequently associated with it (Rosenjack Burchum, 2002). However, culturally specific information does not acknowledge that diversity that exists between, and within cultural groups, and is the antithesis of culturally safe practice. The notion of measuring practice competency is more than technical or psychomotor competency, and must include the cultural dimension of a person's health experience, given the complexities around defining health previously discussed. Durie (2001b) maintains that cultural competency is less about behaving correctly, and more about practising in a sound manner. Durie goes further to say there is a need to develop the concept of cultural safety (that focuses on the recipient's experience) and proposes cultural competence, a notion that focuses on the health care provider's capability to deliver culturally safe practice.

From Durie's (2001b) work, it could be construed that the crux of cultural competency is about:

1. The health care provider (knowledge, beliefs, attitudes, power dimensions).
2. Actions that improve health status.
3. The integration of culture into clinical practice.

I believe there are overlaps between cultural safety and cultural competence, although the recipient of health care determines cultural safety, which can provide ongoing challenges for measuring health care provider's practice. Current attempts to measure cultural safety competency are devoid of client input. However, the notion of cultural competence proposed by Durie (2001b) provides other dimensions that could be assessed. Obtaining accurate feedback from Māori women about the practice of a health care provider is potentially problematic due to the Hawthorne effect described in Burns and Grove (1993) and the reticence to create problems that may negatively affect

future health experiences. Thus, as 'outsiders', health care providers cannot make accurate judgements about whether someone's practice is culturally safe. I propose a measurement of competence (Table 11.2), based on the health care provider's capability to deliver an appropriate and acceptable health service, when working with Māori women. This tool identifies the three key components (that is, the health care provider, actions aimed to improve health status, and integrating cultural beliefs and practices into clinical practice) identified by Durie (2001b) necessary for the appropriate and acceptable practice and performance of a health care provider.

## **Implications for Curriculum Delivery**

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*Ngā Kairaranga Oranga – The Weavers of Health and Wellbeing* also provides a practical framework for curriculum development and delivery. Māori health is a curriculum component for the preparation of most health care providers, such as nurses, midwives and medical practitioners. The education and development of health care providers to be responsive to the health needs of Māori, is aligned to health policy that directs health service delivery, *He Korowai Oranga* (King & Turia, 2002)

As a framework, *Ngā Kairaranga Oranga – The Weavers of Health and Wellbeing*, can be used to explore the various aspects of Māori women's health. I have presented this model in its draft form as a framework for understanding the health and wellbeing of Māori women to undergraduate and postgraduate nursing students. These students have reported that the model could be easily followed, and assisted their understanding of the complexity of Māori women's health and wellbeing.

**Table 11.2**

*Competence of a Health Care Provider's Capability to Deliver a Culturally Appropriate and Acceptable Service*

DIMENSION	ACTION
<b>The health care provider</b>	<ul style="list-style-type: none"><li>• Knowledge and analysis of Māori women's health and the socio-economic and political influences on health status.</li><li>• Identifies beliefs and attitudes held about Māori women and how these may impact on practice.</li><li>• Identifies the power held and its potential impact on the health experience and health outcomes of Māori women.</li></ul>
<b>Actions aimed to improve health status</b>	<ul style="list-style-type: none"><li>• Enquires in a manner that is respectful, clear, and direct.</li><li>• Determines the understanding the Māori woman has of why she is interacting with the health service.</li><li>• Determines essential support person(s) and/or advocate.</li><li>• Involves the Māori woman in the assessment, planning and decision making phases of her health experience.</li></ul>
<b>Integrating culture into clinical practice</b>	<ul style="list-style-type: none"><li>• Explains why information about (cultural) beliefs and practices is being collected.</li><li>• Determines the understanding the Māori woman has of health, wellness, ill-health and illness.</li><li>• Identifies cultural beliefs and practices that need to be observed while interacting with the health service.</li><li>• Incorporates beliefs and practices into the Māori woman's intervention plan.</li></ul>

The model is constructed in such a way that it could be presented as discrete units, such as *Mana Wāhine, The Way It Is*, or *Engaging with Health Services*, or as a whole

using the *weaving of health and wellbeing*. Learning can then be contextualised to the health status data, and applied to practice settings and interactions with Māori women. The effective preparation of health care providers contributes to their making a difference in the health status of Māori women. This model can also provide a platform for reflecting upon previous interactions with Māori women, and how such interactions could be managed differently.

## **Further Research Suggestions**

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There is a paucity of research that looks specifically at the health and wellbeing needs of Māori women. Thus, further research that adds to the knowledge base about Māori women's health and wellbeing must be beneficial. The research outlined in this thesis can be considered complete as the categories and codes have been saturated, however, further theoretical sampling would enable the development of a formal grounded theory. For example, the sample could also be widened to include Māori men, which would move this substantive grounded theory informed by a Māori centred approach to a formal theory about the health and wellbeing of Māori. Māori men come from a similar diversity of cultural identities and socio-economic circumstances as Māori women. While this research is limited in its generalisability as it is representative of the participant sample, the sample could be widened to reflect the diversity that exists amongst Māori women, particularly with regard to cultural identity and socio-economic determinants. The value of further theoretical sampling, such as that suggested, would enable the generation of inductive knowledge that emerges from the participant responses.

As a result of this research with Māori women, I would also recommend that further research could be conducted based on the following hypotheses that can be deductively tested:

1. A 'strengths' based model for working with Māori women is more likely to yield health-promoting behaviours and positive health outcomes.
2. The model, *Ngā Kairaranga Oranga – The Weavers of Health and Wellbeing*, developed in this thesis for working with Māori women is valid in different health settings.
3. Māori traditional healing approaches are reliable, safe and contribute to improved health outcomes.
4. Māori-based treatment and intervention options that are integrated with 'mainstream' treatment and intervention approaches can result in health gains.
5. The integration of Māori values, beliefs and practices with the dominant biomedical practices risk Māori values, beliefs and practices being integrated to the point that they are rendered invisible.
6. Health care providers, who have an analysis of the socio-economic determinants of the health status of Māori women, and an understanding of their interpretation of health and wellbeing and behaviours, are more likely to make a difference in their health outcomes.

In addition to further theoretical sampling and the deductive testing of the above hypotheses, evaluative research that directly relates to the implementation of the model *Ngā Kairaranga Oranga – The Weavers of Health and Wellbeing* could be undertaken in either practice or education. Such research would indicate whether the use of the model is making a difference in the delivery of health services to Māori women through (a) the preparation of health care providers, and (b) their actual practice with Māori women.

## **Conclusion – The Importance of the Weaving of Health and Wellbeing**

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Māori women, like other New Zealand citizens, have the right to optimal health and wellbeing. This right is a basic human right, and Article Three of the Treaty of Waitangi guarantees Māori protection and the same rights as other citizens. Yet, published health status information casts a shadow on how well this right has been realised. The indications are that Māori women generally experience less than optimal health and wellbeing when compared to non-Māori. Health is a complex concept that is socially constructed, and individually defined. It is located within a milieu of influences that include political and socio-economic determinants. Thus, variances exist in how health is defined by individuals and is strongly influenced by their worldviews. The variances that exist between the worldviews of Māori women and the ‘mainstream’ health services they interact with can prove to be problematic for Māori women, as found in those participating in this research.

Current health policy places Māori health as a priority (King, 2000) and *He Korowai Oranga* the Māori health strategy (King & Turia, 2002), identifies whānau ora as its overall aim. Improvement in the health status of Māori women and their health experiences will contribute to achieving the aim of whānau ora. The research in this thesis provides a shared interpretation and meaning that some Māori women have about their health and wellbeing, and their interactions with ‘mainstream’ health services and health care providers. It indicates areas that ‘mainstream’ health services and health care providers could address to improve their efficacy when working with Māori women. Productive interactions with Māori women contribute to a sense of trust in a health service and its health care providers that also ultimately contributes to improved health outcomes.

A grounded theory informed by a Māori centred approach, based on Māori centred principles and Glaserian grounded theory, was used to generate *Ngā Kairaranga Oranga – The Weavers of Health and Wellbeing*, through a process of constant comparative analysis and theoretical sampling, to saturate the categories, concepts and properties that emerged. A model was then developed that conceptualised the interpretations and meaning Māori women in this research have about their health and wellbeing, and interactions with ‘mainstream’ health services and health care providers.

*Ngā Kairaranga Oranga – The Weavers of Health and Wellbeing* is the model (Figure 10.1) that has been generated primarily from the data gathered from the Māori women, and supported by theoretical sampling. This model describes three core categories that integrate the multiple dimensions using the basic social psychological process of *weaving health and wellbeing*. The first core category, *Mana Wāhine*, describes what is important for Māori women’s health and wellbeing, and provides areas that could be explored by health care providers. *The Way It Is*, is the second core category that describes the challenges and barriers Māori women have to achieving positive health outcomes. These challenges and barriers originate from both the women themselves, and from the health services they interact with. *Engaging with Health Services* is the final core category that describes what Māori women need from their interactions with health services and health care providers. The process of *weaving health and wellbeing* explains how the core categories are complexly woven together in a way that is individual to each Māori woman – reflective of the diversity that exists among Māori women.

*Ngā Kairaranga Oranga – The Weavers of Health and Wellbeing*, can be applied within ‘mainstream’ health setting at a number of levels. That is, at the level of:

1. Māori women, particularly the trust they have in health services.
2. The individual health care provider, and the development of appropriate and effective practice.

3. The health service level with regard to their policies and procedures related to Māori women.
4. The macro health system level by supporting the government's health policy.

Specific areas discussed relate to (a) promoting trust in the health service, (b) maintaining the mana and integrity of Māori women, (c) facilitating access and use of health services, and (d) building upon existing strengths. *Ngā Kairaranga Oranga – The Weavers of Health and Wellbeing* provides a model to inform the practice of 'mainstream' health care providers, and provides a useful explanation for understanding the complexities of how Māori women weave their health and wellbeing. Likewise, this model can usefully inform the education and curricula for the preparation of health care providers.

Understanding how Māori women 'weave' their health and wellbeing can positively inform the practice of 'mainstream' health care providers. Having an insight into the complexity of Māori women's health and wellbeing must be beneficial to the health outcomes of Māori women, as the model developed provides a framework that can be used to better meet their health needs when they interact with 'mainstream' health services. *Ngā Kairaranga Oranga – The Weavers of Health and Wellbeing* provides a way for health care providers to instill trust in Māori women to optimise their interactions with 'mainstream' health services. The optimal 'weaving' of Māori women's health and wellbeing is vital to improving their health status and that of their whānau, hapū, iwi or community.

## APPENDICES

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- Appendix 1: Treaty of Waitangi
- Appendix 2: Participant Information Sheet
- Appendix 3: Consent Form

**APPENDIX 1**  
**Treaty of Waitangi**

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**Te Tiriti o Waitangi (Māori Version)**

<p>● Treaty of Waitangi: A Literal English Translation of the Maori Text ●</p> <p>Signed at Waitangi February 1840, and afterwards by about 500 chiefs.</p>			
<p>VICTORIA, the Queen of England, in her kind (gracious) thoughtfulness to the Chiefs and Hapus of New Zealand, and her desire to preserve to them their chieftainship and their land, and that peace and quietness may be kept with them, because a great number of the people of the tribe have settled in this country, and (more) will come, has thought it right to send a chief (an officer) as one who will make a statement to (negotiate with) Maori people of New Zealand. Let the Maori chiefs accept the governorship (KAWANTANGA) of the Queen over</p>		<p>all parts of this country and Islands. Now, the Queen desires to arrange the governorship lest evils should come to the Maori people and the Europeans who are living here without law. Now, the Queen has been pleased to send me, William Hobson, a Captain in the Royal Navy to be Governor for all places of New Zealand which are now given up or which shall be given up to the Queen. And she says to the Chiefs of the Confederation of the Hapus of New Zealand and the other chiefs, these are the laws spoken of.</p>	
<p><b>THIS IS THE FIRST</b></p> <p>The Chiefs of the Confederation, and all these chiefs who have not joined in that Confederation give up to the Queen of England for ever all the Governorship (KAWANATANGA) of their lands.</p>	<p><b>THIS IS THE SECOND</b></p> <p>The Queen of England agrees and consents (to give) to the Chiefs, hapus, and all the people of New Zealand the full chieftainship (rangatiratanga) of their lands, their villages and all their possessions (taonga: everything that is held precious) but the Chiefs give to the Queen the purchasing of those pieces of land which the owner is willing to sell, subject to the arranging of payment which will be agreed to by them and the purchaser who will be appointed by the Queen for the purpose of buying for her.</p>	<p><b>THIS IS THE THIRD</b></p> <p>This is the arrangement for the consent to the governorship of the Queen. The Queen will protect all the Maori people of New Zealand, and give them all the same rights as those of the people of England.</p> <p style="text-align: center;"><i>WILLIAM HOBSON, Consul and Lieutenant-Governor</i></p> <p>Now, we the Chiefs of the Confederation of the Hapus of New Zealand, here assembled at Waitangi, and we, the Chiefs of New Zealand, see the meaning of these words and accept them, and we agree to all of them. Here we put our names and our marks.</p>	<p><b>THE FOURTH ARTICLE</b></p> <p>Two churchmen, the Catholic Bishop, Pompallier and the Anglican Missionary William Colenso recorded a discussion on what we would call religious freedom and customary law. In answer to a direct question from Pompallier, Hobson agreed to the following statement. It was read to the meeting before any of the chiefs had signed the Treaty.</p> <p><i>E mea ana te Kawana ko nga whakapono katoa o Ingarani, o nga Weteriana, o Roma, me te ritenga Maori hoki e tiakina ngatahitia e ia.</i></p> <p>Translation:</p> <p>The Governor says that the several faiths (beliefs) of England, of the Wesleyans, of Rome, and also Maori custom shall alike be protected by him.</p>

(English Version)

<p>● Treaty of Waitangi: English Version ●</p> <p>Signed at Waitangi February 1840, and afterwards by about 500 chiefs.</p>			
<p><b>Preamble</b></p> <p>Her Majesty, Victoria, Queen of the United Kingdom of Great Britain and Ireland, regarding with her Royal Favour of the Native Chiefs and Tribes of New Zealand, and anxious to protect their just Rights and Property, and to secure to them the enjoyment of Peace and Good Order, has deemed it necessary, in consequence of the great number of Her Majesty's Subjects who have already settled in New Zealand, and the rapid extension of Emigration both from Europe and Australia which is still in progress, to constitute and appoint a functionary properly authorised to treat with the Aborigines of New Zealand for the recognition of Her Majesty's Sovereign authority over the whole or any part of</p>		<p>these islands. Her Majesty therefore being desirous to establish a settled form of Civil Government with a view to averting the evil consequences which must result from the absence of the necessary Laws and Institutions alike to the Native population and to Her Subjects has been graciously pleased to empower and authorise me William Hobson, a Captain in Her Majesty's Royal Navy, Consul, and Lieutenant-Governor of such parts of New Zealand as may be or hereafter shall be ceded to Her Majesty, to invite the confederated and independent Chiefs of New Zealand to concur in the following Articles and Conditions.</p>	
<p><b>ARTICLE THE FIRST</b></p> <p>The Chiefs of the Confederation of the United Tribes of New Zealand, and the separate and independent Chiefs who have not become members of the Confederation, cede to Her Majesty the Queen of England, absolutely and without reservation, all the rights and powers of Sovereignty which the said Confederation or Individual Chiefs respectively exercise or possess, or may be supposed to exercise or to possess over their respective Territories as the sole Sovereigns thereof.</p>	<p><b>ARTICLE THE SECOND</b></p> <p>Her Majesty the Queen of England confirms and guarantees to the Chiefs and Tribes of New Zealand and to the respective families and individuals thereof, the full exclusive and undisturbed possession of the Lands and Estates, Forests, Fisheries, and other properties which they may collectively or individually possess, so long as it is their wish and desire to maintain the same in their possession; but the Chiefs of the United Tribes and the Individual Chiefs yield to Her Majesty the exclusive right of Pre-emption over such lands as the proprietors thereof may be disposed to alienate, at such prices as may be agreed upon between the respective proprietors and persons appointed by Her Majesty to treat with them in that behalf.</p>	<p><b>ARTICLE THE THIRD</b></p> <p>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.</p> <p style="text-align: center;"><i>W. Hobson, Lieutenant-Governor</i></p>	<p>Now, thereof, We the Chiefs of the Confederation of the United Tribes of New Zealand being assembled in Congress at Victoria, in Waitangi and We the Separate and Independent Chiefs of New Zealand claiming authority over the Tribes and Territories which are specified after our respective names having been made fully to understand the Provision of the foregoing Treaty, accept and enter into the same in the full spirit and meaning thereof. In witness of which, we have attached our signatures or marks at the places and the dates respectively specified.</p> <p>Done at Waitangi, this sixth day of February in the year of Our Lord, one thousand eight hundred and forty.</p>

**APPENDIX 2**  
**Participant Information Sheet**

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**Māhere**

*Tena koe*

*Ko Tainui te waka, Ko Karioi te maunga, Ko Whaingaroa to moana, Ko tainui te iwi, Ko Ngati Tahinga te hapu, Ko Denise Wilson ahau.*

I pupū ake tēnei rangahau i ngā mea nui o te hauora me ngā manatu hauora mai i te kawanatanga, kaore mai i a koutou, ngā wāhine, ngā tāngata whenua.

Kei te purangi au ki te mōhio he aha te mea tuatahi mo te hauora me te manatū hauora. Me tumanako ka taea tēnei rangahau e koutou, e au hoki hei whakapai ake i ngā kaupapa here e whiwhi ana ngā Māori. Kei te tautuara mai Te Mana Hauora o Te Arawa, Lakeland Health (Te Whakaruruhau), Bay of Plenty Ethics Committee, me te Massey University Ethics Committee.

He ākonga paetahi au kei te School of Health Sciences kei te Wānanga o Massey ki Albany, anā, kei te whakamahia e au tēnei tuhunga roa hei whakaoti i tōku PhD. He nēhi ahau kua rehitatia, kua mahi āhau I te Mātauranga me te Hauora I roto i te rohe o BOP/Waiariki. I tēnei wā he nēhi Whakawhiti Whakaaro au. Ko te mea nui ki au ko te whakapiki haere i te ratonga i ngā Māori i roto i ngā whakatātūtanga i roto i ngā Manatu Hauora.

Ka ahei koe ki te

- Whakawhiwhia ki tēnei pūrongo me ngā kōrero i iwhakamitia ma tō rōpū
- Ki te kore e whakautu i ētahi uiui ki te kore ranei, e whāki i ētahi kōrero
- Makere atu i ngā uiui kia oti rawa
- Homai kōrero i runga i te mohiotanga ka noho muna tōu ingoa ki au te kairangahau. Kaore hoki e puta tōu ingoa, ngā ingoa o ētahi atu mai i tēnei pūrongo.

Mehemea kā whakaae koe, ka tonoa koe ki te

- Kōrero i oū ake whakaaro mo te mantu hauora me ngā mea nui. 11/2 ki te 2 haora te roa.
- Hopu kōrero, ki te tuhi ranei hei whakaatu i pono.
- Tuhituhi au puta i te hui. Ka whakahokia ēnei tuhituhinga ki a koe/to rōpu ranei.
- Ki te wherawhera ōku kaiwhakahaere i ngā mahi mātua. Ko ēnei tāngata noa ka kite i o mahi mātua.
- Uiui anō ki te whakapūmau i ēnei.
- Ki te rangahau nei hei whakaputa, he kōrerorero in hui.

Me mātua whakaetia ngā Kaumatua tautuara. Ko ngā kaiwhakahaere o tēnei rangahau.

Dr Gillian White, RM, MTD, BEd, MA (Hons),  
DipSocSc (Psych), PhD.  
English & Scottish Ancestry  
Senior Lecturer  
School of Health Sciences  
Massey University, Wellington  
Phone: 04-801.2796 ext. 6753

Dr Barry White  
Te Rarawa, Ngati Kahu  
8 Barron Crescent  
Rotorua  
Phone: 07-349.0414 or 025-487.434

Tōku wāhi mahi Nursing Council of New Zealand, Wellington  
Waea: 04-802.0230 or 025.243.3059

Mehemea kaore au i te wātea, waiho mai tōu ingoa me to nama waea, māku e whakahoki atu.

## Information Sheet-

*Tena koe*

*Ko Tainui te waka, Ko Karioi te maunga, Ko Whaingaroa to moana, Ko Tainui te iwi, Ko Ngati Tahinga te hapu, Ko Denise Wilson ahau.*

This research has arisen out of a concern that the health priorities and the health services are developed from a government level with little input from women, such as you, at the 'grassroots level'. I am interested in what you see are priorities for health and health services and hope that this information can be used by yourselves and by me to improve policy decision-making and services delivered to Maori. This research has gained the support of Te Mana Hauora O Te Arawa, Lakeland Health (Te Whakaruruhau) the Bay of Plenty Ethics Committee and the Massey University Human Ethics Committee.

I will be doing this research as a graduate student of the School of Health Sciences at Massey University, Albany and intend to use this study to write a thesis to complete a Doctor of Philosophy degree (or PhD). I am a registered nurse and have worked in both education and clinical practice within the Bay of Plenty/Wairariki region. I am currently employed at Lakeland Health as a Nurse Consultant, where I have a particular interest in improving the services delivered to Maori within mainstream health organisations.

### **If you take part in this study, you have the right to:**

- Receive a copy of the final research report and the information collected for your group.
- Refuse to answer any particular question(s), and/or make known any information you do not wish to.
- Withdraw from the study until such time as the interviews have been analysed, without any effect.
- Provide information on the understanding that your identity will remain confidential to me as the researcher. It will not be possible to identify you or any participants in any reports prepared from this study.

### **If you consent to participate, you will be asked to:**

- Participate in a *hui*, lasting 1 ½ to 2 hours, where you will be invited to discuss your views on health priorities and health services.
- Agree to the interview being tape recorded which will be used to confirm interpretations of the interview and notes taken.
- Agree to my taking notes throughout the hui. These notes will be returned to you or your group.
- Agree to the supervisors of my research seeing the original information collected during this study. These will be the only persons who will have access to any of the original information.
- Agree to a follow-up interview, to confirm or clarify any details of the research findings.
- Agree to the use of the research findings for the purposes of publication and/or presentation at conferences.

**The Kaumatua Support for the study is to be confirmed.**

#### **The supervisors of this study are:**

Dr Gillian White, RM, MTD, BEd, MA (Hons),  
DipSocSc (Psych), PhD.  
English & Scottish Ancestry  
Senior Lecturer  
School of Health Sciences  
Massey University, Wellington  
Phone: 04-801.2796 ext. 6753

Dr Barry White  
Te Rarawa, Ngati Kahu  
8 Barron Crescent  
Rotorua  
Phone: 07-349.0414 or 025-487.434

**I can be contacted at:** the Nursing Council of New Zealand on Phone: 04-802.0230 or 025-243.3059 If I am unavailable please leave your name and phone number and I will return your call when I am available.

**APPENDIX 3**  
**Consent Form**

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## Puka Whakaae

Kua whakamāramatia mai, ā, kua panui au i tēnei pepa. Kua whakautua paingia mai aku patai, kei te mārāma hoki ka taea e au te patai ahakoa he aha te wā.

Kei te mārāma ka taea e au te puta mai i tēnei pūrongo ahakoa, kia aromatawaitia ēnei uiui, me te kore hoki e whakautu i ētahi patai.

Kei te whakaae au kia whakamahia he ripine hopu kōrero, ā kia tuhia.

Kei te whakaae ahau ki te hoatu kōreor ki te kairangahau mehemea kaore i te tāngia tōku ingoa mehemea kaore au e rata. Mo tēnei rangahau noa ēnei tuinga i ahu mai.

Kei te whakaae au ki ngā whakaritenga o tēnei pepa, e ai ki te māhere.

- Whakaae a te Kaumātua
- Whakaae-a-waha
- Whakaae-a-tuhi

Waitahu: \_\_\_\_\_

Ingoa: \_\_\_\_\_

Ra: \_\_\_\_\_

## Consent Form

I have had the details of the study explained to me and have read the Information Sheet. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I understand I have the right to withdraw from the study at any time, until such time as the interviews are analysed, and to decline to answer any particular questions.

I agree to the hui/interview being audio-taped and notes taken.

I agree to provide information to the researcher on the understanding that my name will not be used without my permission. The information will be used only for this research and publications arising from this research project.

I agree to participate in this study under the conditions set out in the Information Sheet.

- Kaumatua Consent
- Verbal Consent
- Written consent

Signed: \_\_\_\_\_

Name: \_\_\_\_\_

Date: \_\_\_\_\_

## References

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- Acer, F. (2002, September). *Some reflections on women's human rights in the 21<sup>st</sup> century*. Paper presented at a Public Forum, Auckland, NZ.
- Ahern, K. J. (1999). Pearls, pith and provocation: Ten tips for reflexive bracketing. *Qualitative Health Research*, 9, 407-411.
- Ajwani, S., Blakely, T., Robson, B., Tobias, M., & Bonne, M. (2003). *Decades of disparity: Ethnic mortality trends in New Zealand 1980-1999*. Wellington, NZ: Ministry of Health and University of Otago.
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4<sup>th</sup> ed.). Washington DC: American Psychiatric Association.
- Annells, M. (1996). Grounded theory method: Philosophical perspectives, paradigms of inquiry and postmodernism. *Qualitative Health Research*, 6, 379-393.
- Annells, M. (1997). Grounded theory method, part I: Within the five moments of qualitative research. *Nursing Inquiry*, 4 (2), 120-129.
- Aroturuki me te Arotakenga (Monitoring & Evaluation Branch). (1997). *Review of the Ministry of Health: Service delivery to Maori*. Wellington, NZ: Te Puni Kokiri Ministry of Maori Development.
- Ashton, T. (1999). The health reforms: To market and back? In J. Boston, P. Dalziel & S. St John (Eds.), *Redesigning the welfare state in New Zealand: Problems, policies, prospects* (pp. 134-153). Auckland, NZ: Oxford University Press.

- Author unknown. (2002). Women's response to stress. *Harvard Women's Health Watch*, 9 (9), 6.
- Babchuk, N. A. (1997, October). *Glaser or Strauss? Grounded theory and adult education*. Paper presented at the 1996 Midwest Research-to-Practice Conference in Adult Continuing and Community Education. Retrieved July 26, 2004, from <http://www.canr.msu.edu/aee/research/gradpr96.htm>
- Baker, C., Wuest, J., & Stern, P. N. (1992). Method slurring: The grounded theory/phenomenology example. *Journal of Advanced Nursing*, 17, 1355-1360.
- Ballara, A. (1998). *Iwi: The dynamics of Māori tribal organisation from c. 1769 to c. 1945*. Wellington, NZ: Victoria University Press.
- Barlow, C. (1991). Whakapapa. Source unknown.
- Barnett, R. & Barnett, P. (2004). Primary health care in New Zealand: Problems and policy approaches. *Social Policy Journal of New Zealand*, 21, 49-66.
- Beanland, C., Schneider, Z., LoBiondo-Wood, G., & Haber, J. (1999). *Nursing research: Methods, critical appraisal and utilisation* (1<sup>st</sup> Aust. ed.). Sydney: Mosby.
- Becker, P. H. (1993). Common pitfalls in published grounded theory research. *Qualitative Health Research*, 3 (2), 254-260.
- Bell, A. (1999). Authenticity and the project of settler identity in New Zealand. *Social Analysis*, 43 (3), 122-143.
- Bennet, P., Norman, P., Moore, L., Murphy, S., & Tudor-Smith, C. (2002). Health locus of control and value for health in smokers and nonsmokers. *Health Psychology*, 16 (2), 179-182.

- Benoiel, J. Q. (1996). Grounded theory and nursing knowledge, *Qualitative Health Research*, 6 (3), 406-428.
- Benzies, K. M. & Allen, M. N. (2001). Symbolic interactionism as a theoretical perspective for multiple method research. *Journal of Advanced Nursing*, 33 (4), 541-547.
- Berger, J. (1987). *Reports from the frontier: The state of the worlds indigenous peoples*. Cambridge, UK: Cultural Survival Inc.
- Bird, L. & Drewery, W. (2000). *Human development in Aotearoa: A journey through life*. Auckland, NZ: McGraw-Hill.
- Bishop, R. (1994). Initiating empowering research. *New Zealand Journal of Educational Studies*, 29 (1), 175-188.
- Bishop, R. (1996). *Whakawhanaungatanga: Collaborative research stories*. Palmerston North, NZ: Dunmore Press.
- Bishop, R. & Glynn, T. (1992). He kanohi kitea: Conducting and evaluating educational research. *New Zealand Journal of Educational Studies*, 27 (2), 125-135.
- Blakely, T. & Pearce, N. (2002). Socio-economic position is more than just NZDep. *New Zealand Medical Journal*, 115, 109-111.
- Blakely, T. & Robson, B. (2003, 1 August). Gaps – who's to blame? *Dominion Post*.
- Blakely, T., Robson, B. & Woodward, A. (2002). Measuring Māori health status accurately – more needs doing. *New Zealand Medical Journal*, 115, 149-150.
- Blumer, H. (1969). *Symbolic interactionism: Perspective and method*. Englewood Cliffs, NJ: Prentice-Hall.

- Bophal, R. (2001). Racism in medicine. *British Medical Journal*, 322, 1503-1504.
- Bowers, B. (1988). Grounded theory. In B. Sater (Ed.), *Paths to knowledge: Innovative research methods for nursing* (pp. 33-59). New York: National League for Nursing.
- Bramley, D., Riddell, T., Crengle, S., Curtis, A., Harwood, M., Nehua, D., et al. (2004). A call to action on Māori cardiovascular health [Electronic version]. *New Zealand Medical Journal*, 117, 957-963.
- Broughton, J. & Lawrence, M. (1993). *Ngā wahine Māori me te kai paipa: Māori women and smoking*. Dunedin, NZ: Department of Preventive & Social Medicine.
- Brown, C. (1999). Ethics, policy and practice: Interview with Emily Friedman. *IMAGE: Journal of Nursing Scholarship*, 31 (3), 259-262.
- Browne, A. J. & Fiske, J. (2001). First Nations women's encounters with mainstream health care services. *Western Journal of Nursing Research*, 23 (2), 126-147.
- Burns, N. & Grove, S. K. (1993). *The practice of nursing research: Conduct, critique & utilization* (2<sup>nd</sup> ed.). Philadelphia: W. B. Saunders.
- Carlson, N. R., Buskit, N. & Martin, G. N. (1997). *Psychology: The science of behaviour*. Harlow, UK: Allyn & Bacon.
- Cartwright, S. (1988). *The report of the cervical cancer inquiry 1988*. Auckland, NZ: Committee of Inquiry into Allegations Concerning the Treatment of Cervical Cancer at National Women's Hospital and into Other Related Matters.
- Charon, J. M. (1998). *Symbolic interactionism: An introduction, an interpretation, an integration* (6<sup>th</sup> ed.). Upper Saddle River, NJ: Prentice-Hall.

- Chenitz, W. C. & Swanson, J. M. (1986). Qualitative research using grounded theory. In W. C. Chenitz & J. M. Swanson (Eds.), *From practice to grounded theory: Qualitative research in nursing* (pp. 3-15). Menlo Park, CA: Addison-Wesley.
- Chiovitti, R. F. & Piran, N. (2003). Rigour and grounded theory research. *Journal of Advanced Nursing*, 44, 427-435.
- Christensen, J. (1990). *Nursing partnership: A model for nursing practice*. Wellington, NZ: Daphne Brassell Associates.
- Colorado, P. (1996). Indigenous science: Dr Pamela Colorado talks to Jane Carroll. *Revision: A Journal of Consciousness and Transformation*, 18 (3), 6-10.
- Coney, S. (1988). *The unfortunate experiment*. Auckland, NZ: Penguin.
- Cooney, C. & Smith, M. (2003, August). *Nursing influencing the DHB environment: Approaches to reduce inequalities and achieve population health gain*. Paper presented at the College of Nurses Aotearoa (NZ) Annual Conference – Absolutely Positively Nursing, Wellington, NZ.
- Cooper, N., Estes, C. A., & Allen, L. (2004). Bouncing back. *Parks & Recreation*, April, 28-35.
- Corbin, J. & Strauss, A. (1990). Grounded theory research: Procedures, canons, and evaluative criteria. *Qualitative Sociology*, 13 (1), 3-21.
- Corbin, J. & Strauss, A. (1996). Analytic ordering for theoretical purposes. *Qualitative Inquiry*, 2 (2), 139-150.
- Coyle J. (1999). Understanding dissatisfied users: Developing a framework for comprehending criticisms of health care work. *Journal of Advanced Nursing*, 30 (3), 723-731.

- CPAC Consortium (2002). *Evaluation of clinical priority assessment criteria programme: Variation in surgical uptake by area, socio-economic status and ethnicity 1995 and 1999/2000*. Wellington, NZ: Victoria University of Wellington.
- Crampton, P. & Davis, P. (1998). Measuring deprivation and socioeconomic status: Why and how? *The New Zealand Public Health Report*, 5 (11/12), 81-84.
- Creech, W. (1999). *The government's medium-term strategy for health and disability support services 1999*. Wellington, NZ: Parliament Buildings.
- Creech, W., & English, B. (1999). *1999 Statement of owner's expectations of hospital health services*. Wellington, NZ: Parliament Buildings.
- Crooks, D. L. (2001). The importance of symbolic interaction in grounded theory research on women's health. *Health Care for Women International*, 22, 11-27.
- Crampton, P., Salmond, S., & Kirkpatrick, R. (2000). *Degrees of deprivation on New Zealand: An atlas of socio-economic difference*. Auckland, NZ: Bateman.
- Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process*. London: Sage Publications.
- Cunningham, C. (1998). A framework for addressing Maori knowledge in research, science and technology. In Te Pumanawa Hauora (Ed.), *Proceedings of the Te Oru Rangahau Maori Research and Development Conference, 7-9 July 1998* (pp.257-263). Palmerston North, NZ: Massey University.
- Cunningham, C. (2000). A framework for addressing Māori knowledge in research, science and technology. *Pacific Health Dialog*, 7 (1), 62-69.
- Cunningham, C. & Durie, M. (1999). *Te rerenga hauora*. In P. Davis & K. Dew (Eds.), *Health and society in Aotearoa New Zealand* (pp. 235-254). Auckland, NZ: Oxford University Press.

- Cunningham, C. & Kiro, C. (2001). *Rapuhia mā te hauoroa Māori*. In P. Davis & T. Ashton (Eds.), *Health and public policy in New Zealand* (pp. 62-81). Auckland, NZ: Oxford University Press.
- Curry, L. (1995). *Women's health research in New Zealand 1976-1986: A bibliography*. Wellington, NZ: Health Services Research & Development Unit.
- Deloria, V. Jr. (1995). *Red earth, white lies: Native Americans and the myths of scientific fact*. New York: Scribner.
- Denzin, N. K. (1992). *Symbolic interactionism and cultural studies*. Oxford, UK: Blackwell.
- Department of Health. (1993). *Whāia te ora mo te iwi: Māori health policy objectives of Regional Health Authorities and the Public Health Commission*. Wellington, NZ: Dept of Health.
- Deveson, A. (2003). *Resilience*. Crows Nest, NSW: Allen & Unwin.
- Dickson, G. (2000). Aboriginal grandmother's experience with health professionals and action research. *Qualitative Health Research*, 10 (2), 88-214.
- Dickison, M. (1994). Māori science? Can traditional Māori knowledge be considered scientific? *NZ Science*, 6-7.
- Dow, D. A. (1999). *Māori health and government policy 1840-1940*. Wellington, NZ: Victoria University Press.
- Durie, A. (1992). *Whaia te ara tika: Research methodologies and Maori*. Abridged version of paper presented to seminar on Maori Research, Massey University, Palmerston North, NZ.

- Durie, A. (1998c). Me tipu ake te pono: Maori research, ethicality and development. In Te Pumanawa Hauora (Ed.), *Proceedings of the Te Oru Rangahau Maori Research and Development Conference, 7-9 July 1998* (pp.257-263). Palmerston North, NZ: Massey University.
- Durie, E. T. (1998d). Ethics and values in Maori research. In Te Pumanawa Hauora (Ed.), *Proceedings of the Te Oru Rangahau Maori Research and Development Conference, 7-9 July 1998* (pp.62-69). Palmerston North, NZ: Massey University.
- Durie, M. (1998a). *Whaiora: Maori health development* (2<sup>nd</sup> ed.). Auckland, NZ: Oxford University Press.
- Durie, M. (2001a). *Mauri ora: The dynamics of Māori health*. Auckland, NZ: Oxford University Press.
- Durie, M. (2001b, November). *Cultural competence and medical practice in New Zealand*. Paper presented to the Australian and New Zealand Boards and Council Conference, Wellington, New Zealand.
- Durie, M. (2004, February). *Public sector reform, indigeneity, and the goals of Māori development*. Paper presented at the Commonwealth Advanced Seminar, Wellington, NZ.
- Durie, M. H. (1995). *Nga Matatini Maori: Diverse Maori realities*. Unpublished paper presented at Wananga Purongo Korororero, Turangawaewae Marae, Ngaruawahia, NZ.
- Durie, M. H. (1996). *Maori science and Maori development*. Paper presented to the Faculty of Science, Massey University, Palmerston North, NZ.

- Durie, M. H. (1997). Identity, access and Maori advancement. In *The Indigenous Future: Edited proceedings of the New Zealand Educational Administration Society Research Conference* (pp. 1-15). Auckland Institute of Technology, Auckland, NZ.
- Durie, M. H. (1998b). Te Oru Rangahau – concluding remarks. In Te Pumanawa Hauora (Ed.), *Proceedings of the Te Oru Rangahau Maori Research and Development Conference, 7-9 July 1998* (pp.257-263). Palmerston North, NZ: Massey University.
- Durie, M. H., Allan, G. R., Cunningham, C. W., Edwards, W., Forster, M. E., Gillies, et al. (1997). *Oranga Kaumatua: The health and wellbeing of older Maori people*. Wellington, NZ: Ministry of Maori Development.
- Editor. (2002, March 30). Māori numbers ‘inflated’. *The Dominion*.
- Editor. (2003, July 16). Hard habits that have to be changed. *The Dominion Post*.
- Eliason, M. J. (1999). Nursing’s role in racism and African American women’s health. *Health Care for Women International, 20*, 209-219.
- Evangelista, L. S. (1999). Compliance: A concept analysis. *Nursing Forum, 34* (1), 5-11.
- Figes, E. (1986). *Patriarchal attitudes: Women in society*. New York: Persea Books.
- Foucault, M. (1972). *The archeology of knowledge* (A. M. Sheridan Smith Trans.). London: Travistock Publications. (Original work published 1969)
- Giddings, L. S. & Wood, P. J. (2000). The methodological journey of a grounded theorist: An interview with Denise Dignam. *Nursing Praxis in New Zealand, 16* (2), 4-16.
- Glaser, B. G. (1978). *Theoretical sensitivity*. Mill Valley, CA: Sociology Press.

- Glaser, B. G. (1992). *Emergence vs forcing: Basics of grounded theory analysis*. Mill Valley, CA: Sociology Press.
- Glaser, B. G. (Ed). (1995). *Grounded theory 1984-1994 volume one*. Mill Valley, CA: Sociology Press.
- Glaser, B. G. (1998). *Doing grounded theory: Issues and discussions*. Mill Valley, CA: Sociology Press.
- Glaser, B. G. (1999). The future of grounded theory. *Qualitative Health Research*, 9, 836-845.
- Glaser, B. G. (2001, December). Grounded theory and gender relevance. *The Grounded Theory Review – An International Journal*, 3, 2-11. Retrieved July 26, 2004, from <http://www.groundedtheory.com/>
- Glaser, B. G. (2002). *The grounded theory perspective: Conceptualization contrasted with description*. Mill Valley, CA: Sociology Press.
- Glaser, B. G. & Kaplan, W. D. (Eds.). (1996). *Gerund grounded theory: The basic social process dissertation*. Mill Valley, CA: Sociology Press.
- Glaser, B. G. & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. New York: Aldine Publishing.
- Glover, M. (1997, December). *Kaupapa Maori health research: A developing discipline*. A paper presented to Hui Whakatipu, Otara, University of Auckland, Auckland, NZ.
- Gray, A. (1994). *Intervention programmes for domestic violence abusers: A literature review*. Wellington, NZ: FVPPC, Dept of Social Welfare.

- Grigg, M. & Macrae, B. (2000). *Whakapakari number 4: Tikanga oranga hauora*. Wellington, NZ: Te Puni Kokiri Ministry of Māori Development.
- Gulzar, L. (1998). Access to health care. *Image: Journal of Nursing Scholarship*, 3 (1), 13-19.
- Guttuso, S. (2003). Becoming a wise old woman: Resilience and wellness in later life. *Health Sociology Review*, 12, 171-177.
- Hadjistavropoulos, H. D., Craig, K. D., & Hadjistavropoulos, T. (1998). Cognitive and behavioral responses to illness information: The role of health anxiety. *Behaviour Research and Therapy*, 36, 149-164.
- Hand, D. (1998). Indigenous health in New Zealand: 'By Māori for Māori'. *Australian Nursing Journal*, 5 (10), 18-20.
- Hayes-Bautista, D.E. (1996). Becoming Chicano: A dissimilation theory of transformation of ethnic identity. In B.G. Glaser & W.D. Kaplan (Eds.), *Gerund grounded theory: The basic social process dissertation* (pp.1-3). Mill Valley, CA: Sociology Press.
- Health & Disability Analysis Unit. (1996). *Part II: The health status of young people*. Hamilton, NZ: Midland Health.
- Health & Disability Analysis Unit. (1997). *Family health services in the Midland Health region*. Hamilton, NZ: Midland Health.
- Health & Disability Commissioner. (n.d.). *Code of health and disability services consumers' rights*. Auckland, NZ: Health & Disability Commissioner's Office.
- Health Funding Authority. (1998a). *The next five years in general practice*. Auckland, NZ: Health Funding Authority.

- Health Funding Authority. (1998b, June). *Health Funding Authority Maori health policy full version*. Health Funding Authority.
- Health Funding Authority. (1998c). *Prioritising health and disability support services: An overview of the HFA prioritisation process*. Health Funding Authority.
- Health Reforms 2001 Research Team. (2003). *Interim report on health reforms 2001 research project*. Wellington, NZ: HSRC Victoria University of Wellington.
- Health Research Council of New Zealand (HRC). (1998). *Guidelines for researchers on health research involving Maori*. Auckland, NZ: HRC.
- Health Workforce Advisory Committee (HWAC). (2003). *The New Zealand health workforce: Framing future directions discussion document*. Wellington: HWAC.
- Hemara, W. (2000). *Māori pedagogies: A view from the literature*. Wellington, NZ: New Zealand Council for Educational Research.
- Henare, M. (1988). Standards and foundations of Maori society. In *Ngā Tikanga me Nga Ritenga O Te Ao Maori, Vol. 3 Part One. Royal Commission on Social Policy*. Wellington, NZ: Royal Commission on Social Policy.
- Henare, M. (1999). Sustainable social policy. In J. Boston, P. Dalziel & S. St John (Eds.), *Redesigning the welfare state in New Zealand: Problems, policies, prospects* (pp. 39-59). Auckland, NZ: Oxford University Press.
- Himona, R. N. (2001). *Raranga – the art of weaving*. Retrieved July 26, 2004, from <http://maaori.com/misc.raranga.htm>
- Hokowhitu, B. (2004). Te tāminga o te mātauranga Māori – colonisation in education. In T. M. Ka'ai, J. C. Moorfield, M. P. J. Reilly, & S. Mosley (Eds), *Ki te whaiiao: An introduction to Māori culture and society* (pp. 190-200). Auckland, NZ: Pearson Longman.

- Holmes, T. H. & Rahe, R. H. (1967). The social readjustment rating scale. *Journal of Psychosomatic Research*, 11, 213-218.
- Howden-Chapman, P. & Cram, F. (1998). *Social, economic and cultural determinants of health: A paper prepared for the National Health Committee March 1998*. Wellington, NZ: National Health Committee.
- Hunn, J. K. (1961). *Report on Department of Māori Affairs: With statistical supplement*. Wellington, NZ: Govt. Printers.
- Ihimaera, W. (Ed.). (1998). *Growing up Māori*. Auckland, NZ: Tandem Press.
- Irwin, K. (1994). Māori research and processes: An exploration. *Sites*, 28, 25-43.
- Jackson, M. (2003). The part-Māori syndrome. *Mana*, 52, 62.
- Jackson, D., Brady, W., & Stein, I. (1999). Toward (re)conciliation: (re)constructing relationships between indigenous health workers and nurses. *Journal of Advanced Nursing*, 29 (1), 97-103.
- Jahnke, H. (1997). Maori women and education: Historical and contemporary perspectives. In P. Te Whaiti, M. McCarthy & A. Durie (Eds.). *Mai i Rangiatea: Maori well-being and development* (pp.96-112). Auckland, NZ: Auckland University Press/Bridget Williams Books.
- Jones, C. (2000a). Levels of racism: A theoretic framework and a gardener's tale. *American Journal of Public Health*, 90, 1212-1215.
- Jones, C. (2001). Cultivating cultural harmony. *Kai Tiaki Nursing New Zealand*, 7(1), 10-13.

- Jones, R. (2000b). Diagnosis in traditional Māori healing: A contemporary urban clinic. *Pacific Health Dialog*, 7 (1), 17-24.
- Karlson, S. & Nazroo, J. (2002). Relation between racial discrimination, social class and health among ethnic minority groups. *American Journal of Public Health*, 92, 624-631.
- Katzer, J., Cook, K.H., Crouch, W. W. (1982). *Evaluating information: A guide to users of social science research* (2<sup>nd</sup> ed.). New York: Random House.
- Keddy, B., Sims, S. L., & Stern, P. N. (1996). Grounded theory as feminist research methodology. *Journal of Advanced Nursing*, 23, 448-453.
- Kilgour, R. (1990). *Hauora Maori literature review*. Wellington, NZ: Dept of Health.
- King, A. (2000). *The New Zealand health strategy*. Wellington, NZ: Ministry of Health.
- King, A. (2001). *The primary health care strategy*. Wellington, NZ: Ministry of Health.
- King, A. (2002). *He korowai oranga Māori health strategy: Discussion document*. Wellington, NZ: Ministry of Health.
- King, M. (2003). *The Penguin history of New Zealand*. Auckland, NZ: Penguin Books.
- King, A. & Turia, T. (2002). *He korowai oranga: Māori health strategy*. Wellington, NZ: Ministry of Health.
- Kirchheimer, S. (2003). Racism should be a public health issue [Electronic version]. *British Medical Journal*, 326, 65-66.
- Knight, K. H. & Eleenbein, M. H. (1996). Relationship of death anxiety/fear to health seeking beliefs and behaviours. *Death Studies*, 20, 23-31.

- Kramer, J. (1996). Indigenous science. *Revision: A Journal of Consciousness & Transformation*, 18, 2-5.
- Laws, M. (2003, 13 July). The real reason Māori don't live as long. *Sunday Star Times*.
- Lovegrove, M. N. (1972). What history tells us about the abilities of the Maori. *Australian and NZ History of Education Society Journal*, 1 (2), 21-31.
- McCarthy, M. (1997). Raising a Māori child under a new right state. In P. Te Whāiti, M. McCarthy & A. Durie (Eds.), *Mai I rangiātea: Māori wellbeing and development* (pp. 25-38). Auckland, NZ: Auckland University Press/Bridget Williams Books.
- MacDonald, M. (2001). Finding a critical perspective in grounded theory. In R. S. Schreiber & P. N. Stern (Eds.), *Using grounded theory in nursing* (pp. 113-157). New York, NY: Springer Publishing Company.
- Macfarlane, A. H. (2000). The value of Māori ecologies in the study of human development. In L. Bird & W. Drewery, *Human development in Aotearoa: A journey through life* (pp. 46-51). Auckland, NZ: McGraw-Hill.
- Mackay, R. (2003). Family resilience and good child outcomes: An overview of the research literature [Electronic version]. *Social Policy Journal of New Zealand*, 20, 98-118.
- McClelland, D. C. (1989). Motivational factors in health and disease. *American Psychologist*, 44, 675-683.
- McKenzie, K. (2003). Racism and health: Antiracism is an important health issue [Electronic version]. *British Medical Journal*, 326, 65-55.

- Malcolm, L. (1996). Inequalities in access to and utilisation of primary medical care services for Māori and low income New Zealanders. *New Zealand Medical Journal*, 109, 356-358.
- Māori Health Commission. (1998). *Tihei Mauri Ora!* Wellington, NZ: The Maori Health Commission.
- Māori Health Group. (1999). *Demographic profile of population in Bay of Plenty locality*. Auckland, NZ: Health Funding Authority.
- Marsden, M. (1992). God, men and universe: A Māori view. In M. King (Ed.), *Te ao hurihuri: The world moves on: Aspects of Māoritanga* (pp. 117-137). Auckland, NZ: Reed.
- Mead, G. H. (1934). *Mind, self and society*. Chicago: University of Chicago Press.
- Mikaere, A. (1994). Māori women: Caught in the contradictions of a colonised reality. *Waikato Law Review*, 2, 125-149.
- Meleis, A. (1991). *Theoretical nursing: Development & progress* (2<sup>nd</sup> ed.). Philadelphia: J.B. Lippincott Company.
- Ministry of Health. (1995). *He taura tieke: Measuring health service effectiveness for Māori*. Wellington, NZ: Ministry of Health.
- Ministry of Health (2000). *Social inequalities in health: New Zealand 1999*. Wellington, NZ: Ministry of Health.
- Ministry of Health. (2001a). *Monitoring ethnic inequalities in health*. Wellington, NZ: Ministry of Health.

- Ministry of Health. (2001b). *Priorities for Māori and Pacific health: Evidence from epidemiology (Public Health Intelligence Occasional Bulletin No. 3)*. Wellington, NZ: Ministry of Health.
- Ministry of Health. (2001c). *Life expectancy and small area deprivation in New Zealand*. Wellington, NZ: Ministry of Health.
- Ministry of Health. (2002a). *Te Puāwaitanga Māori mental health national strategic framework*. Wellington, NZ: Ministry of Health.
- Ministry of Health. (2002b). *Reducing inequalities in health*. Wellington, NZ: Ministry of Health.
- Ministry of Health. (2002c). *Whakatātaka: Māori health action plan 2002-2005*. Wellington, NZ: Ministry of Health.
- Ministry of Health. (2003). *New Zealand health and disability sector: Overview*. Wellington, NZ: Ministry of Health.
- Ministry of Justice. (2001). *He hinātore ki te ao Māori: A glimpse into the Māori world*. Wellington, NZ: Ministry of Justice.
- Ministry of Maori Development (with the Ministry of Women's Affairs). (1999). *Maori women in focus: "Titiro hangai, ka marama"*. Wellington, NZ: Te Puni Kokiri & Ministry of Women's Affairs.
- Ministry of Women's Affairs. (2001). *Māori women: Mapping inequalities and pointing ways forward*. Wellington, NZ: Ministry of Women's Affairs.
- Mohanram, R. (1999). *Black body: Women, colonialism and space*. St Leonards, NSW: Allen & Unwin.

- Moir, M. (1994). *Mataahua wāhine: Images of Māori women*. Auckland, NZ: Tandem Press.
- Moon, P. (2003). *Tohunga: Hohepa Kereopa*. Auckland, NZ: David Ling Publishing.
- Moreton-Robinson, A. (2000). *Talking up to the white women: Indigenous women and feminism*. St Lucia, QLD; University of Queensland Press.
- Morris, M. W. & Peng, K. P. (1994). Culture and cause: American and Chinese attribution for social and physical events. *Journal of Personality and Social Psychology*, 67, 949-971.
- Morse, J. M. (1991). Strategies for sampling. In J. M. Morse (Ed.), *Qualitative nursing research: A contemporary dialogue* (pp. 1127-145). Newbury Park, CA: Sage.
- Murchie, E. (1984). *Rapuora health and Maori women*. Wellington, NZ: The Maori Women's Welfare League.
- Myer, D. G. (1993). *Social psychology* (4<sup>th</sup> ed.). New York: McGraw-Hill.
- National Health Committee. (1997). *The best of health 3: Are we doing the right things and are we doing those things right?* Wellington, NZ: National Advisory Committee on Health and Disability.
- National Health Committee. (1998). *The social, cultural and economic determinants of health in New Zealand: Action to improve health*. Wellington, NZ: National Advisory Committee on Health and Disability.
- National Health Committee. (2000). *Improving health for New Zealanders by investing in primary health care: Committee report*. Wellington, NZ: National Health Committee.
- Noone, J. (2002). Concept analysis of decision making. *Nursing Forum*, 37 (3), 21-32.

- North Health. (1996). *Hauora Wahine Maori: A discussion document on Maori women's health*. Auckland, NZ: North Health.
- Northouse, P. G. & Northouse, L. L. (1985). *Health communication: A handbook for health professionals*. Englewood Cliffs, NJ; Prentice-Hall.
- Nursing Council of New Zealand. (2002). *Guidelines for cultural safety, the Treaty of Waitangi and Māori health in nursing and midwifery education and practice*. Wellington, NZ: Nursing Council of NZ.
- Nutbeam, D. (2000). Health literacy as a public health agenda: A challenge for contemporary health education and communication strategies into the 21<sup>st</sup> century. *Health Promotion International*, 15 (1), 259-267.
- O'Donovan, T., McMillan, K., & Worth, H. (2004). An employment barrier: The health status of DPB recipients' children [Electronic version]. *Social Policy Journal of New Zealand*, 22, 97-107.
- Orange, C. (1987). *The Treaty of Waitangi*. Wellington, NZ: Allen & Unwin/Port Nicholson Press.
- Papps, E. (2002). Cultural safety: What is the question. In E. Papps (Ed.), *Nursing in New Zealand: Critical issues different perspectives* (pp. 95-107). Auckland, NZ: Pearson Education.
- Pearson, D. (1994). Community. In P.Spoonley, D. Pearson & I. Shirley (Eds.), *New Zealand society* (2<sup>nd</sup> ed.) (pp.26-35). Palmerston North, NZ: Dunmore Press.
- Pearson, D. G. (1990). *A dream deferred: The origins of ethnic conflict in New Zealand*. Wellington, NZ: Allen & Unwin.

- Pease, A. (1985). *Body language: How to read others' thought by their gestures*. Avalon Beach, NSW: Camel Publishing Company.
- Penetito, W. (2000). The social construction of Māori relaiity: The role of tastes and preferences. In L. Bird & W. Drewery (Eds.), *Human development in Aotearoa: A journey through life*. Auckland, NZ: McGraw-Hill.
- Pere, R. T. (1991). *Te wheke: A celebration of infinite wisdom*. Wellington, NZ: Ao Ako Global Learning New Zealand.
- Pihama, L. (1993). No, I will not be a post... *Te Pua*, 2 (1/2), 35-37.
- Polit, D. F. & Hungler, B. P. (1991). *Nursing research: Principles and methods* (4<sup>th</sup> ed.). Philadelphia: J.B. Lippincott.
- Pomare, E., Reid, P., Keefe-Ormsby, V., Robson, B., Wātene-Haydon, N., Ormsby, C., et al. (1995). *Hauora Māori standards of health III: A study of the years 1970-1991*. Wellington, NZ: Te Ropū Rangahau Hauora a Eru Pōmare.
- Public Health Committee. (1993/94). *Kia whai te maramatanga: The effectiveness of health messages for Māori*. Wellington, NZ: Ministry of Health.
- Public Health Consultancy Group Wellington School of Medicine and Health Sciences (2001). *An assessment of health needs in the Lakes District Health Board region. Te tirohanga hauora o Lakes*. Rotorua, NZ: Lakes DHB.
- Public Health Group. (1997). *Whaia te whanaukataka: Oraka whanau - The wellbeing of Maori whanau: A discussion document*. Wellington, NZ: Ministry of Health.
- Puketapu-Hetet, E. (2000). *Māori weaving*. Auckland, NZ: Longman.
- Ramsden, I. (1990). *Kawa Whakaruruhau: Cultural Safety in Nursing Education*. Wellington, NZ: Ministry of Health.

- Ramsden, I. M. (2002). *Cultural Safety and Nursing Education in Aotearoa and Te Pounamu*. Unpublished Doctoral Thesis: Victoria University of Wellington, New Zealand. Retrieved May 10, 2003 from <http://kawawahakaruruhau@massey.ac.nz/thesis.htm>.
- Reid, P. (1999a). Ngā mahi whakahaehae a te tangata tiriti. In P. Davis & K. Dew (Eds.), *Health and society in Aotearoa New Zealand* (pp. 83-93). Auckland, NZ: Oxford University Press.
- Reid, P. (1999b). Te pupuri i te ao te tangata whenua. In P. Davis & K. Dew (Eds.), *Health and society in Aotearoa New Zealand* (pp. 51-62). Auckland, NZ: Oxford University Press.
- Reid, P., Robson, B., & Jones, C. P. (2000). Disparities in health: Common myths and uncommon truths. *Pacific Health Dialog*, 7(1), 38-47.
- Roberts, R., Towell, T. & Golding, J. F. (2001). *Foundations of health psychology*. New York: Palgrave.
- Robson, B. & Reid, P. (2002, September). Review of the measurement of ethnicity – Māori perspective. Retrieved July 26, 2004, from [http://www.stats.govt.nz/domino/external/web/prod\\_serv.nsf/htmldoes/](http://www.stats.govt.nz/domino/external/web/prod_serv.nsf/htmldoes/)
- Rosenjack Burchum, J. L. (2002). Cultural competence: An evolutionary perspective. *Nursing Forum*, 37 (4), 5-15.
- Royal, C. (1992). *Te haurapa: A introduction to researching tribal histories and traditions*. Wellington, NZ: Bridget Williams Books.
- Royal, C. (2002). *Indigenous worldviews: A comparative study – a report on research in progress*. Otaki, NZ: Te Wānanga-o-Raukawa.

- Royal Commission on Social Policy. (1988, April). *Volume 2 Part Two: Future directions associated papers*. Wellington, NZ: The Royal Commission on Social Policy.
- Ryan, A., Carryer, J., & Patterson, L. (2003). *Healthy concerns: Sociology for New Zealand nursing and midwifery students*. Auckland, NZ: Pearson Education.
- Sackett, D. L., Straus, S. E., Scott Richardson, W., Rosenberg, W., & Haynes, R. B. (1997). *Evidence-based medicine: How to practice and teach EBM*. New York: Churchill Livingstone.
- Said, E. (2000). Invention, memory, and place. *Critical Inquiry*, 26 (Winter), 175-192.
- Salmond, A. (1997). *Between two worlds*. Auckland, NZ: Penguin Books.
- Sarafino, E. P. (1998). *Health psychology: Biopsychosocial interactions* (3<sup>rd</sup> ed.). New York: John Wiley & Sons.
- Schreiber, R. S. (2001). The "how to" of grounded theory: Avoiding the pitfalls. In R. S. Schreiber & P. N. Stern (Eds.), *Using grounded theory in nursing* (pp. 55-58). New York, NY: Springer Publishing Company.
- Serendip. (1996, December). Rene Descartes and the legacy of mind-body dualism. Retrieved July 26, 2004, from <http://serendip.brynmawr.edu/Mind/Descartes.html>.
- Sibthorpe, B., Anderson, I. & Cunningham, J. (2001). Self-assessed health among indigenous Australians: How valid is a global question? *American Journal of Public Health*, 91, 1660-1663.
- Smith, L. T. (1996). *Nga Aho o te Kakahu Matauranga: The multiple layers of struggle by Maori in education*. Unpublished Doctoral Thesis. University of Auckland, New Zealand.

- Smith, L. T. (1999). *Decolonising methodologies: Research and indigenous peoples*. Dunedin, NZ: University of Otago Press.
- Smith, C. W. & Taki, N. M. (1993). Hoihoi wahine pakeha. *Te Pua*, 2 (1/ 2), 38-42.
- Soldow, G. F. (2001). The paradox: An application of a clinical psychological concept to marketing. *Journal of Advertising*, 7 (4), 40-45.
- Spoonley, P. (1994). Racism and ethnicity. In P.Spoonley, D. Pearson & I. Shirley (Eds.), *New Zealand society* (2<sup>nd</sup> ed.) (pp. 81-97). Palmerston North, NZ: Dunmore Press.
- Sporle, A. (2003). 'So Māori fits in how?' – the realities of attempting to implement kaupapa Māori practice evaluation in a contractual situation. In N. Lunt, C. Davidson & K. McKegg (Eds.), *Evaluating policy and practice: A New Zealand reader* (pp, 64-67). Auckland, NZ: Pearson Education New Zealand.
- Sporle, A., Pearce, N., & Davis, P. (2002). Social class mortality differences in Māori and non-Māori men aged 15-64 during the last two decades. *New Zealand Medical Journal*, 115, 127-131.
- Statistics NZ. (2002a). *Census tauranga 2001 Census snapshot 4 – Māori*. Retrieved March 14, 2004, from [www.stats.govt.nz](http://www.stats.govt.nz).
- Statistics New Zealand. (2002b). *2001 Census ethnic groups (2001) – reference reports*. Retrieved July 26, 2004, from <http://www.stats.govt.nz/domino/external/pasfull/pasfull.nsf/web/Reference+Reports+2001+Census:+Ethnic+Groups+2001>
- Statistics NZ. (2002c). *Census tauranga 2001 Census snapshot 17 – Families and households*. Retrieved March 14, 2004, from [www.stats.govt.nz](http://www.stats.govt.nz).

- Statistics NZ. (2002d). *Census tauranga 2001 Census snapshot 13 – Children*. Retrieved March 14, 2004, from [www.stats.govt.nz](http://www.stats.govt.nz).
- Statistics NZ. (2002e). *Census tauranga 2001 Census snapshot 11 – Women*. Retrieved March 14, 2004, from [www.stats.govt.nz](http://www.stats.govt.nz).
- Statistics New Zealand. (2003a). *Having children younger*. Retrieved April 25, 2003, from <http://www.stats.govt.nz/domino/external/>.
- Statistics New Zealand. (2003b). *Increases in post-compulsory education*. Retrieved April 25, 2003, from <http://www.stats.govt.nz/domino/external/>.
- Stevens Barnum, B. J. (1990). *Nursing theory: Analysis, application, evaluation* (3<sup>rd</sup> ed.). Glenview, IL: Scott Foresman Little Brown.
- Stevenson, B. S., Black, T. E., Christensen, I. S., Durie, A. E., Durie, M. H., Fitzgerald, E. D., et al. (2001, November). *Te Puni Kokiri Fact Sheet 18: Ngā āhua o te whānau Māori mobility, whānau, marae and health*. Retrieved July 26, 2004, from <http://www.tpk.govt.nz>.
- Stokes, E. (1995). *Maori research development*. A discussion paper for Social Sciences Committee, National Research Advisory Council, University of Waikato.
- Suzuki, D. & Knudston, (1992). *Wisdom of the elders*. New York: Bantom Books.
- Tangaere, A. R. (1997). Māori human development in learning theory. In P. Te Whāiti, M. McCarthy & A. Durie (Eds.), *Mai I rangiātea: Māori wellbeing and development* (pp. 46-59). Auckland, NZ: Auckland University Press/Bridget Williams Books.
- Tapsell, R. (2004). Māori health. In I. St George (Ed.), *Coles medical practice in New Zealand* (pp. 44-50). Wellington, NZ: Medical Council of NZ.

- Taylor, S. E., Klein, L. C., Lewis, B. P., Gruenewald, T. L., Gurung, R. A. R., & Judegaff, J. A. (2000). Biobehavioral responses to stress in females: Tend-and-befriend, not fight-or-flight. *Psychological Review*, 107 (3), 411-429.
- Te Awekotuku, N. (1991). *He Tikanga Whakaaro: Research ethics in the Maori community - Draft paper for discussion*. Wellington, NZ: Manatu Maori
- Te Momo, O. H. F. (2003). *Demystifying a relationship between voluntary work and Māori*. Unpublished Doctoral Thesis. Waikato University, New Zealand.
- Tenbenschel, T. & Gauld, R. (2001). Models and theories. In P. Davis & T. Ashton (Eds.), *Health and public policy in New Zealand* (pp, 24-43). Auckland, NZ: Oxford University Press.
- Te Puni Kokiri. (1993). *He kakano: A handbook of Maori health data*. Wellington, NZ: Te Puni Kokiri.
- Te Puni Kokiri. (1995). *Hui whai māramatanga whai oranga: Report of the hui on Māori reproductive health and HIV/AIDS*. Wellington, NZ: Te Puni Kokiri.
- Triggs, S., Johnston., O'Connor, P., & Wong, R. (1995). *Patients in profile: The use of health care services in New Zealand*. Wellington, NZ: Ministry of Health.
- Tukituitanga, C. & Bindman, A. (2002). Ethnic and gender differences in the use of coronary artery revascularisation procedures in New Zealand. *The New Zealand Medical Journal*, 115, 179-182.
- Van den Bos, K., Wike, H. A. M., & Lind, E. A. (1998). When do we need procedural fairness? The role of trust in authority. *Journal of Personality & Social Psychology*, 75, 1449-1458.
- Vandervoot, D. (1995). Depression, anxiety, hostility and physical health. *Current Psychology*, 14 (1), 69-82.

- Veljaca, V-A & Rapee, R. M. (1998). Detection of negative and positive audience behaviours by socially anxious subjects. *Behaviour, Research & Therapy*, 36, 311-321.
- Visser, M. (2002). *Beyond fate*. Toronto, ON: House of Anansi Press.
- Walker, K. (2000). Evidence based practice: Something we cannot NOT want? *Nursing Australia*, 1 (2), 17-21.
- Walker, M. (1997). Beware these seeker of information and knowledge research involving Maori: A paper reflecting an indigenous Maori view on research in Aotearoa (NZ). Unpublished paper.
- Walker, M. (1998). Science and Maori development: A scientist's view. *He Pukenga Korero: A Journal of Māori Studies*, 3 (2), 15-21.
- Walker, R. (1979). A consumer view of research. *New Zealand Journal of Educational Studies.*, 14 (Supplement), 91-93.
- Walker, R. (1990). *Ka whawhai tonu matou: Struggle without end*. Auckland, NZ: Penguin Books.
- Walker, R. (1996). *Ngā pepa a Ranginui: The Walker papers*. Auckland, NZ: Penguin Books.
- Walker, U. (2001, November). A question of ethnicity – one world, different people, many perceptions: The perspectives of groups other than Māori, Pacific peoples and New Zealand Europeans. Retrieved July 26, 2004, from <http://www.statsnz.govt.nz>
- Wareham, J. (1998). Self-sabotage: Why do some of us undercut ourselves on the brink of success. *Across the Board*, 35 (10), 49-50.

- Wass, A. (1994). *Promoting health: The primary health care approach*. Marrickville, NSW: Harcourt Brace.
- Waters, K. R. & Easton, N. (1999). Individualized care: Is it possible to plan and carry out? *Journal of Advanced Nursing*, 29 (1), 79-87.
- Weber, J. & Kelly, J. (2003). *Health assessment in nursing* (2<sup>nd</sup> ed.). Philadelphia: Lippincott.
- White, K. (1999). Theories about health and society. In P. Davis & K. Dew (Eds.), *Health and society in Aotearoa New Zealand* (pp. 19-34). Auckland, NZ: Oxford University Press.
- Willis, E. (1994). *Illness and social relations: Issues in the sociology of health care*. St Leonards, NSW: Allen & Unwin.
- Wilson, D. (2003). The nurse's role in improving indigenous health. *Contemporary Nurse*, 15 (3), 232-240.
- Wilson, D. L. (1997). *Through the Looking Glass: Nurses' responses to women experiencing partner abuse*. Unpublished Masters. Massey University, New Zealand.
- Wilson, D. & Roberts, M. (in press). Māori health initiatives. In D. Wepa (Ed.), *Cultural safety in Aotearoa/New Zealand*. Auckland, NZ: Pearson Education.
- Wilson, H. S. & Hutchinson, S. A. (1996). Methodologic mistakes in grounded theory. *Nursing Research*, 45 (2), 122-124.
- World Health Organisation (WHO). (1978). *Declaration of Alma Ata*. Geneva: WHO.

World Health Organisation (WHO). (2004, April). *Health and human rights*. Retrieved July 26, 2004, from <http://www.who.int/hhr/en/>

Wuest, J. (1995). Feminist grounded theory: An exploration of the congruency and tensions between two traditions of knowledge discovery. *Qualitative Health Research*, 5 (1), 125-137.

Wuest, J. & Merritt-Gray, M. (2001). Feminist grounded theory revisited: Practical issues and new understandings. In R.S. Schreiber & P.N. Stern (Eds.), *Using grounded theory in nursing* (pp. 159-175). New York, NY: Springer Publishing Company.