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A Māori Model of Primary Health Care Nursing

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Te Atihaunui-a-Paparangi

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Abstract

While the philosophy and policy of primary care nursing are consistent with Māori development objectives, the practice can fall short of this ideal. This thesis identifies and examines the shortfall in terms of Māori women's expectations and identifies ways in which traditional nursing practice among Māori communities may be enhanced. The research highlights the need for nursing to broaden our concepts of health, community, and public health nursing, to focus more on issues of capacity building, community needs, and a broader understanding of the social, political, cultural, and economic contexts of the communities we work with.

This research used a critical ethnographic method underpinned by a Māori-centered approach to explore health as experienced by Māori women. The primary data collection involved, a period of intensive fieldwork within the community, use of in-depth interviews, attendance at hui, and a review of literature and policy documentation. The findings of this research articulate a model of health that is a dynamic process based on the restoration of, and maintenance of cultural integrity, and is based on the principle of self-determination. Primary health care is a process of enabling Māori to increase control over the determinants of health and strengthen their identity as Māori thereby improving their health and position in society.

The findings support a substantive Māori model of Primary Health Care Nursing that provides a framework for theoretical research, which will lead to further conceptual refinement. The model also provides a framework for education curricula and nursing practice that will enhance nursing's ability to meet the needs of Māori.

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Māori/English Glossary of Terms

Ahi ka	keep the home fires burning
Aroha	love
Awa	river
Hapū	sub-tribe
Hauora	lifebreath, health
Hui	meeting or gathering
Hui whanui	large meeting/gathering
Iwi	tribe
Kai Awhina	community health worker
Kainga	home
Kaitiaki	guardian
Kanohi	face
Kanohi ki te kanohi	face to face
Kapa haka	form of modern Māori cultural group performance
Karakia	prayer or incantation
Kaumātua	elderly men
Kaupapa	groundwork, topic or subject
Kohanga	nest
Kohanga reo	preschool – language nest
Korero	speak
Kuia	elderly women
Kura	school
Kutu	headlice
Mana	prestige, authority
Mana wahine	prestige and authority particular to Māori women
Mana whenua	having rights over this land

Māori	native peoples of Aotearoa New Zealand
Māoritanga	Māori culture and beliefs
Marae	Māori gathering place, place in front of the meeting house
Marae atea	courtyard in front of a meeting house
Mirimiri	massage
Mua	in front
Muri	back
Noa	free from tapu/restrictions
Oranga	wellbeing/wellness
Pa	village
Paepae	The beam in front of a meeting house. Commonly refers to the seating area for orators.
Pākehā	New Zealand european
Papatuanuku	earth
Rangatira	chief
Reo	language
Ringawera	workers' cook
Rohe	district
Rongoā	natural medicine
Taha	side
Taha hinengaro	emotional wellbeing
Tamariki	children
Tangata whenua	indigenous/people of the land
Tangihanga	funeral
Taonga	precious or valuable item
Tapu	sacred
Tika	justice
Tikanga	protocols and practices
Tinana	body
Tino rangatiratanga	sovereignty
Tipuna	ancestor
Tohunga	skilled person
Tuakana	elder sibling
Tupapaku	body
Tutu	a shrub <i>Coraria Arborea</i>

Urupa	cemetery
Wahine	women
Waiata	song
Waka	canoe
Whaea	mother/aunty
Whakairo	traditional carving
Whakapapa	genealogy
Whakapiripiri	stick close to, fasten
Whānau	extended family
Whanau wahine	the women of the family/whanau
Whānaungatanga	making of a family

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INTRODUCTION

Indigenous health

The process of colonisation, which included the imposition of alien models of development and the imposition of both formal and informal assimilation policies, has contributed to a breakdown of indigenous cultures around the world. This breakdown has resulted in living conditions, per capita income, employment, education and access to resources and services - and consequently health status - that are below national averages (Kunitz, 1994). Such processes similarly affect the indigenous Māori population of New Zealand. Māori social, economic and political status affects their state of health. Just as alienation of land has been accompanied by depopulation, so cultural and political alienation are precursors of poor health and increased mortality (M H Durie, 1998; National Health Committee, 1998; Pomare, 1995). The conventional indicators of life expectancy, morbidity and mortality, indicate the health of Māori is poorer relative to that of non-Māori in New Zealand (National Health Committee, 1998; Pomare, 1995; Public Health Commission, 1994).

During the Māori cultural renaissance of the 80s and 90s there was a constant reiteration of the importance of the Treaty of Waitangi to health, a call for greater resourcing of Māori women in health, and a recommendation for primary health care systems that were relevant to Māori (National Council of Maori Nurses, 1986).

Appropriate recognition of the relevance of culture to health professionals had become a significant issue by 1986 and at several National hui culture was recognised as a basis for health (Durie, 1989). The promotion of cultural safety education in nursing

education emerged from many of these hui. In 1988, following annual meetings of the National Council of Māori Nurses, agreement was reached on a model of negotiated and equal partnership in nursing education. The model provided a blueprint for addressing culture in nurse education in New Zealand and was the forerunner of a new curriculum component that stressed safety in cultural terms. Cultural safety was to ensure no violation of attitudes, values, and actions that had an effect on obligations to the Treaty of Waitangi and the practice of tino rangatiratanga (Ramsden, 1990).

The introduction of cultural safety into the nursing curriculum laid the foundations for nursing practice to enable clinicians to develop models of practice that were more appreciative of the diverse realities of our client base. This was in stark contrast to other nursing theories, which tend to focus on the cultural activities of the patient (Ramsden, 1990). Cultural concepts of nursing care are now theoretically an integral part of the nursing curriculum and nursing practice. Unfortunately, much of the present literature on which we rely to develop nursing curriculum, practice and health policies is presented, not only from a pākehā perspective but also with a strong biomedical focus. This has proved to be of little use to Māori. It gives little or no consideration to Māori health beliefs or values (Pomare, 1988; Rolleston, 1989; Stokes, 1985). There is an increasing need for more research to elicit cultural values and beliefs so that care may be provided within the cultural context of the client. Nurses need to understand 'normal' behaviours in a different cultural group and need to recognise behavioural responses to health and illness. We cannot function as nurses by trying to cure or change a different response simply because we consider it to be abnormal (J. M. Morse, 1992).

Background

Up until the present, health research has focused largely on population statistics with little or no sense of 'real people' in the data. There is substantial data on Māori mortality and hospital-based morbidity but there is a relative dearth of information regarding Māori health beliefs and practices at a community level. Such information will be essential for developing primary health care practices, which are relevant and responsive to communities' needs, wishes, aspirations and expectations. It ought not to be assumed that the aims, aspirations and needs of all Māori communities are the same. Rural and urban, inner city and suburban communities all have different requirements.

Recent studies have indicated that solo-parent families will become the 'norm' for Māori and that most solo parents will be mothers (Malcolm, Bowie, & Kawachi, 1991; Stuart, 1993); therefore, it is important to understand the health needs and expectations from their perspective. As in Western society, much of the research into Māori health has come from the view of experts and academics and that has predominantly been a male middle-class view. If we are to hear the 'voices' of people at the flax roots of society then we must pay attention to what women are saying. There is a great need for more innovative research that would allow the 'voices' of women to be heard. There is also a growing need to balance the view of health held by professionals and academics with that of the ordinary people: those whom the health research and policies actually impact on to the greatest extent.

It is critical that health professionals *know Māori* and that they are clear on the responses required to effect improvements in Māori health status through health service provision. This knowledge relates to the health needs and diverse cultural expectations of consumers. It also relates to knowledge of demographics, lifestyle differences and social, cultural and historical experiences of Māori. Simple focusing on needs has resulted in Māori neither accessing services, nor continuing to access services. Focusing on Māori cultural and socio-economic expectations, particularly in primary care settings, is likely to result in better access and use of health services for Māori with a resultant improvement in health outcomes.

Māori face overwhelming obstacles to achieve their health potential. Nursing cannot afford to focus too long on attempts to develop definitions. The social significance of nursing practice will be determined by our ability to meet the demands of Māori and to develop mid-range theories that describe, explain and predict health in ways that allow not only for their being healthy but also for becoming healthy. If we mean to move forward as a profession we need to listen and take heed of what is being articulated at the grass roots level of society. All cultural beliefs and values are useful for an understanding of health and illness. A Māori perspective is particularly germane in New Zealand. What cannot be contested is nurses and midwives, like other health professionals, must have some competence when called to interact on a professional basis with people of another culture. If we ground our research in the real experiences of people at risk we will be challenged to shed our assumptions of our own relative

privilege. As a result of these considerations, the prime research question this study is concerned with is *understanding health as experienced by Māori women*.

This research uses a critical ethnographic method, underpinned by a Māori-centered approach, to explore health as experienced by Māori women. The women's experiences of health and well-being are explored by undertaking intensive fieldwork within the community and use of in-depth interviews, hui, and a review of literature and policy documentation. The intent is to better understand and describe Māori women's understanding and experience of health within the broader contexts of their daily lives.

Thus the aims of the study are

1. To allow Māori women's perspectives to be heard
2. To describe, by inductive reconstructive analysis, health as perceived by these women
3. To develop a model to describe health as experienced by these women, and
4. Through an understanding of the broader determinants of health, develop strategies to enhance their well-being.

It was my original position that from an indepth understanding of the experiences of Māori women a model may emerge to assist nurses to better understand and support Māori women.

Overview of the thesis

This study was initiated following a period of major restructuring of New Zealand's public services including health, education and welfare. Chapter 1 outlines the major reforms introduced by the National Government in 1991 and subsequent reforms. It examines the political and economic basis for the reforms and previews how the consequences of these changes have impacted on Māori whānau and, particularly, Māori women and outlines how Māori have participated in a reformed health system.

Chapter 2 begins with a summary of the main features of the primary health care approach, as presented in the Alma-Ata Declaration and the Ottawa Charter, then examines how these principles and recommendations have been implemented within the current New Zealand context and, specifically, in relation to Māori primary care services. Models, concepts, and principles of health care delivery and practice have

been subjected to increasing debate as consumer's demands and economic rationalism influence traditional beliefs. This has paved the way for new concepts to become incorporated into health care practices. As primary health care becomes increasingly important to governments and communities, in part because of the emphasis on reducing health care costs and the strong shift to community-based care, there is a growing need to increase multidisciplinary knowledge concerning the many dimensions of PHC practice.

Chapter 3 outlines how nursing as a discipline has long held a philosophical position that is congruent with both the principles of primary healthcare and community development. It will examine current models of primary health care nursing and community nursing and outline the role of nursing in primary health care both from an historical perspective and in the current New Zealand context.

This research takes a Māori-centered approach, uses a combination of methods and utilises a critical ethnographic methodology for data collection and analysis. Critical ethnography was selected for this study as it is qualitative in nature, is directed by the participants and includes a liberation philosophy. By selecting a critical ethnography methodology, the researcher was particularly aware of the concerns among Māori and other indigenous peoples that they had been exploited by past anthropological research. It was particularly important, given this history, to ensure strong adherence to the principles of a Māori-centered approach in relation to the research process. Chapter 4 briefly reviews the traditions of ethnography and outlines the distinctive characteristics of critical ethnography and a Māori-centered approach and the ways in which they have been applied in this study.

While the overarching approach in this research is to give voice to the community of Whanganui Māori women, it is useful to explore what is 'known' about this community.

Chapter 5 describes the community setting for the primary data collection undertaken in this research. It presents briefly a

- summary profile of women
- physical, historical and social description of the Whanganui region
- selected socio-demographic profile of /iwi in the region

- more detailed description of significant contemporary political events that impact on this community.

This context information is presented as vignettes rather than as comprehensive analyses or summaries of data. The purpose of description in this way is to give the context *in overview* thus providing a setting for the primary qualitative data collected. This chapter also provides a description of Te Oranganui health services which are the setting for the sampling of women and are presented in Chapters 6, 7 and 8.

In this research, I present the experiences of a group of Whanganui Māori women through the use of the following descriptive sub-themes: their own health beliefs and practices (Chapter 6), their identity (Chapter 7), and their perception of marginalisation (Chapter 8).

The focus of Chapter 6 is to understand how these women describe their health, how they define the term ‘health’ and what concepts are central to their perceptions of health. People were encouraged to discuss, in their own terms, what was important in achieving health and well-being: to tell their own ‘quintessential little stories’ or counter narratives. To clarify understandings of concepts such as ‘Māori primary health care’ it is first necessary to examine the concept of health on which it is premised.

Chapter 7 focuses on the ways in which the participants describe their sense of ‘self’ and of ‘belonging’: their ways of being and acting in the world that determines their health beliefs and practices. The previous Chapter presented the experiences of the participants’ own health beliefs and practices; this chapter focuses on their sense of identity.

In the previous two data Chapters, I present the experiences of a community of Whanganui Māori women through the use of the following descriptive sub-themes: their own health beliefs and practices, and their identity. In Chapter 8, I discuss how interactions with health professionals and with the health services have contributed to and reinforced their perceptions of their marginalised position in society.

Chapter 9 presents a model for nursing practice using a broad Māori development approach and discusses ways in which nursing, teaching and practice can be enhanced in order to contribute to improved health gains for Māori. The research highlights the need for nursing to broaden our concepts of health, community and primary health care

nursing; to focus more on issues of capacity building, community needs; and to gain a broader understanding of the social, political, and economic contexts of the communities we work with.

The implications of this work are essentially three fold. The model offers some direction for health professionals, such as nurses, when working with Māori whānau. The model provides a framework for a Māori health development curriculum for nursing education. Finally, the model provides rich material for further research and analysis including concept refinement, assessment tool development and instrument testing.

Conclusion

Nursing's focus has been on *managing* the environment within which our clients live as opposed to *changing* the environment. It has been very much a passive rather than an active role. We try to mediate the extraneous variables and adapt to the current circumstances rather than define ways to transform them. If we simply deal with the *status quo* we do not have to address the harder issues of distributive justice or social equity. However, these are the issues we must grapple with if we are to make a difference and stake a substantive professional role in the primary health care arena. When we consider the ever increasing number of individuals and communities with competing interests and needs, how do we, as a profession, work towards ensuring the availability and accessibility of high quality health services to all persons whose health needs are unmet?

This thesis presents a synthesis of the findings from this research in order to articulate a model of primary health care nursing which is responsive to the needs and expectations of a community of Māori women. The research has sought to identify the ways in which a model of primary health care nursing can respond to, and enhance, Māori access to primary care services and, secondly, to assist in the development of both policy and programmes to advance not only health but Māori self-determination.

This model is not intended to be prescriptive but rather point to the 'how' processes and intent of an effective system for working towards empowering the communities in which we work. Although this research has focused particularly on Māori women, I believe the processes outlined in this research could guide primary healthcare practices and be of benefit to any community not just Māori.

CHAPTER ONE

Health reforms

Introduction

Changes in the health system have been ongoing since the mid-1970's; however, the rate of change over the last decade has escalated to such an extent that implementation of one reform is barely completed before another structural change is initiated by central government. This study began following a period of major restructuring of the New Zealand public sector that included health, education and welfare. The fieldwork for this study was carried out during the period 1996-1997.

This Chapter reviews the development of the New Zealand health system over the past two decades with particular emphasis on the reforms introduced by the National government in 1991. The historical context to Māori involvement in the recent health reforms is an important inclusion. A Māori development framework is briefly described because it is this framework that has guided Māori participation in the health reforms. Finally, there is some detailed discussion of the shape of Māori participation in the reforms.

The New Zealand health reforms: 1975-1990

During the term of office of the third Labour Government, in 1974, a major discussion paper endorsed health as a social service rather than a 'marketable product' (New Zealand Government 1975). The report proposed health system restructuring in the form of the establishment of the New Zealand Health Authority: a structure intended to

be responsible for national-level policy making, priority setting and strategic planning. The intention was to induce 'good management principles' that would lead to increased value for money for taxpayers (New Zealand Government 1975). The report, 'The White Paper', proposed the establishment of 14 regional health authorities that would replace the 29 hospital boards. At that time, the boards provided public hospital services. The regional health authorities would be responsible for the development of comprehensive health services that incorporated both primary and hospital rehabilitation services in the state and voluntary sectors (Bowie & Shirley, 1994). The proposal did not prove to be politically durable and, with the 1975 change in Government, it was not pursued.

However, the central tenets of 'The White Paper' were revised with the 1983 return to a National government. A Special Advisory Committee on Health Service Organisation was established under the new Government. The Committee proposed hospital boards be replaced with regional area health boards that would assume overall responsibility for the planning and co-ordination of medical services. The Government was cautious and decided on an incremental approach to health reform: initially establishing two area health board pilot schemes. Following the success of the pilots, the Area Health Boards Act was passed in 1983. The Act enabled hospital boards to move voluntarily towards integrated area health boards with the objective of promoting, protecting and conserving public health, and providing health services in their regions (Dow, 1995). The focus of these changes was on restructuring hospital board funding formulae and introducing 'population based funding'. It was rationalised that this approach would lead to more equitable funding (Bowie & Shirley, 1994). The World Health Organisation concepts of primary health care and health promotion were influential in the gradual process of reform, which led to the passing of the Area Health Boards Act. The Act also provided for the decentralisation of population-based health services that were formerly a responsibility of the Department of Health.

The pace of reform gathered momentum with the election of the Fourth Labour Government in 1984. Cost overruns and many other problems faced by earlier governments had yet to be resolved. Access to primary care had become more difficult for many households with the declining real value of the General Medical Services (GMS) benefit (Ashton, 1992). This should be seen within the context of Social Welfare

benefit cuts and increased rents. Most affected were lower socio-economic groups and, in particular, Māori.

In 1986, the Labour Government established a Health Benefits Review Committee that was charged with examining health benefits within the context of other social expenditure (Scott, Fougere, & Marwick, 1986). The Committee's report outlined five options for the role of the State in health care. Apart from the existing system with increased subsidies, two further options were considered. In the first option, the role of the State was as a residual funder. The second option gave the State the role of dominant funder. The Review recommended that the State continue and strengthen its role as the major funder of health care. Emphasis was placed on the advantages of a provider-funder link. The report argued that the funder's ability to bargain with providers in relation to both service price and quality was an incentive to efficiency. The Review noted that the link would not remove competition, rather any competition would take place in a regulated environment so that access to services by high risk patients would not be compromised.

In 1987, the Labour Government initiated a further review, setting up the Hospital and Related Services Task Force with Auckland businessman Alan Gibbs appointed as chair. The Task Force had a narrow brief confining its attention to public hospitals. The 'Gibbs Report' was highly critical of the public hospital system for lack of management information and absence of productivity measures (Gibbs, 1988). While recognising the Government intended to remain the dominant funder of the hospital system, the Task Force favoured the injection of an element of competition. The Report's key recommendation was to re-establish hospital services along marketing lines.

The Task Force recommended a split between the purchaser and provider roles. A new structure was proposed in which the Government would remain the principal hospital provider but, at the same time, 'modified competition' would be introduced. A three-member National Health Commission would be established as an independent body responsible for funding six regional health authorities (RHAs) and monitoring their performance. The six RHAs would be 'lean, independent elected bodies' charged with purchasing hospital and related services in their respective regions from public, private and voluntary agencies. Payment was to be based on a set fee for a specific service such as a case-weights system of payment, which would also be a way of describing hospital outputs.

Many health professionals saw the Gibbs Report as highly controversial. Generally, they were opposed to what they considered to be excessive use of competition in the proposed model and to the shift in control of health care delivery from area health boards to a new tier of regional government. The Labour Government chose not to implement the recommendations of either the Health Benefits Review or the Gibbs Report in their entirety, although some aspects were adopted in an incremental way. However, the two documents were very successful in stimulating public discussion; much of which focused on the appropriate roles of State and market in the funding and provision of health care. Helen Clark, as Minister of Health, initially oversaw the transition of hospital boards to area health boards that were intended to provide a more integrated approach to the delivery of public health services. Concerns for equity and improved access to health care also led to an increase in the GMS¹ Benefit in October 1988 and then again in September 1990, just before the election. While the latter increase was criticised as an election ploy, it was innovative in offering general practitioners the opportunity to enter into a contract for service with the Government. The fourth Labour Government's final two years in office (1989 and 1990) were characterised by pragmatic incrementalism rather than sweeping change (Bowie & Shirley, 1994).

National's proposals for reform in the 1990s

The election of a National Government in 1990 saw the resumption of the radical reforms of the mid-1980s. The first move came in the Economic and Social Initiative of December 1990. Cuts in social welfare benefits were introduced across the board, prescription charges were increased, and various health subsidies were reduced. Most notable was GMS benefits were reduced for most people.

The National Government's structural change to health policy was outlined in a Green and White Paper released on 30 July 1991, Budget night (Upton, 1991). Following its release, many of the original proposals were modified or abandoned but the main structural changes were incorporated into the Health and Disability Services Act 1993 which provided for the implementation of a new health system from 1 July 1993. The reforms were implemented in haste, unlike the incremental approach adopted in countries such as Britain, the Netherlands, and Sweden. The Government abolished the

¹ General Medical Subsidy.

elected boards of area health boards on 30 July 1991, replacing them with commissioners. However, as operational entities the Area Health Boards did not go out of existence until 1 July 1993 when they were replaced by Regional Health Authorities, Crown Health Enterprises, and a Public Health Commission: thereby introducing the funder provider split. The role of the regional health authorities was to purchase health care through contracts with competing public, private and voluntary health providers. They were also required to monitor provider performance in health care delivery.

To facilitate a more integrated system, the RHAs were given responsibility for purchasing both primary and secondary care as well as disability support services. Public hospitals were reconstituted into 23 crown health enterprises (CHEs). Their function was to provide health care. It is significant to note that CHEs were expected to be as successful and efficient as comparable businesses that were not owned by the Crown (Health and Disability Services Act 1993, Section 11(d);8). CHEs were to operate on a commercial basis with a broadly similar mandate to state owned enterprises with the clear intention they be profit-driven. Public hospitals that were not economically viable were offered for sale to local communities and, if purchased, restructured into community trusts or sold off to the private sector. The Government also proposed that individuals be given the choice of opting out of RHA coverage and instead have their health care provided by an alternative private health care plan (e.g., an insurance company or a Māori Health Care Plan). It was proposed that individuals, under such a system, could transfer their risk-adjusted share of Government funding to an approved Health Care Plan. After considerable public criticism, the introduction of Health Care Plans was indefinitely delayed. Among the problems identified were major difficulties associated with developing a workable risk-adjusted entitlement formula and the questionable merits of introducing a multiple-purchaser environment for the containment of health care costs across the nation.

A National Advisory Committee on Core Health and Disability Support Services was also established. The original intention of the Government was to have this Committee define an explicit list of 'core' health services for New Zealand. This list was to make clear what services the RHAs would be obliged to offer their clients: services which New Zealanders should have fair access to on affordable terms without having to wait an unreasonable length of time. However, the concept of developing a specific list of core health services was soon abandoned. The members decided it would be

‘impossible to implement’ (National Advisory Committee on Health and Disability, 1992). The Committee evolved into an information-gathering body with a range of functions, including the identification of current services with regard to their costs, efficiency, availability and utilisation. A new Public Health Commission was also established to take over the public health functions of the Area Health Boards. Its stated objective was to improve and protect public health and its specific functions included monitoring and analysing the state of public health and advising the Minister of Health on health goals and objectives, programmes and policies and purchasing public health programmes. After 18 months, the Commission was disestablished and its functions were relocated within the Ministry of Health.

The 1996 Coalition health policy

By the 1996 election, it was clear that there was widespread public dissatisfaction with the performance of the public health system (Coney, 1996). Although the number of public hospital discharges was increasing, so too were the costs, CHE deficits, real public expenditure, and waiting lists (Ashton, 1996). This dissatisfaction was also fuelled by closure of local services, increasing problems within both public hospitals and the mental health services which were continuously being highlighted by adverse events experienced by patients, and the high turnover of chief executive officers of CHEs. In light of these concerns, it is not surprising that the first health policy statement from the incoming National led Coalition Government in December 1996 suggested a withdrawal of the market model.

The Coalition Government’s health policy has the overriding goal of ensuring principles of public service replace commercial profit objectives for all publicly provided health and disability services. The Coalition Partners are committed to publicly funded health care that encourages cooperation and collaboration rather than competition between health and disability services. The new focus (for CHEs) will be on achieving health outcomes and improving the health status of the populations they serve (National and New Zealand First, 1996).

Policies introduced in the following months included replacement of the four Regional Health Authorities (RHAs) with a single central funder - the Health Funding Authority (HFA), conversion of remaining CHEs into Hospital and Health Services (HHS), and removal of the competitive profit focus. Part-charges for outpatient services were removed and subsidies for doctors’ visits and pharmaceuticals were increased for all

children under the age of six. A proposal to remove asset testing for the elderly in long-stay hospital care was not implemented; however, the asset threshold was raised so that a larger proportion of elderly in long-term care were now eligible for a government subsidy.

Labour-Alliance Coalition 2000

The election of a new Labour-Alliance Coalition Government in 2000 heralded a return to a more inclusive and co-operative, as opposed to competitive, model of health care. For example, the principles selected to guide health policy included a focus on ‘patients not profit’ and an emphasis on cooperation rather than competition (Ministry of Health, 2000b). The Labour-Alliance reforms indicated a clear swing away from a market-orientated approach towards more consensus-style decision-making. The New Zealand Public Health and Disability Act 2000 and the New Zealand Public Health Services and Health Reforms Act 2001 have both been passed and have led to a number of significant changes within the health sector. Within the Ministry of Health, a Public Health Directorate was established that would provide advice to the Ministry and the other eight directorates about public health. The Health Funding Authority has been disestablished and most purchasing functions have been transferred to the newly established District Health Boards. The reforms have included the abolition of the funder-provider split for those services which are publicly provided, a return to democratically elected representatives on District Health Boards, a return to the monopoly provision of insurance for work related injuries by ACC, and restoration of a non-commercial system of public hospitals (Ministry of Health, 2000b).

To better understand the participation of Māori in the more recent health reforms, a brief description of the historical and Māori development context is useful. This is important, given that Māori participation within the health reforms has occurred within a Māori development framework.

Traditional Māori approaches to public health

Māori society was communal in nature: centred around whānau, hapū and iwi collectives. Everyday living was closely connected to the natural environment that not only provided food, clothing, and shelter but was also a source of identity. Geographical features were personified and people identified themselves in relation to prominent features in their tribal areas, such as a particular mountain or river (M H Durie, 1998).

Customary Māori public health systems were well established by the time of first contact with Europeans in 1769, which accounted for relative Māori good health as described by British explorers (Pool, 1991). Reflected in these systems was recognition of environmental and spiritual determinants of health. The system was regulated by such concepts as 'tapu' and 'noa' (there are many other relevant concepts), which provided a framework for everyday living that was designed to safeguard the well-being of Māori collectives. People, places, and events were all categorised as either tapu or noa. At its most basic, tapu denoted restricted access and noa denoted free and unrestricted access. These states were often not permanent and could be used for particular purposes. As an example, the breeding site of a bird that provided a food source could be imbued with tapu during nesting season in order to protect the resource. Following the nesting period, the tapu could then be lifted by the recitation of appropriate incantations by tohunga. Customary Māori public health systems were presided over by tohunga, who were specialists in various fields. Generally, tohunga were selected for their position on the basis of whakapapa and ability (Buck, 1910; Rolleston, 1989). Overall, this public health system was entirely reliant on the integrity of a Māori worldview, that is people would only follow this system if they believed in the concepts of tapu and noa for instance and the repercussions by the gods for transgressions. Those repercussions could take various forms including illness, disability or, in more extreme cases, death (Buck, 1949; M H Durie, 1998).

Colonisation and Māori health

While colonisation brought with it some benefits for Māori in terms of increased trade opportunities and access to new technologies, other features were devastating and had far-reaching implications. Those features included infectious disease, the introduction of the musket, the undermining of Māori political authority, and land alienation. A pre-contact population of around 100,000 Māori was halved by turn of the 20th century. The settler Government did little to intervene and among some quarters the demise of Māori was viewed as inevitable, if not desirable (Buck, 1949; F. McLean, 1964; R. Walker, 1990; Webster, 1979). The signing of the Treaty of Waitangi between Māori Chiefs and the British Crown in 1840 - motivated by an English concern for both Māori and the British settlers - was intended to provide the framework for the peaceful co-existence of Māori and the settlers in New Zealand. However, the Treaty did nothing to halt the devastation of the Māori population. In some respects it may have contributed

to the population decline as although it confirmed Māori customary title at the same time it provided a tool for the alienation of Māori land in providing for the Crown's pre-emptive right to Māori land purchase. The settler Government was quick to take advantage of opportunities to appropriate Māori land through purchase, confiscation (mainly when Māori resisted land alienation), and through Māori Land Court activities. Each of these mechanisms was consistent with their own legal framework. By 1896, around 55 million acres of Māori land had been appropriated, with land loss corresponding to Māori population decline (Pool, 1991).

Māori, however, were unwilling to be passive participants in their own forecast demise. In 1858, the Kingitanga movement led by Waikato Māori proclaimed the paramount chief Te Wherowhero, Māori King. His position, to rule over Māori customary land, was intended as an equivalent to the position of Governor, who would rule over Crown land. Not surprisingly, this initiative was not warmly received by the Governor of the time (R. Walker, 1990). Another Māori movement, which also emphasised Māori nationalism - the Kotahitanga movement, led to the establishment of a Māori parliament which intended to address the various oppressive laws imposed by the settler government that were constraining Māori. However, the settler Government opposed moves to devolve any authority to the Māori Parliament. At that time, there were only four Māori seats in parliament (to be held by non-Māori on behalf of Māori); established in 1867 out of a concern to maintain the balance of power in the North Island after the population increase in Otago following the gold rush had increased the number of seats that would be allocated to the South Island. These four seats were ineffective in addressing Māori concerns.

The role of Māori in the health sector

By the turn of the 20th century, Māori depopulation had halted and new Māori health leadership had begun to emerge in the form of Western-educated young Māori professionals like the doctors Maui Pomare and Peter Buck and the politician Apirana Ngata, who retained their 'Māoriness' and were still closely connected to Māori communities. In this respect, they held credibility in both Western and Māori eyes. These emerging leaders established the Young Māori Party and embarked on a campaign to promote education as a means to facilitate Māori advancement. The education focus included a concern for promoting Western public health practices compatible with Māori realities.

Increasing Māori pressure for self-determination driven by the Māori parliament and government concern that the ill health of Māori communities presented a threat to the health of Pākehā, as well as a drain on health resources led to the establishment of a Public Health Department, and the passing of the Māori Councils Act in 1900. The Act provided for the establishment of 19 elected Māori Councils who had some public health functions, including the power to make by-laws for such matters as sanitation and drunkenness. Dr Maui Pomare was appointed as health officer to the Māori and a number of Māori community leaders were appointed as sanitary inspectors for Māori communities. The initiative for the Act came from the Te Aute College Old Boys' Association and owed much to the work of politicians Apirana Ngata and James Carroll² (M.H. Durie, 1994b; F. S. McLean, 1964).

The success of the early 20th century Māori health initiatives, owing much to the re-emergence of Māori health leadership, was reflected in the declining impact of infectious disease among Māori - with the exception of the 1918 influenza pandemic (M.H. Durie, 1994b; Rice, 1988; Walker, 1987). Unfortunately, however, the Māori Councils and sanitary inspectors positions were disestablished as a result of policy changes in 1909 when pākehā district nurses replaced them. Māori nurses were not encouraged to work with Māori communities as their ability to work in an impartial manner within Māori communities was questioned. The policy change effectively undermined efforts to regain Māori control over their own health development, shifting control instead firmly back to the Government with health professionals claiming the role that had begun to be filled by community leaders (McKegg, 1991; F. McLean, 1964). The 1907 Tohunga Suppression Act banned traditional Māori specialists - and therefore health leaders - further undermining traditional Māori public health systems (M H Durie, 1998).

By the 1930s, the role of Māori in healthcare had changed to one of supporting Western health professionals to deliver services to Māori communities. Generally, Māori women filled this liaison role and Māori women's organisations began to gain some prominence in Māori health. With the support of leaders of the Te Arawa tribal confederation, a Nurse Robina Cameron began organising predominantly Māori women into local health committees in the Rotorua region. The intention of the committees was

² At this time James Carroll represented the Waiapu Electorate in Parliament. In 1899 he was appointed Minister of Native Affairs, a portfolio he held until 1912.

to bring Western understandings of health and hygiene into Māori homes and to provide instruction in matters relating to childcare and home management. In 1937, the committees together formed the Women's Health League, an enduring Māori women's health organisation (Adams, 1958).

Another similarly influential organisation is the Māori Women's Welfare League, modelled in many ways on the Women's Health League but on a national level. Welfare committees were initially set up by the Department of Māori Affairs to provide a community focus for personal health and welfare issues that would be driven by Māori women. This was a response to the concern that existing tribal committees, dominated by men, often failed to prioritise health and welfare issues instead focusing attention on land and economic matters. At a conference for the welfare committees held in 1951, the Māori Women's Welfare League was formally constituted (Rogers & Simpson, 1993). The League shared the focus of the Women's Health League, that is a commitment to Māori health advancement while at the same time maintaining distinctly Māori approaches, alongside their concern to address broader social issues.

The role of these organisations within the health field was secondary to that of health professionals in that their function was support rather than leadership; their contribution in maintaining a Māori presence within the health field together with their position that Māori cultural preferences were not inconsistent with good health, was significant (M H Durie, 1998). They also provided an entry point for politicising Māori women and introducing them to the process of advocacy (Walker, 1987).

Māori development and health

The 1960s and 1970s were periods of political activism driven by a range of social movements worldwide, including the indigenous peoples' movement. Within New Zealand, Māori political activism of the period culminated with the 1975 land march to Parliament to draw attention to unjust Māori land alienation and the 1977 Bastion Point protest over government inaction in regard to the Orakei land claim by Ngati Whatua. Regular protests were also held at the annual Waitangi Day celebrations to object to the Government's failure to meet its obligations as outlined in the Treaty of Waitangi. These protests were as much about Māori dissatisfaction with their position in New Zealand society generally, as they were about land claims.

Māori political activism was a motivating factor in the Māori development movement that crystallised in the Decade of Māori Development launched at the 1984 hui Taumata (Māori Economic Development Summit). The six themes of the hui, intended to guide Māori development action during the decade were the Treaty of Waitangi, tino rangatiratanga (self-determination), tribal development, economic self-reliance, social equity, and cultural advancement. According to Durie (1998), the Decade stressed Māori confidence in their own approaches and the need for Māori advancement led by Māori. The Decade of Māori development provided the launching pad for a more consistent approach to facilitating Māori advancement in social, economic, cultural, and political terms. Māori development was embraced by Māori as providing the framework for Māori health advancement.

Māori development itself can be understood as the process to achieve Māori self-determination and Māori advancement (Cunningham, 1999; M. H Durie, 1998; Loomis, 2000; Puketapu, 2000).

In a review of Māori development literature, Ratima (2001) identified the defining characteristics of Māori development in terms of, among other things, concept, paradigm or philosophy, principles, processes, and strategies (Table 1).

Ratima (2001) also identifies processes and methods of action that can be used in a variety of settings to achieve the goals of Māori development: empowerment, cultural affirmation, integration, and relevance.

Empowerment as a process has the dual concern of building Māori capacity to identify and address their own development issues and of redistributing power in favour of increased control by Māori over their own development. The process of cultural affirmation is concerned with strengthening Māori beliefs and values towards the goal of cultural integrity. As a process, integration promotes a holistic approach to Empowerment as a process has the dual concern of building Māori capacity to identify and address their own development issues and of redistributing power in favour of increased control by Māori over their own development. The process of cultural affirmation is concerned with strengthening Māori beliefs and values towards the goal of cultural integrity. As a process, integration promotes a holistic approach to

Table 1
Characteristics of Māori development

Characteristics	Māori development
Concept	<ul style="list-style-type: none">• The process to achieve Māori self-determination and Māori advancement
Philosophy	<ul style="list-style-type: none">• Māori worldviews
Principles	<ul style="list-style-type: none">• Self-determination, partnership, participation, protection, diversity, interconnectedness, sustainability
Processes	<ul style="list-style-type: none">• Empowerment, cultural affirmation, integration, relevance
Strategies	<ul style="list-style-type: none">• Quality services• Greater opportunities for Māori participation at all levels and in all sectors• Iwi and Māori community capacity-building

development whereby sectoral boundaries are transcended and there is consistency and co-operation at all levels. Finally, relevance is about ensuring that Māori development is itself relevant to the lived realities of Māori people. The strategies identified in the literature are consistent with the principles and utilise the range of processes described above.

A Māori development approach to health

The Māori development approach to health is integrated (holistic), recognising that health cannot be separated from other cultural, social, economic, and political considerations. Further, this approach expresses confidence in the capacity of Māori to lead their own health development and, indeed, this is promoted as the preferred vehicle for addressing Māori health issues. Essentially, such an approach is concerned with Māori self-determination of their health development and therefore considers health from a Māori perspective.

Māori were particularly concerned that the relevance of culture to health should not only be acknowledged but should underlie all interventions for Māori. This led to the

articulation of Māori-specific models of health. ‘Te Whare Tapa Wha’ (the four walls of a house) is the most widely quoted Māori model of health, another well-known model is, ‘Te Wheke’ (the octopus).

Te Whare Tapa Wha describes four interacting dimensions of health: te taha wairua (spirituality); te taha hinengaro (thoughts and feelings); te taha tinana (the physical side); and te taha whānau (the extended family). Durie (1998), who developed the model, identifies a theme related to each of the dimensions. Te taha wairua is considered as an essential element of good health and is concerned with connections between people and the environment. For some people religious beliefs may be an expression of spirituality. Te taha hinengaro is concerned with the mental dimension of well-being and emphasises that the mind and body are inseparable. Te taha tinana recognises the importance of physical wellness to good health (M H Durie, 1998). From a Māori perspective, body parts are divided into those that are tapu and those that are noa, which can have implications for physical care. Te taha whānau is concerned with the link between health and social context. Essentially, this dimension emphasises that individuals should not be considered in isolation from their whānau and wider social context.

The Te Wheke model identifies eight interacting dimensions of health: spirituality; the physical side; the mind; kinship relationships; the uniqueness of the individual and family; the life principle of people and objects; the link with the ancestors; and the open and healthy expression of emotions (Pere, 1997).

There is much overlap between the two models: in particular they are holistic in nature, give some primacy to spirituality, recognise the importance of whānau, and concerns for cultural integrity are inherent.

The first national Māori health hui in modern times, hui Whakaoranga, was held on Hoani Waititi Marae, Auckland in March 1984. The hui reconfirmed the relevance of Māori models of health and, consistent with a Māori development approach, recommended that funding be made available to establish marae clinics and community health programmes to meet the needs defined by local people, or promoted through local Māori organisations such as the New Zealand Māori Council, the Māori Women’s Welfare League, tribal or Māori committees. In essence, Māori were renewing their call

for self-determination and therefore a greater degree of control over their own health development.

From the early 1980s, Māori attempts to gain a leadership role in Māori health were becoming more apparent. The Māori Women's Welfare League had established a health research unit and from 1981 to 1983 conducted a health survey among Māori women, using Māori frameworks. The resulting report, *Rapuora*, was a milestone in Māori methodology. The report recommended the establishment of marae health clinics with health promotion and primary health care functions (Murchie, 1984).

During the 1980s, a range of Māori lead health initiatives were established. The Women's Health League established the Rotorua-based Tunohopu Health Centre in 1986 and the Tipu Ora well child service in 1991. Both these initiatives are still functioning and Tipu Ora has been acclaimed as a model Māori health promotion intervention. Central to the success of the programme has been its recognition of the link between culture and health and the utilisation of Māori community expertise and networks (Ratima, 1999). Other examples are the health centre at Waihi marae established by Tainui people and at Ruatoki a community health clinic opened adjacent to the local school at the request of Māori community leaders. These two initiatives served rural populations and complemented existing social services.

Māori participation in reformed system

Increasing social stratification, which has positioned Māori among the most socio-economically marginalised, emphasises the need for alternative approaches to Māori health development. Māori themselves have promoted a Māori development framework to guide their participation within the health sector as a means to address the disproportionate ill health suffered by Māori. However, the realities of Māori participation within the health sector and, therefore, the health sector reforms have so far fallen well below the ideals of a Māori development framework.

While the 1990 health reforms received much criticism, they did provide some opportunities for Māori in terms of extension of existing contracts with Area Health Boards and the further development of services. There was positive encouragement for greater Māori participation to develop solutions that would be effective, affordable, accessible, and culturally appropriate. However, the opportunity for Māori to extend their role in Māori health care needs to be viewed within the context of widespread

economic reform, a shift to new right values, a growing focus on competition, open trading with deregulation, and a reduced role for the State. There were concerns that what might initially have been viewed as increased opportunities for Māori to take a leadership role in Māori health development, was little more than a veiled ploy for Government to devolve responsibility for Māori health to already under-resourced Māori communities. Therefore, there was criticism that what was being promoted as partnership could more accurately be labelled as devolution, and that the distinction between iwi authorities and agencies of State were for many becoming less clear. However, others were keen to embrace the reforms as an opportunity for Māori to play a greater role within the health sector (M.H. Durie, 1994a). It is also worth noting that while the Decade of Māori Development had promoted iwi as the vehicle for Māori advancement, recognition of the need for a more comprehensive approach encouraged a greater focus on the role of other Māori community organisations, for example Urban Māori Authorities.

✕ Recent health sector legislation, policy and structures provide support for Māori health ✕ development. The New Zealand Public Health and Disability Act refers to Government-Treaty of Waitangi-based obligations to ensure Māori input into decision-making and for the provision of health and disability services for Māori (Section 4, Part 1). The purpose of the act, in relation to Māori health, is to improve Māori health outcomes and thereby reduce disparities. The Act places responsibility on the newly established District Health Boards (DHBs) for improving Māori health outcomes (Section 22, Part 1, e) through an informed process that involves Māori participation. The Act supercedes the Health and Disability Act 1993 which, while acknowledging the special needs of Māori, did not make reference to Treaty-based obligations.

The major Government structures that have functions related to Māori health are the Ministry of Health, the Ministry of Māori Development, and the District Health Boards (which have taken over the purchasing function of the now disestablished Regional Health Authority). Each of these structures incorporates a Māori focus. The Māori Health Directorate is one of the nine directorates comprising the Ministry of Health and is charged with providing advice to the Crown and other parts of the Ministry relating to Māori health. The Ministry of Māori Development fulfils advisory and monitoring functions in relation to Māori issues within for government and is required to contribute to, among other things, improved Māori standards of health. District Health Boards are

required to have a minimum of two Māori members of the up to 11 total members. In making appointments, the Minister is also required to try to ensure that a minimum Māori membership of the Board is proportional to the number of Māori in the Board's resident population.

In terms of Māori health policy, there is a comprehensive web of policy in place to promote Māori health. The New Zealand Health Strategy released in December 2000 and the Māori Health Strategy (discussion document) released in April 2001 combine to affirm Māori Health as a government priority area. The key objectives for Māori development in health are to

- build the capacity for Māori to participate in the health sector at all levels
- enable Māori to identify and provide for their own health needs
- recognise the importance of relationships between Māori and the Crown in health services, both mainstream services and those provided by Māori
- collect high quality health information to better inform Māori policy and research and focus on outcomes
- foster and support Māori workforce development (A King, 2000).

Despite policy support, the wider disparities between the state of Māori health and the health status of other New Zealanders remains. Much progress has been made, however, in terms of Māori participation as health service providers, particular in primary health care. A variety of iwi and Māori community-based interventions throughout the country address a wide range of health issues. They have a common concern to improve the state of Māori health, a desire for Māori control of their own health development, and attention to cultural and other determinants of health.

Māori primary health care interventions vary in size from relatively small health promotion programmes to the much larger and more comprehensive services, including primary medical services. Te Oranganui Iwi Health Authority for example provides comprehensive care to a client base of more than 3000 in the Whanganui area. Operating from marae and community clinics, general practitioners, registered nurses and community health workers deliver health programmes alongside other tribal

activities. In contrast, Tipu Ora, based in Rotorua, provides a more limited service focussing on the health needs of caregivers and their children. This programme, utilising community health workers, offers education and instruction in parenting skills as well as promoting more effective use of wider health services in the process. Te Whānau o Waipareira Trust in West Auckland, an urban Māori Authority, also offers comprehensive primary care.

In the area of secondary care, the lead has been taken by mental health services with the development of Māori-specific services at Tokanui Hospital (Whaiora) and later at Carrington Hospital (Te Whare Hui, then Te Whare Paea). Most other Māori secondary services are located within public hospitals. One of the more innovative is Te Puna Ora at Tauranga Hospital, which provides a ward-based Māori nursing service, a mental health service, an outpatient medical clinic, and a Māori counseling service. Patients have the option of accessing the Māori nursing services while in hospital and whānau have a point of contact in an otherwise compartmentalised environment. Specialist Māori mental health teams have been established in several CHEs. They provide clinical services alongside specialist cultural assessment and, in some instances, traditional healing.

There are, however, some iwi who have taken the initiative to offer specialist services from a community base. Te Runanga o Raukawa have established a specialist mental health service provided by registered nurses. They offer a range of services including follow-up care for clients with psychiatric disability, forensic and emergency assessments, and counselling. On a larger scale, Hauora Waikato provides a range of psychiatric disability services and has plans to run inpatient services for acute and sub-acute patients. Many Māori groups also provide drug and alcohol treatment centres, and there are a number of District Health Board contracts with Māori groups for sheltered accommodation for people with intellectual and psychiatric disabilities.

Growing Māori interest in the provision of secondary services is driven not only by concern for autonomy and expansion, but for greater integration between primary and secondary services that is consistent with Māori models of health and a Māori development approach.

Conclusion

Traditional Māori public health systems, though undermined by the impacts of colonisation, have provided the foundations for contemporary Māori approaches to their own health development: a distinctly Māori model of health that is holistic in nature, gives primary attention to the spiritual dimension, and also emphasises cultural integrity. Māori, at hui, have called for a Māori development approach to their own health development that would draw on Māori concepts of health and emphasise Māori self-determination and, therefore, leadership. The growing calls by Māori for opportunities to lead their own health development have coincided during the last two decades with a period of regular and extensive health sector reforms in New Zealand. In recent times those reforms have provided legislative, policy, and structural support for Māori health development. This environment has enabled Māori to take a greater role in both the planning and provision of their own health care services. The provision of Māori-specific health services for Māori should be considered as a complementary strategy to culturally responsive and effective mainstream services. This will also be critical if the wide health status disparities between Māori and other New Zealanders are to be addressed.

CHAPTER TWO

Primary health care concepts and challenges

Introduction

Since the concept of primary health care (PHC) was defined and given international recognition at Alma-Ata in 1978 (World Health Organization, 1978), it has become the main focus for the promotion of World health. Models, concepts, and principles of health care delivery and practice have been subject to increasing debate as consumer demands and economic rationalism influence traditional beliefs. This has paved the way for new concepts to become incorporated into health care practices. As primary health care becomes increasingly important to governments and communities partly because of the emphasis on reducing health care costs and the strong shift to community-based care, there is a growing need to increase multidisciplinary knowledge concerning the many dimensions of PHC practice. This chapter begins with a summary of the main features of the primary health care approach as presented in the Alma-Ata declaration and the Ottawa Charter, then examines how these principles and recommendations have been implemented within the current context of primary care in New Zealand generally and more specifically in Māori primary care services.

Ottawa Charter

The Ottawa Charter is a strategic document designed to provide a broad framework for the delivery of primary health care services. The five action areas of the Ottawa Charter are

- building healthy public policy
- creating supportive environments
- strengthening community action
- developing personal skills
- reorienting health service.

Ropiha (1994) has attempted to translate the principles and five action areas of the Ottawa Charter so that they are directly relevant to Māori health promotion. How these relate to Māori health development and, in particular, Māori health promotion is discussed below (Ropiha, 1994).

Building healthy public policy

The principle of healthy public policy, if practised, provides the government with the opportunity to demonstrate a clear political resolve to promote efforts on behalf of indigenous people's well-being. In the New Zealand context, the Māori political systems of iwi, hapū, and whānau need to be recognised on the same basis as mainstream political systems (Ropiha, 1994).

Creating supportive environments

The Sundsvall Conference (1991) identified the need to recognise the different dimensions of the term 'environment', including physical, social, cultural, economic, and political environments. This recognition allows for culturally specific definitions of the dimensions and can have implications in terms of social change; for example, the political environment determines access to resources through legislation, policy direction and the distribution of resources.

Strengthening Community Action and Developing Personal Skills

Ropiha (1994) sees the key to both these principles as the implementation of comprehensive well organised educational strategies involving both communities and individuals.

The community needs to gain the knowledge and develop a level of awareness that will allow them to make informed decisions for the well-being of the total community over a long period of time. The development of personal skills will influence personal commitment to well being and contribute to the overall development of the community through action (pp20-21)

Reorienting health services

Ropiha (1994) clearly signals the priorities for Māori health gains:

- health promotion focus rather than clinical and curative services focus
- development of comprehensive preventative packages that promote well-being
- concentration of services on increasing access and reducing barriers
- highlighting areas in health that directly afflict a large proportion of the Māori population
- provision of services by Māori in a way that is acceptable to Māori.

While Ropiha has focused the Charter in terms of Māori health promotion and has signalled priorities for action, it nevertheless remains a broad strategic document. If it is to be of use to 'grass roots' health professionals then the principles need to be further refined into specific actions that will meet the priority gain areas identified by Ropiha. She also makes assumptions that need to be questioned if we are to pursue a deeper level of analysis of health promotion. Assuming that the development of personal skills will influence personal commitment to well-being is a concept debated widely in the literature (Merideth, 1994). The other issue is the context within which health promotion takes place. Ropiha suggests that although health promotion may occur separately from clinical and curative services, nevertheless the opportunity for health education can often be found when a medical problem exists for the client. The

combination of primary health care services and health promotion can be an effective strategy.

Primary health care

There are numerous definitions of primary health care. These include broad public health definitions which encompass a comprehensive range of services including public health preventative, diagnostic, therapeutic, and rehabilitative services, politics and processes; and the narrower health services definitions which focus on health service provision within formal health services (Pedersen & Wilkin, 1998). This thesis draws on broad public health definitions of PHC as these definitions are more appropriate in explaining the community development philosophies that underpin both nursing and Māori health development.

PHC is defined by WHO as '*essential care made universally accessible to families in a community*'. Health care is made available through the full participation of the family and is provided at a cost that both the community and the country can afford. Full participation means that individuals within the community help define health problems and develop approaches to address these problems. The setting for primary health care is within the community and it reaches across all sectors of society (World Health Organization, 1978).

The most well-known and widely quoted definition of PHC is the Alma Ata definition formulated by members of the United Nations in 1978, which states:

Primary health care is essential health care...made universally available to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination...an integral part of the country's health system...the first level of contact...and the first element of the continuing process.

An important characteristic of this definition is its inclusiveness. It recognises a wide range of factors, agencies, and individuals that contribute to the health of people. It requires a participatory approach and locates individuals within the context of families.

PHC is defined as the first level of public contact with the health system and is based on a philosophy of equity and social justice. It is a strategy concerned with inter-sectoral

collaboration and a set of activities that includes basic clinical services such as health, education, food supply and proper nutrition, provision of safe water and basic sanitation, maternal and child health, immunisation, prevention and control of endemic disease, basic treatment for health problems, and the provision of essential drugs (World Health Organization, 1978).

Health services definitions

The most often quoted health system definitions of PHC have been developed in the United States. They include two definitions constructed by the American Institute of Medicine (IOM). The first was presented immediately following the launch of the WHO definition (Institutes of Medicine, 1978) and was followed by revised and expanded versions in 1994 and 1996; the other is that defined by Starfield. Starfield (1993) identifies four essential features of primary care: care that is first contact, longitudinal, comprehensive, and coordinated. To be 'first contact care', primary care must be readily accessible and patients must use it to gain access to all, or most, necessary services (Starfield, 1993).

Primary health care differs from other types of health care because of the scope, character, and integration of services provided. The literature identifies five attributes as essential to the practice of primary health care: accessibility, comprehensiveness, coordination of service, accountability, and the attention to the needs of a specific community through specific health programmes and services (Bishop, 1998; Pedersen & Wilkin, 1998; Rifkin, Muller, & Bichmann, 1988; Starfield, 1998). An essential element in developing effective PHC services is the concept of community participation.

The principles of primary health care

The five principles of PHC: equity, prevention, appropriate technology, intersectoral action, and community participation represent a philosophy of health in which health improvement for the majority of the world's population depends more on political will than on technological improvements. PHC also depends on the luxury of time and financial resources to pursue the strategy, thereby enabling genuine community participation.

Equity

An approach based on equity implies fair access to goods and services taking into account community needs and the community's capacity to benefit. Consequently, using criteria of needs, those who are most marginalised are favoured and differences in the way people are treated can be justified on the basis of need (Downie, Tannahill, & Tannahill, 1997). While equity has high priority on the New Zealand health agenda (Annette King, 2000), a lack of both resources and political commitment is the major constraint to putting the principle and theory of equity into operation through practice. However, the remaining four principles are more readily translated into practice and thereby more easily gain political support and accompanying resources. To a large extent, the operationalising of these principles has provided the mechanism to facilitate equity.

Prevention

The principle of prevention is important from the perspectives of both cost and human concern. The argument that it was more cost effective to prevent than to continue to treat disease was persuasive. In addition, the idea of 'investment in man' demanded that people stay healthy to participate in production. The emphasis on prevention has made an important contribution to the principle of equity by relocating funds from secondary and tertiary centres to PHC initiatives that often target the most vulnerable in society.

Appropriate technology

The emphasis on appropriate technology has highlighted the need to shift spending from increasingly available and expensive medical high technology to the application of simple solutions to practical problems. The funding shift from curative to preventative care is a major challenge complicated by changing disease patterns and demographics and by increasing pressure from technologists and the medical profession for funds to advance medical science.

Intersectoral action

The intersectoral approach is consistent with a definition of health that acknowledges social, economic, cultural, and political determinants. Critical to this approach is the acknowledgement of those environments that are detrimental to health and the development of a more integrated means to address them. This requires the cooperation

of services and Ministries across sectors and will include, for example, a focus on housing, employment, health education, and social services. The development of an intersectoral approach is often limited by the fact that for many government Ministries and local bodies, health is not a high priority and there is strong competition for limited resources.

Community participation

Community participation is central to the World Health Organisation concepts for both primary health care and health promotion. The World Health Organisation sees primary health care as

the most local part of a comprehensive health system and recognises that the public should participate both individually and collectively in the planning and implementation of health care' (World Health Organisation, Canadian Public Health Association, & Health and Welfare Canada, 1986).

Public demand for a more community-orientated approach to primary health care delivery is recognised as a major structural and organisational challenge to health service delivery both in the UK and Europe (Saltman & Figueras, 1997).

Community participation in primary health care occurs across the range of activities, including receiving the benefits of a programme, participating in programme implementation, monitoring and evaluation, and contributing to programme planning and management (Dwyer, 1989; Rifkin et al., 1988). Potential benefits from community participation include improved effectiveness, efficiency, better coverage and equity in resource allocation, and greater self-reliance (World Health Organisation, 1986).

Utilising community knowledge and support helps cut across language and cultural barriers and is essential for the success of health promotion and prevention activities. Community participation also improves the democratic process, enables social change, and enhances the learning process in PHC, keeping organisations abreast of changes in society (Dwyer, 1989; Pritchard, 1994; Richardson & Bray, 1987; Rifkin et al., 1988). While there is limited evidence linking community participation and primary health care with improved health care outcomes, the potential for it to do so via the benefits outlined is significant.

Yet community participation in isolation will not guarantee improved health outcomes but is an important part of strategies to improve health. Community participation often

creates controversy, promoting, as it does, an active healthcare role for both client and community therefore challenging the role of the health professional. This is due to its broad community development focus and advocacy role that has, in many cases, led to political activism. Nevertheless, community participation has emerged as the primary health care principle with the highest profile.

Approaches to primary health care

Community development

The community development approach evolved from social reform movements in the 1960s and embraces the idea that politicisation is a desirable and necessary means for communities to achieve health goals. Increasingly during the 1960s and 1970s the United Nations advocated a community development approach aimed at instigating change from within communities. The concept was popularised and community participation was identified as a key element of community development. The idea of community development was embodied in the 'Health For All 2000' strategy, the Alma-Ata declaration, the Lalonde report, and later the Ottawa Charter (Lalonde, 1974; World Health Organisation et al., 1986; World Health Organization, 1978). The 'health for all' philosophy synthesised community development ideas into a coherent framework and emphasised the need to understand health needs within the context of the social and economic forces. Nio Ong (1993) points out that there has been considerable opposition to community development projects due to their inherently political nature and because they are time consuming and may deliver intangible results; they also tend to be small-scale and frequently fail to make an impact on political formulation (Nio Ong, 1993).

It should be emphasised that a community development approach to reducing health inequalities is not merely a community-based one. Community-based approaches are usually defined by external experts, or institutions, and involve the mobilisation of community resources to address an identified health problem. An example might be an immunisation programme delivered by multiple community agencies in response to an outbreak of meningococcal meningitis. In the community development model, the community identifies their needs and resources are made available to help the community to meet them.

Community development is one of three basic approaches to health. Each view implies a specific view of the definition of health, the involvement of the community in health

matters, and the amount of control the community has over health resources (Rifkin, 1983).

The first is the medical science approach. This is based on the medical model, equates health with the absence of disease, and suggests any improvements in health depend on medical technology and public compliance with 'doctors' orders'. The second is the health planning approach, which sees health in the World Health Organisation's terms of physical social and mental well-being. With this approach, improvement in health occurs where there is adequate provision for health services. Rifkin describes the third approach, which is the community development approach. This views health as a human condition rather than a service. In this approach, a healthy community exists when the public has authority and control over its own health resources.

Community Orientated Primary Care (COPC).

Community orientated primary care represents a less radical reorientation of PHC than community development. Although in some contexts it may be regarded as a transitional organisational form, power and resources are not transferred to the community but services are specifically provided to meet the measured needs of the defined community. COPC has been defined in many ways; common to all of them is the idea that it is an approach to PHC that uses epidemiological and clinical skills in a complementary fashion to tailor programmes to meet a particular defined population (Abramson, 1988). It gives specific recognition to the interaction between the various socio-economic determinants of health, as well as the overlap between health services and the social and individual behaviours that influence health. A community-orientated approach to health applies the methods of clinical medicine, epidemiology, social science, health services research, and evaluation to defining and characterising a community, identifying community health problems, modifying programmes to address these problems, and monitoring the effectiveness of the programme modifications (Abramson, 1988; Blumenthal, Mort, & Edwards, 1995; Geigor, 1984).

Intrinsic to this approach to primary health care is the continuing relationship between the community and the provider organization, often described as longitudinality of care (World Health Organisation, 1986). Primary care organisations adopting a COPC model demonstrate a number of features. First, and critically, they assume responsibility for the health of populations. Those organisations organised around a geographical area

assume responsibility for community-based services. Second, the health professional becomes part of a team responsible for providing population-based care. As patients live longer and patterns of morbidity change in community settings, primary care organisations will be responsible for health promotion and maintenance of well-being. Third, health-care practitioners training programmes will become more responsible for training in methods of population-based care. Fourth, attention will be drawn to COPC as health planners recognise the ability of PHC organisations to work with communities, to organise more efficiently both to prevent disease and to promote health using newer medical technologies in a responsible manner. Finally, advances in health information will inform communities of trends in health and disease; therefore allow planning for the health of communities (Abramson, 1988; McMurray, 1999; Nutting & Connor, 1986; Tollman, 1991).

Reducing health inequalities through primary health care

The extent and significance of health inequalities between ethnic and socio-economic groups in New Zealand is now well documented (Ministry of Health, 1999a). Improvements in the health status of New Zealand population as a whole will not be achieved without reducing these inequalities (National Health Committee, 1998).

There has also been a number of international reports on health inequalities with well-researched strategies to reduce these inequalities. Recurrent themes in these reports are addressing the broad socio-economic determinant of health as part of a PHC, focussing on promoting good health, improving access to early intervention and prevention, and building partnerships with communities and local providers (Acheson, 1998; Health Canada, 1999b; US Department of Health and Human Services, 2000).

International research supports the role of PHC in both improving health status and reducing health inequalities (Shi, 1997; Starfield, 1994). Others show that PHC may mitigate, though not prevent, the adverse effect of income inequality on health status (Bunker, Frazier, & Mosteller, 1994; Lantz, House, Lepkowski, & al., 1998; Shi, Starfield, NKennedy, & al., 1999). Countries orientated towards a strong primary care infrastructure achieve better health outcomes as assessed by a variety of measures (Bunker et al., 1994; Shi, 1997; Shi et al., 1999; Starfield, 1994). It appears that it is not the number of primary care doctors that matter but the way resources are distributed and the clear specification of roles. Research by Starfield (1996) suggests that countries

orientated towards a strong PHC infrastructure tend to achieve better health outcomes (Starfield, 1996). PHC in these is characterised by more equitable distribution of resources, fewer barriers to access, choice of primary care provider, and integrated services.

Health inequalities call for urgent action within the health sector to integrate patient-centred and population-based health initiatives to improve health status (Freyman, 1989; Lee, 1994). There is growing interest in population approaches as a basis for action to improve health and reduce health inequality (Annette King, 2000). In many New Zealand communities, action is already being taken and there are already many exciting population-based initiatives in PHC, some within a community-based framework (Ministry of Health, 1999b).

A population-based approach consists of organised responses to promote and protect the health of identified groups and reduce inequalities between groups. The approach is explicit in acknowledging that socio-economic conditions are key factors in determining people's health and that socio-economic inequality produces a gradient of health stages, with the most disadvantaged individuals and groups experiencing the worst health outcomes (Coster, 1999; Cumming, 1999). Population-based approaches do not replace but rather compliment high quality care for individual patients. They provide the framework within which high quality and equitable care can be provided to individuals and groups of people.

International experience

Internationally, a number of countries are encouraging PHC services to adopt a population-based approach to improve the health of the population over all and reduce inequalities between groups. In the United Kingdom, since the early 1990s, the National Health Service contract with GPs has provided incentives for the development of general practice-based health promotion and disease prevention programmes. Experience suggests that while the contract facilitated the expansion of health promotion and disease prevention services (LeTouze & Calnan, 1996), many programmes failed to target those most at risk of ill health (Gillam, McCartney, & Thorogood, 1996), there are difficulties of monitoring and accountability, (Baeza & Calnan, 1998), and evidence that the community most at risk of ill health tend to experience the least satisfactory access to preventative services (Birmingham Health

Authority, 1995). The authors all concluded that funding of PHC should be allocated on the basis of need to assist when addressing inequalities in PHC. They argue that population-based approaches are insufficient on their own to reduce health inequalities and need to be supported by equitable funding.

Evaluation studies of the UK total purchasing pilot scheme highlighted three reasons why their PHC models overall have not led to a more population-based approach: underdeveloped organisational capabilities for promoting population-based health, inadequate assessment of population-based need, and lack of support by organisation and managerial culture for population approaches (Birmingham Public Health Alliance, 1998).

Based on Canadian experience, several reports concluded that the WHO 'Health for All' policy could only be achieved through the integration of health promotion, disease prevention, and PHC (Advisory Committee on Population Health, 1994; Canada PHA, 1997; Health Canada, 1986). The reports suggest that implementing a population approach requires a change in the way Canadian PHC is funded, organized, and delivered. The key changes required include working in partnership at a variety of levels, building accountability in to the system, making policy choices that are informed by evidence, and relocating resources (including power and authority) away from professional groups to people in the communities.

A review of 500 initiatives in the United States in the mid 1990s documented six types of benefits from collaboration between clinical medicine and population health (Lasker, 1997). This review supports an approach to PHC based on strategies such as improving services by co-ordinating care for individuals, improving access to care by establishing frameworks to provide services for the uninsured, and improving the quality and effectiveness of the services by applying a population perspective. They also highlighted the importance of addressing community health problems, strengthening health promotion and health protection by mobilising community resources, and shaping the future direction of health system by collaborating around policy, training, and research.

A 1998 review of general practice in Australia recommended further enhancing of the population health role of general practitioners through the divisions of general practice in close co-operation with the existing public health networks. Three important changes

supporting the population health role in Australia have been funding for the establishment of the division of general practice - equivalent in some respect to IPA in New Zealand, funding for general practice-based research, and the establishment of support and evaluation source units. The quality of existing population health approaches in general practice is very variable. GPs indicated a need for specific training in population-based approaches to health promotion and health maintenance, including the broader roles of self-advocacy, liaison with population health agencies, and a greater participation in state or national surveillance activities (Towler, 1999).

Primary Health Care Services have been identified as essential to improving health and reducing inequalities. Good primary health care allows timely community-based access to effective and appropriate intervention, diagnostic and treatment support services, helping people to enjoy the best possible health and independence, and minimising unnecessary use of secondary care services. As identified in the New Zealand Health Strategy, PHC will be critical to improving health and in reducing inequalities in health status between Māori and Pacific people and other New Zealanders (Ministry of Health, 2000b).

As outlined above, the World Health Organisation defines PHC as a level of care that is the first point of contact with the health system based on a philosophy of equity and social justice. It is a strategy concerned with inter-sectoral collaboration and a set of activities that includes basic clinical services. Within New Zealand, PHC should also be considered in the context of the principles of the Treaty of Waitangi: partnership, protection, and participation (Royal Commission on Social Policy, 1988).

The Treaty of Waitangi and health

The Treaty of Waitangi, signed in 1840 between representatives of the British Crown and New Zealand's Māori chiefs, is generally regarded as the treaty of cession that established the modern state of New Zealand (Barrett, 1997). The three articles contained in the English translation of the Treaty provided for a transfer of sovereignty (article one), a continuation of existing property rights (article two), and citizenship rights (article three) (M.H. Durie, 1994b). The wording in the te reo Māori text, however, conveyed quite different meanings from those conveyed in the English text. Māori generally understood Article One to be the transfer of governance rights, therefore legitimating the New Zealand Government. Article Two provided for Tino

Rangatiratanga, the right for tribes to exercise authority over their own affairs. Article Three, by promising 'all the Rights and Privileges of British subjects' implied equity as much as citizenship and as such implied that there would be no serious gaps in outcomes between Māori and other New Zealanders (M.H. Durie, 1994b).

The New Zealand government largely ignored the Treaty, especially with regard to health, education, welfare, and housing, up until the last 25 years' when it has been given increased recognition. This recognition has resulted in a range of responses, the most important of which was the establishment in 1975 of the Waitangi Tribunal whose task is to investigate and report on breaches of the Treaty. Other responses relevant to health and public policy, according to Durie (1994), have included:

- 1985 Standing Committee on Māori Health recommendation that the Treaty be regarded as a foundation for good health
- 1986 Director General of Health's recommendation that the Treaty be integrated into health services
- 1988 Royal Commission on Social Policy's recommendation of the three principles relevant to both social policy and the Treaty: partnership, participation, and protection
- 1992 Government's key statement on the Treaty as it applies to health, gives recognition of Article Three rights (M.H. Durie, 1994b).

Although it has been used to aid the interpretation of the law generally, the Treaty of Waitangi has been enforceable only when it has been incorporated into legislation. The Health and Disability Services Act 1993 refers to Māori special interests but falls short of specifying the Treaty as an obligation on the Crown (M.H. Durie, 1994b).

Despite the Government's difficulties in developing a coherent, consistent policy with regard to health and its obligations under the Treaty, the acceptance in 1992 by the Minister of Health of the Treaty of Waitangi as the 'founding document of New Zealand' went some way towards the appreciation of health as a combination of social, cultural, economic, and political factors. A large gap remains between the acceptance of the Treaty and how it influences policy development, which would translate into actual health gains for Māori. However, two ideological movements have resulted in

unparalleled opportunities for Māori health development. The first is biculturalism and the effect this has had on reshaping our approaches to health and the second is the health reforms guided by the Health and Disability Services Act 1991.

PHC and population-based approaches in New Zealand:

As in the countries surveyed above, PHC in New Zealand is still largely synonymous with general practice and much of the information on access, funding, and other issues relates to General Practice. The central problem for GPs in New Zealand in attempting to focus effectively on preventative care has been summed up by Foote (2000), who observes that 'Health conserving behaviour tends to be a middle-class habit and that GPs tend to be teaching to the converted' (Foote, 2000). This view of health is not only a middle-class habit, it is a white, middle-class way of thinking. Some groups within the community have the luxury of thinking of health as a central point of life and this is promoted by the popular press and advocated by the health and fitness industry. For many socio-economically disadvantaged groups in society, however, this is not an option. The assumption that individuals are responsible for their health and that families and communities are less accountable needs to change.

New Zealand's fee for service funding system for Primary Care encourages service providers to locate in areas where there are more people and fewer socio-economically disadvantaged groups. The resulting uneven distribution of practitioners exacerbates inequalities, access, and funding disadvantages especially for rural people and poorer communities. Other funding mechanisms such as capitation may make the distribution of resources more equitable but are unlikely on their own to stop practitioners preferentially locating in well-populated, wealthy areas.

New Zealand's National Health Committee has defined PHC as local, first-contact care for people that is accessed by self-referral (National Health Committee, 2000). It comprises a range of services, delivered by a range of health practitioners, designed to keep people well: from health promotion and screening to diagnosis and treatment of medical conditions. A distinction is sometimes made between primary medical care and PHC. This distinction is becoming increasingly artificial. It is clear from the definitions in the literature that general practitioners and practice nurses are the major providers of PHC in New Zealand today and they often provide primary medical care (Carryer, 1999; Ministry of Health, 2000a). The increasing acceptance of the importance of the

primary care team, the overlapping roles of doctors and nurses, and the necessity for co-operation between many different primary care providers means that the distinction may actually confuse a discussion of PHC. Nursing does not support this position, as will be discussed in Chapter 3. The recent formation of a college of Primary Care by the Royal New Zealand College of General Practitioners and the Practice Nurse branches of the New Zealand Nurses Organisations is a step towards the development of a primary care team approach.

A primary health care team should be characterised by management that fosters a team approach and utilises a range of skills necessary to provide the essential services. There should be opportunities for continuing education and understanding of, and responsiveness to, both the principles of the Treaty of Waitangi and cultural issues in the whole population. The team should include a focus on health-related community development and inter-sectoral initiatives. Orientation towards a population-based approach will require training and work force development for practitioners both in PHC and secondary care organisations.

While there are a number of population health initiatives in PHC underway in New Zealand, little long-term evaluation of these initiatives has been carried out - often because sufficient time has not yet elapsed. Many of these initiatives are documented in the National Health Committee background papers and in previous Ministerial publications (Carrier, 1999; Crampton, Dowell, & Bowers, ; Cumming, 1999; Gribben & Coster, 1999; King, 2000b; Ministry of Health, 2000a).

Māori primary health care

Māori involvement in primary care and public health has had a very long and varied history. Early Māori community involvement in health was exemplified by the work of people such as Maui Pomare, Tutere Wirepa, and Te Rangihiroa (Sir Peter Buck) (Dow, 1995; Durie, 1987; Lange, 1972). These men, with the help of the Māori councils and the Māori health inspectors in the early 1900s, provided both leadership and public health regulation enforcement. Other significant initiatives were those developed by the Women's Health League who provided information on hygiene, nutrition, disease prevention, and parenting and with the Māori Women's Welfare League who focused on housing, education, health, and discrimination in urbanised communities.

The 1970s marked the beginning of a cultural renaissance for Māori, with increasing political action directed at reaffirming The Treaty of Waitangi, addressing grievances, facilitating Māori self-determination, and participating in societies. By 1984, calls for recognition for the Māori world view, for increased partnership with the Crown and for self-determination had grown. The hui Taumata (the Māori Economic Summit, 1984) launched the Decade of Māori Development (1984-1994) within a framework of Māori self-sufficiency and control. Although the main focus of the hui Taumata was economic development, social policy and development health was also discussed. Hui participants also expressed their desire for greater participation in the allocation and distribution of health resources and financial support for Māori health initiatives.

By 1984, several important initiatives had been started, including marae and community based clinics at Waihi Marae and Ruatoki. These clinics emphasised a positive approach to Māori health, confirming Māori health philosophy and models. They delivered Māori health-care programmes and advocated Māori health initiatives, designed to meet Māori health needs as defined by Māori people.

Over the rest of the decade the number of Māori health initiatives slowly increased. There were a wide variety of programmes but several common themes were apparent. The programmes are based on Māori models of health, focused on health promotion rather than emphasising ill health and practice was driven by Māori desires for self-determination. The hui, Te Ara Ahu Whakamua (the Māori health decade hui), held in Rotorua in 1994 reiterated the importance of cultural identity, self-determination, economic and social factors, whānau, wairua, and bodily and mental health as components of Māori well-being (Dyall & Wauchop, 1994). The hui called for the recognition of diverse Māori realities (M. Durie, 1995). Increased involvement of Māori at all levels of the health sector, and restated the belief that services provided 'by Māori for Māori' would achieve health gains that seem to elude mainstream providers (M. H Durie, 1994).

Over the same decade, 1984–1994, there were also significant developments to the Crown's response to Māori. These developments included increasing government recognition of Māori rights, some acknowledgement of Māori grievances, inclusion of the Treaty of Waitangi in Crown papers, establishment of various Māori Health Committees and units, recognition of Māori health as a health gain priority area, and the development of policy guidelines for Māori health.

During the health reforms of the 1990s, Māori, in particular, indicated their desire for greater autonomy and flexibility in the delivery of health care (Durie, 1996b; Ministry of Health, 1997; Te Puni Kōkiri, 1998). There was both recognition of the poor health status of Māori in the area and a strong desire amongst iwi to provide services that have control of health resources. Although the Health and Disability Services Act did not refer to the Treaty of Waitangi or the Crown's obligation to Māori under the Treaty, reference was made to Māori health gains, to Māori participation and planning, and implementation of health policy, and, Māori provider development which emphasised Government objectives throughout the 1992–1997 period and were a significant aspect of the health policy changes during the 1990s. Partly as a result of these policies, a diverse range of iwi and other Māori community based primary care initiatives emerged during the early and mid-1990s.

By the time the health reforms were at the decade of Māori development had afforded some groups the opportunity to develop and manage Māori health programmes and services and develop workforce and management skills. Many groups were ready to negotiate contracts for new services, including health promotion, health education, and community health programmes as well as contracts with provision of primary medical care. As a result, there are currently around 200 Māori health service providers, many of who provide Primary Care Health services. In general, the development of the initial programmes occurred after the community, in partnership with people or groups interested in health, identified areas of need. Subsequent development of services has occurred as a result of negotiation with funders after further health needs have been identified or as a result of the health services submitting responses to requests for proposals by various funding authorities.

Examples of Māori primary health care initiatives

In October 1992 Raukura Hauora Ō Tainui Trust opened its first Marae based clinic. By May 1993 the Trust had opened 4 marae-based clinics all of which were staffed by doctors and nurses. The four clinics were located in Waihi Marae, Turangawaewae, Karaka, and Tuhikaramea.

A further example of iwi-based primary initiative is Te Waipuna Primary Medical Service in Whanganui, which came into existence following 7 years of Māori health development by iwi in the Whanganui area.

The first Māori community health service, Te Korimako Primary Community Health Service, was established in 1984 and in 1986 was among the first tangata whenua providers to secure funding from an Area Health Board to provide Community Services.

Te Oranganui Iwi Health Services was formed in 1992 and in turn established Te Waipuna Medical Services in 1993. The primary medical service rapidly expanded from its initial manager, doctor and nurse-base: employing midwives in 1994, starting Maternity Support Services in 1995, and securing a contract to provide reproductive health and contraception services in 1997. In 1994, a rural suitcase service was started with doctors and nurses visiting marae-based clinics. In 1998, a separate iwi-integrated care organisation, Taumata Hauora, was formed as part of a strategy to manage health resources and improve the health status of the local iwi population.

A pan-iwi urban organisation, Te Whānau O Waipareira Trust located in Waitakere, Auckland, started establishing Primary Care Services in late 1991. In 1992, two part-time GPs were employed. In 1997, the Trust's Health Corporation 'Wai Health' included:

- a general practice clinic
- a dental clinic
- a women's health programme
- kaumātua and rangatahi programmes
- an alcohol and drug service
- Parents as first Teachers programme
- a programme for children recently discharged from hospital
- a Youth One-Stop-Shop
- a health promotion programme;
- well child programmes (Crengle, 1997).

The extent of change in the area of Māori health services was profound. The financial and more general support provided for the development of Māori Primary Care services may be judged as perhaps one of the principal successes of the reforms of the past

decades. The success was more evident in iwi-based rather than in non-iwi-based services.

Māori primary health care teams

A variety of staff are employed within Māori Primary Care Services including doctors, nurses, midwives, managerial, and administrative staff. In addition, many services employ community health workers or Kai Awhina. Māori staff are preferred, where possible, and in most services community health workers, managerial, and administrative staff and nurses are Māori. In some areas, most notably with doctors and midwives, lack of a sizeable Māori workforce means that non-Māori staff are frequently employed in these positions.

Community Health Workers or Kai Awhina play a major role in the health services that employ them. They use members of the local community and significant networks within that community and represent the face of the Māori service within the community. They have a number of roles, including providing health information, coordinating and undertaking health and education activities, some clinical roles for example, checking baby weights and well child services, advocacy support for people, and whānau, and, if necessary, providing transport. This is not a complete list of the various roles and generally there is a move away from generic community health workers who are expected to have wide expertise.

Accountability, humility, and reciprocity are key features of successful participation in a community-based team that never stops trying to involve consumers. Full participation of community members is believed to be the only model that will lead to positive outcomes.

From this description of the development of Māori Primary Care, the following core themes are identified. There is a strong commitment to

- *Māori governance, management and delivery*, which enables services to be delivered by Māori for Māori
- *Māori concepts and philosophies* as central principles to the organisation, staff and clients

- *Māori cultural values beliefs and practices*, which are used in the development and delivery of services
- *Community input and accountability*, which are possible through specific mechanisms within the service
- *Utilise Māori staff*, where possible, to provide services that are high quality, affordable, accessible, and acceptable to the clients.

Two philosophical approaches frame the services: positive Māori development and the use of a Māori-model of health and well-being.

Despite growing numbers of Māori-specific primary health care interventions, Māori access to primary health care interventions remains poor. In an integrated primary care utilisation study, Gribben (Coster, 1999) found that although consultation rates for Māori and Polynesian patients were higher than the European rate, their rates were less than expected on the bases of known health status. In addition, Māori and Polynesian patients utilised fewer referral services including laboratory, pharmaceutical, and radiology services. There is some evidence that Māori tend to defer accessing health services, resulting in higher rates of hospital admissions (Malcolm, 1995). Government policy objectives in achieving better access to health care for Māori have as yet to be achieved. The current fee for service system offers barriers to Māori and other low-income populations. These groups under utilise primary health care services, despite their poor health status and, therefore, expected higher rates of utilisation and over utilise of secondary care services possibly because of late presentation with more serious illness (Barnett & Coyle, 1998; Gribben, 1996).

Māori services are effective in addressing many of these needs, doing so is more costly in both monitoring and in staff resources but achieves health gains. Funding levels may be inadequate for the high level of poor health and the way in which the services are delivered. There is a high demand for workers and a need for increasing the knowledge and skill base of workers. There is also need to support the development of information technology capabilities for providers.

By Māori for Māori Services

The identification of local community need is a key feature of the Māori Primary Care Service development. The central belief of Māori Primary Care Providers is that 'by

Māori for Māori' services were resolved and possible health care gain for Māori. What constitutes a 'by Māori for Māori' service? Generally they are operated by a Māori organisation or group, they are governed by Māori and are based on kaupapa Māori, and utilise tikanga in the development of the delivery of their service programmes.

These services are accountable to the Māori community and utilise where possible, Māori staff, provide the Māori community with high quality services that are affordable, accessible, and appropriate. They will characteristically use a Māori model of health rather than the Western paradigm illness-model as a base for developing and delivering health services to Māori. The most widely used model is that of Durie 'Te Whare Tapa Wha', which describes four dimensions of health.

This model forms the basis of the kaupapa and service approach adopted by many Māori Primary Care Services. Essentially, in order for an individual to be healthy all four factors must be healthy. That is a person cannot be considered healthy unless all dimensions are vital and thriving. However, as documented at the Hui Te Ara Aha Whakamua, Māori working within the health sector believe that economic, cultural including land and tino Rangatiratanga, education, and unemployment factors which impact on the health of the individual and their whānau must be addressed when considering their health and well-being. Maximising the well being of health in Māori attention to these determiners and health gain cannot be separated from positive Māori development. Positive Māori development refers to Māori social, economic, and cultural advancement within a framework of Māori self-sufficiency and Māori control. The commitment to positive Māori development further widens the scope of Māori health services and their staff.

Summary

This chapter has broadly described the accepted models of primary health care and analyses of its implementation internationally, in New Zealand and, importantly, within Māori health approaches. This serves as an introduction for the following chapter which discusses nursing models of primary health care and nursing's role in the delivery of primary care services.

CHAPTER THREE

Nursing and primary health care

Introduction

The previous chapter presented a summary of the main features of the primary health care approach, as presented in the Alma-Ata declaration and the Ottawa Charter. It examined how these principles and recommendations have been implemented within the current context of primary health care in New Zealand generally and more specifically in Māori primary care services. Nursing as a discipline has long held a philosophical position that is congruent with both the principles of primary healthcare and community development. This chapter situates nursing in the delivery of primary health care. The focus is on the philosophical and theoretical intent of nursing and its congruence with primary health care, and how nursing can best meet the challenges that face health care providers in the current New Zealand context.

The Ministerial Taskforce on Nursing (Ministry of Health, 1998b), the National Health Committee report on primary health care (National Health Committee, 2000), and the government Primary Health Care Strategy (Ministry of Health, 2001) all acknowledge the role nursing could have in New Zealand in the provision of primary health care with particular reference to reducing inequalities in health, improving population health overall, effectiveness of funding mechanisms, and identifying barriers to providing population based programmes .

Primary healthcare and primary care

There is considerable controversy over what constitutes primary care and primary health care (PHC). Primary health care can be distinguished from primary care in a number of ways. Primary health care is generally defined more broadly than primary care, includes a comprehensive range of services including public health, preventative, diagnostic, therapeutic, and rehabilitative services. PHC is essential care made universally accessible to families in a community. Health care is made available to families through their full participation and is provided at a cost that the community and the country can afford. Full participation means that individuals within the community help in defining health problems and in developing approaches to address the problems. The setting for primary health care is within the community and it reaches across all sectors of society (World Health Organization, 1978).

As outlined in the previous chapter these terms are often used interchangeable. Currently the National Health Committee (NHC) combines primary health care and primary care jointly as:

Local first contact cares for people that are accessed by self-referral. It comprises a range of services, delivered by a range of health practitioners, designed to keep people well and out of hospital, from promotion of health, screening for disease to diagnosis and treatment of medical conditions. In contrast, primary medical care refers to assessment, diagnosis and treatment services provided by general practitioners.

The PHC concept within the NZ context has been largely used by politicians, professionals, and managers as an agent of change, that is the reforms created the environment that then led to PHC movement nationally and internationally. The concern is with the balance of power resources status as much as with effective and efficient provision of healthcare. In PHC, two major themes shift the balance between primary and secondary sectors in the health care system, and shift the emphasis within the primary sector from individual professions (medicine in particular) to multi-disciplinary teamwork. For these purposes, politicians and policy makers have largely avoided precise definitions that might restrict the scope of action

Nursing models, on the other hand, continue to clearly differentiate between these terms using the board based WHO definition of primary health care and defining primary care or, as some refer to it, *primary medical care*, as a personal health care system that

provides for first contact, continuous, comprehensive, and coordinated care. It addresses the most common needs of clients within a community by providing preventative, curative, and rehabilitative services to maximise their health and well-being. Although primary care practitioners are urged to consider the client's social and environmental attributes in diagnosing, interventions are directed primarily toward an individual's pathophysiological process (Starfield, 1996).

Primary care is an essential part of the overall primary health care system, as stated in the Government's primary health care strategy, but as long as primary care is covertly understood as primary medical care then community development, disease prevention, and health promotion will be marginalised. The health episode characterised by self-referral to medical care is a reactive process to a health crisis rather than a proactive intervention for health. Self-referral requires that clients are able to make informed decisions, have motivation, transport, a belief that the service is culturally appropriate, and a certain level of private resource to enable access to services.

The New Zealand Health Strategy has stated that the formation of PHC organisations will be 'not for profit bodies' and 'must be able to show that all providers and practitioners can influence the organisation's decision making, rather than one group being dominant' (Ministry of Health, 2001). The Ministerial Taskforce on Nursing outlines some of the barriers that impact on nursing's ability to participate fully at all levels of decision making, noting that nursing services such as Public Health Nurses and Plunket nurses are often rigidly constrained by contractual boundaries which do not always meet the needs of either the family or the community (Ministry of Health, 1998b). During the last two decades these perceived barriers have resulted in limited expressions of nursing's potential and have discouraged the collaborative relationships often stated by many health professionals as being desirable in order for populations to be served (Carrier, 1999).

Primary health care nursing encompasses population health, health promotion, wellness care for children, adolescents, and adults, first point of contact care, and community partnership. These services are provided in both urban and rural settings and geographical areas on these boundaries and include a diverse patient mix of ethnic and cultural groups. The changing structures of primary health care in New Zealand and, in particular, the role of nursing has been recognised at the government level within the recently released document (Ministry of Health, 2001).

Philosophical congruence of nursing with primary health care

As a philosophy, PHC is based on the tenets of social justice, equity, and self-reliance. As a strategy, PHC focuses on individual community needs, maximises the involvement of the community, includes all relevant sectors and agencies, and uses only technologies that are accessible, acceptable, affordable, and appropriate. Key principles include equity, access, empowerment, self-determination, and intersectoral collaboration (McMurray, 1999). Nurses are familiar with these concepts and most nursing curricula and texts clearly advocate this broader approach to primary health care.

Nursing in the context of health care

While nursing in its own right is a profession, it is collaborative in nature and nurses provide complementary skills to other care professionals as members of health care teams. Nursing focuses on the client relationship and, therefore, continuity of care and monitoring and evaluation in relation to all levels of care. Generally, there has been some confusion as to accountability with the popular perception that medical practitioners have the medico-legal responsibility for their own actions and the actions of nurses. However, the Nurses Act 1977 provides for the accountability of nurses for their own actions. Unlike other more specialist health professionals, nurses tend to be present throughout the health care continuum.

In everyday practice, nurses provide a unique contribution to care outcomes through their presence and thoughtful assessment, planning, implementation and evaluation activities, which are focused on the 24-hour experience of patients and their families (Ministry of Health, 1998b).

From a nursing perspective, the concept of health takes account of cultural, gender, and socio-economic factors in relation to both people's understanding of, and access to, good health. Consistent with this, nursing practice is concerned with working with people to achieve their own health potential despite difficult circumstances.

The Ministerial Taskforce on Nursing (Ministry of Health 1998) outlines clearly the gap between what nursing is in its intent and theoretical foundation, and the reality of nursing in most practice settings. The Taskforce noted that nurses, such as practice nurses, were frequently unable to contribute as full and equal team members because they had limited access to resources, physical workspace, and postgraduate education to maintain and enhance their skill base. They argue that the potential of nursing in the

community is often subsumed into a role that is 'little more than assistance' with primary medical care (Ministry of Health, 1998b). The success of any contribution that a primary health care nurse can bring to a community is dependent on the quality of relationships he or she makes with community members and other health professionals. However, it is not clear in the New Zealand health system exactly what individual health professionals each contribute to a primary health care team. They generally work as individuals in a team setting but not as collaborative partners.

Primary health care nursing

Although there are numerous definitions of community health nursing, public health nursing, and community based nursing, there is a general consensus within the profession as to how these roles are defined. The following definitions are those most often presented in the literature:

Community-Orientated Nursing Practice is a philosophy of nursing service delivery that involves the generalist or specialist public health and community health nurse providing health care through community diagnosis and investigation of major health and environmental problems, health surveillance, and monitoring and evaluation of community and population health status for the purpose of preventing disease and disability and promoting, protecting, and maintaining health in order to create conditions in which people can be healthy

Public Health Nursing Practice is the synthesis of nursing theory and public health theory applied to promoting and preserving health of populations. The focus of practice is the community as a whole and the effect of the community's health status (resources) on the health of individuals, families, and groups. Care is provided within the context of preventing disease and disability and promoting and protecting the health of the community as a whole.

Community Health Nursing Practice is the synthesis of nursing theory and public health theory applied to promoting, preserving, and maintaining the health of populations through the delivery of personal health care services to individuals, families, and groups. The focus of practice is health of individuals, families, and groups, and the effects of their health status on the health of the community as a whole

Community-based Nursing Practice is a setting-specific practice where by care is provided for the ‘sick’ individuals and families where they live, work, and go to school. The emphasis of practice is on acute and chronic care and provision of comprehensive coordinated and continuous services. Nurses who deliver community-based care are generalists or specialists in maternal-infant, pediatric, adults, or mental health nursing (Health Canada, 1999a).

Models of community and public health nursing

Community and public health nursing both seek to empower individuals, families, and groups to participate in creating healthy communities. The prevailing theory about how healthy communities develop has been that individuals and social groups clarify their identities first, then protect their own rights while also considering the rights of others (Stanhope & Lancaster, 1996; Westbrook & Schultz, 2000). More recent studies on the moral development of women, though, suggest that women first participate in a network of relationships of caring for others and then consider their own rights (Gilligan, 1982). This position has also been substantiated in the nursing literature, especially as it relates to vulnerable groups (Blumenthal et al., 1995; Meleis, 1990), and in this research the participants’ concern for whānau was always their first priority. The ideal for a healthy community is a balance of individuality and unity. Community and public health nurses seek to promote healthy communities in which there is individual freedom and responsible caring for others. They seek to empower human beings to live in ways that strengthen resilience, decrease preventable diseases, disability, and premature death and relieve experiences of illness, vulnerability, and suffering (Gadow & Schroeder, 1996; Swanson & Nies, 1997).

Empowerment is articulated as a process of assisting others to uncover their own inherent abilities, strengths, vigor, wholeness, and spirit (Skelton, 1994). Empowerment depends on the presence of hope (Jones & Meleis, 1993) and it is a process by which possibilities and opportunities for the expression of an individual’s and community’s being and abilities are revealed (McFarlane & Fehir, 1994). Nurses can assist this process by fostering hope and by removing barriers to expression (Jones & Meleis, 1993; Kuokkanen & Leino-Kilpi, 2000; McFarlane & Fehir, 1994).

Nursing theory and community health nursing

Nursing theory and community health nursing, in particular, have relied heavily on General Systems Theory. General Systems Theory views the community as an open system that consists of a set of interacting elements that must exchange energy, matter, or information with the external environment to exist (Katz & Khan, 1966; von Bertalanffy, 1968). Open systems include individuals as well as social systems such as families, groups, organisations, and communities. The assumptions that relate to all open systems are similar to those underlying holism in nursing (Allen, 1995). There is an underlying belief that a system is greater than the sum of its parts. One cannot understand a system by studying its parts in isolation. The primary relationship is focused on how the system interacts with the environment and changes over time. These exchanges are seen to be circular and increase in complexity over time. There is also an acceptance that there is no one right way to achieve specified goals. Self-care and environment have become key concepts in community health nursing, reinforcing the goals of individual responsibility and the responsibilities of community as secondary to this (Stanhope & Lancaster, 2000; Swanson & Nies, 1997).

Modern nursing

Modern nursing began with Nightingale's environmental approach and nurses applied other models from other sciences such as psychology, sociology, ethics, health education, and the sciences. During the mid 19th century there was a strong focus on both social and political issues in public health. Nightingale's curriculum to educate district nurses reflected that focus (Newell, 1981); it also addressed individual social and health reforms. She was influential in shaping British health policy related to a number of issues, one of which was the institution of the workhouse reforms to reduce air pollution. Poverty was a particular concern of hers; she described it as a state of mind - not only of economics, and believed that nurses should 'depauperise' those in poverty by addressing that state of mind and bringing about social reform. She challenged the ineffectiveness of a treatment and cure approach and wrote that 'money would be better spent in maintaining health in infancy and childhood than in building hospitals to cure disease' (Newell, 1981)(pg 108). Nightingale's focus extended from

individuals to communities and ranged from personal care to political activism³. This multifaceted approach is consistent with current conceptualisations of public health policy.

Early public health nursing was also firmly grounded in a nursing paradigm and existed outside of medical jurisdiction and followed the Nightingale tradition. This entailed a strong emphasis on the development of community coalitions for influencing health and social policy and a focus on the broad determinants of health. During the later half of the 19th century, new developments in both science and technology saw public health policy and practice radically change. The application of scientific principles to the issue of health catapulted medicine to a dominant position in public health. Germ theory which emerged in 1870, gave the developing science of medicine a model with which it would view disease to the present time. Epidemiology and the advancement of statistics provided the tools by which population norms could be created and deviations from these norms identified. As these advances were incorporated into the field of public health, a biomedical view of health gained dominance and approaches to improving health shifted to the treatment and prevention of disease. Public health knowledge suddenly became useful to governments and industries. Healthier populations meant healthier workforces to advance industry and healthier armies to win wars. This narrow medicalised interpretation of health as primary disease prevention led to the steady but inevitable decline of public health nursing services.

Population health movement

Thomas McKeown (1979) challenged common wisdom that medical interventions were responsible for declining morbidity and mortality rates (McKeown, 1979). His studies showed that disease rates were more directly linked to nutrition, family planning, adequate housing, and other social factors than to medical interventions; thus, once again redirecting attention to the broader determinants of health. This work influenced the Lalonde Report 1974 and led to the development of the population health movement in the early 1980s (Lalonde, 1974). The issuance of the Lalonde report was a

³ Nightingale was a brilliant woman and an accomplished statistician. She used statistics to demonstrate the need for improvements in sanitation and healthcare. Her ability to use scientific research to demonstrate the need for reforms helped her immensely in her mission to improve peoples' lives. She

watershed in Canadian and global approaches to health; it marked a paradigm shift in public health that gave rise to the anti-medical establishment health promotion movement. The report proposed a framework for health that moved beyond the treatment paradigm and encompassed a 'health field' composed of human biology, environment, lifestyle, and health care organisation. It challenged the supremacy of scientific knowledge by encouraging a creative and innovative approach to health.

It advocated elevation of *care* to the same level as *cure* so that people with chronic illness could be cared for adequately and stressed that cost effectiveness included issues of access and effectiveness, not only cost. Unfortunately the major thrust of this very comprehensive report was a lifestyle approach to health promotion that has tended to overly emphasise individual solutions to health problems precipitated by broader social factors.

The ideas espoused in the La Londe report were reinforced and expanded in the Alma-Ata declaration through the delineation of the tenants of Primary health care. Nurses were considered by the World Health Organisation to be pivotal in providing primary health care services and in achieving the goal of health for all by the year 2000 (World Health Organization, 1978). Thus, internationally the paradigm shift away from the narrow disease focused approach of medicine towards a broader vision of health and health care was beginning to take hold.

In 1986 that shift gained considerable momentum following the development of the Epp framework and then the Ottawa Charter. The Epp framework, a Canadian federal document, identified three challenges to achieving health: reducing health inequalities, increasing prevention efforts, and enhancing people's ability to cope (Epp, 1986). The framework included strategies such as fostering public participation, strengthening community health services, and co-ordinating healthy public policy. It denounced the strategies that focused on individual responsibilities for health or 'blaming the victim' while ignoring the social and economic conditions that support them. This framework provided the basis for the Ottawa Charter, the outcome of the first International Conference on Health Promotion. It was based on the philosophy of primary care articulated in Alma-Ata in 1977 (World Health Organisation et al., 1986). Important to

accomplished reforms in health and sanitation in the British Army, in civilian hospitals, in workhouses and in homes in England and other parts of the world.

nurses are some less frequently emphasised aspects of the charter. These include references to caring, holism, and ecology as essential to health promotion, the identification of advocacy for health, enabling people to achieve their fullest health potential, and mediation of differing societal interest as the cornerstones of health promotion.

At the same time, the nursing profession struggled to assert its professional independence from medicine. Major changes in the organisation of services, and the nursing workforce, have had a major impact on the roles and responsibilities of nurses working in the community (Littlewood, 1995). Through the 1970s and 1980s the profession was ambivalent about its role within the PHC team. On the one hand it wanted to be accepted as an equal partner but on the other it sought independence from doctors through the abolition of practice attachments and focused on nursing-led PHC services (Splann Krothe, Flynn, Ray, & Goodwin). Simultaneously, the rapid growth in the number of practice nurses appeared to reinforce the role of nurses as ‘handmaidens to doctors’ within a GP-led team (Carrier, 1999).

Evidence in the literature tends to suggest that theoretical thinking in CHN is still at an emergent or tentative level of development. The espoused focus of CHN on health promotion and health protection of communities has not been borne out in practice. Interventions, research, and practice remain primarily at the level of individual persons. Most nursing interventions are directed towards promoting, maintaining, or restoring individual human agency in health and illness. The challenge for the profession is to move to a more community orientated model of practice in order to move beyond the current constraints as defined above.

Community orientated primary health care

A community-orientated primary health care model is a community-responsive model of health care delivery that integrates aspects of both primary care and public health. It combines the care of individuals and families in the community with a focus on the community and its subgroups when services are planned, provided, and evaluated (Abramson, 1988). Although still professionally focused, it invites community participation but is not community driven nor community owned. The most effective and sustainable individual and system changes come where there is active participation by the people who live in the community, regardless of who initiates the process own

goals and solutions (Bent, 1999; de Lacey, 1989). Sharing of power, knowledge, financial support, and active participation with as many diverse community leaders as possible will help ensure a more accurate and comprehensive representation of the community's needs as well as a wider array of solutions (McFarlane & Fehir, 1994). Health care in this context cannot be separated out from wider community development such as housing, economics, and employment.

Nursing must become aware of the costs of nursing services, identify aspects of care where cost savings can be safely achieved, and develop knowledge on how community nursing practice affects - and is affected by - the principles of economics. Focus must be on improving the overall health of the communities, defining its contribution to the health of the nation, deriving the value of nursing care, and ensuring its economic viability within the health care market place. Nurses must effect health care system change by providing leadership in developing new models of care delivery that provide effective, high quality care and assume a greater role in evaluating client care and nursing performance.

Measuring the difference nursing makes

It is not straightforward to measure the total contribution nursing makes to health outcomes because this partly involves measuring skills such as explaining, listening, and understanding the needs of clients. Research shows that clients value these types of skills but they are not readily quantifiable (Barham, 1984; Carryer, 1999; Falk Rafael, 1997). Notwithstanding these difficulties, it is possible to measure and cost, in a range of practice settings, the contribution nursing makes to the delivery of health and disability services and patient outcomes (Westbrook & Schultz, 2000). Internationally, there is now a substantial body of research showing that nurse-led health services both in the community and in acute hospital settings have positive effects on health-care delivery and on the health outcomes of clients. Nursing can be shown to be more cost-effective than medical services in a number of settings, with no loss of safety and effectiveness (Splann Krothe et al.). Recent nurse-led pilots in primary health care in England have provided a way forward for nurses to manage, lead, and contract medical practitioners in for services (Koperski, Rogers, & Drennan, 1997). These pilots have heralded a different approach to primary and some secondary care services. Such projects could spell the end to the traditional GP role. In the future GPs will specialise in certain conditions and refer patients to other nurses. Indeed, nurses are often better at

routine management of chronic conditions such as asthma and diabetes. Acute services in hospitals also benefit from the extensive use of nurses, that is patients cared for by nurses recover faster from surgery, spend less time in hospital, and are less likely to be readmitted. Well documented studies by medical and nursing researchers found positive links between the numbers of nurses involved in care, their educational qualifications, and lower mortality rates and decreased lengths of hospital stays for patients (Ministry of Health, 1998; Sharmian, 1997; Splann Krothe et al., ; Swanson & Nies, 1997).

There is now a large body of international evidence on the cost-effectiveness of the nursing model and its approach to health services (Spitzer, 1974). These range over neonatal care, first visits to a practitioner, and visits for continuous care. Nurses in advanced practice can (and do) substitute for doctors in the United States, providing a variety of primary-care services (Stanhope & Lancaster, 1996; Westbrook & Schultz, 2000). One American economist has estimated that the cost to the United States of not using advanced-practice nurses to their fullest potential is US\$6–9 billion a year {Nicholas, 1993 #2836}. This is only a small proportion of total United States spending on health services but it is nevertheless a worthwhile saving that can be redirected into other health priorities. Future developments in health care could make the role of the nurse even more central to health and disability services delivery. Researchers at the University of York in England have arrived at the startling conclusion that anywhere from 30% to 70% of the tasks currently performed by doctors could safely be passed on to nurses with existing technology (Wyke, 1997).

The primary and secondary health-care services of various countries are organised in different ways and, therefore, service and cost-effectiveness measures are not strictly comparable from one country to another. The international research, however, clearly makes a case for the role and scope of nursing in New Zealand to be expanded (Ministry of Health, 1998). There is tentative agreement in the literature that the benefits from expanding the role and scope of nursing will result in better health outcomes for consumers and in more effective health-care services (Carrier, 1999).

Current New Zealand context

Collaboration between health professionals is critical but poor identification of disciplinary skills, confusion over accountability, inequitable workloads, vested interests, role ambiguity, status differentials, and struggles with authority and power

persist (Ministry of Health, 1998). While nurses have experience with forming partnerships with individuals, families and communities in many community settings, and especially within general practice, the employer/employee relationship or the notion of delegated medical authority confines nursing to an assistant role and frequently precludes collaboration and the appropriate utilisation of nurses. NZ has considerable investment in nurses and currently subsidises general practitioners to employ the majority who work in primary health care as practice nurses at a cost of \$30 million per annum (Barnett, 1998). It is questionable as to whether this now represents value for money or whether it is based simply on history. The taskforce notes that the practice nurse subsidy is one of several barriers to the development of primary health care nursing (Ministry of Health, 1998).

In addition to practice nurses, primary health care nursing is established in communities at a number of levels and through contributions from various contracts such as well child services, home health, domiciliary nursing, health promotion, communicable disease screening, and management. Not only has this led to fragmentation of service delivery but also there are gaps and duplication of services and confusion surrounding the roles of the various nurses (Littlewood, 1995). Walsh (1999) argues that the contract culture has altered nursing to a commodity (Walsh & Gough, 1999). This reduces the strength and usefulness of nursing and supports a medical and reductionist health service focus on what are often deeper family and community health problems that would benefit from a more holistic or 'global' response. Nurses understand health as a linear continuum and reject dichotomous notions of health and illness. Holistic concepts of health that recognise the socioeconomic determinants of health are familiar to nurses. From this basis nursing responds to individuals and communities appropriately to their context and their status on the health continuum and works to maximise health and wellness. Nurses have experience in forming partnerships with individuals and communities. As such they are prepared for a primary health care role (Shields & Lindsay, 1998).

Nursing will need to move beyond traditional nursing practice in conventional health services. Werner (1998) challenges us to join with social activists, alternative economists, ecologists, grass roots organisations, and other agents of change to advance a multisectorial strategy that puts the basic needs of all people, especially the disadvantaged, before the interests of the rich and powerful (Werner, 1998). Nurses will

need to be advocates, monitors, catalysts, and enablers. They will be scientifically and technically skilled; they will be knowledgeable about economics, politics, and global issues. But most of all they will be partners with communities at local, regional, and national levels. The process of enabling people to increase control over and improve their health will be an integral part of nurse's roles. There is an urgent call to move from a model of primary care to a model of primary health care (Wuest & Stern, 1991). Models of primary health care nursing need to move beyond the systems approach, to develop more creative and innovative approaches designed in consultation with, rather than for, communities that take account of the diversity within and across communities.

NZ does not provide many positive examples from which to draw, with the exception of nurses working in Māori primary health care services. In Northland many of the Māori health initiatives are nurse led services, for example:

- Hauora Whanui (KawaKawa) - a comprehensive mobile community service
- Hauora O Te Hiku O Te Ika (Far North) - a nurse led, nurse run primary health care service
- Kia Mataara (Far North) - another nurse led, nurse run primary health care service
- Te Ha O Te Oranga (Kaipara) - a nurse led community health service
- Te Puna Hauora (Awataha Marae, North Auckland) offers a comprehensive nursing service, home visiting, family assessments and disease management plans.

All of these nurse led services grew to include general practitioner involvement in augmenting the existing services they provide. Only one non-Māori nurse led initiative is funded in this same region. Walsh and Gough (1999) have argued that the contract culture of the current health market in the UK has altered nursing to a commodity, which is shaped and driven by that market (Walsh & Gough, 1999). A similar argument has been made in NZ (Ministry of Health, 1998). Nursing work is becoming increasingly specific and in effect 'broken down' into disease categories or age ranges or even in relation to body parts. An example is the development of 'Disease State

Management' postgraduate education programmes. This is complicated because on one hand specialisation is useful and allows for the development of a type of expertise. On the other hand it reduces the strength and usefulness of nursing and supports a medical and reductionist health service focus on what are often deeper family and community health problems that would benefit from a more holistic or 'global' response. The immediate goal for nursing is to develop primary health care roles that directly meet the needs of the community they serve. Both generic nursing skills and specialist nursing skills will be required to meet the challenges that lie ahead.

Summary

As a profession there is increasing demand for education to focus on population based quality health care facilitating the transition to interdisciplinary, population-focused healthcare. Nursing as a profession is beginning to recognise the guiding principles of community-orientated primary care. These principles should direct our common understanding of primary health care nursing, and community health nursing, facilitate relationship building with healthcare clients and health professionals, and thus help provide opportunities for co-creating healthy communities. Nursing practice should be directed towards strengthening agency within groups and communities to co-create health through partnership and intervening in the environment to support collective agency.

The new public health marks a return to a conceptualisation of health that is consistent with a nursing paradigm and, thus, useful in supporting nursing's role in primary health care. However in order to take full advantage of this knowledge and effectively challenge administrative constraints, it is critical to reclaim this legacy in primary health care and critically appraise outside influences that threaten to undermine our work and educate the public and other disciplines about nursing's unique focus on primary health care.

Table 2

Characteristics of a nursing model of primary health care

Concept	<ul style="list-style-type: none">• Universal acceptability and coverage in relation to need• Community and individual involvement and self-reliance• Intersectoral action for health• Appropriate technology and cost effectiveness
Mission	<ul style="list-style-type: none">• Leads to improved health outcomes
Philosophy	<ul style="list-style-type: none">• Equity, social justice, self-reliance
Principles	<ul style="list-style-type: none">• Intersectoral action, equity, prevention, community participation, appropriate technology
Strategies	<ul style="list-style-type: none">• Intersectoral collaboration• Equitable distribution of resources• Increase access to services (choice)• Comprehensive care• Integration of services• Appropriate services

CHAPTER FOUR

Theoretical position

Introduction

This study focuses on the health beliefs and practices of Māori women as a particular domain for in-depth analysis. These foci will be examined within the broader context of the whānau and the historical, socioeconomic, cultural, and political factors that influence Māori health behaviors and practices. This research takes a Māori-centred approach, uses a combination of methods, and utilises a critical ethnographic methodology for data collection and analysis. Critical ethnography was selected for this study as it is qualitative in nature, is directed by the participants, and includes a liberation philosophy.

In selecting a critical ethnography methodology, the researcher was particularly aware of the concerns among Māori and other indigenous peoples that they had been exploited by past anthropological research. Given this history, it was particularly important to ensure strong adherence to the principals of a Māori-centred approach in relation to the research process. This chapter briefly reviews the traditions of ethnography and outlines the distinctive characteristics of critical ethnography, and a Māori-centred approach and the ways in which they have been applied in this study.

Qualitative approaches are being used increasingly in both nursing and health research generally when endeavoring to understand behaviors in culturally and linguistically diverse groups, many of which do not share the same cultural beliefs and values about health and illness as mainstream Western society (Boyle, 1994; de Laine, 1997;

Leininger, 1985). Ethnography, because of its focus on culture, has in the past been presented as an appropriate method for the study of health beliefs and practices. There is, however, considerable debate in the literature about the appropriateness of this method, not only because of its ethnocentric focus but also because of the authoritative stance of the researcher. (Carspecken, 1999; Hammersley, 1992; Marcus, 1998)

Ethnographic traditions

Ethnography evolved historically in cultural anthropology, with a typical focus on small-scale societies: often tribal or village level groups in Africa. The term ethnography was originally applied to studies of a localised group of people who shared similar social and cultural characteristics. Members of the group usually had a strong sense of unity based on common factors of language, residence, social relationships, religious and political beliefs, and practices (de Laine, 1997; Denzin, 1997). This definition still has cogency today, as most ethnographies focus on a group of people who have something in common - although in current ethnographies the commonalities may differ from traditional ones. Participants in an ethnography, for example, may share a work site, a lifestyle, a nursing home, or a management philosophy (Boyle, 1994; Leininger, 1985; J. M. Morse, 1992).

Agar (1980) noted that ethnography is both a process and a product. He states that, as a product ethnography is usually a book, the focus of which is on a particular social group and of which discussion is fairly broad. Agar (1980) states:

There will be a dash of history, something about the various environments-physical, biological, and social –and some detail on the things the group does and beliefs they hold (p.1).(Agar, 1980)

Ethnography as a process is how an ethnographer endeavors to learn about, or understand, some human group and the name for ‘doing ethnography’ is fieldwork. The need for a systematic approach to fieldwork had its origins in the work of Malinowski (1922) who broke with the tradition of the ‘armchair’ anthropologist when he entered the field to study the Trobian Islanders. His classic ethnography “Argonauts of the Western Pacific” provides a testimony to the value of participant-observation for an understanding of the culture of an indigenous group. Participant-observation has become the anthropological hallmark for promoting an understanding of culture (Malinowski, 1961).

Ethnography is based on the assumption that culture is learned and shared among members of a group and as such can be described and understood (J. Morse, 1992). Culture has multiple definitions and the ethnographer's theoretical orientation influences how she or he will make inferences from what people say and do. The concept of culture enables the ethnographer to go beyond what people say and do to understand that shared system of meanings we call culture (Boyle, 1994; Denzin, 1997; Hammersley & Atkinson, 1995). The goal of ethnography is to discover the cultural knowledge people use to organise their behavior and interpret their experience. As Germain (1986:148) describes the research process:

... the ethnographer participates in the events of the subculture and with the help of cultural informants (persons with particular knowledge of the subculture), looks for connections, patterns, themes, or relationships that have meaning for the people in it. These themes include but are not limited to the shared knowledge, norms (rules of behavior), values, belief systems language rituals, economics, role behaviors, or patterns of social interaction among the members of the subculture (Germain, 1979)

Although ethnographic field research has been used in anthropology for nearly a century, its use in nursing is relatively new. Leininger (1985), a nurse anthropologist, advocates the use of this method and has identified two types of ethnography useful in nursing: the 'mini' ethnography and the 'maxi' ethnography. A mini-ethnography is small in scale and focuses on a specific cultural scene. A maxi-ethnography is a largescale comprehensive study of both the general and specific aspects of a culture. The mini ethnography is suited to researchers who have limited time but wish to learn about a cultural scene from the informant's point of view (Leininger, 1985).

In more recent times, some concerns have arisen over the use of the terms 'mini' ethnography and 'maxi' ethnography. Morse (1991) notes that at a qualitative research symposium in Chicago, November 16-17, 1987, participants felt that 'mini' had a connotation of 'meager' or 'less than' giving the false impression that the mini ethnography is less significant than the traditional anthropological 'maxi' ethnography. It has been suggested that more holistic, anthropological ethnography be referred to as traditional ethnography and the nursing, topic-orientated 'mini' ethnography be referred to as focused ethnography but this issue remains unresolved. Nursing ethnographies

have usually focused on health beliefs and practices and how these are related to other social factors (J. M. Morse, 1992)

Most textbooks on fieldwork suggest ethnography contains aspects of both art and science. Agar (1980) states quite emphatically, 'Without science we lose our credibility. Without humanity, we lose our ability to understand others' (Agar, 1980)(p.13). There are similarities with the characteristics required of 'good' ethnographers and those developed in nursing, suggesting that as nurses we are well suited to ethnographic research. Traits such as empathy, reflection, and intuitive understanding combined with a high degree of ambiguity and uncertainty, perceptiveness and abstract thinking are characteristic of both nurses and ethnographers. According to Lipson (1989):

While simply being a good clinician does not a good ethnographer make, there are skills common to both endeavors; good interviewing and careful listening; astute observation and interpretation on several levels simultaneously (e.g., verbal and nonverbal behavior, meaning and context); and intentional use of self (*Lipson, 1989*)

As well, all ethnographies have certain hallmark characteristics. These characteristics often overlap and are interrelated although any one ethnographer may emphasise one over the others. Ethnographies are holistic and contextual in nature; they are reflexive and use both emic and etic data (Boyle, 1994; J. Morse, 1992).

By the 1980s and 1990s there was a noticeable shift away from the interpretive approach to a more critical stance. As noted by Hammersley (1995), there have been increasing calls for a critical ethnography. The term critical ethnography is used in a variety of ways. The most common application implies:

An 'appropriation' and 'reconstruction' of conventional ethnography so as to transform it into a project concerned with bringing about human emancipation, this usually being interpreted in socialist, and/or feminist terms (*Hammersley & Atkinson, 1995*)

From a post-modernism perspective, ethnographic practices are ways of acting in the world. These ways of acting, interviewing, and observing produce particular situated understandings; the validity or authority of a given observation is determined by the nature of the critical understanding it produces. These understandings are based on glimpses and slices of the culture in action. Any given practice that is studied is

significant because it is an instance of a cultural practice that happened in a particular time and place. This practice cannot be generalised to another practice. Its importance lies in the fact that it instantiates a cultural practice, a cultural performance, story telling, and a set of shifting, conflicting, cultural meanings (Carspecken, 1996; Hammersley, 1992; Marcus, 1998; Thomas, 1993).

As a style of analysis and discourse, critical ethnography is embedded within conventional ethnography and, as a consequence, critical and conventional ethnographers share several fundamental characteristics. Among these are reliance on qualitative interpretation of data, core rules of ethnographic methods and analysis, adherence to a symbolic interactionist paradigm, and a preference for developing grounded theory (Denzin, 1997). Nonetheless, several characteristics distinguish each from the other. At its most general, conventional ethnography refers to the tradition of cultural description and analysis that displays meanings by interpreting meanings. Critical ethnography refers to the reflective process of choosing between conceptual alternatives and making value-laden judgments of meaning and method to challenge research, policy, and other forms of human activity. Conventional ethnography describes *what is*, critical ethnography asks *what could be* (Carspecken, 1996; Hammersley, 1992; Herzfeld, 1989; Thomas, 1993)

Critical ethnography is not simple criticism, nor is it to be confused with critical theory as associated with the Frankfurt School which is a theory of capitalist society. Critical ethnography is conventional ethnography with conscious political intentions that are orientated towards emancipatory and democratic goals.

Conventional ethnographers generally speak *for* their subjects, usually to an audience of other researchers. Critical ethnographers, by contrast, accept an added research task of raising their voice to speak *to* an audience *on behalf* of their subjects as a means of empowering them by giving more authority to the subject's voice. As a consequence, critical ethnography proceeds from an explicit framework that, by modifying consciousness or invoking a call to action, attempts to use knowledge for social change. Conventional ethnographers study culture for the purpose of describing it; critical ethnographers do so to change it. Conventional ethnographers recognise the impossibility, even undesirability, of research free of normative and other biases but believe that these biases are to be repressed. Critical ethnographers instead celebrate

their normative and political position as a means of invoking social consciousness and societal change (Boyle, 1994; Carspecken, 1996; Hammersley, 1992; Thomas, 1993)

Critical ethnography is more than the study of obviously oppressed or socially marginalised groups because researchers judge that all cultural members experience unnecessary repression to some extent. Critical ethnographers use their work to aid emancipatory goals or to negate the repressive influences that led to unnecessary social domination of all groups. Emancipation refers to the process of separation from constraining modes of thinking, or acting, that limit perception of and action toward realising alternative possibilities. Repression is the condition in which thought and action are constrained in ways that banish recognition of these alternatives. Critical ethnography is simultaneously hermeneutic and emancipatory (Carspecken, 1996; Herzfeld, 1989; Thomas, 1993).

Conventional ethnography assumes the status quo, affirms assumed meanings where others might exist, and seldom reveals the perspective of research subjects on the researcher. Such research is organised around a normative epistemology that assumes that the normal is what is most representative of a larger population and it is that normal population that most generalisations are directed. Less attention is thereby given to the non-representative marginal formations that can exist in any social structure.

Kaupapa Māori research and Māori-centred research

Since first contact with Europeans, Māori society has provided fertile ground for research carried out by non-Māori (Linda Tuhiwai Smith, 1992). As the subject of research, Māori people have been described by some commentators as ‘guinea pigs’ (Stokes, 1985)(pg 3) to ‘mainly non-Māori hit-and-run researchers’ (Durie, 1996a)(pg 3). While non-Māori researchers, and to some extent their academic community, have accrued career and personal benefits from the research, in too many cases Māori have seldom benefited. Too often the outcomes of such investigations have the possibility of the belittlement of Māori history, knowledge, and learning and the reinforcement of negative stereotypes. Further, much of the existing research on Māori merely describes what Māori already know and offers few insights (Bishop, 1996; Cunningham, 1998; Durie, 1996a; Smith, 1999).

The exploitative nature of past research has generated debate among Māori as to whether it is appropriate for non-Māori to do research on Māori. One faction of this debate argues that Māori should undertake all research on Māori. Stokes (1985) argues that Māori have not been served well by non-Māori researchers but that it is not simply an issue of 'race'. She maintains that the central issues are whether the researcher is bi-lingual and bi-cultural, is closely involved with the issues facing Māori society today, and has the skills, knowledge, and expertise to confront and investigate these issues. According to Stokes, appropriate researchers may be either Māori or pākehā (Stokes, 1985). Bishop and Glynn (1992) also support a bi-cultural approach to research among Māori, insisting that there is a place for non-Māori researchers and their expertise, providing the methodology is empowering or emancipatory. They suggest a collaborative and interactive approach whereby the control of the research remains with whānau, and the researchers - both Māori and Pākehā - are accountable to whānau (Bishop, 1995). What is problematic about this approach is an assumption that regardless of whether one is Māori or Pākehā, the relationship to the research is the same. Such an approach ignores, for example, the influence of iwi, hapū or whānau affiliations. Further, academic protocols regarding the publication of research reports, privileges the name of the researchers as the authors and therefore authorities but problems arise if non-Māori researchers are seen to be the voices of Māori, for example at national and international conferences.

The counter-claim that Māori people are best qualified to research the lives of Māori is also problematic as the competence of a researcher to undertake Māori health research is not simply a matter of ethnicity (Smith, 1996). A researcher's knowledge of Māori process, competence in the Māori language, their tribal affiliations, for example, may each require consideration in relation to a given project. It cannot be assumed that all Māori who undertake research are conversant with Māori process and have other cultural competences. As with academic enquiry in other fields, the necessary scholarship to research and record issues, in this instance Māori issues, is also a requirement of a competent researcher (Walker, 1996).

A further issue to be considered is the restraints placed on research by Māori leadership as to what knowledge is suitable to be freely transmitted. Tribal elders closely regulate some aspects of whānau and hapū knowledge so that access depends on obtaining the permission of the kaumātua and other whānau members, which in turn may depend on

other factors such as the researchers' tribal links (Smith, 1996). Unless specifically invited by an iwi, researchers from outside the tribal group may be disadvantaged, as iwi may be suspicious of the motives of those from different tribes. With regard to some types of knowledge, elders may consider criteria relating to the age or gender of the researcher. The association of knowledge with maturity means that for some categories of knowledge a younger person may require the guidance of elders for their work to be accepted by a Māori audience. Issues of gender may be relevant in regard to particular categories of knowledge. For example, knowledge relating to childbirth is more readily associated with women and knowledge relating to whakapapa may be more readily associated with men. However, this may well be a recent phenomenon since it is recorded that certain women as well as men were and are repositories of whakapapa (Mahuika, 1992) and in some tribal areas men were known to take part in childbirth and child rearing practices (Pere, 1984)(pg 59).

The debate as to who should undertake research among Māori is, however, only one aspect of the overall concerns held by Māori about research in their communities. Criticism and/or rejection by Māori of non-Māori approaches to enquiry into the lives of Māori people is primarily about concerns over methodology and interpretation located within a western positivist tradition (Smith, 1995). The positivist position that there is one reality able to be investigated in an objective way by a researcher who is entirely independent of the community being studied has been increasingly criticised by both western and non-western researchers. This has led to the articulation of competing paradigms, often grouped together as 'critical theory'. These competing paradigms, such as feminist and action research, recognise the value-based nature of research and are more holistic and context sensitive. To some extent, the concerns that have stimulated the emergence of these new paradigms have parallels with Māori concerns. Such concerns generally relate to the ways in which Māori participate in research and include issues of accountability, definition and methodology, intellectual property rights and the underlying issue of consistency with a Māori world view. It is these types of concerns that have led Māori to redevelop their own approaches to research, the most commonly referred to being 'kaupapa Māori research' and 'Māori-centred research'. Both these approaches, though in the early developmental phases, provide clear direction for Māori health research.

Kaupapa Māori research has been described as a social project concerned with areas of strategic importance to Māori development and defined as research over which Māori maintain conceptual design, methodological and interpretative control (Smith, 1999). Put another way, it is '*research by Māori, for Māori, with Māori*' (Smith, 1999)(pg1). Importantly, kaupapa Māori research is firmly based upon a Māori worldview. Ratima (2001) identified, through literature review, five principles underlying a Māori inquiry paradigm that are of particular relevance to Māori health research: interconnectedness, Māori potential, Māori control, collectivity, and Māori identity. According to Ratima, 'the integrated basis of Māori worldviews is the primary characteristic of Māori inquiry paradigms' (Ratima, 2001). Together, the five principles help to make explicit the Māori inquiry paradigm within which kaupapa Māori research might be located. It is that paradigm that provides a way of framing and structuring the way we think about the world in Māori terms; in this sense it may be considered as a lens through which to view the world. Given that it is positioned within a Māori worldview, kaupapa Māori research is also based on the assumption that Māori knowledge and ways of knowing are valid and draws on the cumulative experience and perspectives of Māori.

Smith (1999) argues that kaupapa Māori is a 'conceptualisation of Māori knowledge'. It is a way of abstracting that knowledge, reflecting on it, engaging with it, and at times provides a process for critiquing the construction of Māori knowledge. A good example of this latter quality is in the development of Māori women's theories of Māori society, which question the accounts of men, including Māori men, while maintaining the position that despite a shared concern for gender issues, Māori and non-Māori women do not have the same perspective.

The relationship between kaupapa Māori research and critical theory has been the subject of some discussion. Bishop (1996) argues that critical approaches have, in fact, failed to address the issues of communities such as Māori and that, moreover, the development of alternative approaches by Māori reflect a resistance to critical theory (Bishop, 1996). Smith (1999) however, contends that:

Kaupapa Māori is a 'local' theoretical positioning which is the modality through which the emancipatory goal of critical theory, in a specific historical, political and social context is practiced ((Smith, 1999), pp 202)

Smith also refers to the work of Pihama (1993), which locates kaupapa Māori research in relation to critical theory and the notions of critique, resistance and emancipation:

Intrinsic to kaupapa Māori theory is an analysis of existing power structures and societal inequalities. Kaupapa Māori Theory therefore aligns with critical theory in the act of exposing underlying assumptions that serve to conceal the power relations that exist within society and the ways in which dominant groups construct concepts of common sense and facts to provide ad hoc justification for the maintenance of inequalities and the continued oppression of Māori people. *((Pihama, 1993) pg 57)*

Critique, resistance and struggle are concepts that have been characteristic of the post-colonial Māori experience and, therefore, it is not surprising that many Māori researchers adopt a critical approach. Generally, kaupapa Māori research embraces a sense of strategic positioning across a variety of sites towards the goal of facilitating positive Māori development. The purpose of kaupapa Māori research is the generation and transmission of Māori knowledge.

In common with kaupapa Māori research, Māori -centred research also aims to generate and transmit Māori knowledge. Durie (1996) identifies three principles of Māori -centred research – whakapiki tangata (enablement, enhancement or empowerment), whakaurunga (integration), and mana Māori (Māori control).

Consistency with the first principle of whakapiki tangata (enablement, enhancement or empowerment) requires that research involving Māori should enhance both their health status and their ability to take control of their own health. The second principle, whakaurunga (integration), recognises the holistic view of Māori and the links between health and wider spiritual, environmental, social, economic, cultural, political, and historical factors. The third principle, mana Māori (Māori control) relates to issues of control over research which involves Māori. The principle of Māori control is derived from the concept of tino rangtiratanga (self-determination). This principle has implications for, among other things, intellectual property rights, guardianship, Māori participation, and partnership. Consistency with this principle would see a shift in the position of Māori from passive participants to 'drivers' of Māori health research.

The principles outlined by Durie are entirely consistent with kaupapa Māori research, which raises the question of what distinguishes one approach from the other. According to Cunningham (1998), the approaches differ in terms of loci of control, the form of Māori participation, and what constitutes acceptable research methods. Essentially, kaupapa Māori research should be controlled by Māori institutions (such as iwi), while

Māori-centred research may be based within a non-Māori organisation (such as a university). It is also reasonable to expect that kaupapa Māori research will be characterised by wholly Māori participation and the use of Māori specific methods, while these characteristics would not be a criterion for Māori-centered research.

Suffice to say, there is much overlap between the two approaches and they have yet to be fully developed to a stage where their differences are clearly articulated. In this research, the researcher has used a Māori-centered approach as outlined by Cunningham (1998). Māori-centred research provides the research methodology, guides the application of critical ethnography and, therefore, the selection of methods and the process of analysis. The driving principles are interconnectedness/integration, Māori potential/enhancement/enablement/empowerment, Māori control, collectivity, and Māori identity. Examples of how these principles have been applied in this study are the adoption of a Māori holistic concept of health (interconnectedness/integration) so that primary consideration has been given to ensuring that the research incorporates a whānau as opposed to an individual focus, which emphasises whānau-based decision-making and participation (collectivity); and that benefits the community Māori potential/ enhancement/ enablement/ empowerment); and is carried out in partnership with the community; the principal investigator has whakapapa links to that community (Māori control); and works closely with Māori institutions and in a way consistent with Māori cultural processes (Māori identity).

An important point to make is that a Māori-centred approach was considered by the researcher to be a critical factor in the success of the research. At a practical level, this type of approach was necessary to ensure credibility among the community and to gain their support and, therefore, participation in the study. Without this approach, it is doubtful whether this investigation would have found acceptance with a Māori audience or the Māori health research community. The approach is also necessary for the production of knowledge valid in Māori terms and, therefore, will be acceptable to Māori in informing the development of nursing practice among Māori communities. Additionally, the approach is consistent with critical ethnography which is orientated towards emancipatory goals.

Methods

An overview

The framework for this study is a Māori-centred approach and within this framework critical ethnography provides the study methodology. Consistent with the Māori-centred approach, it was intended from the outset that this research would both benefit the development of the local community (and therefore the researchers own whānau, hapū, and iwi) and be culturally safe. The researcher also made the commitment that, consistent with the Māori-centred approach, the research would be guided by whānau, a process which proved to be both time consuming and challenging.

The following sections outline the methods for data collection and analysis which were selected as consistent with both the Māori-centred approach and critical ethnograph and were able to address the research question. The primary data sources were participant observation, informal discussions, and in-depth interviews with a group of Māori women who were members of the Whanganui Māori community and were employed within an iwi-based Māori primary health care service, Te Oranganui, located in Whanganui. The rich data collected in this way were supplemented by literature and service, programme, and policy document review as secondary data sources. Both primary and secondary data were analysed through the process of reconstructive analysis. The data collection and analysis are described in the following sections according to five stages of a critical ethnography: stage one – fieldwork; stage two – preliminary reconstructive analysis; stage three – in-depth interviews; stage four – community relationships; and, stage five – wider systems relationships.

The research question

There is a need for research to clarify Māori cultural beliefs relevant to health and wellbeing, so that nursing care may be provided in a way that is appropriate given Māori cultural preferences. Nurses need to have some understanding of what constitutes ‘normal’ behaviours for a particular cultural group to recognise behavioral responses to health and illness, and to practise in a culturally appropriate way. ‘We cannot function as nurses by trying to cure or change a different response simply because we consider it to be abnormal’ (Morse, 1988, pg iv). A greater understanding of the health beliefs and practices of Māori women, while at the same time acknowledging diversity among Māori, will contribute to improved nursing practice and education.

Māori women's health beliefs and practices at a community level potentially provide a well of information to inform the development of nursing education and practice that is relevant and responsive to Māori women's needs and expectations. This study investigates those beliefs and values within the broader Māori development and New Zealand contexts to provide a database to inform the planning of appropriate nursing education and care as it relates to Māori. The research addresses the question *'What are the central characteristics of primary health care nursing practice that are responsive to Māori (women) within the broader Māori development, professional and New Zealand contexts?'*

Accessing the community

The researcher is a member of Te Atihaunui-a-Paparangi and linked to the broader Whanganui community through her whakapapa. The researcher initially approached members of her own whānau still living on the marae (Māori community centre) and arranged a hui (Māori community meeting) to discuss the proposed research, provide an opportunity to address any issues they may raise, and to seek their support. Hui participants discussed the negative impact of past research projects at length and stated they could see no benefit for communities and that benefits instead accrued to researchers and their institutions, such as those academic qualifications Mason Durie refers to as the 'self aggrandisement of the researcher'. From a Māori community perspective, research has most often been used by government departments to undermine the position of Māori. Research is sometimes seen as means of justifying the minimal distribution of resources to Māori. For example, Department of Conservation research is regarded as a means of transferring control of natural resources from Māori to the State in the name of conservation (Monitoring and Evaluation Branch, 1998). These issues were all pertinent at the time of this study, with the occupation of a hut on 'conservation land' and a highly publicised occupation of council land within the tribal rohe. Another area of concern raised at this hui was data collection, management, and ownership of information. It was agreed that the community would support the researcher conditional upon joint ownership between the iwi and the researcher.

Despite their reservations, hui participants were very supportive of one of their own whānau undertaking research on an issue they considered to be of priority. It was made explicit that the researcher's whakapapa (geneological) connections were a criterion that helped secure their approval. From the researcher's perspective, those connections

placed an additional obligation on her to ensure that the processes undertaken would at all times maintain the cultural integrity of those involved and that the overall research programme would, in the first instance, be of benefit to the community.

It is important to note that developing a research partnership, even when working within one's own tribal boundaries, still requires work to build trust. In fact, a close relationship with respondents is at time counter-productive in that respondent expectations can be greater with 'their own'. Gaining support in a participatory way and negotiating the parameters of the research was a time consuming process. However, the researcher considered it was essential that the nature of the research be carefully negotiated to ensure ongoing Māori input and that the project not only had no harmful impacts, but was actually beneficial. To this end clearly identified accountability procedures needed to be established before commencing the research.

Initially the position of the community was that *'they didn't really understand what I was doing but because I was family they would support me'* (fieldnotes). This position created an ethical challenge for the researcher as informed participation was critical to minimising the negative effects of participation. It took some time for an 'informed' relationship to emerge, to operate ideally as a partnership, and to therefore enable a degree of community ownership. Several levels of consent were negotiated before approval for the study was gained. As noted above, a hui was initially held with members of the researcher's whānau who were living on the marae at the time of the study. Following this, a further hui was arranged with the Marae Health Committee and kaumātua (elders) to gain their support. Once support was given at that level, the researcher arranged a meeting with local iwi. This was necessary because the researcher was to be working within their tribal boundaries under their 'mana whenua'. Once this support was gained, a proposal - which was subsequently approved - was prepared for the Massey University Human Ethics Committee for ethical approval.

The process employed by the researcher in accessing the community was consistent with a Māori-centred approach. For example, the principle of 'Māori control' was reflected in the participatory and partnership approach and in seeking approval for the research from whānau, the marae health committee, kaumātua, and iwi. This approach was intended to ensure the research was not driven solely by the researcher's agenda but also by community priorities. Further, the position of the researcher was that the research design should not be exclusive and therefore input from the wider whānau, that

is the Māori community, was accepted. As a second example, the principle of 'Māori identity' was reflected in the use of Māori -specific methods, that is hui that followed Māori processes throughout. Māori specific methods contribute towards establishing a sense of control and ownership for Māori and towards providing credibility for the research⁴.

Sampling strategies

The sampling strategy appropriate for ethnographic research is that of purposeful (or theoretical) sampling where the researcher selects participants according to the needs of the study. Morse (1989) describes the process of purposeful sampling as follows:

Initially the researcher will interview informants with a broad, general knowledge of the [culture], or those whose experience is considered typical. Then as the study progresses and the description is expanded more specific information is required, and participants with that particular knowledge are sought. Finally, informants with atypical experiences are sought so that the range of experiences and the breadth of the concept or phenomena may be understood. (Morse, 1989) pg119

Central to this sampling strategy is the requirement that the researcher is able to select the informants to be interviewed. Informants are selected on the basis that they have knowledge of the culture and are willing and able to share that knowledge with the researcher. Additional criteria for selection were that potential participants were Māori women and that they were either employed by Te Oranganui or had accessed those services during the 12 month period that the researcher was based within the organisation. Sample size cannot be predetermined because it is dependent on the nature of the data collected and the time it takes to reach a situation where no new information is being generated. The total fieldwork period for this study was 18 months. An initial 6-month period involved setting up the study (including gaining community approval) and during the additional 12-month period the researcher was located within Te Oranganui. Being based within the organisation facilitated access to potential research participants and the recording of detailed observations of their practices, actions, and interactions.

⁴ For further discussion regarding this process see Appendix 1.

Stage one: Fieldwork

In traditional ethnographic research, the researcher enters the field as a stranger and learns about the culture by asking questions and seeking clarification from cultural informants. With an increasing emphasis on doing fieldwork in 'one's own culture,' the researcher can no longer claim the role of stranger. While the researcher was unable to claim such a role, it was also a mistake to assume that she could be considered an insider. Linda Aamodt (1981 pp135-140) notes that ethnic insiders are not as much inside the cultural setting as assumed and that because society is formed of many subgroups, with each geographically isolated group differing culturally from its neighbour, no researcher is likely to be a complete 'native' of the group under study.

Reconstructive analysis seeks the insider's view. But there is of course a dialectic play between insider and outsider views. There is never a totally insider view, just as there is never a totally outsider one. Understanding necessitates a movement between the claim to a floating third-person position and the claim to a totally immersed insider position. Understanding occurs not through occupying one position or the other but rather learning the cultural movement between them. Understanding is intersubjective, not subjective or objective.

Fieldwork offers the researcher a rare in-depth view of the participants' lives; it is a privileged position and one that the researcher is careful not to abuse. Being able to facilitate an approach to research that was working within Māori frameworks, weaving together the ideas, concerns and strengths of the Māori community and those of healthcare professionals, was a challenge.

The researcher's position within the community challenges the traditional position of the researcher as tuakana (the older, wiser, knower), which is where many researchers stand. In this study, the researcher, though known to the community, had not interacted substantially with that community and therefore in some respects could be considered a stranger. The researcher became a participant in a context where power and control are located within the collective and where knowledge is created, gathered and processed for the benefit of the collective. This position involves connection, engagement, and involvement with the research participants within their own cultural worldview. I was actively engaged in their worlds. A feeling of connectedness was created as the degree of involvement developed and was also enhanced by a number of other facts such as the

researcher's age, being a middle-aged mother and grandmother, and being a nurse and academic. The notion of knowing within a participatory context-driven domain characterises the concepts of connectedness, engagement, and participatory consciousness. This is consistent with the Māori term for connectedness and engagement *whānaungatanga* and is one of the most fundamental concepts within Māori culture, both as a value and as a social process. Whananguatanga consists literally of kin relationships between ourselves and others and is constituted in ways determined by the Māori cultural context. A key element, however, is that it is not simply a matter of kin connectedness and task engagement but is also a matter of a focus on the group rather than the individual. It is through this process that I not only established my relationships but was also allowed to become involved in their struggles, which therefore established both my connectedness and my commitment to the kaupapa.

Contact with Te Oranganui, the research site, was initiated through one of the researcher's own whānau members who was employed as the organisation's Clinical Manager. She initially acted as a sponsor, speaking on the researcher's behalf to the CEO and arranging a meeting between the CEO and the researcher. The meeting established CEO approval for the research, access to office space in the corporate section of the organisation, and access to all other sections of the organisation including the Te Korimako team of community health workers, the medical centre, the rural suitcase service, the midwifery team, and the mental health team. The organisation comprised a diverse group of primary healthcare workers working at a variety of levels and in a variety of settings.

In the initial phase of the fieldwork or data gathering, the researcher endeavored to make herself as unobtrusive as possible within the social site in order to observe interactions. Later, she developed a more interactive role, participating as appropriate in hui and other meetings, assisting in the completion of research proposals, providing continuing education for community health workers and, at times, providing clinical support. Through initial observations of participants and their interactions at other sites, the researcher was able to identify those 'other' sites that were of particular relevance to this study. In that way she could define the boundaries of what constituted relevant 'other' site interactions for inclusion in this research. Participants were observed interacting at a variety of 'other' sites (e.g. kohanga reo visits – Māori pre-school

centres, rural clinics, marae, and mental healthcare settings) with a range of stakeholders (e.g., other health professionals and Māori community health workers).

From the outset of fieldwork, the researcher began building a primary record through conversations, through reviewing programme documents and other literature, and through general observation. Information was recorded in fieldnotes (a record of observations), and a research journal (containing her reflections on the observations recorded in the fieldnotes). The information collected at this point was entirely monological as it was simply a record of her own observations and reflections on the site, activities, and interactions. During this phase she was able to become immersed in and familiar with the site through observation and evaluation, begin to identify key areas of interest through connecting observations to themes derived from the literature, gain credibility, and develop a trusting relationship with informants. It was a time of orientation to the organisation, its philosophies and its ways of working.

Stage two: Preliminary reconstructive analysis

The preliminary reconstructive analysis was confined to data derived from one research site (Te Oranganui) and one cultural group (Māori women). This stage involved analysis of fieldnotes and the research journal to determine interaction patterns, their meanings, power relations, roles, interactive sequences, and evidence of embodied meaning. The analysis at this stage was reconstructive because it began by articulating cultural themes and social systems factors that were not readily observable or articulated by the group. A reconstructive analysis emphasises insider's views and meaning fields by articulating the perceptions of objectivity, the allegiances to norms and values, and the representation of subjective states that participants routinely employ. Thus it brought attention to the ambiguities, cultural drifts and shifts, and even to contradictory claims made in everyday life. What emerges is not a single reality but a field of reality claims consistently made by the participants. People live with conflicting and sometimes contradictory conceptions of reality but there is a tendency towards unification in cultural processes when there are larger issues at stake.

Preliminary reconstructive analysis provides speculations about the meaning of interactions recorded in the primary record. This early analytical work would be checked and expanded, following collection of data from in-depth interviews. This sort of analysis is reconstructive because it reconstructs explicit discourses and cultural and

subjective factors that are largely tacit in nature in order to identify underlying meanings. All acts of meaning are contextual. The meaning fields associated with these acts will be constituted by an interactive syntax of past action, present perceptions, and future expectations. The meaning of any act will in part also depend on its location within a stream of interaction. The preliminary reconstructive analysis is very much a circular process in that the researcher moves from the tacit (intuitive and undifferentiated) towards the explicit and then locates the identified explicit themes back within their wider context. The preliminary reconstructive analysis stage also included feedback to participants of observations to date, in order to check the consistency of observations with participant perspectives. Peer de-briefers check the inference level and appropriateness of codes used to organise data for analysis. The process of preliminary reconstructive analysis enables the identification of issues for further exploration during ongoing participant observation and in-depth interviews.

Stage three: In-depth interviews

The preliminary reconstructive analysis guided the formulation of an interview schedule comprising open-ended questions tailored to the research question. Twenty-five in-depth interviews were carried out and data collected through these interviews were further supplemented with information from 'conversations' and group discussions at the research site and associated 'other' sites as described above.

Analysis of interview data followed the process of reconstructive analysis. Aside from the value of the interview data information in its own right, it was also used for validity purposes to check the consistency of suppositions developed during earlier analysis.

Stage four: Local systems relationships

Stages four and five are concerned with systems relationships, at the local and national level respectively. Before discussing the approach taken in this study to elucidate relevant systems relationships, for clarity it is first useful to provide some background to systems analysis.

Society is not regarded as a single entity but rather as a complex set of intersecting factors. Thus, there is no single social system but rather many system relationships that bring about varying degrees of interaction between social groups and social sites (though often one social group dominates). Systems analysis necessitates moving

beyond reconstructive analysis, as it attempts to explain cultural formations in terms that go beyond the culture of a specific group. Systems analysis must be open to as many cultural contributions as practicably possible in a study. In this study, it begins with the participant's experiences and life situations as have been elucidated through work carried out in stages one to three. These early stages emphasise social integration whereas stages four and five emphasises systems integration and the relations between social and system integration. While a wide range of factors are involved in system integration, they generally fall under one of the following three categories of conditions of action: cultural milieu, economic relations, and political relations.

Cultural conditions of action operate internally, not at the volition of the actors as systems of values, beliefs, and desired identities. Culture is a fundamental and necessary resource for social action. But culture is simultaneously a constraint as actors can only be innovative to the extent that available culture allows. One cannot act in ways that would contravene norms, values and desired identities. Actors are more likely to employ strategies that enjoy wide recognition by members of their cultural group and it is these types of strategies that in turn affirm cultural identity. Moving outside of these constraints creates identities such as 'radicals', such as the Pakaitori protestors (Holloway, 1997).

Political and economic factors (such as external resource constraints) operate externally to the volition of the actors. Political conditions of action involve formalised relations of authority distributed throughout society, such as laws produced by the governing political system and maintained and enforced by the justice system. Those with wealth have a disproportionate influence on the political system compared with the poor. This point highlights some of the overlap between the conditions, as wealth is an economic condition of action. The way in which people can meet their basic needs for food, clothing, housing, and medical care is economically conditioned. People themselves produce and reproduce system relations under the influence of external conditions.

During the first three stages of the research, the focus was primarily on one social site and one cultural group. Stages four and five are concerned with the complex relationships that exist between the social site of focal interest and various 'other' social sites. These relationships have to do with system factors.

Stage four explores the relationship between the research site and its surrounding community, including other iwi and hapū, and government organisations (in particular the Health Funding Authority). The purpose of stage four is to discover and describe system relations between social sites that are brought about primarily through cultural forms. Systems analysis involves matching the reconstructions developed in earlier stages of the research with those pertaining to other sites. The researcher is looking for matches and inconsistencies between subject's experiences in differing settings in order to understand the relationships between sites. Systems analysis involves the review of literature, fieldnotes, and research journal information particularly as it relates to 'other' sites, such as marae and kohanga reo.

Stage five: Wider systems relationships

At this level the researcher seeks to explain findings in stages 1-4 by reference to the broadest social features. It is a process of connecting reconstructive analysis with systems theories. Analysis at this level involves investigation of the relationship between cultural reconstructions and the physical, political, environmental, social and economic environment in which the subjects live. Data from both primary (fieldnotes, research journal, in-depth interviews) and secondary (literature) sources are utilised.

As an example, cultural themes that have emerged through reconstructive analysis may be traced to environmental conditions and in turn these conditions may be explained by wider economic and political factors. The reclaiming of cultural integrity, cultural validity and authority for texts is but part of a wider process of being critical of colonial and neo-colonial hegemonies and is consistent with a Māori-centred approach.

It is important to acknowledge that behavior and experience are also located within a wider socio-cultural and political context and there is always the danger that a purely interpretive approach, which merely mirrors the individual subjective experience, and will be conducive to victim blaming. This is what has occurred with much Māori health research in the past.

The focus of research has to move away from individual characteristics to those of social, economic, political, and cultural factors that induce and sustain individual behaviors and within which disease and unhealthy lifestyles are perpetuated. Previous research has focused on morbidity and mortality: a demographic view, with little sense of the contextual factors that influence people's realities. Health policy is also

determined in these terms, consequently ordinary people in the community tend to see the system as 'dumping' policies, structures, and services on them in an impersonal way without regard for their wishes, their distinctive culture, region, or community characteristics. If progress is to be made in improving Māori health, new concepts, knowledge, and skills must be introduced. Analyses are needed that break away from the narrow confines of biomedical research and economic rationalism to encompass more socio-cultural and politically conscious constructs that will empower people and involve communities (Raeburn, 1994)

Ethical issues

While ethical issues have been discussed throughout this chapter, some specific ethical concerns and the ways in which they have been addressed in this study are described in this section.

The Māori-centred approach taken in this research was adopted to ensure that the research was ethically sound from a Māori perspective. Consistent with this approach, before commencing this study extensive negotiations were undertaken with participants and local iwi. The researcher spent much time ensuring that ethical issues were discussed fully and the utmost effort was maintained throughout the research to respect and protect the informants' cultural values and information.

From the perspective of a Māori-centred approach, it was important to develop a partnership with the participants and to ensure they were fully informed at all stages of the research. The development of a relationship based on trust between the researcher and the participants was intrinsic to how data were obtained and utilised in this study. An interactive approach was vital to involve all research participants in the construction of meaning and the validation of knowledge. It was emphasised that each person had valuable knowledge that they could contribute to the research. The reciprocal relationship established a two-way exchange of information and promoted interaction between the researcher and participants. However, there are those who would argue that such a two-way flow of information is impossible to achieve and that a one-sided relationship, in which the researcher is the power holder, is unavoidable. The latter argument is based on the premise that on the basis of a higher standard of education researchers have a higher status than research participants. Such arguments reflect a

limited conceptualisation of knowledge and attribute little value to experiential knowledge, such as that gained over a lifetime by the women in this study.

As a safeguard to ensure that basic ethical standards were met in this project, ethical approval was sought and approved by the Massey University Human Ethics Committee.

All research requires that the researcher undertakes certain procedures in order to maintain ethical standards. Informed consent was sought face-to-face from all participants for their involvement in the study. All participants had the right to remove from their own data anything they felt had been misrepresented or should for other reasons be retracted. They also had the right to add anything they felt was necessary for clarification. With their permission, in-depth interviews were audiotaped and it was emphasised that if they wished the tape recorder could be turned off at any time. Tapes were only accessible to the researcher and her supervisors and were stored securely when not in use. Audiotapes will be erased at the end of the study unless the participants wish to retain them. Some of the interviews, especially with the kaumātua of the marae, may be a valuable resource for the people as may some of the photographs or video recordings and these data will be retained by the participants. Anonymity of participants was ensured by the use of pseudonyms in all data sources and in the final report.

Information Dissemination

The audience for this research is primarily located in three domains: Māori communities (including iwi), applied settings (service providers, policy makers and funders), and academic institutions. With these domains in mind, a range of dissemination techniques are employed in order to ensure that the findings from the research are accessible to a diverse audience. The main technique will be presentation of results at hui, and provision of summary reports, conference papers, and publications in academic journals.

Conclusion

There is a mandate and an ethical responsibility that nurses provide care that is culturally competent. Societal trends, such as increasing diversity, increasing attachments to unique identity as self-defined or as defined by society, healthcare trends to move from secondary to primary care, increasing focus on community care, and

increasing inequality in access to healthcare, heighten the tension and urgency around culturally competent knowledge.

Innovations and inquiry are needed to inform cost containment and quality assurance, provide understanding of consumer health needs, and to engage a committed investment in the well-being of diverse communities through primary health care. The most visionary forms of investigation to meet these goals necessarily involve groups who have first-hand experience of the failures of the present care system; those who live at the margins, not at the privileged centre.

Whereas conventional research is focused on normative experience in health care arenas, this research deliberately sampled those excluded from access to health care services: Māori women and Māori women in a socio-economically deprived area, outsiders to the power economic security, and social acceptance afforded to those who live more closely to middleclass, white New Zealanders. These women bring a wealth of experience from the margins to challenge the impressions of current health care delivery.

Analysing women's stories, although new to nursing science, is a methodology recognised for its potential to explicate health related phenomena more fully. It is a powerful way of capturing the consumer's struggles to obtain healthcare for several reasons: first, significant life events are commonly communicated in story form, so narrative inquiry taps into people's everyday ways of expressing themselves; second, stories incorporate the context and chronology of events while imparting the meanings they have for the storytellers; third, stories relate larger cultural themes and values. Hence, in telling stories of their health beliefs and practices and healthcare encounters, individuals not only convey personal interpretations of what happened to them but also describe healthcare environments and communicate social, economic and political consequences of the structuring of health care.

This chapter has described the way in which this research has sought to integrate a Māori inquiry paradigm with a western-driven research strategy, design and method. A range of Māori process issues have been identified and the ways in which these issues have been addressed within this research has been discussed. The following three chapters analyse the data beginning with chapter 6, which outlines the participant's experiences and their health beliefs and values. In chapter 7, the researcher expands the

analysis by situating the participants within their ‘specific historical cultural reality’. Chapter 8 draws together the data from the previous two chapters and extends the analysis to look at the relationship between the cultural reconstructions and the physical, political, environmental, social, and economic environment in which the participants live.

CHAPTER FIVE

Whanganui community Māori profile

While the over-arching approach in this research is to give voice to the community of Whanganui Māori women, it is useful to explore what is 'known' about this community. This chapter describes the community setting for the primary data collection undertaken in this research. It presents briefly a

- summary profile of Māori women
- physical, historical and social description of the Whanganui region
- selected socio-demographic profile of Māori/iwi in the region
- more detailed description of significant contemporary political events which impact on this community.

This context information is presented as vignettes rather than as comprehensive analyses or summaries of data. The purpose of the presenting the description in this way is to provide the context *in overview* thus providing a setting for the primary qualitative data collected.

This chapter also provides a description of Te Oranganui health service that is the setting for the sampling of Māori women and presented in Chapters 7, 8 and 9.

Context No. 1: Māori women in Aotearoa/New Zealand

The Ministry of Women’s Affairs in their 2000 document “Māori Women in Focus” provide a summary of the known data from official statistics, such as the New Zealand five-yearly census of populations and households and from numerous published works. The document identifies how dramatically the life experiences of Māori women have changed, particularly during the last half of the twentieth century.

They report that during the 1950s, the Māori female population was predominantly young and largely rural. Māori women left school early and were likely to marry and have children at a young age (Pool 1991). Some entered the workforce but very few went on to further education and training.

Throughout the 1950s, many Māori families moved from rural to urban areas. During this time, Māori women were more likely than non-Māori women to participate in the labour force as they took advantage of the opportunities which presented themselves from expanding industries. Although the education status of the Māori population was low, the availability of a large range of low-skilled occupations meant that both Māori men and women had the opportunity to participate in the labour force and two-parent, two-income Māori families were relatively common at this time.

Economic restructuring and state sector reforms in the 1980s had a major impact on industries and occupations where Māori women were most concentrated. Since then, the decline in job opportunities, combined with increased responsibilities of parenting (as a result of the increase in one-parent families), has limited Māori women’s access to employment. This, in turn, has had a negative effect on the economic circumstances of Māori whānau.

The following Table summarises key facts about Māori women:

Table 3
Māori Women in Focus

<ul style="list-style-type: none">• Life expectancy at birth has improved (52 years in 1952 to 72 years in 1992) but still lags behind non-Māori women (79 years)• In 1996 only 3% of Māori women are over 65 years; in 2046 this will grow as a proportion to 14%• Māori women have more children than non-Māori women, and they commence child-bearing at younger ages. However, Māori women now have far fewer children that they did in the 1950s and 1960s• This more youthful profile of child-bearing affects Māori women’s participation in post-compulsory education, and in the labour force• Māori women today are less likely to live in urban areas (35% of Māori compared with 50% of non-Māori women live in the 5 largest cities)• Fewer than 20% of Māori women today live in extended whānau circumstances• Māori women are vulnerable to unemployment – in 1996 the unemployment rate was 19% compared with 7% for non-Māori women• 41% of Māori children (0-14years) live in families with annual income of less than \$20,000 per annum; this compares with 20% of non-Māori children.
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Source: Ministry of Women’s Affairs and Te Puni Kōkiri.

Some of these data are worth exploring in more detail.

Income – Māori women have lower medium incomes than other groups, \$11,200 in 1996, about 88% of that of non-Māori women. Very few Māori women earn high incomes in 1991, only 3% earned over \$30,000 per year compared with 9% of women

in the total population. Māori women are very likely to be dependent on government income support.

Working patterns – Māori women are slowly increasing their participation in the workforce but are still concentrated in unskilled, lower income occupations, and are significantly more likely to be unemployed than non-Māori. Unemployment is highest among the 25-30 year old group and there is a significantly higher proportion of Māori women in that age group.

Educational attainment – Years of formal education and qualifications achieved are strongly linked to high incomes. In 1996, 31% of Māori women had no post-school qualifications and only 3% had degrees. Māori women have had limited access to higher schooling or tertiary education and are still under-represented in professional occupations.

Housing

A significantly lower percentage of Māori than non-Māori own their own homes freehold. This means that in retirement many Māori women have continued high housing costs.

Family formation

In 1991, 46% of Māori women had dependent children. The other 54% is made up of girls, those who have not had children or have postponed childbearing, and those who are no longer dependent. A high proportion of Māori women live and work in households with children. Māori women are still likely to have larger families than non-Māori, with average live births per woman 2.1% compared to 1.9% for non-Māori. Māori women are also more likely to be sole parents with dependent children than non-Māori, 19% of Māori women and 5% non-Māori. They are also more likely to be in two parent families with dependent children. Māori women are more likely to be divorced or separated than non-Māori and also to be cohabitating. A significant proportion of Māori women are caring for a physically or mentally handicapped person or an aged person and they are also more likely to be caring for a whangai, even at older ages. Only 4% of Māori women live alone and living alone is strongly related to age.

Socio-economic risks to health

There are well-documented and persisting inequalities in health for Māori in New Zealand. There is also evidence that these inequalities are linked to socio-economic factors (Core Committee Report). This recent New Zealand work confirms international evidence that social, physical, cultural, and economic factors are the main determinants of health.

The availability of food, as an example, provides a perspective on the effect of socio-economic factors on health. In the 1997 National Nutrition Survey Māori women (25-44 years) were more likely than Māori men and women of any other age to state that their household ran out of food due to lack of money.

Health affecting behaviours

Smoking is a major cause of preventable death. Māori women have the distinction of having among the highest rates of tobacco smoking in the world. High consumption rates of alcohol and comparatively low rates of physical activity also bring health risks for Māori women.

Summary – The experience of Māori women in New Zealand now can be summarised as being characterised by such indicators as low income, housing problems, sole motherhood and ill health of themselves and those for whom they care.

Context No. 2: Whanganui Region

Wanganui, or more correctly Whanganui, is a provincial city in the central region of the North Island of Aotearoa, New Zealand. Nowhere in Whanganui are people far from either the river, the sea, or the land. The area has a long history of Māori settlement, and there has been a long and, at times, turbulent relationship between tangata whenua and the European settlers and those who followed after them.

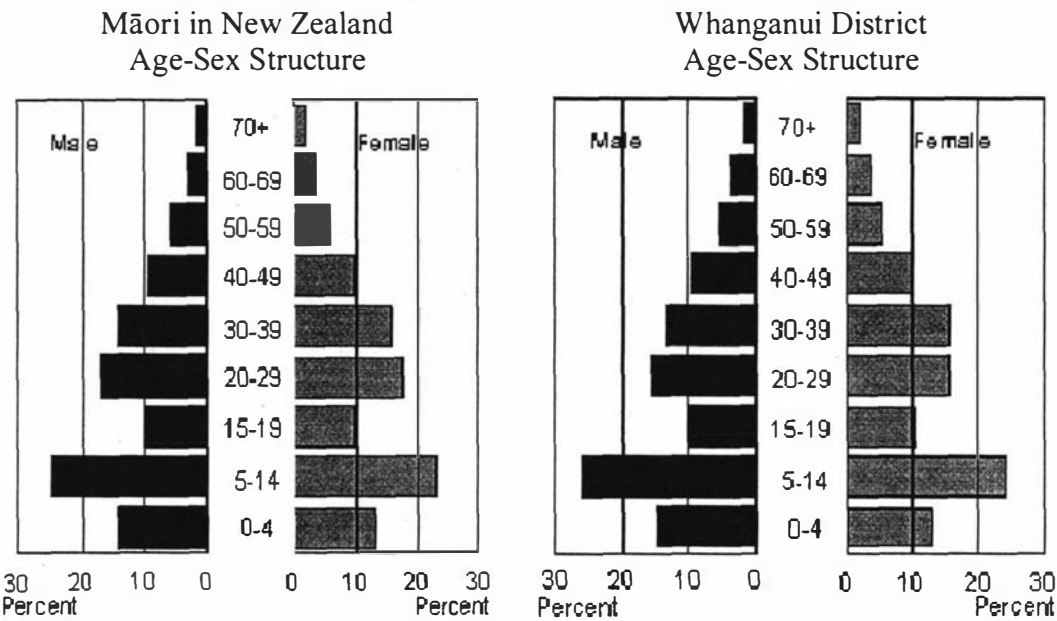


Figure 1: Map of Whanganui/New Zealand

Socio-demographic profile – Whanganui Māori

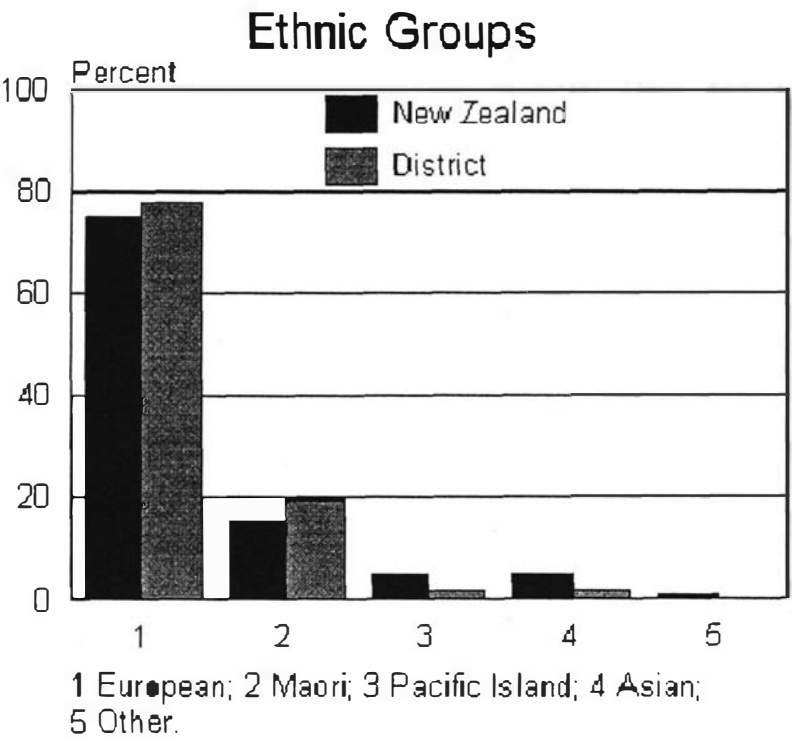
The total number of people living in Whanganui at the time of the 1996 census was 45,042. Over the decade 1981 to 1991 the population of Whanganui urban area increased by 4%, a growth rate typical of the Central Region as a whole. Most of this growth occurred in the early to mid 1980s. The population of rural Whanganui grew by 8% over that decade. The rate of growth between 1991-96 was only 0.8%. As at the 1996 population census, there were 8,241 Māori residents in Whanganui. Within the core area, Māori make up 27% of the total population. In rural Whanganui, Māori make up 17% of the total population. This was an 11.1% increase on the 1991 census and consistent with the migration from larger urban centres over the last decade.

Age and sex – Māori population



- 5.5% of Māori people in the Whanganui District are aged 60 and over compared with 5.0% for all Māori in New Zealand.
- The proportion of preschool-age Māori children living in the Whanganui District is 13.9% compared with 13.7% for all Māori of preschool-age.

Ethnic Groups

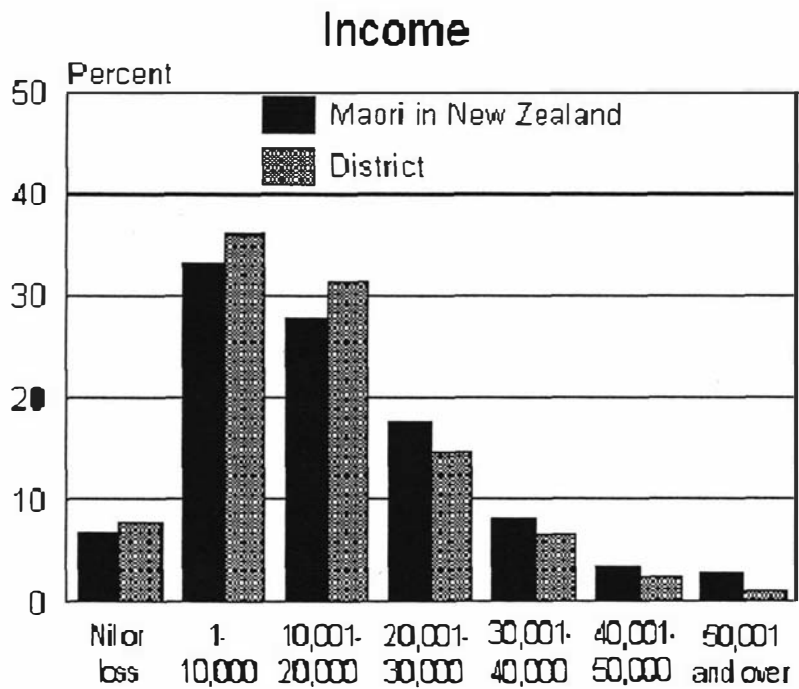


- 77.8% of people (33,249) in the Whanganui District said that they belong to the European ethnic group. For all New Zealand, 74.8% said they belong to the European ethnic group.
- 19.3% (8,241) said that they belong to the Māori ethnic group compared with all of New Zealand at 15.1%.
- The population of the Whanganui District contains a smaller proportion of Pacific Island People (1.5%) and Asians (1.4%) compared with the whole of New Zealand (at 5.0% and 4.6% respectively).

Household Income

Household income levels in Whanganui families are on average considerably lower than for the Central Region as a whole. 54% of the households in the Whanganui district receive a total income of less than \$30,000 as compared to 41% in the Central Region. 75.5% of Māori aged 15 and over receive an annual income of \$12,900 or less compared with 67.8% for Māori in New Zealand as a whole.

For Māori:



- 75.2% of Māori people aged 15 years and over in the Whanganui District have an annual income of \$20,000 or less, compared with 67.8% for Māori in New Zealand as a whole.

- 1.0% of Māori people aged 15 years and over in the Whanganui District have an annual income of more than \$50,000 compared with 3.0% for Māori in New Zealand as a whole.
- 2,214 or 45.7% of Māori people aged 15 years and over said they received a government benefit in the 12 months before the 1996 Census. For Māori in New Zealand as a whole 39.5% of people aged 15 years and over received a government benefit.

Income Support

In the Whanganui district, 77% of families receive some kind of income support as compared to 70% for the Central region as a whole. Main types of benefits received were national superannuation and family benefit, alone or in combination with other benefits. Two or more benefit types were received by 29% of families in the Whanganui district compared to 21% for the Central Region as a whole. Within Whanganui 39% of families living in the core area received two or more benefits compared to 29% of rural Whanganui and 22% in the rest of Whanganui. 85% of Māori families in Whanganui district received some kind of income support, compared with 76% for non-Māori families. Two or more benefits types were received by 47% of Māori families compared with 46% of non-Māori families.

Social Factors

Unemployment for Māori in the Whanganui region is high for both men and women. 28% of Māori men and 27% of Māori women are unemployed at the time of the 1991 census. The unemployment rate is much high among young Māori aged 15 to 19 years. 59% of young Māori men and 48% of Māori women are in that age group.

Cot death is the leading cause of death in Whanganui children. In the years 1985 to 88, 21 Māori babies died from cot death. The cot death rate among Māori children in Whanganui is about 3.7 times higher than for non-Māori rate. The median age for mothers who had lost babies to cot death was 23. Of those mothers, where information is available, 62% smoked more than 10 cigarettes a day. The most disadvantaged part of Whanganui had about 5 times the cot death rate experienced in the most advantaged areas. There is also a particularly high rate of hearing test failures and also a higher rate of admissions for respiratory disease in all ages. For 1984/88 the incidence of rheumatic

fever for Māori children in Whanganui was 2.7 times the incidence for non-Māori. Injuries are also a leading cause of admittance to hospital for Whanganui children: with Māori children having slightly higher rates than non-Māori.

Deprivation

Data from the 1996 census was used to create the NZDep96 index of deprivation, a tool to measure socio-economic deprivation, and thereby inequalities, at the population level. The tool has been used to measure socio-economic deprivation by ethnic group and shows wide disparities between the position of Māori and that of the group 'European and Other'. Māori are disproportionately represented in the most deprived areas of New Zealand. There is much local and international evidence to support the link between socio-economic deprivation and poor health status. The Whanganui District deprivation profile, compared with other districts, shows a relatively deprived district with higher proportions of people living in relatively deprived areas (Crampton, 2000). This profile may be in part a reflection of both a relatively high Māori population and a large proportion of retirees.

Context No. 3: Recent political history

Whanganui Māori have had a high political profile in recent years with the much publicised occupation of Pakaitore (Moutua Gardens). This was an occupation which had as high a profile as those which occurred at Orakei (Bastion Point) or the Raglan Golf Course. The position of Māori within the Whanganui region is influenced by this recent, high-profile land occupation⁵.

Whanganui and its surrounding settlement are situated on land which is under the guardianship of the iwi of Te Atihaunui-a-Paparangi, Ngati Apa, Nga Rauru-ki-tahi, and Tamaupoko. Māori regard themselves as the guardians of Papatuanuku, the earth mother, not as her owners; individual ownership of land is a concept that came with the European settlers. Māori within their tribal areas have associations with the whenua (land) that distinguishes them from Māori who are not from that tribal area. This close connection to the land is often shown through the returning of the whenua (placenta) back to the tribal area of the parents and is constantly referred to in many other rituals. In Whanganui, as in many other parts of Aotearoa, grievances stemming from the loss of land to the settlers last century await resolution. Local tribes are demanding their right to exercise *Whanganuitanga*, which has been stated as:

The supreme authority of Te Atihaunui-a-Paparangi in its own district to be the guardian of the land and river and all its resources and to legislate according to Māori custom lore how the land and people are to be protected.

In February 1995, the tangata whenua of Whanganui exercised their *Whanganuitanga* through reclaiming an old pa site traditionally known as Pakaitore, also known as Moutua Gardens. Those involved in the occupation of Pakaitore argued that the practice of *Whanganuitanga* is essential in order for gains to be made in health, education, and well-being of tangata whenua in Whanganui.

What was it all about? Many words were written and spoken on the occupation, some of them contradictory. The most coherent summary of the view of many was that published in a national newspaper (*The Dominion*) on 24 March 1995. Essentially, as the statement above demonstrates, it was an assertion of rangatiratanga. This article outlines how a range of cultural practices such as the burial of the whenua became sanctioned by

iwi in ways that shaped and ensured the survival of Māori custom, culture, and lore. Niko Tangaroa⁶ later elaborated that it was the entire range of traditions and values embodied in stories, waiata, and occasions such as tangihanga that:

‘are quite unique as they are with all tribes and they make us what we are.’

It is the river for the Whanganui people and for many other indigenous tribes that actually shape the attitudes and values of the people in the ways reflected in the wisdom of the whakatauki:

‘I am the river and the river is me’.

Out of this process came rights and obligations, political power, and rangatiratanga, what the occupiers called Whanganuitanga. They rejected the idea of land as a commercial commodity that could be traded, rather they took the view that land is the source of life and rights and therefore gives rise to unique concepts about the status of all the people who live upon and within it. (Jackson M 1995 Dom 10th May). On the one hand, this statement was a denial of crown sovereignty and law assumed since the signing of the Treaty of Waitangi; on the other it reasserted iwi traditional rights and obligations to care for the land.

The land occupation was just one of many strategies adopted by Māori over the past 150 years to protest the alienation of Māori land and lack of progress on claims before the Waitangi Tribunal. Over the years Te Atihaunui-a-Paparangi have expressed their attachment to the river in many ways by various forms of protest. During the early part of this century they asserted their rights over eel weirs, customary rights to fishing, to impeding the passage of boats up river and by laying a number of claims for loss of fishing stocks, the removal of shingle, and by laying claim to the bed of the river. While some courts have upheld some claims, these decisions have been over turned by higher courts which found it impossible to accept the translation of Māori lore into European law (Downes, 1915; Young, 1998).

⁵ For a detailed account of the occupation at Pakaitori refer to p. 103

⁶ Niko Tangaroa, along with Tariana Turia and Ken Mair were the leaders of this occupation and their spokespersons.

Whanganui River

For many years the Whanganui tribes have sought a return of the Whanganui River, maintaining that the Crown had wrongfully assumed ownership. Although Judge Brown at a Native Court hearing in 1939 concluded that the Whanganui tribes were the owners of the river, the Crown appealed first to the Māori Appellate Court and then to the Supreme Court.⁷ Concerned that other tribes might take similar action, Judge Hay ruled that the Coal Mine Amendment Act of 1903 had vested ownership of the riverbed in the Crown. Whanganui interests were overlooked in a series of actions, including the diversion of the riverhead waters into Lake Taupo in 1960. A lengthy hearing before the planning tribunal regarding water flows in the river again raised the issue of ownership and in 1991, negotiations⁸ with the Crown commenced regarding river ownership. They were again suspended pending a wider river policy.

As early as 1895, Meraina Rauangina and 151 other Whanganui women lodged a petition concerned not so much with damage to eel weirs but the effects of the river boats on the shore line and the channels '*Petitioners pray that the right of the Māoris on the Whanganui river not be interfered with*'.⁹ Early the following year the eel pa which had hindered navigation was removed with the consent of the Māori owners. The visit to Pipiriki the previous November by the Premier was said to have influenced this decision.¹⁰ The lower river Māori, led by prominent chief Wiremu Hipango filed the next river petition in 1914 concerning Government appropriation of Māori land for reserves.¹¹ Hipango, a man of considerable mana, had backed his own words by creating the reserve of Hipango Park in 1930 from his own hapū reserves. His actions shamed the government into creating the Whanganui River Reserve Commission, a three-man team which viewed the reserves and heard Māori grievances concerning lands that had been taken and allegations of undue pressure from the government to sell. Evidence was also given of the need to conserve forestry for catchment purposes. Two further petitions ensued in 1927, both claiming compensation for loss of reserve land on

⁷ The Māori Appellate Court upheld the Brown decision.

⁸ AJHR1896 c-1, 114

⁹ Meraina Rauangina and 151 Others, Petition no 126, AJHR, 1895 1-3

¹⁰ AJHR1896 C-1, 114.

¹¹ MA 2459,%/13/188,box 1, NAW. Interview with Huia Hipango

the riverbanks and of fishing and gravel removal from the river.¹² In latter years there have been a number of high profile occupations continuing to protest the alienation of Māori land and lack of progress on claims before the Waitangi Tribunal (Young, 1998).

Late in 1993 a small group of protesters occupied a Department of Conservation hut at Tīeke, along the Whanganui river. This occupation continues today. Trampers visiting the area are not turned away or made to feel unwelcome but they were exposed to the history of the complaint from a Māori perspective. The occupiers felt that other avenues of complaint had failed, especially with the Department of Conservation, and that there was no alternative but to take the law into their own hands. Government response was predictably terse and a serious confrontation was only avoided by the intervention of tribal elders who eventually persuaded the Department of Conservation to enter into an arrangement with the occupiers that would enable them to occupy the hut lawfully and to not hinder access to the hut and surrounding area by others. Tīeke was not the only conservation property subject to Māori occupation and although it was a protest at the lack of progression over claims before the tribunal, it was also symptomatic of the growing discontent felt by many Māori at the growing alienation from traditional lands rivers and forests.

The protest at Pakaitore, although lasting only 80 days from the 28th February until the 18th May 1995, was just another step in the long running claims to the Government for restoration of Māori land and the return of the riverbed. Growing anger and frustration over both the lack of progress with current claims and the Government's proposals for the settlement of Treaty of Waitangi claims, the so called 'fiscal envelope', triggered a series of incidents that lead to the occupation. Firstly on the 20th of December the statue of Sir John Ballance had a head and foot knocked off, the Māori rights action group Te Ahi Kaa claimed responsibility saying Ballance was anti Māori. Then in January 1995 Sir Hepi Te Heuheu called a hui at Hirangi which condemned the government proposals and may have acted as a sign for more radical groups to express their outrage in other ways. On the 3rd of February members of Te Ahi Kaa, barricaded the motorway north of Whanganui with old fridges and whiteware to draw attention to the longstanding grievances over Whanganui river lands and as a challenge to weekend holiday makers to consider what Waitangi day stood for. Further protests and violence

¹² For detailed discussion on these claims see Young, D. *Histories from the Whanganui river: Woven by Water* 1998.

followed during celebrations at Waitangi on the 6th of February. The crown representatives and the Governor General were the recipients of verbal and gesticulated insults generated by the Government's treaty settlement proposal which promoted court action and the Government's subsequent withdrawal from Treaty celebrations at Waitangi. At Whanganui, meanwhile, the repaired statue of John Ballance was again decapitated on the 13th of February and the Mayor Chase Poynter expressed outrage on behalf of the city. Following on from this incident, 150 Māori established Pakaitore Marae at the gardens on the 27th of February. Coincidentally the occupation coincided with the Crown's Fiscal Envelope hui to be held further up river at Kaiwhaiki on the 28th of February. Although it has not been acknowledged at any stage, some commentators believe it may have been a deliberate boycott of the hui. Kaumātua Niko Tangaroa maintained that they were there to celebrate Whanganuitanga but when the Mayor visited the marae later he was advised that Māori wanted the return of the land and that the occupiers were simply exercising rights to use land that they already owned.

There was considerable confusion between Poynter and the police about the terms of the occupation, and local and national media, in turn, exacerbated this. A poll of district councillors had shown strong support for settling the dispute by dialogue; however, there was pressure from the community to take more decisive action to prevent the incident from becoming another Bastion Point. Regardless, by mid-March the situation had begun to resemble Bastion Point in more ways than one. Construction of a substantial meeting house had begun and the occupiers showed signs of settling in for the long winter. Niko Tangaroa was adamant that they were at the gardens to stay. The Mayor took on the negotiating role himself and tried to convince the protestors that the gardens belong to the city, not Māori; he also made it clear that the council would not negotiate while the gardens were still occupied. Spokesman Ken Mair replied by saying iwi would not be bound by pākehā law.

When it was clear that the occupation did not have the full support of tribal elders, both the police and the District Council entered into discussions with Kaumātua from neighbouring marae. Of major concern to all tribes was the resolution of long standing grievances which had already been filed with the Waitangi Tribunal. They were keen to make progress on their claims and therefore did not see the occupation as an advantage nor did they seriously entertain the thought that a show of force or defiance of the law

would bring speedy results. Yet not withstanding any reservations they may have had, the call for them to speak out against the occupation was fruitless. There was no condemnation of the occupation by the elders; in fact there were several meetings between Whanganui iwi and the protestors but the issues debated were far more complex than simple law and order or the maintenance of good public relations. Instead the focus was on relationships between hapū, iwi strategies, observance of tikanga, and the relative merits of various iwi claims. The occupiers always denied any iwi opposition to the occupation and, in the long run, the maintenance of reasonably clear lines of communication and good will between the occupiers and the Kaumātua outside Pakaitore enabled the occupation to be concluded without the use of force or loss of dignity for all those involved. By resisting the crown's invitation to condemn the occupation, iwi had shown that it is possible to resolve disputes between Māori in a positive way.

Nearly two years after the occupation at Pakaitore and with the Whanganui claim still not heard, one Whanganui hapū, Tamahaki - concerned that their views were seldom given adequate consideration - this time protested on the river. When Winston Oliver, a tourist operator, tried to sail his houseboat the MV Georgina up the river he was met by a flotilla of canoes and a hail of stones from hapū members lead by Ken Mair and Niko Tangaroa, both of whom had played prominent roles at Pakaitore. A spokesman for the hapū, John Maihi, delivered a letter setting out the basis for their actions: inadequate consultation, environmental impact on the river wilderness, pollution, effects on the river ecology. “(t) his river is our spiritual, cultural, and historical ancestor. It has aspects that must always be protected.” Winston Oliver choose to ignore the letter and presumed to pursue his goal of sailing up river, yet another example of the constant ignorance and disregard of the concerns of local iwi.

This is a community that has steadfastly fought over many years for the return of their Taonga that are so inextricable tied into their health and wellbeing. Identity and health are closely linked and many would argue that without a secure identity we cannot hope to make significant gains in all areas of development, let alone health and well-being. Throughout Māori thought, there is constant reference to the interdependence and interconnectedness of land, rivers, mountains, and ancestors to the individual, the whānau, hapū, and iwi. This interconnectedness and the interdependence of all spheres of past, present, and future is inextricable tied to health and wellbeing of Māori (M.H.

Durie, 1994b). There are three key factors in identity formation for Māori which promote collective and individual wellbeing -these are quoted by many writers and speakers in the area – firstly, whakapapa or genealogy combined with access to land, turangawaewae bound together by the ancestral language: Te Reo Māori. From these combined strengths, a vital spirit emerges that expresses the true essence of what it means to be Māori. Nowhere is this essence demonstrated more clearly than in the children who are now emerging from Te Kohanga Reo and Kura Kaupapa schools.

The occupation of Pakaitore was as much about identity, health, and wellbeing as protest over loss of land. For many of our younger generation, it was about whakapapa, interdependence, land, and creating in that environment a strong sense of identity. It was about being healthy in a holistic sense. Interdependence is a key concept in Māori thought and it is seen as a desirable state necessary for the achievement and maintenance of healthy development. This contrasts dramatically with the Western emphasis on individualism, independence, and pursuit of individual interests without heed for the concern of others, which for Māori is considered an unhealthy state. The loss of the language, as with the loss of the land, has served to undermine traditional determinants of healthy identity formation; whakapapa has thus become the governing factor in Māori identity claims and in the establishment of rights.

Land, rivers, and mountains have great sentiment attached to them and the strength of ancestral associations with them are a key component of a healthy Māori (Dyall). These concepts are seen as key to establishing a strong healthy sense of oneself and one's place in the world.

The 1980s saw Māori families leaving major urban areas for smaller cities, towns and rural localities and the least urbanised regions of the country. Just how much of this movement can be described as return migration is not known, but recent work by statistics New Zealand monographers suggests that some of the families on the move are returning to their tribal areas. Between 1986 and 1991, Northland had the highest influx of Māori. Most of them came from the Auckland region. Auckland in turn suffered the highest outflow, closely followed by Wellington. Although its inflow was not as high as the inflow in Northland, the Bay of Plenty emerged as a major destination for Māori migrants. Moreover, unlike Northland which derived most of its migrants from the one source - Auckland, the Bay of Plenty drew people from nearly every other region. The direction of movement differs according to age. Young adults tend to move

to Auckland, Wellington, Canterbury and Otago, the main centres for tertiary education, training and jobs. Families and the elderly tend to move in the opposite direction. The demographic future of the Māori population poses as much of a challenge to Māori as it does to national and local government and the rest of society.

Context No. 4: Te Atihaunui-a-Paparangi

At the 1996 Census, Te Atihaunui-a-Paparangi had a total of 6,153 affiliated members. A total of 3,297 (or 54%) said that Te Atihaunui-a-Paparangi was the only iwi they belonged to. Overall, people who belong to Te Atihaunui-a-Paparangi made up 1% of the total Māori descent population. Within the iwi tribal boundaries, Te Atihaunui-a-Paparangi made up 14% of the Māori descent population.

Since the 1991 Census, the number of people who identified with Te Atihaunui-a-Paparangi increased by 1695 or 38%. Over the same period the Māori descent population increased by 13%.

Urban and rural distribution

In 1996, 85% of Te Atihaunui-a-Paparangi lived in urban areas. Of these, around three quarters (77%) lived in main urban areas with populations of 30,000 or more. Older Te Atihaunui-a-Paparangi (aged 65 and over) were most likely to live in rural areas (24%) while those aged 25-34 and 15-24 were less likely to do so.

Age structure

The Te Atihaunui-a-Paparangi population is concentrated in the younger ages, as illustrated in Figure 3. In 1996, 36% were children aged under 15 years while only 4% were 65 years or older. Over half (53%) of Te Atihaunui-a-Paparangi were female. There has been little change in the age distribution of Te Atihaunui-a-Paparangi population since 1991.

The age profiles of Māori and European ethnic groups in Whanganui district are quite different: 50% of the Māori population is under 20 years of age as compared to 28% of the European population. In Whanganui district as a whole, 33% of all families with dependant children are single parent families at the time of the 1996 census. This is considerably higher for the Central Region as a whole. Māori had the highest proportion

of single parent families with dependent children in the Whanganui district as a whole, 47% compared with 25% of European families.

Unemployment

Te Atihaunui-a-Paparangi unemployment rates, like those for the total Māori decent population, have dropped since the 1991 Census. By 1996, the unemployment rate for men had fallen from 29% to 13%.

Context No. 5: Te Oranganui

Te Oranganui Iwi Health Authority (Inc) brings together the combined interests of iwi in the Whanganui, South Taranaki, and Rangatikei region to provide a comprehensive and integrated range of primary health care services. The organisation was established in 1991, facilitated by an amalgamation of two services in the late 1980's: Te Waipuna o te Awa, representing Hinengakau, Tama Upoko, and Tupoho, all strands of the river that make up the iwi of Te Atihaunui a Paparangi and the service of Te Korimako, representing Ngati Apa, Otaihape, and Nga Rauru Iwi.

Te Oranganui has developed significantly over the years to a position where there is the capability of offering primary medical services and a wide range of health related services to approximately 6,000 clients. The Health Funding Authority, the Crown purchaser of health services in New Zealand, funds the organisation. The initial development was greatly assisted by the Whanganui River Development Board, an organisation developed by Māori in the Whanganui region for the purpose of receiving education funding from the Crown, who provided premises for the organisation.

The mission statement of the organisation states the intention to:

Improve the health status and wellbeing of whānau who live in the tribal areas of Whanganui, Ngati Apa, Nga Rauru, and Otaihape in significant and measurable ways through the affirmation and restoration of rangatiratanga of whānau, hapū and iwi, and through a range of quality primary health care services that meet the identified needs of their population (Te Oranganui, 1996).

Te Oranganui provides a primary medical service, a midwifery service, a community health service, and a mental health service.

Te Oranganui is an emerging model of Māori health service delivery and reflects the direction, identified by many Māori, to be taken if we are to improve Māori wellbeing. “Whaia te Whānaumatanga Oranga Whānau” - a Government document on the wellbeing of Māori families, promotes the development of population-based strategies that are identifiably Māori and validate Māori communities (Ministry of Health, 1997). Pomare (1995) suggested that Māori health service development at a community and primary health care level may increase early intervention by improving accessibility and appropriateness of services. Both these papers indicate that it will be important to purchase and deliver community based primary care services if we are to improve Māori health. Te Oranganui is attempting to address Māori health priorities by identifying population-based health needs from a Māori perspective and providing a range of services at a primary health care level.

Te Oranganui, like other leaders in Māori health development, has concentrated much of its energies in the last decade on wider iwi development. It is recognised by the organisation and by other Māori health leaders that it is now time to move towards whānau development and whānaungatanga (Durie, 1994).

Profile of the women in this research

The women that participated in this research all lived within their own traditional lands either on or very close to their family marae. Although their ages crossed three generations they had many characteristics in common. They all have a strong interest in Māori development in its broadest sense. They had all been involved with initiatives such as education, health, and workforce development. They all had families and all had experiences in both mainstream health services and with the local iwi health provider. Several of the participants worked for the iwi health initiatives as well as being involved with other Māori development initiatives, such as social services, kohanga reo, kurakaupapa schools, and iwi radio,

All the women actively participated in the occupation at Pakaitori, which also demonstrates their personal commitment to the broader issues of Māori development such as Tino rangitiratunga. They have a high level of political awareness and a strong commitment to whānau development as the starting point for broader iwi development, and work tirelessly towards this goal.

Most of the women in this study have suffered years of hardship and deprivation through the larger structural issues such as lack of employment, minimal levels of education, poor housing, and lack of opportunities.

Conclusion

This chapter has provided a brief overview of the setting for this community of Māori women by presenting a range of data and information of relevance. None of this information is obscure and is easily obtained in detail elsewhere: descriptive reports of Māori disparities in a range of outcome areas are numerous. The intention of this overview is to provide an understanding of the way in which the reality of the respondents is generally portrayed, particularly to those such as health professionals who access research reports and policy documents produced by the health sector *about* Māori.

Such portrayals frequently lead to the stereotyping of communities. Yet these portrayals fall short of the lived realities of the women in this study and do not provide the necessary fine detail to enable development of a responsive model of primary health care nursing.

The following chapters enable this fine detail to be explored. They concentrate on these women's own health beliefs and practices, their identity, and their perceptions of their marginalised position.

CHAPTER SIX

Māori health beliefs and practices

Introduction

The object of the first stage in any ethnographic research is to see things “from the native’s point of view” (Denzin, 1997). In this research I present the experiences of a group of Whanganui Māori women through the use of the following descriptive sub-themes: their own health beliefs and practices (this chapter); their identity (Chapter 8); and their perception of marginalisation (Chapter 9).

The focus of this chapter is to begin to understand how these women describe their health, how they define the term ‘health’, and what concepts are central to their perceptions of health. People were encouraged to discuss, in their own terms, what was important in achieving health and well-being: to tell their own ‘quintessential little stories’ or counter narratives. In seeking to clarify understandings of concepts such as ‘Māori primary healthcare’, it is first necessary to examine the concept of health on which it is premised.

While Māori and non-Māori live side-by-side they do not always share the same environments nor the same narratives and neither do they subscribe to identical values or aspirations. To provide healthcare to populations with a range of needs and expectations, it is important for healthcare professionals to acknowledge and value diversity. Throughout the previous decade there have been numerous challenges

directed at both health professionals and policy analysts to move beyond the imposed stereotypical views of Māori and take cognisance of the diverse social and cultural realities within which Māori live (Durie, 1984). In order for this to happen, health professionals must have access to information regarding Māori health beliefs and practices. This study will provide this type of information by outlining in some detail the diverse health beliefs and practices of participants.

Within nursing settings, structural barriers are often imposed upon patients and the impact of those barriers on particular patients varies according to cultural preferences (Meleis, 1990). There is a need to develop knowledge about how societies at large and healthcare systems in particular may unwittingly marginalise some patients on the basis of culture. Discussing their understanding of health is one way that people can give expression to their cultural notions of well-being and quality of life. Health is a key word or generative concept that is a value attached to, or suggestive of, other cultural values. As nurses, we must consider the constraining social conditions that impact upon the client's health potential in some communities and societies and question the validity of the common assumption that health is a personal matter. Increased clarification for nurses about Māori beliefs and practices relating to health is important to avoid unintentional marginalisation of patients on the basis of culture.

Consistent with the Māori-centred approach adopted in this study, Te Whare Tapa Wha (M.H. Durie, 1994b) underlies reconstructive analysis in this chapter. Therefore, notions of wellness, holism, whānau, spirituality, and cultural integrity are central. The notions of whānau, spirituality, and cultural integrity in relation to Māori beliefs and values are discussed below in distinct sections.

Whānau has been defined as an extended family network with descent from common ancestors and within which mutual obligations are maintained (Durie 1994; Pere 1984; Metge 1995; Ratima 1996). Spirituality is concerned with the link between people and the environment. While formal religion may be one reflection of spirituality, others include relationships with and understandings of the environment. From a Māori perspective, cultural integrity is an essential component of good health. Cultural integrity implies a secure Māori identity and this in turn may be expressed in equally valid though varied ways by different individuals. Generally, Māori identity has links to personal perceptions, cultural heritage, and access to Māori institutions (Durie 1995).

The notions of wellness (i.e. a positive concept of health) and holism are not discussed as individual sections as they are inextricably connected to each of the other ‘notions’ and attempting to distinguish them is not useful. It is worth noting generally that each area (wellness, holism, whānau, spirituality, and cultural integrity) overlaps and, therefore, while for clarity there has been a distinction drawn between the last three, this distinction is somewhat artificial. A final section in this chapter discusses the data in relation to primary health care.

Peoples’ perceptions of health and illness are inextricably linked to their cultural beliefs and values. The failure of some health service providers to acknowledge and understand these issues has contributed to the increasing health inequalities. When Māori talk about health they take into account either consciously or sub-consciously the four cornerstones of health: Taha Wairua – the spiritual, Taha Hinengaro the mental, Taha Tinana – the physical, and Taha Whānau-the family. When a person is ill, Māori often look beyond the obvious physical symptoms in order to determine the cause:

It is also about what are the things that keep you physically healthy as well, so you must have to think about your mental health, your psychological health and all that, and using those things to keep you safe.

Basically who you are and who we come from, all these very basic things that we as Māori have lost because of the advent of the ‘fifties’ and the ‘sixties’ assimilation in getting Māori to come to the urban areas.

But if you did need health care for me, in my own situation, what I would do and why I actually looked at alternatives that we had and who I could go to. I’m talking about whānau particularly, because I know that has been an option for me. [R]

Whānau

Healing

A consistent theme across interviews was the link between whānau and good health, that is for healing to progress whānau support will be required. Health is discussed in terms of immediate whānau, extended whānau, and whānau a iwi (Metge, 1995). When these women speak about threats to health or explanations for improving or maintaining health, one or more of these related concepts frame the discussion and are attributed the ‘healing’ process and improvement and maintenance of health. Throughout these

interviews, the women spoke of ‘healing’ and this is in itself significant for healing denotes a process that involves a personal response or involvement. Here the emphasis is on the person’s own capacities and strengths and their underlying beliefs and relationships. Healing is an active process, not a passive process. It cannot simply be prescribed; it is a process which involves whānau:

Healthy for me is just being whānau – your immediate whānau first, your extended whānau, and then you have your whānau a iwi that's all around the river so we can come together in gladness and sadness. [R3]

There can be just us that are home and then they hear there is a little bit of sadness in your whānau and then the cousins come and the aunties come, that's the healthy lifestyle for me. [I1]

Then the aunties ring the nannies and the nannies come and then the river is like a bongo drum anyway, and messages go out and those ones come as well, so that's a healing process, it's just having your whānau around you. [R3]

The whānau is central to the healing process, which acknowledges the importance placed on both immediate and extended family. Healthy for these women is “just being with whānau”; family is the prime support system for Māori, providing both care and nurturance. The immediate family tends to provide support on an emotional and spiritual level while the extended family provides physical support, taking over the role of the immediate family through feeding and attending to the needs of the immediate family. This process allows the immediate family to give emotional and spiritual support to the patient and to each other to strengthen and nurture the family. The whānau mediates physical, emotional, and cultural needs and maintains the integrity of the unit as a whole. This is in contrast to the Western model of health and to many nursing models that focus strongly on the individual, on individual responsibility and self-care, and on the physical aspects of healing. The participants in this research are not talking about healing in solely a physical sense; they are expressing healing as being both a physical and spiritual process.

And in between all that is the rongoā and just being whānau loving one another; that's all a healthy lifestyle in my eyes, and sharing and caring, that kind of stuff. [R1]

Aroha

The value most often associated with whānau is aroha, which is usually translated into English as love. Although aroha shares some of the same connotations as its English translation, it is not the same as love as it is perceived within an English context. In classical Māori, aroha is used primarily as love of those known as kinsfolk, including the gods, and was not used for sexual love. Rangimarie Rose Pere (1991) defines aroha as: “unconditional love that is derived from the presence and breath of the creator a pillar of life Io Matua. Evil and negative thoughts cannot flourish where absolute aroha reigns. Aroha is truly a divine love because it knows no bounds and is infinite.” (p.6)

In this particular whānau, aroha is particularly associated with kinship ties and particularly with love for members of the same whānau, hapū, and iwi. The Māori version of ‘charity begins at home’, aroha begins with whānaunga. Even more important than affection are caring acts, especially in times of sickness, need, or other trouble. Rangimarie Rose Pere insists that aroha is only meaningful when actioned. (p.6)

Whānaungatanga

Closely associated with aroha is the concept of whānaungatanga, referring to extended family in its widest sense. This concept extends the meaning of whānau beyond members of the immediate family to all other relatives. Because they are not necessarily of the same descent lines, the value of whānaungatanga reinforces the commitment members of a whānau have to each other but also reminds them of their responsibilities to all their other relatives.

The processes of healing, as defined by the participants, are based on the concept of whānaungatanga as it operates within a whakapapa-based whānau. (Metge, 1995; Ratima et al., 1996) It is about the nurturing of kinship relationships, extended family cohesion - especially at a time of sadness or ill health, and the reinforcement of whānau obligations and commitments. This process not only strengthens the family but also places health as a function of whānau. It highlights the principles of collective responsibility and interconnectedness. It gives support to the immediate family, it promotes shared responsibility, it relieves stress, and it allows ‘the healing to begin’.

Going to people like M. M he's really a very sick man in pākehā terms but M.can be as sick as, but when it comes to our own whānau or our tamariki and

we need him, I don't care how sick he is, he gets well, he makes himself well to be where he has to be for our people. [R1]

If he is sick and once we get him around and he rings our whānau to come then the healing begins again. [R1]

Collective responsibility

Whānau are buffers to limit stress, they create a sense of cohesion and confidence that things will work out and allow coping with often overwhelming stresses. Collective responsibility, mutual support, sharing and providing care are all dimensions of whanangataunga that are especially strong in this research. This may be for a number of reasons. Firstly, as previously outlined, the participants in this research are strongly linked to a whakapapa-based whānau and, therefore, the process for maintaining health or beginning the healing process is focussed strongly on the concepts of whānau and whānaungatanga, as outlined in previous chapters. The rural environment also contributes to the maintenance of such concepts as the participants have all remained close to their ancestral lands and have had continual access to those aspects of Māori society that have maintained continuity over time (M. H. Durie, 1995b). The whānau have the capacity to perform those tasks that Māori expect of whānau: *No matter how sick When we need him he will come, he will make himself better.* The individual will always be secondary to the needs of the wider whānau. Both the individual and the whānau have the resilience that enables them to respond to adversity when needed.

The idea of collective responsibility and involvement in whānau demonstrates an essential difference between Māori and non-Māori models of primary health care. (Patterson, 1992) sees this concept of collective responsibility as central to a Māori world view and compares it with the Pākehā view that sees individuals as the bearers of responsibility. He states that whānau is the ultimate source of collective responsibility. Tariana Turia, in her initial development of Te Oranganui, talked about strengthening families so they would be able to take up responsibilities. Pere (1984) describes whānaunatanga as all generations supporting and working alongside each other; families are expected to work alongside each other in the community to help strengthen the whole (Pere, 1984). The fact that it is sometimes, or even often, not achieved is not a valid criticism of an ideal. This research community constantly utilises the diversity and flexibility inherent within their whānau to reach creative solutions to deal with crises.

Spirituality

Customary Māori understandings

Concepts of spirituality and the use of traditional health practices were in most cases limited mainly to the use of karakia (incantations) and water. For some it is *just any water* for others it is specific springs that have ‘special healing powers’: again highlighting the diversity within whānau¹³:

I always pray, and I know they will show me some sign that I am not supposed to be doing recording stories from hui, etc, my cord will just blow up or the recording will not come out, and it has happened kai te pai. [AR]

I have got four girls and one son but even because I am from (place) and their father’s from (place) our ways are a little bit different. Where if our girls got sick, I would take our girls to the tap if I didn’t get down to the river and that was O.K because we believed it was the water, and the water still comes from there wherever it is coming from. So I believe that, but with (person) he would actually put our kids in the car and take them way back up to your windy old road to their little Lourdes and it’s a little spring on the bank ... or he would go back to the camp. [R2]

I never doubted it because he never said what I was doing was wrong, so who was I to say so if he wanted to do that at 1 or 2 o’clock in the morning, I would do it. He won’t use water from anywhere else and if he has to, he will fill up a flagon of that water and bring it home

But I would use any water because it still comes from the sky, as far as I’m concerned. [R2]

Concepts such as ‘tapu’ and ‘noa’ that in traditional times were the basis of the public health system have become part of the collective unconscious but they continue to influence cultural beliefs even when they are beyond conscious appreciation. A code of social and environmental responsibility, based on the principles of tapu and noa, evolved in New Zealand in response to the quest for survival and the need to adapt to the environment. Later, missionaries tended to misinterpret the code as part of a

¹³ Water from special springs or rivers is often used for ritualistic purposes; indeed the symbolic properties of water are, as important as the physical attributes. Within streams and rivers there are certain areas which hold particular significance either in spiritual or historical terms.

religious system, equating tapu with sacredness and missing the more fundamental application to health, safety, and the avoidance of risk (M H Durie, 1998).

There are many interpretations of tapu; most emphasise a sacred quality and are linked in some way to gods or divinities. Eldson Best for example conceptualised tapu as a product of religious observations, highly spiritual and somewhat apart from everyday life (Best, 1924a). Other authors link tapu with chieftainship, 'high birth', and the discretion of tohunga to demarcate people and places of special significance (M H Durie, 1998). But Te Rangi Hiroa discussed a more utilitarian view of the purpose of tapu. He drew a connection between the use of tapu and the prevention of accidents or calamities, implying that a dangerous activity or location would be declared tapu in order to prevent misfortune. More than a divine message from the gods, or the recognition of status, the conferment of tapu was linked to healthy practices (Te Rangi Hīroa, 1970). Durie (1998) takes a similar view: he described tapu as a type of public health regulation, basically concerned with the avoidance of risk and the promotion of good health (M H Durie, 1998). In contrast, noa was a term used to denote safety; harm was less likely to befall anyone who entered a noa location, ate food rendered noa by cooking, or touched a noa object.

The different views of tapu and noa, one stressing sacredness and its opposite secularity and the other emphasising danger and then safety are not necessarily at odds, although they have different implications. Explanations of tapu as primarily religious in nature appeal to those who seek spiritual answers for societal conduct. The more temporal view holds sway where survival and health maintenance are seen as the main challenges for tribal societies. But common to both views is the acceptance of tapu and, to a lesser extent, noa as codes for social conduct and adaptation to the environment (Best, 1924c; Salmond, 1997).

Many of the participants spoke of traditional practices that they maintained for no other reason than *it just felt right* or it was *the way their mother did it*.

But I was screamed at once, ... well, I know not to wash my face and my hands in the sink and all that, and I went to do some washing and I just threw in B's things in the water anyway, with others, and gosh ... they were, I thought the end of the world had come. You shouldn't do that! You mustn't wash that! But what's the difference? They've all got to be washed anyway. But that was the old peoples' way. [A1]

I remember when I went to my grandmother's funeral – I was sick as a dog and I was dying for a cup but I wouldn't bring it into the tent. Gosh, before the night was out I was sick, and I didn't know what was wrong, till I came home, and started thinking ... but they were all having a cup of tea ... But then I sort of realised, oh, I think that's where my trouble is, then I went to the water and I blessed myself, and I was right as rain in a couple of hours. [A1]

And the other thing is being healthy the healthy lifestyle for us even in our bodies our washing you know way back and even today you don't wash your tea towels with your clothing you don't wash the baby cloths with the adult clothes and those kind of things. [B1]

And some of the beliefs like the Ringatu church is that women didn't wash their clothes with the men and women don't wash in their house, they wash outside in the cold water so it all goes back to the power of the water. [B1]

So that's another healthy lifestyle washing tea towels with your sheets those just got thrown in the rubbish if that happened. [I2]

Washing in the sink is a real no no that's unhygienic for me that's how we've been brought up, you don't wash in the sink . [I2]

Although participants do not speak about traditional concepts such as tapu and noa as outlined above, they nonetheless adhere to rituals that were originally based on measures employed to maintain hygiene in earlier times and that are now continued because *that was the way they were brought up* or *that was how the old people did it*.

But for many others there was a strong blending of traditions and, at times, conflict and difficulty living between two worlds. Two worlds is a term frequently used to define difference or conflict in beliefs, that is living between two worlds. The dynamics of different beliefs and practices within the whānau highlight the diversity within whānau and enable us to view health as a dynamic process involving conflicting values and beliefs.

We believe very strongly in our water, that water is more powerful than any doctors' medicine I mean they help maybe a little bit but I know at least 9 out of 10 will never go to a doctor without first going to the water, those kind of things they never go believing that the pākehā medicine is fixing them but it may help them a little bit. [AR]

So you know it's not all sitting in the surgery or lying in a bed.

I got a niece who lives at the doctors, but while she lives at the doctors she's still practicing her own our own medicines; its not the medicine from our tipuna but she's working on herbs and those kind of things that our Kuia knows all about anyway - so while she's living at the doctors she still has all these little mixtures that her and her tamariki take. [W2]

Our own people are starting to go to her now. You known what can you give me for a sore tummy or what can you give me for my headache. She still says go to your doctor, I suppose we need one another or a lot of us do but we have our own healing and I am a very healthy Māori in Māori terms that's how I feel. [W2]

The power of our prayers and the rongoā that we believe in like see we have all our stuff that our people are starting to pick up on again the different native plants they use so for me that's my health I am in excellent health if I am looking on the Māori side. [R2]

Although the extent of traditional healing on a national scale is not known, this research would suggest that in this iwi traditional healers have a sizeable following and there is an increasing interest in the traditional methods. Traditional healing is inextricably intertwined with culture: their philosophical roots, delivery systems, treatments are consistent with wider cultural beliefs systems and values. It is important not to equate traditional healing simply with the use of native plants and herbs; healing is based on a code of practice that draws on ethical, cultural, and philosophical principles as well as the use of particular plants.

Medical pluralism is a characteristic of modern society. Illness may be perceived quite differently in different cultures because socio-cultural factors are themselves determinants of morbidity and mortality (Kunitz, 1994). It is therefore not surprising that people seek help from a number of different sources at the same time. Many of the participants in this research accessed medical treatment along with alternative healing practices not normally considered scientific. Although to many health professionals this may appear to be inconsistent, the practice is sufficiently widespread to suggest that healing is not the province of any one single profession or group nor is a single approach likely to be regarded as comprehensive, at least in the minds of patients and families. Choice is an important safeguard. While modern healthcare practices may be beneficial in certain situations, they may do little to satisfy the patients/whanua's cultural expectations.

Religion

There has been a strong Catholic influence in the Whanganui area. Values of sacrifice can be seen here, as well as basic Christian values of care and concern for the less fortunate and the giving of oneself for the good of the whole. Rather than traditional values alone, there is a melding of the old and the new in constant changing of values and beliefs to reflect the reality of their lives. There is a spirit of selflessness:

Just being whānau, loving one another, that's all a healthy lifestyle in my eyes and sharing and caring, that kind of stuff. [R2]

For many kuia there remains a strong influence, both through colonisation and Christianity, which is reflected in their beliefs and practices. In the early part of the century, the conversion to Catholicism was very strong throughout the river with a large settlement at Jerusalem and increasing numbers of missionaries frequenting the region, with easy access up the river to large settlements of Māori. Following the establishment of the Catholic mission station at Jerusalem by Suzanne Aubert in 1883, their presence on the river continues uninterrupted to this day and the influence is as profound as it is enduring. The sisters are welcomed on to any river marae as tangata whenua. Also there was a very extensive public health nursing service that saw pākehā nurses spending weeks at a time on the different marae 'ministering' to the community:

Nurse J was the district nurse, she used to ride the horse. She brought the stuff for the kutus and the brown ointment for the sores all the kids had sores and they used to weep at night. [J1]

Cause we couldn't sleep uncle T used to chuck us outside under the cold tap, cause we used to scratch the whole time. But nurse J used to bring this brown medicine to put on the sores.

She visited the maraes and stayed for sometimes a week; she didn't visit the schools. There were 50, 60 families here, then she used to do all the marae. [J1]

When M got bad burns she was in hospital and they were doing skin grafts and she looked shocking, and then the old people got together and gave me a good talking to, they didn't want them touching her. [H1]

It was quite awkward. The doctors spoke to me about it and I had agreed but the old people didn't approve they thought it was wrong.

I had to bring her home they thought they were experimenting with her and I got a good telling off for telling the truth to the Doctors about why I was bringing her home. [H1]

Cultural integrity

For many of the older generation there was to be no mixing of the two cultures. For many you must '*do one or the other but you cannot mix the two together*'. For others who for a number of reasons are marginalised or disenfranchised, these concepts will have little or no meaning within the context of their lives:

I always think well, if you have one, then you either do one or the other, you know! Because on the Māori side – well, you do the Māori. Because it's no use trying to have the two together! Because I don't think that's right. You've got to carry on with your Pākehā life and the Māori ones, well, you may as well do one and do it without the other. So as far as my health's concerned I will always, I've always been on the Pākehā side and I think it's through speaking to that side that I'm still here today. [A1]

So I brought her home and nanny used to get on her canoe and go over in that gully over there and get this tutu and then she would bring it back and boil it then bathe her in it...It didn't take the scar away she still has a very bad scar...But I found that very difficult because I was brought up by a European grandmother and she spoke to me about it and said I should have let the Doctors do it because they know what they are doing they are trained to do it. I should have let them complete the skin grafts. [H1]

But it was the old people here I found it very hard to lock into the ways of the old people here. I guess we had lived different lives we were more in the city and the pākehā influence and it was listening to two different lots of families. [H1]

In traditional times there was a high degree of suspicion of western medicine. This is clearly demonstrated in this instance, unlike the younger generation who often take a more pluralistic approach — combining the use of modern medicine and complementary healing practices simultaneously.

The important implication from this research is that whānau should not be put in a position of having to choose between one approach or another, nor should they be discouraged from discussing involvement in traditional healing. There is merit in being

able to incorporate more than one approach to treatment and healing, especially at the primary care level where pluralism is most appropriate. Traditional healing also helps support wider values consistent with self-determination as it affirms native control and authority and appeals to a pre-colonial era when healing and wider cultural values were synchronised (Warry, 1998).

Understandings of primary health care

Primary health care is often interpreted as primary medical care. It is seen as disease focused, not as health promotion or health education. This has many implications when our healthcare system is endeavoring to change its focus to health promotion, early intervention and disease prevention:

I believe I have been healthy because the only time I went to the doctor was when I was ready to have a baby, and I mean ready to have a baby, not going through the testing and all that unless I felt there was something wrong . [H]

I say that Māori's have their own ways of being healthy because I haven't been to a doctor in eighteen years and I have never needed a doctor because if I feel down I go by my Kuia and she mixes me a rongoā, a pick me up, sort of like an energiser or those kinds of things. [I]

The opinions of many of the participants are echoed in these two quotes. Most only access primary care services when they perceive they have a problem or are ill. When access to resources and healthcare are limited through distance, lack of money, transport, appropriate services, time, etcetera, people learn to differentiate between what does not require expert care and when they will first call on 'local experts', kuia, kaumātua, and/or whānau. Such help is affordable, accessible, acceptable; it is help from insiders who can be trusted and understand the social context.

Primary care is focused on doctors and not nurses. With the relentless cutbacks in nursing services, nursing has become invisible in this community. Traditionally, the district nurse arrived 'on her horse and stayed for a week, and treated all the families':

Like, say, concerning your health, you always went to a doctor, and as for the district nurse, well, we didn't have much to do with her. If it was anything to do with our health we'll go to our doctor.

As long as primary care is covertly understood as primary medical care then community development, disease prevention, and health promotion will be marginalised. Health in

this instance is characterised by self-referral to medical care, a reactive process to a health crisis rather than a proactive intervention for health. Self-referral requires that patients are able to make informed decisions, have motivation, transport, a belief that the service is culturally appropriate, and a certain level of private resource to enable access to service. As long as primary care is presented in such a way, nursing will also be marginalised.

The role of nursing in the community is becoming increasingly specific and in 'effect broken' down into disease categories, or age ranges, or even in relation to body parts. This is complicated because on the one hand specialisation is useful and allows for the development of expertise in a specific field but on the other it reduces the strengths and usefulness of nursing and supports a medical reductionist health focus on what are often deeper family and community health problems that would benefit from a more holistic focus. Nursing philosophies are based on a holistic concept of health but in reality practice is focused very much on the individual and/or family. If we are to make a difference, then nursing will need to develop primary health care roles that directly meet the needs of the community they serve. Both generic nursing skills and specialist nursing skills should compliment the work of an integrated healthcare team.

Health and illness situations require a level of understanding that is not required in other situations in which two strangers meet. To begin to understand how individuals and groups experience and respond to health and illness, which is what nursing is all about, requires understanding what people value in life, what priorities they have, how they usually respond to disruptions in their lives, how they prefer to express their discomfort, and are what the most comfortable ways to express their thoughts and feelings. Understanding includes making connections and achieving syntheses that may go beyond the perception and knowledge of the provider and client.

What this means for a Māori primary health care model is that healthcare is not something that is done to someone or even to some group at arms length: it is about a process of intimate involvement and responsibility and requires an understanding of fundamental differences in value bases between Māori and non-Māori approaches. In particular, an understanding of whānau dynamics, including relationships within the whānau, and an understanding of the history of these relationships is essential. Practitioners working within Te Oranganui are not removed from the responsibilities of working for the collective good in the way other health workers delivering health

programmes may be. They often have kinship ties to the families they are working with and are therefore subject to the same expectations as other members of the whānau. This sometimes involves the workers in situations that challenge professional ethics and boundaries and create conflicts between personal and professional roles.

Conclusion

A central theme that has emerged in this chapter has been the relationship between whānau and healing. Health for the women in this research cannot be separated from their immediate whānau or extended whānau or whānau-a-iwi. Individualism is not the 'norm' for these women; their isolated experiences are not meaningful nor are they representative of the core of health for them. These Māori women define health as being inextricably tied to the concept of whānau. Generally, in this research, whānau healing can be described as a collective process facilitated through the expression of cultural and spiritual values. Whānau healing recognises both individual and group interests, involves reciprocal care, is concerned with the retention and strengthening of Māori identity, promotes the health and well-being of the individual, and includes a focus on strengthening the whānau structure and, therefore, whānau capacities.

The whānau included in this research demonstrated a number of capacities including the capacity to care, the capacity to share, the capacity to empower, and the capacity to strengthen identity through a sense of belonging.

The capacity to care is a critical role for whānau. Unless whānau can care for young and old, the sick and the disabled, and support members in times of need, then the fundamental purpose of whānau is lost. The ability to care within this research context is greatly enhanced because of the geographical closeness of all the participants and their strong whakapapa ties. The capacity to share depends on generosity and a sense of collective responsibility. This is aptly demonstrated in this research, as is the spirit of selflessness. But this is not a one-way process, it is very much a reciprocal process. The capacity to empower, as it relates to a whānau healing process, means giving strength and support and acting as a buffer to stress that in turn enhances and enables the healing to begin.

Values that are central to whānau healing are aroha and respect for spirituality. Aroha is enacted in the healing process through actions of caring, sharing, and just being with

whānau, especially in a time of need. It is particularly strong in this whakapapa-based whānau and maybe the kinship ties in this particular situation strengthen this value. Spirituality among the participants was expressed as a blending of customary and Christian beliefs and values. There has been a blurring of boundaries and many have integrated the best of both worlds. For some Māori elders this is not comfortable assimilationist indoctrination, but with the passage of time this has mellowed and in subsequent generations a constant blending can be observed. Emphasising the spiritual does not mean lack of respect for the physical; instead of negating one another they are seen as complementary. Complementarity, as for example between the sexes or the concepts of tapu and noa, is reflected in many aspects of Māori society.

While it would at this stage be premature to draw conclusions, it would be reasonable to say the findings contained in this chapter indicate that the concept of 'whānau healing' will have implications for nursing practice among Māori communities. For the participants in this research, health is more about being with whānau, caring for whānau, supporting whānau, and being aware of the strong spiritual sense of well-being that can be achieved from a truly integrative and dynamic model of health. The following table summarises the key characteristics of the health beliefs and practices of the women in this research:

Table 4
Key characteristics of health beliefs and practices

Health Beliefs and Practices	
Concept	Hauora-like, holistic, wellness
Principles	Whānau, Aroha, Spirituality
Strategies	Caring, sharing, being with,

CHAPTER SEVEN

Māori women's sense of self

Introduction

This chapter focuses on the ways in which the participants describe their sense of 'self' and of 'belonging' and their ways of being and acting in the world that determines their health beliefs and practices. The previous chapter presented the experiences of the participants' own health beliefs and practices and this chapter focuses on their sense of identity.

Smith (1992) argues that the centrality of Māori women's identity and the attendant specificities of historical and cultural realities are denied full expression when subsumed within existing analysis that situate Māori as 'other' or subsume Māori within their norms. Smith maintains that the first task of any theory is to make sense of the reality of the women who lived within its framework. This means 'making transparent the centrality of our identity in this specific historic and cultural reality which we endure' (Linda Tuhiwai Smith, 1992)(pg 35). The centrality of the identity of the woman in this study, and their specific historical cultural reality, is grounded in whakapapa and in the customary tribal traditions and values of their tipuna. Although grounded in whakapapa, their identities are also strongly influenced by a multitude of socio-political factors that represent the diverse realities in which Māori live (M. H. Durie, 1995a) and in which the participants develop and sustain their identity.

Whakapapa provides an expansive framework that is inward looking, recognising the origin of phenomena while simultaneously requiring an outward focus based on growth

and development (Durie & Kingi, 1997; Linda Tuhiwai Smith, 1992). This framework enables the researcher to situate the participants within the extended social networks to which they contribute, seeking a relational understanding of one to the other. Whakapapa, as an analytical tool, thus encapsulates a form of cultural capital that Bourdieu (1974) based on connective principles that include notions of complementarity, reciprocity, and guardianship.

The longitudinal study of Māori Profiles, Te Hoe Nuku Roa, (M. H. Durie, 1995b) four cultural identity profiles were identified: a secure identity; a positive identity; a notional identity; and a compromised identity. The study links a secure Māori identity to access to cultural resources that encompass people, land, language and knowledge. It identifies seven characteristics that are important markers of personal identity: self-identification; whakapapa (ancestry); marae participation; involvement in whānau; access to whenua tipu (ancestral land); contacts with Māori people; and ability in Māori language. These characteristics centrally locate both primordial and circumstantial factors as intersecting threads in the construction of identity in contemporary contexts.

Glazer and Moynihan (1975) conceptualise identity in primordialist terms, arguing that identity resides

Deep in the history and experience, and they must in some way be taken into account by those who govern society. (Pg.19)

They further argue that the hope of doing without ethnicity (as its subgroups assimilate to the majority group) may be as utopian and as questionable an enterprise as the hope of doing without social class in society. The terms in which one understands ethnicity and the world is, according to Geertz (1973), 'less a matter of social circumstances or construction than being derived from primordial origins.' ... (p.258)

A historical context

Most of the women in this research grew up in the post-war era of the 1950s, 60s, and 70s when there was an enormous demographic shift to the urban areas (R. J. Walker, 1990). Many of the whānau of the women involved in this study were faced with the dilemma of holding on to their culture or trying to create a better life for their children and physically sustaining them.

I was bringing up all these children, and very limited quarters, the facilities were very limited, like outside loos, and carrying bath water, all that sort of stuff. But I felt strong enough to be able to do it, and also have these children. I mean, I could never do it today, but you never thought about it in those days, because it was as though, I have to do it, and so you go on and you did it. You never talked about how tired you are and how rundown you could be and how it affected the children. You didn't have time for all that, so I suppose in the long run it was good for everyone, it taught us a lot. Taught me a lot of tolerance, and all about tolerance, anyway. I needed a lot of that. [H]

It was a period when race relations were presented both here and abroad as being exemplary. Walker (1990) maintains that the notion of 'harmony' as portrayed both here and overseas was a result of the

crushing of the prophets Te Whiti and Rua Kenana [which] ended any immediate pursuit of sovereignty in the new nation, that claimed for itself a reputation of having the finest race relations in the world. (p.186)

In many respects, the Second World War also helped mask the growing inequalities within the nation. By highlighting a commonality of purpose, the need jointly to fight the external threat to Western culture, attention on the cultural erosion occurring within our shores was minimised. The paradox, however, as noted by Mead (1996), was identified in 'that Māori soldiers who fought in World War II were regarded as winning 'citizenship''(of our nation) (pg.27). But for many, the international view of racial harmony did not match the lived realities of the women's narratives. Walker (1990) maintains that the struggle against pākehā hegemony in the post-war era was led by women and the establishment of the first national Māori organisation, the Māori Women's Welfare League, in 1951.

The tensions faced by many whānau as they raised children while attempting to balance economic viability suggests that the notion of 'one nation one people' cost the dominant group little while it actively attempted to bankrupt the other culturally. This is a term recently revitalised during the occupation at Pakaitori by the 'one New Zealand' group. The dilemma for most was that both their parents and their grandparents genuinely thought assimilation was the 'best way to go', that they should do everything they could to ensure their children's success. To facilitate this, anything Māori was marginalised particularly the culture and the language:

... probably because he had been brought up to talk pākehā, and the pākehā had got you this, and that, and that, and Māori didn't get you anywhere, and was back in those days, that's how their kōrero was, aye. To be a pākehā. To get a job. To get money. To feed your whānau and all that.

This process was also enhanced by the very strong presence on the river of the Roman Catholic missionaries and the district nursing services, both of which served to entrench in these communities the taken-for-granted assumptions of colonial superiority. Capturing the cultural high ground was very dependant on a particular conceptualisation of difference that placed the coloniser at the centre and the Māori, as indigenous, on the deviant periphery. For whānau, the impact, as previously noted by Walker (1990) and Durie (1997), reached into the very core of cultural values, beliefs, and practices. (Durie, 1997; Walker, 1990 #2749).

The relentless undermining of Māori values, language, knowledge, and ways of being in the world has had a lasting effect on the health, spirituality, education, family, and social advancement of Māori (Durie, 1997). The ability required to develop and sustain a personal and social Māori identity for each generation, under such pressure, highlights the grit and determination of these whānau, hapū, and iwi:

You know, they cut off (things Māori). I've found the old people cut off at their time, and they didn't bother because it was a new world, a new generation – and they just left it aside.

Just like with B. The same thing – we were told the sooner we were educated, the sooner we learnt the ways of the Pākehā we would survive.

Because it was survival you know, in the pākehā world, and that's how I was brought up, and they just cut off – those things (Māori) just got cut off.

Home-place

The traditions and values of the women were transmitted, expressed, and affirmed from their various 'home-places' and across generations. Home-place refers to the multiple sites within specific tribal boundaries. When discussing identity, home is employed as a comprehensive metaphor for ancestral place, that is turangawaewae, marae, iwi, kainga, urupa, awa, and maunga. The individual and collective relationship one has with these sites may be considered on a physical or metaphysical level. A physical level may be attained either through residency at home-place and the activation of ahi-ka – literally

keeping the home fires burning – or by the regular return of non-residents who maintain an active role within whānau and hapū affairs:

I never left home, although I actually lived in town until a year ago. I actually came home at least once or twice a month. I keep in touch all the time. The longest I have ever been away was 3 months but – I never left home
(Participant A)

Non-residents who are dislocated by time, space, and distance but still claim their right to whakapapa, to acknowledge the iwi affiliations, may have a metaphysical link to the home-place. This metaphysical link could be likened to the emotional link to the metaphorical homeland of Hawaiki, the narratives of Hawaiki such as those found in whakatauki, waiata, and karakia. They reinforce a strong sense of identity and oneness and link the past with the present and the future. Hawaiki is often referred to as the source of human life. Objects of remarkable power and value such as plant, creatures, and treasures were said to have been brought from Hawaiki. Hawaiki is alluded to as a desirable place and references are often made to it in times of loneliness and sadness (Orbell 1985, 11-7).

At a metaphysical level, associations with Hawaiki maybe likened to the connection a person feels when identifying with the home-place of their ancestors, despite being alienated by time, space, and distance. Connections to the home-place at a physical and metaphysical level are part of the reality of what it means to be Māori. In terms of Māori realities, Durie has stated that Māori health is concerned with diverse realities and about reconciling the past with the future (1994 pg 1). The Māori women in this study have a strong sense of their own realities. Most were born and raised in small, rural communities of close, extended family along the shores of the river. Within these locations, a sense of home-place and of 'belonging' was fostered, in part by whakapapa ties, together with an understanding of the significance of those ties that was consolidated by growing up in the home-place. From this position, the woman experienced the full extent of whānau interactions across generations; they gained access to some of the benefits that whānau relationship present. Furthermore, they encounter varying degrees of exposure to tribal kawa and tikanga within a range of hapū contexts that helped to shape them and define their realities.

The women born during the 1920s to 1940s grew up within their tribal areas in a 'typical marae situation'. All actually lived on or in proximity to their marae, which was

the central focus of community activities. They all still remain on the marae or in proximity and actively participate in all hui on the marae, although one participant stated that she: *'doesn't go down there [the marae] much these days.'*

Life within these communities provided significant interaction with whānau. For most of them, large whānau characterised their upbringing and their sense of home-place: 'All those familiar aunties, uncles and cousins who invariably lived in, or visited, or stayed'. As children they were also permitted a degree of freedom to 'play and swim in the river', for example without constraints of being closely guarded over. Most as children learnt to work in the kitchen and work in the dining room; there was constant encouragement to participate in activities on the marae. As children, they often considered being brought up on the marae

as really good fun, especially when Mum and them were working in the kitchens and we would go down and play around with all the kids down there and then troop home afterwards. [D2]

The experiences of the second and third generation of women were very similar to the first generation, as most were born and raised either on or near the marae. Like their mothers and grandmothers, they enjoyed the freedom their elders had enjoyed as children – spending time on the marae or down at the river.

For whānau who are distanced from home-place by time and space, visits were special times where there was always a very strong sense of 'aroha' in terms of treatment and reception shown to them by whānau. In this context, conversation between parents and grandparents was always in Māori but they spoke English to the children. These grandparents were community leaders and at the marae *'nanny will be out in the front as a kuia. I don't think I have a memory, really, of nanny as being out the back.'* For those who lived away from home, there were constant reminders of their identity. These were continually reinforced and affirmed through the stories told by the family – adults swapping stories, especially at significant family gatherings such as Christmas, tangihana and other family celebrations.

Expression of Māori identity

In this study, most of these characteristics emerged as significant for the women. The experience of growing up in the context of home-place described by many of the women in the study reveals five significant threads:

- their physical links to the land
- knowledge of whakapapa
- living close to whānau
- the importance of the marae
- experiences of Māori language.

Ancestral land

A physical attachment to ancestral land provides a sense of home-place that comes primarily from the position of ahi-ka, that is of having lived in the home-place: keeping the hearth warm among close kin. Metge (1976) regards attachment to ancestral land as a social and economic asset, as well as a symbol of group identity. (pg 49) There were the day-to-day activities that centered around the intimate and interactive relationship with land and rivers, endorsed by concrete experience such as:

swimming in the river, catching crawlies in the creek, picking watercress at the spring, whitebaiting with our mothers and grandmothers, picking blackberries, smoking eels, washing clothes in the river and pushing a waka laden with blackberries across the river. [G2]

Whakapapa

Knowledge of whakapapa was identified as central to participants' identity as Māori. Linda Smith (1992) maintains that:

when Māori women control their own definitions the fundamental unit of identity which can make sense of different realities lies in whakapapa. (pg.39)
(Linda Tuhiwai Smith, 1992)

While the depth of each individual's knowledge of whakapapa varied, they all used whakapapa as a referential matrix with which to construct the chronology of significant events in their lives: 'when (name) died we were in Australia' to contextualise their life histories, 'we grew up among our mother's people' to substantiate claims to the home-

place; 'my mother is (iwi) through her father ...' or to describe their relationship to whānau 'my grandmother and your grandmother were sisters', or 'my dad and your dad were brought up as brothers.' There was constant use of such examples to describe their life histories. As noted previously, the use of whakapapa was significant in locating the relationship of the researcher with the participants and the researcher's family to those of the participants'.

Proximity to whānau

Participants emphasised the importance of being close to and surrounded by whānau, which encompasses parents, grandparents and other extended family, for a secure identity. Smith (1992) asserts that in terms of understanding what it means to be Māori and female, the discourse of whānau is often overlooked. Women with strong whānau links take these links for granted as *part* of being Māori – they underrate this distinction, a characteristic of Māori identity. Yet many women talked about the significance of having many relatives around them in their lives. Many had experienced the cultural benefits that accrued from living on the ancestral lands and having access to close whānau contact, especially in times of 'gladness and sadness':

My mother was a saint, she was a lovely lady, to me she was the last lady. But she taught us a lot of things, she never drummed Māoritanga into us, but she did make a point of telling us what was wrong – not so much what we should do, she pointed out what was wrong and what we didn't do. And that was one of the very – oh, there were many, many things that she told us that I still maintain today, and I actually passed on to the children. And possible they accept it because of no other reason except that I said that my mum told me that. If you were to ask them, possibly they would say the same thing.

I mean, I nursed my mum for six years, and I had all these children in between. The district nurses were absolutely marvellous with her, the doctors were just fantastic, I can't speak enough about what they did for my mother and the fact that I have children all this time. I mean, I was clocking them about every 18 months to two years, but still nursing a very sick mother. They had suggested The Home of Compassion, all these sorts of places, but as I said to one district nurse, 'Over my dead body,' and she said, 'Well, it may be, dear.'

Whānau involvement is also characterised by helping parents with difficult children or caring for sick relatives. Caring for children is a philosophy that underpins the practice of whangai. Whangai is an institution similar to the western notion of adoption. It was

not customarily regulated by a legal contract nor was the identification of biological parents concealed. This important practice is arranged for a number of reasons, for example, the continuation of whakapapa or the maintenance of ahi-ka. Children are often considered as whangai of childless couples (Metge 1976 pg 145). Whānau who relocate may leave a child as whangai for a relative to foster in the home-place to retain ahi-ka connections. There are numerous examples of whangai within the study group. Parents were often asked to whangai a child when it was thought by hapū members that particular couples might remain childless. In many instances, it was a sister or brother of the parents. Grandparents were often asked to whangai grandchildren for ahi-ka reasons to maintain connections in the home-place.

Marae participation

Participants identified the marae as a locus of whānau and hapū interactions. Metge (1976) identifies the marae as a key symbol for collective identity: 'the institution of the marae comprising both the physical complex of land and buildings and the ideas and practices centered on it' is a significant aspect of being Māori (Metge, 1976)(pg 48-49). The significance of the marae was endorsed by the frequent references to the women's parents or grandparents either being out the back, in the kitchen, or out the front. Concepts of front (mua) and back (muri) are significant locatives that designate spacial zones of ritual within the context of the marae. 'Out the front' delineates the space of the paepae, the marae atea and, by implication, the formal roles assigned to those who occupy those spaces. 'Out the back' defined the spaces of the ringawera (the workers) whose responsibility it is to feed the guests (Salmond 1978). This is certainly the case for many participants in the research. There were often references to mothers working in the kitchen and grandmothers out the front. Learning to work in the kitchen is part of a process of apprenticeship over a lifetime that will see one's role change and move from the back (the kitchen) to the front (Rangihau 1975 pg 170). However, it should be emphasised that the roles regulated by the front or backspace are complementary, as endorsed by Rangimarie Rose Pere (1982). The people who work at the back of the marae complex, in terms of cooking and catering for the physical well-being of the guests, are just as important to marae procedure and protocol as those who have a role out the front (pg.66). In terms of marae participation, the experience of the women varied although all regularly participated at tangihanga and other activities on the marae.

Māori language

A woman's experience of Māori language was identified as important. While those in the second and third generation were used to hearing Māori language spoken around them as children, they were never taught by their parents or grandparents to speak te reo Māori. Māori language was the accepted medium of communication between grandparents only. The adults often used Te reo Māori as a method of excluding children from adult conversations.

The attitudes of the generation aged between 60-80 years towards Māori language needs some explanation here. These adults reflect the influence of a colonial government whose historically expressed contempt was manifest in an assimilationist agenda that, since the turn of the century, propagated a powerful ideology of Māori language as a barrier to progress and success in the real world of the pākehā (Walker 1990 pg 146-147). This ideology was enshrined in state education policies and practices that saw the prohibition of Māori language from school precincts enforced through acts of institutional terrorism: by the practices of corporal punishment (Ibid: 47). Such violent acts were common experiences among several generations of Māori children spanning five decades. In her autobiography, Mihipeka Edwards (1990) vividly recalls her own beatings as an infant by a female, pākehā teacher (pg 28-29). Mihipeka's experience also highlights the compliance of pākehā women with the education policy and their role in administering abusive and violent acts to Māori children. Many participants particularly describe how their parents and grandparents were not allowed to speak Māori even though it was the first language of many: 'It was get the cane across the knuckles or around the legs or don't speak it at all'.

Māori language is a significant factor for all the women in this study. For their grandparents it was the first language, yet sadly, circumstances of the historical moment in which they grew up meant many of the women reached adulthood unable to speak Māori. As a consequence, the reclamation of further links with tipuna through an understanding of Māori language remains a long-standing struggle.

Role models

The assimilationist agenda was not restricted to use of Māori language, although this one policy would in effect lead to widespread loss of the culture. The effect on many of 'the old people' was that they believed the only way to survive was to abandon their

culture and adopt the ways of the pākehā. In terms of traditional healing and use of traditional medicines, although many of the participants had mothers or grandmothers who knew and continued to practise these traditional methods all their lives they never taught their families:

My grandmother always used it (rongoā/traditional medicines), my mum's mum, but she never taught her family.

And I can remember my mum's mother, still using those things, dandelion, and getting the stuff out of it. They did it, it died where they were because they thought, 'Oh, it's a different world' you know! But then they still, you know – Uncle Jack did – he carried on with it.

The women spoke often of others within their whānau who helped shaped them and who maintain a significant presence in their lives: their mothers, their grandmothers, and aunties provide positive models of womanhood that were grounded in specific sets of experiences and informed by culturally and tribally specific knowledge. For some of the women in this study, these models were reinforced and confirmed within the wider context of the hapū and such institutions of the marae as tangihanga and hui whanui. Several families refer to models of strong-minded women; in many families it was the grandmothers who 'wore the pants in the family'. Many report several generations of women in their families who were strong-minded:

Very, very strong-minded women. The women did the hard graft stuff and the hard talking, and the men support it – that's what I have been raised with. None of them compromised in what they believed in.

Perceptions of strong-minded women are of authoritative, forceful, and effective women who make the decisions and strategise while others carry them out. One family, for example, described how their daughter suffered bad burns and was to undergo skin grafts when:

...the old people got together and gave me a good talking to. They didn't agree – they didn't want them (doctors) touching her, and it was quite awkward because of the mother-in-law. It was her, really – and so it was like listening to two different types of families.

She was brought home and treated by the nannies and '...so anyway she came right, but you know, I guess if we had allowed them to continue with the skin grafts it would have been smoother.'

While women bear children, raising them was not considered solely their exclusive responsibility. The whole whānau were responsible for parenting and ensuring that the children's welfare and development were secure. However, it was the older generation who assumed the greatest responsibility as reflected in the story above and in the following example:

But, you see, in the old days when they had the old people they were always there. When I had (daughter) I wasn't allowed to wash her – I used to have to sit there, and I used to be quite nervous about it because auntie S used to come in, and they'll sit on the floor and away she'd go, and I wasn't allowed to wash her. I had to just sit quietly and prepare myself for feeding. I was scared to touch her because of that. It was like they were watching me. But that's how the old people did it in those days. I was frightened I might do something wrong in front of them.

There is a veiled allusion to being like a man, with implications of strong-mindedness associated with being male. Rose Pere (1997) points out the connection between women and the processes of the mind that underpin the meaning of the word 'hinengaro'. As Pere (1997) explains, *hine* is the conscious part of the mind and *ngaro* is hidden as the subconscious. *Hinengaro* refers to the mental intuitive and feeling emotions: thinking, knowing, perceiving, remembering, recognising, feeling, abstracting, generalising, sensing, responding and reacting are all processes of the *hinengaro* mind (Pere, 1997)(pg32).

In this view, thought processes are connected to women in terms both of their emotional status of intuition of feeling and of the rational states of abstraction and the life of the mind. This view of women as simultaneously possessing both emotional and rational states of mind is reinforced in cosmology: 'taranga was free to make decisions despite the moral consequences of her actions. It was Murirangawhenua who possessed the formula and the strategy that allowed Maui to tame the sun and successfully fish up Aotearoa' (Jenkins, 1992)(pg38). As Jenkins points out, in cosmology 'while men have the physical strength, women assume the balance of power in the psychological dominance they achieve through the knowledge they have of the universe' (Jenkins, 1992)(pg 38). Hardworking women are described as enterprising and tireless workers:

There was nine of us in there, nine, eleven of us. And we managed, because one day for washing, one day for polishing the floors, another day for cooking, and another day for this. You had to, otherwise you would have been in a mess,

living like pigs. You had to have a programme for the children. And you grow your own Kai. We always grew our own vegetables.

Many describe their nannies in the 60s:

‘She was one of the toughest, strongest, hardest, most hardworking women I have ever known in my lifetime.’

This work ethic of grandparents is repeated by their children:

Mum’s brothers and sisters all work really hard. They are all hard workers like nanny and koro. Nannies often dug huge vegetable gardens, they split maire – and maire is really hard, hard wood to split – but my mother used to do it.

The ethic of hard physical work, particularly for the collective good of the whānau, remains an important value in Māori society. However, the emphasis on hard work as experienced by the women was also influenced by the social historical moment in which they were raised: hard work was necessary for parents and grandparents to make ends meet. For Māori in rural settings in the 1950s and 1960s, the reality of their lives was characterised, among other factors, by a reliance on subsistence farming and unemployment which helped precipitate the urban migration (Walker 1990 pg 197). While women as strong may relate to descriptions of the assertive women, the strong-willed or the hard worker, strong women may also be associated with quiet strength, humility, and peacemaking, that is mothers as the peacemakers in the house. It was also customary practice, in times of crisis, that highborn women were married to ensure lasting peace and security between warring factions. Historically many stories are told of daughters consenting to marry not for love but because of their father’s wishes and because it was a convenient way to make peace and save the lives of their people. (Best, 1924b, 1941; Marsden, 1992; Smart & Bates, 1972; Young, 1998) Grandmothers were often described as very humble, unassuming, gentle people. Humility is highly regarded by Māori as an important strength and some writers believe humility is a vital aspect of being Māori, as the notion of showing off is not a Māori quality. The influence of nga kuia, nga whaea, nga tuakana in the lives of Māori women is a reoccurring theme in writing by or about Māori women. Linda Smith and Harata Solomon describe how their grandmothers were major influences in their lives (Rogers & Simpson, 1993; L.T. Smith, 1992)(pg 204). Ngahuia Te Awekotuku described her kuia as being “my most beloved mentor and my strongest influence” (Rogers & Simpson, 1993)(pg 24). Other women such as Kathy Irwin (1992 pg 54), Hannah Te Hemara (Rogers & Simpson,

1993)(pg 49), Rangimarie Parata (Rogers & Simpson, 1993)(pg 128) have described the influence of their kuia and whāia in shaping their lives as women and as Māori.

Mana wahine – the power of women

Mana wahine is a strong cultural concept that situates Māori women in relation to each other, to their tribal group (Smith 1993 pg 61), and to Māori men. Many women were critical of the lack of men's involvement in political and cultural groundwork. By comparison they emphasised the visibility of Māori women as the initiators and driving forces behind kaupapa Māori programmes and as being at the forefront of the drive for Māori self-determination.

The women acknowledged the driving force and passion of Māori women to implement the direction of Māori. Many of the women, faced with the daily struggles they encounter and with the barriers to their ways of being Māori and women, when asked what it was that sustained them in their work, gave them energy, and helped them maintain their sense of well-being, replied that water and the reciting of karakia were important to keeping safe and providing a sense of personal well-being. This follows customary practices where water and karakia are inseparable in rituals of symbolic purification and spiritual and physical well-being (M.H. Durie, 1994b)(pg 11). Others seek out and establish anchors who they describe as people to whom they could refer, to whom they could talk. These were most often older Māori women within the whānau, other Māori people outside and maybe in workplaces. It was important to have a safe haven, which could be home, partner or one's whānau, or rituals with karakia and water.

Cultural revitalisation

English replaced te reo Māori, western health practices replaced traditional methods, professionals replaced the tohunga, nannies replaced the whānau. Language replacement struck right at the core of Māori culture and identity. European settlement had a devastating effect on Māori culture, manifested in alienation from land, language-loss, and marginalisation within the new society created by pākehā. Māori identity is constantly undermined by the negative portrayal of Māori in all major indices of social status such as housing, education, health, justice, and employment. The annual presentation of such statistics helps to reinforce the pākehā position of superiority and to further undermine Māori identity and culture, reinforcing an increasing sense of hopelessness or powerlessness to change things.

Before urban migration Māori identity, language, and culture were taken for granted, but with increasing urban migration there was a sharpening of Māori identity in relation to the dominant pākehā culture. Migration to the cities exposed Māori for the first time to the full assimilation ethos of metropolitan society. Three phases of development followed urbanisation. First, survival: living in a cash-based society, with regular work needed to survive and feed families. Second, a heightened sense of difference, lack of whānau support, nuclear families, and individuality all led to a heightened sense of loss of identity. To ensure continuity of identity, organisations and voluntary groups arose in the form of culture clubs and tribal associations, together with the development of the urban marae. Third, came increasing confidence in Māori identity, which is manifest in cultural assertiveness. Māori are now challenging pākehā society for a fair share of resources and a transformation of monoculture institutions. They have rejected assimilation and integration and asserted their own identity as tangata whenua in relation to the dominant pākehā group. It is this positive embracing of identity that is the driving force of the current regeneration of Māori culture.

Although traditional Māori culture was considerably transformed by the missionaries and the trauma of colonisation, it was never lost. At the centre of this culture is its spirituality, which is deeply rooted in the mythology of papatuanuku, the mother earth, and connection with the land as tangata whenua.

The marae is the bastion of cultural conservatism where the mythological, traditional and spiritual between the land, the living, and the dead are constantly reiterated and unified in the rituals of encounter. Of particular significance is the tangihana (funeral), where the deepest cultural elements of spirituality, mythology, tradition, and kinship are expressed in the oratory of the marae.

As noted in Chapter 6, these women were well aware of the tensions faced by whānau as they struggled to raise often very large families while attempting to balance what they valued with economic viability, with dire results for the culture of the whānau:

Because it was like security, it was a place they could go to, it was whānau, security and a meal. And being part of a family. And that's what our people miss today, that unity thing. And even the kids, they have no confidence, and even with the cooking sessions, the girls would make a chocolate cake, or fudge or something, and they would be so thrilled with what they had done ... B's

child she said to me; "They think I can't bake, they won't believe that I made this."

But then you see in the old days when they always had the old people, the old people were always there.

Conclusion

For the women in this study, the concept of 'home-place' was central to their achievement of a secure Māori identity. The connection to their 'home-place' was expressed at physical and/or metaphysical levels. Closely connected to this concept of home-place were five factors identified as underpinning a secure Māori identity: links to ancestral land; knowledge of whakapapa; living in close proximity to whānau; access to marae; and experiences of Māori language.

Significant in the lives of all the women, and reinforcing of their identify as Māori, were positive role models of womanhood grounded in specific sets of experiences and formed by culturally specific knowledge. These role models of strong women included grandmothers, mothers, aunts, sisters, and cousins and they continue to influence the lives of participants. Participants indicated that mana wahine, or power as Māori women, was a driving force of Māori community initiative and at a personal level the maintenance of whānau wahine relied on support and interactions with other Māori people and customary practices relating to water and the recitation of karakia. As a final but important point, participants indicated that despite the impact of colonisation, Māori continued to value and to seek to perpetuate their own distinctive cultural identities.

CHAPTER EIGHT

Māori women's perceptions of and responses to marginalisation

Introduction

In the previous two data chapters I presented the experiences of a community of Whanganui Māori women through the use of the following descriptive sub-themes: their own health beliefs and practices; and their identity. In this chapter I will discuss how interactions with health professionals and with the health services have contributed to and reinforced their perceptions of their marginalised position in society.

Defining marginalisation – direction from the literature

Marginalisation has been proposed as a significant concept that needs to be considered and understood when attempting to deliver quality healthcare (Hall, 1999; Hall, Stevens, & Melesis, 1994). In attempting to deliver quality healthcare to marginalised populations, nurses are encouraged to focus on responding to the effects of marginalisation. The definition of marginalisation highlights the effects of disenfranchisement based on race/ethnicity, socioeconomic status, and sexual orientation; and demonstrates how groups are perceived as being on the periphery when viewed from the centre of society (Hall, 1999).

The concept of marginalisation as defined by Hall (1994) was generalised from the political struggles of women, people of colour, the poor, immigrants, the mentally ill, children, and the victims of violence in the United States (Hall et al., 1994). Feminist theorists such as bell hooks (1992) use the term 'marginalisation' to include race, class, and gender as the sources of exclusion (hooks, 1992). Other critical theorists have addressed the concepts of marginalisation through the analysis of oppressive education (Carspecken, 1996) and a western medical system that fosters iatrogenic illness (Illich, 1976). These critical theories are also compatible with the concept of marginalisation.

An understanding of research participants' lifestyles and situations is essential in developing substantive knowledge. This knowledge provides the context for the phenomena observed, the research question offered, and the interpretation of results. Knowledge without such context leads to marginalisation of populations through stereotyping. The task for this researcher is to develop a historical context and, systematically, to develop and maintain the socio-cultural context of the research. This context includes sensitivity to structural conditions that contribute to participants' responses and to interpretations of situations informed by experiences, by validation of perceptions, and by a careful review of existing knowledge.

When people are marginalised they are stripped of their voice, their power, and their rights to resources. Marginalised people become reflective about their situation and, over an extended period of time, have developed a substantive understanding of the effects of their marginalisation (Meleis). They have also developed coping strategies to deal with these effects. These actions are not well understood by those who are outside of the group. Whereas marginalised people tend to possess an in-depth knowledge about mainstream society, the reverse is rarely true. Fundamental knowledge about marginalisation evolves from an understanding of how people are treated, the processes by which they are marginalised, and how their culture and/or their identity contribute to their marginalisation. It also evolves from uncovering the responses of healthcare professionals when they encounter people who differ from themselves because of race, gender, or socioeconomic status.

Giving voice to perceptions of being marginalised

As described above, marginalisation is understood from a theoretical perspective and there is a healthy debate in the literature. The following section gives practical voice to

the realities of the community of Māori women who have participated in this research. In analysing their responses, four main issues consistently appear in their discourse and highlight the experiences that inform the respondents' own perceptions of their marginalisation. The first issue concerns the attitudes and behaviour of health professionals. The second focuses on socio-economic factors. The third focuses on the difficulties of physical access to services for remote communities. Finally, there are a number of mediating influences, including community health workers and the role of whānau and culture.

Experiencing the attitudes and behaviours of health professionals

The attitudes of health professionals can have a negative impact on the outcomes for patients when there is a lack of understanding of the contexts of their lives. The participants in this research all experienced, at some stage in their lives, a sense of marginalisation or a sense of being 'outside the dominant system': beyond societal protection and resources. Marginalised people believe that they are often regarded disrespectfully, for instance:

I can always remember the sister coming in and saying oh I was lazy because I was resting and I turned around and said to her when I get home I'm working like a Trojan and I'm going to make the best of this time while I'm here, as if I'm supposed to be active. And she said, oh you should be up and about, and whatever, and I was enjoying it. Relaxing and also when I had, I think - it was the eighth [baby] one, and they questioned me why I wasn't breast feeding, and they came in and spoke to me about that and I said because the last one, oh number nine, the last time when I went home, I fed [baby] for two weeks and the milk went off. Because I had the others. I was up half the night, trying to feed the baby, and eight of them and you know how we were packed in, we couldn't get the beds in, we started building them up and then I hit a toe, I have a stubbed toe here, it's always been like that because every time I walk past the furniture I keep knocking it round the corners.

By assigning negative values such as 'lazy', those at the centre (health professionals) reinforce their sense of belonging and a belief of a singular moral 'reality'. This behaviour reinforces the perception of marginalisation:

Yes, well I had a very unpleasant experience when I had number seven. The doctor, I can remember him saying, Mrs ... she's an old hand, she's done this over and over again, and brought these students in, and it just put me right off.

That was the worst birth I ever had, I had stitches and that was number seven. With M, and it just put me off, and because they all came in, it was just like I was a guinea pig, and I really resented that. It just put me right off. I just couldn't do anything, nothing happened, I couldn't get rid of it! (laugh) I thought, gee it really annoyed me, you know, didn't ask, just went ahead when they were there, just probing and measuring, and pressing, and students all around me. [H2]

These types of encounters with the health services and health professionals have helped to reinforce the negative perceptions of mainstream health services held by many Māori within the community:

It must have been hard for our people though. Even when with, you know when I came, when they were sick they hated going to the Hospitals, they wouldn't go. I remember all that trouble, because they wouldn't go to the hospital. I don't know what it is about our people, it's just something in them. [R2]

They wouldn't go to the doctor, they felt better with their own. Otherwise they wouldn't go. My dad was the same. [H2]

My Dad went to him (*Doctor*). He had an ulcer and he (*the Doctor*) didn't even look at him. He just said he better give up smoking then. He said I've never smoked a cigarette in my life why would I give up smoking when I don't even touch it and he didn't even look at him. [B2].

These women have internalised the negative images, the negative stereotypical names assigned to them by mainstream. It is through just such painful experiences as these outlined above that the concept of cultural safety originally arose (Ramsden, 1990). However, to think these incidents are purely historical would be naïve as we see and hear daily through the media the same familiar processes of stigmatisation, especially within the area of mental health, that continue to marginalise many in the population, including Māori. The dynamics of scapegoating has a long history in which selected victims who symbolically embodied 'the sin of the majority' were driven out of the societal centre (Hall, 1999). The scapegoats of past centuries past, witches, heretics, and madmen were ostracised, tortured, and often executed. Contemporary scapegoats include persons of colour, gay men, lesbians, addicts, illegal immigrants, and those infected with HIV. The media has been a powerful tool in reinforcing both stereotypes and marginalisation (Lupton, 1999). The effects of institutional racism are well

documented as are the ongoing effects of assimilationist policies and practices (Rei, 1998; Tuhiwai Smith, ; Walker, 1987).

Community health workers – marginalised and mediating?

An issue closely associated with professional attitudes and behaviours is that of professional gate keeping. Much of the debate around this issue has centered on the roles of different health professionals: doctors and nurses (Carrier, 1999; Harris, 1999; Hodder, 1999; Longley, 1999; Porter, 1995 #84; Porter, 1995). Māori have a clear understanding of what is necessary to promote and maintain well-being. Community health workers find themselves at the intersection of the professionals and the community. What nurses/midwives, as health professionals, need to accept is that many community health workers have an in-depth understanding not only of the whānau but of what is considered appropriate for patient care and safety. It is clear from this research that the role and status of the Māori community health workers is not fully understood by the professional staff working within the organisation; while community health workers empathised with the community's perceptions of marginalisation, they were ironically marginalised themselves:

(CHW) is whānau, she's a concerned whānau, but I suppose they were looking at it from the nurse's point of view, because she's not qualified. You know I really got quite annoyed about it because she would defer to anybody, you know. And I thought, well! And then they complain about a girl going in there to try and help one of her own. I think they were looking at the nursing side.
[O2]

The community health workers often found themselves in a rather uncertain position: other health professionals implied boundaries of clinical expertise while clients expectations did not fit this professionally-limited role. CHWs maintained that they focused

not on the physical dimensions of health but on the spiritual and mental dimensions regarded more essential for a Māori cultural identity.

But in reality within the community they were often expected to demonstrate clinical competence through taking of blood pressure, checking eyes, giving advice on family planning, and asthma education. One midwifery community health worker explained that: *'the mothers expect us to know as much as the midwife almost'*. When she

explained she could not answer her clinical questions the client then asked: '*Well what do you do?*' The client's perception was that she should be able to answer all questions otherwise there was no point in her being there (Field notes Sept 96).

Funding favours health professionals. This is possibly due to a number of reasons, not the least being lack of research to define the role of the CHW, lack of information to support their effectiveness or otherwise in the community, and lack of recognised training and education. There is increasing need for in-depth analysis of the effectiveness of the CHW (Mburu, 1994) to substantiate the importance of network links between individuals and their social groups, and the extent to which individuals can promote survival and well-being of the community as has been outlined in this research.

Cultural practices as mediators

The concepts of whānau and whānaungatanga are key concepts in maintaining well-being. At the interpersonal level, these concepts mediate the physical and emotional safety of immediate whānau. The whānau acts as a barrier to protect and nurture the individual and immediate family in times of crisis. The whānau are also important in enhancing spiritual and emotional well-being and maintaining integrity, uniqueness, and autonomy.

Whether it is described as cultural sensitivity, cultural appropriateness, or cultural safety, it is the responsibility of all service providers to take into consideration the cultural aspects that surround assessment, treatment, and care procedures when dealing with Māori. The simplest of gestures can often be the most meaningful for Māori: being recognised as a valued member of the whānau, the respect that is paid to elders, and the atmosphere of love and understanding:

And do you know, we've got an old kaumātua, he was brought up by these people and he wouldn't, it was a job getting him to the doctor. Well, he loves it down there (Te Oranganui). Comes every Thursday, she's (CHW) got to go and pick him up and bring him down. And he loves it. [I2]

And my family in town, K goes to [doctor] ... and my mother. And they love it. The atmosphere is wonderful. The support. And they love it. It's just like, it's lovely. [H2]

And of course, the (healer)...goes in, and she's into all the Māori medicines, and mum loves the doctor there. She's says, it's relaxing, they don't feel threatened, and its, so wonderful, it's our own people. [B2]

Just the way, their aroha, it's just the atmosphere. It's just a different atmosphere. [I2]

The marginalisation experienced in mainstream services has had long-term effects on both mortality and morbidity outcomes for this Māori community, as outlined in Chapter 6. The long-standing reluctance to access mainstream services has in the past been seen as a reason for increases in admission rates to secondary services (Armstrong & Armstrong, 1991; Brown, 1998; Malcolm, 1995) and highlights the importance of improving access to primary services. Iwi provider organisations such as Te Oranganui have played a key role in improving access to primary care services for both Māori and lower socio-economic groups, but overall mainstream services still remain inaccessible to many in the community, especially those in the lower socio-economic groups.

Socio-economic factors

Socio-economic status is also linked to health status (Howden-Chapman & Tobias, 1999; Pomare, 1988). The socio-economic indicators identified are income, employment, housing, education, and family structure. Many of these issues were referred to in many hui because of the perceived impact on the health status of their whānau and the wider community.

Marginalisation has health implications that can best be understood by explicating its relationship to the concept of vulnerability. Exploring the properties of marginalisation exposes the links between vulnerability and health for those living at the edges of society and suggests that the health consequences of marginalising experiences result not only from the perception of marginalised persons but also from the contingencies of their environment.

For many of the participants in this research, health *per se* was not a priority for many of the women - it was survival on a daily basis:

Okay I'll worry about it [health], but we, having a big family as you probably realise, you've got all sorts of problems facing you every day, and you think what the hell have I got today, what are we going to do about that. So then you get on with it and do something and try and work it out the best way you can. But,

everyday things, the things that are happening around us, you think well what can I do about it. [R2]

The priorities in my life go - food, clothes, house and then if any is left over, the doctor. [I2]

Health for these women cannot be separated from their family, children, parents, extended family, neighbors, and friends: *the everyday things*. Individualism is not the norm for these people and their isolated experiences are not meaningful nor are they representative of the core of health for them. Well-being for these women is in relief from worrying. They spend a great deal of their time worrying. They worry about the whether they can pay the bills, buy food and clothing. They worry about their children: are they going to take drugs or get into trouble with the police, whether will they get a job, or whether they will get pregnant?

When discussing the issues for youth today, one participant notes that the ability of whānau to support training through marae-based programmes strengthens the youth and gives them a strong sense of security and well-being:

Because it was like security, it was a place they could go to, it was whānau, security and a meal. And being part of a family. And that's what our people miss today, that unity thing. And even the kids they have no confidence, and even with the cooking sessions, the girls would make a chocolate cake, or fudge or something, and they would be so thrilled with what they had done ... B's child she said to me, they think I can't bake, they won't believe that I made this.

The benefits for the youth within the community were obvious, but the cost to the well-being of the tutors and the marae was in many cases high:

We used our own resources from the Marae, and they weren't used to tutoring, teaching, and they needed a bit of training too, and we got that through the college, but oh dear. It was awful. Oh, the young people. They were into drugs, and they were tattooing themselves. With ink or something I had for the art kept on disappearing and I had no idea, I was wondering what they were doing in the toilets, and so I went in there and they were tattooing, using the ink and needles to tattoo themselves. I didn't know what was happening. Green! I really was so Green! I wasn't used to that sort of thing. Gosh, it's like another world. And you know the girls, and of course the poor tutor, the person in the end, they had to sleep in there with them, they had to have someone to sleep with

them, well she'd be a wreck and during the night, making sure the girls were where they were and the boys. It was really, you know. Big responsibility. I found it difficult.

This is just one example of the ways in which devolution of state responsibilities for child welfare to the community has impacted on whānau, hapū, and iwi. The cost in both human and financial terms has been great.

Economics

Economics covers the set of contingencies that affects marginalised people's access to resources of all kinds. This property obviously includes social class and income but also the costs related to education, transportation, health, and ecological issues. Economic risk includes combinations of these costs which further marginalise the impoverished and exacerbate the health problems that result from profit centred health systems. The lack of services in rural communities is a well-recognised phenomenon. Respondents voiced a strong desire to have services that increased access, especially marae based services:

Well, it meant that if we went down there [city], we'd have to find our way down, and pay for our fee, whereas here [marae] we just walk down to the doctor, and then we get our medicine when he gives it, well he's right next door to the chemist. Well, that's the way we look at it. Because we still have to pay our way to get into town. So if we could have our own here, well, all the better, they'd get our support. [A2]

Before they waited until they're really sick before they go to the doctor, but now, well I've noticed lately, since we've had the clinic here (marae), she just starts to get a bit of a cough, she'll say Oh I think we better get the doctor. And of course they just ring them up. But it's all right for us to say things like that but there are only two of us. [A2]

Physical access

Access to health care also comes into this equation; for these people it is another key issue. Problems of access to services reported ranged from hospital waiting lists to travelling to services. Lack of access as a result of major road blockages or washouts has a particular impact on those Māori living in the rural areas.

This is as far as the road goes. Further north for more of our people but they are reached by boat everyone is entitled to services no matter where they live, this is semi-civilisation for us. [B2]

Another concern expressed by rural Māori was the tourist industry and the increase in population caused by an influx of tourists. Not having health services to cater for the Māori population who live up the river raises concerns, but there is an extra issue because, once again, the resources they do have are used to cater for tourists who have not taken local terrain into consideration and come unprepared for the environment they are visiting. Inadequate equipment and lack of local knowledge often leads to the need for expensive emergency services and rescue and medical support. This all has an impact on the local community.

The barriers which prevented access were wide-ranging and impacted on people at different levels, whether or not they were Māori. Barriers such as cost, lack of transport, lack of information, and knowing how to gain access to services are issues which faced the general population. Many iwi providers make an effort to eliminate as many of the barriers as possible by taking services to the people rather than people having to come to the services. Some services are more able to be delivered in this way than others. The midwifery service was seen to be well received by the women because *the midwives come to our homes and we do not have to go into the centre for care*. This type of approach in the maternity area eliminates both the transport and cost barriers for clients, also often clients are more comfortable in their own environment, feel more relaxed, and have a greater sense of autonomy (Malcolm et al., 1991).

Even though Māori within the Whanganui area are closer to service providers than those based up the river, access to those services is still an issue. Travel time may not be a problem but the cost often is:

There has been a whole lot of money wasted in terms of trying to get Māori to actually access the services. I don't think accessibility is an issue, it's always affordability. [C2]

Cost is a major barrier to Māori getting appropriate and necessary health services. This issue was of particular concern to the Kaumātua Kaunihera as many of them wanted to be cared for by their whānau members but there was no financial support:

I won't ask my whānau for help because I know they don't receive any more money for helping me and they would have to use their money to come to me. I can't see why a total stranger who doesn't know me and will not understand my needs can get paid for looking after me when my own family who know me and know what I want and need have to use their resources. [R2]

Returning people back to the community so that the community can become more responsible for their care places huge cost on whānau. They often lack the resources to care for themselves and cannot easily provide for the care of their children no matter how much they want to. For some it is a difficult choice to make:

I want my boy out of Kimberley because I know that he is not happy there but I can't bring my boy home because there is no money to support him in the community. My boys' sickness is my sickness. [B1]

Paying for specialist services but not getting any results of very disheartening for some:

It was \$40 the first visit and I went back for three visits after that and it was \$25 each visit. That was seven years ago. I haven't heard nothing and I still won't go back. I just think they should have got in touch with me if they had thought of something (*hui participant*)

Using services because they are the cheapest does not necessarily guarantee that these will be quality services:

I was looking for the most economical, cheapest dentist I could find and obviously you are going to get someone who is not as reputable, those better places you have got to pay a lot but I just can't afford it. (*hui participant*).

GPs, pharmacies and diagnostic and dental services were all identified as carrying large costs. This is a major issue for many people:

They could never find my problem so I flatly refused to go back just to pay \$25 to hear 'We still don't know what it is' so I never found out what it was. (*hui participant*)

I don't like the fact that we pay double on public holidays like Waitangi Day. After hours are dearer as well, so you really have to be sick within a certain time, it's cheaper, but sick between nine to five Monday to Friday (*hui participant*)

For elderly people, who have to visit doctors on a regular basis, for example kidney problems, the monthly cost of visits far outweighs the financial support available to help cover them:

I have to visit the doctor each month for a full medical. Travel into town and then my regular dose of medicine cost \$40 as well as what it costs me to see the doctor. I don't think I need to see him every time but I have to get my medication (*hui participant*)

The high morbidity rate within the community necessitates regular checks to monitor conditions such as blood pressure, but if these occur when finance is low they will not go:

I have heart problems and I need to get my blood pressure checked every month. If I can't afford to go to town or to the Doctor I won't go. I will miss the checks because they are too expensive. (*hui participant*)

This situation would appear to be the 'norm' in this community and has serious implications not only for clients but also for health services. This is not an isolated incident and is supported by extensive research literature on utilisation of secondary services by Māori (Barnett & Coyle, 1998; Gribben, 1996; Malcolm, 1995).

Conclusion

There is much evidence to support the contention that Māori are marginalised within New Zealand society in cultural, economic, social, and political terms (Crampton, Salmond, Woodward, & Reid, 2000; Howden-Chapman & Tobias, 1999; National Advisory Committee on Health and Disability, 1998; Pomare et al., 1995). However, the impact of Māori people's interactions with health professionals and health services in terms of their experience of marginalisation has not been well explored. This chapter has identified the attitudes of health professionals, physical access to services, economic and cultural factors as significant issues in framing Whanganui Māori women's perceptions of their marginalisation.

Without knowing the health related responses of the marginalised, community health assessments will be inadequate in estimating communicable and toxic disease threats and in suggesting solutions to problems stemming from social alienation, economic deprivation, and political oppression. Access to health resources is only part of the struggle for marginalised persons. They must also have the political and economical

resources to ensure that their basic needs are met, as well as the social legitimisation and respect necessary to make decisions affecting their health.

Access implies not only that the services are affordable and geographically available, but also that they are socially and culturally appropriate and geared toward effectively meeting the critical health needs of diverse communities. For evidence-based nursing to have real effect, investigations must link concerns about the economic, political, and cultural viability of systems of care with a comprehensive understanding of individual experiences of those systems.

Vulnerability has negative and positive implications, as expressed in its two major aspects of risk and resilience. Risk is the increased potential to develop illness as a result of disproportionate exposure to damaging environmental factors. Resilience incorporates the capacities gained from person-environment interactions that foster survival (Hall et al., 1994). Resilience includes not only genetic predisposition and learned abilities, but also environmental factors that enhance well-being.

Although nurses often focus on risk in dealing with vulnerable populations, resilience is an important aspect of marginalisation because it fosters understanding of how individuals and groups creatively manoeuvre and use resources at hand to avoid illness and to maximise their chances of survival.

This focus creates a unique lens through which to view nursing phenomena. By examining the margins, nurses can gain knowledge about the whole that has previously been unavailable. With marginalisation as a guiding concept, inquiry can more accurately explicate the health and health care of diverse populations because it helps avoid universalisation of empirical and clinical approaches and impresses on us the need to approach members of marginalised groups with an attentive ear to their experiences and an alert eye to their struggles.

It seems likely that depending only on individual resilience and strategies can potentially lead to individual fatigue and a series of potential problems. Group strength and genuine social support are essential for survival and health. Advocating social transformation is common to critical theory, but it is painfully evident that critique alone does not ensure social change. A significant barrier to action is the lack of in-depth analysis and intervention on the economic front. In the words of a poor Latina

woman, 'I don't care about your revolution, if I can't get rice and beans'. bell hooks believes that post-modernism can either separate or create new human bonds depending on whether it creates or destroys options for the marginalised. Taken to its logical end, post modernism implies validation of subjective realities for marginalised people but does not necessary affirm their claim to rationality. In this case, marginalised people do not gain credibility and power as each reality is equally valid or invalid.

Post-modernist rejection of meta-narrative may inadvertently devalue collective stories as sources of solidarity and identity for marginalised groups. Rejection of the universal undermines the idea of all-inclusive human rights. Some feminists have cautioned against accepting such an extreme post-modern position. The value of post-modernism in reflecting the complexity of realities in marginalisation is significant. There is undoubtedly a middle ground within this perspective that does not constrain but enhances social change. Post modernism challenges nurses about judging and enforcing norms to control marginalised persons. Such judgement is glaring in such nursing terms as "non-adherence and non-compliance".

As a nursing concept, marginalisation implies a deliberate focus on functions of boundaries, environment at the borders and transitional human experiences, especially as each of these relates to health and illness.

Innovations and inquiry are needed to inform cost containment and quality assurance and provide understanding of consumer health needs and to engage a committed investment in the well-being of diverse communities through health promotion and empowerment. The most visionary forms of investigation to meet these goals necessarily involve groups who have first hand experience of failures of the present care system: those who live at the margins, not at the privileged centre.

CHAPTER NINE

Discussion

The introduction of ‘cultural safety’ into the nursing curriculum laid the foundation to enable nurses to develop models of practice that were more appreciative of the diverse realities of our client base. The theory of cultural safety puts the nurse as the focus of insight and change, not the patient. This approach was in stark contrast to other nursing theories that tended to focus on the cultural activities of patients. Cultural safety, as noted earlier, evolved from the ‘pain’ experienced by Māori and that ‘pain’ has been used to inform both nursing and midwifery practice. The purpose of this research has been to articulate one model of primary health care nursing that is responsive to the needs and expectations of a community of Māori women, taking into account the many changes that have occurred within the broader Māori and New Zealand context since the introduction of cultural safety into nursing. The issues surrounding the introduction, implementation, and subsequent controversial history of cultural safety is not the focus of this Thesis¹⁴.

Although Māori primary care providers have been instrumental in developing services to meet the particular needs and expectations of Māori, mainstream service providers - in general, have not. As the majority of nurses are ‘mainstream’, it is important to facilitate the further development of acceptable models of practice for nurses especially when working with clients from cultures other than our own. This research has sought

¹⁴ For further discussion on these issues the reader is referred to Ramsden, 2000 & 2001.

to allow Māori women's perspectives to be heard in such a way so as to locate their experiences in the substance of the data. In order to do that, inductive reconstructive analysis has been applied in a manner consistent with critical ethnographic methodology. The topic of interest was presented to these women as an open question: *Tell me about health, what does this mean to you?*

As noted in Chapter 1, I originally held the position that theory generated from the experience of these women may assist nurses to better understand and support Māori women to achieve improved health outcomes. The basis of this argument was founded on the position that no substantive work to date had specifically identified the dynamic relationship that these women have, not only with each other but also with the wider cultural, social, economic, political and physical environments. Nurses were working without substantive framework from which to explore the experiences of Māori women. This position has now been addressed. The dynamics between Māori women, their whānau, and their aspirations have been identified in this work. This research enabled these women to express the importance of understanding past experiences that have influenced their attitudes and behaviours, hence the historical nature of narratives expressed in this research as they situate the participants' experiences and help define their realities.

The implications of this work are essentially threefold. Firstly, the model developed in this research offers direction for health professionals, such as nurses, when working with Māori women and whānau. Secondly, the model provides a framework for a Māori health development curriculum for nursing education. Finally, the model provides rich material for further research and analysis including concept refinement, assessment tool development, and instrument testing. This final chapter will articulate the model and elaborate on its implications for nursing practice education and further research.

Discussion of findings

While the philosophy and policy of primary care nursing are consistent with broad Māori development objectives, the practice can fall short of the ideal. This thesis identifies and examines the shortfall in terms of a community of Māori women's expectations and presents a model for practice that can offer useful understanding for nurses working with Māori women. It is important to remember at this stage that a model is a type of shorthand for complex ideas. For many nurses and nurse practitioners

dealing with complex health issues, a model for practice can provide a short cut to enable effective communication, assessment, diagnosis, and intervention with the client group. This research articulates a model for nursing practice using a broad Māori development approach. The model suggests ways in which teaching and practice can be enhanced in order to contribute to health gains for Māori. The research highlights the need for nurses to broaden our concepts of health, community, and public health nursing; to focus more on issues of capacity building and community needs; and to gain a broader understanding of the social, political, and economic contexts of the communities we work with.

Cultural safety education has established a solid base for graduates to develop a more in-depth understanding of the broader issues that Māori have outlined in their drive for positive Māori development, and which cannot be separated out from Māori *health* development. Within a Māori worldview these are one and the same. They are inextricably linked. It is a simultaneous process based on the key defining characteristics of self-determination, autonomy, capacity building, intersectoral collaboration, social, cultural, economic and political advancement and environmental protection. Health gains for Māori will be measured by increased participation at all levels of society, protection of the environment, increased educational achievement, and the development of a secure identity: not just the reduction in rates of secondary services usage or increased use of primary care services.

Nursing's focus has been on *managing* the environment within which their clients live as opposed to *changing* the environment; it has been very much a passive rather than an active role. We try to mediate the extraneous variables and adapt to the current circumstances rather than define ways to transform them. If we simply deal with the *status quo* we do not have to address the harder issues of distributive justice or social equity. But these are the issues we must grapple with if we are to make a difference and stake a substantive professional role in the primary health care arena. When we consider the ever increasing number of individuals and communities with competing interests and needs, then how do we - as a profession - work towards ensuring the availability and accessibility of high quality health services to all persons whose health needs are unmet?

This chapter presents a synthesis of the findings from the previous chapters in order to articulate a model of primary health care nursing which is responsive to the needs and

expectations of a community of Māori women. The research has sought to identify the ways in which a model of primary health care as implemented by nurses can respond to and enhance Māori access to primary care services and, secondly, to assist in the development of both policy and programmes to advance not only health but Māori self-determination.

In undertaking the development of this model for practice I have used an analytical framework that draws on the descriptions of PHC, Nursing PHC, and Māori Development paradigms, as outlined in Chapters 2, 3, and 4. These criteria are as follows:

- the intent of the paradigm
- the particular approach taken
- the concept of health which is used
- the specific practices which are emphasised
- the outcomes which are produced.

The intent of the paradigm covers the philosophy, values, aims and objectives that are articulated. *The particular approach taken* identifies whether a sectoral or a holistic or a particular developmental stance is taken. *The concept of health* refers to whether a Western concept of health or a Māori concept of hauora is referenced. *Specific practices* identifies the practical measures which are emphasised. *Outcomes* are again those articulated for each paradigm.

My contention is that the Nursing-PHC paradigm does not require a fundamental rethink yet there are substantive practical changes that are required, as well as structural and economic changes at a societal level, to fully realise the potential of nursing as summarised in Table 5.

Table 5
Analytical framework

	Nursing-primary health care Paradigm	Māori (Health) Development Paradigm	Study Community's Paradigm
Intent	Overall focus is on healthcare of individuals, families, and groups in communities to preserve, protect, and promote or maintain health	Positive development - the process to achieve Māori self-determination, autonomy, cultural integrity, and improved Māori outcomes	The development of a 'health service' that restores and maintains the rangatiratanga of whānau, hapū and iwi
Approach	Sectoral, professional, medical approach	Whole systems approach	Holistic iwi development approach - based on tikanga in terms of values, attitudes and practices
Concept	Health	Hauora	Hauora
Orientation – specific practices	Disease management but actively in the context of prevention, health promotion and health education	Wellness, well-being	Well-being; creating community capacity such as the capacity to care, share and empower
	Community-based	Iwi, hapū and whānau based	Whānau based healing
	Individually focused but in the context of family and community	Collective focus	Healing is a collective process facilitated through the exercise of cultural and spiritual values
	Self-care and environment	Self-determination, collective responsibility Inter-connectedness Secure identity, equity and social justice.	Intergenerational responsibility iwi development interdependency collectivity Mauri use management
Outcomes	Disease management	Oranga Māori	Building whānau and hapū and iwi capacities
	Prevention, health promotion and health education		
	Validating professional praxis	Validating Māori paradigms	Validating Whanganuitanga

Intent

The intent of each respective paradigm is markedly different.

The Nursing PHC philosophy is, unsurprisingly, congruent with the PHC paradigm. Key principles include equity, access, empowerment, self-responsibility and intersectoral collaboration. As with PHC generally, Nursing PHC aims to reduce the level of preventable illness, reduce admissions to secondary and tertiary facilities, and reduce barriers to accessing PHC.

Māori (Health) Development (M(H)D), on the other hand, seeks to support oranga Māori in parallel with supporting other aspects of broad positive Māori Development such as cultural affirmation. Key principles include rangatiratanga (self-determination), interconnectedness, holism, cultural integrity, and sustainability. It does not principally seek to enable an interaction with (orthodox) healthcare systems except to the extent that such systems can contribute to Māori Development, for example, by supporting hauora.

The women in this community hold views consistent with Māori Development with the exception that the focus is on Whanganuitanga with its important idiosyncracies. Key principles include strengthening specific whakapapa links and knowledge; maintaining autonomy and control; transmitting health beliefs and practices; and strengthening whānau. The community also values the development of a health service that restores and maintains the rangatiratanga of whānau, hapū and iwi and is based on tikanga Māori in terms of values, attitudes and practices.

Approach

The approach that is taken again shows a marked difference between the paradigms.

NPHC is community-based practice that focuses on the individual within the family and the community. Nurses who work in PHC are most often located within General Medical Practices. Those that are community-based are generally employed on a contract base to deliver specific programmes such as well child, sexual health, family planning and communicable disease screening and management. This has led to widespread fragmentation of services and confusion surrounding the roles of various nurses.

M(H)D providers take a systems approach and utilise a community empowerment model of practice that focuses on interdependency, capacity building, well-being and wellness, and the development of a secure identity.

The women in this research use an iwi development focus with the overall goal of Whanganuitanga. This is based on a community development model with the goals being to enhance the ability of the community to care effectively for one another, to share resources, and to empower the whānau, hapū, and iwi.

Concept

The theoretical concept of health that is evident shows some overlap yet has significant distinctions.

NPHC utilises a reasonably holistic concept of health that recognises the socio-economic determinants of health. Nurses understand health as a linear continuum and care for individuals and communities taking into account the context. They work to maximise health and wellness

M(H)D uses the concept hauora which includes a focus on not only physical health but on the dynamic interaction of people with each other as well as with the wider cultural, social, economic, political and physical environments. The classic model of Durie: taha tinana; taha wairua; taha hinengaro and taha whānau. Health is the outcome of all these variables acting together in a balanced way. Māori health is the product of the combined forces acting on the past and present experiences that serve to define Māori realities.

Women in the research community and the primary health care services provided are guided by the concept of hauora. There is a strong focus on interdependence, intergenerational responsibility, collectivity and self-empowerment through an understanding of 'who we are and how we survive, grow, and expand, and add depth to the life of the whānau, hapū, and iwi'. The concept is to strengthen people's capacity to determine their own values, priorities, and outcomes and to enable whānau and hapū to achieve their goals.

Orientation - specific practices

There are similarities again evident in each major paradigm; the study community paradigm provides finer detail.

Under the PHC model, nurses work alongside communities to set priorities for health promotion strategies, plan and implement activities that help communities to achieve improved health, and act as an advocate. The overall goal of practice is to empower the community and to facilitate community ownership and control. In reality most practices fall short of the ideal and community nurses remain isolated within the healthcare team and are frequently precluded from working in a collaborative way with communities because of issues of resourcing and control.

M(H)D models of practice utilise a population-based approach and are committed to a positive Māori development framework that fosters Māori development through capacity building, integration of services, increased opportunities for participation at all levels of society, increased access to resources, and intersectoral collaboration.

Women in the research community also utilise a positive Māori development model. The key difference is that the primary focus is whānau and hapū development and Whanganuitanga. They strengthen the whānau to care for each through practices based on the concepts of whānau, aroha, whanangatanga, and manākitanga.

Outcomes

The outcomes that are sought from each model again show distinction.

PHC nursing model conceptualises outcomes through reductions in the level of preventable illness, reducing admissions to secondary and tertiary facilities, and reducing barriers to accessing PHC.

In M(H)D, a key indicator of Māori well-being is *oranga*¹⁵ Māori: collective well-being, autonomy, self-determination, environmental protection, and Māori identity.

Women in this research group measure effective practices as those that strengthen the capacities of whānau and hapū, strengthen identity and especially Whanganuitanga; increase the level of collective well-being, autonomy and self-determination; and environmental protection.

This analysis of the similarities and differences between these paradigms leads to the articulation of the following framework that is intended to give direction to nursing

¹⁵ Livelihood.

primary health care. I have named this framework ‘‘A Māori model of primary health care nursing’’. This name recognises the intention of the framework in providing direction to the existing model of nursing.

Table 6
A Māori model of primary health care nursing

	Nursing primary health care for Māori
Intent	Māori PHC, a process of enabling Māori to increase control over the determinants of health and strengthen their identity as Māori and thereby improve their health and overall position in society.
Concept	Holism, self-determination, cultural integrity, diversity, sustainability
Approach	A balance between interacting spiritual, mental, social, and physical dimensions.
Orientation - strategies	Community development through capacity building, advocacy, relevance, resourcing, cultural responsiveness, empowerment, connectedness
Outcomes	Secure Māori identity, strengthening Māori collectives, increased participation in all sectors of society,

Intent

Community development

Community development is about change based on the democratic principles of equity and the freedom to participate. It aims for social change to meet the needs of communities. More specifically with regard to the health of the community, development is based on a social model that involves practical strategies to achieve positive change.

It includes:

Interventions to change those aspects of the environment which are promoting ill-health, rather than continue to deal with illness after it appears, or continuing to exhort individuals to change their attitudes and lifestyles, when the environment in which they live and work gives them very little choice or support for making changes. (South Australian Health Commission 1988)

Although community development is associated with the promotion of well-being, on a practical level it is more often involved with solving problems for people so they may

achieve well-being. Current health systems are shaped by the larger political systems within which they function. Similarly, the health of the community is shaped by the political, economic, and social system of society. If nurse practitioners are to fulfill their role in community development they need to be cognisant of the social structure within which they operate.

Community development is a complex process because it involves people working together in harmony to gain control over community resources and, because it often results in disharmony with those who hold power, it is based on both consensus and conflict. The high profile occupation of so-called 'local body' land in Whanganui is an example of this process whereby local whānau, hapū, and iwi worked together to gain control over significant land resources; this in turn created wide-spread disharmony both locally and nationally.

By its very nature community development generates criticism of bureaucratic attitudes, policies, and programmes. It also stirs up conflict and minor revolution when groups begin to demand public control over land and resources. Successful development requires some level of consensus among the community to combine, in an atmosphere of mutual support, to resolve their common problems.

Empowerment

Community development is about change in the distribution of power in society. It occurs when groups in society recognise their interests are not being met; where they become convinced that by working together and utilising the force of their combined power their ends can be achieved. Positive Māori development involves an implicit understanding that the present structure in society has caused their plight and that any action will necessitate conflict with existing interests. This is the point at which development moves beyond the communal self-help activity to meet needs and becomes social action with the potential to challenge and condemn the nature of power distribution and the control of resources in society.

Any analysis of community development without due recognition of the fundamental power elements involved and without clear acceptance of the conflict likely to emerge is fated to irrelevance and impotence. The review of the literature has outlined two perspectives on community development. One perspective sees community development as activities to get services to the people who need them. COPHC, a Māori

community development model, proposes that if power is equitably redistributed then social justice would prevail and services would be available to the people who need them. If existing power structures are to be challenged and if social change is ever to occur, there must be programmes aimed at empowering communities to participate and work together to achieve structural change.

Community development is concerned with societies' decision-making systems and the way they exclude some groups from community resources. As a profession, nursing must aim to empower the community to remove any constraints against freedom of choice, to reduce economic scarcity, to reduce the misdistribution of wealth, and to prevent vested interest in controlling the economy.

Practitioners must facilitate the self-esteem and confidence of both the individual and the community by increasing their opportunities for self control and direction over their lives: enabling them to take power over the decisions which affect their health and well-being. Peggy Koopman-Boyden (1988 NZ Royal commission on Social Policy) noted three major strategies for empowerment:

- community education
- full participation and representation of the community in decision making at all levels
- elimination of political or legislative discrimination against the community concerned.

Koopman-Boyden was speaking of empowering the elderly in the community; nevertheless, the principles behind these strategies apply equally to the wider population. Health practitioners have a major role in community empowerment and a responsibility to be involved in each of these three strategies.

The concept of empowerment figures prominently in the power analysis of health educators and other social change professionals for whom facilitating individual and community empowerment is central but a cautionary attitude towards the rhetoric of empowerment also is important. Particularly in these times of fiscal retrenchment, the language of individual and community empowerment and self-reliance is frequently being invoked by conservative policy makers to justify cut backs in entitlement programmes and health and social services. While embracing the authentic notions of

empowerment, part of the worldview of health educators involves the rejection of the argument that individual and community empowerment can take the place of a broader societal level commitment to creating the conditions by which people and communities can be healthy.

The goal of facilitating empowerment can be particularly hard to live up to when funding is not only grossly inadequate but is also targeted at reducing cholesterol levels among people who cannot find employment or reducing smoking when coping as a solo parent in poor housing and unemployed.

Health professionals can increase the victimisation of people living in socially disadvantaged conditions through their attitudes and exercise of power over their clients. If professionals respect the leadership prerogative of communities and see themselves as part of the community, it will go a long way to change the current power differentials.

Capacity building

The challenge - and the dilemma - for nursing is how to integrate our special knowledge and resources in ways that strengthen rather than diminish community capacity in the process. Listening actively and empowering personal dialogues, nurturing community resources, helping to access hidden information, and transferring skills in locating information and other sources of power are among the contributions nursing can make to grass roots organising processes. These goals can be achieved by learning about, understanding, and participating in the community. We can begin by recognising and building upon the ways that women have worked effectively within their communities; begin by building upon existing structures. As professionals we need to develop a more facilitative approach to practice and attempt to view the situation through the vision of the community, not just nursing. This can be achieved by using the process of praxis to understand the historical, political, and social context of the community. As nurses we must value the unique knowledge that women in the community possess and foster leadership from within the community and understand and support their needs for separate programmes and organisations.

An increasing emphasis by funders and policy makers on primary health care strategies such as community participation, partnerships, and coalition building offers unique opportunities to help broaden the scope of our professional contributions to improving

the health of communities; we need to look for the strengths on which people and communities can build in achieving and maintaining health. A good health educator remains in the background so that achievements and victories are seen as being of and by the people and communities rather than of and by outside professionals.

Recognising diversity

Nurses need to embrace diversity not as a problem or obstacle to be dealt with but as a rich resource and an opportunity to be seized. The principle of diversity recognises that, even though they share a number of commonalities, Māori are not a homogenous group and they live in diverse socio-economic and cultural realities. The goals of the participants in this research are focused very much on developing their unique identity as an iwi not as Māori, hence the drive at all levels for Whanganui tino rangatiratanga. There is a call for health practitioners to take account of tribal difference. Although there are some collective characteristics of Māori, they will not apply equally to all Māori individuals. For example, while some Māori will feel more at ease in a Māori context others may prefer to access mainstream services. We must broaden the options available by developing services that will take cognisance of the diverse and dynamic nature of Māori society.

Collective responsibility

This will require a new way of conceptualising community, changing our focus from the community as a social or demographic entity or unit with which we interact to a community as a multidimensional/dynamic whole or system of which we are part. This view is consistent with a Māori worldview that encompasses an integral relationship between past, present, and future; between the environment and people; and emphasise collectiveness and interdependence. Working from a whānau basis implies much more than working in a community with families. The idea of collective responsibility and involvement in whānau dynamics is the essential difference between Māori and non-Māori models of community practice (M H Durie, 1998; Gifford, 1999). The concept of collective responsibility is central to a Māori worldview and is in direct opposition to the pākehā view of individual responsibility (Patterson, 1992; Metge, 1995; Ratima, 1998). The concept of strengthening families, the basis of many primary care initiatives, recognises the importance of collective responsibility in achieving better health outcomes for Māori. Pere (1984) describes whānaungatanga as all generations supporting and working alongside each other. As seen in this research, the support of

family was integral to beginning the healing process and to being and becoming healthy.

What this means for a new model of primary health care nursing is that it is not something that is done to or for someone or even some group at arms length. It is about a process of intimate involvement and responsibility and requires an understanding of fundamental differences in value base between Māori and non-Māori approaches. In particular, it requires an understanding of whānau dynamics including relationships within the whānau, their strengths and weaknesses, and an understanding of the history of these relationships.

The concept of collective responsibility raises many issues for nursing, especially for a multi-disciplinary team involving Pākehā health professionals. The concept of privacy and confidentiality is challenged by ideas of collective responsibility, as is the idea of professional boundaries. The tensions that this concept creates within the health care context are constantly being debated and opinions explored whereby a range of values, ethics, and principles held by all members of the team can be accommodated without diminishing the importance of Māori values that are central to the provision of service for Māori.

Interdependence

Closely aligned with collective responsibility is the concept of interdependence. It emphasises the links between people, generations, and also the environment: extending the concept of holism as currently defined in many community or public health nursing models. As outlined in Chapter 5, many community health and primary health nursing models relate autonomy of the individual with health while most Māori models of health development focus on ideals of whānau hapū and iwi interdependence. Autonomy in this model is a group goal not an individual goal and outcome measures for health are focussed at the level of whānau/hapū and iwi as opposed to the individual.

The use of community networks is critical in actually reaching many of the most vulnerable clients within the community, especially with the mobility of many Māori whānau; this is where the community health workers are at their best. They also have the ability to communicate with the client base in a way that an outsider can never achieve because of the interconnectedness within the community. Therefore it is crucial that we begin to recognise and appreciate the key role that they play in accessing clients

within a community context. The community health workers have the capacity to access Māori networks which nursing or mainstream providers do not. This interconnectedness also facilitates the sharing of information with friends and whānau. These Māori networks are useful as an informal mechanism through which information provided by interventions can be disseminated more widely. This informal transfer of information highlights the importance of up-skilling the workforce to ensure that the information that is being disseminated is evidence-based as well as appropriate. Nursing has a critical role to play in enhancing the effectiveness of this workforce by adopting a more collaborative role that entails mentoring, teaching, supervision, and genuinely valuing these members of the community.

Although their interconnectedness is often perceived as a strength, there is evidence - both within this research and in the literature - that highlights the serious disadvantages that are also encountered. Most often these workers live in the communities they serve and are, therefore, called upon at all hours. It is in effect a seven day a week, 24 hour a day job and there is a high level of stress that can in some cases lead to burnout. These workers often also suffer the same distress as those in their community: poor housing, lack of formal education, and whānau commitments that drain financial resources (Mburu, 1994; Taiapa, 1994).

Concept

Holistic concept of health

The health and well-being of communities is significantly dependant on how people and practitioners define these concepts in relation to their everyday lives and work. The Ottawa Charter for Health Promotion (1986) and Māori models of health each recognise the need for an expanded and more holistic appreciation of health and well-being.

The Ottawa Charter states that:

Health promotion is a process of enabling people to increase control over, and to improve their health. To reach a state of complete physical, mental, and social well-being, an individual or group must be able to identify and realise aspirations, to satisfy needs and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not as the object for living. Health is a positive concept emphasising social and personal resources, as well as physical capabilities (World Health Organisation et al., 1986).

As a profession, we have continued to ignore the broader context of the environment and readily place the responsibility for the local and global environment on politicians or ecologists. Perhaps it is time to understand and act as one. Māori have always taken a holistic view that includes a focus on a strong, healthy environment together with a spiritual focus on health and well-being. The very clear understanding of Māori communities of the connection between land, health, and well-being is highlighted in this research. The community's belief in the significance of the environment to the healing process and of traditional practices in maintaining the health of communities is evident. This observation reflects those reported in the literature (Best, 1924b; M H Durie, 1998; Metge, 1995).

Working with communities and individuals towards achieving health and well-being raises many philosophical and pragmatic questions for nurses as primary care providers. In these times of increasing challenges on many fronts, a more holistic, integrated and collaborative response is urgently needed. We have been working with the obvious but not the basics. Jaffe (1980) powerfully reminds us of the essence of community life and the health and well-being of individuals:

When a person loses intimate, meaningful contact with his or her community, with the love and care of others, and with a sense of inner coherence, unity, and purpose in life, the seeds of disease are created. This illness is an outgrowth of a social/spiritual and existential crisis.

A broad Māori Health Development model, by pointing out the basics needed by Māori communities to grow and survive, empowers us to reach within and rediscover and use what has traditionally been the heart of 'helping': the affirmation of the whole and the integration of all systems (holism). In doing so, we can find whole solutions to the problems of the health care system. People cannot effectively promote a healthy lifestyle when surviving day-to-day, dealing with issues of unemployment, poor housing, and poverty. Programmes aimed at improving health will not only consist of direct health care and services: they will include activities which have a more indirect impact on health such as the provision of affordable housing; and whole-life education such as literacy programmes and employment. These activities will not involve only one discipline but teams of practitioners, educationalists, politicians, and community advocates who together can achieve a healthier society.

Equity

The unequal distribution of wealth, health, and life chances in this community has been heavily determined by the interaction of political, economic, and socio-cultural factors. The dynamics of race/ethnicity, gender, and class and the role of broad social influences in determining the health of this community and its access to resources, has been highlighted. A primary health care approach based on equity implies fair access to goods and services, taking into account community needs and the communities' capacity to benefit. Consequently, using criteria of needs, those who are most marginalised are favoured and differences in the way people are treated can be justified on the basis of need (Downie et al., 1997). Equity of access and outcome have high priority on the current New Zealand health agenda (National Health Committee, 2000). A lack of resources and political commitment is the major constraint to operationalising the principle of equity.

Social justice

At a time of increasing inequalities in health and other outcomes within society at large, there is an acknowledged need for social justice and community empowerment to overcome inequity and oppression and so reduce the political disharmony that they cause in society (Labonte 1989). Because health is a political issue, nurses can only be of practical use to their communities once they recognise the causes of powerlessness and are prepared for the difficult task of working together with the community to challenge the authoritarian traditions that cause oppression. Although some nurses see political activity as outside of their realm of professional practice, they can only successfully support their community if they are prepared to become involved in the social, economic, and political arenas that influence the local community.

Social justice is the very foundation of public health and contrasts sharply with the dominant worldview of market justice. Market justice emphasises individual responsibility, minimal collective action, and freedom from collective responsibility except with respect other persons' fundamental rights. The market justice ethic in turn underlies the strong tendency to frame and view problems and their solutions in individual terms, further reinforcing the 'victim blaming' or 'lifestyle approach'

Orientation – strategies

This model is not intended to be prescriptive but rather point to the ‘how’ processes and intent of an effective system for working towards empowering the communities in which we work. Although this research has focused particularly on Māori women, I believe that the processes outlined below should guide all primary healthcare practices and would be of benefit to any community, not just Māori. The stories told in this research have highlighted some of the facilitative factors that this community uses to enhance its abilities to grow and survive, in spite of overwhelming odds. These are the challenges for nursing if we are to make a significant difference to the lives of the families/whānau and communities we work with.

Having a clear vision and articulating it

This will challenge us to develop an ability to ‘see’ the vision of the community, not just nursing. An ability that allows us to see the whole: to move beyond the illness, the disability, and the individual; to foster creativity within the community; and maintain the cultural integrity of its vision. Without vision we are left with people and systems that see only disability, despair, and limitations. This attitude is not only disempowering it also creates a sense of helplessness. We need to be aware not only of the risks to well-being but of those aspects of being that have sustained and maintained communities through years of colonisation; those things that enhance a community’s ability to not only survive but to maintain a strong sense of its own identity and for the well-being of the whole.

Being responsive to the needs and expectations of Māori

The new public health mandate requires us to be more responsive to the broader environment and to respond appropriately. This will entail an ability to listen to, understand, and express the needs, expectations, and wants of the whānau and be open to meet all the demands of a community. This is often too difficult so broader issues are ignored. In many situations we are pushed to case manage others or to provide therapy with little or no thought to the individual, the whānau, or the community. We have overlooked the personal abilities of the community. It is easier to do for rather than do with. We have ignored the vision and the motivation of the community.

Demonstrating commitment

There needs to be a strong commitment to working together from a place of respect, care, sincerity, and trust to ensure the development of a partnership. These are all values that nursing has long held but too often the constraints of time, energy, and resources prevent the development of true partnerships.

Enabling collaboration

Collaboration requires nursing to look beyond the differences: accepting diversity, mutual respect. Supporting interdisciplinary collaboration and intersectoral collaboration is the key to addressing the broader socio-economic determinants of health.

Empowerment of communities and clients

The reality of the principle of empowerment is that it gives power to the people and, at the same time, is a process that never takes it away. An empowering relationship is one that enables people to develop and grow through respect, building on positive strengths, and having shared goals. At the national and International level, it is advocating for development of healthy and culturally affirming public policies.

Providing adequate resources

Having adequate resources – funding, people, environment, equipment, time, and space - enhances success. The transferring of resources is part of the empowerment process. Rather than acting as the gatekeepers, we must move to a more radical model of PHC that has a community development focus as opposed to a community participation model of development. The transferring of both resources and power is a goal to work towards, but do we have the courage of our convictions!

Implications of ‘Nursing Primary Health Care for Māori’

There is a constant tension between facilitating the freedom of individuals and nurturing a community in which people feel connected enough to care for one another. As nurses we can learn from communities, such as the one in this research, where there is a strong sense of interconnectedness. In gaining a greater understanding of the resilience of this community and its ability to survive the social, cultural, economic, and historical assaults on its identity and integrity; and in exploring the values and principles that have

held this particular community together; we can begin to develop a more comprehensive, broad-based model of primary health care that will meet the needs of those most vulnerable in our society.

Rather than begin with a disease focus and an individual focus, we need to move to a focus on building communities through strengthening their identity, building their capacity to enable good health, and focusing more on issues of equity and social justice. The outcome will be *oranga Māori*: a secure identity, a strong community, and increased well-being at both the individual and community level. We need to develop an integrated, comprehensive strategy to build healthy communities at all levels, from flax-root community to the Nation. Nurses working within a primary health care context must be advocates for communities in order to achieve a just and equitable distribution of resources.

The strategies to achieve this goal have been developed from the current research and are based within a positive Māori development framework. This research has highlighted the need for a greater understanding of Māori domains and a greater focus on capacity building and community building. It also highlights the need to develop models of practice that focus on intersectoral cooperation and which are relevant to community needs as opposed to professional agendas. Nursing must develop an advocacy role that demonstrates a greater concern and understanding of the issues around social justice. We must also enable the transfer of power and knowledge through an understanding of the effectiveness, efficiency, and affordability of a strong community development focus.

Māori face overwhelming obstacles to achieving their health potential. Nursing cannot afford to focus too long on attempts to develop definitions. The social significance of nursing practice will be determined by our ability to meet the demands of Māori and to develop mid-range theories that describe, explain, and predict health in ways that allow not only for being healthy but also for becoming healthy. There is an urgent need to move nursing education and practice into places where people live; then we will increasingly create contexts for scholarship that will be grounded in the real experiences of people. We will be challenged to shed assumptions of our own relative privileged position and we will begin to hear the real experiences of people who have taken every step they know to protect themselves, yet still become 'victims. From a position of being part of the community, we will be better able to investigate the real conditions of

poverty, unemployment, and sickness and other threats to well-being. Then we will begin to create theories that rest on different assumptions from our own relatively privileged position.

Conclusions

This framework gives direction to the existing model of primary health care nursing. If PHC nursing were to take direction from this framework we would see a number of shifts. Clearly the framework does not suggest that the current model is fundamentally flawed; neither is wholesale change required. It is the implementation of the model that requires substantive modification.

The strategies outlined above and the practice implications discussed will require a major commitment from nursing to ensure that our models of practice will advance Positive Māori Development. Two conclusions can be drawn from this research. First, there is no simple or mechanistic explanation of Māori health status. Health is a product of social, cultural, and economic factors interacting in very complex ways that have evolved over time. Secondly, in order to achieve health gains for Māori, models of practice must be congruent with Māori understandings. Health cannot be separated out from Māori women's lives, nor for that matter can Māori lives be separated from the diversity of experience that constitute modern living.

Māori health requires whānau, hapū, and whole Māori communities to take control of their own futures and to do so in a way that strengthens identity and builds on community capacity. Health is a collective challenge. Nursing can make a difference but only in so far as we can develop services that incorporate Māori cultural norms and are delivered in a way that is acceptable to Māori.

Workforce

Work force development is a critical issue not only for nursing but for Māori in particular. This needs to be addressed if we are to improve health gains for Māori and the population in general. Two recent Ministerial documents, the Ministerial taskforce on Nursing and the National Health Committee reports on primary health care, set out clear guidelines for workforce development and contain specific recommendations for Māori (Carryer, 2001; Ministry of Health, 1998b; National Health Committee, 2000). This research supports the recommendations and further development of specific

programmes in post-graduate education that will be directed by evidence-based practice and assume responsibility and accountability for maximising patient benefits. There is the potential for the model developed in this research to be used as an integral element of a broader curriculum in order to facilitate common understandings, a consistent approach, and clarity of understanding surrounding Māori Primary Health Care.

Research

The establishment of a number of Māori health research units has seen a burgeoning of Māori health research and researchers and this bodes well for the future. Nonetheless, there is a need for a more comprehensive, consistent, and coordinated approach to Māori primary health care research. This framework is potentially a foundation for broader Māori primary care research programmes, specifically in nursing. The model will require research on a number of levels: theoretical and methodological development as well as applied research. There is also the urgent need for more indepth analysis of the concepts and principles as outlined in the framework.

Understanding the positive experiences of Māori health will help health practitioners to understand the difficult and sometimes painful experiences that Māori encounter in the mainstream health services. This work is unique in that the women's experience has not focused solely on the negative but has outlined those concepts that are key in achieving a sense of well-being for this group of women. Further, it is unique in that it is representative of one specific community of Māori women. While the abstractions of their experience may hold credibility for other Māori women, the work is not a definitive position. Rather, it is a starting point from which to understand the dynamics of Māori health. Finally the model is unique in that it contributes to the body of knowledge on Māori women's health and outlines strategies for nurses working towards development of models of practice that will meet the needs of diverse Māori communities.

Appendix one

Reflections of a Māori researcher

Māori health research as a distinct entity has been influenced by a number of developments over the last fifteen years. Influences have included the worldwide move by indigenous peoples towards self-determination, the reaffirmed commitment by the New Zealand Government to the Treaty of Waitangi, and the increased recognition that Māori worldviews and Māori understandings of knowledge are themselves distinctive (Durie 1995). For the purposes of this study, however, I would like to focus on a more immediate level and discuss issues pertaining directly to my own development as an emerging Māori health researcher. Therefore, I shall start with the issue of funding and development of Māori health research and then proceed onto Māori frameworks for carrying out research.

The Health Research Council Act 1990, the purpose of which was the improvement of human health by promoting and funding health research, enabled the establishment of the Health Research Council of New Zealand (HRC) (Durie 1995). This body was required to appoint members to a Māori Health Committee which allowed for a degree of representation and influence over the funding of health research in Aotearoa. Subsequently, two Māori Health Research Units (Ngā Manawa Hauora) were established in 1993. These units played a key role in terms of developing ideas and discussion about kaupapa Māori research, but they also provided a valuable training ground for emerging Māori researchers.

In 1995, policy guidelines for the Health Research Council (Shipley, 1995) made clear the obligations expected of the HRC with regard to "the special needs of Māori". Māori needs and perspectives were to be integral criteria when considering the purchasing and provision of health research and further development and maintenance of the Māori health research community was to be given particular attention.

This commitment has provided continued funding for both Māori health research units, albeit tenuous, and has also ensured funding of other Māori individuals and groups engaged in Māori health research in a diverse range of settings. I do not propose that funding and development of Māori health research is without problems or at a point of strength. Durie (1995) points to the lack of recognition and status given to the Māori Committee of the HRC when compared with the Biomedical Research or Public Health Research committees. More recently discussion by Māori health researchers at the HRC Women's Research Hui, held in Auckland in November 1998, highlighted continuing issues that need addressing if we are to advance the purchasing and provision of Māori health research.

However problematic the issues are at a wider level, at a personal level I have benefited greatly by the support of the Health Research Council of New Zealand and the support of Te Pūmanawa Hauora. Financial assistance given by the Council has enabled me to complete this Doctoral study. Support from Te Pūmanawa Hauora has enabled valuable discussion about Māori ways of working in research and provided opportunities for support and guidance.

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MASSEY UNIVERSITY DEPARTMENT OF NURSING STUDIES

Information Sheet

Project Title

An Ethnographic Study of Maori Women's Health Beliefs and Practices on a Rural Marae.

Researcher

Maureen Holdaway. Phone Hm 3433052: Wk 3453009 .
PhD student, Massey University.

As part of my work towards a university nursing degree, I am undertaking a study of the health beliefs and practices of Maori women on a rural marae. At this stage I would like to thank my whanau for their support and encouragement so far, and for allowing me to undertake the study on our marae.

The purpose of the study is two-fold. Firstly to gain an indepth understanding of the health beliefs and practices of Maori women on a rural marae: and secondly to develop a data base for the marae and local iwi, on Maori women's health beliefs and practices so that women can actively participate in the formation of iwi health care planning to ensure women's health needs are addressed.

Participation in this project would mean that I will come to the marae, several times over the next 6 months, to talk with you about your health beliefs and practices. With your permission I would like to use a tape recorder so that I can accurately record what we say. You will be able to ask for the tape to be turned off at any stage if you wish. These tapes will later be transcribed.

If you decide to participate in this study anything you tell me will be kept in confidence. Your name or any other identifying details will not be used in the research report, and the results will be available to you.

The researcher will also ensure that the participants' cultural values will be respected and protected at all stages of the research.

If you have any question now or at any stage during the study I will be happy to answer them.

Maureen Holdaway
PhD Student
Nursing Studies Department
Massey University

CONSENT FORM

As a participant in this research your cultural values will be respected and protected at all times. The information you share will be confidential, and you will not be identifiable in any written documentation. You will be free to withdraw at any time and all material relating to you, including audiotapes will be either erased or returned to you.

Declaration

I have read the attached information sheet and have had the nature of the proposed research fully explained to me. I understand that as a participant in this research I will not be able to be identified in written material and that my right to privacy and my cultural values will be respected at all times. I also understand that I can discontinue my participation at any time and if I do so all material relating to me, be it written or taped, will be erased or returned to me.

Date _____

Signed _____
(Participant)

Date _____

Signed _____
(Researcher)