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TINO RANGATIRATANGA IN HEALTH POLICIES AND PRACTISES

A Kaupapa Māori analysis of the 1996 National Cervical
Screening Programme's Policy document
– the years 1990 to 2000

A thesis
submitted in partial fulfillment
of the requirements for the degree
of
Doctor of Philosophy
at
The University of Waikato
By

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The University of Waikato
2010

WHA KARAPOTOTO

Abstract

The purpose of my doctoral research was to investigate tino rangatiratanga in health policies and practises in Aotearoa. My research involved defining tino rangatiratanga and exploring the expression of tino rangatiratanga in health policy and practises. A kaupapa Māori analysis of the 1996 National Cervical Screening Programme's Policy document was at the core of the policy investigation. The analysis involved developing a kaupapa Māori analysing framework and then analysing the 1996 National Cervical Screening Policy document for empirical and normative judgements at four discursive levels, health gains, health objectives, health goals and fundamental underlying values. A Kaupapa Māori research design drew on interdisciplinary scholarship on colonisation, Te Tiriti o Waitangi, community psychology, public policy, disability theory, feminist theory and discourse theory.

I argue that the dominance of Western cultural norms and state-directed policies were made possible by the signing of Te Tiriti o Waitangi. The signing of Te Tiriti saw Crown sovereignty being implemented and tino rangatiratanga ignored. The consequences for Māori have been disastrous with loss of land and economic base which has resulted in poor health status. I also argue that tino rangatiratanga has the potential to transform the social and political context that frame Aotearoa society. Such an approach raises a critical dilemma for the state as meaningful recognition of tino rangatiratanga requires waiving full and absolute sovereignty which currently resides in the state. Hence some scholars argue that tino rangatiratanga is a site for constructive engagement where state and Māori relationships can be renegotiated. The extent to which this potential for constructive engagement is being realised in however is inadequately explored in the scholarly literature. Exploring the relationships between tino rangatiratanga and health policies and practises as undertaken in my thesis will therefore contribute to scholarly knowledge on the subject.

The findings from the research show that tino rangatiratanga is indeed a complex, fluid, multi-faceted and context related concept. Within the context of my research, tino rangatiratanga is defined as Māori sovereignty, self determination, and positive Māori development. As a Māori value it is about mana and tapu of rangatira or leadership personified. Within policies, tino rangatiratanga has emerged through resistance and demonstration and is actualised through Tiriti legislation and policies.

The legitimisation of tino rangatiratanga in cervical screening services sees Māori leadership at national, regional and local levels and Māori involvement through wide ranging consultation but the Crown still controls the policy process and therefore the outcomes. Most cervical screening services are still owned and operated by the Crown or Crown agencies.

One of the consequences of Crown control is that Māori women are still twice as likely to get cervical cancer and four times more likely to die from it. To some degree this may be the result of resource allocation and the result of

discriminatory service practices but also the result of resistance to the procedure itself.

Tino rangatiratanga within cervical screening services could be strengthened through iwi ownership of some cervical screening register sites. At the time of my field work (2000) there were 14 sites, all owned and operated by Crown agents. Tino rangatiratanga could also be strengthened through funding criteria that ensure practitioners are safe to practise, through the adoption of less invasive procedures and through the legitimisation of Māori healing practises such as rongoā and karakia.

Overall if tino rangatiratanga is to be given full effect within the policy domain Māori must have a well established asset base, they must be in control of the decision making making process including resource allocation, service delivery must address the diversities of Māori realities and Māori must be the recipients of policy decisions made.

HE KUPU WHAKATAU

Preface

The spirit of the thing given.

The taonga and all things termed strictly personal possess a hau, a spiritual power. You give me one of them, and I pass it on to a third party; he gives another to me in return because he is compelled to do so by the hau my present possesses. I, for my part, am obliged to give you that thing because I must return to you what is in reality the effect of the hau of your taonga.

For within Māori law, the legal tie, a tie occurring through things, is one between souls, because the thing itself possesses a soul, is of the soul. Hence it follows to make a gift of something to some one is to make a gift of part of oneself, ones soul (Maus, 1954, p. 25).

The contents of this thesis represent the hau of many spirits.

MANAKOHANGA

Acknowledgements

To my supervisors Dr Neville Robertson, Professor Russell Bishop, Dr Chris Ruka, Dr Priya Kurian and to Professor Jane Ritchie who oversaw the completion of the thesis.

To my research whānau including the participants and those people who were generous with their time and resources.

My extended whānau Linda Wilkinson, Sonya McNeil, Celia Smith and John Wihōngī and my sons Hoani and Ra.

Finally to those organisations who funded the various stages of this study, Te Runanga o Ngati Porou, Manaaki Tauiira, The Māori Education Foundation, The University of Waikato, the Health Research Council and Nga Pai o te Maramatanga.

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HE KUPU HOU

Glossary of Māori words

ahi ka	people who remain in their tribal areas; occupation rights
ake	up; self
ako Māori	culturally preferred pedagogy
Aotearoa	New Zealand
Ariki rangatira	paramount chief or chieftainess
Aroha	love
aroha ki te tangata	love of the people
Atua	God
awa	river
haere	go
haere mai	welcome, come here
haere tonu	keep going
hapū	a collection of whānau
harakeke	flax leaf
harirū	shaking hands
hau	wind, essence
hauora	health in the group context
Haumia-tiketike	God of wild and uncultivated food
he	a, an. Some
hihiri	long for, eagerly desire
hikoi	walk
hinengaro	mental, emotional
hōngī	greeting, press noses
hui	gathering, meeting
i	by, from, with (used to indicate object of a verb)
Io	the supreme god
ika	fish, victim
iwi	a collection of hapū who originate from the same ancestor, sovereign nations
kai	food
kaimahi	workers
kainga	home; village

kaitiaki	knowledge holders, custodian of taonga
kaitiakitanga	the duty and role of the custodian
kanohi ki te kanohi	face to face
karakia	prayer
karanga	to call
katoa	all, every
kaumātua	elder
kaupapa	philosophy, collective vision
kaupapa Māori	Māori philosophy
kawa	ceremonial, to carry out a ceremony
kawakawa	native plant
kāwanatanga	governorship
kia piki ake i nga raruraru o te kainga	mediation of socio-economic and home difficulties
koha	gift
kohekohe	a native tree
Kohuiarau	Māori political movement initially made up of seven main tribes
kore	not (will not)
koroua	elder - male
kotahitanga	unity, solidarity
koutou	you (more than two)
kuia	elder – female
kune	to grow
kupapa	Māori who sell out to Pākehā
kupu	word
kura	school
mahara	to think about; consider
mana	power
mana Atua	power of the gods
manaaki, manaakitanga	caring, hospitality, mutual elevation of mana in the research process
manako	long for; set one's heart on
manuhiri	visitors
Māori	first nations people of Aotearoa
marae	Māori meeting house and its grounds
mātārīki	pleiades stars, breeze from the North East

matatau	know, understand
mātauranga	knowledge
matua	parent
maunga	mountain
mauri	life force
mauriora	inner well being
mihi, mihihi	greeting or farewell, formal speech
mo	for; about
moana	sea
mokopuna	grandchild, either male or female
mōteatea	traditional chant
motuhake	independent, separate, special, absolute
na	there (by the speaker)
nei	indicates connection to the speaker
nga hau e wha	the four winds, north, east, south and west.
nga Manukura	leadership, chiefs in council
nga matatini Māori	diverse Māori realities
nga pou mana	Māori model of health
Nga Tama Toa	a group of Māori who protested against the dominance of Pākehā oppression, young warriors
no	of; belonging to
noa	to make useable again; cleanse from the spiritual
oku	my, mine (plural)
oranga	well being at an individual level
pa	Māori villages sites
pai	good
Pākehā	person of non-Māori descent
pakeke	adult
papa	father
Papatūānuku	earth mother
po marie	good night
poroporoaki	farewell process
powhiri	traditional welcome
pua	to bloom
puawai	to bloom; come to fruition
puhaehae	envious, envy

pupuke	well up; rise
purotu	be pleasant, agreeable, beautiful
pūtea	money, funding
ra	day, by way of, date, sun, over there
rakiraki	duck
rangatahi	youth
rangatira	chief
rangatiratanga	chiefly, leader, relative autonomy
rangi	sky, heaven
Ranginui	sky father
rapaki	girdle, sash
raro	under, bottom, below
raruraru	trouble
Rātana	religious sect
rātou	they, them (three or more)
reira	there; then; already mentioned
rongoā	herbal medicine
Rongamatane	God of cultivated foods
take	issues, concern, agenda item
tama	son
Tangaroa	God of the sea
Tane Mahuta	God of forests and birds
tangata	people, person
tangata whenua	original people of the land living in the area
tangi	to weep, mourn
taonga	treasure, property
taonga tōkū iho	treasures handed down from our ancestors
tapu	sacred, divine; principles under which Māori live
tautoko	to support
Taumatauenga	God of war
Tauwhiri-matea	God of air, winds, storms
te	the
te ao	the world
te ao hou	the new world
te ao hurihuri	a revolving world of never ending changes
te iwi Morehu	survivors

Te Ka Awatea	Coming of the dawn – National New Zealand First Government
te mana whakahaere	autonomy
te māramatanga o Ihowā	knowledge of the Creator
tēnā koe	greetings to you
tēnei	this
te pae mahutonga	the Southern cross, a Māori model of health
te reo	the Māori language
Te Tiriti o Waitangi	Williams version of the Treaty of Waitangi
Te Whaia Te Ora Iwi	1993 National Governments Māori Health policies
te whare tapa wha	a contemporary Māori model of health
te whare o te tangata	the house of the people
te whare tangata	the reproductive aspect of the female body
te wheke	the octopus, a Māori module of health
Te Whiti	Māori prophet who practised passive resistance during the 19 th Century
teina	younger sister of a sister or younger brother of a brother
tikanga	Māori values and beliefs
tohunga	an expert in identified fields, for example a tohunga in the health field would be an expert in the healing practises of the Māori.
toiora	healthy life styles
tōkū	my, mine (singular)
tu	stand
tuakana	older sister of a sister or older brother of a brother
tuna	eel
tupuna	ancestor
tūrangawaewae	ancestral land; rightful standing place
ukaipo	mother whose breasts nourished the babe in the night/the breasts of the mother
utu	reciprocity, maintaining balance and harmony, vengeance, payment
wahine, wāhine	woman, women
waka	canoe
waiata	singing, song
waiora	well being
wairua, wairuatanga	spirit; spirituality

wananga	to meet and discuss; a place of learning
whaea	aunty, mother
whakapāpa	genealogy
whakatau	intently; pause
whānau	family, extended family
whānau ngatanga	relationships between extended whānau, interconnectedness
whangai	adoption, adopted child
whare	house
whare nui	sleeping house
whare wananga	house of learning
whenua/wenua	land

Chapter One

TIMATATANGA

Introduction

He ika kai ake i raro, he rapaki ake i raro (as a fish nibbles from below, so an ascent begins from the bottom)

Interpretation: - development of a skill requires much practise. The successful completion of an important project depends on planning and the necessary groundwork.

With the arrival of Pākehā in Aotearoa, Māori health has gone from one of the best in the world to one of the worst (Milroy & Mikaere, 1994, p. 5). Although some progress has been made toward improving the situation, Māori still lag behind Pākehā and the gap between Māori and other New Zealanders has widened (Te Puni Kokiri, 2000; Waitangi Consultancy Group, n. d.).

Until the early 1980s, the poor state of Māori health was largely attributed to a biological susceptibility to disease, and unhealthy and unhygienic living conditions (Durie, 1998b; Valencia, 1997). These understandings came from a scientific, individualistic, bio-medical understanding of disease. Since the 1960s, with the emergence of a global resistance to the dominance of Western ideologies, a paradigm shift has occurred. It is now generally recognised that causes of ill health are multifaceted and influenced by a wide range of health determinants, such as socio-economic, cultural, political and environmental factors (Durie, 1998b; Heller, Price, Reinharz, Riger, & Wandersman, 1984; Ministry of Health, 2002; National Health Committee, 1998). Indeed many scholars argue the inadequate state of Māori health can be attributed to colonisation and the influence of Western cultural norms (Awatere, 1984; Durie, 1998b). Durie, for example, argues that the ‘medical interest in physical disease greatly outweighed an interest in the person as a whole within a sociological and ecological environment’ (Durie, 1998b, p. 69). Western cultural norms and state-directed policies resulted not only in the capture of resources from Māori but also in sustained efforts to integrate and assimilate Māori into the cultural

norms of the Pākehā (Fleras & Spoonley, 1999). Despite the significant scholarly attention to a wide range of issues underpinning the poor state of Māori health (Broadbent, Kunowski, & Worrall, 1988; Durie, 1994c; Dyll, 1997; Lange, 1999) there has been little or no focus on the implications of the pivotal concept of tino rangatiratanga in policies and the implications in practise, in cervical screening services. My research seeks to address this gap in scholarship. Kaupapa Māori theory will underpin the study.

Kaupapa Māori theory

Kaupapa Māori theory is a growing body of knowledge that normalises Māori realities both traditionally and in contemporary settings. Within the context of this thesis, kaupapa Māori theory is about power. Kaupapa Māori theorists have drawn on the work of a number of international theorists to articulate power and power dynamics within kaupapa Māori theories. Foucault and Said are two such theorists. Foucault, a post-structuralist, uses discourse theory to deconstruct discourses or disciplines to demonstrate how power acts to give agency to some groups but not to others (Foucault, 1972, 1977). Said, a post-colonialist drawing on the work of Foucault and Gramsci provides an analysis of power that postulates why some discourses are more powerful than others (Gramsci, 1992; Said, 1979). Said in his work challenges imperialism (colonisation) and racism. While drawing on post-structuralism and post-colonial theory to demonstrate power relations, Māori in Aotearoa have unique ontologies and epistemologies that acknowledge tikanga Māori and give agency to the diversity of Māori realities. Within this is the acknowledgment that power is more than just dominant discourses it is also about the power of the gods that is personified in Māori leadership or tino rangatiratanga.

Tino rangatiratanga

Tino rangatiratanga is a complex, fluid, and context related concept. In some cases it is recognised as iwitanga, in others as Māori sovereignty, yet in other instances as a made up word that is no longer relevant (Awatere, 1984; Christie, 1997). For those who believed tino rangatiratanga is still relevant, debates arose around who was entitled to tino rangatiratanga status, how relevant tino rangatiratanga was to Māori who lived outside their tribal boundaries and how relevant it was to those who did not identify iwi connections. Other scholars argue that the significance of tino rangatiratanga is such that it has the potential to transform the social and political contexts that frame New Zealand society (Fleras & Spoonley, 1999).

Historically tino rangatiratanga referred to the absolute mana and tapu of rangatira. Such a concept was reflected in He Whakaputanga o te Rangatiratanga o Nu Tirene and again in Article II of Te Tiriti o Waitangi. Through He Whakaputanga o te Rangatiratanga o Nu Tirene Māori sovereignty was recognised throughout the world. While Māori sovereignty was reiterated in the William's version of the Treaty and the role of the Queen was to govern, this was not the case in the Hobson's version. Hobson's version talked about British sovereignty over all of Aotearoa (Article I) while Article II states that Māori would retain:

the full exclusive and undisturbed possession of the lands and estates, forests, fisheries and other properties which they may individually or collectively possess, so long as they wish and desire...

Such an understanding was a far cry from Māori sovereignty. The differences between the two versions of the Treaty have created tensions between Māori and Pākehā through to the present day.

Tino rangatiratanga became the catch cry for Māori resistance in the late 1960's. Young, educated, often well travelled Māori argued that the Treaty was a sham and began to demonstrate against the disparities that existed between Māori and Pākehā in

state owned institutions such as the education department, justice and health. They called for the Crown to honour its responsibilities.

The Treaty raises a critical dilemma for the state as meaningful recognition of tino rangatiratanga requires waiving full and absolute sovereignty which currently resides in the state. Hence some scholars argue that tino rangatiratanga is a site for constructive engagement where state and Māori relationships can be renegotiated (Fleras & Spoonley, 1999). The extent to which this potential for constructive engagement is being realised in practise, however, is inadequately explored in the scholarly literature. Exploring the relationship between tino rangatiratanga, health policies and health practises as undertaken in this thesis contributes to scholarly knowledge on the subject.

Public policies

Public policies are those policies that are largely responsible for the distribution of public resources (Fischer, 1995; Kingdon, 1995; Lasswell, 1936; Stone, 1997). A wide range of definitions exist. For example, Fischer defines public policies as ‘political agreement on a course of action (or inaction) designed to resolve or mitigate problems on the political agenda – economic, social, environmental and so on’ (Fischer, 1995, p. 2). Shore and Wright argue that policies are political tools used by Governments ‘to regulate a population from the top down, through rewards and sanctions’ (Shore & Wright, 1997, p. 5). Dye suggests it is ‘Anything a government chooses to do or not to do’ (Dye, 1972, p. 2). Anderson suggests policies are ‘a purposive course of action by an actor or a set of actors in dealing with a problem or matter of concern (Anderson, 1984, p. 3). Discursively policies are viewed as sites of struggle over ideas and their meaning (Fischer, 1995, 2003; Stone, 1997).

As such, policymaking is a constant discursive struggle over the definitions of problems, the boundaries of categories used to define them, the criteria for their classification and assessment, and the meanings of ideals that guide particular actions (Fischer, 2003, p. 61)

Within the context of the current study, policies are generally treated as discursive texts through which governments maintain control over society. Within Aotearoa, during early colonisation, policies that advanced capitalism were hegemonic. Since the introduction of a neo-liberal state, hegemonic policies are those policies that advance neo-liberal economics (Mills, 1997; Robinson, 1998). The primary purpose of colonisation was the acquisition of land and expansion of Britain as a nation. The legislation and policies developed once the Tiriti was signed were about acquisition and assimilation. For example, the 1841 Lands Claims Ordinance gave statutory recognition to a Crown right of pre-emption, at the expense of any Māori right of rangatiratanga. The 1862 Native Land Act legalised the breakdown of Māori communal ownership of land, and the 1865 Native Land Courts through the courts alienated 10 million acres of Māori land and continued the breakdown of Māori communal land ownership (Durie, 1998a; Gilling & O'Malley, 2000; Nga Tangata Cosmos, n.d.). Such policies advanced colonisation while creating major health problems for Māori, whose ideas of health were intricately linked to the land. Having an understanding of discourse and hegemony provides an understanding of how the colonisation process contributed to the state of Māori health today.

Health policies

The current study explores and analyses the way in which the dynamics of tino rangatiratanga play out in health policies and practises in Aotearoa, with specific focus on the cervical screening programme. Health policies have been defined as:

...statement[s] of the targets that have been selected: in the maintenance, protection and improvement of health, the reduction of susceptibility to disease and of its occurrence, the treatment of diseases and disability... (Sayers, 1992, p. 22).

Within the Aotearoa health system health policies have been defined as:

...a systematic course of action undertaken by government agencies that not only affect the formal institutions of the health care system but that also has an added influence more broadly on the health of the community (Davis & Ashton, 2001, p. 4).

Neither of these definitions acknowledges the influence of underlying conflicting ideologies on the development of health policies. For example, health policies in Aotearoa predominantly reflect the underlying bio-medical discourse of the dominant Pākehā culture. The bio-medical discourse became the norm through a process of production and reproduction. For example, the bio-medical discourse was brought in with the missionaries and once doctors arrived the discourse was reinforced. The bio-medical model was legitimated within the health sector and across other sectors such as schools and churches until it became accepted as the norm. While bio-medical models were being produced and reproduced in early settler nations, Māori health discourses existed as resistance. Marginalisation involved the de-construction of Māori realities and the construction of Pākehā realities. Legitimising the bio-medical model of health saw the allocation of health resources going to doctors, hospitals and other Pākehā institutions and service providers. Although contested, such practises continue into the present day.

As public policies, health policies determine who gets health services, what these health services are, when they will be provided and who will provide them (Davis & Ashton, 2001; Kelsey, 1998). While this seems simple enough, in practise health policies involve a complex array of values and beliefs, stakeholder groups, and political agendas vying for acknowledgement and legitimisation (Davis, 2001; Fischer, 1995; Shore, 1997; Stone, 1997). Reflected in the policies of those countries colonised by Great Britain are patriarchal, capitalistic, sexist, and racist cultural values and beliefs (Awatere, 1984; Bassnett & Trivedi, 1999; Pandey, 1999; Pearson, 1990; Spoonley, 1990; Trivedi & Mukherjee, 1996). The influence of these discourses in policies and practises in Aotearoa contributed to the marginalisation and alienation of Māori (Bishop, 1994; Cheyne, 2000; Durie, 1999a; Flera et al, 1999; Kelsey, 1998). With the resurgence of the Māori revitalisation movement in the 1960's and 1970's Māori asserted their tino rangatiratanga rights and argued that if health policies were to meet the needs of Māori they needed to be developed by Māori (Bishop, 1994; Cheyne, 2000; Durie, 1999a; Flera, 1999; Kelsey, 1998). The assertion of tino rangatiratanga in health policies provided space for Māori cultural practises in health services. However, there is little scholarly analysis about the shape

of tino rangatiratanga in policies and practise and the implication this has on Māori health. The current study seeks to explore these issues within the cervical screening context.

Health practises

Health policies are primarily implemented through health services. In Aotearoa most of these health services are owned, operated and managed by Pākehā. The literature suggests that these services create barrier to access for Māori (Ratima, Durie, Allan, Morrison, Gillies, & Waldon, 1995; Rua, Faull, Parata, Haereroa, Ansley, & Wihongi, 1998; Wihongi, 1998). The barriers created by the bio-medical discourse include fragmentation of services and practitioner bias or discrimination (Ajwani, Robson, Tobias, & Bonne, 2003; Durie, 1998b; Ratima et al., 1995). With the revitalisation movement in the late 1960s to 1970s Māori health discourses were legitimated and Kaupapa Māori services emerged as resistance. Yet what did this mean in practise?

To address this question, a case study of the cervical screening services is at the centre of the current study. The case study explores the discursive interactions between health policies and practises and how these impact on Māori. Cervical screening services are important because they address an area of concern for some women, in particular some Māori women. The cervix forms part of te whare o te tangata. Te whare o te tangata is important to Māori because it represents the place from which people are born and hence the continuation of a nation. One of the consequences of colonisation has been the deterioration of health for all Māori but Māori women are the most burdened (Ministry of Māori Development, 1993; Ministry of Women's Affairs, 2001; Northern Regional Health Authority, 1996; Pomare, Keefe-Ormsby, Ormsby, Pearce, Reid, Robson, & Watene-Haydon, 1995). This is partly reflected in the incidence of cervical cancer. Cervical cancer is the third most common form of cancer for Māori women (Pomare et al., 1995; Te Ropu Rangahau Hauora a Eru Pomare, 2006). Although there has been an improvement in the mortality and morbidity rates for all women in Aotearoa, Māori are still more than twice as likely as Pākehā to get cervical cancer and four times more likely to die from

it (Ministry of Health, 1999; Ratima, Durie, Potaka, & Ratima, 1993; Sadlier, Priest, Peters, Crengle, & Jackson, 2004). Māori women (46%) are also less likely than Pākehā women (73%) to have a smear (Whittaker, 1999b). To what extent can this be attributed to a lack of tino rangatiratanga in the development and implementation of cervical screening services rather than merely individual factors? The study explores this question through a Kaupapa Māori analysis of the 1996 National Cervical Screening Programmes Policy document, a survey questionnaire, whānau hui, and kanohi ki te kanohi discussions with women.

Context for the present study

When developing the current study I wanted to move away from a deficit approach to research, which seemed to dominate the health service sector, to one of competency. In a deficit approach the locus of control is with the individual. In this case the individual is viewed as being responsible for events that occur in his or her life and therefore he or she is responsible for making changes (Albee, 1980; Tyler, Brome, & Williams, 1991; Tyler, Pargament, & Gatz, 1983). A competency approach, on the other hand, acknowledges the influences of political systems and policies. The focus of change then includes the political systems and policies as well as the individual (Albee, 1980; Tyler, Brome, & Williams, 1991).

My passion for Māori health, tino rangatiratanga and health policies and practises comes from a combination of being Māori (Ngati Porou, Ngapuhi, Rongowhakata, Te Aitanga a Mahaki, Te Whānau a Apanui, Ngai Tahu) in a colonised country and over thirty years of work in the health sector, firstly as a nurse, and then as a researcher and policy analyst. During this period, I became involved in the Māori revitalisation movement and took part in such acts of reclamation as the Land March, Bastion Point and the Waitangi demonstrations of the 1970s. During this period I began to recognise the importance and influence of policies and also the importance of the Treaty as a focus for change. Added to this, a combination of racist practises in Pākehā health services and a sense of freedom when working in iwi settings saw me set out on a search for a discipline that would increase my skill base with respect to

research and policy analysis while advancing tikanga Māori. In 1985, I completed a Massey University paper in community psychology. During the course of the paper ‘a light went on’ and I thought ‘this is it’! The community psychology lecturer informed me that Waikato University was the only University in the country that provided community psychology training. I went through the process of seeking entry and in 1998 was accepted into the Post Graduate Diploma in Community Psychology. The training provided an opportunity for me to complete a post graduate study in community, organisational and iwi development, policy development and analysis, extend my research skills and provide me with the skills to contribute to the advancement of Māori health service in my iwi areas.

I have been actively involved in the development and inclusion of tino rangatiratanga in health services within my iwi areas and nationally. However, my specific thesis topic with its focus on health services to Māori evolved through consultation with academic advisors, whānau, hapū, iwi and kaimahi. Extensive consultation is important when research involves Māori. In my case, I recognised that Māori and iwi specific research was limited and funds scarce. Therefore, consultation with whānau, hapū and iwi was important if whānau, hapū and iwi rights and aspirations were to be addressed. Finally, the consultation process provided opportunities for me to address any concerns raised by whānau, hapū and iwi.

Thesis structure

Chapter One provides a brief introduction and context to my thesis making transparent the values and beliefs that underpin my research. Chapter One also introduces the whakapāpa of my thesis.

The purpose of Chapter Two seeks to define critical terms related to my thesis. Chapter Two begins by defining kaupapa Māori recognising that kaupapa Māori theory emerges from multiple ontological and epistemological positions and therefore multiple theoretical positions. Next, Chapter Two acknowledges that an underlying discourse within kaupapa Māori theory is one of power, political power, iwi power,

emancipation, transformative power, wāhine Māori, liberation, empowerment and tino rangatiratanga. I draw on the work of post structuralists such as Foucault and post colonialists such as Said to argue that kaupapa Māori theory provides a mechanism through which colonial power can be transformed within health policies and practises within Aotearoa. Finally, Chapter Two positions my thesis within a post-colonial kaupapa Māori framework in that it is strongly political and challenges colonisation.

In Chapter Three I propose that rangatiratanga is a traditional term that has been generalised to meet contemporary Māori realities and is strongly political. Like Flera and Spoonley I argue that in contemporary Aotearoa tino rangatiratanga is a contested site and a site of struggle over ideals. Within this is a range of definitions arise, from absolute Māori sovereignty to tino rangatiratanga as a non-entity. I also acknowledge the role of He Whakaputanga o te Rangatiratanga o Nu Tirene and Te Tiriti of Waitangi in the defining and re-defining tino rangatiratanga in contemporary Aotearoa concluding that in contemporary Aotearoa tino rangatiratanga provides a mechanism through which Māori and the State can seek to reach an understanding that restores Māori health status to at least the level of Pākehā.

Chapter Four provides an overview of the influence of policies particularly with reference to Māori. Policies determine who gets what, when, where and how (Lasswell, 1936). While policies determine who gets what, when, where and how, discourse theorists argue that the underlying values and beliefs of the policy makers influence how a policy will be defined, what solutions are generated and who will benefit (Anderson, 1997; Cheyne, O'Brien, & Belgrave, 2000; Davis & Ashton, 2001; Fischer, 1995; Kingdon, 1995; Stone, 1997). Within Chapter Four, I argue, that tino rangatiratanga is crucial to any policy debates in Aotearoa, regardless of whether the issue is a Māori issue or not. It is through the development and implementation of tino rangatiratanga policies that the disparities between Māori and other ethnicities will be addressed.

Chapter Five adopts a discursive approach to exploring Hauora Māori highlighting the tensions that exist between Hauora Māori and Hauora Pākehā. The influence of

colonial policies in the colonisation of Māori health is discussed from the periods 1840-1970 (Dow, 1999; Durie, 1998a; Lange, 2000). The revitalisation of Māori health discourses and State policies are explored within the context of the Māori revitalisation movements. Critical events are discussed, particularly legislative and policy events, which impacted on Māori health (Durie, 1994b; Durie, 1998a; Kirk, 1974; Royal Commission on Social Policy, 1988; Te Puni Kokiri, 2000). Chapter Five illustrates that tino rangatiratanga exists as resistance within the health sector and that tino rangatiratanga exists counter hegemonically to kawanatanga.

Chapter Six provides a theoretical and methodological explanation for the development of my thesis. I explore the development of Kaupapa Māori as the theoretical and methodological framework of choice, based on the writings of scholars of Kaupapa Māori, colonisation, Treaty of Waitangi, community psychology, public policy, disability theory, feminist theory and discourse analysis. In this, the disjuncture between Kaupapa Māori and positivist, scientific and individualistic philosophies are identified. The influences of ideology and dominant discourses are explored in the context of health policies and practises. The stages in the development of a Kaupapa Māori analytical framework are provided drawing on Fischer's practical deliberation framework (Fischer, 1995). Methodological choices and processes are presented and ethical statement provided.

Chapter Seven presents a definition of tino rangatiratanga from kaitiaki who work in the health sector. The analysis shows a complex range of tino rangatiratanga definitions and ways in which tino rangatiratanga exists within current policy and practises.

A Kaupapa Māori analysis of the 1996 National Cervical Screening Programmes policy document is at the core of Chapter Eight. The analysis draws on the Kaupapa Māori policy analysis framework developed in Chapter Six. A Kaupapa Māori policy analysis framework has tino rangatiratanga as its normative value. Consequently the analysis explores the document for tino rangatiratanga discourses as defined in Chapters Three and Seven. What the analysis demonstrates is that the 1996 National Cervical Screening Programmes Policy document is strongly influenced by a bio-

medical and epidemiological discourse. However, within the policy document is a tino rangatiratanga discourse.

Chapter Eight explores Māori women's tino rangatiratanga as it related to life in general and te whare o te tangata specifically. I propose that the imposition of acquisition and assimilation policies have led to a breakdown in Māori women's tino rangatiratanga and therefore health status. I argue that the assimilative legislation and policies not only marginalise Māori women because they are Māori but because they are Māori women. With respect to te whare o te tangata, Chapter Eight demonstrates that an inverse law exists for Māori women as they are more than twice as likely as non-Māori to get and die from cervical cancer but they are less likely to access services.

Chapter Nine provides a thematic analysis of whānau hui and the kanohi ki te kanohi discussion with participants. Four main themes emerged and are presented under the following headings: alienation and oppression, Kaupapa Māori, practitioner attitudes and gender, and opportunistic smear taking. The findings show some alarming facts that over all Māori women's experiences of cervical screen include extreme discrimination based on marital status, abortion history, sexual orientation and race.

Chapter Ten concludes the thesis by providing a synopsis of the study arguing that tino rangatiratanga exists counter hegemonically to kāwanatanga in the 1996 National Cervical Screening Programmes Policy document. Historically as well as today kawatanga results in Crown driven policies that in some cases marginalise and alienate Māori. The 1996 National Cervical Screening Programmes Policy document is no exception. While it is evident that the National Cervical Screening Programme takes their kawatanga responsibilities seriously by endeavouring to protect tino rangatiratanga it is a limited type protection. Dominant with the 1996 National Cervical Screening Programmes Policy document are bio-medical and epidemiological discourse and it is these services that receive most of the cervical screening budget to the detriment of Māori and women. The consequence for Māori is that although they get cervical cancer twice as often as other women and are four

times more to die from it they are less likely to access cervical screening services.
Chapter ten describes the finding in more detail.

Chapter Two

KAUPAPA MĀORI

Māori philosophises

Tawhiti rawa tou, haerenga ake te kore haere tonu

We have come too far not to go further, we have done too much not to do more (Sir James Henare, Nga Puhī)

Lewin, a social psychologist, stated that ‘there is nothing more practical as a good theory’ (Lewin, 1952, p. 169).

Theories set out to state what the basic assumptions are (Crotty, 1998; Davison & Neale, 1994; Patton, 1990). Like worldviews, theories determine the way in which we make sense of the world (Davison & Neale, 1994; Patton, 1990). Hence theories reflect the taken for granted underlying values and beliefs of the writer, researcher and or evaluator (Crotty, 1998; Davison & Neale, 1994; Patton, 1990). Like discourses, theories legitimate and validate some forms of knowledge while marginalising and alienating other knowledges. In this sense theories normalise. Like paradigms, theories determine what questions will or will not be asked, and also the range of possible methodologies and the range of possible solutions. Further in the case of feminist and kaupapa Māori theory, theories dictate who can do the research and under what conditions.

Within Aotearoa Western theories have had a more insidious purpose, that of defining and controlling the realities of indigenous cultures. Post-colonial theorists would argue that Western theories do this by ‘othering’ indigenous cultures by writing about Māori from a Western value base, in which portrayal of the indigene was often romanticized and sexualised (Said, 1979). Said argued such value bases were racist and imperial (Said, 1979).

In the process of colonisation theory was often used to justify the use of force and other acts of violence against indigenous cultures (Hiroa, 1958; Orange, 1989). For

example, by constructing Māori, theoretically, as savages, dumb and illiterate, the colonisers were able to justify the use of force and violence to acquire assets such as land. Through a process of socialisation the coloniser's values and beliefs were ingrained not only within the colonial society but through education into the indigenous cultures. The indigenous cultures then maintained the image and replicated it themselves.

Scott argued that:

We need theory that can analyze the working of patriarchy in all its manifestations – ideological, institutional, organisational, subjective – accounting not only for communities but for change over time. We need theory that will let us think in pluralities and diversities rather than of unities and universals. We need theory that will break the conceptual hold, at least, of those long traditions of (Western) philosophy that have systematically and repeatedly construed the world hierarchy in terms of masculine universals and feminine specificities. We need theory that will enable us to articulate ways of thinking about (and thus acting upon) gender without either simply reversing the old hierarchies or confirming them. And we need theory that will be useful and relevant for political practice (Scott, 1988, p. 33).

Similarly, Māori need theories that can analyse the workings of colonisation in all its manifestations. Māori need theories that make visible the relationship between Western philosophies and the impact these have had on Māori today. Māori need theories that transcend Western ways of knowing and makes visible Māori realities and the diversities of these realities (Bishop, 1994; Tuhiwai-Smith, 1999). Māori need theories that actualise tino rangatiratanga. Kaupapa Māori theories are such theories.

The purpose of Chapter Two is to explore the origins of Kaupapa Māori theories in an endeavour to provide a context for positioning tino rangatiratanga and health policies and practises within Aotearoa. The Chapter is divided into two sections. The first section, explores Kaupapa Māori theories and the second provides a summary of Chapter Two and introduces Chapter Three.

Kaupapa Māori theories

Patton argues that ‘qualitative inquiry is not a single thing with a singular subject matter’ (Patton, 1990, p. 65). Similarly, Kaupapa Māori theory is not a single theory with singular subjects (Pihama, 2001). Neither does it emerge from a single ontological or epistemological position.

Kaupapa Māori is multi faceted, plural, fluid, complex, context related, diverse and tribally bounded. The purpose of this section is to locate Kaupapa Māori theories within a traditional framework and explore the development of Kaupapa Māori theories as resistance in contemporary Aotearoa.

Traditional Origins of tino rangatiratanga

Kaupapa Māori theories are not new (Pihama, 2001). Kaupapa Māori theories have existed since mai ano. Traditional Kaupapa Māori theories were intricately linked to the spiritual realm. Māori oral histories show they believed they came from the gods and this was reinforced by their daily cultural practises. Hiroa refers to two main ontological cosmologies, common and secret:

...theories that concern the natural phenomena fall into two categories, that which is commonly known and given to the public by expert genealogists and a more select version said to be held by an inner circle of priests who considered it to sacred to be divulged to the common people (Hiroa, 1958, p. 433).

The commonly known cosmology involved the creation stories of Papatūānuku, and Rangi, and their children; Tangaroa, Rongomatane, Haumia-tiketike, Tane mahuta, Tawhiri-matea, and Tumatauenga. Unlike Christian cosmology the gods had both female and male energies (Hiroa, 1958, p. 438). It was through Papatūānuku that the first human was born (Mikaere, 1995).

The secret cosmology, which was recently made known, involved many more gods and talked of Io Matua and the twelve heavens. Io Matua had many attributes and Te Rangi Hiroa acknowledges six, Io Matua, the parent of all things, natural phenomena,

plants, animals, man and the gods; Io Matua Kore, who had no parents, who had nothing but himself; Io Matua Te Pukenga, the sources of thought, reflection, planning; Io Te Wananga, the source of all knowledge; Io Mata Ngaro, who is hidden and unseen; and Io Te Waiora, the sources and giver of life. Further Dr Rose Pere, one of the tohunga who held the secret knowledge, adds that Io matua was made of two essences, both female and male.

While there were two primary cosmological ontologies, common and secret, traditional Kaupapa Māori theories also included theories that were scientific. Two examples are theories relating to navigation and medicine.

Māori were recognised as great navigators using the knowledge of the stars to navigate the world (Best, 1972). Best commented:

He [Māori] studied and knew the movement of the stars, made use of them in navigation and time management. By his study of the heavenly bodies, he was enabled to become the foremost Neolithic navigator of the grey ages (Best, 1972, p. 64).

Best's writings reflect a certain colonial superiority toward Māori that was typical of his time (e.g. 'Māori beliefs concerning the heavenly bodies were very different from our own, and must be compared with those of other uncultured races' (1922, p. 1)) but he goes on to say that Māori knowledge of the heavenly bodies was in 'several instances a scientific one' (1922, p. 2).

Knowledge about Māori medicine is contestable. At times it is described as archaic and at other times ahead of its times (Hiroa, 1958). Hiroa cites examples of clearly scientific treatments for common ailments, heat for boils, incising, herbal remedies (Hiroa, 1958, p. 407). However, he also argues that herbal remedies were not really used until after colonisation. Yet others argue there is evidence to show that Western medicine utilised Māori medicinal knowledge to advance Western knowledge (Dr Chris Ruka, personal communication, March 2000).

Ontologically then Māori beliefs were based on theist cosmology and science. Epistemologically, mātauranga Māori or Māori knowledge has been referred to as

esoteric, cosmological, evolutionist and by the less informed as superstitious, ritualistic and barbaric. Best argues that:

His [Māori] mystic mothers prompted him to indulge in introspection, thought, to evolve abstraction, to conceive quality, spiritual potential and intelligence (Best, 1973, p. 7).

Traditionally Māori acknowledged six different levels of knowledge; te rapunga (seeking), te kukune (growth), te pupuke (swelling), te hihiri (energy), te mahara (thought), te hinengaro (mind), and te manako (longing). These ways of knowing were handed down from the Gods in kete of knowledge known as uruuru matua (the knowledge's of peace, goodness and love); uruuru rāngai (the knowledge's of prayers and incantations and ritual) and uruuru tau (the knowledge's of war, agriculture, woodwork, stone work, and earthwork) (Hiroa, 1958).

Epistemologists argue that there are differences between common sense knowledge and true knowledge. Common sense knowledge is that which is understood by social groups but is not knowledge that can be justified or tested. True knowledge is (a) a belief, (b) which can be justified, and (c) can be tested. True knowledge is what scientists are interested in. Knowing what is true knowledge and what is not true knowledge is argued to be imperative to our existence (Lehrer & Truncellito, 2004; Pullock & Cruz, 1999).

Tikanga Māori was justified through oral histories and whakapāpa (Nepe, 1991; Pihama, 2001). Similar to qualitative research tests for truth included; the acknowledged expertise of the speaker (ariki rangatira, rangatira, tohunga), whaikōrero and the agreement by iwi at hui a iwi, and many people with the same knowledge (Nepe, 1991; Pihama, 2001).

Mātauranga Māori was studied in two main schools the 'kura' and the 'whare' wānanga (Best, 1923; Hiroa, 1958). Kura wānanga was where common knowledge was learnt and whare wānanga was where higher knowledge was learnt. It was in kura and whare wānanga that mātauranga Māori was learnt. Also mātauranga was

learnt through socialisation and exposure to whakapāpa, whaikōrero, haka, waiata, harakeke, carvings and cultural practises.

Contemporary expressions of Kaupapa Māori theories drew on traditional knowledge as well as contemporary knowledge.

Contemporary expressions of tino rangatiratanga

Māori values and beliefs were in strong contrast to those of the dominant values of the colonisers, of capitalism, patriarchy and racism (Awatere, 1984; James & Saville-Smith, 1990; Mikaere, 1995). Through the process of colonisation Kaupapa Māori theories were marginalised in much the same way other cultural practises were.

With the signing of Te Tiriti o Waitangi (see Appendix 2) a concerted effort was made to assimilate Māori into the cultural norms of the Pākehā. To some degree this was because the colonisers believed that Māori were dying out and it was necessary to assimilate them before they totally disappeared (Dow, 1999; Durie, 1998b; Ngata, 1898). More likely though, coming from the age of Darwinism, they believed that they were superior and Māori were inferior and that Māori dying out was just a process of natural selection. Hence Kaupapa Māori theories might be understood to have become politicised at the signing of Te Tiriti. For what happened is that Article I of Hobson's version of Te Tiriti was implemented while Article II was ignored (Durie, 1998a; Kawharu, 1989).

Māori were not passive through this attempt at assimilation. Many rangatira objected and resisted through warfare, through passive resistance and through other political activities (Durie, 1998a; Walker, 1990)

In the 1960 there was a major resurgence of political activity, which saw Māori assert their Tiriti rights in many domains, housing, justice, education and health (discussed more fully in Chapter Four). Out of this grew what is now referred to as contemporary Kaupapa Māori theories.

While drawing on traditional tikanga Māori contemporary Kaupapa Māori theories are also overtly strongly political. Prillentsky, a community and critical psychologist, argues that politics is critical to well being and one role of the community psychologist is to act politically to address oppressions and empower and liberate those people who are most affected (Prilleltensky, 2008). Within Aotearoa those most affected are Māori, Pacific Peoples and those from lower socio-economic groups (Ajwani, Robson, Tobias, & Bonne, 2003; Te Puni Kokiri, 2000). For the purposes of my thesis I will be focusing on Māori. There is widely held belief amongst practitioners, both Māori and Pākehā, that if we get it right for Māori we will get it right for all people. The political nature of Kaupapa Māori theories is reflected in the way Kaupapa Māori theories challenge the dominance of tikanga Pākehā in societal domains of health, housing, education, and justice (Durie, 1998a; Durie, 1998b; Jackson, 1998). It is reflected in the way Kaupapa Māori theories claim Article II rights of Te Tiriti o Waitangi, te tino rangatiratanga (Bishop, 1994; Tuhiwai-Smith, 1999). It is reflected in Māori struggle and resistance to being assimilated or integrated into any society but theirs (Durie, 1998a; Tuhiwai-Smith, 1999). But are Kaupapa Māori theories legitimate?

There are theorist who argue that indigenous theories do not exist and that in some cases indigenous theories are just another agent of hegemony (Widdowson & Howard, 2008).

However, Lewin postulates:

The history of acceptance of new theories frequently shows the following steps: At first the new idea is treated as pure nonsense, not worth looking at. Then comes a time when a multitude of contradictory objections are raised, such as: the new theory is too fancy, or merely a new terminology; it is not fruitful, or simply wrong. Finally a state is reached when everyone seems to claim that he had always followed this theory. This usually marks the last state before general acceptance (Lewin, 1952, p. 43).

While drawing on discourse theory, post-colonial theory, and feminist theory Kaupapa Māori theories have a distinctness that is uniquely their own, that uniqueness is tino rangatiratanga and tikanga Māori. With a background of

colonisation and resistance, drawing on critical theorists such as Walker, Foucault, and Said Kaupapa Māori theories began to take on a shape of its own. Te Awekotuku states that:

Research is about the gathering of knowledge – more usually, not for its own sake, but for its use within a variety of different applications. It is about control, resource allocation, information and equity. It is about *power* (Te Awekotuku, 1991a, p. 13).

Similarly Kaupapa Māori theories is really about power, the power to define, the power to determine, the power to reclaim, the power to make decisions. Kaupapa Māori theories are about tino rangatiratanga. Bishop argues that:

...self-determination (tino rangatiratanga) as a major focus of Kaupapa Māori has seen the development of Māori initiative asserting the right of Māori people to reject this dominance [of Western values] and in education has promoted a series of Māori controlled educational institutions (Bishop, 1994, p. 176).

Tuhiwai-Smith and Reid argue that ‘tino rangatiratanga goes straight to the heart of Kaupapa Māori’ (Tuhiwai-Smith & Reid, 2000, p. 9). Smith argues tino rangatiratanga, or Māori control, is imperative to Kaupapa Māori theories and education (Smith, 1997, 2002). For Bishop the components of tino rangatiratanga include emancipation, empowerment, and reclamation. Like Bishop, Irwin postulates empowerment as part of Kaupapa Māori theories and also argues it is about liberation (Irwin, 1992b, p. 4). Tuhiwai Smith proposes a rangatiratanga principle that is about Māori control. For Pihama power is about ‘transformative power’. Transformative power is ‘to think and act in terms of Kaupapa Māori whilst experiencing colonisation is to resist dominance’ (Pihama, 2001, p. 81). Power and power relations are inherent in the writings of many freedom fighters from around the world.

Kaupapa Māori theorists align themselves with freedom fighters from around the world when they draw on the writings of critical theorists while maintaining a distinctness that is uniquely Māori.

Critical theory:

...presents an attitude of antagonism and critique in the face of the deeply problematic contemporary social formation. It sustains an effort to theorize the present as a moment between the past and the future, thus holding up a historicizing mirror to society, one that compels recognition of the transitory and fallible nature of society, one that insists that what is can be disassembled and improved considerably. Critical theory goes against the grain of legitimating process endemic to power formations, a discursive mechanism through which the fortitude of institutions is naturalized and universalised. Critical theory is a disruptive counterforce to the inscription on the face of social practices which says “Do not tamper with me for I am good, just and eternal” (Poster, 1989, p. 3).

Two critical theorists of distinction are Foucault and Said. Foucault, a post-structuralist and discourse theorist, proposes a power/knowledge formation called disciplinary power (Foucault, 1980). He argues that people with knowledge have power over those who do not. For example, those who have scientific knowledge have power over those who do not (Ball, 1990; Dreyfus & Rabinow, 1982; Foucault, 1980). Parker postulates that people who have psychological knowledge have power over those who do not (Parker, 1992). Kaupapa Māori theorists argue that those who have colonial knowledge have power over those that do not. Within certain settings, such as medical settings, only those with ‘the knowledge’ can speak. That is people with specialised medical knowledge have agency to speak, while those who do not cannot (Bishop, 1998; Foucault, 1980; Parker, 1992; Scott, 1988).

These power relations exist within discourses (sometimes referred to as disciplines). Discourses determine to a large degree what can be said and thought and by whom. They also determine when, where and with what authority knowledge can be spoken (Ball, 1990; Parker, 1992). It is through this process, discourses legitimate some forms of knowledge while marginalising others (Bishop & Glynn, 1999; Dreyfus & Rabinow, 1982; Foucault, 1980). For example, Western judicial knowledge is legitimated, by lawyers, in court rooms. Discourses exist within discursive settings, such as schools, hospitals, churches, and collude to produce and reproduce discourses that legitimate the dominant worldview (Doolin, 1997; Foucault, 1980; James &

Saville-Smith, 1990; Parker, 1992). Dominant discourses silence minority voices while legitimating dominant voices (Connell, 1987; Parker, 1992; Spender, 1982).

Of interest to my thesis is the notion that power exists in relation to resistance or struggle (Foucault, 1977; Dreyfus, 1982; Ball, 1990). While some discourses are dominant, they are constantly shifting and changing to make room for other discourses. For example, while scientific medical knowledge exists, Māori health discourses also exist. Hence, in the late 1960s, Māori health discourse began to re-emerge as resistance. Discourse theory thus provides explanations for the fluid nature of reality and the development of other ways of being.

Drawing on Foucault's work Said, another critical theorist postulates another form of power, that of hegemony. In his work on *Orientalism*, Said explored the relationship between discourse and hegemony (Said, 1979). Said drew on Gramsci's concept of hegemony to explain how some discourses become dominant (Gramsci, 1992). Hegemony occurs through a complex process of consensual domination or democracy (Bayoumi & Rubin, 2001; Robinson, 1998; Said, 1979). In this sense, hegemony is the process where one class or strata (dominant group) gains and maintains control over another class or strata (non-dominant), through active consent. The process involves:

...the internalisation on the part of [the non-dominant group] of the moral and cultural values, the codes of practical conduct, and the world view of the dominant...group... (Robinson, 1998, p. 21).

The worldviews of the dominant group are internalised as the social logic of the system of domination itself and 'acts as a cohesive force in social unification' (Robinson, 1998, p. 21).

Hegemony in the Gramscian sense then is:

...a social relation, which binds together a "bloc" of diverse classes and groups under circumstances of consensual domination, such that subordinate groups give their "spontaneous consent" to "the direction imposed on social life" by the dominant group (Robinson, 1998, p. 21).

Hegemony is not only used to gain and maintain control over the non-dominant groups, but also to maintain control within the dominant group itself. Hegemony works by promoting the beliefs and values (ideologies) of the dominant group as normal and secondly by blaming minority groups because they do not fit the 'normal' pattern (Pearson, 1990; Prilleltensky, 1994; Robinson, 1998). Said, as post-colonialist challenged both colonisation and racism. Colonisation will be discussed more fully in Chapters Three, Four, Five and Six but simply put colonisation is 'the control of a specific territory by a non-indigenous group through either limited or massive settlement' (Pearson, 1990, p. 28). Racism has been defined as prejudice plus power (Spoonley, 1990). Racism exists when a person or group views another person or group as inferior based on race alone and then has the power to discriminate (Jones, 1999; Ministerial Advisory Committee, 1988; Spoonley, 1990). Four forms of racism have been discussed by theorists: personally mediated, cultural, institutional and internalised. Personally mediated racism exists when someone has the power to discriminate at an individual level. It manifests as jokes about a person based on race and being treated badly by health professionals (Ministerial Advisory Committee, 1988).

Cultural racism exists when one group is disadvantaged and another advantaged as a result of the dominant group's beliefs and values (Ministerial Advisory Committee, 1988). Its most obvious form in Aotearoa is the assumption that Pākehā culture, lifestyle and values are superior to those of Māori. For example, within the context of the current study the belief that the bio-medical model of health is superior to the more holistic Māori health model. Cultural racism becomes institutionalised racism when the beliefs and values of the dominant culture become ingrained in policies and legislation and has severe consequences for the non-dominant group. Racism at this level plays out as 'differential access to the goods, services and opportunities of society based on race' (Jones, 1999: 15). The effects of institutional racism are seen as disparities which exist between housing and employment opportunities for Māori and Pākehā. It plays out as the disparities that exist between Māori and Pākehā health status. Finally there is internalised racism where the non-dominant culture accepts what the dominant culture says about them. Internalised racism manifests as

resignation, helplessness, and hopelessness. It also manifests as the non-dominant culture believing that the dominant group is superior to them and acting accordingly like valuing doctors and nurses from the dominant over those of the non-dominant culture. Internalised racism is a hegemonic process, where people become their own worst enemies (Prilleltensky, 1994; Robinson, 1998). Like critical theorists contemporary Kaupapa Māori theories challenge colonisation, capitalism, racism, and patriarchy.

In contemporary Aotearoa, the strongest challenge to colonisation came from Awatere. Awatere, a Māori clinical psychologist, wrote a series of articles for Broadsheet Magazine, which were later published in a book called Māori Sovereignty (Awatere, 1984). Within the book Awatere challenged colonisation and what she called white hatred.

Irwin challenges colonisation when she challenges the intrusion of tikanga Pākehā and colonial influence on who can speak on a Marae. For example, in her rendition of the debates surrounding speaking rights on the marae she argues that:

those ‘on the Pākehā side’ have been accused of trying to analyse Māori culture in Pākehā terms, in order to give the colonisation of our culture and people a twentieth century face, in the name of feminism and equality of rights. Those on ‘the Māori side’ claim that Pākehā ideas have been used to make observations and judgments about the Māori worlds with little or no attempt to reconcile the different epistemological bases of the two cultures (Irwin, 1992b, p. 8).

Within this debate were discussions about what is meant by ‘speaking’? Irwin argues that speaking is more than whaikōrero, it is about karanga, waiata and tangi ‘legitimate and highly valued Māori oral arts’ (Irwin, 1992b:12 -13). Such valued practises were not viewed as talking by Pākehā.

Further, in discussing the first Māori women to attend Oxford Irwin challenges the dominance of colonisation and patriarchy when she states:

From Makareti Papakura, the first Māori to study at Oxford University and the first Māori to write a book on Māori society – *Old Time Māori* – we learn what happens to women who reject the role that the world has reserved for them and who attain excellence (Irwin, 1992a, p. 79).

Makareti's work was 'relegated to obscurity' (Irwin, 1992a, p. 79). Such thinking was typical of patriarchy, where women were barely recognised let alone a Māori woman.

Within the health sector, like community psychologists in America, Kaupapa Māori theories challenge the dominance of Western medical models. Western medical models that were largely set up to service individuals are not able to fully provide for these individuals in a global economy that is less and less able to provide adequate health services for any one but the rich, neither can Western medical models adequately provide for collective societies, with their reductionalist and medical approach that views the person as a particular condition rather than as part of a whānau or other type of collective (Prilleltensky, 2008; Prilleltensky & Fox, 2007; Tuhiwai-Smith & Reid, 2000).

Within the health sector Kaupapa Māori theorists utilise quantitative data to provide a Kaupapa Māori analysis of medical data, such an analysis legitimates Māori realities within the text of the research. Reid refers to this as looking from a different mountain top (Dr Paparangi Reid, personal communication, June, 2005). Using quantitative methodologies Kaupapa Māori theorists identify issues of relevance to Māori and provide an analysis that highlights inequalities. Such an analysis provides alternative solutions to that proposed by Western analysis.

Research conducted by theorists such as Dr Paparangi Reid, Dr Sue Crengle, Dr Ricci Harris all utilise quantitative data and a Kaupapa Māori analysis to make their point. That is not to say that they reject critical theory or constructivism but they utilise the tools of positivism to support their Kaupapa Māori perspective.

For example, Grengle, Pink and Pitama study on respiratory disease used quantitative data to show Māori 's were 3.9-4.08 times more to be hospitalised for bronchiectasis in the years 2003-2005 (Robson & Harris, 2007).

Harwood and Tipene-Leach used quantitative data and Kaupapa Māori analysis to show in the years 2000-2004 Māori were 6.81-8.03 times more likely to die from diabetes related illness (Robson & Harris, 2007).

Dr Ricci Harris and colleagues used positivism to quantify racism in health practise demonstrating that self reported experiences of racism are linked to poorer health outcomes (Harris, Tobias, Jeffreys, Waldegrave, Karlsen, & Nazroo, 2006).

While a strong discourse within Kaupapa Māori theories is challenge and resistance there is also a strand of celebration. Irwin, a Māori feminist, argues 'we need to actively honour, to celebrate the contributions, and affirm the mana of Māori women' (Irwin, 1992b, p. 1). Celebrating being Māori and being Māori women highlights the progress made in reclaiming tikanga Māori.

What Kaupapa Māori theories does do is provide Māori solutions to oppressions and the dominance of Western discourses – they provide Kaupapa Māori solutions that include, reclamation, decolonisation processes and tino rangatiratanga.

Summary

Kaupapa Māori theories are multi-faceted, complex, fluid and situationally bound (Smith, 1992; Tuhiwai-Smith, 1999). Traditionally Kaupapa Māori theories were intricately bound in theist cosmology, as well as empiricism and positivism (astrology, navigation, natural sciences, medicine). While contemporary theorists might argue that Kaupapa Māori theories have out of necessity become political, in fact Kaupapa Māori theories have always been political (Tuhiwai-Smith, 1996). Māori have always asserted our right, if not with other iwi then certainly since early colonisation. While maintaining some of its traditional characteristics contemporary Kaupapa Māori theories like community psychology, has become more overtly

political, tino rangatiratanga being at its core. As such like post-colonialism, contemporary Kaupapa Māori theories challenge colonisation, capitalism and racism. Like feminism, Kaupapa Māori theories challenge patriarchy. Kaupapa Māori theorists seek to emancipate, liberate, empower and transformation. Kaupapa Māori theories seek to provide a space in which Māori realities are legitimated and Māori values normalised.

Chapter Three explores the multiplicities of tino rangatiratanga in more depth.

Chapter Three

TINO RANGATIRATANGA

Full and absolute chieftainship

...tino rangatiratanga is a site for constructive engagement where state and Māori relationships can be renegotiated (Fleras & Spoonley, 1999, p. 14).

Learned scholars and activists argue that tino rangatiratanga is a site for constructive engagement between Māori and the Crown (Durie, 1995b, 1998a; Fleras & Spoonley, 1999). While tino rangatiratanga is a traditional Māori value it came to the forefront of political activities during the 1960s Māori resistance movement. At this time Māori activists, academics and Pākehā allies, influenced by international resistance movements, argued that the Crown was remiss in implementing Te Tiriti and held the Crown to account. Demonstrations and other acts of resistance followed. As a result, legislation, policies and programmes were initiated to address the discrepancies between Māori and Pākehā in Aotearoa.

While debates about Te Tiriti raged across the nation integral to this were debates about the meaning of tino rangatiratanga which polarised the nation. At one end of the debate some argued tino rangatiratanga was total Māori control over all of Aotearoa (Durie, 1998a; Fleras & Spoonley, 1999; Kawharu, 1989; Orange, 1989). Such statements caused alarm and put fear into the hearts of some Pākehā. At the other end others argued that tino rangatiratanga was a non-entity and should be gotten rid of (Christie, 1997; Fleras & Spoonley, 1999; Graham, 1997). Emerging within the tino rangatiratanga debates is a discourse about tino rangatiratanga being a contested site and a site for constructive engagement between Māori and the state (Fleras & Spoonley, 1999). Constructive engagement between Māori and the Crown would require the Crown ceding its power and restoring tino rangatiratanga.

Restoring tino rangatiratanga could benefit all peoples of Aotearoa. For example, tino rangatiratanga would see environmental issues being taken seriously, local leadership, and an improvement in national relationships (Durie, 1998a; Fleras & Spoonley,

1999; Graham, 2000). Restoring tino rangatiratanga would threaten Crown dominance. Such a move is not something the Crown would take lightly.

Chapter Three discusses tino rangatiratanga definitions and its application in policy and practise. Section one provides a brief historical overview of the origins of tino rangatiratanga and the relevance of He Wakaputanga o te Rangatiratanga o Nu Tirene (The Declaration of Independence) (see Appendix 1) and Te Tiriti o Waitangi. Section two explores the complexity of contemporary definitions of tino rangatiratanga focusing on three discourses, Māori sovereignty, Māori self-determination and Māori positive development. The relevance of tino rangatiratanga in policy is the focus of section three. Section four discusses the practise of tino rangatiratanga and section five concludes the Chapter by summarising key points from Chapter Three and introducing the topic of Chapter Four, tino rangatiratanga in policies.

Historical overview

Tino and rangatiratanga is a traditional Māori value originating from the words tino which means absolute and rangatira which means chief (Williams, 1985). The literal translation is absolute chieftainship (Durie, 1998a; Kawharu, 1989). The rangatira aspect of the word related to iwi leaders who were revered because they could whakapapa back to the gods (Hiroa, 1958; Kawharu, 1989; Mahuika, 1975). Hence rangatira were born with what is referred to as inherited mana (Hiroa, 1958; Mahuika, 1975; Marsden, 1977).

Typically rangatira were the first born of the first born and accorded high levels of mana. At times when they were unable to perform their rangatira duties the responsibility was passed on to the next person in line. Inherited mana was not the only attribute that rangatira had: they could also earn mana in their life time if they achieved great things for their hapū and iwi (Hiroa, 1958; Mahuika, 1975). For example, Princess Te Puea, a Tainui rangatira, was the first born of the first born and in her life time she set up Turangawaewae Marae, managed the political relationships

with the colonisers, set up the first health centre for Māori in Aotearoa and guided her iwi and other iwi through troubled political times (see Figure 1) (King, 2003).

Figure 1: Health Centre at Te Puea Herangi's marae



Mana was not the only attribute rangatira were accorded: tapu was another. Tapu referred to protection from the gods (Durie, 1994c; Hiroa, 1958). At the extreme end, tapu meant anything the rangatira touched was sacred and needed to be treated with caution or awe (Hiroa, 1958). For example, utensils used by rangatira could not be used by others and certain customary rituals could not be conducted unless an ariki rangatira was present. The mana and tapu of iwi was directly related to the mana and tapu of their rangatira. These values and understandings of tino rangatiratanga still exist in contemporary Aotearoa (Durie, 1998a; Kawharu, 1989; Mahuika, 1975; Marsden, 1977).

Since colonisation and the imposition of Crown values rangatira status has mostly been attributed to men. However, historically such status was also awarded to women. Hiroa argues that rangatira were typically the first born of the first born male and that the first born of the first born females were merely figure heads (Hiroa, 1958). Mahuika contests this, providing documented evidence of women who were rangatira and ariki rangatira (Mahuika, 1975). Further Wallace, in her paper on women who signed Te Tiriti, provided evidence of female rangatira who were

signatories (Wallace, 1989). With the arrival of the colonisers attempts were made to deconstruct the mana, tapu and gender of rangatira. Colonial values did not support the notion of whakapapa to the gods or Māori women as leaders, even though Queen Victoria reigned in England (Awatere, 1984; James & Saville-Smith, 1990; Mikaere, 1995; Milroy & Mikaere, 1993).

He Wakaputanga o te Rangatiratanga o Nu Tirene.

The era of assimilation began with the arrival of the Pākehā, and continues through to the present day (Durie, 1998a; Kirk, 1974). Contributing to the assimilation process was He Wakaputanga o te Rangatiratanga o Nu Tirene.

He Wakaputanga o te Rangatiratanga o Nu Tirene was written by James Busby¹ and signed by the United Tribes of Aotearoa on the 28th of October 1835 (Durie, 1998a; Orange, 1989). He Wakaputanga recognised Māori as a sovereign nation by King William IV (Durie, 1998a; Orange, 1989). Such a move enabled Māori to negotiate a treaty with the British as a sovereign nation as treaties are between sovereign nations (Durie, 1998a; Orange, 1989; Walker, 1990). Further, he Wakaputanga meant Māori could continue to trade more freely around the world.

There was another reason for He Wakaputanga o te Rangatiratanga o Nu Tirene, French colonial interests. The French Government was looking to annex Aotearoa as a colony of France (Orange, 1989) something the British did not want (Durie, 1998a; Orange, 1989). Busby thought that by writing and signing he Wakaputanga the French would be prevented from claiming Aotearoa as French territory, leaving the way open for British sovereignty (Orange, 1989).

While Māori viewed He Wakaputanga o te Rangatiratanga o Nu Tirene as Māori sovereignty Busby had other plans. Busby viewed He Wakaputanga o te Rangatiratanga o Nu Tirene as a step toward British sovereignty (Cox, 1993; Durie,

¹ the British Government appointed James Busby as its official Resident (a sort of junior consular representative, without effective powers because New Zealand was not within British jurisdiction).

1998a; Kawharu, 1989; Orange, 1989). When Great Britain decided to annexe Aotearoa He Wakaputanga o te Rangatiratanga o Nu Tirene proved to be a hindrance. It was in an endeavour to negate Māori sovereignty that Te Tiriti o Waitangi was written (Durie, 1998a; State Services Commission, 2004).

Te Tiriti o Waitangi

Te Tiriti o Waitangi was a document signed in 1840 and represented an agreement between the United Tribes of Aotearoa and the British Crown (see Appendix 2). Informed scholars have written about te Tiriti in detail (Durie, 1991; Durie, 1998a; Kawharu, 1989; Orange, 1989, 2001; Te Puni Kokiri, 2001). What I provide here is a brief synopsis of te Tiriti to contextualise my thesis.

Two primary texts of Te Tiriti exist, in particular, Māori (by Henry Williams) and English texts (by Hobson). Differences exist between the two texts which have created tensions through to the present day. Article I of the Henry Williams' Māori text makes reference to kāwanatanga of the Crown while Article I of Hobson's text makes reference to the sovereignty of the Crown (Durie, 1998b; Kawharu, 1989; Walker, 1990; Williams, 2001). Kāwanatanga meant governorship, while sovereignty meant complete ownership. As Māori signed Henry Williams' text they believed they retained sovereignty over their land, their people and their resources. The Crown, on the other hand, signed Hobson's text and believed they had sovereignty. Once Te Tiriti was signed the Crown was relentless in acquiring land through warfare and legislation. When Te Tiriti was signed Māori owned 66,400,000 acres of land. By 1975 this had dropped to 300,000 acres. Alongside this was the assimilation of Māori into the social norms of the Pākehā. Again, state-directed legislation led the way. For example, the 1852 Constitution Act meant only individual land owners could vote. Māori, in contrast, were collective owners. Another example is the 1863 Suppression of Rebellion Act meant Māori who resisted colonisation had their land confiscated and this had a direct relationship on Māori health and well being. Those iwi who had the most land confiscated had fewer live births (Pool, 1991). Yet another example is

the 1908 Tohunga Suppression Act which was introduced to stop tohunga from practising. The Act seriously marginalised Māori healing practises (Durie, 1994c)

Article II of William's text promised Māori '...te tino rangatiratanga o rātou wenua o rātou kainga me rātou taonga katoa...' (the full chieftainship of their lands, their villages and all their possessions) (Durie, 1999; Kawharu, 1989; Te Puni Kokiri, 2001; Williams, 2000). Article II of Hobson's text says the:

Queen of England confirms and guarantees to the chiefs and the tribes of New Zealand and to the respective families and individuals the full exclusive and undisturbed possessions of the Lands and Estates, Forests, Fisheries and other properties which they may collectively or individually possess, so long as it is their wish and desire...

Scholars argue that tino rangatiratanga is more than '...full exclusive and undisturbed possession of the lands and estates...' (Durie, 1998a; Kawharu, 1989; Maniapoto-Jackson, 1989). These scholars argue tino rangatiratanga or full chieftainship referred to iwi sovereignty or full power, control and authority over tribal areas, resources and people. Since 1840 Māori have asserted, with some success, their tino rangatiratanga rights, even as the Crown sought to implement their version of Te Tiriti. However once Māori were out-numbered by Pākehā the Crown excluded any notion of tino rangatiratanga. Once firmly in control of the political situation, the Crown continued to implement legislation and policies that stripped Māori of their land, their culture and their possessions. These policies have influenced the state of Māori health through to the present day (Dow, 1999; Durie, 1991; Durie, 1994c; Kelsey, 1990; Lange, 1999; Newell, 1954; Ngata, 1898). The differences between William's and Hobson's Article II of Te Tiriti o Waitangi are at the heart of the tensions that exist between Māori and the Crown.

Postcolonial theorists argue that along with colonialism came transliteration.

Transliteration in this sense is the re-writing of indigenous realities from a colonial perspective (Bassnett & Trivedi, 1999; McLeod, 2000; Pandey, 1999). Not only did these transliterations portray indigenous cultures as inferior to the colonisers but also lost the 'poetry' of indigenous realities. Hence 'tino rangatiratanga' was regarded as

the equivalent to ‘full exclusive and undisturbed possession of the Lands and Estates, Forests, Fisheries and other properties’, rather than the ‘full chieftainship of their lands their villages and all their possessions’. Full chieftainship means much more than ‘full and exclusive and undisturbed possession.’ At the very least, it refers to total control and authority over lands and fisheries. Underlying this is the kaitiaki relationship rangatira have to the land, estates, forests and fisheries, relationships originating from Māori beliefs and values that view these entities as being of part of the whole. Some Tiriti scholars argue the transliteration was a deliberate endeavour to mislead Māori and acquire land for settlement (Durie, 1998a). Whether the result of transliteration, or a deliberate attempt by the colonisers to mislead Māori, the differences between the two texts of Te Tiriti led to numerous misunderstandings over succeeding years.

The Crown's total disregard for the promises made in Article II of Te Tiriti was another contentious issue (Maniapoto-Jackson, 1989; Walker, 1990). Since the Māori revitalisation movement of the late 1960 and the establishment of the Treaty of Waitangi Tribunal, the Crown has endeavoured to attempt to right the wrongs of the past (Mikaere, 2000; Renwick, 1993; Te Puni Kokiri, 2001). The Māori revitalisation movement brought Tiriti issues to the forefront of race relations in Aotearoa, while the Waitangi Tribunal is argued to have provided a setting in which Māori and Pākehā can talk to each other and resolve past Tiriti breaches (Durie, 1998a; Mikaere, 2000; Renwick, 1993).

The Māori revitalisation movement and the establishment of the Tribunal coincided with international moves to address the rights of indigenous people (Durie, 1998b; Renwick, 1993). While there has been more than a little resistance from Pākehā, tino rangatiratanga can no longer be dismissed as special pleading given that Māori concerns are also the concerns of indigenous peoples globally (Renwick, 1993).

Contemporary definitions of tino rangatiratanga

Contemporary definitions of tino rangatiratanga are multifaceted. Awatere defines tino rangatiratanga as ‘Māori ability to determine our own destiny and to do so from the basis of our lands and fisheries’ (Awatere, 1984, p. 80). Gardiner defines it as ‘the desire Māori have to have control over their lives, their assets and resources, and to determine themselves where they may wish to go’ (Gardiner, 1995, p. 81). Durie defines it as Māori leadership personified and ‘the advancement of Māori people as Māori and the protection of the environment for future generations’ (Durie, 1998a, p. 4). For Parata it is about keeping iwi strong economically, educationally, and health wise because these are the platforms for achieving political power (Parata, 1995). Common to these definitions is power, control and authority.

Power, authority and control

However tino rangatiratanga is defined the underlying discourse is one of power, authority and control with respect to Māori economic, social and cultural development (Durie, 1995a, 1997b, 1998a; Durie, 2000; Fleras & Spoonley, 1999; Henare, 1998; Henry, 1995; Kawharu, 1989; Parata, 1995; Te Puni Kokiri, 2001; Turia, 2000). One form of power, authority and control postulated by post-colonial/postcolonial theorists is that of the written word (Bassnett & Trivedi, 1999; McLeod, 2000; Pandey, 1999). Similar to Gramsci hegemonic theory, post-colonial theorists argue indigenous realities are deconstructed and reconstructed in the written word of colonialism. The reconstructions of indigenous realities then become the norm and taught back to indigenous people in schools and other social settings. Two outcomes result. Firstly some indigenous peoples internalise the teaching of the colonisers leading to poor self-image and resulting poor health (Naumann, Harrison, & Winiata, 1990). Secondly, some indigenous peoples resist (Durie, 1998a; Fleras & Spoonley, 1999; Walker, 1990).

As mentioned in Chapter Two, according to poststructuralists power, authority and control are reflected in dominant discourses (Doolin, 1997; Foucault, 1980; James &

Saville-Smith, 1990; Parker, 1992). Dominant discourses silence minority voices while legitimating dominant ones (Connell, 1987; Parker, 1992; Spender, 1982). Alongside dominant discourses, non-dominant discourses exist as resistance. In Aotearoa, while kawanatanga and other Western discourses exist as dominant discourses, tino rangatiratanga and other Māori discourse exist as resistance and in some settings as dominant.

Post-colonialism and poststructuralism provide ways in which colonial power, authority and control can be deconstructed. They also provide ways in which multiple solutions can be generated. However these theories provide a view of power, control and authority from the worldviews of the 'other'.

Kaupapa Māori theories add another dimension, that of the mana, tapu and whakapapa of rangatira. Fleras and Spoonley argue '...tino rangatiratanga is the supreme power from which all specific powers related to self-determination derive their legitimacy or effect' (Fleras and Spoonley, 1999:27). In some cases this power may be understood to be the mauri or active spiritual life force (Durie, 1995a; Flera & Spoonley, 1999). In this sense power, authority and control are more than the written word or discursive interactions: it is the power of the gods. Within the context of tino rangatiratanga power, authority and control is personified in Māori leadership. In some cases, these leaders may have inherited and achieved mana. However, in today's modern milieu leaders may only have achieved mana (Durie, 1998a). Three tino rangatiratanga discourses will be more fully explored sovereignty, self-determination and positive Māori development.

The sovereignty discourse

The debates about tino rangatiratanga include debates around sovereignty. Donna Awatere brought Māori sovereignty to the forefront of contemporary race relations following the publication of *Māori Sovereignty* in 1984. In her book, Awatere challenged Pākehā hegemony and defined Māori sovereignty as 'the Māori ability to determine our own destiny and to do so from the basis of our lands and fisheries' (Awatere, 1984, p. 80). As a psychologist, Awatere was well aware of the need for

positive Māori development and the influence of words in the process. The words she used were not chosen lightly. She foresaw a long and arduous struggle as most iwi did not have an asset base, nor was the Crown willing to address Māori sovereignty.

Gardiner asserts sovereignty as ‘the desire Māori have to have control over their lives, their assets and resources, and to determine themselves where they may wish to go’ (Gardiner, 1995, p. 81). Such a notion is uplifting but until such notions are firmly embedded in legislation and policy Māori will continue to struggle to exist within a colonised nation state.

Parata argues that tino rangatiratanga is a collective right and that collective is iwi. Such an understanding is reflected in her definition of tino rangatiratanga. She argues that Māori as individuals already have tino rangatiratanga, through Article III of te Tiriti. What is required now is iwi sovereignty. She defines iwi sovereignty as iwi decision-making powers and representation in Parliament (Parata, 1995; Te Puni Kokiri, 2001). Māori leadership or rangatiratanga was extinguished in colonial society through the imposition of dominant colonial discourses. There needs to be a concerted effort by Māori to legitimate Māori leadership to ensure we move into the future with our tino rangatiratanga intact.

Another sovereignty definition is the ‘repository of the lawful right to control the activities of those within a nation state at a national level and to enforce such control’ (Graham, 2000, p. 193). While in today’s technocratic globalised world the notion of sovereignty has begun to have less influence in political debates and governance of countries, the sovereignty debates within Aotearoa have contributed to understandings of tino rangatiratanga (Christie, 1997; Durie, 1995b, 1998a; Graham, 1998b; Jackson, 1991; Keith, 1995; Parata, 1995).

Reclamation is a key term in the sovereignty discourse and is related to reclaiming, restoring and re-writing of Māori cultural values and practises (Durie, 1995b; Fleras & Spoonley, 1999; Henry, 1995; Kawharu, 1989; Melbourne, 1995; Parata, 1995; Te Puni Kokiri, 2001; Walker, 1995). Māori have retained a considerable amount of their tikanga even though there has been a concerted effort to extinguish it. However,

tikanga Māori exists within the hegemony of tikanga Pākehā. That is tikanga Māori within Aotearoa society is subordinate to tikanga Pākehā. For example, the English language is compulsory within most schools while Māori is not, despite both being official languages. The reclaiming, restoring and rewriting of Māori values and practises are critical if Māori are to advance as Māori and if Māori are to remain healthy (Naumann, Harrison, & Winiata, 1990). For instance cultural identity has been linked to well being as has knowing your own language (Durie, 1998a). The reclaiming of te reo Māori through the resurgence of Te Kohunga Reo and to a lesser degree Kura Kaupapa Māori has been a Māori success story.

Some Pākehā and Crown representatives argue that tino rangatiratanga no longer exists. Others persist in their endeavour to deconstruct tino rangatiratanga through to the present day. Efforts to deconstruct tino rangatiratanga would mean Māori would no longer be a threat to the Crown and further acts of marginalisation and alienation could continue unchallenged. Some scholars argue the Crown has the legal right to sovereignty; hence power control and authority, but that Māori have the moral right because of Article II of the Māori text of the Treaty (Parata, 1995). Other scholars argue finding the balance is the challenge for Māori and successive governments (Durie, 1999; 2000; Flera & Spoonley, 1999).

If He Wakaputanga o te Rangatiratanga o Nu Tirene is taken into consideration where Māori sovereignty was recognised by King George and in Article II of Te Tiriti where Māori tino rangatiratanga was assured then it suggests that at the very least there was a shared sovereignty (Durie, 1998a; Orange, 1989). As such Māori have the right to make laws for themselves and the Crown to write laws for the British. While tino rangatiratanga was debated as Māori sovereignty another discourse emerged that of self-determination.

The self-determination discourse

To a large degree Māori self-determination was influenced by international resistance movements and activities with whom which Māori are keenly involved. For example, Māori were major players in the development of Mana Tangata, the Draft

Declaration on the Rights of Indigenous Peoples in 1993. Within Mana Tangata, self-determination is defined as the rights human beings have either as individuals or groups to control their own destinies (Durie, 1998a; Henare, 1998; Soloman, 1998; Te Puni Kokiri, 1994d).

Within the self-determination debate Henare argues tino rangatiratanga rights are ‘...sought on the basis of inherent entitlement and not as a privilege conferred by government policy’ (Henare, 1998, p. 108). Such a position emerges from the influence government policies have had in eroding Māori tino rangatiratanga. If Williams’s text of Te Tiriti is accepted as authoritative in contemporary Aotearoa, and this not an agreed position, then the Crown’s Tiriti responsibilities include, at least, the protection of Māori tino rangatiratanga.

Within Aotearoa, self-determination also encompasses political freedom and economic, social and cultural development, which is not surprising as Māori were instrumental in developing the Draft Declaration on the Rights of Indigenous Peoples (Durie, 1995b, 1998a; Henare, 1998; Soloman, 1998; Taiaroa, 1998; Te Puni Kokiri, 1994d; Williams, 1989).

Durie argues self-determination is the advancement of Māori as Māori and the protection of the environment for future generations. Advancing as Māori relates to:

- advancing socially, economically and culturally, individually and collectively
- having power and control over natural resources, productivity, health, education, language and decision making, and
- the recognition that change is natural

Protecting the environment for future generations relates to Māori involvement in ‘shaping the national ethos and refocusing the balance between development and sustainability’ (Durie, 1998a, p. 14).

The advancement of Māori as Māori and the protection of the environment for future generations are reliant on hapū, iwi and local, regional and national leadership and

strategic relationships between Māori and the state, Māori and Pacific Islanders and Māori and other indigenous peoples (Durie, 1998a).

There is some debate over the use of the term self-determination as it relates to indigenous peoples at an international level (Anaya, 1997; Durie, 1998a; Henare, 1998; Te Puni Kokiri, 1994d). Generally, dominant cultures or governments argue self-determination has not been accepted by some states and this justifies not including it in the laws of the state (Anaya, 1997; Henare, 1998). Indigenous theorists produce a counter argument which asserts that the lack of recognition by some states may be a reflection of the lack of recognition by the law rather than the other way around (Henare, 1998). Regardless, the application of self-determination has resulted in the strengthening of indigenous peoples from within colonised states and 'promoted the downfall of classical colonial structures' (Anaya, 1997, p. 2). While sovereignty and self-determination tino rangatiratanga discourses existed another one to emerge was positive Māori development.

Positive Māori development discourse

Drawing on lessons from the past and from alliances with other indigenous cultures Māori continued to assert their tino rangatiratanga nationally and internationally.

Tino rangatiratanga in the positive Māori development discourse is about forward thinking. Durie argues that Māori need to focus on future development rather than be caught up in what he calls the 'grievance' mode. He argues too much valuable Māori time and energy is being spent on grievances, with little monetary pay off, time and energy, which could be better spent on positive Māori development (Durie, 2000). Tino rangatiratanga parameters exist in the positive development discourse but Durie cautions the parameters are yet to be fully developed.

Within the positive Māori development discourse tino rangatiratanga is about Māori leadership, (tribal, political, within whānau and by men and women), moving away from dependency of the state, and recognising that tino rangatiratanga was not static or singular. Iwi development is one way of strengthening tino rangatiratanga another

is the establishment of a national Māori body politic that develops and addresses Māori policy making (Durie, 1998a). Another aspect of tino rangatiratanga as positive Māori development is Māori ownership of laws and policies for Māori. Within the positive Māori development discourse there was strong focus on expecting the Crown to meet its Tiriti obligations and in this was the settling of Treaty claims. Yet another aspect of tino rangatiratanga as positive Māori development was one of economic development.

Economic development was the focus of Hui Tauamta in 1984. Within the hui discussion was a strong theme of iwi development. Not surprisingly one of the outcomes of the hui was the devolution of services to iwi Māori. A number of issues became apparent quite quickly. Firstly, while government was willing to devolve services to Māori they were less willing to provide the resources required to maintain these organisations (Mental Health Commission, 1998). During this time a number of Māori initiatives were established and then abandoned, as it became apparent government commitment was tokenistic and paternalistic. For example, while allocating money to Māori health development, Government also put in place strict contractual and auditing accountabilities which meant Māori health providers were strictly monitored (Diane Gibson, personal communication, October, 1998). Added to this was the recognition that in some cases iwi were in no position to provide services due to lack of infrastructure and resources such as money and skilled people.

Following Hui Taumata was 20 years of economic development and the neo-liberal reforms. The reforms had a mixed impact on Māori develop. On the one hand the economic reforms provided opportunities for Māori to via for and win contracts to provide services. On the other hand Māori unemployment was at its peak with approximately 24% of Māori being unemployed compared to 9% of non-Māori.

With respect to advancing as Māori in an international context, it is worth noting that for those American tribal Indians who have been successful in developing economically four inter-related strategies were evident: sovereignty or self governance, governance structure, culture, and strategic thinking (Cornell, 2000). Sovereignty or self-governance referred to the removal of outsiders from decision

making roles and replacing these people with tribal members. The outsiders who were removed from decision-making positions were re-positioned as resource people. Along with this were tribal organisational structures that had stable rules, depoliticised business operations and dispute resolutions and adopted bureaucratic structures and procedures. While adopting bureaucratic structures and procedures were important these structures and procedures had to fit with tribal culture and had to have tribal support or the tribes did not precede successfully. Finally those Indian nations that thought strategically were more successful than those that did not (Cornell, 2000). Positive Māori development follows similar lines but remains strongly political in its dealing with the Crown or Government.

Social equity was another aspect of tino rangatiratanga as positive development. While recognising that gains had been made in the preceding 20 years participants at 1994 at Hui Whakapumau and then again at the 2000 Nation Building and Māori Development Hui in 2000 acknowledged while gain had been made in the restoration of tino rangatiratanga further gains were required as inequalities existed between Māori and Pākehā and it was the Crown's responsibility to address these inequalities. To some degree scholars argued that this was the result of institutional racism and therefore strategies needed to be developed to change this. As a consequence the Labour government reiterated its support by developing and implementing policies to ensure more work is done to reduce these disparities. While there were some repercussions from the public about this a number of strategies have been developed and implemented over the last four to five years. The strategies included fast tracking the processing of Waitangi Tribunal Claims, monitoring state sector performance by implementing policies to make government agencies more accountable for spending on improving outcomes for Māori, allocation of capacity building monies to help government departments develop Māori appropriate services and to help whānau, hapū, iwi and Māori organisations 'to build the strategies, systems, structures and skills that they need to control their own development and achieve their own objectives' (Horomia, 2000:9).

A vision for the future

A strong tino rangatiratanga vision for the future that came out of hui Whakapumau which was centred on the well-being of future generations and included; a clean safe environment, healthy bodies, liberated minds, educational and technological skills and knowledge, strong whānau led by women and men, citizenship of the world, a secure Māori identity – united under a common heritage and shared goals, a collective Māori voice, Māori ownership of laws and policies for Māori and ko te aroha.

The policy implications

Falling out of the debates about tino rangatiratanga are policy discussions. Durie highlights the amount of work required in the policy domain with respect to tino rangatiratanga in a policy framework he has postulated (Durie, 1998a). Within the policy framework Durie identifies eight dimensions, mana atua, mana tupuna, mana tangata, mana whenua, mana moana, mana tiriti and mana motuhake.

Mana atua relates to environmental issues and emerges from the relationship Māori have with Papatūānuku, Rangi and other lesser gods (Buck, 1958; Durie, 1998a; Mikaere, 2000). Mana atua highlights the importance of the environment to Māori and the necessity to protect the environment for nga mokopuna (Buck, 1958; Durie, 1998a, 1998b; Henry, 1995; Mikaere, 2000). Mana tupuna is about reclaiming, reconstructing and affirming Māori cultural values and beliefs (Durie, 1998a, 1998b; Mikaere, 2000; Tuhiwai-Smith, 1999). Thus, it is about asserting Māori as an identity in Aotearoa (New Zealand) (Durie, 1998a). Mana tangata refers to the right of all Māori, individually or collectively, to determine their own policies, to actively participate in the development and interpretation of the law, to assume responsibility for their own affairs and to plan for the needs of future generations. Mana tangata reflects a Māori constitutional element that has assumed importance over the last 155 years and especially since post-war urbanisation. It recognises that not all Māori are linked to tribal structures and networks and also takes into account the fact that there

are many policies which impact on all Māori but do not have relevance at iwi level. Mana whenua and mana moana recognises the right Māori have to the resources of the land and the sea. Mana tiriti takes a number of shapes within tino rangatiratanga as self-determination that range from being a scam to the nations foundation document (Durie, 1998a; Graham, 1997). Te tiriti also recognises the importance of the Treaty in policy development. Finally mana motuhake is about tino rangatiratanga and the political structures that may advance Māori self-determination (Durie, 1998a). Mana motuhake also recognises Māori unity (Durie, 1995a, 1995b). While Māori have differences relating to iwi and hapū they also have commonalities relating to their histories and their destinies.

Tino rangatiratanga in practise

While traditionally, tino rangatiratanga was about mana, tapu and whakapapa of rangatira, with colonisation, the signing of Te Tiriti o Waitangi and the imposition of assimilation policies this is no longer the case. Colonisation has been very successful in deconstructing Māori social structures to the point that iwi leadership is hard to distinguish within contemporary Aotearoa. Not only has Māori leadership been deconstructed, iwi no longer live in one bounded tribal area. The implications for tino rangatiratanga have been profound. Debates have arisen around whom, how and whether tino rangatiratanga can be implemented (Christie, 1997; Durie, 1995b; Parata, 1995).

Individual expression

Some scholars hold tino rangatiratanga is an individual right about self expression and taking control of one's own life and making positive lifestyle decisions (Management/policy Group 2, 2003). Some Māori would suggest that such a notion is not about tino rangatiratanga but an individual's aspiration. Scholars argue that individuals can only claim tino rangatiratanga within the context of a collective and that collective is whānau, hapū or iwi (Parata, 1995). An example of tino rangatiratanga in practise on an individual level is portrayed in the Quit Me Mutu

advertising campaign where Peter Sharples states ‘to me tino rangatiratanga is about taking control of my life’ and in this case he makes a choice to give up smoking.

Iwi expression

If tino rangatiratanga is about mana, tapu and whakapapa or Māori leadership personified then tino rangatiratanga is about iwi; the restoration of iwi leadership, iwi decision making and iwi resources. The process is ongoing and has not been an easy journey for most iwi given resistance from the Crown and Crown agencies.

Initiatives are being implemented to strengthen Māori leadership in many domains including education and health with training programmes being funded and implemented. While these initiatives are being implemented leadership issues are also being addressed through iwi mandated tribal leaders. In some cases these leaders are traditional leaders, first born of the first born. In other cases they are young dynamic Māori who are experts in the chosen disciplines such as law, health, education and research.

An example of tino rangatiratanga at an iwi level is health initiatives owned and operated by iwi. In the 1993 Health Reforms a number of iwi took the opportunity to formalise their health services to whānau and hapū. One iwi was Ngati Porou who in 1995 formed an Incorporated Society whose primary responsibility was to provide health services to whānau and hapū. Iwi leadership was represented on the Board of Trustees that included representatives from each hapū. Consultation with each hapū meant iwi voice was legitimated in decisions impacting on whānau, hapū and iwi. The primary role of the Board was to provide iwi and strategic leadership for the delivery of health services to whānau and hapū. Ngati Porou Hauora’s vision is:

Manaakitia nga mea katoa hei oranga, wairua, hinengaroa, tinana, me te whānau (to promote total family healthcare, spiritually, mentally and physically) (Ngati Porou Hauora & Ministry of Health, 1999, p. 6).

Integral to the implementation of tino rangatiratanga within Ngati Porou was the adoption by the Board of Ngati Poroutanga as the underlying tikanga for service

delivery. Ngati Poroutanga included knowledge of Ngati Porou tikanga with respect to whakapapa and preferred methods of service delivery such as whānaungatanga and manaakitanga. Another strategy was the reclaiming of Te Puia Hospital (Ministry of Health & Ngati Porou Hauora, 1999). Before it was returned to Ngati Porou it was being administered by Gisborne Hospital. ²Ngati Porou Hauora, with support from Pākehā allies, has used the opportunity to restructure health services to whānau, hapū and iwi.

Pan-tribal expression

As explained earlier acquisition and assimilation policies contributed to the deconstruction of Māori society. One of the outcomes has been the disenfranchisement of urban Māori. For some Māori this matter has been resolved through the establishment of roopu that operate under traditional iwi tikanga. For others it has been the establishment of pan tribal groups. For one group of Māori, living in Auckland, the solution was to form a pan tribal group. To a large degree the pan tribal group was to provide urban Māori with some cultural stability. As more and more Māori moved into cities such as Auckland social and health services were required. The establishment of pan tribal organisations for whānau living in urban areas seemed a natural conclusion to urbanisation. However, the establishment of these organisations has not been without issues.

Firstly, urban Māori were not recognised as an iwi and iwi were identified as preferred service providers in government policies (Ministry of Māori Affairs, 1988). Hence urban Māori could not access funding to provide for their whānau. Secondly, iwi and the Crown argued that pan tribal groups were not an iwi and did not have the same rights as iwi. Iwi believed they could provide for the own whānau, urban or rural. Regardless, pan tribal groups emerged and sought funding along with other iwi. One notable example is Waipareira Whānau Trust (wai 414) who claimed the right to provide services and to access resources for service delivery to people in the

² Interestingly enough, when Te Puia Hospital was returned to Ngati Porou, attempts were made by the Gisborne Hospital Board to reduce the funding allocation by one million dollars (anonymous, personal communication, December, 2000).

Auckland region. The outcome of the claim was the recognition, by the Waitangi Tribunal, of the right pan-tribal organisations has to provide services to people in urban areas and the right they have to access necessary resources (The Waitangi Tribunal, 1998).

National expression

Another way in which tino rangatiratanga has been asserted is through national Māori bodies politic (Cox, 1993; Durie, 1998a). The need for a national Māori body politic has grown out of the recognition that Māori are now a diverse group with some Māori being iwi based and committed, some being iwi committed but urban based and some having no contact with iwi at all but still considering themselves Māori (Durie, 1995b, 1998a, 1998b). Given these dynamics, it has become evident there is a need to ensure national Māori policies reflect contemporary Māori needs and realities. While attempts have been made in the past (see Table 1) as well as currently to establish a national Māori body politic no consensus has been reached about which group, if any, would represent Māori and how this is to happen (Durie, 1997b, 1998a; Fleras & Spoonley, 1999; Mikaere, 2000; Parata, 1995; Potiki, 2000; Walker, 1990).

Table 1: Name of body politic by date established

Name of body politic	Date
Kohuiarau	1816
United Tribes	1831
Confederation of United tribes	1835
Kingitanga	1858
District rūnanga	1861
Kotahitanga	1892
Māori Council	1900
Ratana	1918
Te iwi Morehi, Te Māramatanga o Ihowa	1925
Tribal communities	1945
Māori Women's Welfare League	1953
New Zealand Māori Council	1962
National Māori Congress	1990

Parallel development

Endeavours have been made to implement parallel development models within Aotearoa in endeavours to reclaim tino rangatiratanga within a colonial nation state.

Parallel development is an attempt to end Pākehā hegemony by explicitly addressing issues of power and control in organisational structures and by respecting the right of Māori to be self-determining. Inspired by the Treaty of Waitangi, parallel development attempts to establish a genuine partnership between Māori and non-Māori and to incorporate this into organisational structures and decision-making processes (Nikora & Robertson, 1995, pp. 1-2).

Parallel development was pioneered by the women's refuge movement and has been utilised to varying degrees in other organisations (Archer, 1993: Cooney, 1996: Glover & Sutton, 1991: Nikora & Robertson, 1995). Parallel development recognises Māori as: tangata whenua who have the right to tino rangatiratanga or self-determination, unique with unique needs, the best people to meet these needs, and having diverse realities. (Balzer, 1994: Cooney, 1996: Durie, 1994: 1995: Nikora & Robertson, 1995). Parallel development models are difficult to implement and require a certain commitment and maturity on the part of those involved. Nikora & Robertson identify several key elements that contribute to the establishment of parallel development organisational models: the establishment of separate caucuses, decision making through discussion and negotiation, each caucus being responsible for the delivery of culturally safe services, parallel appointments in most service delivery staff positions, co-operation, and respecting difference while reflecting a commitment to a common goal (Nikora & Robertson, 1995).

Examples of parallel development in the health sector were the Joint Venture Boards, established during the 1993 Health Reforms in some regions in attempts to address the health disparities between Māori and Pākehā. The Boards were made up of two caucuses, Māori (tangata whenua) and Pākehā (Health Funding Authorities). The decision-making processes within the Joint Venture Boards varied depending on the take and urgency. Minor issues were dealt with in-house. Major take went back to the

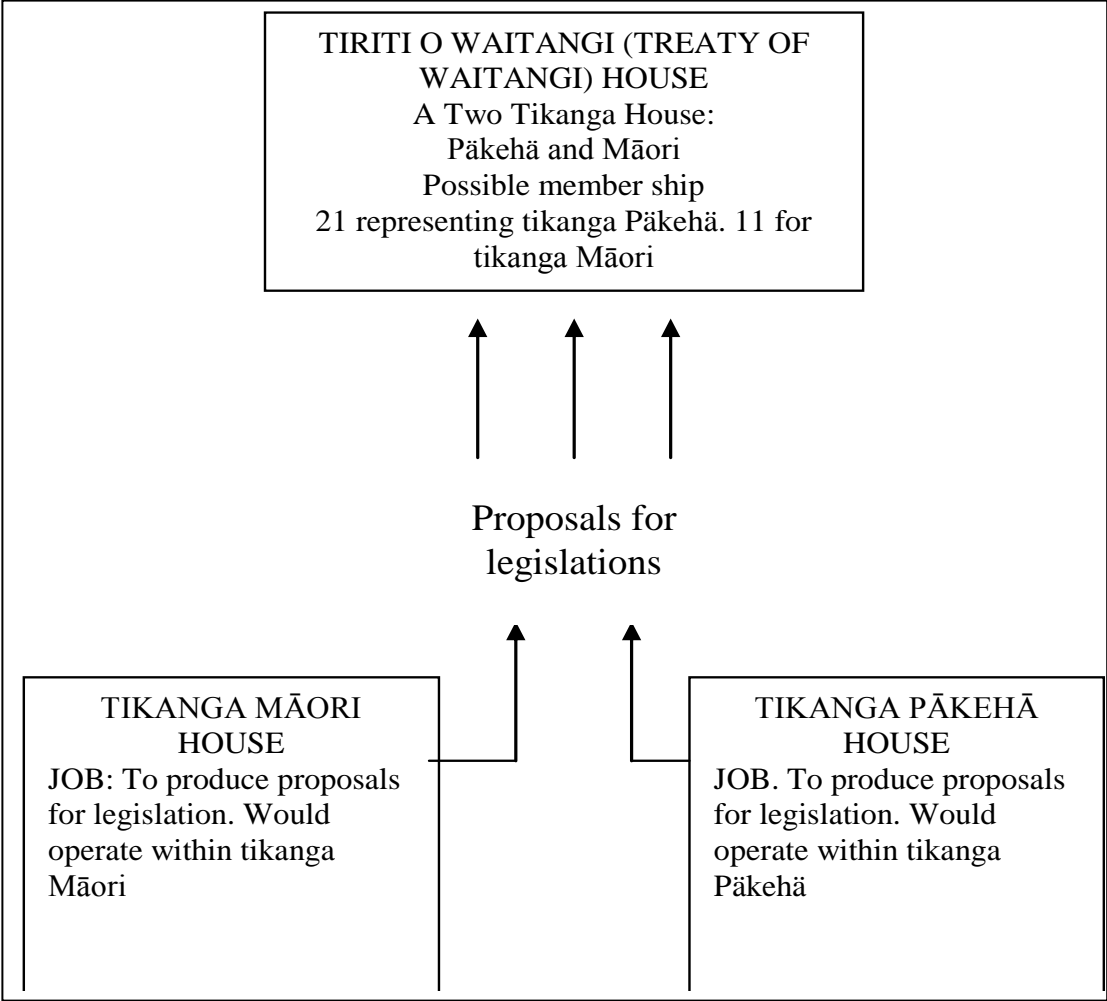
caucus's respective social structures. For tangata whenua it meant taking the take back to komiti hauora, Board of Trustees and sometimes even hui a Iwi. For Pākehā it means taking the take back to their regional office. Each caucus was responsible for the delivery of culturally safe services. Recognising that Māori were lagging behind in regard to having organisations to deliver culturally safe services, energy and funding was poured into establishing and developing Māori health provider services (Te Puni Kokiri, 2001). Theoretical models of parallel development have been mooted. Three examples are those postulated by Parata, Winaita and Trotter.

Along the lines of a Native American model, Parata proposes a senate. The senate she proposes is made up of Crown representatives and representatives from a Confederation of iwi Māori (Parata, 1995). The confederation of iwi Māori make decision relevant to each of their iwi but come together with the Crown to make decisions for all people in Aotearoa.

Similar to Parata, Winiata's parallel development model also has two political bodies that come together to make decisions for all people in Aotearoa. Unlike Parata, the tikanga Māori house include representatives from hapū, iwi, waka, pan-Māori, marae based Māori and those Māori separated from their marae whose job it is to make decisions based on tikanga Māori. Alongside this is a Tikanga Pākehā House whose job it is to make legislation regarding Pākehā (see Figure 2) (Winiata, 2000).

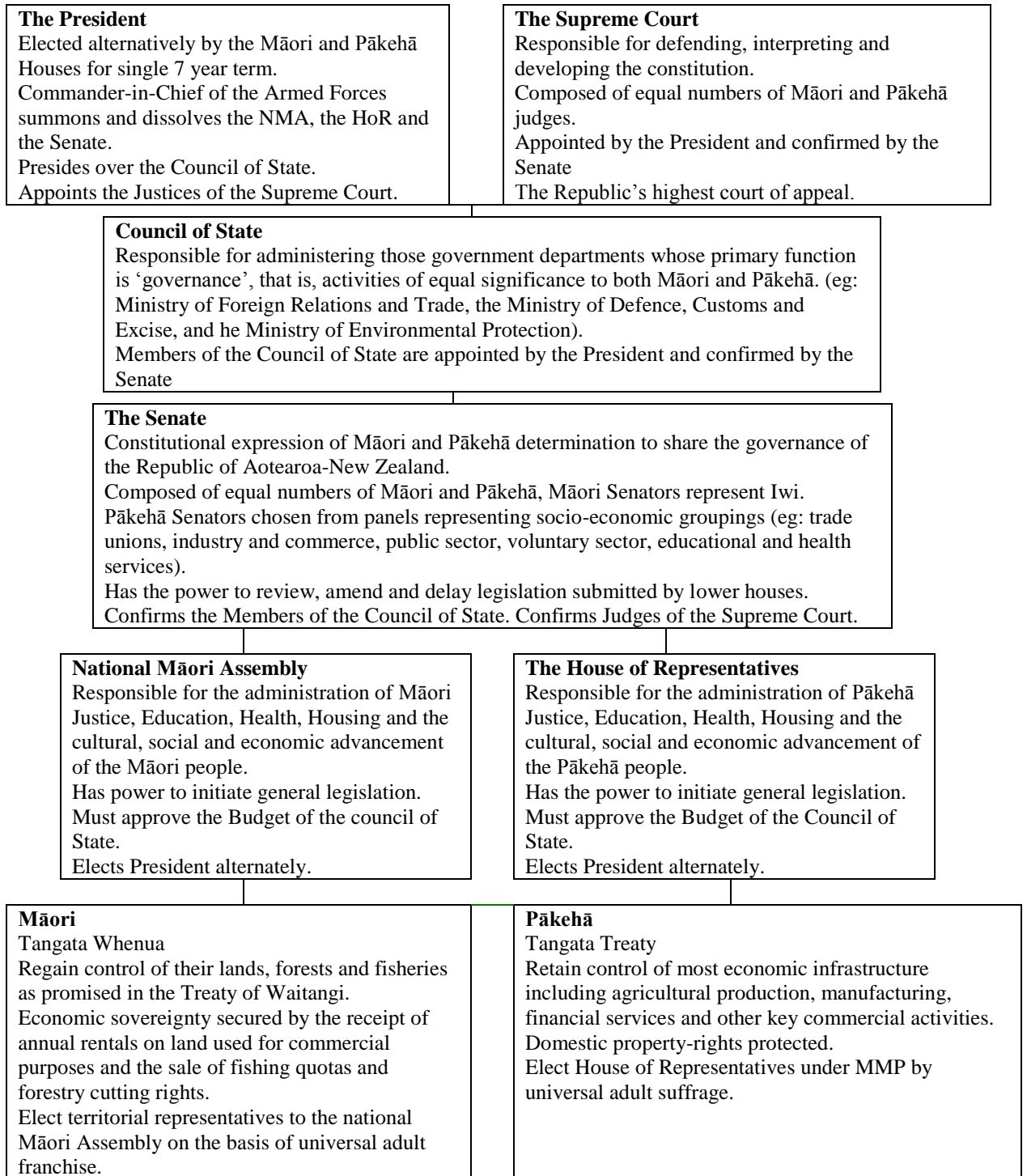
A detailed parallel development model is proposed by Trotter (see Figure 3). Trotter's framework provides a way in which Māori can regain their tino rangatiratanga within a nation State. Such a model not only provides avenues through which Māori can work on restoring their sovereignty but also ensures Tangata Tiriti contributes by paying rentals on commercial properties and fishing quotas. The Māori house comprises of elected territorial representatives to a national Māori assembly. The tasks of the Māori house are to regain tino rangatiratanga (Trotter, 1995).

Figure 2: Winiata's framework for a national Māori body politic



(Winiata, 2000, p. 206).

Figure 3: Trotters framework for a national Māori body politic



Decolonisation

Some Treaty theorists argue that decolonisation is critical to the implementation of tino rangatiratanga. Decolonisation, as explained by Fanon, as:

...a historical process...the meeting of two forces, opposed to each other by their very nature...[it] never takes place unnoticed, for it influences individuals and changes them fundamentally...(Fanon, 1965, p. 30).

Decolonisation challenges colonisation and refers to a process of reclaiming, reconstructing, and revitalising indigenous realities. It is linked to a range of far reaching political choices, including the formation of a new states (Bishop, 1996; Bishop & Glynn, 1999; Graham, 1998a; Quentin-Baxter, 1998; Tuhiwai-Smith, 1999). In Aotearoa the notion of the formation of a new state is not something that is encouraged by the Crown or supported by Government. Firstly there is a fear of loss of power and resources, and secondly there is the fear of the establishment of an apartheid system similar to that which existed in South Africa (Anaya, 1996; Graham, 1998a).

Decolonisation was a process that took place most notably during the late 1960 when the young accomplished Māori leaders who had been politicised by such people as Paulo Freire, Che Guevara and Malcolm X 'forg[ed] international alliances with radical countries and revolutionary movements of the Third World countries' (Awatere, 1984, p. 79). One of the consequences of these alliances was a new wave of young Māori leaders who actively challenged existing hegemony and endeavoured to politicise others. For example, within the Women's Refuge Movement, Māori women actively challenged Pākehā and Māori alike about the appropriateness of services being delivered to Māori by organisations that were run by Pākehā. Māori women argued that as most of the clientele were Māori women, Pākehā women must move over and let Māori lead (Campbell, 1998). The result of these activities was the establishment of separate caucuses within the refuge movement.

In a less dramatic way, a decolonisation process has taken place in the Anglican Church with the establishment of a Tikanga system in 1992 (Melbourne, Undated). The Tikanga system emerged as a result of Māori and Pākehā active within the church searching for ways of addressing the rights of Māori and finding ways of power sharing. The system involves three cultural streams, Māori, Pākehā and Pacifica. Each stream is responsible for making decisions for their own people. In cases where there are tensions between the streams, strategies are implemented to ensure Māori are not alienated (Paterson, 1995; Te Paa, 1995). These strategies include each culture being responsible for running their part of the church. If any common issues come up unless a consensus can be arrived at no decision is implemented. Prior to the establishment of the tikanga system decisions were commonly made and implemented by Pākehā. Such processes required commitment and maturity in each of the groups and a willingness to reflect their values and beliefs. Currently this approach has been mooted as a model for government structures as well (Fleras & Spoonley, 1999; Paterson, 1995; Te Paa, 1995).

Summary

While some scholars argue tino rangatiratanga is a complex, multifaceted, fluid and context related Māori norm others are clear that tino rangatiratanga is about mana and tapu and whakapapa or as Durie argues Māori leadership personified (Durie, 1998a; Fleras & Spoonley, 1999; Hiroa, 1958).

The debates about tino rangatiratanga became most apparent during the 1960's Māori resistance period when Māori demonstrations began as Māori claimed their Article II Tiriti rights. In some cases scholars argued tino rangatiratanga was a made up word and of no use today (Christie, 1998). For others it is about Māori sovereignty (Awatere, 1984; Parata, 1995). Intricate to debates about tino rangatiratanga are Crown claims of sovereignty and desire to maintain it.

Three tino rangatiratanga discourses explored in the current thesis were, sovereignty, self-determination and positive Māori development. The differences between the

three were the amount of power control and authority Māori had and the nature the relationship Māori have with the Crown. For example, the power, control and authority discourse in tino rangatiratanga as sovereignty is about supremacy and the lawful right to control the activities within a nation state. Tino rangatiratanga as self determination and positive Māori development take a lesser view and view power, control and authority as power, control and authority over decision making processes. There are those that argue tino rangatiratanga can be practised at individual, whanau, hapu, and pan tribally, generally though scholars believe that tino rangatiratanga is about collective action and that collective is iwi.

Regardless of the debates about tino rangatiratanga and how it can be practised, tino rangatiratanga does have the potential to engage Māori and the Crown in meaningful debates about te Tiriti o Waitangi. For meaningful debate, the Crown will need to address its Article II Tiriti responsibilities and find ways to protect Māori tino rangatiratanga. One step in that direction is to implement Tiriti legislation and policies.

A tino rangatiratanga policy making framework has been mooted by Durie but, as he argues, it is complex and difficult to implement. A tino rangatiratanga policy process might:

- challenge the dominance of colonial discourses in the policy process
- establish and maintain both strategic domestic and internationally alliances
- establish Tiriti clauses within existing Crown legislation
- develop Tiriti principles to actualise tino rangatiratanga in practise
- embed tikanga Māori within Crown policies
- develop infrastructures to effectively implement tino rangatiratanga policies.

Chapter Four explores the influence of Crown directed policies in the marginalisation of tino rangatiratanga and how tino rangatiratanga in contemporary legislation and policies has the potential to change the political landscape.

Chapter Four

TE MANA O NGA TUHITUHI KORERO

The power of policies

Ehare taku toa, he taki tahi, he toa taki tini

My success should not be bestowed on to me alone, as it was not individual success but success of a collective

Government legislation and policies have played a large part in the marginalisation of tino rangatiratanga. As mentioned in Chapter Two and Three this was made possible by the signing of Te Tiriti o Waitangi and the legitimisation of Hobson's text as authoritative. While the Crown sought to embed its assumed position, Māori fought to retain sovereignty. An uneasy peace reigns where the Crown argues the Treaty gave it the right to make laws for the country and Māori argue that those rights are only valid if tino rangatiratanga is protected (Te Puni Kokiri, 1999b, 2001). International interpretative rules in the form of *contra preferentum* remains clear on this matter; in cases of ambiguity, a treaty is to be interpreted against the party drafting it, in this case the Crown (The Waitangi Tribunal, 1989). Regardless the Crown continues to establish and implement policies at times that are not only harmful to Māori tino rangatiratanga but to the nation as a whole.

The purpose of Chapter Four is to explore the dynamics of tino rangatiratanga as played out in colonial legislation and policies. Section one begins by discussing policy in its broader sense exploring definitions and processes in an endeavour to provide a backdrop to understanding how colonial legislation was used to colonise. The processes used to embed colonial legislation and a policy is at the centre of section two. Section two demonstrates how the Treaty of Waitangi was used as a hegemonic tool of oppression. Acknowledging legislation and policies as sites of struggles over ideals, section three, discusses tino rangatiratanga responses to the imposition of colonial legislation and policies. Section four questions tino rangatiratanga as a site of constructive engagement and presents a tino rangatiratanga

policy framework from the literature. Section five provides a summary of key points from Chapter Four and introduces Chapter Five.

What are policies?

In some contexts, policies are understood to be organisational level administration documentation that are used to ensure staff achieve what it is they are paid to achieve. In other cases policies are thought to be written documentation that governments use to administer resource allocations. The idea that policies might be more than administrative mechanisms began to emerge in the 1930's when Lasswell, a psychologist and political scientist, argued that policies are political and determine who get what, when, where and how (Lasswell, 1936). In the 1950s, with the establishment of policy analysis as a discipline, theorists began to study policy in earnest (Fischer, 1995). Critical questions arose about whose values drove the policy, whose needs were being addressed and how policies act to address the needs.

Fischer defines policies as 'political agreement on a course of action (or inaction) designed to resolve or mitigate problems on the political agenda – economic, social, environmental and so on' (Fischer, 1995, p. 2). Fischer's definition highlights the political nature of policies. A problem is identified and political agreement is reached about what, if anything, to do about it. Similar to Fischer, Dye suggests policies are 'anything a government chooses to do or not to do' (Dye, 1972, p. 2). Dye's definition reinforces the power government has to decide what is to be done or not done. The link between politics and power is further articulated by Shore and Wright who argue that policies are political tools used by Governments 'to regulate a population from the top down, through rewards and sanctions' (Shore & Wright, 1997, p. 5).

Governments use policies to manage society by rewarding those who comply and often punishing those who do not. Simple examples are traffic rules such as those relating to speed. Drivers who stay within the speed limit are rewarded by not being fined, those who do not, are fined. While developing policy definitions scholars began to debate the policy process.

Policy processes

For Māori policy processes are important because as Shore and Wright argue policies are mechanisms through which Governments control the populations, in this case Maori. Further as discursive text policies provide a rationale and evidence to support the integration of tino rangatiratanga in Crown legislation and policies. As mentioned earlier discursive theorists argue policies produce, reproduce and legitimate dominant realities while marginalising minority ones (Fischer, 1995; Shore and Wright, 1997). There are four main types of policy processes acknowledged here; rationalist, stakeholder, participatory, and neo-liberal (see Table 2). Another emerging one is the incremental policy process.

Table 2: Types of policy processes

	Rationalist	Stakeholder	Participatory	Neo-liberal
Decision making process	Problem and solution identification	Manage divergent interests and values through negotiation, bargaining, brokerage, compromise	Produce legitimate consent through citizen participation, debate, discussion	Allocate resources efficiently through intuiting and maintaining market-like mechanisms
Decision makers	Politicians and experts	Interest groups, government, agencies	Citizens and social movements	Consumer
Implementation	Through clearly identified stages and structures	Through interest groups	Through citizens and social movement groups	Through the market place

(adapted from Tenbensen & Gauld, 2001, p. 40)

Rationalist policy approach

Rationalist policy processes were theorised as linear, sequential and orderly. Such policy processes are favoured by the Crown and crown agents, in Aotearoa.

Rationalists treat policy issues as problems that need to be solved. The process often involves, problem identification, development of possible solutions and implementation and evaluation of the chosen solution (Anderson, 1997; Colebatch & Parkin, 1998; Davis & Ashton, 2001; Kingdon, 1995). Those who make the decisions are frequently politicians or experts in a particular policy field such as medicine. Rationalist policy processes act by legitimating majority voices, which in Aotearoa are those of Pākehā, and marginalising minority voices, which in Aotearoa are those of Māori and other minority groups. In effect the rationalist model marginalises tino rangatiratanga (Fischer, 1995; Shore & Wright, 1997).

Stakeholder policy approach

In the stakeholder process, focus is on including a range of divergent interests and values through negotiation, bargaining, brokerage and compromise. The decision makers here are the Crown, Crown agencies and interest groups, including Māori (Davis & Ashton, 2001). While Davis and Ashton argue that in the stakeholder process interest groups implement policies in Aotearoa Government and government agencies are intimately involved in the implementation and evaluation of policies as they typically fund the implementation of selected policy solutions. History shows that not only were Māori voices not hugely influential in policies, Governments and government agencies seldom funded Māori policy solutions fully.

Participatory policy approach

Closest to a tino rangatiratanga process is probably the participatory process. Similar to Māori decision making processes the participatory process involves producing legitimate consent through citizen participation, debate, and discussion. The people who make the decisions are citizens and social movements. Implementation of the policies again occurs through citizens and participants in social movement groups. For example, policies to establish and implement te Kohanga Reo and Kura Kaupapa Māori were largely driven by Māori and eventually funded by the Crown. While it looks like these policies are established and implemented by citizens and participants

in social movement groups the Government is very much in control. The control is exercised through the development of Government criteria for the use of funds and the Government evaluation models in the implementation of the policy. A subtle means of marginalising tikanga Maori.

Neo-liberal policy approach

Within neo-liberal policy processes the focus is on allocation of resources through market-like mechanisms. The decision makers are the consumer and implementation of the policies is market driven. For example, in the health sector the 1993 Health Reforms saw the instigation of user pay health services (see Chapter Five). Critiques of this framework argue Government only pretend to involve consumers and at the end of the day the decisions implemented are really those decisions Government wants (Kelsey, 1998; Shore & Wright, 1997). Within Aotearoa, the neo-liberal process has provided a mechanism through which Māori were able to compete for funding on the open market.

Incremental policy approach

Other scholars argues it is not possible to identify a clear-cut group of decision makers, or an event, which can be pinpointed as the moment when a particular policy decision are made (Kingdon, 1995; Stone, 1997). As a consequence other theorists argue policy making is incremental. Incrementalists argue policy arises from a continuous bustle of activity in which people do not perceive themselves as making policy but over time the congruencies of small acts set the direction and the limits, of government policy (Kingdon, 1995; Stone, 1997).

Policies: the marginalisation of tino rangatiratanga

Who the decision makers are is important in the development, implementation and evaluation of policies. Policies act like paradigms. The values and beliefs of the policy makers determine what policy issues will be taken seriously, the solutions

generated, how and who will implement them, and most importantly whose values and belief will be used to evaluate them (Fischer, 1995; Stone, 1997). As mentioned previously tikanga Māori was holistic, collective, socialist, and some say genderless society where the physical, emotional, mental and spiritual realms were interconnected (Cunningham, 1998; Durie, 1998b; James & Saville-Smith, 1990; Pere, 1991). In contrast, the dominant values and beliefs of the Crown, crown agents and missionaries were capitalistic, racist, and patriarchal and based on christianity (Awatere, 1984; Dow, 1999; Lange, 1999; Mikaere, 1995; Newell, 1954).

When society acts discursively to legitimate one sub-set of society over another then we enter the world of discourse theory. Discourse theorists argue that discourses (sets of values and beliefs) collude across discursive fields (schools, churches, justice systems and in this case policies) to embed dominant discourses, in this case capitalistic, racist, sexist and christian discourses (Awatere, 1984; Durie, 1998b; Foucault, 1977; Robson & Harris, 2007). The dominance of capitalistic values saw the implementation of hegemonic legislation and policies implemented (Awatere, 1984). The dominance of racism saw the marginalisation and alienation of Māori (Awatere, 1984; Durie, 1998b; Fleras & Spoonley, 1999). The dominance of patriarchy saw the marginalisation and alienation of women (Awatere, 1984; Irwin, 1992b). The dominance of Christian beliefs saw Māori spiritual beliefs marginalised and alienated (Durie, 1998b; Mikaere, 1995). Once Te Tiriti was signed another dimension was added, that of Crown sovereignty.

The values and beliefs of the early colonial policy makers were to impact on the policy solutions found, acquisition and assimilation solutions. Policy subsystems provide an explanation of how this occurred (Foucault & Rabinow, 1991; Howlett & Ramesh, 1995; Hult & Walcott, 1990). Policy sub-systems are systems consisting of interested stakeholders (private and state) who advance a particular issue (policy formation communities) and the networks that exist to achieve the policy outcomes (policy formation networks) (Aitkinson & Coleman, 1992; Howlett & Ramesh, 1995; Hult & Walcott, 1990; Katzenstein, 1977; Waarden, 1992). Policy sub-systems

provide a way of understanding the dynamic interplay between policy making and policy actors.

Early colonial policy formation communities were made up of decision makers with acquisition and assimilation epistemologies. Policy formation communities can be extremely powerful in finding policy solutions as at times they act discursively to develop and support each other's interests (Cater, 1964; Howlett & Ramesh, 1995; Shore & Wright, 1997). For example, theorists have found:

...interest groups, congressional committees and government agencies in the United States...developed a system of mutual support in the course of constant mutual interaction over legislative and regulatory matters. These three-sided relationships in areas such as agriculture, transportation and education were dubbed the 'iron triangle' to capture the essence of their iron clad control over many aspects of the policy process (Howlett & Ramesh, 1995, p. 125).

In my view early colonial policy communities that acted as iron triangles were the Crown, crown agents and the missionaries. While iron triangles do exist and are influential, other policy communities also exist.

A hegemonic community is one where the state and society generally agree about the parameters of an issue and there is a clear identifiable epistemic community. An imposed community exists when there is a dominant episteme but the state and society are divided over the appropriateness of an idea. A leaderless community exists when the state and society agree and there is no dominant episteme. Where as an anarchic community exists when state and societal actors are divided and no dominant episteme exists (Howlett & Ramesh, 1995; Sabatier, 1993).

Drawing on the preceding perspective, early colonial policy communities might be understood to be hegemonic. Firstly, the state and the colonial community generally agreed on policy solutions, because they had similar epistemologies. Māori were not actors in the government political arena. The establishment of the 1852 Constitutional Act put substantive barriers to Māori men participating in government. The Act excluded any one who was under 21 years and did not hold individual land title from

voting. The policy solutions generated suited the cultural norms of the dominant group which focused on land acquisition and assimilation (Awatere, 1984).

Within policy sub-systems are policy formation networks. Policy formation networks vary according to the number and type of participants (committed, temporary, long term, short term) and their relationship to each other (Howlett & Ramesh, 1995; Waarden, 1992). These networks join the government in policy making (Aitkinson & Coleman, 1992; Katzenstein, 1977; Sabatier, 1993). Policy formation networks are made of individuals and groups, who not only have common epistemologies but also an interest, usually material, in the policy (Aitkinson & Coleman, 1992; Katzenstein, 1977; Sabatier, 1993). Early colonial networks consisted of individuals who were politicians, missionaries, and doctors and groups such as political parties, churches, and hospitals. The common epistemology was land acquisition and assimilation of Māori into the cultural norms of the Pākehā.

As mentioned earlier crucial to the implementation of the acquisition and assimilation policies was the adoption of Hobson's text of Te Tiriti as authoritative and the implementation of Article I of Hobson's version.

Article I of Hobson's text quite clearly gave the Crown sovereign rights over Aotearoa, whereas Article I of Williams's text did not. With sovereignty in mind the early colonial Government set about developing and implementing what Awatere and Said refer to as hegemonic legislation and policies (see Table 3) (Awatere, 1984; Said, 1979). For example, the 1841 Lands Claims Ordinance gave statutory recognition to a Crown right of pre-emption, at the expense of any Māori right of tino rangatiratanga. The 1862 Native Land Act led to the breakdown of Māori communal ownership of land, and the 1865 Native Land Courts through the courts alienated 10 million acres of Māori land and continued the individualisation of Māori land ownership (Nga Tangata Cosmos, n.d.). Such legislation had a severe impact on Māori land ownership and therefore tino rangatiratanga. From owning 66,400,000 acres of land in 1840 by 1975 this had dropped to 300,000 acres.

Table 3: Links between colonial legislation and Māori land ownership

Date	Colonial legislation	Māori land ownership³
1840	Treaty forged	66, 400, 000
1841	Land claims ordinance	
1844	Protectorate Department abolished	
1852	The Constitution Act	34,000,000
1862	Native Land Act	
1863	Suppression of Rebellion Act New Zealand Settlement Act	
1864	Native Reserves Act	
1865	Native Land Courts	
1866	Oyster Fisheries Act The East Coast Land Titles Investigation Act	
1868	East Coast Act	
1873	A new Native Land Act	
1877	Fish Protection Act	
1879	Amendment to the Native Land Act Peace Preservation Bill	
1880	Māori Prisoners Act	
1881	West Coast Settlement Act Native Reserves Act	
1886	Native Lands Administration Act	
1887	Native Land Act	
1892	Native Department abolished	II,079,486
1893	Native Land Purchase and Acquisition Act	
1894	Advances to Settlers Act Native Land Court Act Validation of Invalid Land Sales Act Māori Land Settlement	
1903	An Act reaffirms Judge Prendergasts 1877 ruling that the Treaty is a nullity	
1905	Further amendments to the Native Land Act	
1908	Tohunga Suppression Act	
1909	Native Health Act	7,137,205
1952	Public Works Act	
1953	Māori Affairs Act Town and Country Planning Act	
1967	Māori Affairs Amendment Act Rating Act	
1975	Treaty of Waitangi Act	3,000,000

³ In acres

As Māori have whakapāpa links back to the land, Papatūānuku (the original earth mother) land ownership was an integral part of tino rangatiratanga. Acquisition legislation and policies seriously undermined these links and therefore tino rangatiratanga and were integral to the assimilation process.

Simultaneously to land acquisition the Crown developed assimilation policies. Assimilation policies sought to establish government control over Māori by phasing out tribal authority. They were in effect hegemonic policies which established Pākehā as the dominant group. Assimilation policies viewed Māori as the problem, what is now known as a social order approach to policymaking.

In an endeavour to get policies recognised as worthy of consideration policy makers often use language and other forms of rationale to support their case (Kingdon, 1995; Stone, 1997). Early colonial policy makers used blaming language and fear tactics to get their policy issues recognised. For example, in 1863, fearful of the influence of the prophet Rua Ratana, the Suppression of Rebellion Act 1881 was established. The Act was used to imprison Te Whiti and his followers by labelling them as rebels. Numerous legislation and policies solutions were generated during early colonisation. While ostentatiously formulated to ‘help’ Māori, they had a more insidious purpose, which was control and assimilation (Awatere, 1984; Barrett & Connolly-Stone, 1998; Cheyne, O'Brien, & Belgrave, 2000; Dawson, 2001; Dow, 1999; Pearson, 1990; Saraga, 1998).

As a result of colonisation and acquisition and assimilation legislation and policies land was not the only thing Māori lost, their health was also seriously compromised, as measured by population growth.

An alternative solution: tino rangatiratanga

As sites of struggle, policies provide settings in which multiple conflicting ideals exist (Fischer, 1995; Stone, 1997). They also provide opportunities for the development of alternative solutions and the development of new discourses. So to some extent policies can be viewed as discursive fields in which discourses vie for

expression. The provision of opportunities for the development of alternative solutions and the development of new discourses does not happen as a natural course of events. Rather they emerge as the result of struggle and resistance. In contemporary Aotearoa, while there have been acts of resistance at an individual, whānau, hāpu an iwi level, it was through collective resistance across the nation that most gains were made.

Māori assertion of tino rangatiratanga

With the emergence of young dynamic educated Māori leaders, in the 1960s tino rangatiratanga emerged as collective resistance (Durie, 1998a; Walker, 1990). For example, one memorable act of resistance was the Māori Land March in 1975. At the time, Māori were having problems getting loans to develop their land (Rua Paul, personal communication, April, 1975). Alongside this were Crown policies which confiscated Māori land that was not being lived on or not being developed (Rua Paul, personal communication, February, 1975). In response to these oppressive pieces of legislation the Land March emerged. The well-coordinated act of passive resistance took the country by storm and was the beginning of similar acts of resistance elsewhere in the nation. With the growth in resistance toward oppressive colonial policies, Māori activists shifted their focus from the land issues to Te Tiriti o Waitangi and the Waitangi celebrations (Walker, 1990). Activists argued, for a time, the celebrations were a sham as Te Tiriti was a fraud (H.A.R.T. meeting, 1976).

Takaparawha (Bastion Point) was another focus of resistance. In 1977, the Government proposed to sell land at Takaparawha which had earlier been taken from Ngati Whatua. The land was to be used for high priced housing. Because it was the only piece of Ngati Whatua land that had not been taken by the Crown or in private ownership, an occupation followed. Eventually Takaparawha and other land were returned to Ngati Whatua. Critical to these events was the establishment of Nga Tama Toa and the Māori women's movement. The former was established during the late 1960's and early 1970's (Awatere, 1984; Whitmore, 2000).

While Māori activists were challenging the Crown about land acquisition, contemporary Māori women were challenging patriarchy and racism (Dann, 1985; Te Awēkotuku, 1991b). In the 1970s, with the emergence of Nga Tama Toa and Māori women's involvement in acts of resistance, a strong network of Māori women emerged; women like Ngahuia Te Awēkotuku, Vapi Kupenga, Kataraina Pipi, and Huhana Tuhaka. For these women and others like them the struggle was for recognition as Māori women in their own right as well as a struggle for the recognition of Māori rights within Aotearoa (Dann, 1985). Te Tiriti was the vehicle used as a mechanism of resistance by these women (Mikaere, 1995; Mohanram, 1999).

The media played a huge part in publicising the ongoing progress of Māori resistance. During the Land March, Waitangi Day and Takaparawha occupation, the media were not far behind. While in most cases media coverage was racist it served to make visible Māori resistance at a national and international level (Awatere, 1984; Walker, 1990).

Alongside the Māori resistance movement were Pākehā allies (Consedine & Consedine, 2001; Huygens, 2006; Margaret, 2002). Pākehā allies were generally those Pākehā involved in community groups who were actively resisting colonial thinking such as H.A.R.T (Halt All Racist Tours), Women's Refuge, Rape Crisis and Greenpeace. The most critical politicising event was probably the Springbok tour, which saw Māori and Pākehā standing together demonstrating against apartheid in South Africa (Consedine & Consedine, 2001; Margaret, 2002). Ironically while Pākehā demonstrated against oppressions in other countries, they were largely blind to similar oppressions occurring for Māori in Aotearoa. However, the 1981 Springbok tour demonstrations did bring to the fore issues of oppression that were to eventually influence Pākehā thinking about domestic racism and Tiriti breaches.

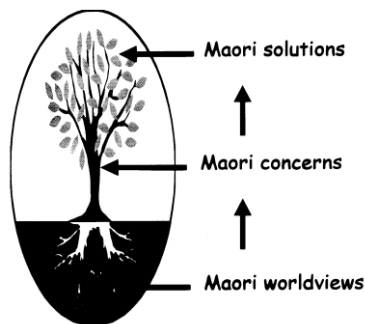
At the same time sub groups within the dominant culture began to demonstrate against gender oppression and racist practises in other countries. Feminists across a wide spectrum of views and identities began to make space for themselves in what

had previously been male-dominated domains, such as academic and political settings.

During this resistance, tino rangatiratanga met Crown sovereignty head on. While debates about Te Tiriti had been rumbling in the background since its signing, it was in the 1960s that tino rangatiratanga re-emerged with force. Within the policy domain questions arose around who should make policy decisions impacting on Māori, who should control them and who should benefit (Cheyne, O'Brien, & Belgrave, 2000; Durie, 1998a). Crown Tiriti policies tended to treat Māori as homogenous, ignoring the rich diversity of Māori voices. Māori are not homogenous people, and over a short period of time, those iwi who did not belong to a runanga and refused to join, argued their Tiriti rights to establish a separate relationship with the Crown.

The key policy formation communities were now the Crown, crown agencies, iwi, hāpu, whānau, Māori organisations, Pākehā allies, non-allied Pākehā groups, feminists, and people with different abilities. With Māori activists and Pākehā allies now being involved in policy making a different story had begun to be played out. A paradigm shift began to occur, from Māori being defined as the problem, to the Crown being defined as the problem (Jackson, 1991; Smith, 1988; Te Puni Kokiri, 2001; Tuhiwai-Smith, 1999; Walker, 1990). Within this policy community tino rangatiratanga was asserted through the establishment of Tiriti policies within sectors such education, justice, and health. Tino rangatiratanga in the policy making process, involved policy issues that emerge from Māori worldviews, that address Māori concerns and find Māori solutions (see Figure 4) (Haereroa, 1998).

Figure 4: Illustration of tino rangatiratanga in policy making



(Haereroa, 1998).

As the result of resistance by oppressed cultures globally, the resurgence of Māori resistance nationally and a developing Pākehā social consciousness, over one hundred and sixty years since the signing of Te Tiriti, Aotearoa saw the partial recognition of tino rangatiratanga, as Tiriti clauses were added to Crown legislation. For example, Part 3A of the Māori Fisheries Act 1985 made references to Article II of Te Tiriti. The State Owned Enterprises Act, 1986, where it was mandated that ‘Nothing in the Act shall permit the Crown to act in a manner that is inconsistent with the Treaty of Waitangi’ (“The State-Owned Enterprises Act 1986”, 1986), was a turning point. What followed was the introduction of Tiriti clauses in other sectors. For example the Resource Management Act required local authorities to have regard to Māori concerns when considering building consent and other land use applications; the Hazardous Substances and New Organisms Act 1996 requires the Environmental Risk Management Authority to have regard to Māori concerns and finally the Public Health and Disability Act 2000 includes a Tiriti clause which states:

In order to recognise and respect the principles of the Treaty of Waitangi, and with a view to improving health outcomes for Māori, Part 3 provides for mechanisms to enable Māori to contribute to decision making on, and to participate in the delivery of, health and disability services (“New Zealand Public Health and Disability Act”, 2000, p. 5).

Tino rangatiratanga has also been influential in genetic engineering and air waves. In 2000, a Royal Commission on Genetic Engineering urged the Government to make all speed in responding to a Māori declaration of property rights in all indigenous

flora and fauna. Another example involved the air waves claim in which Māori were granted rights to a quarter of the radio spectrum auctioned in 2000.

The Waitangi Tribunal

Following the appointment of Matiu Rata as the Minister of Māori Affairs in 1975, the Waitangi Tribunal was established to hear contemporary claims of breaches of Te Tiriti and to make recommendations for their settlement (Gilling & O'Malley, 2000). The 1975 Treaty of Waitangi Act did little to advance Māori rangatiratanga but it set the scene for further development. Although the Tribunal may be argued to be yet another hegemonic mechanism introduced by the Crown it has gone from strength to strength and is now recognised as a leading force in Tiriti claims. Its findings are beginning to influence the health, education and other social sectors. Critical to these changes was the appointment of Judge Eddie Durie as Chairperson to the Tribunal in 1981, the 1985 Treaty of Waitangi Amendment Act, which broadened the powers of the Tribunal to include claims dating back 1840, and finally the 1988 Treaty of Waitangi (State Enterprises) Act, which gave the Tribunal, under certain circumstances, powers to *order* (not just recommend) the return of Māori land to its rightful owners (Durie, 1998; Gilling & O'Malley, 2000; Williams, 2000). Initially the Tribunal comprised of three people. Today it has a staff of over 150 people (Te Puni Kokiri, 2001).

The Tribunal has argued that it is the intent of Te Tiriti that is important (Durie, 1998a). The Tribunal proposes that the intent of Te Tiriti is the protection of the Māori people and culture in exchange for the powers of government (Te Puni Kokiri, 1999b, 2001). Further it argues that any Tiriti issues arising may be resolved through the principles of Te Tiriti (see Table 4).

Table 4: Principles emerging from the Articles of the Treaty of Waitangi

Waitangi Tribunal	Court of Appeal	Royal Commission on Social Policy
Partnership	Partnership	Partnership
Active protection	Active protection	Participation
Good faith		Protection
Redress		

(compiled from Durie, 1994c; Te Puni Kokiri, 2001).

However, some Māori argue the principles of Te Tiriti are Crown constructs and basing Māori-Crown relationships on the principles ignores the tino rangatiratanga status of Māori (Durie, 1998b; Royal Commission on Social Policy, 1988). The Crown principles were developed by the government in an attempt to understand and implement Te Tiriti. In developing the principles the Government re-interpreted Te Tiriti based on its perspective rather than Māori perspectives and, some scholars argue, effectively re-wrote Te Tiriti (Durie, 1998b; Royal Commission on Social Policy, 1988). To guide settlement claims these principle now include, good faith, restoration of relationships, just redress, fairness between claims, transparency and Government-negotiated (Te Puni Kokiri, 2001). Other principles utilised by the Crown were partnership, protection (active) and participation.

For example, in some cases, theorists argue Tiriti discourses emerge from the the three ‘ps’, partnership, participation and protection while others argue Tiriti discourses arise from the Articles (kawantanga, tino rangatiratanga and oritetanga that more realistically reflect the Crown’s responsibilities (Durie, 1998b; Royal Commission on Social Policy, 1988). When using the principles Article II is taken to mean protection of things Māori (Te Puni Kokiri, 2001). When using the Articles it is taken to mean tino rangatiratanga or Māori power, control and authority.

The Crown justification for the use of principles in policy development involved the complexities of making sense of the different texts (at least nine copies of the English text exist), making sense of the different interpretations and finding a common ground between the Māori and English text of Te Tiriti (Durie, 1998a; Orange, 2001;

Royal Commission on Social Policy, 1988; Te Puni Kokiri, 2001). While Tiriti principles are advanced and considered to be effective in mediating the differences between the interpretations of Te Tiriti, a number of criticisms arose. Tiriti theorists argue that by using the principles instead of the Articles, the true meaning of Te Tiriti may be lost (Durie, 1998a; Durie, 1998b; Royal Commission on Social Policy, 1988). For example, the principle emerging from Article II of Hobson's version of Te Tiriti is active protection. Article II of Te Tiriti was about tino rangatiratanga which is much more than active protection.

As already mentioned, focusing on the principles alone there is the possibility that Te Tiriti and its meaning may be re-written (Royal Commission on Social Policy, Vol II, 1988). For example, in July 1989 the Labour Government developed Tiriti principles for Crown action and argued that these principles were drawn from legislation about Te Tiriti but scholars argue that the Government drew on their own understanding of Te Tiriti while minimising Māori tino rangatiratanga (Durie, 1998a; O'Sullivan, 2008; Rumbles, 1998; Williams, 1989).

Tiriti principles are being mooted and implemented and give rise to a number of theoretical and practical issues. To simplify matters Durie argues that the principles emerging from the Tribunal are used in Tribunal claims; those emerging from the Court of Appeal are related to issues to do with the State Owned Enterprises Act 1986; and those from the Royal Commission on Social Policy are related to social policy issues (Durie, 1994c; Durie, 1998a).

To give effect to tino rangatiratanga the principles mooted by the Tribunal (partnership, active protection, and redress) are considered within the historical, social, spiritual, cultural and political location of the claim for redress (Wharehuia Milroy, personal communication, April, 2002). Hence, the Tribunal principles when applied are fluid and flexible and dependent on the nature of the claim, the location in which the claim is taking place and the interpretation of the principles by Māori who are knowledgeable about individual iwi, hapū and whānau kawa and tikanga, Māori and Pākehā knowledgeable about the law, and Māori and non-Māori who have life and academic experience in the claims process.

One principle identified by the Court of Appeal is partnership. With respect to Article I partnership is about protecting Māori tino rangatiratanga. From the Court of Appeals perspective partnership is achieved by acting reasonably, honourably and in good faith, making informed decisions through consultation and fiduciary duties (Te Puni Kokiri, 2001). While being lofty principles the principles are ambiguous and the expression of these principles are often left to individual interpretations. Similarly when the principles are applied cross-culturally, there is a high likelihood that conflict will occur because the underlying discourse is a Crown discourse.

The principles mooted by the Royal Commission on Social Policy (partnership, protection and participation) were not linked to any Statutes and hence do not have any legal standings (Durie, 1998b)⁴. Without legal standing the protection and expression of tino rangatiratanga are reliant on people's good will. Added to this the principles mooted by the Royal Commission on Social Policy have been criticised as being influenced by the Anglican Church Bicultural Commission whose emphasis was on working partnerships rather than the words of Te Tiriti itself (Mason, 1993).

The expression of tino rangatiratanga through the application of Tiriti principles, as outlined by Durie, is therefore not as simple as it appears. In practise, the players themselves often determine the relationships. For example, Te Puni Kokiri, a government department responsible for advising the Crown and other Crown departments on Māori issues, asserts that Tiriti relationships emerge from the principle of rangatiratanga and all other relationships are guided by this one principle (Te Puni Kokiri, 1999b).

Finally, from which version of Te Tiriti do these principles emerge from? The Crown has ruled that in Tiriti negotiations as well as in judicial systems both versions of Te Tiriti must be considered. However, the Contra Preferentum principle argues if there are any ambiguities the matter should be resolved in favour of the party that did not draft it (The Waitangi Tribunal, 1989). The acceptance of Contra Preferentum principle would see Māori tino rangatiratanga at the forefront of all legislative and policy endeavours. An example of this was the States 1994 Settlement of Treaty of

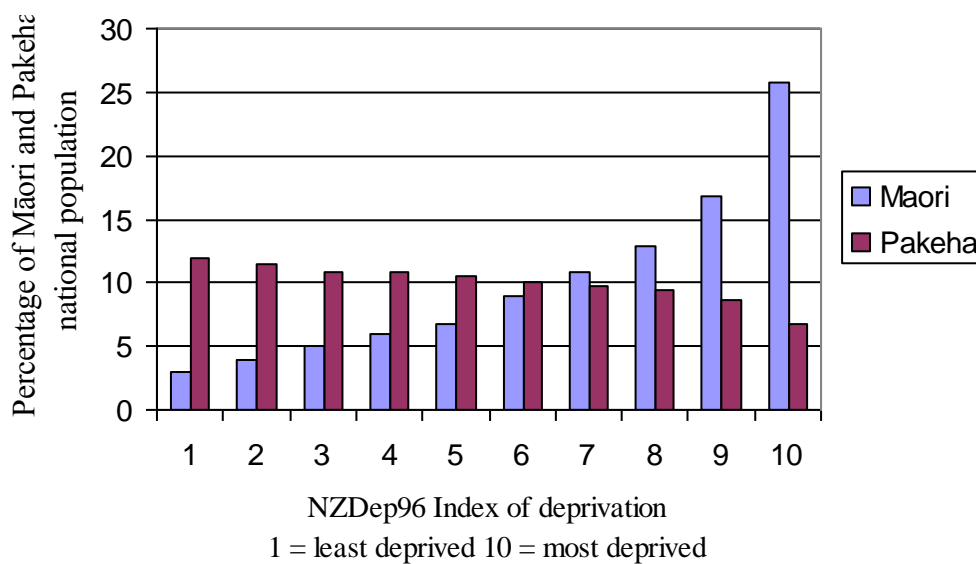
⁴ A Treaty clause has since been included in the New Zealand Health and Disability Act, 2000.

Waitangi Claims proposal, commonly known as the Fiscal Envelope. What the State elected politicians that formed the Government of the day did was put a time limit and cap on any Treaty Claims, thereby abdicating Crown responsibility to address Breaches to the Treaty, again ignoring tino rangatiratanga.

It is thus evident that the implementation of tino rangatiratanga through Tiriti policies is complex and are often determined by the setting, the sector (health, judicial, education), the location (tribal) and the people involved (whānau, hapū, iwi, Māori organisations, Pākehā organisations, Government agencies, and of course the Crown). The implementation of tino rangatiratanga through Treaty legislation and policies has seen some benefits for all New Zealanders (Ajwani, Robson, Tobias, & Bonne, 2003; Cook, 1984; Huygens, 2007; Kirton, 1997; Te Puni Kokiri, 2000).

However, Māori still lag behind Pākehā (see Figure 5). Māori are less likely to have a formal qualification, less able to secure employment and therefore have less income coming into the household, are less likely to have access to transport, and a high proportion do not own their own homes, compared to Pākehā (Te Kanawa, 2000).

Figure 5: Deprivation profile of Māori and Pākehā



If as Flera and Spoonley argue tino rangatiratanga is a site for constructive engagement between Māori and the Crown, further engagement is required.

Summary

Crown legislation and policies continue to play a large part in the marginalisation of tino rangatiratanga. To a degree this reflects the dominance of Crown values in policymaking. Like paradigms the values and belief of the policymakers influence what issues are considered for policy, what solutions are found, what resources are applied and how the policy will be implemented and evaluated. If, as some scholars argue, policies are becoming central concepts in the organisation of contemporary society, it seems logical then to view policies as contemporary mechanism for the reclamation, restoration and rewriting of Māori tino rangatiratanga (Durie, 1994c; Durie, 1998a; Shore & Wright, 1997). For this to happen Māori must have more say in the development and implementation of policies that some argue impact on them and others argue impact on all people in Aotearoa.

With the signing of Te Tiriti o Waitangi and the implementation of Hobson's text, early colonisation saw a dominance of tikanga Crown over those of Māori tino rangatiratanga. The dominant policy formation community was hegemonic, the common epistemology within the policy community was acquisition and assimilation. The policy formation networks consisted of Crown agents, experts and very few Māori.

Māori resistance to the implementation of Hobson's text of Te Tiriti o Waitangi saw the establishment and implementation of Tiriti legislation and policies. However, Māori and the Crown come from different perspectives, Te Tiriti and The Treaty, hence Tiriti legislation and policies are implemented through Tiriti principles who some argue are colonial constructs and attempts to re-write Te Tiriti. Regardless the implementation of Tiriti legislation and policies has contributed to health gains for all New Zealanders.

Chapter Five demonstrates the influence of colonial legislation and policies in, health. The influence of colonial health policies is shown to have been detrimental to Māori tino rangatiratanga and health status. The Chapter also demonstrates the implementation of tino rangatiratanga policies in health service practises.

Chapter Five

HAUORA MĀORI

Māori Health

Māori health centres ‘on the personal and the collective...the relationships between the [people] and the environment both physical and spiritual’ (Cunningham, 1998, p. 396)

Māori health has gone from one of the best in the world to one of the worst (Mikaere & Milroy, 1998). To a large degree this has been the result of colonisation and the implementation of hegemonic legislation and policies (Awatere, 1984; Bishop, 1994; Tuhiwai-Smith, 1999). Early colonial legislation and policies sought to acquire land and in the process assimilate Māori into the cultural norms of the Pākehā and in the process Māori tino rangatiratanga was marginalised. A consequence of the marginalisation of Māori tino rangatiratanga is the poor health status for Māori (Dow, 1999; Durie, 1994c).

Chapter Five reviews Māori health practises in an endeavour to frame Māori health for the purposes of this study. Following this, discursive interactions between colonial health legislation and policies and Māori health are discussed showing the effect of colonial health legislation and policies in the colonisation process. Contemporary relationships between health legislation and policies and Māori health revitalisation are discussed, and the development of health services as they relate to Māori is highlighted.

Māori health

Traditional Māori health discourses were about maintaining a holistic balance between the spiritual and psychic worlds, the political world, the environment (the land, the sea, the bush, the birds, the fishes), the people (whānau, hāpu and iwi), the person’s position in Māori society (ariki rangatira, rangatira), tuakana/teina relationships, the past, the future and the present, and between the inanimate and the

living (Cunningham, 1998; Davis & Ashton, 2001; Dow, 1999; Durie, 1994c; Durie, 1999; Durie, 2001; Durie, 1997c). As mentioned earlier Māori believed we came from the gods and would return to the gods. Therefore, our mental, emotional, and physical health were intricately linked to the spiritual world (Durie, 1998b; Hiroa, 1958; Pere, 1991). Spiritual practises were integrated into the very existence of Māori well-being. Included in the spiritual practises of the Māori were our connections to our ancestors (Pere, 1991). Closely associated with the spiritual aspect of Māori health was mauri. Mauri is difficult to define but it is often referred to as the breath of life or life force. All living things had mauri. Without this they would die.

Another aspect of Māori health discourses was politics, Māori politics which were as important in the past as they are today. Traditional Māori politics were determined by the tikanga of the iwi. Decisions concerning whānau, hapū and iwi were made at hui, and kanohi ki te kanohi (Durie, 1998a; Pere, 1991). Included in the politics of Māori health were Māori economic and domestic affairs (Durie, 1998a; 1998b; 1999; Pool, 1991). The land, sea and human resources provided an economic base, which enabled Māori to barter for goods inter-iwi and internationally.

Environmental issues have always been important to Māori as a healthy environment meant a healthy whānau, hapū and iwi. Māori had whakapāpa connections to the land. Papatūānuku was considered the earth mother and represented a source of food and income. Within traditional Māori society whakapāpa linkages to particular iwi boundaries determined land ownership. Being able to establish whakapāpa linkages to a particular piece of land determined a person's tūrangawaewae (place to stand), which in turn related to issues of identity and hinengaro (mental health) (Durie, 1998a; 1998b; Hiroa, 1958; Lange, 1999; Pere, 1991; Pool, 1991). Links to iwi land gave Māori particular kaitiaki responsibilities. It was the responsibility of iwi to make sure the land was looked after for future generations (Durie, 1998a; 1998b; Hiroa, 1958; Pere, 1991). Māori links to the land on a more personal level were about rejoicing and enjoying working with and on the land (Pere, 1991). Māori had similar beliefs and responsibilities with regard to the moana in that the moana was to be respected as a source of food and cared for. Customary rituals were practised to

ensure the seabed was not over-exploited and would provide food for generations to come.

Another traditional health discourse was mana tangata or the importance of Māori people (Durie, 1994c; Durie, 1997c; Pere, 1991). Mana tangata was about people's position in the whānau, hapū and iwi, their roles and responsibilities as whānau, hapū and iwi members, their relationship to themselves and to the world. It was also about their spiritual, mental, emotional, and physical health.

A key cultural practise was taonga tuku iho which, refers to the 'highly prized practises and beliefs of our forbears, our ancestors' (Pere, 1991:28). One such practise was te reo which was important because it is through te reo that cultural nuances are passed down and that cultural norms learnt. Cultural norms and nuances are critical to the self-esteem of Māori and therefore their hinengaro. Māori society was an oral society. Hence, customary practises and whakapāpa linkages were passed on through te reo. Māori spiritual practises were integral to healing. Karakia was used in treating illness, particularly with respect to illnesses that had no known causes (Hiroa, 1952). Māori societal structures provided social support and created order in people's lives. Other healing practises included rongoā, and mirimiri.

Integral to the maintenance of the balance between mana wairua, the political, the environment and mana tangata were the cultural beliefs of tapu and noa. Within the health context tapu ensured whānau, hapū and iwi remained healthy. For example, within the pa, certain areas were kept for toileting purposes and other areas for food scraps (Durie, 1998b; Lange, 1999; Newell, 1954; Pere, 1991; Pool, 1991). Another example was during childbirth and for a time following, women and children were kept separate from others. This was partly to ensure mother and child were protected from disease during a vulnerable time but also to provide a time for mothering and without other demands being expected.

Existing alongside tapu was noa. In the health context, when the rules and regulations of tapu were removed the thing or behaviour became noa. This meant whānau, hapū and iwi were able to access things or practise behaviours which had previously been prevented. For example, in some cases when food was scarce a tapu was put on it to prevent people from gathering it until it was bountiful again. When it was in abundance the tapu was removed and people were again allowed to access it (Durie, 1998b; Hiroa, 1958; Lange, 1999; Newell, 1954; Pere, 1991; Pool, 1991). With the arrival of the Pākehā, the ability to practise Māori healing began to change.

Colonisation and Māori health

With the arrival of Pākehā, new communicable diseases were introduced; land wars occurred and colonial legislation and policies were implemented. Communicable diseases and colonial legislation and policies played a major part in the colonisation of Māori health.

Communicable diseases

The introduction of communicable diseases to a country and people who had not experienced these diseases before had detrimental effects. Pre-European contact communicable diseases existed in Aotearoa but the forms and durations of the diseases were mild (Dow, 1999; Lange, 1999). With the arrival of Pākehā, new diseases were introduced and the duration and incidence of communicable diseases increased (see Table 5) (Durie, 1998b; Hiroa, 1958; Pool, 1991).

Table 5: Diseases and the year introduced

Year	Disease
1770	Venereal disease Dysentery
1780	Tuberculosis
1790	Influenza
1810	Measles
1820	Catarrh Whooping cough
1830	Erysipelas
1850	Mumps Scarlet fever
1860	Typhus

(Ngata, 1898; Pool, 1991).

The impact of communicable diseases on the health of Māori can be illustrated using Pākehā migration (and associated diseases) and Māori population growth rate. During the second half of the nineteenth century, when Pākehā migration was relatively high, Māori growth rate was low. Toward the end of the nineteenth century when Pākehā migration had dropped, Māori population growth rates improved. One explanation was that as the Pākehā population levelled out and fewer migrated, Māori were able to recuperate from the onslaught of communicable pathogens (Durie, 1998b; Pool, 1991). Another was that Māori began to develop immunity to some of the diseases. Yet, another was the natural resilience and adaptability of Māori (Pool, 1991). Other contributing factors were the establishment of a Māori Parliament and Māori Council, the emergence of tribal, health, and political Māori leaders and the establishment of an infrastructure for the administration of health services to Māori (Dow, 1999; Durie, 1998b; Lange, 1999).

The establishment of a Māori Parliament grew from the discontent Māori felt about Tiriti relationships and the continued genocidal policies being implemented by the colonial Government within Aotearoa (Durie, 1994). The establishment of a Māori Parliament forced the colonial Government to pass the Māori Councils Act 1900 which led to the establishment of nineteen Māori Councils (Dow, 1999; Durie, 1987, 1999; Houghton, 2001; Lange, 1999). The formation of the Councils was an attempt by the colonial Government to appease Māori discontent by providing them with a

legal entity to have some say in government at a local level (Dow, 1999; Durie, 1987, 1999; Houghton, 2001; Lange, 1999).

At the same time Māori doctors were emerging from Universities and the Health Department was established (Durie, 1998b; Ngata, 1898). The Health Department provided an infrastructure through which Māori health policies and initiatives could be administered. The Māori doctors who emerged had the mana to facilitate tribal tino rangatiratanga in the reclaiming and recovery process. In fact without the involvement of tribal leaders and the Māori doctors, it is thought that Māori would have become extinct as predicted by early colonial politicians (Durie, 1998b; Ngata, 1898). For example, Dr Maui Pomare, the first Māori medical officer of health, whose very large task was to address the effects of colonisation on Māori, implemented a strategy which involved Māori council members becoming sanitary inspectors (Durie, 1998b). As sanitary inspectors, the council members took the lead in cleaning up living conditions for Māori. As a consequence of colonisation and assimilation policies the tapu and noa processes used to order society had collapsed, resulting in substandard living conditions. The Māori Council provided a vehicle through which early health promotion, disease prevention and data collection could be administered (Durie, 1998b). The strategy proved to be successful and Māori health began to improve. While partnerships between the Māori and the Health Department proved to be effective, in 1909 the role of the sanitary inspectors was disestablished and replaced by district health nurses (Durie, 1998b). In my view, as agents of hegemony, these nurses legitimated bio-medical models of healing while minimising or alienating Māori healing practises. In 1920 Te Rangihiroa was appointed as the first Director of the Division of Māori hygiene. Like Pomare, he recognised the importance of tribal leadership in Māori health gain. However his attempts to revive the Māori councils as leaders in the health sector failed, partly, because the Councils were grossly under-funded and partly because by then the imposition of the bio-medical model of health was being felt (Durie, 1998b).

As colonisation and Pākehā health discourses became entrenched within Aotearoa societal structure Māori health practises ceased to exist as a crucial part of the early

health care system. While ‘genocide⁵ was the fear of the 1800’s, ethnocide⁶ was the threat for Māori by the mid 1900’s’ (Durie, 1998b, p. 47). In this domain Māori women stepped forward as leaders. One of the early leaders was Te Puea Herangi, who attempted to establish a Māori hospital (King, 2003). When this failed, because of lack of support from the colonial Government, she supported the establishment of a medical clinic on her Marae, Tūrangawaewae. Another organisation emerged, led by Māori women, the Māori Women’s Health League.

The Māori Women’s Health League was established by a district health nurse who, having concerns about women and infant mortality rates, initiated relationships with wāhine Māori in the Te Arawa district. The primary focus was on improving health conditions for Māori women and children. The League proved to be successful and more branches were established in other tribal areas such as Tairāwhiti, Tuwharetoa and Whakatohea (Durie, 1994c).

Colonial legislation and policies

Shore and Wright argue that legislations and policies act as:

...cultural texts, as classificatory devices with various meanings, as narratives that serve to justify or condemn the present, or as rhetorical devices and discursive formations that function to empower some people and silence others (Shore & Wright, 1997, p. 7)

As previously demonstrated colonial legislation and policies were instrumental in undermining Māori health (Durie, 1995b; Fleras & Spoonley, 1999; Shore & Wright, 1997). Legislation and policies acted as cultural texts that legitimised the dominant discourses of Pākehā society while marginalising Māori. Within the health sector, dominant discourses were played out in legislation, policies that advanced the bio-medical and marginalising Māori health discourses. There were two types of colonial

⁵ A form of one sided mass killing in which the state or other authority intends to destroy a group, as that group or membership of it are defined by the perpetrator (Chalk, 1994:52)

⁶ When “an ethnic group is denied its right to enjoy, develop and transmit its own culture and its own language, whether individually or collectively” (Schabas, 2000:182).

health legislation and policies. The first type constructed and legitimised the bio-medical discourse of health, while the second were mostly concerned with assimilation and control.

The construction of the bio-medical discourse

The construction of the bio-medical discourse involved discursive interactions between policy formulation communities and policy formulation networks. Bio-medical discourse was strongly individualistic, scientific and reductionist, generally attributing diseases to one primary cause and minimising non-medical causes and solutions (Dow, 1999; Durie, 1994c; Heller, Price, Reinhartz, Riger, & Wandersman, 1984). Initially, the legislation and policies that constructed and legitimised the bio-medical discourses in Aotearoa were those that were developed and implemented to address issues arising from the introduction of communicable diseases (Dow, 1999; Durie, 1998b).

Early colonial policy formulation networks consisted of Māori, missionaries, doctors and parliamentarians. These policy networks included policy actors who supported a 'social justice approach' and ones that supported a 'social order approach'. Policy issues can be framed as social justice or social order issues (Dalton, Draper, Weeks, & Wiseman, 1996b; Saraga, 1998). The social justice approach frames issues broadly, acknowledging that personal or societal issues are often caused by inadequate systems. The social order approach frames issues within a deficit framework where personal or societal issues are attributed to a 'lack' in the individual. In the social justice approach, solutions are focused on societal systems. In the social order approach, solutions are focused on the individual (Dalton, Draper, Weeks, & Wiseman, 1996a; Fleras & Spoonley, 1999; Saraga, 1998). For example, with respect to Māori health, a social justice approach recognised that health policies and practises produced and reproduced racist discourses. The production and reproduction of racist discourses resulted in poor service delivery to Māori and, therefore, the poor state of health could be attributed to institutional racism rather than Māori themselves. A 'social order approach' adopts a deficit approach to policy issues, where causes are

usually unitary and where personal or societal issues are attributed to a ‘lack’ in the individual (Dalton, Draper, Weeks, & Wiseman, 1996a; Fleras & Spoonley, 1999; Saraga, 1998).

Initially the policy formulation communities who brought the ‘native health problem’ (as it was called during early colonisation) to the attention of the colonial Government were concerned missionaries and doctors with a social justice epistemology. These actors identified that a problem existed and attributed it to communicable diseases, the behaviour of unruly settlers, to God and to land felling (the stripping of trees from the land) (Dow, 1999; Durie, 1998b; Lang, 1981; Owen, 1981). For example, in June 1839 John Dunmore Lang wrote to the Right Honourable Earl Durham:

Of the character of European population, now permanently settled in New Zealand, it is scarcely necessary to inform you Lordship. With a few honourable exceptions, it consists of the veriest refuse of civilized society – of run-away sailors, of runaway convicts, of convicts who have served out their term of bondage in one or other of the two penal colonies, of fraudulent debtors who have escaped from their creditors in Sydney or Hobart Town, and of needy adventurers from the two colonies, almost equally unprincipled. In conjunction with the whalers that occasionally visit the coast, the influence of these individuals on the natives is demoralizing in the extreme...[he refers to]...scenes of outrageous violence, injustices and oppressions...(Lang, 1981, pp. 7-8).

Alongside a social justice policy formulation community, was another community with a different epistemology, that of social order. The social order policy formulation community were those people interested in acquisition and assimilation. The social order policy formulation community attributed the poor state of Māori health to biological causes (inherent ethnic weaknesses), a theory proposed by Darwin that was in vogue at the time (Dow, 1999; Fleras & Spoonley, 1999; Kingdon, 1995; Lange, 1999). For example, Māori death rates due to measles, whooping cough and tuberculosis were attributed to inherent biological weaknesses rather than the influx of settler diseases. These examples illustrate issues of power and control.

Whoever has the power to define has the power to decide (Shore & Wright, 1997; Wilson, 1997). The policy formulation community that had the power to define were those from the social order policy formulation community. It was in the best interests of this community to project Māori negatively to justify cultural assimilation and land acquisition. The dominant health discourse within this policy community was bio-medical (Durie, 1998b; Lange, 1999; Rua et al., 1998). Discourses act discursively to produce and reproduce themselves (Foucault, 1980). The advancement of the bio-medical discourse was closely linked to those of Christianity and Western institutions of justice and education in what be considered an iron triangle. For example, the missionaries who were among the first settlers to arrive in Aotearoa, brought not only theology but also Western medicine (Dow, 1999; Durie, 1998b; Lang, 1981; Owen, 1981). At the time, Māori were struggling to deal with onslaught of communicable diseases and sought assistance from the missionaries, as their own practises were not working. With the early settlers came their institutions including the justice and education systems. The justice system legitimated the bio-medical discourse within colonial health legislation by initiating laws, such as the 1908 Tohunga Suppression Act, that made some Māori healing practises illegal (Dow, 1999; Durie, 1998b). The schools were influential in reproducing the bio-medical discourse through the practise of medicine and legitimating it in the school curriculum (Edwards, 1990).

The use of the bio-medical discourse to define Māori health was to have detrimental effects on Māori tino rangatiratanga then and in the future. The bio-medical discourse supported the Darwinian theory of evolution, which asserted the notion of the survival of the fittest (Valencia, 1997). Colonial interpretation of social Darwinism in Aotearoa was to explain the Māori health issue as a Māori problem rather than as a combination of factors such as colonisation, communicable diseases, and land acquisition (Health Department, 1910; Newell, 1954). For example, J. Mason, a Chief Health Officer for the Health Department, attributed the state of Māori health to ‘indolence and laziness, leading to poverty, and sickness’ (Health Department, 1910, p. 4).

Another way Māori health was defined bio-medically was through the use of statistical information. While statistical information in itself can be useful, how it is interpreted is important. The early missionaries and doctors used mortality and morbidity data to emphasize the urgency of the Māori health issue. However, in this case, the use of mortality and morbidity data tended to support the ‘survival of the fittest’ theory, disguising within it the broader issues of land acquisition and assimilation policies. Alongside statistical data, colonial narratives or stories completed the framing of Māori health within a bio-medical framework by portraying Māori as ‘non-compliant’, ‘lazy’, and ‘dumb’ and therefore responsible for their own illnesses (Dow, 1999; Lange, 1999).

Once the issue of Māori health had been defined within a bio-medical framework, it is not surprising that the proposed solutions were also bio-medical. Through discussions with missionaries and doctors, the colonial government generated a number of solutions; these included the employment of more doctors and nurses and the building of hospitals. The policy solutions were not very successful. The policy initiatives failed due to; lack of funding from Government, conflict between health policies and other assimilation policies, lack of suitable infrastructures and more fundamentally, the lack of responsiveness to tino rangatiratanga (Awatere, 1984; Dow, 1999; Durie, 1998b).

While successive colonial Governments indicated an interest in addressing Māori health issues, often resource allocation was not forthcoming. For example, in 1854/55 the Government allocated £36,000 to civil establishment (which included health and social services), £2070 (5.75%) of which was allocated to the treating of ‘native patients’ (Dow, 1999, p. 13). Even less was allocated to Māori health in 1946, with £3635 (0.13%) of a total civil establishment budget of £2,692,389 being allocated to ‘native health’ (Government Printers, 1946, p. 13). Such budgetary decisions indicate that Māori health clearly was not a priority for the Government⁷.

⁷ It is worth noting that while I attempted to source funding allocation for Māori health – the periods 1990-2000 the information was not available. In discussions with the Ministry of Health I was told the information was not gathered. I understand since 2003 the information is now part of the monitoring process of the health sector.

Conflicts also existed between addressing Māori health policies and land acquisition policies. Māori and Pākehā alike argued the poor state of Māori health was the result of loss of land yet the Government continued to confiscate it (Durie, 1998b; Pool, 1991). Seriously addressing Māori health meant the Government would have to shift from a focus on colonisation (land acquisition and assimilation policies) to honouring Te Tiriti by protecting Māori tino rangatiratanga (Durie, 1995a; Kawharu, 1989; Rangihau, 1975; Te Puni Kokiri, 2001).

The serious issue of lack of responsiveness to iwi Māori across health policy concerned the tensions between the holistic health practises of Māori and the bio-medical health practises of Pākehā (see Table 6). As previously addressed Māori health discourses were holistic in nature capturing aspects of the spiritual and psychic worlds, the political, the environment, the people, the past, the future and the present, and between the inanimate and the living (Cunningham, 1998; Davis & Ashton, 2001; Dow, 1999; Durie, 1994c; Durie, 1999; Durie, 2001). Bio-medical discourses, on the other hand, emerged from a scientific background where unitary notions of disease and treatment existed. The focus was on the individual and parts of the individual. Bio-medical discourses seek to identify, diagnose and treat illnesses. In the process the context of the individual is lost.

Table 6: Comparisons between dominant Māori and Pākehā health discourses

Dominant Māori health discourse	Dominant Pākehā health discourse
Holistic	Reductionalist
Collective	Individualistic
Subjective	Objective

(compiled from Davis & Ashton, 2001; Dow, 1999; Durie, 1998b)

Māori viewed bio-medical services with suspicion. For example, Māori perceptions of hospital services were related to the number of Māori who died. In 1951, six Māori died in one hospital. The consequence of this was Māori put a tapu on the hospital and would not use it (Dow, 1999; Lange, 1999; Newell, 1954; Pool, 1991). Another key issue was the lack of an effective infrastructure through which health policies

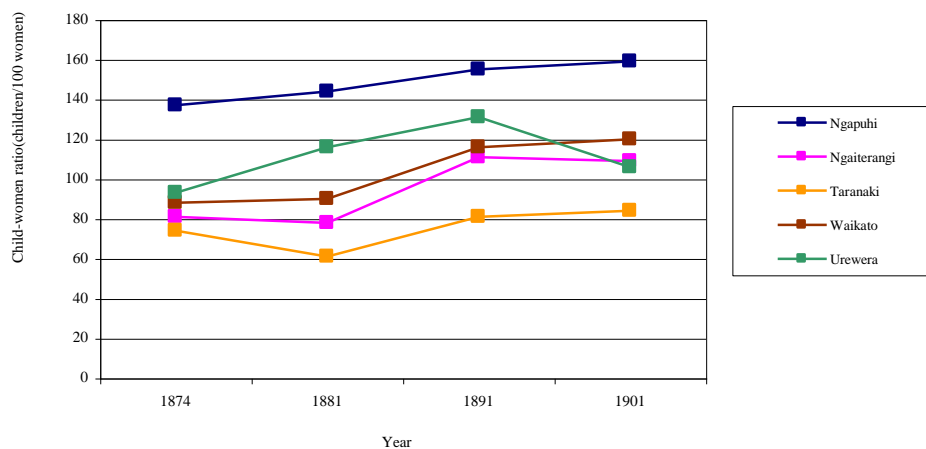
could be implemented. Generally, the doctors and each hospital acted independently of the others, which led to lack of consistency and confusion in the delivery of early health services (Dow, 1999; Lange, 1999). Until the early 20th century, Māori health issues were addressed through the Native Affairs Department. Then, in 1900, with the scare of a plague outbreak, the Health Department was formed (Dow, 1999).

Policies that addressed Māori health issues were largely developed by the colonial Government. Because Māori were not players in the colonial political arena they were not able to influence policy decisions. This meant Māori had little input into the defining of policy issues of relevance to them.

Assimilation and control

Assimilation legislation and policies were those legislation and policies which sought to assimilate Māori into the cultural norms of the Pākehā and to control those Māori who were considered unruly (Cheyne, O'Brien, & Belgrave, 2000; Dow, 1999; Durie, 1998a; Fleras & Spoonley, 1999; Lange, 1999). Many colonial policies could be argued to have pursued these outcomes one way or another. For example, early land confiscation legislation has been linked to the health of Māori as illustrated in Figure 6 (Pool, 1991).

Figure 6: Child women ratio for several iwi subject to land confiscation



(Pool, 1991, pp. 95-96)

In Figure 6, Māori health is measured by child-women ratios (number of children per 100 women). The child-women ratio was considerably lower for those iwi who had experienced early land confiscation (Taranaki) than for those who had not (Nga puhi). Oliver suggests these early land confiscation legislations was the beginning of social policy in Aotearoa (Oliver, 1988, p. 4).

Of particular interest to this study are those health legislation and policies which had a broader kaupapa of assimilation and control, for example, the 1900 Māori Council Act, the 1907 Tohunga Suppression Act and the 1908 Native Health Act (Durie, 1994; Dow, 1999). Section 16 (5) of the Māori Council Act 1900, allowed the Council to pass by-laws to regulate and punish tohunga (Māori or European) who practised ‘upon the superstition or credulity of any Māori in connection with the treatment of disease’ (Government Printers, 1900). The Māori Council Act 1900 was followed by the Tohunga Suppression Act 1907 which ‘sought to prohibit the activities of Māori Tohunga...’ (Government Printers, 1907). While it is generally understood the reason for this Act was to regulate health services it had a more sinister purpose, which was to control the Prophet Rua Kenna’s activities. At the time, Prophet Rua Kenna had a large following of supporters. The Crown felt threatened by his philosophies and his power and developed the Tohunga Suppression Act (Dow, 1999; Durie, 2000). The legislation legitimised the bio-medical discourses of health while marginalising Māori and, in fact, any health services different from the ‘mainstream one’. In 1909, the Native Health Act was passed to stop Māori women from breast feeding their babies and adopting whāngai children (Mikaere, 2000; Turei, 2004). This Act came about because Māori women were adopting abandoned Pākehā children (Mikaere, 2000) and the Government objected so strongly a law was established to stop it.

From a colonial perspective assimilation health policies could be considered to have been successful given the underlying issue was to acquire land and assimilate Māori into the cultural norms of the Pākehā. From a bio-medical perspective, it could be argued the policies were partially successful because the mortality and morbidity rates for Māori improved. From a tino rangatiratanga perspective, assimilation health

policies have proved to be detrimental not only to the access of health services but also to the wellbeing of Māori over all. Alienated from their tūrangawaewae, their economic base and their cultural structures, the impact on the overall health of Māori was noticeable even in the early days (Lange, 1999; Newell, 1954; Pool, 1991).

Tino rangatiratanga – reclaiming Māori health practises

Toward the later part of the 20th Century tino rangatiratanga within the health sector became more political and shaped by a number of events (see Table 7).

Table 7: Timeline of some of the events contributing to the revitalisation of Māori health practises

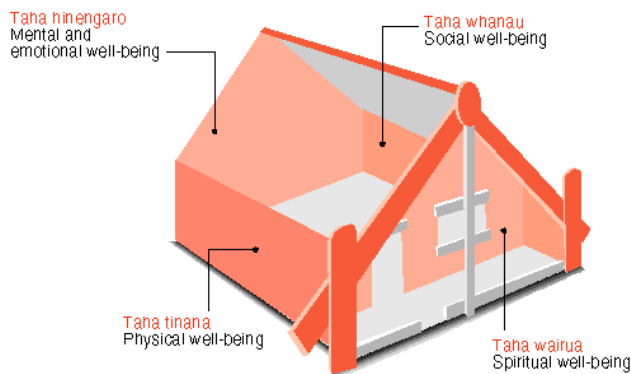
TIME	EVENT
1960-ongoing	Māori resistance movement
1984	Introduction of neo-liberal governing model
1985	The recognition of Te Tiriti as the foundation document of good health for all New Zealanders
	Te Urupare
	Te Ka Awatea
1993	Health Reforms
	Whaia te ora mo te iwi
1996/97	Māori Health policy guidelines
1999	Labour Party Elected
2000	1993 Public Health and Disability Act was amended
	New Zealand Health Strategy introduced

Māori resistance and Māori health: 1960s – 1970s

As a consequence of the Māori resistance movement in the late 1960s to early 1970s, the Government was forced to address its Tiriti responsibilities within a number of areas including health (Ballard, 1994; Durie, 1995b; Tuhiwai-Smith, 1999). While Māori health discourses existed prior to the resistance movement, as a consequence of Māori resistance they became more visible. A number of Māori health hui were held where broader perspectives of health were acknowledged. For example, in 1978

Tipene-Leach and Hoskins identified the cultural needs of Māori consumers in clinical settings (Tipene-Leach & Hoskins, 1988). At the same time a number of holistic approaches to health emerged. Probably the most familiar was Te Whare Tapa Wha. Te Whare Tapa Wha was conceptualised by Durie following at a training hui for the Māori Women's Welfare League (see Figure 7). The model proposed a link between the wairua, hinengaro, tinana and the whānau. Te Whare Tapa Wha model was integrated into health services in Aotearoa and proved useful for Pākehā practitioners and quickly adopted by the health sector, including the National Cervical Screening Programme. One of the limitations of Te Whare Tapa Wha is that it did not acknowledge the wider determinants of health such as the environment and the political context.

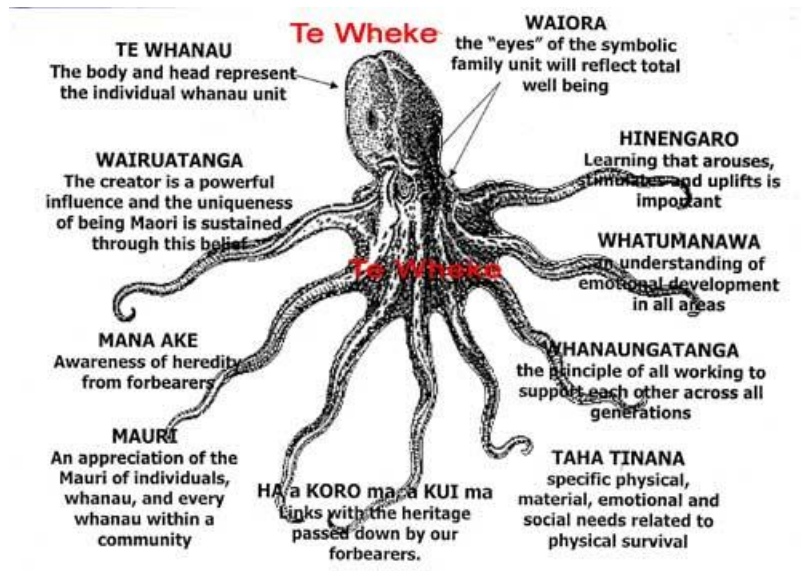
Figure 7: Te whare tapa wha



(Durie, 1998b)

Another model was Te Wheke (see Figure 8) which was developed by Rose Pere and has since been adopted by the Rotorua School of Nursing (Ballard, 1994; Durie, 1995b; Durie, 1998b; Pere, 1991; Tuhiwai-Smith, 1999). While highlighting the interconnectness of Hauora Māori, Te Wheke emphasised the link between health, culture and politics.

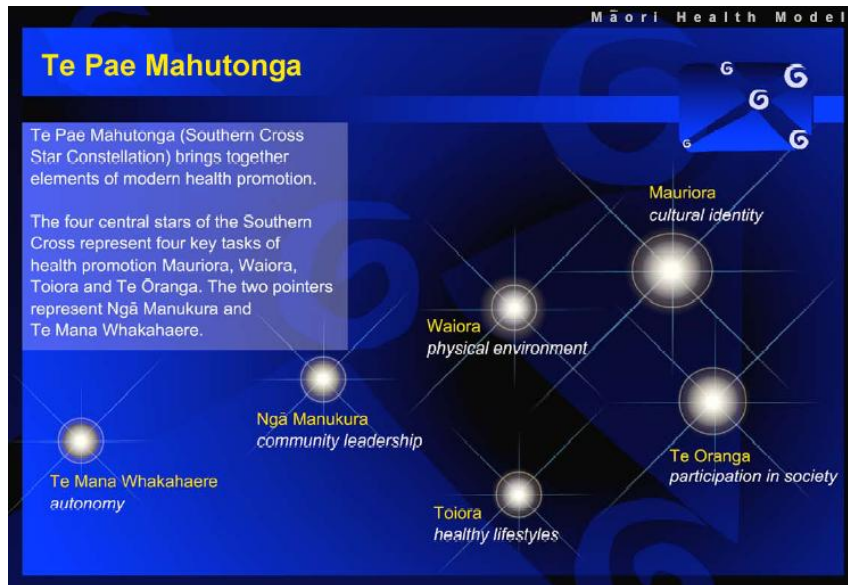
Figure 8: Te wheke



In 1999 another model was advanced, Te Pae Mahutonga (see Figure 9). Te Pae Mahutonga was developed by Durie and presented at a health promotion hui in 1999. It is derived from work done by Pomare during his time as the Medical Officer of Health in the 1920's. Te Pae Mahutonga is symbolically represented as the Southern Cross. The four central stars are Mauri Ora (the indigeneity principle), Waiora (the ecological principle), Toi Ora (the health lifestyles principle), Te Oranga (the societal principle). The two pointers are Nga Manukura and Te Mana Whakahaere. In its current interpretation, Mauri Ora refers to the need indigenous people the world over have for a cultural identity. Having a strong cultural identity has been linked to good health, while not having one has been linked to poor health. Waiora connects human wellness with cosmic, terrestrial and water environments. Waiora recognises the links between a healthy environment and a healthy body. Toi Ora argues risk-laden lifestyles lead to poor health. Risk laden lifestyles are closely linked to poverty, deculturation and colonisation. Hence a healthy lifestyle approach needs to take a broader perspective and address the broader determinants of health. Te Oranga argues health is totally linked to socio-economic circumstances. Good health cannot be attained where there are policies which lead to unemployment or diminished access to education. Nga Manukura (leadership and relationships) recognises that good health requires reciprocal collaborative relationships between Māori and other health

professionals. Of particular importance is tribal or Māori community leadership. Finally Te Mana Whakahaere (Autonomy) is about the degree of control or self governance Māori have over their destinies.

Figure 9: Te pae mahutonga



(Durie, 1999)

Te Pae Mahutonga emphasises a link between health, culture, environment, and the political. Te Pae Mahutonga advances tino rangatiratanga as a key health strategy for Māori and is being introduced across a range of health and social services. The uniqueness of Te Pae Mahutonga is that it clearly addresses the wider determinants of health and provides a model that is acceptable and measurable.

The reclamation and legitimation of Māori models of health emerged around the time bio-medical models of service delivery were being challenged by women and people with disabilities globally (Ballard, 1994; Rua et al., 1998; World Health Organisation, 2002). Bio-medical models of service delivery were argued to create barriers to access for women and people with disabilities because bio-medical models of service delivery viewed health from a reductionist perspective. Similarly Māori argued bio-

medical models of health created barriers to access for Māori and these barriers included the use of medical jargon and the attitudes of the health practitioner.

The reclamation and legitimization of Māori models of health during this period saw health services begin to address the wider determinants of health. The neo-liberal reforms were critical to these changes particularly Article II or tino rangatiratanga.

Neo-liberalism: The Reforms of 1984

Tino rangatiratanga in health revitalisation did not occur in a vacuum. From 1984 until 2000, Government was dominated by neo-liberal philosophy. Prior to 1984 Aotearoa was largely a welfare state where the Government provided support for those in need. The welfare system was introduced in the early 20th Century mainly to address issue arising from the abandonment of women and children (James & Saville-Smith, 1990). In 1984, with the coming to power of a Labour Government, it was argued the country could no longer sustain the welfare system in its current form, preparing the way for the introduction of neo-liberal economic reforms (Davis & Ashton, 2001; Huygens, 2006; Kelsey, 1998). Kelsey argues that the introduction of neo-liberal reforms in Aotearoa was a planned activity by Pākehā decision makers (Kelsey, 1998). She states:

There had to be a systematic programme, carried out with precision and discipline by a group of strategically placed individuals, supported by institutional power (Kelsey, 1998, p. 28).

The people who implemented the neo-liberal economic reforms had planned well ahead and included Roger Douglas, several Labour Party Members of Parliament, an economist in the Opposition's Research Unit and a Treasury official. These people, Kelsey argued, wrote and implemented a 51-page 'Economic Policy Package', a package which was to advance neo-liberalism in Aotearoa.

The 1984 neo-liberal reforms were part of a much larger reform of the public sector. Within the policy sector, discourse analysts argue neo-liberalism disguises the political nature of health policies by recasting what are essentially political issues into

neutral scientific language (Shore & Wright, 1997). 'Central to the process is the use of expert knowledge' (Dreyfus & Rabinow, 1982, p. 9). The development of neo-liberalism within the health sector saw the establishment of a variety of advisory groups. The advisory groups were made up of 'experts' in particular areas of health. For example, children's health was led by expert groups whose role it was to research and implement strategies to address children's health (Ministry of Health, 1998a). The group was initiated at Government level and implemented across strata's (national, regional, and local).

Within a neo-liberal government, 'freedom' acts as an instrument of government control by creating new subjects of power and new intermediaries who intervene in the social construction of a new society (Foucault, 1980; Shore & Wright, 1997). Thus to construct a 'free society' and 'free market' entails:

a variety of interventions by accountants, management consultants, lawyers, industrial relations specialist and marketing experts in order to establish the conditions under which the 'laws of supply and demand' can make themselves real, to implant the ways of calculating and managing what will make economic actors think, reckon and behave as competitive, profit seeking agents, to turn workers into motivated employees who will freely strive to give of their best in the workplace, and to transform people into consumers who can choose between products (Rose, 1992, pp, 2-3).

Under the guise of science, the neo-liberal government created new 'subjectivities' called 'experts' who then become the regulators in neo-liberal governments by normalising certain practises and behaviours such as clinical practise (Burchell, Gordon, & Miller, 1991).

Within Aotearoa and the health sector, neo-liberalism provided an environment which was more conducive to the expression of tino rangatiratanga (Durie, 1998b). It was during this time that Māori health providers began to emerge. It was during this period that Te Tiriti o Waitanga was acknowledged as important to health.

Te Tiriti as a foundation document - 1985

In 1985, one hundred forty-five years after Te Tiriti was signed, it was recognised by the Government as the foundation document of good health for all of Aotearoa (New Zealand Board of Health, 1987). The result of this was a number of policies looking at Māori health and the development of Tiriti statements within health and social services. However as Durie infers, Tiriti health policies are toothless without the underlying support of legislation. He comments:

There are two points to be made concerning the Treaty in legislation. First there is no reference to the Treaty in any social policy legislation. Where express Treaty reference is made, it is in relationship to physical resources such as the environment, land, or the sea. Second, recognition of Māori interests in social policy legislation appears to arise from a concern about the cultural values or disparities in Māori/non-Māori standards rather than from any sense of Treaty-based obligation or rights quite apart from equity issues. The implication of this is that, although the Government can accept the relevance of the Treaty to tribal property (as provided by Article II), it is not yet been able to accept the full implications of the Māori version of the same Article with its broad definition of taonga and its promise of tino rangatiratanga (Durie, 1994c, p. 94).

Durie makes a distinction between Tiriti and Māori policies (see Table 8). The Crown has fiduciary duties in Tiriti policies while they do not in Māori policies.

Table 8: Treaty of Waitangi policy and Māori policy

	Treaty policies	Māori policies
Broad aims	National development	Māori development
Benefits/costs	All New Zealanders	Māori
Justification	Terms of colonisation	Māori are a significant part of the population
Focus	Pan-sectoral	Sectoral
Time	Past and future	Present and future
Obligation	Mutual respect	Meeting Māori needs
Emphasis	Māori-Crown relationships	Government objectives for Māori

(Durie, 1998a, p. 207)

While the Tiriti was recognised as the foundation document of good health for all New Zealanders the implementation of the vision was difficult. Firstly, as previously mentioned, Te Tiriti was difficult to define and in fact debates continue today. In the health sector the discussion arose around whether to use the principles (partnership, protection, participation) or the provisions (kawanatanga, tino rangatiratanga and ōritetanga). If the provisions were used, whose interpretation of Te Tiriti was to be used, Williams or Hobson's? If the principles were to be used, whose principles, the Tribunal's or that of The Royal Commission on Social Policy (see Chapter Four). In current practise the three 'P's are frequently advocated; partnership, protection and participation. However theorists argue the principles are colonial constructs and do not address Tiriti issues within the health sector (Durie, 1998b; Royal Commission on Social Policy, 1988). As things lie there is still some debate around what Te Tiriti should look like in health legislation and policies. Māori agree that tino rangatiratanga can not be truly actualised within a health environment that did not recognise Te Tiriti except as part of health policies that fall out of other Pākehā legislation (Durie, 1994b). However, Māori and the Crown continued work together in an endeavour to develop policies to address Māori tino rangatiratanga.

Te Urepure Rangapu - 1988

In an endeavour to support tino rangatiratanga in 1988 the Labour Government developed a strategy, Te Urepure Rangapu (Ministry of Māori Affairs, 1988). The document proposed that all government departments were to develop strategies to support tino rangatiratanga; within health service delivery, bi-culturalism became the catch word of the time. Within Te Urepure Rangapu iwi were recognised as the body that Government were to develop relationships with. Such a move brought to the forefront Māori diversity. Many Māori were urban-based and had no traditional links or knowledge about their iwi. The devolution of services to iwi meant some Māori would not benefit. However it was argued that those Māori who did not have links to iwi would benefit through Article III rights, the same access to services as British citizens. During this era bi-culturalism emerged but they proved to be ungainly and difficult to implement (Durie, 1994c)

Te Ka Awatea - 1991

Not to be up surged, the National Party introduced Te Ka Awatea (it is dawn) (Ministry of Māori Development, 1991). The purpose of Te Ka Awatea was to stabilise positive Māori development by developing long term strategies. Criticisms arose from people who thought that the document was just another neo-liberal strategy to reduce costs to government by providing policies through which Māori would provide for themselves at less cost to the government (Henare, 1995). While the implementation of Te Ka Awatea was later abandoned by National and successive Labour Governments the policy document was crucial in that it re-asserted and defined relationships between Māori and Crown within social services (including health) for the future which was limited to Crown sovereignty in exchange for protection of Māori tino rangatiratanga (The Waitangi Tribunal, 1992). Further, the document acknowledged that:

Māori have a distinctive and unique place in New Zealand society that must be preserved and enhanced; and that Māori must be able to participate fully in the future development of the nation (Ministry of Māori Development, 1991, p. 64).

The distinctive and unique place Māori have in New Zealand society contributed to the reclaiming of tino rangatiratanga in health practises.

The 1993 Health Reforms

The 1993 Health Reforms implemented under a neo-liberal ideology had a major influence on Māori health development. User pays, market-driven health services were introduced and the funder-purchaser split occurred (Devlin, Maynard, & Mays, 2001; Ferguson, 2002; Gauld, 2003; Kelsey, 1998; New Zealand Public Health Commission; Te Puni Kokiri, 1993b). Despite the government's argument that such changes would benefit the country in the long run, their implementation was problematic. Those hardest hit by the changes were low-income families (single parents, the elderly, Māori) (Davis & Ashton, 2001). However, middle-income families also felt the price of neo-liberalist health policies, as they were the group

who could not get assistance because they had become the ‘new rich’. The structural changes included: the replacement of the District Area Health Boards with four Regional Health Authorities, a purchaser-provider split, the integration of primary and secondary care, the definition of core health services, establishing separate systems for the public health work of health promotion and health protection, rationalising user part charges and bringing in health care plans to compete for public funds and offer alternative services (Te Puni Kokiri, 1993b).

The Regional Health Authorities became the purchasers of health services in consultation with the community (Kelsey, 1998; Te Puni Kokiri, 1993b, 1994b). The rationale for this was to ensure the best and most affordable services for the least money (Kelsey, 1998; Te Puni Kokiri, 1993b, 1994b). The hospitals then became Crown Health Enterprises and were run as businesses (Kelsey, 1998; Te Puni Kokiri, 1993b, 1994b). Change agents were brought in from other sectors such as the Labour and Education Departments, Forestry and the private sector to facilitate this change. Health professionals and health services became known as “providers” and patients as “consumers”. The defining of core health series were those services that Government deemed all people ‘should have access to, on affordable terms, without unreasonable waiting time’ (Te Puni Kokiri, 1993b, p. 8). Numerous advisory groups were set up to identify and develop core health services.

The integration of primary and secondary care was an endeavour to close existing gaps and increase accessibility. Internationally it was recognised that prevention was cheaper than cure (Bethwaite, Rayner, & Bethwaite, 1986; World Health Organisation, Nov., 1986). The development of a separate system for Public Health sought to increase the role of the Public Health sector in health service delivery. Again, this was to reduce the costs of health services for Government. The user part charges were again an attempt by Government to reduce the cost on the Government budget. While the user part charges were introduced, Health professionals such as general practitioners, private radiologists, pharmacists and physiotherapists used the opportunity of the introduction of user part chargers to increase their charges to the consumer.

Māori had provided health services in the past. However these health services were often provided under the guise of education, employment or other social services. Under a neo-liberalist, market driven health system competition was encouraged (Kelsey, 1998). Government believed competition would improve services, increase service choice and reduce costs. One of the strategies was the establishment and development of new health service providers. These services included what had been commonly referred to as alternative health practitioners. Alternative health practitioners included naturopaths, osteopaths, and Māori health providers.

With the implementation of the 1993 Health Reforms, transitional funding was allocated to Māori for provider infrastructure establishment and development (Te Puni Kokiri, 1993b). At the same time, Te Puni Kokiri encouraged and supported the development of Māori providers both in and outside of the health sector by supporting Māori business development (Te Puni Kokiri, 1994a, 1994b, 1994c). Over time it became evident that while some Māori provider services were well on the way to providing health services, others had a long way to go. Further, while millions of dollars had been allocated to Māori provider development, it was disproportionate to what was being spent elsewhere and it was not enough to meet the need of Māori providers. For example, from a total health budget of approximately \$5,700 billion, \$40 million (0.007%) was allocated to Māori (Te Puni Kokiri, 1998; The Treasury, 1997). Some Māori providers were new Māori providers, others were developing and yet others were extending their services, hence the financial needs were diverse.

The services which fared well were those that were in some way autonomous, had strong leadership, a collective and achievable kaupapa, iwi commitment, an established infrastructure and had business interests that generated other forms of income (Ngati Porou Hauora, 2002). For example, Turanga Health was a Māori provider that flourished throughout this period. The organisation had a collective vision which included tino rangatiratanga by the year 2000, strong politicised leadership, and commitment by all three iwi to the development of their iwi to become self sustaining by the year 2000, a dream that has been actualised (Wihongi, 1995).

Within this was the acknowledgement that more skilled Māori health professionals were required. Lack of a skilled workforce was identified in two main areas, business management and administration, and skilled clinical practitioners; for example nurses, doctors, psychologists, physiotherapists, laboratory technicians (Dow, 1999; Durie, 1994c). A number of strategies were implemented by Māori and the Government to address workforce development, which included funding allocation for training providers, employing skilled Māori and Pākehā to provide a particular service and contracting in skilled people to work alongside Māori or to train Māori in particular areas and in Māori settings such as hospitals and Māori organisations. These are still in progress and proving to be successful (Durie, 1994c; Ministry of Health, 2005).

Funding allocation and health contracts included a Tiriti clause and generic health providers were put on notice that they would have to begin to provide more culturally appropriate services or find their funding allocation being reduced.

During this time, Health Funding Authorities were urged to consult and develop relationships with Māori to ensure Māori needs were addressed. These relationships closely resembled parallel development models. For example, in the 1990s joint ventures were formed between Government agencies and iwi or other Māori organisations. The relationships were built upon common goals and for mutual benefit (Department of Health & Te Puni Kokiri, 1993; Durie, 1994c).

Successive governments failed to adequately fund Māori provider development; the catch-cry for Māori was 'being funded to fail' (Mental Health Commission, 1998). While millions of dollars was available for Māori health development, the allocation of these monies dependent on meeting criteria determined by Government which resulted in the monies sitting in Government health funding organisations and being returned to central Government, or utilised for non-Māori health services (Accountant, Health Funding Authority, personal communication, May 1998). However, the control remained with the Crown.

Te Whaia Te Ora o Te Iwi - 1993

Very little Māori health policy work was done from 1985 through to 1993 when Te Whaia Te Ora o Te Iwi, a Māori policy document was adopted by Government to guide services to Māori (Department of Health & Te Puni Kokiri, 1993). In this document, the Government stated that:

The Crown [would] seek to improve Māori health status so in the future Māori will have the same opportunity to enjoy at least the same level of health as non-Māori (Department of Health & Te Puni Kokiri, 1993, p. 13).

Te Whaia Te Ora o Te Iwi included Māori policy directives, such as: greater participation of Māori throughout the health sector, resource allocation priorities, which took account of Māori health needs and perspectives, and development of culturally appropriate practises and procedures as integral requirements in the purchase and provision of health services (Department of Health & Te Puni Kokiri, 1993, p. 14).

While the policy was a step toward addressing tino rangatiratanga theorists argue the policies were not linked to any Tiriti legislation (Durie, 1998b; National Advisory Committee on Health and Disability, 2002). As previously mentioned this meant the policies were not enforceable by law, as were other health policies such as those in mental health. Nor were they linked to any sound accountable implementation process (National Advisory Committee on Health and Disability, 2002). In effect generic providers were not held accountable for non performance.

1996/97 Māori Health Policy Guidelines

In 1996 the National government reaffirmed its commitment to the Tiriti with the development of Māori Health Policy Guidelines (Shipley, 1996/97). The guidelines asserted that:

Māori as tangata whenua hold a unique place in our country, and that the Treaty of Waitangi as the nations founding document. To secure the Treaty's place within the health sector as fundamental to the improvement of Māori health in the medium term (Shipley, 1996/97, p. 3).

Māori realities were recognised through the development of health services which were provided by Māori for Māori, or culturally-effective services, whether delivered by Māori or non-Māori, and services provided by Māori organisations using non-Māori professionals. Further 'areas of special focus' were included such as provider development, new purchasing arrangements for co-ordinated care, refocusing on primary health care and early intervention, continuing to improve Māori mental health service, inclusion of traditional Māori healing models in purchasing arrangements, culturally effective health service, workforce development, effective consultation with Māori, direct participation of Māori in management of service delivery and giving priority to service delivery that operate under Kaupapa Māori (Shipley, 1996/97).

In line with these policy directives, there was an increase in Māori providers from 30 in 1993 to over 220 in 1997 (Te Puni Kokiri, 1998). However, like Te Whaia Te Ora o Te Iwi, scholars argued these policies were not Tiriti based, were not linked to an overall framework of Māori development, and lacked links between the policies, the implementation of the policies and lines of accountability (Ferguson, 2002; National Advisory Committee on Health and Disability, 2002). In 1998, the Health Funding Authority promoted Māori health policies indicating they would ensure that Māori needs were met not only by explicitly providing ways in which Māori health gains could be achieved but also by ensuring equitable funding allocations and incorporating a Māori health/Tiriti clause in their contractual arrangements with providers (Health Funding Authority, 1998).

While indications suggested these policies were influencing the state of Māori health positively, with improvements across a range of indices, inequalities still existed (Ajwani, Robson, Tobias, & Bonne, 2003; Robson & Harris, 2007; Te Kanawa, 2000).

Labour Party Elected

A Labour-led Government was elected in late 1999. The Labour Party had advocated Māori health policies which comprised of (a) supporting iwi development projects that offered a range of different activities and strategies with a view to improving health status; (b) supporting iwi development including the development of primary health services, as part of the wider development of iwi/urban, pan-iwi, education, social services, housing employment, and training services; (c) identifying inter-agency initiatives that improve health outcomes for tamariki, rangatahi and the whānau; (d) allowing for greater flexibility in the range of services for low-income whānau particularly for tamariki, kuia, and koroheke, through the use of capitation and alternative funding methods; (e) ensuring Māori have equitable representation on District Health Boards; and (f) ensuring that cultural safety is part of ongoing quality and safety monitoring, across the health sector; and considering Māori health service providers for all ambulatory and ancillary health service provision (Labour Party, 2000).

With a change in Government and issues arising from an inefficient and ineffective health system, amendments were made to the 1993 New Zealand Public Health and Disability Act which pre-empted a restructuring and re-configuration of the Aotearoa health system (see Appendix 3). The four Regional Health Authorities were disbanded and 21 District Health Boards were established. One of the purposes of the District Health Boards was to provide local leadership for the purchase and delivery of health services. The New Zealand Public Health and Disability Act 2000 provided legislation outlining the performance expected of the health sector, in particular the District Health Boards (see Appendix 3). Various health strategies were also introduced and included the New Zealand Health Strategy and discussion documents

circulating for the New Zealand Disability Strategy and He Korowai Oranga, the Māori Health Strategy.

The New Zealand Health Strategy provides a plan for health action in Aotearoa. The strategy endeavours to identify and address those areas of the greatest benefit to the society with particular reference to reducing the inequalities. The strategy acknowledges Te Tiriti o Waitangi and the special relationship that exists between Māori and the Crown (Ministry of Health, 2000b).

Summary

The colonisation of Māori health involved the introduction of communicable diseases, and the establishment of colonial health legislation and policies. Communicable disease had a huge impact on the well-being of Māori with a drop in population from over 80,000-100,000 in 1840 to 41,993-43,927 in 1891 (Department of Statistics, 1956; Durie, 1998b; Pool, 1991; Statistics New Zealand, 1996, 2001). While the Māori population began to recover in the early 1890's the loss of land and associated colonial policies saw Māori health status remain poor compared to Pākehā.

Voices that were legitimated during this time were those of doctors, missionaries and politicians with a social order agenda. The voices that were marginalised were Māori and Pākehā with a social justice agenda. The dominant discourses, which were produced and reproduced, were bio-medical and Christian discourses.

Māori tino rangatiratanga during this time remained active with Māori leaders emerging at tribal, health professional and political levels. To some extent the involvement of Māori at these levels contributed to an increase in population rates and an improvement in health for Māori.

However while overt health policies did not seem to be working to well for Māori the colonial Government continued to develop and implement genocidal and ethnocentric health policies.

Consistent through the development and establishment of Māori health policies is the call for tino rangatiratanga. Tino rangatiratanga was the catch cry of the Māori resistance movement of the 1960s-1970s and was reiterated through various stages of Māori health policy development. One of the early issues, as Durie argues, was the fact that while Te Tiriti existed in other legislation it did not exist in health legislation which meant that Tiriti policies were not a legislative right rather they were add on to Pākehā legislation (Durie, 1994b). It was not until the year 2000 that a Tiriti clause appeared in health legislation ("New Zealand Public Health and Disability Act", 2000).

With respect to health, while achieving a certain amount of headway, scholars argue that Tiriti policies and Māori health policies emerging from mainstream legislation reflect Article I (kawanatanga) and Article III (citizenship rights) of Te Tiriti while ignoring Article II (tino rangatiratanga) (Durie, 1998b; Fleras & Spoonley, 1999). Further these policies are needs driven rather than rights driven (Durie, 1998a; Fleras & Spoonley, 1999).

My thesis explores these issues within the context of the cervical screening programme. Chapter Six explains the methodological approach adopted.

Chapter Six

MĀTAURANGA MĀORI ME NGA AHUATANGA MAHI

Theory and methodology

A methodology seeks to ‘frame the questions being asked, determine the set of instruments and methods to be employed and to shape the analysis of research. It is a theory and analysis about how research does or should proceed. Within an indigenous framework methodological debates are ones concerned with the broader politics and strategic goals of indigenous research (Tuhiwai-Smith, 1999, p. 143).

The purpose of Chapter Six is to develop a theoretically grounded methodological framework for my study. It is now widely acknowledged that a researcher’s beliefs, values, and academic discipline contribute to the theoretical and methodological choices s/he makes (Bishop, 1994, p. 396; Patton, 1990; Stanfield 11, 1994). Further, the political, social, historical, spiritual and cultural environments in which the research takes place influence the research process (Bishop & Glynn, 1999; Doolin, 1997; Patton, 1990; Stanfield 11, 1994; Tuhiwai-Smith, 1999). My methodological choices were strongly influenced by my commitment to tino rangatiratanga and my experiences, as a Māori woman, of being brought up in Aotearoa and working in the health sector. Consequently I have made choices that advanced tikanga Māori while endeavouring to be mindful and respectful of people from outside of my culture. I drew on an interdisciplinary scholarship on Kaupapa Māori, colonisation, Treaty of Waitangi, community psychology, public policy, disability, feminist, postcolonial and discourse theory in order to develop a Kaupapa Māori framework that operationalised tino rangatiratanga as legitimate representation, and reciprocity.

Theoretical Framework

Kaupapa Māori research emerged at the interface between Western and Māori ontologies and epistemologies during the Māori revitalisation movement of the 1970s (Bishop, 1994; Bishop & Glynn, 1999; Jackson, 1998; Smith, 1992; Tuhiwai-Smith,

1999). During this time Māori were active in challenging the dominance of Pākehā values and beliefs in many areas such as justice, health, welfare and education. At the same time they argued for space for Māori values and beliefs (Bishop, 1994; Tuhiwai-Smith, 1999; Walker, 1990). Initiatives such as kura kaupapa Māori emerged and also kaupapa Māori healing models. The main thrust of Kaupapa Māori research is tino rangatiratanga (Bishop, 1994; Tuhiwai-Smith, 1999). As a principle in Kaupapa Māori research, tino rangatiratanga is about reclaiming and redefining Māori knowledge and realities (Bishop, 1994, 1996; Durie, 1997a; Te Puni Kokiri, 1999a; Tuhiwai-Smith, 1999). Such reclaiming and redefining of Māori knowledge and realities begins with an acknowledgment of the impact of colonisation and Western worldviews on Māori (Bishop, 1994; Jackson, 1998; Tuhiwai-Smith, 1996). Kaupapa Māori theorists argue that scientific, positivist research paradigms have dominated the research sector to the detriment of Māori (Bishop, 1994; Keefe, Cram, Ormsby, & Ormsby, 1998; Tuhiwai-Smith, 1999). Research originating from such predominantly individualistic paradigms cannot adequately address issues arising from Māori realities that are grounded in a collectivist society (Bishop, 1994, 1996; Royal, 1998; Tuhiwai-Smith, 1999). While Western research models have a place in research, just as Western medicine has a place in health, they ought not to be at the cost of exclusion of Māori research models as has been the case until the last decade. Not only is such exclusion unethical, it is also costly to the country, in terms of the consequent waste of financial, social and cultural capital (Cunningham, 1998; Davies & Mansourian, 1992; Durie, 1997a; Mead, 1993; Mental Health Commission, 1998; Smith, 1992).

There are a number of ways in which tino rangatiratanga can be operationalised within the research sector. For example, Bishop operationalises tino rangatiratanga as initiation, benefits, representation, legitimisation and accountability (Bishop, 1996). Briefly summarised, initiation is about who initiates the research and how it is initiated; benefits is about who benefits from the research and how they benefit; representation is about whose worldviews or 'voices' are heard; legitimisation is about whose realities are meaningful and given credence; and accountability is about who researchers are accountable to and who will own and disseminate the results.

Within the context of my research, tino rangatiratanga is operationalised as representation and reciprocity (Bishop & Glynn, 1999; Tuhiwai-Smith, 1999).

Representation

To make sense of a complex world, theorists argue that people use symbolic representation (Fischer, 2003; Hall, 1997; Stone, 1997). Symbolic representation is the use of language and meaning to make sense of the world. Constructionists argue that people do not just use symbolic representation to make sense of the world but that they also construct their world through common cultural signifiers. As mentioned in Chapter Two, Foucault, as a constructionist, argued that people not only construct their realities, they also produce and reproduce these realities, and do so in settings he called discursive fields (Foucault, 1977, 1980). Discursive fields are social settings in which competing ways of understanding the world are experienced by a person. He argued that people construct their realities through the use of discourses or sets of beliefs, terms categories and statements that have historical, institutional and social implications (Parker, 1992, 1998; Saraga, 1998). Dominant discourses tend to explain the most dominant forms of social interactions as being natural. It is through the production and reproduction of these dominant discourses within discursive fields that inequalities are produced or minority voices are made invisible. Foucault also argued that people are not just recipients, within discursive fields, but are also actors, which give rise to the creation of other discourses (Foucault, 1977, 1980). Often these discourses begin as resistance to the dominance of dominant discourses. Such is the case in the research sector.

Within Aotearoa, the dominant discourses within the research sector are positivist and scientific. The positivist and scientific discourses are produced and reproduced across a range of discursive settings such as academia, health, schools, and justice. Kaupapa Māori theorists challenged the dominance of the positivist and scientific research discourses and presented a Kaupapa Māori discourse. Within a Kaupapa Māori discourse, representation is about Māori worldviews being given primacy and the construction of Māori realities in the text of the research (Bishop, 1994, 1996; Bishop

& Glynn, 1999; Smith, 1992; Tuhiwai-Smith, 1999). Cunningham points out that Māori worldviews are:

Centred on the notions of connectedness and interdependence, on the personal and the collective, and on the relationship between [people] and the environment, both physical and spiritual (Cunningham, 1998, p. 396)

Examples of representation are the use of Māori processes within the research process and the construction of Māori realities within the text of the research.

The dominance of positivist and scientific research discourses has far reaching effects. Theorists argue that a researcher's theoretical perspective determines what is researched, how the research is conducted, how the information is interpreted and, most importantly, in the case of health research, what interventions arise and are implemented (Bishop & Glynn, 1999; Davison & Neale, 1994; Patton, 1990; Tuhiwai-Smith, 1999). Hence research that originates from Western worldviews carries with it Western understandings of reality which are represented in the text. For example, the nuclear whānau is reflective of a dominant Western reality. Māori notions of whānau, on the other hand, acknowledge the influence of the extended whānau. Research that arises from the nuclear whānau understanding do not address the needs of the extended whānau. This was illustrated by sudden infant death syndrome (SIDS) research conducted in the 1970s that resulted in the development and implementation of interventions that reduced the rate of SIDS for Pākehā but not for Māori (Sprott, 1996; Tonkin, 1989).

Three issues arise from the notion of representation, namely 'othering', acknowledgment of diversity and mātauranga Māori (Bishop & Glynn, 1999; Royal, 1998; Tuhiwai-Smith, 1999; Wilkinson & Kitzinger, 1996). Within feminist research, discussions have arisen around 'othering' that question whether researchers can conduct cross-cultural or cross-gender research on, with and for minority cultures without further oppressing them (Edwards, 1996). Othering is a process in cross-cultural research where the realities of the researched are constructed through the worldviews of the researcher or through what post colonialists call transliteration (Bassnett & Trivedi, 1999; McLeod, 2000; Pandey, 1999). Transliteration is the

process through which indigenous realities are deconstructed and reconstructed in the written word of the coloniser. (Ashcroft, 2001; Childs & Williams, 1997; Crane & Rajan, 1996; Trivedi & Mukherjee, 1996). In this way, minorities are usually constructed negatively. These reconstructed realities are then reproduced in educational settings and other discursive fields like hospitals and the justice system. There are those feminist researchers who argue cross-gender and cross-cultural research is necessary or minority voices would not be heard. Others argue that research conducted on, with and for minority cultures by the dominant cultures cannot truly represent the voice of the minority cultures or group (Bishop & Glynn, 1999; Dudgeon, Oxenham, & Grogan, 1996; Durie, 1997a; Royal, 1998; Tuhiwai-Smith, 1999). Similarly, there are some Kaupapa Māori theorists who argue that Pākehā researchers can conduct research that involve Māori as participants and others who do not (Bishop & Glynn, 1999; Smith, 1992; Tuhiwai-Smith, 1999) Those who do argue that Pākehā can conduct research on, with and for Māori also argue there are certain criteria or conditions that apply (see Table 9) (Bishop, 1994; Smith, 1992; Tuhiwai-Smith, 1996).

Table 9: Cross cultural models of research involving Māori

Model	Description
Tiaki model (Mentor model)	Where the research process is guided and mediated by authoritative Māori
Whāngai (Adoption model)	The researcher becomes one of the whānau who just happens do be doing research
Power sharing model	Where community assistance is sought by the researcher so that a research enterprise can be developed in a meaningful way
Empowering outcome model	Where the research supplies answers and information that Māori want to know

(Cram, 1993, p. 29)

From a Kaupapa Māori perspective, research on, with and for Māori is a process of claiming ‘insider’ status, whereby researchers refuse to “reduce ourselves or our research participants to ‘other’ (Keefe, Cram, Ormsby, & Ormsby, 1998, p. 6)

Kaupapa Māori researchers challenge the dominance of scientific, individualistic and positivist research paradigms within the research sector. Within the positivist research paradigm, objectivity and distance from the researched is argued to increase validity and reliability and therefore the objectivity of the research (Anastasi, 1982; Conrad & Maul, 1981; Keppel & Saufley, 1980). Kaupapa Māori researchers argue that this is not the case when research involves Māori.

Historically, research has been conducted on Māori by Pākehā. Because of this, Māori are often suspicious of Pākehā researchers. When research involves Māori, Kaupapa Māori theorists argue that the closer the researcher is to the participants the better. Put another way, whakapāpa connections to the researched can facilitate the research process (Bevan-Brown, 1998; Bishop & Glynn, 1999; Keefe, Cram, Ormsby, & Ormsby, 1998; Tuhiwai-Smith, 1999). Keefe et. al. argue the whakapāpa connections Māori researchers have to the researched can result in ethically, systematically and ‘scientifically’ sound research (Keefe, Cram, Ormsby, & Ormsby, 1998, p. 6). For example, Keefe et. al. conducted research on unemployment following the closing of Whakatu Freezing Works in Heretaunga. Some of the researchers had whakapāpa connections to the participants and as a consequence were able to access information that was not otherwise available. Furthermore, interpreting the data from a Māori epistemological tradition allowed researchers to test (and challenge) Western theories of unemployment as well as demonstrate that ‘unemployment is associated with unrecognised health costs to Māori’ (Keefe, Cram, Ormsby, & Ormsby, 1998, p. 5).

However it is the *nature* of the whakapāpa connections to participants that facilitates the process, not just having whakapāpa connections. In some cases a researcher’s whakapāpa connections to participants may create difficulties especially if these connections are historically problematic (Tuhiwai-Smith, 1996). For example, while working with a whānau I discovered that my cousin had married one of their daughters and then left her for another woman. My working relationship with this whānau was quite tense for a while and it would not have been helpful had I wished to conduct research with them.

Another issue arising from a focus on representation is the recognition of diversity. How does a researcher address issues of diversity or difference within the research process? From a community psychology perspective, diversity is about valuing human difference, recognising that diversity leads to ‘more robust communities because the knowledge and experience of diverse groups can be utilised in facing challenges and developing solutions to complex problems’ (Department of Psychology, 2003, p. 21).

From a feminist and disabilities perspective, diversity is about issues of difference, recognising that the challenge is not for recognition as a homogeneous group but for greater understanding and incorporation of difference (Munford & Sullivan, 1997; Yeatman, 1994; Young, 1990).

The challenge is to show how a politics based on difference can achieve enhancement of everyday lives while recognising that these lives are plural and based upon multiple identities and selves (Munford & Sullivan, 1997, p. 25).

From a Kaupapa Māori perspective, diversity is about the recognition of differences of culture, iwi affiliation, socioeconomic status, sexual orientation and abilities. Durie notes ‘Māori live in diverse cultural worlds. There is no one reality nor is there any longer a single definition which will encompass the range of Māori lifestyles’ (Durie, 1994a, p. 214). Durie identifies four broad categories of Māori realities related to their connections to Te ao Māori, links mainly to te ao Māori, links mainly to te ao Pākehā, links to both and no links to either (Durie, 1995a, 1998a).

Rangihau goes on to argue that while there are contemporary cultural differences there are also iwi differences (Rangahau, 1975). He argues each tribe has its own cultural and historical associations and he therefore thinks in terms of iwitanga (Tuhoitanga, Ngati Poroutanga) rather than Māoritanga (Durie, 1998b; Rangihau, 1975).

Another dimension of diversity is socio-economic status. In recent years, the relationship between a person’s socioeconomic status and health has been widely

acknowledged. Socio-economically most Māori do not fare well and this is becoming increasingly more obvious in recent health statistics.

Gender too must be considered, such as recognising the mana of Māori women and the relationships that exist between female and male in Māori terms. Māori and Pākehā feminists have challenged the status of Māori women using marae kawa as an example of how women are held to be inferior to men, based on Pākehā patriarchal norms (Ka'ai, 2005; McIntosh, 2001). In some tribal areas women are not allowed to speak on the marae. Some feminists view this as an example of Māori women being undervalued by Māori men (Larner, 1995). Historically, however, power and control issues were less to do with gender and more to do with people's status, for example, the relationships between tuakana and teina, rangatahi and pakeke, pakeke and kaumātua (Mikaere, 1994; Tai, 2005). The issues that exist today might be argued to reflect Western feminist assumptions often based on stereotypes of Māori women as victims, which must be challenged.

There are also those Māori who live in heterosexual relationships and those who live in same sex relationships. Heterosexual dominance in the research sector is well known and gay and lesbian women argue that space must be made for same sex families and gay and lesbian realities (Sang, 1989).

Finally there are those realities that arise from people's abilities. Disability theorists argue that the dominance of abled people's worldviews in the research sector has suppressed the voices of those people with disabilities.

Cultural, socioeconomic and gender specificities, sexual orientation and abilities are all issues of representation that need to be addressed in the research process.

Such issues of diversity may be addressed through the establishment of a research whānau and the process of consultation which will be discussed in the methodological design section (Bishop, 1996; Durie, 1997a; Health Research Council, 1998).

Finally representation is about mātauranga Māori or the recognition of traditional Māori epistemologies in the research process. Mātauranga Māori is a way of intuitively knowing when something is right and involves a spiritual or psychic element (Salmond, 1980). Royal proposes Kaupapa Māori research comprises of six components: rangatiratanga (leadership), manaakitanga (mutual elevation of mana in the process), whānau ngatanga (inter-connectedness), tohungatanga (expertise), ūkaipō (those spaces and places where one is nourished) and kotahitanga (unity of all things in the world) (Royal, 1998). Similarly Smith proposes five principles of use in the education sector which have been applied to the research sector and include rangatiratanga (relative autonomy), taonga tuku iho (cultural aspirations), ako Māori (culturally preferred pedagogy), kia piki ake i nga raruraru o te kainga (mediation of socioeconomic and home difficulties) and the kaupapa of kotahitanga (collective vision) (Smith, 1988).

Building on Smith's work, Tuhiwai-Smith proposes five principles for Kaupapa Māori research. A brief outline of each principle is presented here (for more detail see Tuhiwai-Smith, 1996). The principles are: whakapāpa (the way we think and come to know the world), te reo (a window to ways of knowing the world), tikanga (customary practises, obligations and behaviours or the principles which govern the world), rangatiratanga (control over the decision making process), and whānau (cultural ways of organising and supervising the research and gender issues) (Tuhiwai-Smith, 1996). A number of data gathering methods are acknowledged within these frameworks and include whakapāpa, waiata (cultural knowledge depicted in singing), harakeke (cultural knowledge emerging from woven patterns), and mōteatea (traditional chants). Mātauranga Māori can also be protected and endorsed by the establishment of a research whānau. Smith asserts a 'research whānau' or a 'whānau of interest' 'provides a support structure which has in-built responsibilities and obligations' (cited in Tuhiwai-Smith, 1996, p. 18). Along with academic supervisors, research whānau also include kaumātua and cultural supervisors (Irwin, 1996). However, the use of tikanga does not preclude the use of Western research methods. Tuhiwai-Smith, Smith, Bishop and Cunningham all acknowledge that the use of Western research methods such as statistics may be

helpful in the research process (Bishop, 1994; Cunningham, 1998; Smith, 1992; Tuhiwai-Smith, 1996). Neither does the use of tikanga preclude the involvement of Pākehā researchers. In Bishop's case, this is a reflection of the lack of Māori researchers and the need to close the gap through collaborative research (Bishop, 1994). For Cunningham the critical issue is the level of Māori involvement in the research process (see Table 10) (Cunningham, 1998). Cunningham provides four levels: research not involving Māori, research involving Māori, Māori-centred research and Kaupapa Māori research. Research not involving Māori is research that has no Māori input and is considered to have no value to Māori. Such a notion has been challenged, because as Cunningham argues, all research in Aotearoa impacts on Māori. The 'research involving Māori' level has Māori involved in the research process as minorities. In the 'Māori-centred research' level Māori have more involvement and in the 'Kaupapa Māori' level Māori own and control the research process.

Reciprocity

Reciprocity is about the nature of relationships the researcher has with participants. A reciprocal, collaborative, and co-operative relationship has been advocated by theorists of colonisation, the Treaty of Waitangi, community psychology, feminism and disabilities (Ballard, 1994; Bishop & Glynn, 1999; Health Research Council, 1998; Nikora & Robertson, 1995; Tyler, Pargament, & Gatz, 1983; Wilkinson & Kitzinger, 1996). Within the context of my research these relationships were also about tohungatanaga, tikanga Māori, and rangatiratanga. Tohungatanga was about recognising that while I might have particular research knowledge and expertise, Māori participants are experts in their own right. Within Māori settings, there are expert researchers and experts with respect to Māori processes and knowledge. When researchers seek to gather information from Māori it is acknowledged that now, or sometime in the future, they must reciprocate. Reciprocity may involve the swapping of information, the provision of services or participating in the benefits of the research outcomes.

Table 10: Cunningham’s research models and levels of Māori involvement					
Characteristics	Research not involving Māori	Research involving Māori	Māori centred research	Kaupapa Māori research	
Description	Research where Māori participation or data is neither sought nor considered relevant; research whose results are thought to have no impact on Māori.	Research where Māori are involved as participants or junior members of a research team; Research where Māori data is sought and analysed; Research where Māori may be trained in contemporary research methods and mainstream analysis.	Research where Māori are typically senior members of research teams; Research where a Māori analysis is undertaken and which produces Major knowledge, albeit measured against mainstream standards for research.	Research where Māori are significant participants and where the research team is typically all Māori; Research where a Māori analysis is undertaken and which produces Māori knowledge; Research which primarily meets expectations and quality standards set by Māori.	
Example	Quantum chemistry, clinical trials, volcanology.	Analysis of ethnic differences in disease rates, genetic study of familial cancer.	Longitudinal social science study of Māori households.	Traditional study of cosmology; study of cultural determinants of health.	
Control	Mainstream	Mainstream	Mainstream	Māori	
Māori participation	Nil	Minor	Major	Major, possible exclusively	
Methods/tools	Contemporary	Contemporary - mainstream	Contemporary – mainstream and Māori	Contemporary – mainstream and Māori	
Analysis	Mainstream	Mainstream	Māori	Māori	

It is well known that where we position ourselves academically, politically and culturally influences our research interests and the way in which we gather, interpret and disseminate information (Doolin, 1997; Patton, 1990; Stanfield 11, 1994). Researchers do not exist in a vacuum and although we approach research with our academic, political and cultural values and beliefs, within Māori research settings, tikanga Māori often dominates. In such settings, while we may be there as researchers, tikanga Māori dictates that we behave in certain predetermined ways. For example, in Māori cultural settings whānau may position us as rangatira (leader), pakeke (adult), whaea (aunty, older wiser person), nanny (grandmother) or rangatahi (child). Each of these positions requires certain culturally-bound behaviours. When positioned as rangatira there is the expectation that the researcher will provide a leadership role and also be knowledgeable about their take (concerns, issue) and iwi/hapū kawa. As a pakeke, the researcher may be expected to concede to kaumātua with respect to kawa and also to manaaki and tautoko whānau. Being positioned as whaea acknowledges the researcher as an older person to younger whānau members and in this position a researcher may be expected to tautoko and manaaki younger whānau members with respect to research as well as whānau existence. As a rangatahi the researcher is there to listen and do what they are told. Being able to respond to the culturally-bound behaviours eases the research process. Reinharz refers to this positioning as situationally created selves (Reinharz, 1997).

In 1986, Puaoteata-tu⁸ showed the social welfare services in Aotearoa to be racist in their practises. Since then, ‘consultation with Māori has been regarded as a desirable if complicated step in designing social programmes’ (Durie, 1994, p. 181). Te Puni Kokiri provides minimum requirements for effective consultation which include: clear aims and objectives; Māori who are knowledgeable about Māori tikanga and the consultation topic; a realistic time frame so that all interested stakeholders can be consulted; transparent processes; and an opportunity for post-consultation hui (Te Puni Kokiri, 1993a).

⁸ This piece of ground breaking research was commissioned by the government to determine whether the social services were addressing the needs of Māori families and if so how and if not why not.

A key strategy within the consultation process is being able to identify community leaders. In his writings on health promotion Durie suggests that Māori leadership is integral to the success or failure of health promotion within Māori communities (Durie, 1999). Similarly, the identification of community leaders is equally important in research (Royal, 1998; Tuhiwai-Smith, 1999).

In summary, representation involves challenging the dominant scientific and positivistic research discourses and the creation and implementation of a Kaupapa Māori approach. A kaupapa Māori approach includes the construction of Māori realities in the text of the research, recognising the diversity of Māori realities and the inclusion of mātauranga Māori in the research process (see Table 11). Reciprocity is an acknowledgment of reciprocal collaborative relationships, tohutanga, tikanga Māori and rangatiratanga. Components of the theoretical framework are applied to an analysis of public policy, specifically health policy. The place of ideology and hegemony in public policies and discussion of the policy making process are explored next.

Table 11: Goals and components of the theoretical framework

Goal	Component
Representation	challenging construction of Māori realities diversity mātauranga Māori
Reciprocity	collaboration tohungatanga tikanga Māori positioning/subject positions rangatiratanga

Methodological design

A multi-methodological Kaupapa Māori research design was developed. It comprised of: the development of a Kaupapa Māori analytical framework, the establishment of a research whānau, consultation, discussions with kaitiaki, a Kaupapa Māori analysis of the 1996 National Cervical Screening Programmes Policy document, whānau hui, kanohi ki te kanohi discussions and the administration of a semi-structured questionnaire with recipients of the service. Each of these aspects are discussed in the following sections.

The development of a Kaupapa Māori analytical framework

The overall analytical framework for the study drew on discourse theory, in particular, Fischer's practical deliberation framework (Fischer, 1995). Fischer argues that a practical deliberation framework seeks to 'investigate empirical and normative policy judgments' (Fischer, 1995, p. 17). Like Kaupapa Māori research, Fischer's practical deliberation framework seeks to challenge the dominance of positivism in the evaluation of policy. Like Stone (1997) and Būhrs and Bartlett (1993), Fischer argues that policy evaluation is often conducted from a technocratic perspective that in effect 'quietens' the minority voice by focusing on empirical rather than normative knowledge or underlying values and beliefs (Buhrs & Bartlett, 1993; Fischer, 1995; Stone, 1997). Furthermore he states that policy evaluation needs to be conducted on two levels, what he describes as first and second order evaluation. Within each of these orders are two discursive levels that address relevant questions; technical and analytical discourses in the first order and a systems and ideological discourses in the second order (see Table 12). Within the context of my research the use of a practical deliberation framework provides a mechanism through which the juxtaposition of Māori and Western realities may be explored.

Table 12: Fischer’s practical deliberation framework

Level	Discursive level	Organising question
First order	Technical analytical discourse: Program verification (outcome)	Does the program empirically fulfil its stated outcome?
	Contextual discourse: Situational validation (objectives)	Is the program objective(s) relevant to the problem situation?
Second order	Systems Discourse: Societal vindication (goals)	Does the policy goal have instrumental or contributive value for society as a whole?
	Ideological discourse: Social choice (values)	Do the fundamental ideals (or ideology) that organise the accepted social order provide a basis for legitimate resolution of conflicting judgments?

(Adapted from Fischer, 1995, p. 18)

Within this framework, policy evaluation occurs at a micro and macro level. At a micro level, the policy is examined in the service setting. In the present case, this is cervical screening settings. However the evaluation does not just seek to investigate the outcomes of the service but also whether the programme’s objectives are relevant to the issue. So in the current study it does not only gather information about how many Māori women have had a cervical smear and related services, but also whether cervical screening service objectives are relevant to these women. At a macro level, programme evaluation explores the implications of cervical screening policies on society as a whole, particularly with respect to difference and explores if and how this difference is addressed (Fischer, 1995). Fischer refers to this difference as ‘conflicting judgments’ (Fischer, 1995, p. 18). An evaluation can begin at any of the discursive levels depending on the issue identified. For example, an evaluation of cervical screening services may begin at the first order evaluation and discourse levels, investigating whether strategies are being implemented to reach ‘at risk’ groups (Ministry of Health, 2000a). Or it might begin at the second order evaluation and ideological discourse level, asking whether the underlying values of cervical screening services address Māori realities (Ministry of Health, 2000a).

The adoption of a practical deliberation framework in researching the definition and implementation of tino rangatiratanga in health policies and practises is ideal given the political and cultural environment which frame cervical screening services. Further, such a framework allows the researcher to examine not only those discursive interactions relevant to being Māori but also those relevant to being a Māori woman (Rixecker, 1994).

The aspects of Fisher's practical deliberation framework that the evaluation draws on are his acknowledgement of the influence of discourses, ideologies, values and beliefs on the outcomes of policy development and implementation. Drawing on Fischer's practical deliberation framework, in particular his organising questions, and tino rangatiratanga, a Kaupapa Māori policy analytical framework was developed to address policy issues relevant to my thesis (tino rangatiratanga in health policies and practises). At a policy programme level the Kaupapa Māori analysis of the 1996 National Cervical Screening Programmes Policy document seeks to determine whether in the implementation of the policy, there have been health gains for Māori and Māori women. At this micro technical level quantitative and qualitative data is sought, comparing Māori women's experiences with other ethnicities. Again at micro policy relevance level the Kaupapa Māori analysis examines the objectives of the 1996 National Cervical Screening Programmes Policy document to see whether the objectives address Māori women's realities, particularly those related to tino rangatiratanga. At a macro second order level the Kaupapa Māori analysis of the policy document adopts a systems view asking whether the policy goal is relevant to tino rangatiratanga and therefore Māori women's health. Finally, again at a macro level, the Kaupapa Māori analysis; explores the policy document for discourses that are relevant to the current investigation, those of tino rangatiratanga and kawanatanga and health discourses, tensions that exist, how these tensions are mediated, culminating with the generation of tino rangatiratanga alternative. The first two columns in the Table 13 relate to Fischer's organising questions and the last one to tino rangatiratanga.

Table 13: Kaupapa Māori analytical framework

Discursive level	Organising questions	Tino rangatiratanga
Policy programme	Does the programme empirically fulfil its stated outcome(s)?	Are there health gains for Māori?
Policy relevance	Is/are the objective(s) relevant to the problem?	Do the objectives address Māori women's realities?
Policy goal	Do the policy goals contribute to the health of women?	Do the policy goals benefit Māori society as a whole?
Policy values	Do the fundamental values that organise the cervical screening programme provide avenues for addressing conflicting values?	Is tino rangatiratanga reflected in the 1996 National Cervical Screening Programme's Policy document. Are there any tensions between tino rangatiratanga and other values. If so how are these addressed?

(Compiled from information in Bishop, 1994; Fischer, 1995; Smith, 1988)

The establishment of a research whānau and the consultation process

Within the Kaupapa Māori research design, two inter-related processes were used, the establishment of a research whānau and consultation. The establishment of a research whānau involved discussions with various people throughout the research process. Like Irwin's (1994) research whānau, mine included Māori who were knowledgeable about research and tikanga, whānau/hapū from my iwi, academics who were knowledgeable about my research and academic discipline, Māori organisations, Māori individuals, and Māori and non-Māori who were knowledgeable about my topic. Like Māori societal whānau, my research whānau consisted of interested people who were closely aligned to my work and available to discuss issues at any time and people who were less interested but wanted to be kept in touch with respect to each of the stages as I completed it. A research whānau also strengthens the trustworthiness, reliability and validity of the research (Minichiello, Sullivan, Greenwood, & Axford, 1999). A research whānau provides opportunities for peer debriefing which is:

...a process of exposing oneself to a disinterested peer in a manner paralleling an analytic session and for the purpose of exploring aspects of enquiry that might otherwise remain only implicit within the inquirers mind (Minichiello, Sullivan, Greenwood, & Axford, 1999, p. 426).

The process of consultation was complex and lengthy and reflected the importance of whānau networks. Initially my research topic was to explore Māori women's perception and practise of well-being. Consultation began two and a half years before formal data gathering and was initiated by informal discussions with whānau, hapū and iwi. The purpose of these initial discussions was to determine whether my topic was relevant to them and to seek possible participants. From these discussions it was suggested that it might be safer to research people from my own iwi. There were two reasons for this. Firstly, if I researched Māori women from other iwi, I might inadvertently trample on their mana, and secondly, working in this way could produce valuable iwi-specific information. The implications of these methodological decisions meant the findings from the current study cannot be generalised to other iwi.

The next step in the consultation process occurred eighteen months later within academia. During this stage I was asked to begin to frame research objectives. Framing research objectives was academically challenging as I had to translate my understanding of my research objectives into an academic discourse expected of doctoral level study. In my mind what I intended to do was very clear. However, although it was clear to me, I had to make it clear to academia. In further discussions with whānau, I finally began to narrow down my research objectives.

Another step in the process emerged as the result of my work on the National Cervical Screening Review 2000. During the review, I recognised that there were differences in the definition of the Treaty of Waitangi in policies and health practises and wondered if these differences might impact on service delivery to Māori. I focused on Article II, tino rangatiratanga, as this Article has been largely ignored by the Crown. The final purpose for my research was to examine the discursive interactions between tino rangatiratanga, Māori health, health policies and health practises. The objectives were to explore how contemporary kaitiaki define tino

rangatiratanga, determine whether tino rangatiratanga existed in health policies and, if so, how this impacted on Māori women who used cervical screening services.

Once the purpose and objectives had been framed, I moved onto developing the methods to be used in the research.

Methods

The research was conducted in two stages: (1) investigating the definition of tino rangatiratanga, and (2) a Kaupapa Māori analysis of the 1996 National Cervical Screening Programmes Policy document.

Investigating the definition of tino rangatiratanga

Investigating the definition of tino rangatiratanga involved kanohi ki te kanohi discussions with nineteen kaitiaki. As with key informant interviews, kanohi ki te kanohi discussion with kaitiaki are valuable because participants provide an overview of a programme, policies, past histories, and future plans from a particular perspective (Patton, 1990). However a researcher needs to consider that in some cases kaitiaki provide their own perspective of things, which may be very different from other understandings of the issue. Hence it is important to select carefully with a view to ensure that multiple perspectives are represented.

Participant selection

Kaitiaki were selected from people who were knowledgeable about tino rangatiratanga, Māori health, health, policies and cervical screening services, at national, regional, and organisational levels (see Table 14).

Table 14: Level, position and numbers of kaitiaki

Positions held		Number of kaitiaki	
Level	Position	Approached	Accepted
National	Policy makers	6	2
Regional	Kaitiaki of health services	12	11
Organisational	Managers of Māori Provider services	2	2
	Managers of the Public Health Units	2	2
	Managers of Cervical Screening Units	2	2
Total		24	19

Data gathering

A discussion schedule was used to gather information from kaitiaki (see Appendix 4). The discussion schedule sought to gather information from participants about their understanding of tino rangatiratanga and its relationship to health policies and practises. Each participant was mailed an information sheet and a discussions schedule (see Appendix 4). Of the twenty four kaitiaki who were contacted, nineteen accepted, four declined and one did not respond to either the mail out or a subsequent email. I rang those participants who had agreed to participate to arrange a time and place to meet. Before each of the discussion sessions I gave the participant a copy of the information sheet to refresh their memory and asked them if they had any questions. Once all the questions had been answered the participants signed a written consent form and the data gathering began.

Data was gathered in a number of settings from both Māori and Pākehā kaitiaki. I met kaitiaki in their work environments or in other suitable venues such as coffee shops or motels. The messy reality of research in the field was evident during this process. For example, in one case, I had had initial discussions with a kaitiaki about my research and because he was away on holiday, when I rang to make arrangements to meet with him, I asked his receptionist to block out a two-hour appointment for me to meet with him on his return. When I arrived he could not remember our initial discussion. I

reiterated the purpose of my visit and he laughed and said he appreciated my taking the initiative of booking a two-hour slot in his very busy day.

Similarly, in another case, when I arrived to meet a kaitiaki he had gone out to lunch with a friend. I rescheduled the appointment with him and asked his receptionist to contact me when he returned. Once I had completed the interview he suggested I meet and interview another kaitiaki who he believed could provide further insight into the practise of tino rangatiratanga in health policies and practises. Finally, he asked if I would provide professional and academic supervision for one of his staff while I was there. She was completing a nursing degree and needed guidance on research processes and design. This was an example of reciprocity and manaakitanga in practise.

I met another kaitiaki (a kaumātua) in a motel as she was well known, very busy and needed a place she would not be found and interrupted. This particular discussion was governed by tikanga Māori. At the beginning of the session she cited her whakapāpa and said a karakia. I responded in kind. Then we began working through the discussion schedule. She lay on the motel bed and talked. When she tired we stopped had something to eat or drink, rested or went for a spa and then continued. This process continued over two days.

In yet another case, a kaitiaki arranged to meet me at a coffee shop. She thought it would be easier for me if we did this as she lived in an isolated rural community and finding her house may have been a problem. We met at ten o'clock in the morning and at this time she informed me someone was flying in to meet with her urgently and this person would also be joining us. We established our whakapāpa connections and caught up on each other's lives. Before we began the data gathering I said a karakia and then went through the information sheet with her and asked her to sign a consent form. Once this formality was completed we began our discussion. Five minutes into the discussion her next appointment arrived and that person joined us for morning tea. The new arrival indicated she was happy to wait while we completed what we had to do. As the discussion progressed the new arrival began to join in and then apologised when she realised what she was doing. I pointed out that she had a

stakeholder interest in my research (as a funder), and given that, I outlined my ethical responsibilities and we continued. The responses were exciting and interesting. Half an hour later, four other people arrived, three to meet with the kaitiaki and one to meet with me. Hence I was unable to complete this discussion. However this kaitiaki had previously indicated she was happy to complete the discussion by email, which is what we did. Once the others arrived they got on with their discussions and I watched consensual decision making in practise as these women from competing health provider organisations (both Māori and Pākehā) made collective decisions to address the needs of their community, over a cup of tea!

The data gathering process illustrated the interplay between tikanga Māori and subjectivity.

Data analysis

Kaupapa Māori theorists argue Kaupapa Māori research has inbuilt mechanisms to ensure Māori ways of analysing and interpreting the data are adhered to (Smith, 1992; Tuhiwai-Smith, 1999). Given this, I used an analysis procedure which Bishop & Glynn (1999) refer to as spiral discourse. Like memory work and inductive analysis, spiral discourse is an analytical procedure of co-construction, where ‘mutual understanding/exploration through spiral discourse as a means of storying and restorying experiences, thoughts and reflections’ are adopted (Bishop & Glynn, 1999, p. 120). It is through the process of spiral discourse that Māori realities are legitimised in the findings.

Similar to inductive analysis, in spiral discourse the initial recorded information was transcribed and sent back to kaitiaki to provide an opportunity for them to make changes or withdraw any information they wanted. One kaitiaki made changes to her transcript, which did not influence the overall context of her transcript. The changes made involved spelling and minor content changes (dates and times of events). Once the transcripts had been returned they were loaded into NVivo, a computerised qualitative data analysing tool. Coding began with examining the text for any references kaitiaki made to the definition of tino rangatiratanga, tino rangatiratanga in policies and tino rangatiratanga in practise. Once these broad themes had been located

the data was then examined for codes related to what kaitiaki felt were elements of tino rangatiratanga in each of these areas.

Kaupapa Māori analysis

The Kaupapa Māori analytical framework was used to analyse the 1996 National Cervical Screening Programmes Policy document (Ministry of Health, 1996) (see Appendix 4). This involved a Kaupapa Māori analysis of the policy document at a macro level and whānau hui, kanohi ki te kanohi discussions and a survey questionnaire with recipients of cervical screening services at a micro level (see Table 15).

Table 15: Kaupapa Māori framework

Level of analysis		Tino rangatiratanga	Data gathering/analysis
First order (micro level)	Policy programme	Are there health gains for Māori women?	Literature review Whānau hui
	Policy relevance	Do the objectives address Māori women's realities?	Kanohi ki te kanohi discussions with Māori women
	Policy goal	Do the policy goals benefit Māori and society as a whole?	Kanohi ki te kanohi discussions with kaitiaki
Second order (macro level)	Policy values	Is tino rangatiratanga reflected in the 1996 National Cervical Screening Policy document? Are there any tensions between tino rangatiratanga and other values. If so how are these addressed?	Kaupapa Māori analysis of policy document

(Compiled from information in Fischer, 1995 and Ministry of Health, 1996)

Kaupapa Māori analysis of the policy document

A policy analysis attuned to the theoretical constitution of facticity directs investigations toward aspects of policy making that are overlooked or obscured by the myth of the given (Fischer, 2003, p. 14).

Such an approach examines the text for power relationships that are produced and reproduced within institutions to advance the ideologies of the dominant group, in this case Pākehā in Aotearoa (Foucault, 1977, 1980). Texts are either linguistic or non-linguistic communications (Fischer, 2003). In the current study one type of text is the 1996 National Cervical Screening Programmes Policy document. The use of a Kaupapa Māori analysis in the current study provided a mechanism through which competing discourses and tensions between these discourses can be identified. In the current study the process of a Kaupapa Māori analysis involved identifying story lines within the policy document which told power and control stories (Fischer, 2003; Hajer, 1995; Stone, 1997). Story lines are ‘a generative sort of narrative that allows actors to draw upon various discursive categories to give meaning to specific or social phenomena’ (Hajer, 1995, p. 56). In the current study, the 1996 National Cervical Screening Programme’s Policy document is examined for story lines about tino rangatiratanga and other dominant discourses in particular kawanatanga (bio-medical and epidemiological discourses).

Whānau hui and kanohi ki te kanohi discussions

Whānau hui and kanohi ki te kanohi discussions with participants involved identifying iwi and community leaders. Five tribal and community leaders within the Ngati Porou, Nga Puhi, and Rongowhakaata areas were approached and asked if they would participate in the study. The purpose of the study was explained to them and a discussion schedule and information sheet provided (see Appendix 4). They were then asked if they would be willing to assist in identifying women for the study. The selection criteria for inclusion were age (20 – 69 years), cultural identity, and smear taking history (had at least one smear). Age was selected as a criterion as the literature indicates that there is a difference between the smear-taking behaviour of

Māori women who are over 40 years of age and those under 40 years of age (Ministry of Health, 1999). Similarly the literature shows there is an ethnic difference in smear taking behaviour and finally, whether or not a woman has had a smear and when is relevant to the analysis of the information. The leaders were given two weeks and then were approached again. Four of the leaders agreed and one did not. One tribal leader did not wait two weeks but rang me three days later and asked how many groups I needed.

Once women had been identified the leaders made the initial contact and I followed up with a phone call or *kanohi ki te kanohi*. At this time I answered any further questions that arose and arranged a suitable time and venue for the discussion. During the data gathering stage any other questions were addressed and ethical issues discussed. As instructed by the academic ethical reviewers, signed informed consent was sought from each participant. Following the *whānau hui* women were then asked if they would complete a semi-structured questionnaire (see Appendix 6). When women were first contacted they were asked whether they wanted to be part of a *hui* or to meet individually. A total of four *whānau hui* were held and four women asked to meet individually because of other commitments.

Whānau hui, like focus group interviews, provide a social venue through which information can be gathered (Patton, 1990). Unlike focus group *hui* that suggest one to two hours is a suitable data gathering time, *whānau hui* take as long as they take to gather information and begin to analyse it. This can span from a couple of hours to several days.

Whānau hui one involved seventeen women and men for the formal *powhiri* stage and eleven women for the data gathering stage. The *hui* was held at an urban *marae*.

The *powhiri* process illustrates how representation and reciprocity are played out within *Kaupapa Māori* research context. The *powhiri* process firstly positioned me as researcher in the context of *te kawa o te iwi* and then informed me of the cultural positions and roles I was expected to fulfil (*manuhiri* and *rangatira*). The *powhiri* for *whānau hui* one included; *karanga*, *kau hau*, *mihimihi*, *hōngi harirū* and *poroporoaki*.

The karanga began the process of whakapāpa, whānaungatanga and positioning.

Haere mai, te rangatira e..., haere mai, haere mai, haere mai.

The karanga issued by the tangata whenua kai karanga made reference to myself (rangatira) which informed me that special status was being accorded to me based on my tipuna and whānau connections to the iwi. During the karanga, whakapāpa, whānaungatanga and kawa were laid out. Whakapāpa is considered to be the key to the gateway of knowledge (Tuhaka, personal communication, April 1998). Being able to whakapāpa to participants enables the researcher access to knowledge that may not otherwise be available to researchers. Whānaungatanga has a number of meanings within contemporary Aotearoa (Nikora, 1998). Within the context of my research whānaungatanga referred to the connections between the research whānau, the participants and myself. It also referred to a data gathering method. While the status of rangatira surprised me it is also indicated that once the formalities were over it would be expected that I would facilitate the proceedings.

...te karanga i tēnei ra, tēnā koe e pai karanga i te kia matau i pō mārie...

My kai karanga responded to the welcoming karanga by acknowledging the greeting of the tangata whenua. As expected within my iwi boundaries my kai karanga was male. I arrived at 8.30am expecting to meet my kaumātua (male) outside the whare nui, but in his place stood a mana tane rangatahi. The rangatahi informed me my kaumātua was unable to make it as he had been called away to a tangi. Within Māori culture, the tangi takes precedence over other things, in this case the whānau hui. However my kaumātua had not left me standing alone: it would not be tika or respectful. Hence, he had sent his nephew.

Tēnā koe e te whare e tu nei, i te kaupapa i tēnei ra, no reira ahh...tēnā koe, tēnā koe, tēnā koe.

My kai karanga acknowledged the tipuna o te iwi and the take of the day and we then moved into the whare nui.

In the whare nui, we completed our mihimihi. The mihimihi provided another opportunity to whakapāpa and acknowledge whānaungatanga. Within the whare nui both men and women were permitted to speak. The mihimihi began with an opening prayer by tangata whenua. Each speaker identified their whakapāpa, in Māori if they were fluent in Māori or English for those who do not speak Māori. A waiata indicated that the tangata whenua had completed their mihimihi and it was now time for manuhiri to mihi. When my turn came I provided a brief whakapāpa establishing my links to Ngapuhi through my father:

Tēnā koutou katoa
Ko Herena Wihōngī au, no Tolaga Bay
Ko Hauiti tōkū hapū,
Ko Ngapuhi, ko Ngati Porou, ko Rongowhakata, ko Te Aitanga a Mahaki,
ko Te Whānau a Apanui ōku iwi.
Ko Uawa tōkū awa.
Ko Titirangi tōkū maunga.
Ko Hone Wihōngī tōkū papa. He tama ia o Jack Rupert Wihōngī, no Pipiwia
me Awarua.
Ahh tēnā koutou, tēnā koutou, tēnā koutou katoa.

I also informed tangata whenua that I had been brought up in Tolaga Bay and therefore had close links to Ngati Porou. Manuhiri mihimihi finished with a waiata led by the kai karanga, who placed a koha on the ground, a book by Bishop and Glynn called *Culture Counts; changing power relations in education*. In contemporary Māori society a koha is given to assist in the cost of the hui and also as a sign of respect to tangata whenua (Duncan, undated). Once tangata whenua had accepted the koha we moved onto the next stage of the powhiri, the hōngī and harirū. The purpose of the hōngī and harirū was to remove the tapu from the proceedings. Following this we all had a cup of tea which provided another opportunity for informal whakawhānaugatanga.

Once the powhiri was over I was able to move onto the data gathering aspect of my research. Before the data gathering began, I explained the study and answered any questions that arose. I then explained the ethical issues involved in research and asked everyone to sign a consent form (see Appendix 6). Asking for signed ethical

consent as directed by the academic ethical reviewers had repercussions. Six months after the hui during a post-consultation hui I was informed by one of the tribal leaders that asking for signed consent could have been construed as an insult as the powhiri process represented informed ethical consent within their iwi context! Following the signed ethical consent process I indicated they could withdraw or change any aspect of their information until such time when I had completed the final analysis. I also indicated that while I would be using some of their information and while they might recognise their own information, their anonymity would be maintained, as no names would be used. Once this had been completed, I facilitated a discussion around the discussion schedule having received permission from the participants to record the hui.

Although the tape did not work in whānau hui one, I had facilitated discussions, the key points of which were written on newsprint. Additionally each participant completed a questionnaire. With these and loose informal discussion following the hui I pieced together most of the information.

When the information related to my take had been gathered, a poroporoaki process followed. The poroporoaki provided an opportunity for closure. During the poroporoaki each of the whānau offered a closing mihimihi. During my mihimihi I informed whānau that as a result of whānau consultation I would be facilitating two additional hui the following day, one on cervical screening and one on Kaupapa Māori research. During the additional hui other areas in which I could provide assistance were identified and included providing them with information on how to access resources and doing a literature search on library databases.

Whānau hui two involved five women and was held in the conference room of a Māori provider service. An informal powhiri began the data gathering process. While the powhiri process was informal (did not include a karanga) the intent was the same: to establish my links to tangata whenua (the women) and therefore my right to be doing the research I was doing in the area I was doing it and to establish and determine what my positions were within the context of this Māori organisation (rangatahi, pakeke, tohunga). Once the powhiri formalities were over and

participants knew who I was, where I had come from and what my take was, we were able to move into gathering information related to cervical screening.

The data gathering stage was similar to whānau hui one. In the poroporoaki, as per the reciprocity principle, I indicated I was available to provide services with respect to my skills/connections now or in the future. The participants indicated they would like me to run a research hui, help conduct a needs assessment and develop a customer satisfaction survey.

Whānau hui three involved two women, a mother and a daughter, and was conducted at the home of these women. I contacted this whānau kanohi ki te kanohi and established a time and venue to conduct the hui. On arrival at the venue the hui began with a cup of tea and kai and loose discussions around whānau happenings. The real intent of the ‘loose discussions’ around whānau happenings was to establish whether I could be trusted with the knowledge they were going to discuss with me. Questions such as “where are you now” and “who are you with” and “what are you doing” were all about trust. Had I not proven my trustworthiness the discussion would not have been completed or the information shared would have been limited. Once these formalities were over, I explained the study and answered any questions about the research. I also sought informed consent and permission to record the hui. On receipt of these I began informal discussions around cervical screening based on the discussion schedule. When this had been completed I asked each participant to complete a questionnaire. In this instance my koha was food and assistance in washing the dishes as well as negotiating whānau raruraru, providing manaaki and looking after mokopuna. Reciprocity was about assisting in writing and formatting a reference for one of the whānau members.

The participants in whānau hui four were two women in an established relationship. I initially contacted these participants by phone to see if they would be willing to participate. They rang me on several occasions following my initial contact to remind me to come and see them and to set up a suitable time and venue. When a time and venue had been established it was arranged that I would stay the weekend with them and take my son with me. On arrival we discussed whānau happenings

and sorted out sleeping arrangements. The next day we began the data gathering. A similar process as for whānau hui three occurred. While no questions arose before I began to gather the data, questions were asked during the data gathering stage. At these times I would stop and answer them. My koha was buying lunch.

Four participants opted for kanohi ki te kanohi discussions because of work commitments and locality. Two of the participants were excluded because in one case the transcription was inaudible and in another the participant did not fit the criteria. Of the two that were left one did not arrive on the day. The one that participated was in the 35-46 age range and self identified as of Ngati Porou and Irish descent and identified her hapū as Hauiti. The discussion was conducted at her home. A similar process as for the whānau hui was followed.

Similar to kanohi ki te kanohi discussions with kaitiaki, a spiral discourse process was used for data analysis (Bishop & Glynn, 1999). The initial recorded information was transcribed and sent back to participants, either by email or post. A stamped return address envelop was included in those transcriptions that were posted out. Any amendments were made to those who requested it. Once this had been addressed the completed transcripts were loaded into NVivo. Coding began with examining the text for commonalities and then for differences. The code emerged from the text of the transcript.

A question of ethics

A code of ethics is said to be an ‘expression of a profession’s self comprehension’ (Kimmel, 1996, p. 26); ‘moral guides to self-regulation, attempts to ensure the appropriate use of skills and techniques’ and ‘principles specifying the rights and responsibilities of professionals in their relationships with each other and with the people they serve, as well as stating prescriptive, normative, values reflecting the consensus of the profession’ (Keith-Spiegel & Koocher, 1985, p. 2). Codes of ethics are also considered to be ambiguous and ‘contain inconsistencies that could lead to

potential conflict when one attempts to apply the code to certain situations' (Keith-Spiegel & Koocher, 1985, p. 2) such as cross-culturally.

Colonisation and Treaty theorists argue that the question of ethics is about 'tikanga' – for 'tikanga' reflects our values, our beliefs and the way we view the world (Te Puni Kokiri, 1994e, p. 9). Tuhiwai-Smith argues, within Kaupapa Māori research ethical codes 'extend far beyond issues of informed consent and confidentiality' (Tuhiwai-Smith, 1996, p. 27). The Psychology Department's Research and Ethics Committee at the University of Waikato (1997) cautions researchers that ethical approval when research involves Māori is not just about individual informed consent but also consent from whānau/hapū/iwi or Māori organisations as well.

Given these arguments and my academic discipline, my research was guided by the New Zealand Psychological Society's Code of Ethics, the Australasian Evaluation Society's Code of Ethics and te kawa o te iwi/organisations (Australasian Evaluation Society Inc., 1997; The New Zealand Psychological Society, 1998).

To proceed academically, permission was sought from the Psychology Department's Research and Ethics Committee, acting under the delegated authority of the University of Waikato Human Research Ethics Committee, the Regional Health Ethic Committees and Māori (organisations in some cases and iwi in others). An issue that was highlighted when seeking ethical approval from both the ethics committees was the dominance of the empirical scientific paradigm. In the case of the Psychology Department's Research and Ethics Committee one of my reviewers indicated I needed to approach my participants by mail. I had adopted a Kaupapa Māori approach which involved consultation and discussions with participants. In some cases approaching these participants by mail was considered rude. In the case of the Regional Health Ethnic committees the dominance of empirical scientific model was evident in the forms I had to fill out (Appendix 7) and then the discussions I had with them over a six month period during which time the reviewers indicated they were not familiar with qualitative methods and did not understand what I was endeavouring to accomplish. In the end I was told I did not need ethical approval from them. Ethical approval was also sought from individuals, whānau/hapū/iwi and

iwi organisations. Ethical permission was sought from individual participants when a consent form was signed. At this time, participants were again informed of their rights to withdraw from the research at any time. Ethical permission was sought from whānau/hapū/iwi during consultation and from the Māori organisations involved, before commencing the data gathering. Permission from whānau/hapū/iwi and Māori organizations was given verbally. Ethical issues emerging from te Tiriti o Waitangi were addressed by the adoption of a Kaupapa Māori research framework and addressing issues of tino rangatiratanga (legitimate representation, rangatiratanga and reciprocity).

Summary

A methodological design was developed from the writings of Kaupapa Māori, Treaty of Waitangi, policy evaluation, community psychology, feminist and disability theorists. A Kaupapa Māori framework emerged which operationalised tino rangatiratanga within this research context as representation, and reciprocity. Representation is the primacy of Māori worldviews in the research and the construction of Māori realities in the text of the research. Reciprocity is the nature of relationships researchers have with the researched. A multi-methodological Kaupapa Māori research design emerged from the readings and included: the development of a research framework, the establishment of a research whānau, consultation, discussions with kaitiaki, discourse analysis of the 1996 National Cervical Screening Programmes Policy document, whānau hui, kanohi ki te kanohi discussions with recipients of the service and a semi-structured questionnaire.

Chapter Seven defines tino rangatiratanga from the perspective of 19 kaitiaki.

Chapter Seven

NGA KORERO O NGA KAITIAKI

Discussions with knowledge holders

E kore e monehunehu te pumahara, ki nga momo rangatira o nehera, na ratou i toro te nukuroa o Te Moana-a-Kiwa me Papatuanuku. Ko nga tohu o ratou tapuwae i kakahuitia ki runga i te mata o te whenua, he taonga, he tapu.

Time will not dim the memory of the special class of rangatira of the past who braved the wide expanse of the ocean and the land. Their sacred footprints are scattered over the surface of the land treasured and sacred (Ta Hemi Henare)

Chapter Seven provides the findings and discussions from kanohi ki te kanohi discussions with nineteen kaitiaki. Within the Chapter each of the kaitiaki have been allocated pseudonyms. The Chapter is divided into four sections. Section one explores the definitions of tino rangatiratanga proposed by kaitiaki. Section two the implications of tino rangatiratanga in policies and section three how tino rangatiratanga is expressed in practise. Finally section four provides a summary of key points and introduces Chapter Eight.

Defining tino rangatiratanga

What is tino rangatiratanga? Does it exist in contemporary Aotearoa? If so who can express it? The answer to these and other questions are found in discussions with kaitiaki. In the wake of early colonisation and the subsequent change in Māori social landscapes, defining tino rangatiratanga has become difficult. If tino rangatiratanga is inherited power and control, does this mean that only those people who have whakapāpa links to rangatira can claim it? If it is achieved power and control, does that mean anyone who has achieved in the eyes of Māori or Pākehā can claim it? If someone claims rangatiratanga status who do they have rangatira over: all Māori, a sub-group, whānau, hapū, iwi or waka? What emerged from discussions with kaitiaki are very clear understandings of what tino rangatiratanga means to them.

When asked what tino rangatiratanga meant to him, Hoani (Māori, tane, learned scholar, policy maker and Manager of a large Māori Provider), commented:

Tino rangatiratanga is such a wide concept. What the hell do people mean by tino rangatiratanga? Do they mean taking over control of government at the very left, or do they mean maintaining our dignity in the most conservative way on the right? Or is it such a wide concept that nobody has decided what it means and should it therefore be gotten rid of?

Hoani's comment highlights the struggles over ideas about tino rangatiratanga. Debates about the meaning of tino rangatiratanga emerged during the 1960's not long after Māori began to demand their rightful place in Aotearoa and actively demonstrate against Article II breaches of Te Tiriti. People like Christie argued that it was a non-entity, that it was a word that did not exist prior to the signing of the Treaty. Others argued that it is inherited and achieved mana and tapu or as Durie argues leadership personified (Christie, 1997; Durie, 1998a; Mason, 1993). Hoani's questioning of what tino rangatiratanga meant was rhetorical because he went on to argue:

...tino rangatiratanga does have an original meaning because it is a Māori word...it's a set of Māori words which is around the concept of rangatira or inherited and achieved mana. Rangatiratanga means absolute chieftainship. Chiefs have power and authority, they don't necessarily have ownership, they have power and authority. I think it is very important to know that there is a meaning to the words...tino rangatiratanga is about control...and chiefs have power and authority, they don't necessarily have ownership, they have power and authority...

With colonisation, the subsequent loss of land, urbanisation and the imposition of Western political systems, Māori tino rangatiratanga has been gradually eroded and marginalised. Yet theoretical understandings of tino rangatiratanga place at their heart the concept of power, control and authority (Durie, 1995b, 1998a; Durie, 2000; Fleras & Spoonley, 1999; Henare, 1998; Henry, 1995; Kawharu, 1989; Parata, 1995; Te Puni Kokiri, 2001; Turia, 2000). Such an understanding of tino rangatiratanga finds wide acceptance among those interviewed in the study. Like Hoani, Hiria (Māori,

wahine, policy maker) recognised that tino rangatiratanga does exist. She commented:

The word 'tino' is an intensifier and the word 'rangatiratanga' broadly speaking relates to the exercise of 'chieftainship'. Its closest English translation is self-determination - although many also refer to it as 'absolute sovereignty' or Māori independence. I favour the concept of self-determination...tino rangatiratanga to me is self rule by the Māori...to do...with their people as they see fit, their whānau, their hāpu and their iwi in terms of basically looking after their own families in their own way...so tino rangatiratanga allows Māori people to practise their own culture, their own way, taking care of their own taonga, without Government interference...

In Hiria's case she believed tino rangatiratanga was self-determination and for her self-determination was about iwi control over things Māori. The role of the Crown was to stop interfering. International research shows self-determination has the potential to strengthen indigenous cultures from within a nation state (Anaya, 1996). One way for this to happen, indigenous self-determination needs to be legally supported. In Aotearoa this is reflected to some degree with environmental law and very recently within health law. Generally speaking though, Māori self-determination is driven by Māori commitment and resistance.

While Hoani defined tino rangatiratanga as the power, authority and control of rangatira, and Hiria as self determination, another kaitiaki highlighted the spiritual component of tino rangatiratanga. Mereanna (Māori, wahine, policy maker) commented:

My understanding is that sovereignty is not something that Māori ever gave to anyone else. Tino rangatiratanga confers that we have "ownership" because we are Māori and the sovereign referred to is not the Queen, but refers to the concept of Io Matua Kore the Supreme Being.

Based on historical information, Christie and Mason argue that Māori knew they were signing away their sovereignty when they signed the Treaty (Christie, 1997; Mason, 1993). However, traditional meanings of tino rangatiratanga are about the ability rangatira have to whakapāpa to the gods (Durie, 1998a; Hiroa, 1958). So it is

highly likely that Māori did not sign their sovereignty away. The findings would suggest that there were two different types of sovereignty being discussed at the time, the sovereignty Māori had with the gods and the sovereignty the colonisers had to the Queen of England. It would seem that the latter is the one most commonly understood by the Crown, so it is this definition that would have been included in the Treaty.

For some kaitiaki in the current study tino rangatiratanga was about relationships with the crown. Hiria talked about tino rangatiratanga being no interference from the Government. Along similar lines Kowhiti (Māori, wahine, kaumātua, policy maker, kaimahi) argued that tino rangatiratanga was about:

...not having to negotiate with Crown laws and not having to be dependent on Crown funding

Since the signing of Te Tiriti o Waitangi Māori have had to negotiate with the Crown or Crown agents for resources and be accountable for these resources. Much along the lines of research based on Western values and beliefs focusing on social pathological characteristics and functional inadequacy of Māori so did the lines of accountability. Accountability was determined by Western cultural norms and in the case of health, bio-medical models. As tikanga Māori are holistic, collective, and subjective being accountable to the Crown was burdensome. It meant if Māori were going to address the needs of whānau, hāpu and iwi they would need to work from a tikanga Māori base. If they were going to meet the needs of the Crown they would need to work from a Western value base. Working from two different value bases was difficult. One hundred and sixty years after the signing of Te Tiriti it is not uncommon for Māori to feel like moving away from dependence on the Crown. A sentiment espoused by Durie (Durie, 1998a). Similar sentiments were highlighted by Mereanna who commented:

Autonomy which is not controlled monitored or owned by the Crown but belongs to us the Māori people

The desire for a life without the Crown is a dream for many Māori, not just those three who highlighted it in the current study. Decades of oppression and marginalisation has taught Māori that at times the Crown does not really have Māori interests at heart. Unemployment, justice education and health statistics all demonstrate this. What Māori believe is that they can provide for their own people and they can do it better. To do this they must have a strong asset base. As mentioned in Chapter Three autonomy, or in this case tino rangatiratanga, has led to an improved health status for other indigenous cultures (Cornell, 2000). Trying to achieve tino rangatiratanga through te Tiriti is one way but for Māori to move out from under the paternalism of the Crown they will also have to find ways to do it themselves. Some iwi have already achieved this through Treaty claims, through wise investments and the re-establishment of iwi asset base. The journey will not and has not been easy but the improvement in education and health status shows that something is working.

While for some kaitiaki tino rangatiratanga was about power, control and authority of rangatira within a colonised context it was also about control over the decision making processes. Hoani commented:

My understanding of tino rangatiratanga is about the ability to control our own decision making and to effect pathways that those decision makings impinge on... in relation to tino rangatiratanga and the treaty te mea nei te tiriti, ko te tino rangatiratanga i runga i te whenua, i runga nga roto, i runga i ngahere wera mea.

Involving Māori in decision making has been an ongoing issue. The Crown is required by law to consult with Māori if the issue is one arising from a legal statute with an appropriately worded Tiriti clause (Durie, 1998a; Te Puni Kokiri, 2001). As there are very few of these any need to consult is based on the principles coming from partnership such as good faith and judiciary duties (Durie, 1998a; Te Puni Kokiri, 2001). When the Courts argue that partnership is an unequal partnership where the Crown is the senior partner then it is unlikely that tino rangatiratanga is paramount (Te Puni Kokiri, 2001). The Tribunal argue each partner has equal status and it is the responsibility of the Crown to 'protect Māori to protect themselves and to strengthen

Māori to strengthen themselves and that Māori protect themselves through the exercise of tino rangatiratanga' (Te Puni Kokiri, 2001, p. 77).

In 1986, Puaoteata-tu⁹ showed the social welfare services in Aotearoa to be racist in their practise (Ministerial Advisory Committee, 1988). Since then, 'consultation with Māori has been regarded as a desirable if complicated step in designing social programmes' (Durie, 1994c, p. 181). Solutions to decisions that impact on Māori can be found through consultation but knowing who to consult with has been an ongoing cry from the Crown. The Tribunal makes it clear who the Crown is to consult with. Consultation should occur with all interested Māori. All Māori refers to iwi, hāpu, whānau, Māori organisations, pan-tribal organisations and individuals. Consultation is considered a two way process. So commitment is required by both parties, Māori and the Crown. A number of consultation frameworks have been mooted. The Courts provide a consultation framework which includes, the provision of relevant information, that the parties approach the consultation with open minds that each party takes notice of what the other is saying, that each party wait until the other has spoken before making a decision (Te Puni Kokiri, 2001). The Courts argue consultation is not an end in itself or presenting Māori with a 'fait accompli'.

It can be seen that consultation is about commitment and finding solutions that not only protects tino rangatiratanga but also the requirements of the Crown. Consultation requires a high level of communication, and involvement, that occur kanohi ki te kanohi, this requires the provision of relevant information in time to make informed decisions, further hui where Māori debate and consider the information and then hui where Māori make their views known. Interested Māori need to be fully supported.

Like Hoani, Mereanna argued that tino rangatiratanga was about decisions making. In Mereanna's case she recognised that having an economic base would make it that much easier:

⁹ This piece of ground breaking research was commissioned by the Government of the time to determine whether the social services were addressing the needs of Māori families and if so how and if not why not.

...for me, true tino rangatiratanga means that as a Māori I can get with my whānau and as a whānau we can make some decisions that...because we have the economic ability and the knowledge base and all those other things to do so

Within this context, whānau referred to the whakapāpa connections Mereanna had to her immediate and extended whānau and the linkages they had to their tribal land and other asset bases including intellectual knowledge. Tino rangatiratanga then moves from being chieftainship or Māori sovereignty to Māori control over a decision making process within the context of whānau, hapū and iwi. If the asset base was tribal assets, then 'true tino rangatiratanga' could be said to exist. If, on the other hand, the whānau did not whakapāpa to a rangatira and they were only making decisions for their own immediate or extended whānau and they were basing these decisions on personal assets, could tino rangatiratanga then be said to exist? From a traditional perspective, where tino rangatiratanga is considered to be the power, control and authority of a rangatira then the answer would be no. However in contemporary times, where tino rangatiratanga has taken on new meaning and can include individual power, control and authority the answer could equally be yes.

When kaitiaki talked about tino rangatiratanga as self-determination they saw tino rangatiratanga in relationship to kawanatanga, rather than Crown sovereignty. For example Jocelyn (Pākehā, wahine, policy maker, Crown agent) commented:

To me tino rangatiratanga is a group of people [Māori] going off on their own being supported by the Crown...they're not necessarily standing next to each other...they could be standing quite a way back but they are allowing them to stand on their own and finding their own way.

Jocelyn is an informed Crown agent and knows that as a Crown agent it is her responsibility to support Māori to support themselves.

Herena (Māori, wahine, policy maker, General Manager Māori provider) argued tino rangatiratanga was about the relationships established by the signing of the Treaty:

...I think too it is about the concepts of the Treaty of Waitangi and Te Tiriti o Waitangi and knowing those differences because when you know those differences then you know you're on a better road to understanding what tino rangatiratanga is all about.

The difference between the different versions of Te Tiriti has caused confusion for the Crown and Māori (Durie, 1999; Kawharu, 1989; Orange, 1989). As discussed in Chapter Three the Crown implemented Article I of Hobson's text and ignored Article II and Williams version. While Hobson's text was being implemented Māori challenged its imposition in a number of ways (see Chapter Two, Three and Four). The pathway to emancipation for some Māori was through understanding the Treaties and then asserting Te Tiriti in their dealings with the Crown. Asserting Te Tiriti meant taking Māori resistance internationally. As mentioned earlier in the Chapter international law states when there is doubt about the meaning of treaties between indigenous cultures and colonisers it is the indigenous treaty that takes precedence (The Waitangi Tribunal, 1989). While Treaty debates continue in Aotearoa Te Puni Kokiri argue the nature of the relationship between the Māori and the Crown is the exchange of power for protection (Te Puni Kokiri, 1999b). In discussions about the Treaty partnership the Tribunal argues the Crown is to support Māori to support themselves through tino rangatiratanga (Te Puni Kokiri, 2001). It is these understandings that Herena refers to. Knowing the difference for some brings freedom and liberation from the oppressor.

Finally in understanding the meaning of tino rangatiratanga as self-determination Kowhiti (Māori, wahine, kaimahi) believed it was about progress as people. She commented:

The chrysalis [Kowhiti's whānau, hāpu and iwi] has been hanging around a long time, all we need is the right time to come and boom...we're going through the chrysalis stage and then there will be a butterfly...I'm determined there will be a butterfly in terms of the whole hāpu coming together and flying. We've got a big project at our Marae, we've got the mana, we've got the money, we got a man, a whānaunga, who will lead the project...Auckland whānau are ready to do whatever we need, and I think the butterfly will be set free...so self-determination, apart from every individual is about our progress as people.

While Kowhiti understands tino rangatiratanga to be self determination and about people's progress she identifies that whākawhānaungātangā and nga hau e wha¹⁰ are important. The links that tangata whenua have to whānau living outside their tribal boundaries are an integral part of whānau, hāpu and iwi development. Tribal members go away to be educated and while some do not return their expertise is called upon to further whānau, hāpu and tribal tino rangatiratanga.

Finally Hoani argued that:

Now true tino rangatiratanga would be when we are able to leave our Māori workplace, go home, switch on our Māori TV, turn down the Māori radio, get our Māori kai out of a fridge, NOW that would be exciting.

Summary

In summary tino rangatiratanga has different meanings for different people; one person rhetorically questioned whether it existed; another argued that tino rangatiratanga is a Māori word that relates to rangatiratanga and also about power and control, another that it was about the difference between Te Tiriti and The Treaty of Waitangi. Yet others argue that tino rangatiratanga is about independence from the state and emancipation, the ability for whānau, hāpu or iwi to get together and make decisions without inference from the Crown. One person argued it was not something that could be given away because it was about sovereignty of the Atua. Overall Māori kaitiaki did not talk about the principles but often alluded to Te Tiriti and the Articles. From a Crown agent perspective it was about supporting Māori to support themselves. Overall kaitiaki acknowledged and justified the existence of tino rangatiratanga as alive and well in Aotearoa.

¹⁰ People who live outside their tribal boundaries

Tino rangatiratanga and health policies

Discussions with kaitiaki showed that tensions exist between tino rangatiratanga and kawanatanga and that these tensions are being mediated through national Māori body politics, giving effect to kawanatanga, and strengthening alternative policy making processes. The tino rangatiratanga and health policies section is divided into three parts; tino rangatiratanga versus kawanatanga, mediating tensions and a summary of key points from the section.

Tino rangatiratanga versus kawanatanga

Discourse theorists argue policies are sites of struggle in which multiple conflicting ideals exist (Fischer, 1995; Stone, 1997). While multiple conflicting ideals, or what Kingdon refers to as epistemes exist, within Aotearoa an imposed policy formation community dominates. As explained in Chapter Four imposed policy formation communities are communities that have a dominant episteme but the state and society are divided over the appropriateness of an idea. The dominant discourse is kawanatanga and the state and Māori society are divided over the appropriateness of the discourse. The resurgence of Māori resistance in the 1960s saw tino rangatiratanga come to the forefront of political activities and become a force to be reckoned with. As such tensions exist within policy formation communities as the Crown struggles to address their Treaty obligations. Kaitiaki within the current study identify three key areas of tension or struggle, the implementation of Article I, assimilation policies and the rationalist policy making process.

The implementation of Article I

The implementation of Article I of Hobson's text over Article II of either text was noted by Hoani:

...kawanatanga is the bit that got implemented and tino rangatiratanga is the bit that didn't get implemented.

As mentioned in Chapter Three the colonial agenda was acquiring land and assimilating Māori into the cultural norms of the colonisers. To achieve this, a Treaty was developed and signed between the Queen of England and the United Tribes of New Zealand (Durie, 1999; Kawharu, 1989; Orange, 1989). As also mentioned in Chapter Three Hobson's text was given precedence over the Williams version. Hence Articles I and to a lesser degree III were implemented and Article II ignored. Māori consistently resisted such colonial moves but as the numbers of Pākehā increased, a Westminster political model adopted, and legislation developed that prevented Māori from being involved in policy making decisions Article I epistemic were firmly embedded. Iwi resented such impositions and endeavoured to address the betrayals by open warfare, passive resistance and more recently politically (see Chapter Three and Four). Through major resistance activities such as the Land March, Waitangi demonstrations and then the establishment of the Waitangi Tribunal Māori have regained some ground but still have a long way to go. For example, once the Treaty claims have been settled Māori would have got back 1-2% of the real value of what they lost (Rumbles, 1999). In a land where Māori are tangata whenua and tino rangatiratanga is paramount to their survival it seems remiss of the Crown to continue to ignore its Article II Treaty obligations. Particularly as previously mentioned indigenous treaties takes precedence when there is any ambiguity between treaties. Within Aotearoa the indigenous treaty states that Māori retain their sovereignty while the Crown makes laws to govern.

Assimilation policies

The total disregard of Williams's text of Te Tiriti has meant assimilation policies continued to marginalise Māori through to the present day. Within the health sector this has meant Māori health practises have been marginalised and Western models legitimated, particularly the bio-medical model. The legitimation of Western health practises has meant Māori health practises existed 'underground' or to the side of Pākehā society. Māori in the know knew how to access them but these health practises were not seen as viable policy solutions nor funded until the 1993 Health Reforms.

In an endeavour to address the burden of an ever growing health budget the Government had adopted a neo-liberal approach where competition was encouraged and in the health sector a user pays policy was adopted (Davis & Ashton, 2001; Milroy & Mikaere, 1994). With these changes Māori health practises were legitimated as Māori health providers grew from 30 to over 200. Typically though the budget allocated was far less then allocated to Western medical services and Māori providers have done well to accomplish what they have to date. Given this tino rangatiratanga in current health policy formation, for some Māori, is to be extra vigilant. Rua (Māori, male, policy maker, general manager of a large Māori provider) commented:

It's understanding over time the impacts of government policy . . . everything around how Māori have been pushed to one side and subtly sort of marginalised in policy and government decision making . . . we need to ensure that we are not marginalised...

Ensuring that Māori are not marginalised is not an easy task for Māori policy makers with a tino rangatiratanga agenda. Firstly, Māori need to be in a position to identify their own social issues, they then need to define the issues in Māori terms, find a way of getting the issue on the political agenda, followed by being able to generate Māori solutions. Once this is completed making resource allocation and evaluation decisions come next. At each stage Māori ideals were consistently challenged by other stakeholder interests particularly those of the Crowns. Evidence demonstrating Māori tino rangatiratanga was not being protected.

In Aotearoa the Crown controls policy decisions. The Crown ultimately defines the policy, generates solutions, allocates resources and evaluates. Historically, the defining of health issues from a Crown perspective have been criticised because Bishop argues they 'have to often focused on social pathology characteristics, on cultural deprivation or the functional inadequacy on minority groups' (Bishop, 1994, p. 175). To a large degree such policy making processes reflected kawatanga in practise. While endeavours were made to involve Māori, usually through consultation, the Crown fell short of meeting its kawatanga obligation which was

to protect tino rangatiratanga. One of the results are the appalling health status of Māori compared to other ethnicities (Pomare et al., 1995).

Needing to be vigilant was also carried over into the evaluation of policies. One way in which colonialism seeks to recreate itself is through the written word. As such policies can and do create reality. In the case of health policies in Aotearoa one way the Crown achieves this is through the development of health sector standards based on guidelines that are dominated by Pākehā 'health experts'. Compliance to these health sector standards increases the changes Providers have to be funded. Non-compliance reduces these chances. Through the mechanism of reward and sanctions Crown neo-liberal health policies recreate themselves in contemporary Aotearoa. Such a process was alluded to by Rua who when discussing tino rangatiratanga in health service development and Crown policies commented:

I mean you probably see it in the levels of accreditation and standards that have been regurgitated which actually tell you how to provide your service...

Rua believed that health sector standards and accreditation processes based on kawatanga meant that in practise he was being forced to develop service models that reflected tikanga Pākehā a value base which was, individualistic, reductionalist, clinical, and bio-medical, the tikanga of health experts. Rua did not believe that such a model fitted with tino rangatiratanga. Tino rangatiratanga in his mind was the provision of holistic services based on tikanga Māori. The use of health sector standards and accreditation processes that reflect kawatanga is a continuation of assimilation policies.

Rationalist policy making

While Crown policies continued to assimilate through colonial policies that embed the tikanga Pākehā health 'experts' the dominance of Pākehā health 'experts' combined with a rationalist policy making processes has had a more sinister effect, more Māori die. Hoani provides an example of the effects of rationalist policy making processes within the health sector:

...there is a policy for instance that you put people who smoke on the bottom of the list for heart transplants because, you know, they're not gonna survive very long because they smoke and they're gonna be back in three months. Therefore the government thinks "Let's not waste our money, for Christ sake, give it to someone who has given up smoking and on the straight and narrow". Unfortunately what happens with this policy, it's a good policy, but it's not a tino rangatiratanga policy because its outcome is that a helluve a lot more of those people in that position are Māori and a helluve a lot more of those Māori in that position smoke. In fact that's the reason they're there, because they smoke, and because they're in that hard up file. It is much harder for them to give up smoking than a group of other people and so what happens is they miss out. Therefore, it actually becomes a racially selective policy and gets rid of Māori off the waiting list.

The use of selection criteria based on tikanga Pākehā that was individualistic, reductionalist, bio-medical meant Māori were selected out. Durie refers to this type of policy making as ethnocidal (Durie, 1998b). With the rise in Kaupapa Māori theories that sought to analyse the world through tikanga Māori, policies, such as the heart transplant policy, was seen to be unjust, unfair, inequitable and racist. While the policy might be a good policy because it selects out people who are high risk it is not a fair, just or equitable because most of these people are Māori. Most of these people are Māori because they live in an oppressive society where they have been marginalised and alienated. Te Tiriti o Waitangi was adopted as the foundation for good health for all New Zealanders (Durie, 1998b). To give effect to such lofty ideals policies need to address Māori realities, through the implementation of tino rangatiratanga. In contemporary Aotearoa Māori realities include those that have arisen as the result of the impact of colonial acquisition and assimilation policies.

While rationalist Crown policies are unfair, unjust, inequitable and racist another impact of rationalist Crown policies is that they make it difficult to implement tino rangatiratanga. Rangimai (Māori, wahine, policy maker, planner) highlights this point when she talks about implementing Crown health policies within a large Māori provider setting. Rangimai commented:

I think that most policy, which is pushed from top down, it doesn't work. I think that most people operate within the shadows of policy but their practise, the way the rubber hits the road, is actually very much dependent on them and the interactions with the people that they serve. So in an implicit way the feedback that [iwi health provider name] gets from the consumer and the services in the [iwi health provider name], is marked by the way we deliver our service...so I think that for the practitioners that are genuinely connected to the people that they serve, their practise reflects the way they interpret the policy, and how that impacts on people within the community that they serve. So for us one of the things that we're looking for in policy development is the behavioural changes that are needed as a result of that policy in order to make an impact

Policies that are 'pushed from the top down' reflect a rationalist policy making process. Pushing policies from the top down really means the implementation of kawanatanga, as the Crown controls the policy making process. In an endeavour to give effect to tino rangatiratanga which in this case means meeting the needs of whānau, hāpu and iwi, Rangimai works in 'the shadows of policy'. In 'the shadows' is where I suggest tino rangatiratanga exists in this case.

Rationalist colonial policies do not only push tino rangatiratanga into the 'shadows' they also act to re-create themselves and further marginalise Māori. Hoani commented:

Have you heard of the silo...mentality?...The silo mentality is where people of like minds get together, put walls up around themselves and then try to solve a problem. So what they've got is their own resources and their locus of control is only over those things that they're good at

Within colonised countries the 'silo' mentality are often dominated by the Crown and Crown agents and health experts. Such policy formation communities run the risk of developing policies that only address the policy issues that affect themselves, finding solutions that solve their issues, and developing evaluation criteria that measure the impact of the policies from their value base. Such policy processes continue to alienate Māori and tino rangatiratanga.

Tensions identified by kaitiaki in the current study seem to be between tino rangatiratanga and kawanatanga, the imposition of assimilation policies and the

dominance of Pākehā health ‘experts’ and tikanga in the development of policies that impact on Māori are rationalist policy making processes. While such tensions exist kaitiaki in the current study also identified many ways in which these tensions were being mediated.

Mediating tensions

Fisher argues that rationalist policies or what Buhrs and Bartlett refer to as analytically centric policy making take for granted the underlying values of the policy formation communities (Buhrs & Bartlett, 1993). The taken for granted Crown values of health policies, creates barriers to accessing to health services for Māori which mean that Māori tino rangatiratanga is not being protected (Article I) and are not benefiting from the goods of society (Article III). Therefore we see more Māori dying than Pākehā (Ajwani, Robson, Tobias, & Bonne, 2003; Robson & Harris, 2007; Te Ropu Rangahau Hauora a Eru Pomare, 2006). It is crucial within any colonised country, when evaluating policy, to evaluate the underlying tikanga of the policy.

The main focus of this section is to examine alternative policy solutions generated by kaitiaki, or to examine ways in which the tensions between tino rangatiratanga and kawanatanga can be mediated. Kaitiaki proposed a number of mediating solutions that include a national Māori body politic, giving full effect to kawanatanga and strengthening alternative policy making processes.

A national Māori body politic

The Crown has dominated the policy making arena since the signing of Te Tiriti o Waitangi. Colonial legislation and policies continue to embed kawanatanga that marginalise Māori and legitimate colonialism. Māori have attempted to hold back the tide of colonisation through various mechanisms as discussed in Chapters Three and Five. One such mechanism was the establishment of various national bodies (Cox, 1993). A national Māori body politic has had some success in stopping the flow of colonisation. For example, the New Zealand Māori Council was instrumental in stopping the sale of Crown assets through the development of the State Owned Enterprises Act (Durie, 1998a; Durie, 1998b). However, in general a national Māori

body politic is purpose built and responds to major breaches to Te Tiriti such as the Fiscal Envelop.

A more proactive stance would be to have a national Māori politic working continuously to develop Māori legislation and policies either outside or within the current state structures. Durie argues that to give effect to tino rangatiratanga in policy making a national Māori body politic is required (Durie, 1998a). The issues are how the body politic is to be established is and who will be the representatives on such a body. In the current study some kaitiaki believed it was not possible or even desirable to have a national body politic, other kaitiaki agreed one was required but wasn't sure how it would be established.

Initially Hoani questioned the need for a national Māori body politic. He commented:

I don't see how there could be a national body for it...I don't know why there ever would be, could be or should be...tino rangatiratanga is both a contextual set of thoughts and a wide variety of behaviours that go along with those basic thoughts...I mean what would you do, I mean the only way that you could get a single tino rangatiratanga organisation to handle everything would be a head of a Māori government.....why would we want to be centralised people when we have nothing to do with Ngati Kahungungu or Nga Puhi or Ngai Tahu...we're Hawkes Bay people that's the only place we're interested in...and our level of leadership should be local. I guess that is real tino rangatiratanga. So great, let's just decide that in Hawkes Bay we won't worry about anybody else or parliament, we'll just be local. Well the only people we are going to interact with is council, but I mean they certainly aren't aware, they're not going to give us anything

Like Parata and others Hoani believed tino rangatiratanga was about local or iwi leadership (Durie, 1998b; Parata, 1995). Unlike Parata and Durie he did not see a need for a national Māori body politic. One of the issues he highlights though is that at a local level there is no body politic of equal mana for iwi to have a relationship with. Further, the Crown agents do not want or know how to have a Tiriti relationship with Māori at a local level. While arguing that a national Māori body politic was not desirable or possible on reflection Hoani remembered that a national Māori body politic did exist. He explained:

Now there have been ones who have protected, if you like...the science of tino rangatiratanga...the ethics of tino rangatiratanga, and that's all those people who have talked about it for years and wrote about it and read about it, analysed treaties and what's happening overseas. So they're the academic unit, they're still out there and exist, people like . . . [name of rangatira] in Tauranga, people like...[name of rangatira] in Rotorua... there is a tino rangatiratanga movement that have had formal meetings for 20 years, a thinking, espousing, analytical debating body. Now of course, they also have hangers-on and they also have protestors and often there's a mix of the academic and the protestors ...They certainly exist....

Traditionally the holders of the knowledge of tino rangatiratanga were often rangatira, and some tohunga (Best, 1923; Hiroa, 1958). While the colonisers attempted to assimilate Māori, bodies, like the one Hoani talked about, continued to exist. The fact that they were not well known suggests that they existed 'underground' or counter hegemonically to kawanatanga. Such bodies often existed to challenge the Crown in their dealings with Māori. An example of this was the Kawharu's interpretation of William's text of Te Tiriti (Kawharu, 1989). Because of his understanding of tino rangatiratanga Kawharu was able to provide a convincing counter argument to the Crown's understanding and implementation of Te Tiriti (Kawharu, 1989). Investing time and money into such activities is costly in time and money and Durie argues it is time to look toward the future (Durie, 1998a). Such a body politic would and could strengthen tino rangatiratanga in health policies at a national level. Again the issue is how?

While Hoani acknowledged the existence of the holders of the knowledge of tino rangatiratanga Rua acknowledged the existence of current national Māori body politic:

...there are some bodies that have the ability to influence policy changes, bodies like Māori Women's Welfare League and Te Kohanga Reo. Other bodies might include District Health Boards and maybe Ministry of Health

While bodies like the Māori Women's Welfare League and Te Kohanga Reo exist to provide a tino rangatiratanga voice within particular sectors, do they really reflect a national Māori body politic or are they part of the picture. Durie argues that tino

rangatiratanga is Māori leadership personified which is about whakapāpa linkages to tupuna and achieved mana (Chapter Three) (Durie, 1998a). Are the people on these bodies then truly representative of tino rangatiratanga or do they represent Māori. There are people within these bodies that do have whakapāpa connections to tupuna and are recognised as iwi leaders but then the question arises about how they came to be sitting on these bodies. Were they selected by iwi, the Crown or some other body? Such dilemmas need to be addressed if true tino rangatiratanga is to be implemented through policy.

Critical to discussions about a national Māori body politic were debates about Māori leadership. Kaitiaki in the current study propose that a national Māori body politic needs to be truly representative of Māori and that ‘true’ Māori representatives are those Māori who have inherited or achieved mana and are selected by their iwi to represent them. Rua and Susan (Pākehā, wahine, activist, policy maker) argued true iwi representation in parliament was problematic using the ‘voting’ method because most Māori do not vote hence the people who win represent only a small percentage of iwi, those that took the time to vote. Hoani argued that ‘true’ iwi representation in parliament was problematic because the people who get voted in were those that got the most media coverage. Kaitiaki proposed that ‘true’ iwi representative would be better reflected if the people who represented iwi in parliament were iwi leaders.

Hoani commented:

What we need to somehow...do is to have local leadership...appointed by real people...appointed or endorsed on the basis of history of hard work rather than twelve minutes on the television with a smart mouth. It may actually be hereditary leadership so maybe the [name of rangatira] or [the rangatira's] sons or daughters that are representative. I mean it may be that there are room for others of us to come through because we're great performers, not necessarily great bloodline, great rangatira. If that was done, if those people were put forward and sent to Parliament, instead of having that crowd that we've got down there, like [person's name] and them, then we would have true representation

Hoani's whakaroa reflects that of Parata who postulated a Māori confederate as a national Māori body politic (Parata, 1995). Parata postulated that the Māori Confederates made of representation from each iwi.

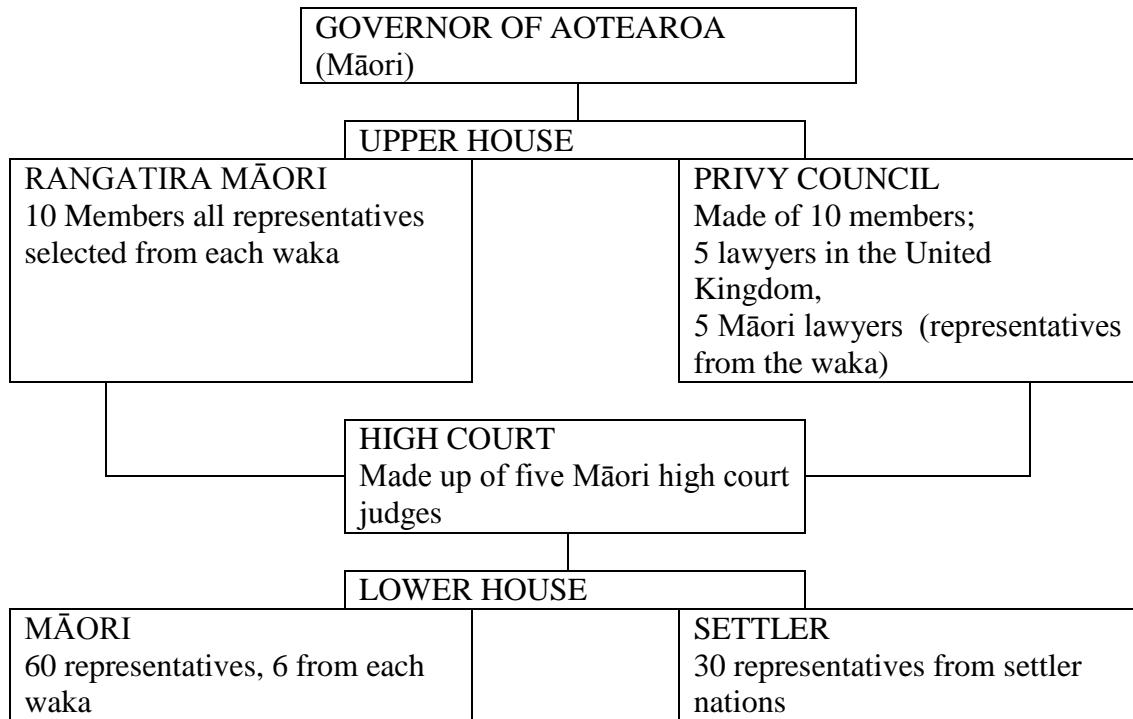
Other existing national bodies politic were acknowledged. Mereana discussed Māori Councils:

...we had tribal committees with local executives for the Māori Council... we lost a lot of that when they [Crown] first introduced the Iwi Runanga Bill... during this time Māori set up Trust Boards and Runanga and these became the local executives, but they didn't align to the Māori Council. So actually the Māori Council... still functions. But the other thing with that Runanga structure when it evolved, they actually devolved the Māori Councils that were on each marae. The Māori councils were the ones who were doing the health and social policy - looking after the people stuff on the Marae, so it was very hāpu and whānau based. The Māori Councils got devolved and then the Runanga got started up and that was Ka Awatea stuff... then in the 1996 Tau reviewed the Māori Development Act and so the Māori Councils came back into vogue again

The disestablishment of the Māori Councils was a move by the Crown to further assimilate Māori into the cultural norms of the Pakeha. Contemporary national Māori bodies politic seem to have evolved to meet the needs of the Crown. To provide mechanisms through which the Crown could have discussions with tangata whenua.

Finally Ra (Māori, male, kaumatua, learned scholar, policy maker) provided a model of a national Māori body politic. This was a sovereign body which actualised tino rangatiratanga (see Figure 10).

Figure 10: National Māori body politic



As can be seen, while replicating a Westminster parliamentary model, most of the decision makers are Māori. The Governor of Aotearoa is Māori and represents the Queen. In the upper house two parliamentary bodies exist. A Rangatira body comprising of representatives from nga waka and a Privy Council body made of lawyers from England and five from Aotearoa. The representatives for Aotearoa are all Māori. The High Court is made up of Māori judges. It is in the lower house that settler nations have a voice. Kaitiaki Nine believes the model he presents will actualise tino rangatiratanga at a local (iwi or hapū level), regional (waka) and national (waka katoa) and international level. Such a structure would see Māori decisions being made by Māori, Māori solutions being found by Māori and the potential to develop evaluation criteria based on Māori values. While a Māori government might be something some Māori yearn for it is unlikely to emerge in the near future. A more contemporary tino rangatiratanga perspective in policy making was a relationship between tino rangatiratanga and kawanatanga.

Giving effect to kawanatanga

Giving effect to kawanatanga needs to be balanced by protection of tino rangatiratanga. In contemporary Aotearoa one understanding of Te Tiriti that influences policy development is that Te Tiriti is understood to be the exchange of power for protection (Te Puni Kokiri, 2001). The Crown has a long history of disregarding such an arrangement (Durie, 1998a; Kawharu, 1989; Orange, 1989). Hoani compares the expected relationship between tino rangatiratanga and kawanatanga to be similar to the relationship between the King Herod and the Roman Empire. King Herod was the King of a Judea which was being ruled by the Roman Empire. The Roman Empire allowed him to continue to reign as King under his own government although they were in command. Hoani commented:

... when you have a governor...there is a belief or an expectation that your tino rangatiratanga will still continue as it did with Herod...they retained their kingship and they retained a certain amount of ownership of their land.

Te Tiriti o Waitangi led Māori to believe they would be treated with respect and that their tino rangatiratanga would be left intact. To give effect to such understandings requires the implementation of full kawanatanga – making laws while protecting Māori tino rangatiratanga and according to the Courts there should be very few times when tino rangatiratanga can not be protected (see Chapter Three).

Hiria reinforces the relationship between tino rangatiratanga and kawanatanga when she commented:

...Yes but tino rangatiratanga can't work properly without kawanatanga working properly...and so to implement tino rangatiratanga properly we need resources, resources is money, and if the government doesn't give over an equitable share and in fact more than an equitable share, then tino rangatiratanga can't be implemented effectively

As mentioned in Chapter Four, policies determine who gets what when where and how (Lasswell, 1936). The policy process includes allocation of resources to fund policy solutions. If one adopts the position that Te Tiriti o Waitangi gives the Crown the right to make laws while protecting tino rangatiratanga then as Hiria notes the

Crown's responsibility is to allocate resources to support tino rangatiratanga. While the allocation of resources to address Māori health is difficult to track the information available in public documents show that health was under resourced and more so Māori health (Government Printers, 1946). While attempts were made to access financial records of monies allocated to Māori health from 1990 to 2000 I was not successful but I was informed by Ministry that this information was not gathered.

While endeavours have been made to try and address the under resourcing through the establishment of Te Tiriti o Waitangi Tribunal the Crown continues to struggle with fully committing to tino rangatiratanga.

Like Cunningham's notion that Māori need to be involved in all research being conducted in Aotearoa, Hiriā believes that Māori should be involved in all policy being developed. She highlighted this by commenting:

...in terms of kawanatanga...the partnership should, in terms of the government implementing Acts and Statutes, should have Māori input into every Bill that enters the House in today's society. So if there are any, Bill at all really, not just the ones that they think might impact on Māori, any act or statute in this country impacts on Māori, so it should always have Māori input

Consultation with the Crown has been ongoing but whether effect is given to the outcome of the consultation is often the issue. Historically there have been tensions and these tensions still exist. However, solutions are being generated.

Within the cervical screening unit the policy makers consider their kawanatanga responsibilities very seriously. The way the programme addresses their kawanatanga responsibilities is through reflective practise, addressing inequalities, listening, Māori leadership, and consultation. Jocelyn, (Pākehā, wahine, policy maker) articulates her processes in her endeavours to give effect to kawanatanga and protect tino rangatiratanga:

Policy development and tino rangatiratanga is about being proactive rather than reactive in addressing Māori rights within the health sector. It is about having evidence to show us that there are inequalities and then addressing these. It is about developing policies that are sustainable and sustainable policies are those that are acceptable to Māori. Questioning whether the training has been appropriate and have we taken on board what Māori have actually said...or have we actually gone out and said to them, this is what you need. My kawanatanga responsibility is to ensure Māori take a lead in the relationship. That we [Māori and the Crown] have an understanding as to how we are gonna move forward not necessarily being focused on the outcomes...but that we've working together in partnership to actually get there. My understanding of tino rangatiratanga is looking at what that means for Māori when you're considering health and how that understanding and how our responsibility associated with that needs to be incorporated. So in many regards it's looking at the whole person and the cultural requirements. The best way to approach that and what I always look for in regards to this is that we have Māori input. So it's not a matter of me sitting here saying this is the way it should be. There also needs to be consultation and input from Māori about the best way to actually address it...I try and look at what the politics with little 'p'¹¹ associated with all of this is. So that ultimately you're gonna have an outcome which is hopefully a consensus around the best way to move forward with the policy.

The seriousness in which Jocelyn took her kawanatanga responsibilities is reflected in her considered comments about how she gives effect to kawanatanga. Firstly, she acknowledges that knowing how to give effect to kawanatanga is about being informed and being informed may require training for some people (within the Ministry of Health). Secondly, she acknowledges that adopting an inequalities approach was one way to begin to give effect to kawanatanga. Addressing inequalities was about knowing the statistical information required to make policy decisions. Stone and Kingston argue policy makers use language and other forms of rationale to justify policy decisions (Kingdon, 1995; Stone, 1997). In Jocelyn's case she looked for statistical information that showed that inequalities existed for Māori. From this she was able to provide a rationale to move forward in the development of sustainable policies. Thirdly, she questioned whether the Crown had heard what Māori had to say with regard to policy making and this she recognised that consultation and Māori leadership was important:

¹¹ Politics that exist within groups as opposed to the politics of Government.

...yes you may have input from an individual but what I would really be seeking is . . . a collective . . . iwi or a Māori organisation . . . to me it depends on the issue . . . it depends on who in Māori you are actually consulting with and what their expectations are . . . sometimes what their tribal affiliations are. Because how you would consult with one group is not the same for another. So, and it would vary around the country

The depth of knowledge of her kawanatanga responsibility was reflected in Jocelyn's comments about recognising she had to get a collective (iwi) voice as well as an individual voice. She also recognised that one collective may have different views to another.

While giving effect to kawanatanga is not easy it is possible and the cervical screening unit has provided one way in which a Crown agent achieves this. The cervical screening unit protects tino rangatiratanga by checking the robustness of their kawanatanga position and then through consulting and Māori leadership.

Strengthening alternative policy making processes

While strengthening kawanatanga by protectiong tino rangatiratanga was one strategy used to address tensions between kawanatanga and tino rangatiratanga another was Te Tiriti o Waitangi. When talking about policies that select Māori out from receiving heart transplants Hoani commented:

...well there's two ways to do something about that . . . there's a philosophical argument going about which way is right. One is to make sure that Māori have equitable outcome in terms of heart transplant (Article III) . . . we will have quotas and say that at least 20 percent of the heart transplants have got to go to Māori. The other way is to get rid of the original policy

Article III of Te Tiriti o Waitangi guarantees Māori the same rights as British subjects (Durie, 1998a; Kawharu, 1989; Orange, 1989). In this sense Māori are entitled to equitable distribution of heart transplant, something that does not currently happen. Hoani went on provide a solution to the silo mentality was mooted by Hoani who commented:

Whereas what they really needed was their medical mates in on it, their social worker mates in on it, their teacher mates in on it, their road worker mates in on it, their truck driver mates in on it, so suddenly you get this huge view and everybody says that! that! that! So the intersectoral collaborating group get things done and the other group doesn't and unfortunately governments are classic silo thinkers. You've got the health people saying, "oh yeah we want to get rid of the cigarette smoking" and you've got the Treasury saying "oh you can't put a tax on this because it is free choice", and you've got the social welfare officer saying, you know, something else. .

Hui a iwi is the process used by Māori to ensure policies are inclusive. Within the policy discipline the policy making process Hoani is referring to is what is known as a participatory policy making processes. Participatory policy making processes is one way tino rangatiratanga may be expressed in health policies because it includes Māori in the process. However, full tino rangatiratanga will not exist until Māori control the process.

Ra acknowledged the need to take policy discussion further when he commented on policy decisions made by the Crown:

I suppose there are other avenues around mobilising DHB...or MOH and [that is about] taking them to settings of Māori...that's what we did with our kaumātua programme...I'm not the expert so we go to the kaumātua because they're the ones that live and breathe the programme...and they could tell you point blank and if you can't take it that's your problem...if you want some directness and you want some view points then hear this...here's your setting . . . give us the framework on how we are going to approach because you don't want to tick a box (kaitiaki 1).

Benefits

Lasswell argues policies determine who gets what when where and how, and, critically, who benefits (Kingdon, 1995; Shore & Wright, 1997). Within Aotearoa since the signing of Te Tiriti and implementation of Hobson's version, the people who have benefited the most have been the colonisers. Māori as tangata whenua have been more and more marginalised and disadvantaged as evidenced by the health statistics (see Chapter Five). What was not implemented was Article II of either text of Te Tiriti. In contemporary Aotearoa, with a certain amount of international and

national resistance to the imposition of colonial policies, tino rangatiratanga is seen to have been integrated into some Crown legislation and policies through Tiriti clauses (Durie, 1998b; Te Puni Kokiri, 2001). While there have been some gains (see Chapter Five) for Māori they still benefit less than Pākehā. Legitimizing tino rangatiratanga in health policies through Tiriti health legislation may improve health gains for Māori. Overall kaitiaki in the current study believe the inclusion of tino rangatiratanga in health policies will benefit all peoples. The following three comments illustrate this point:

I believe that Māori will benefit, but then I believe overall that there will be a benefit for all New Zealanders, because I think if you raise the level of health of Māori then there are gains for everybody (Jocelyn)

If beneficial to Māori it is beneficial for all New Zealanders ...not only result in an improvement in services, but also by adding value to things Māori This would result in better self-esteem and a more positive attitude (Mereanna)

There is a place for tino rangatiratanga in all New Zealand policies and service delivery (Susan)

Summary

Findings from discussions with kaitiaki about tino rangatiratanga and health policies demonstrates that policy making processes are certainly sites of struggle over ideals, within contemporary Aotearoa. The ideals are tino rangatiratanga and kawanatanga. Historically, at times, the Crown has been remiss in addressing its Tiriti obligations, in particular giving effect to tino rangatiratanga in legislation. The Crown's failure to fulfil its Tiriti obligations has caused Māori to be extra vigilant, recognising the assimilation effects of some Crown policies and the detrimental effect this has had on Māori health. While the struggle is primarily between tino rangatiratanga and kawanatanga, the implementation of kawanatanga has seen the imposition of Pākehā norms in the health sector. These norms are often individualistic, scientific, bio-medical, reductionalist and racist. The dominance of these norms has in some cases, such as the heart transplant policy, left Māori dying.

Mediating the tensions to some degree is about giving effect to tino rangatiratanga, either through the establishment of a national Māori body politic, giving effect to kawanatanga or strengthening alternative policy making processes such as hui a iwi or other participatory processes.

Tino rangatiratanga in practise

Theoretically tino rangatiratanga is about the mana, tapu and whakapāpa of rangatira. Since the signing of Te Tiriti, it has also been defined as full and absolute chieftainship, Iwi/Māori sovereignty, self determination, autonomy, positive Māori development and iwitanga. In the context of my investigation tino rangatiratanga was seen to be practised at an individual, whānau, hāpu, iwi, pan tribal and organisational level. The range of tino rangatiratanga practises was highlighted by a comment made by Hoani:

There are a lot of people who have picked up on an activity, a series of activities that they describe as tino rangatiratanga movement activities, like for those who have protested. For one brand it means sovereignty, for the other brand it means by Māori for Māori, for the other brand it means let's speak Māori and not English. So it's got lots of different expressions here and it's going to have lots of different expressions depending upon what branch of life you are working in. Again this depends upon who's doing what. So if you have a bunch of university students who are thinkers, they will be doing a lot of theorising and espousing on the theory of tino rangatiratanga. Whereas if you had ones who might possibly be like myself, for instance, who started my tino rangatiratanga practise at work in my mature life, then it might mean talking Māori to my Māori whānau

The complexity of tino rangatiratanga in practise is highlighted by Hoani who identifies that tino rangatiratanga is situationally bound, context related and dependent on the persons subject positioning (Durie, 1998b; Fleras & Spoonley, 1999). Durie postulates Māori are not homogenous: therefore in policy development and service delivery the diversity of Māori realities need to be addressed (Durie, 1995a; Durie, 1998b). Similarly tino rangatiratanga varies not only from situation to situation but also from iwi to iwi, hāpu to hāpu, whānau to whānau. Discourse theorists argue a person's sense of themselves is determined by their interactions

within different social situations and that this later influences how they view the world (Foucault, 1977; Hall, 1997; Parker, 1992; Scott, 1993). Such an analysis provides an explanation for the different views people have of the world and, in this case tino rangatiratanga. According to Hoani, for people who are activists, tino rangatiratanga is about protesting. For people who are university student tino rangatiratanga is about theorising and espousing tino rangatiratanga. Such knowledge suggests that policies and services need to be situationally developed and address rangatiratanga as perceived by each whānau, hāpu and iwi.

Parata argues tino rangatiratanga could only be practised at iwi level (Durie, 1998a; Parata, 1995). Durie and Te Puni Kokiri argue that it can be practised at iwi, hāpu, whānau, and individual, Māori organisational and pan tribally (Durie, 1995b, 1998a; Te Puni Kokiri, 2001). Kaitiaki in my study argue that it can be practised at individual, whānau, hāpu, iwi and through a national Māori body politic.

Is tino rangatiratanga an individual right?

Some kaitiaki in the current study believe that tino rangatiratanga can be practised at an individual level. Building on the notion of tino rangatiratanga as power, control and authority, two primary themes emerged with respect to individual tino rangatiratanga. The first theme is having the power to make choices. The other, of a more political nature, challenges hegemony.

Having the power to make choices involved autonomy over decision making and reclaiming of mana or power. Hine, (Māori, female, policy maker, Manager Health service) talked about having tino rangatiratanga over decisions related to her health choices: “It’s self-determination and at an individual level...I think I have the power to say what I want when I go into a clinic”. In this instance, Hine equated tino rangatiratanga with self-determination, and then to making choices about her health. The generalisation of tino rangatiratanga in contemporary Aotearoa reflects the impact of assimilation policies and a mixed understanding of tino rangatiratanga. At a stretch, tino rangatiratanga might be about individual tino rangatiratanga if the person was a rangatira and could whakapāpa back to the gods, but if they weren’t, then

individual tino rangatiratanga as self-determination would seem to be a post-colonial construct. In this case the term post-colonial refers to something that happened following colonisation not that colonisation is over.

Kowhiti also viewed tino rangatiratanga as self-determination but in her case tino rangatiratanga was a reclamation process, moving from individual self-determination to claiming tino rangatiratanga as part of a hāpu. An example of tino rangatiratanga as individual choice comes from a comment made by Kowhiti when she talked about her brother's recovery:

...you see my brother had his leg off and he left his car at my home when I went away. When I got back he'd got his car back. He said I've been for a drive - with one leg, you see his car is an automatic car and it's his left leg that's gone, so he was able to do that, because that's all you use. So in his personal self-determination, he got in his car and drove. You know this brother of mine, he's very quiet and the other day I took him to the mental health awareness week and my brother, who never gets involved he was doing the kapa haka in his chair. He would no more stand up when he had two legs to do the haka and here he was doing the kapa haka in his chair, so to me that is self-determination and that is development

Such a powerful statement illustrates self-determination at an individual level. By taking control of his own life Kowhiti's brother began his journey toward the reclamation of his individual tino rangatiratanga. Kowhiti believes that the journey toward whānau, hāpu an iwi reclaiming tino rangatiratanga begins with individual reclamation. As Kowhiti went on to argue "when somebody makes one small move towards their own personal progress and development that has to be the answer for Māori".

According to Kowhiti individual tino rangatiratanga was a process. Using herself as an example, she explained that her tino rangatiratanga was something that grew and changed over time, from individual to hapū tino rangatiratanga. In the beginning, a stage before tino rangatiratanga was a period of awakening:

You know there was a first stage. I never had this awareness of our reo, even though I could – I never spoke it because of what happened at school. You know we were whipped. If you spoke reo, you were to be punished, whipped, put in a box. So personally, it was difficult to be comfortable in the Māori world...

During this stage of awakening, Kowhiti began to understand that her tino rangatiratanga had been taken away from her and that being punished for speaking Māori had had a long-term effect on her tino rangatiratanga. During this time she felt uncomfortable being in the Māori world. There are accounts during early colonisation and well into the 20th Century, of Māori being punished for using their own language (Edwards, 1990). A person's culture, their self-esteem and tino rangatiratanga are intricately linked to their language (Durie, 1998b). Hence the imposition of the English language over that of Māori was an effective means of marginalising and colonising, making Māori realities invisible.

The period of awakening was followed by a period of authority or reclamation. The period of authority or reclamation included pain and then growth. During this time Kowhiti reclaimed her mana as a woman and as a Māori woman, which meant separating from her violent partner:

...your own personal development and your relationship with your husband and your children and your parents, that took up all my time. In my heart, at a personal level, I hung on to the fact of who I was and that was self-determination. I rode it all out. It was painful living in that abusive relationship but I came through. I came through, and then I separated from my husband

The final stage was returning to the whānau and hapū, becoming part of the collective voice again. During this time she became politically active within the health sector and initiated changes at a hapū, iwi and national level.

Another example of individual tino rangatiratanga was proposed by Hoani:

...actually part of our tino rangatiratanga is to say... “No I’m not going to give it to the cigarette company”...they’re out... “No I’m not going to give into the booze company”...they’re out... “maybe I can smoke a couple of joints, but at least I can grow them, but I’m not giving it away to anybody else” ...

For Hoani, tino rangatiratanga is about making a choice from a position of power. It is about challenging the dominance of capitalism and making lifestyle choices that advance individual tino rangatiratanga.

In summary then, some individuals are taking the term tino rangatiratanga and extending it to include individual self-determination. The previous three examples highlight different aspects of tino rangatiratanga from an individual perspective. In one instance it was limited to making personal health choices, in the other two examples it was about the personification of tino rangatiratanga or reclaiming personal power over one’s life. In some cases, as illustrated in the previous section, tino rangatiratanga is about individual self determination. In other cases, as illustrated the next section, it was about the individual in the context of the whānau.

Or is it about whānau?

While there were those who believed that tino rangatiratanga was about individuals there were those who believed it had to do with whānau. A comment by Hiria illustrates this point:

At an individual level rangatiratanga is expressed through one’s determination and drive to be master of one’s own destiny within the whānau unit. Successes are a result of a combined whānau effort and accordingly failures too are borne by the whānau and must be rectified through a process of hohou te rongo known today as restorative justice

Hence while tino rangatiratanga exists for individuals, Hiria believed this could only be claimed within the context of whānau. One issue that arises from this is who or what is whānau? The literature defines whānau as (a) blood descent from common

ancestors or whakapāpa connections, (b) a set of siblings born to the same parent, (c) descendants from a relatively recently named ancestor traced through both male and females links, regardless of whether they know or interact with each other, (d) descent plus active participation, and (e) descent groups at hapū and iwi level (Hiroa, 1958; Metge, 1995).

Today whānau has been generalised to encompass groups who have congregated together for a common cause such as sports groups or work groups or even research groups. Some theorists argue generalising to this extent makes the concept of whānau meaningless but Durie argues that ‘whānau has simply evolved to meet new circumstances’ (Durie, 1997c, p. 2). For Hiria, whānau represented her partner (female), her ex-partner’s child (with no whakapāpa connections to her or her current partner), her own children, her own parents and her partner’s parents, her brothers and sisters and her partner’s brothers and sisters. Her understanding of whānau included people with and without whakapāpa linkages to her. So does tino rangatiratanga exist for all these people or just the one’s she has whakapāpa connections to. The literature would suggest it would only relate to those she has whakapāpa connections to but in practise for her all those people in her whānau whether they have whakapāpa connections to her or not have tino rangatiratanga rights.

The complex nature of tino rangatiratanga becomes more apparent when discussions involve whānau. Within this context, issues of whānau relationships, whakapāpa and asset base are shown to influence contemporary understandings of tino rangatiratanga. Traditionally, tino rangatiratanga was about total iwi control over their people and their possessions (Durie, 1995b, 1998a; Kawharu, 1989). In contemporary Aotearoa there are those who also consider tino rangatiratanga to be a hapū and iwi concept.

Or hapū and iwi?

Generally speaking kaitiaki argued that tino rangatiratanga was about hapū and iwi.

For example, Hiria argued:

I do not think tino rangatiratanga exists for urban Māori unless they have a direct tribal connection that ensures they share in the benefits their respective iwi have to offer and conversely requires some input from them. Urban Māori belong with their iwi. Anything less is a compromise and people are obliged to fit into the mainstream. At the present time this is white middle class New Zealand society. Māori comprise approximately 10% of the New Zealand's population. From each vote, Education, Health, Social Welfare, Justice and others, 10% of New Zealand's total annual budget should be turned over to Māori tribal groups, defined by waka areas, without set criteria or accountability to central government. Last year this amounted to 4 billion dollars, so 400 million should be turned over to Māori interests. How they spend it is up to them. If they run out tough! If it gets ripped off tough! Tino rangatiratanga does not mean running back constantly for more because you have mismanaged. Yes, initially there will be some costly and maybe traumatic upheavals but I believe eventually the will to survive will prevail and the real 'chiefs' will rise through the ranks and sensibly guide and lead their people from an iwi perspective. Money would be distributed directly from the Treasury coffers to iwi, per head of population, to pass on to hapū and then whānau. Each iwi will decide where their priorities lie and budget accordingly purchasing expertise as required, this is Article II. Under Article III disenfranchised Māori and urban Māori should still have access to mainstream services.

Like other Tiriti theorists, such as Parata and Durie, Hiria believes tino rangatiratanga can only be practised at an iwi level (Durie, 1998a; Parata, 1995). In this instance, iwi is seen as the political body to manage things Māori. Such a position within the health sector would mean that Māori would get a fair share of the health budget and could therefore have more control over their health. As things stand Māori compete for health funding alongside other providers (Ministry of Health, 2001). To get health monies Māori feel they have to "run a gauntlet", as opposed to their Pākehā counterparts (Rangimarie, Māori, wahine, policy maker, chief executive officer, Māori health provider). While the Government has a Tiriti obligation to protect Māori tino rangatiratanga, it seems that at times in the health sector this is not happening.

Within the current study, kaitiaki considered tino rangatiratanga was at its strongest at hapū and iwi level, and within tribal areas. However the relationship between iwi tino rangatiratanga and Pākehā was considered problematic because firstly there is no Pākehā entity with the same mana and secondly the local bodies such as, District Councils and District Health Boards, which do exist, do not know how or are unwilling to work with Māori. Such thinking was reflected in a comment made by Hoani:

...why would we want to be centralised people when we have nothing to do with Hawkes Bay or up North or down South. We're Taranaki people...that's the only place we're interested in...and our level of leadership should be local. I guess that is real tino rangatiratanga. So great, let's just decide that in Hawkes Bay we won't worry about anybody else or Parliament. We'll just be local. Well the only people we are going to interact with is council, but I mean they certainly aren't aware, they're not going to give us anything.

Hoani highlights the differences between iwi tino rangatiratanga and Westminster models. For those iwi who signed Te Tiriti the relationship was between Rangatira and the Queen of England. Then it was between Rangatira and the Queen's representative (the Governor General). Now it is between iwi and Government and at a local level the government bodies are those such as City Councils. City Councils lack the mana of the Queen of England and are limited by the legislative framework within which they operate. Such processes illustrate the way colonisation marginalised tino rangatiratanga within Aotearoa.

It was evident in the discussions with kaitiaki that those iwi who were practising local tino rangatiratanga successfully had a high degree of self governance. They were able to make decisions that affected their whānau, hapū and iwi because they had the structures in place to manage this and an asset base that afforded them a certain degree of independence from the Government. For example, in Hoani's case, the organisation he worked for was owned and operated by local iwi. The organisation was managed by a Board of Trustees made up of representatives from each hapū. Alongside this were kaumātua who ensured the tikanga remained intact. A common

kaupapa existed and the asset base was tribal people, tribal land and tribal sea interests.

In practise, tino rangatiratanga in service delivery is about services that are owned and operated by iwi and where tikanga Māori is the norm. It is also about struggle, challenge, reclamation, decolonisation and growth and celebration. As it is about mana, tapu of rangatira it is also a localised form of power, control and authority, but this is limited and bounded by government legislation and health policies.

Two examples from the current study demonstrate the complexity of tino rangatiratanga in a setting fraught with tensions, not only from iwi but also from the Crown. One model is the Mātāriki model and the other the chrysalis, the butterfly and the rainbow model. The Mātāriki model emerges from a corporate organisational structure which assumes tikanga Māori as the norm. The chrysalis, the butterfly and the rainbow process is a process of tino rangatiratanga which is growing and evolving over time.

The Mātāriki model

The Mātāriki model is an ahi ka service delivery model. The Mātāriki model is iwi specific, has a common kaupapa, and acts politically to address health issues. The Mātāriki model also celebrates successes and develops strategies to address the threats to service provision. Information for the model was drawn from the organisation's strategic and business plan and discussions with Rua.

The Mātāriki health model grew out of the 1993 Health reforms. Up until the Reforms, where Māori competed for and won health contracts, the Provider provided health services under the guise of social, housing and justice services. The Provider also utilised funding from wise investments. Wise investments saw the Runanga assets base grow from \$10,000 in 1986 to \$10 million by 1995. Wise investment and the political astuteness of the Trustees meant the Provider was well positioned to respond to the changing health environment of the 1990's. From successfully winning health contracts the Runanga went on to complete a provider purchaser split. The

health provider arm was established and following the vision of tino rangatiratanga by the year 2000 developed a vision of its own which was:

To increase participation in health services for whānau, hāpu, iwi and others residing in the rohe

The Provider recognised that acting politically was crucial if it was to survive the troubled waters of the 1993 reforms. It also recognised that if it was to be successful in achieving health gains for whānau it would also need to provide services from a tikanga Māori perspective. The use of tikanga Māori is two fold. Firstly, like tino rangatiratanga, tikanga Māori provides a site for constructive engagement or a process of decolonisation. Colonisation legitimated Western knowledge and deconstructed Māori knowledge. Through a process of consensual domination the colonisers were successful in embedding tikanga Pākehā in the social structure of Aotearoa.

In an endeavour to undo the harm from this, Māori sought to reclaim tikanga as the norm. In the case of the Mātāriki model tikanga Māori within the Provider setting provided a space for constructive engagement between the Provider and whānau where colonial knowledge could be challenged safely and Māori knowledge re-asserted. Secondly, the utilisation of tikanga Māori normalises and legitimates tikanga Māori. Tino rangatiratanga in practise is about finding Māori solutions to Māori issues (Durie, 1998b). Kaupapa Māori theorists argue that finding Māori solutions requires starting from a Māori value base (Bishop & Glynn, 1999; Durie, 1998b). In the past starting from a tikanga Pākehā base has meant the solutions have emerged from a tikanga Pākehā. As the reader may recall from Chapter Two and Five, dominant Māori health values are vastly different to the dominant bio-medical Western Model. Tikanga Māori is strongly collective, subjective and holistic as opposed to the dominant tikanga bio-medical one of individualism, objectivism and reductionalist. Endeavouring to find solutions to Māori health issues through dominant Pākehā bio-medical value systems has resulted in major disparities across most health indices (Durie, 1998b; Robson & Harris, 2007).

The dominance of the bio-medical discourse in health service delivery contributes to Māori mortality (Ajwani, Robson, Tobias, & Bonne, 2003; Robson & Harris, 2007). Tino rangatiratanga in practise is also about utilising tikanga Māori. Durie postulates the use of mana atua, mana tupuna, mana tangata, mana whenua, mana moana and mana motuhake. In the case of the Mātāriki model of practise it is about manaakitanga, whānaungatanga and kotahitanga. Manaakitanga is about how the provider will behave toward whānau, by being respectful and supporting the uniqueness of each whānau. Whānaungatanga related to the whakapāpa connections employees had to whānau, hapū and iwi. Whānaungatanga in the health sector is similar to whānaungatanga in the research sector, it carries with it certain obligations and responsibilities beyond that of service delivery. It requires the recognition that each staff member has whānau responsibilities toward everyone who accesses the service. Kotahitanga reflects the collective rights, responsibilities and roles the Provider has to whānau, hapū and iwi that required honesty and integrity in service delivery. Kotahitanga is important because the Provider represents three different iwi, with three different tikanga bases. Rua asserted that the values of the service “ensure that the services we provide are consistent with the implicit teachings of our tipuna”.

Acting politically

In an endeavour to address the needs of their whānau, hāpu and iwi the Provider knew they had to act politically if they were to achieve health gains. “We represent three iwi who are unique in that we choose to position ourselves politically to achieve their tino rangatiratanga”. Acting politically meant forming political alliances, recruiting and training whānau, and acting as an employment broker.

Forming political alliances was an important aspect of the Mātāriki health model. By forming a political alliance with the general practitioners in the area Rua was able to position the service to take advantage of the opportunities that arose, such as setting up a Primary Health Organisation. Primary Health Organisations seek to provide a local context to service delivery (Ministry of Health, 2001). Government provides funding for the establishment of Primary Health Organisations. Rua’s organisation’s share of the funding came to \$600,000 and with this came a 33% stakeholder interest in the Primary Health Organisation, for the first year then a 50% stakeholder interest

there-after. The Māori provider organisation then went on to invest the \$600,000 to be utilised to develop their health services:

...and what we looked at was tailoring the \$600,000 to our captive audience....kaumātua programmes, hearing test, eye test free of charge, mental health, oral health, getting the dentist in...

Not only was the Provider able to provide kaumātua programme and hearing tests: it was also able to reconfigure general practitioner services to be more responsive to Māori:

...the PHO [Primary Health Services] is a vehicle aimed at reducing the barriers of primary health care access. Its primary focus was around GPs [general practitioners]. So the challenge to us was around fee reduction. The other challenge for us was around configuring the GP [general practice] so that it is a lot more responsive to Māori

Acting politically has some health gains for whānau within the three iwi the Provider represented. Celebrating the gains was another aspect of the Mātāriki health model.

Tikanga Māori

Tikanga Māori in service delivery is about normalising tikanga Māori. An example of normalisation of tikanga Māori in Rua's organisation was the development of a management structure. Rua commented:

We organise our service around the Māori calendar...we try to chalk out each quarter...like spring... summer... autumn.... winter.... We will all know what's happening in the community....so we all know the pre-season rugby season is going to happen soon and we need to be there because in Gisborne there's all this contact sport that Māori participate in...now if that happens on a Saturday and Sunday we need to be there....if that means we are not working on a Monday then that's what it means . . because the Monday is no good....if we have to go to the shearing sheds that's what we do....we talk about cooking broccoli etc....you know all that seasonality....It reflects the uniqueness of our rohe... because we are either whenua based or moana based. So if we are out at sea then a lot of our interventions reflect that...so it's no goodI mean a lot of people go to the sea....so we need to start talking about things like . . . water safety at appropriate times, rather than wait for the event to happen . . . that's no good....we try to talk about legal limits and protocols around catchments and all that sort of stuff. . .

Adopting a model of practice that reflected the seasons meant the Provider was able to be more responsive to each of its iwi. Knowing the different iwi and what might be required during the different seasons meant the Provider was able to plan pro-active to events that were particular to Māori within each iwi rohe. In addition, staff knew where to access whānau when required such as the sharing sheds or down at the wharf. In a study on unemployment Keefe et al. demonstrated that having whānaungatanga connections to research participants meant the research team had access to information that other researchers would not have been able to access (Keefe, Cram, Ormsby, & Ormsby, 1998). Similarly whānaungatanga in the Mātāriki model meant staff had access to information about whānau and where whānau were that would not be readily available to other service providers.

Infrastructure development

In the development and implementation of Māori Health Provider services infrastructure development included workforce development. During the early days of Māori Provider development there were not enough qualified Māori to deliver health services (Durie, 1996). To address the lack of skilled workforce in the short term Māori learnt on the job. In some cases taura worked alongside experienced employees, in other cases taura received on the job training or work based training. In the Mātāriki service delivery model the Provider actively recruited, trained and employed whānau from their three iwi. Rua commented:

We recruit people with skills, life experiences, people who are in the Marae, rugby teams, netball teams, who have strong networks in the community. People who live and breathe iwitanga and then we support their development over a period of time. Things like, maybe, health promotion, or smoking cessation all the health programmes and so forth but primarily it's about, life experiences. Be they with rangatahi, be they women, be they men, be they koroua because all of us come from a different domains. With respect to training what we try to do is start with things like whakawatea, and decolonisation. We've got to start with those things first, otherwise people with vested interests will take over. Then we look at health specific topics and we try to tailor it for our area

Recognising that some whānau have been affected by colonisation a core part of the training is about reclamation and decolonisation. Decolonisation involved a process

of conscientisation and emancipation where iwitanga and tikanga Māori was legitimated. Following a decolonisation process whānau were then provided training in specific areas identified by a health need assessment. While training and employing whānau to work for the Provider, the Provider also acted as an employment broker.

Employment brokering

Employment brokering was a unique aspect of the Mātāriki model. Employment brokering was about addressing the socio-economic determinants of health. Poor health is linked to income and income to employment (Creed & Klish, 2005; Keefe, Cram, Ormsby, & Ormsby, 1998; Virtanen, Kivimaki, Vahtera, & Koskenvuo, 2006). Employment figures for Māori have been consistently lower than for Pākehā. Rua recognised that employment was crucial to improving health outcomes for Māori. He formed a relationship with the training arm of the Runanga and brokered relationships with employers. He also addressed the difference between what employers were paying and the minimum wage. Rua commented that “some local employers pay \$7.00 an hour while the minimum rate is \$11”. The organisations response to this was to:

...develop within our organisation an employment broker service which contracts with organisations such as the [name of commercial organisations] who pay us and then we pay the employee a basic rate of about \$11. Some employers, if they see an opportunity will take advantage of it. Our role is to break that job experience dependency that exists for individuals

Bio-medical services tend to be reductionist and provide services for particular medical or surgical conditions. Māori recognise that health is more than just the physical and also that providing health services also means addressing the wider determinants of health which in this case was employment. However, Māori health providers are not funded by the Crown to provide such services and must find the money through other avenues. A kawatanga response would be for the Crown to provide Māori with their share of the health budget. That would be one way of supporting Māori to support themselves. Another way would be to fully fund infrastructure development.

Celebration

Moving from resistance to a place where tikanga Māori is the norm or where tino rangatiratanga is being practised is certainly a time for celebration. In a relatively short time the provider had made huge gains in terms of service development and service provision. Rua commented “now is the time to stand up....to celebrate all our successes”. Reclaiming the right to provide services for Māori by Māori that are based on tikanga Māori has been an ongoing battle. It is right that the providers can now feel a sense of achievement and to celebrate these achievements. Tino rangatiratanga brings with it certain challenges which Rua explains in the next section.

Challenges

While the practise of tino rangatiratanga brings reward it also brings challenges. For Rua the challenges included internal politics, infrastructural issues, the dominance of Pākehā discourses and racism. “Internal politics” referred to the criticisms the organisation dealt with from whānau.

One of the limitations which exist for us are the internal politics which exist for Māori. It is hard enough fronting up to mainstream without all that...

One of the major issues for Māori providers is the amount of raruraru they deal with daily from whānau who have issues with the organisation, whānau who have issues with people who work in the organisations and whānau who have unresolved personal issues which are played out at hui a iwi. Managing this is time consuming and makes life more difficult in an already hostile environment.

Infrastructural issues were also an issue:

One of the issues of being a Māori provider is the amount of paper work we are expected to deal with. Some Māori providers do not have the infrastructure to cope with the workload as opposed to large mainstream services such IHC [an organisation that primarily supports intellectually handicapped children and their whānau/family] and CCS [an organisation that supports children with a disability and their whānau/family]. We are like backyard cousins

The marginalisation of tino rangatiratanga has meant that Māori providers have not developed at the same rate as Pākehā providers. During early colonisation bio-medical services were legitimated and resourced gathering strength until today hospitals and general practitioners receive most of the health budget (Dow, 1999; Government Printers, 1946; Lange, 1999). With the 1993 health reforms Māori received funding for service delivery but not infrastructure development. It was not until 1997 that the Crown, under pressure from Māori, realised that if Māori Providers were to succeed the Crown needed to support Māori provider infrastructure development. As mentioned in Chapter Five, a tokenistic \$40 million was allocated for the infrastructure development for more than 200 Māori providers, at a time when the total health budget was approximately \$570 billion (The Treasury, 1997).

Another issue that arose in the practise of tino rangatiratanga was the dominance of “mainstream” discourses. Rua commented:

...the District Health Board and the Ministry of Health force us to fit a particular service model. In the past we did as we saw fit and if everything worked out that was fine. If it did not, then we learnt by our mistakes. Now all of a sudden we have to conform! I can see some merit in it if diversity was recognised. For example, how Māori provide services in say Auckland or Wellington would differ from say Ngai Tahu. National Standards and accreditation is about conforming to what mainstream wants

Rua’s comments highlight several issues: how dominant policies act to marginalise; the recognition that Māori are a diverse group; the fact that this diversity is not recognised in policies; and the way policies act to create new realities. At the time of writing compliance to National Health Sector Standards was integral to service development. As policies National Health Sector Standards normalise dominant tikanga. While a lot of work has gone into developing sector standards that recognise diversity from Rua’s perspective not enough work has been done because he still feels he has to change the way he delivers services to meet these standards. Shore and Wright argue that policies create new realities and Rua’s comments highlight this point (Shore & Wright, 1997). However, from Rua’s perspective they also serve to marginalise tikanga Māori.

Yet another challenge was mainstream resistance. Rua explained that in developing programmes for rangatahi he had tried to work with a local non-Māori Provider and the local schools but had found them uncooperative:

We have tried to develop relationships with the schools and they have given us 3 o'clock time slots when the kids are tired so we have developed activities outside the school times for rangatahi such as touch rugby

He anticipated providing health promotion programmes such as immunisation, swimming and keeping yourself safe programmes. However, a time slot of 3 o'clock suggested to Rua that the schools were not interested in working with them to provide services. So Rua's organisation decided to provide evening programmes:

We have converted the old Salvation Army Church to provide services to rangatahi. We open it up on Friday night for music evenings and such like. It is about providing for a captive audience and addressing those issues that arise from parents not being home

When the health of rangatahi is a priority for the government it seems unfortunate not to make the opportunity to work with a Māori health provider to address the needs of rangatahi. Further to this, intersectorial collaboration is a strategy being endorsed by Government to address the health needs of all people in Aotearoa (Ministry of Health, 2000b, 2001; , "New Zealand Public Health and Disability Act", 2000).

Summary

The Mātāriki model of tino rangatiratanga exemplifies iwi tino rangatiratanga. The practise of tino rangatiratanga within this context involved a concerted effort by three iwi to maintain the tino rangatiratanga that they had and reclaim the tino rangatiratanga that had been lost. Crucial to the process was the development of a common kaupapa and commitment by whānau and hapū to achieve their tino rangatiratanga status by the year 2000. A number of strategies exist within the Mātāriki model to achieve this. The strategies include, political strategising, developing iwi specific management models, employing whānau who have whakapāpa connections to the rohe, providing training for these whānau, iwi. It is also about decolonisation, reclamation and celebration. Limitations exist to the

practise of tino rangatiratanga in the Mātāriki model. These include internal politics and the dominance of mainstream discourse and racism.

The chrysalis, the butterfly, and the rainbow

A different model of practise was one asserted by Kowhiti. The chrysalis, the butterfly and the rainbow was a metaphor used by Kowhiti to describe tino rangatiratanga within her hapū and iwi. The chrysalis, the butterfly and the rainbow model of delivery was about reclamation, leadership, wairuatanga, by Māori for Māori, activism, restructuring of health services and addressing the challenges.

Reclamation

In reclaiming their tino rangatiratanga Kowhiti explained:

So at the moment we're going through a, what's that stage where just before you become a butterfly, chrysalis stage, where things are changing. That's a nice way of putting it. The chrysalis has been hanging around a long time, all we need is for the right time to come and boom because we've got all the talent, we've got all the skill. All hapū have these skills and talents amongst us and slowly now we've got all this rōpu, our own whānau, hapū coming together for the reo, so we're in our own way creating our own self-determination. We're going through like the chrysalis stage but there will be a butterfly. There will be a butterfly in terms of the whole hapū coming together and flying, flying up into the rainbow. So tino rangatiratanga is about whānau, hapū, urban and rural working together to achieve our self-determination

To some extent, Kowhiti's comment illustrates the stage of development some hāpu and iwi are at. Through a reclamation process, in this case te reo, hapū and iwi are beginning to work together to achieve tino rangatiratanga. In the chrysalis, the butterfly and the rainbow model ahi ka whānau (providers, farmers, kohanga reo, kura kaupapa) have links with nga hau e wha whānau (lawyers, lecturers, funders). When ahi ka whānau need help to get something done they contact nga hau e wha whānau with the expertise to help. Such processes help ahi ka whānau to achieve their goals. It is through the ahi ka nga hau e wha interplay that hapū and iwi are able to reach their dream, the rainbow, tino rangatiratanga.

Leadership

Traditionally tino rangatiratanga was about the mana, the tapu and the whakapāpa rangatira or inherited leadership (Durie, 1998a; Fleras & Spoonley, 1999). Hiroa, Mahuika and Durie also argue Māori leadership could also be achieved, through work done for iwi (Durie, 1998a; Hiroa, 1958). With colonisation and the deconstruction of Māori societal structures inherited leadership was marginalised (James & Saville-Smith, 1990; Mikaere, 1994). As a consequence for some hāpu and iwi leadership is no longer so easily defined. Kowhiti highlights this point when she comments:

Māori people are now ready. You know, all we want is some leadership but being a traditionalist, even though I believe in mana wahine, I also believe in the role of the man. I always like men to start karakia. I like men to do the mihimihi, but there are so few men who will step up now. They're intimidated by all the women

While Māori leaders still existed and in some areas are quite strong they had little influence in decision making within Pākehā society or within the domains of the dominant culture. Part of the reclamation process has been the legitimising of rangatira within their iwi and then within society as a whole. To a large degree this movement is critical to tino rangatiratanga. While Kowhiti is concerned about the lack of Māori male leaders it is, in fact, not uncommon for iwi to have women as rangatira (Mahuika, 1975; Mikaere, 1995).

Wairua

When discussing tino rangatiratanga Kowhiti talked about the wairua of the journey:

. . . I always have a vision of things Māori. I always have a wairua for Māori things, you know, just looking out there and you see those trees moving with the wind, you know, you can actually feel your kaupapa Māori going there. It is anything to do with Māori. There's always a calm, then a storm, then a calm. This is how I see things in terms of anything to do with wairua Māori. At the moment the rainbow is moving up quicker, stronger, and you know with these Māori providers they're accessing the rainbow, so that the rainbow has moved up and they become stronger.

In this analogy Kowhiti explained that the rainbow represented tino rangatiratanga. Tino rangatiratanga has been a constant struggle for Māori and emerges in many

guises within this thesis. Kowhiti believes that her hāpu and iwi is making it and she can see an end to it, an end where her hāpu and iwi practises tino rangatiratanga. Three tino rangatiratanga discourses exist within the current study, Māori sovereignty, as self-determination and as positive Māori development. Kowhiti's example alludes to the journey towards tino rangatiratanga as Māori sovereignty.

By Māori for Māori

The wairua of tino rangatiratanga was further articulated by Kowhiti when she described what she saw as the characteristics of a “by Māori for Māori” service:

...you know when you see a Māori face eh. You relax. You know there's a difference. There's a wairua between you and the worker. It is about mana wahine, it is about manaakitanga, it is about having a Māori face to the service.

In this case Kowhiti felt comfortable because there was a Māori face to the service. She felt she did not have to explain everything in detail and would not be exposed to racist practises. Having a Māori face to service delivery was also about tikanga Māori being the norm. For example, making whakapāpa connections is a cultural norm. When a service provider is Māori, Kowhiti believes that she is able to use normal Māori processes and ask “ko wai koe?” (who are you?) and “kei whea koe?” (where are you from?). Knowing who someone is and where they come from breaks down barriers and enables deeper levels of communication to occur very quickly. The real question being asked here is “can I trust you”?

Other cultural practises of importance to Kowhiti were mana wahine and manaakitanga. Mana wahine referred to women within her iwi who provide leadership, women who are activists, women who fight for their tino rangatiratanga and who may even go to jail for that cause:

I love Māori women, I love, you know, the [activist] of this world, and [activist] of this world. I love anyone that is promoting good things for Māoridom. I've always supportive of mana wahine. I think, even in my own family I have cousins that are in the church. My cousin [person's name]. She's just fabulous at that work and I love her, I'd like to kick her arse sometimes, but I love her because she's a woman, she feels for her people and I think that's where the future of Māoridom has gone towards strong women

Manaakitanga was the about being looked after within Māori provider services. This included benefiting from the Māori provider services that were fully resourced.

I tell you what of all the health organisations I've been in [name of Māori provider] is the most totally supportive. Now, if I said I want this, this and this, I tell you in, what, in two two's it is all there. I've not had to fight for anything. It just happens. Normally if you have initiative you know always a reason why so and so can't help, eh? Not with [name of Māori provider]

One of the consequences of colonisation was the marginalisation of Māori healing practises (Dow, 1999; Durie, 1998b). This meant that Māori health providers were not funded. Within this context Māori provided health services under the guise of other services such as housing and education. More funding was made available in 1993 which saw the growth of Māori health providers but providers still argued they were under-funded (Davis & Ashton, 2001; Durie, 1994c; Mental Health Commission, 1998; Rua et al., 1998). Kowhiti's comments reflect further growth in Māori provider development.

“By Māori for Māori” services were seen by Kowhiti as ones which provided both a clinical and cultural perspective:

...knowledgeable people both clinically and culturally providing services and providing direction. It is also about knowing your stuff, knowing the clinical aspects and being able to translate this into Māori ways of knowing. It is about having the right people in the right place at the right time.

Again Kowhiti's comments reflect progress in Māori provider development. For a time in the late 20th century there was a struggle over health discourses, clinical or bio-medical and cultural. Given Māori values and beliefs had been marginalised,

Māori argued that health services needed to be culturally based. Pākehā (the funders) argued that they needed to reflect best clinical practises. Since 1993 Māori recognise that health services need to be both clinically and culturally safe.

Activism

Kowhiti recognises the inequalities that exist for Māori within the health sector. She cites an example of one service where “there were fourteen Pākehā co-ordinators, not one Māori”. As a consequence of this, Māori, in this case Māori women, began to actively resist and argue for a space for themselves within this sector. Some progress has been made: four of the fourteen positions are now held by Māori. Kowhiti talked about other acts of resistance by her and other mana wahine.

It is about activism and being radical...somebody said “oh you’re a radical”. I said “yeah I am”. I said “anybody who wants changes is radical”...that’s what it means...a person who wants change...you know I am a radical, but not a not a bloody what’s her name . . .you know . . . out there fighting like [person’s name] she’s a radical she wants change...and you know I admire her, admire anybody that’s picks up the fight for Māoridom, to that extent – she went to jail you know...

In conversations held with her co-workers, Kowhiti explained that activism existed on a continuum. In some cases activists or radicals are sent to jail whereas in her case she wanted to see things change for Māori. While she may be viewed as an activist by some, by others she is considered a change agent.

Restructuring health services

The restructuring of health services has been crucial to the practise of tino rangatiratanga. One such restructure was the 1993 Health Reforms. The 1993 reforms meant whānau could chose a provider and the more politicised Māori encouraged their whānau to register with a Māori provider. To establish themselves as a Māori Provider, Māori organisations had to have at least 2000 registered whānau. The number of registered whānau was related to the amount of funding that could be secured (Te Puni Kokiri, 1993b). The registration of whānau became important.

Again the 1993 Health Reforms did not occur in isolation. Rather the changes were part of a global trend toward consumer driven services. Part of the consumer driven movement meant whānau had the right to access their medical records. Up until the reforms the medical records about a person were held by the doctor and access to them was difficult. With the introduction of a neo-liberal government, the 1993 health reforms, and a move toward consumer driven services consumer information was more accessible. If someone wanted to view their own information they could do. Kowhiti commented:

Māori health providers now have doctors and you can pick up your notes from mainstream providers and take them to the Māori provider

Two issues are highlighted here; the provision of general practitioner services within Māori provider settings and ownership of health information. With the development of Māori health provider services during the 1993 Health Reforms and more funding being made available Māori, health providers were able to purchase general practitioner services. With this strategic move they were able to capture more of the health budget. During this time the dominance of the bio-medical discourse within service delivery was being challenged and there was a strong shift away from the dominance by providers. The shift meant that consumer could have access to their own notes and even pick them up. In the past patients/consumer were not allowed access to their files but instead files were transferred from doctor to doctor. This was a move away from the medical view of the patient as a passive and subjective recipient of services and the professional as the objective expert who claims specialist knowledge which might not be understood by the consumer or which might influence or bias the consumer's behaviour.

Challenges

Within the chrysalis, the butterfly and the rainbow process, challenges were acknowledged – institutional racism, kūpapa and puhaehae.

Kowhiti highlights a form of institutionalised racism where Pākehā are valued over Māori. In this instance a person Kowhiti had recruited for a Pākehā organisation, to

be a health promoter, was relegated to working in the linen cupboard as she could not drive. The person had the skills to promote health to Māori and could have worked alongside someone who did drive. Kowhiti went on to comment:

...and there she was a linen maid. I can't remember the exact details, you try your hardest to get it right for them [Pākehā providers] and it works and then they transfer the person to do another 'Māori job'...but I'm saying if they needed another doctor...there is always money available for that...but never for another Māori worker to make it easier for Māori to come to, you know. When there is not much money left, Māori miss out. Even when there is money Māori are generally employed as co-coordinators, not managers. Managers have a budget. As co-ordinators, we don't have access to budgets. Managers have access to the pūtea and we [coordinators] get the crumbs when we're made co-ordinators...

The example of institutionalised racism illustrated here marginalises Māori economically and culturally. In some instances Pākehā practitioners and health practises are valued more than Māori and are therefore legitimated in the health sector with Pākehā practitioners having positions of responsibility and getting higher wages than Māori.

Another limitation to the practise of tino rangatiratanga is kupapa or Māori who support Pākehā to the detriment of Māori:

There's kupapa who will always say Pākehā's right, white is right. I started a saying some years ago; sugar, salt, cream, milk, cigarettes - all wrapped in white, and I always finish, and some white men. Even the paper that the treaty was written on was white bullshit. You know, in terms of your health, sugar, salt, all these sorts of things, cigarettes, are bad for you

Kowhiti argues some Māori will support Pākehā endeavours to control or dominate other Māori. Historically there have been Māori who for some strategic reason have supported Pākehā in the quest for power, control and authority. Kowhiti's comments highlight that this still exists today. Kowhiti goes on to argue that things white are bad for Māori and therefore Pākehā are bad for Māori. Such an analogy simply depicts colonisation and its effects on Māori.

Another limitation was puhaehae. Kowhiti commented:

...when we were young, you all go to parties. Everybody's quiet eh and there's a guitar there and no one will play it. Suddenly someone's game enough to have a little strum and soon as he starts playing everybody wants it. See things in Māoridom haven't changed. You get good at playing a guitar and there's always somebody who wants to play it. I fear that's what will happen to Māoridom.

Like Hoani, Kowhiti highlighted the difficulties that exist when working with her own. She was referring to her experiences working in the health sector and the difficulties puhaehae can cause in the actualisation of tino rangatiratanga.

Summary

The findings from discussions with kaitiaki and the literature show that tino rangatiratanga is indeed a flexible and multi-faceted concept. For some kaitiaki tino rangatiratanga is a cultural norm and referred to the mana, tapu and whakapapa of rangatira. It was about mana atua, mana motuhake, it was about Māori sovereignty, Māori self determination, and knowing the difference between Te Tiriti and The Treaty. The leadership discourse was a strong one in discussions with kaitiaki. In some cases it was about traditional Māori leadership, rangatira who had inherited or achieved leadership at an iwi level. In other cases, it was about Māori leadership within pan tribal groups, and other Māori entities such as health organisations. Theoretically, tino rangatiratanga was about absolute Māori control over Aotearoa, Iwi control over things Māori, Māori control over things Māori, and Māori control over decisions that impact on them.

While tino rangatiratanga as a cultural norm and concept is complex and multifaceted giving effect to tino rangatiratanga in the policy domain is equally complex and multifaceted. Tensions continue to exist between tino rangatiratanga and kawanatanga. These tensions are felt by kaitiaki in the policy domain in that they argue Crown policies serve to marginalise Māori healing models and exclude some Māori from accessing services necessary to their survival, such as heart transplants.

Mediating the tensions to some degree is about giving effect to tino rangatiratanga, either through the establishment of a national Māori body politic, giving effect to kawanatanga or strengthening alternative policy making processes such hui a iwi or other participatory processes. The national body politic that was mooted was a parallel development model with waka and or iwi and or Māori making decisions for Māori and Pākehā making decisions for Pākehā but coming together to make decisions for the good of the country.

At the practise level tino rangatiratanga is also multifaceted. At a practise level tino rangatiratanga was about by Māori for Māori services where tikanga was the norm. It was also about restructuring of health services, reclamation, decolonisation, political alliances, celebration, and challenges. It was about addressing the wider determinants of health and inequalities by addressing socio-economic difficulties, racism and the dominance of “mainstream” discourses. It was also about challenging the issues that arise within iwi settings like puhaehae and kupapa.

Within the current study tino rangatiratanga could be expressed at hapū, iwi, pan tribal and Māori organisational level. It could also be expressed at an individual and whānau level. At an individual level it was about making decisions about issues that impact on Māori individually, like visiting the doctor or choosing not to smoke for political reasons. One kaitiaki argued that tino rangatiratanga could only be expressed at an individual level within the context of whānau because individual successes and failures impacted on whānau. At a whānau level it was about making decisions that impacted on whānau, from a sound asset base.

Chapter Eight introduces Māori women’s health and a discussion on the development and begins the first and second order analysis of the 1996 National Cervical Screening Programme Policy document.

Chapter Eight

TE WHARE O TE TANGATA

The house of humanity

Ka ora to wahine puapua, ka ora to whānaupuawai, ka ora to hapu puawānanga, ka ora te iwi purotu (the health of the iwi is dependent on the health of the hapu, the health of the hapu is dependent on the health of the whānau, the health of the whānau is dependent on the health of the women) (song by Kataraina Pipi).

Māori women's tino rangatiratanga has been severely compromised by colonisation (Awatere, 1984; Mikaere, 1995, 1999b; Pihama, 2001). While the advancement of acquisition and assimilation policies marginalised and alienated Māori, Māori women experienced further oppression as the result of patriarchy (Awatere, 1984; Mikaere, 1995, 1999b). One of the outcomes is Māori women's health is one of the worst in Aotearoa (Mikaere, 1995, 1999b). Of particular interest to the current study is te whare o te tangata. Te whare o te tangata is the women's reproductive region and as such is considered a taonga. As a cultural norm te whare o te tangata area is important because it is the place through which Māori are brought into the physical realm, is the personification of Papatūānuku and is necessary for the continuation of Māori nations. However, with respect to te whare o te tangata, statistics show that an inverse law exists for Māori women (Ajwani, Robson, Tobias, & Bonne, 2003). Māori women are more likely to get and die from cervical cancer and less likely to access suitable services.

Chapter Eight explores Māori women's health in relation to te whare o te tangata, cervical cancer and cervical screening. Section one provides an over view of Māori women's tino rangatiratanga and the impact colonisation has had on this. Section two explores the relationship between Māori, cervical cancer and cervical screening services, section three begins a kaupapa Māori analysis of the 1996 National Cervical Screening Programmes Policy document. Section four provides a summary of key findings from Chapter Eight and introduces Chapter Nine.

Te tino rangatiratanga o te wahine Māori

Māori women's tino rangatiratanga is closely linked to Papatuanuku whom we whakapāpa to through our turangawaewae. The links between Māori, our land and well-being have been illustrated in two studies, one where Māori women's well being was linked to whether or not they lived in their tribal area and another where land confiscation was shown to cause a reduction in well-being based on child birth rates (Murchie, 1984; Pool, 1991). Traditionally Māori women were acknowledged as vital members of Māori society; were recognised as rangatira, land owners, warriors, and decision makers (Hiroa, 1958; Mahuika, 1975; Mikaere, 1995).

With the arrival of the settlers and the imposition of colonial cultural values and beliefs, over time, Māori women's tino rangatiratanga was deconstructed. As mentioned previously colonisation involved hegemony and transliteration. Hegemony saw Māori Christian patriarchy beliefs being subsumed into Māori cosmology and then being taught back to Māori and Pākehā as Māori norms (Awatere, 1984; Mikaere, 1999a). In the process Māori women were further marginalised and, like Pākehā women, reconstructed as chattels and possessions (Jenkins, 1988; Mikaere, 1994; Mikaere, 1995, 1999a, 1999b). This is illustrated by Jenkins who argues:

Western civilisation when it arrived on Aotearoa's shore, did not allow its womenfolk any power at all - they were merely chattels in some cases less worthy than the men's horses. What the colonizer found was a land of noble savages narrating . . . stories of the wonder of women. Their myths and beliefs had to be reshaped and retold. The missionaries were hell-bent (heaven-bent) on destroying their pagan ways. Hence, in the re-telling of our myths, by Māori male informants to Pākehā male writers who lacked the understanding and significance of Māori cultural beliefs, Māori women find their mana wahine destroyed (Jenkins, 1988, p. 161).

Māori women were marginalised because of both gender and culture. An early example was the signing of the Treaty of Waitangi (Mikaere, 1995; Wallace, 1989). The signing of the Treaty required the signatures of as many iwi as possible. As was the norm for some iwi their rangatira were women. When it came to the signing of the Treaty Māori, naturally, expected their rangatira to sign on their behalf.

...it is plain from the Treaty that some women did sign it. That they did so was entirely consistent with the political authority that they exercised, authority that their communities accepted unquestioningly (Mikaere, 1995, p. 71).

While some colonisers recognised the status of Māori women some did not. For example, Bunbury, a Major in the 80th Regiment, was sent from New South Wales to assist in the gathering of signatories to Te Tiriti. An instance was recorded where he would not allow a women of high standing rank to sign Te Tiriti.

Bunbury, however, refused to allow the signing of the daughter of Te Pehi, a celebrated Ngati Toa chief...her husband...possible inferior to her in rank, would not sign, possible as a consequence (Orange, 2001, p. 90).

Mikaere argues that the imposition of Pākehā cosmology and Christianity played a large part Māori women's marginalisation.

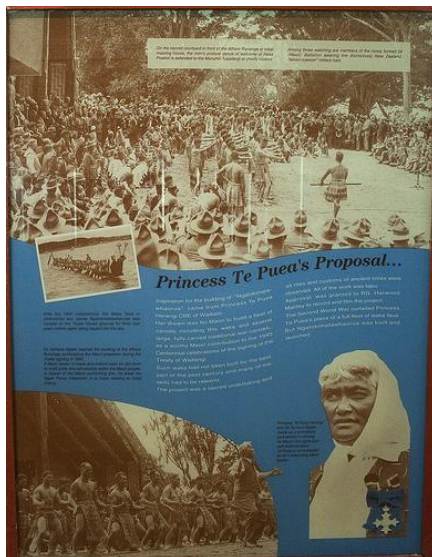
The colonisation of Māori cosmology has been insidious, its long term effects devastating. The implications are particularly dire for Māori women (Mikaere, 1995, pp. 2-3).

It was within Māori cosmology that Māori women's tino rangatiratanga was legitimated. For example, Hineahuone, gave birth to the first human, Hinetitama. Hinetitama, gave birth to Hinerauwharangi, and became Hine-nui-te-po, guardian of the underworld, Mahuika, was the goddess of fire and Muriranga-whenua, magic jaw was used by Maui used to fish up Aotearoa. With colonisation and the hegemonic process of consensual domination or democracy (see Chapter Two) Christian and patriarchal beliefs were assimilated by Māori and Māori women were relegated to the status of 'chattels' and 'servants' to her male partner (Awatere, 1984; James & Saville-Smith, 1990; Mikaere, 1995).

With the continued advancement of Western patriarchal discourses Māori women's tino rangatiratanga was further diminished. In line with such discourses where 'men' were viewed as head of the household and the breadwinner and 'women' as his helper Māori women, along with other minority groups, became alienated within the dominant culture. One way in which this was achieved was through the construction

of Māori women as ‘bad mothers’, ‘whores’ and ‘easy’ or sexually available (Mikaere, 1995). The ‘bad mother’ existed hegemonically alongside the notion of what a ‘good mother’ was. A ‘good mother’ was generally Pākehā, who was provided for by her ‘husband’ and who bottle-fed her babies. A ‘bad mother’ was generally Māori, who lived in an extended family setting and who breast-fed her babies. The construction of a ‘bad mother’ was influenced by the missionaries who believed it was sinful for a mother to bare her breasts. One of the outcomes of the interplay between patriarchy and Christianity discourses led to the development and implementation of health policies which defined breast-feeding as bad and then through such organisations as the Plunket Society and the Public Health system began to systematically ‘educate’ out breast feeding in Māori society (Mikaere, 2000; Turei, 2004). One of the consequences was an increase in early childhood deaths (Blaiklock & Hoskins, 1988; Mitchell, Tuohy, Brunt, Thompson, Clements, Stewart, Ford, & Taylor, 1997).

Figure 11: Te Puea Herangi o Tainui



While Māori women’s tino rangatiratanga was being reconstructed within Pākehā social settings within Māori settings some Māori women, to some extent, retained their tino rangatiratanga. For example, Te Puea Herangi continued to remain strong and lead their iwi through the difficult years of colonisation (see Figure 11) (King, 2003). With urbanisation and the breakdown of whānau, hapū and iwi systems the

maintenance of Māori women's tino rangatiratanga became extremely difficult. Māori women's health status continued to deteriorate, along with the rest of Māori society.

Contemporary Māori women's and health

Māori women continued to assert their tino rangatiratanga in contemporary Aotearoa being at the forefront of many resistance activities.

Figure 12: Dame Whina Cooper



For example, Dame Whina Cooper, with the assistance of her whānau, hapu, iwi and Pākehā allies was heavily involved in the planning and leading out the 1975 Land March. Figure 12 shows Dame Whina Cooper talking to the hikoi on their arrival in Wellington. While some Māori women continued to be rangatira some were colonised. The education system was influential as it was at school that Māori children were taught not only Pākehā knowledge but also how 'bad' it was to be Māori (Awatere, 1984). The second class citizenship mentality was rife and as a consequence many Māori were unable to get jobs. The jobs they were able to get were often poorly paid (Durie, 1998a; Pearson, 1990).

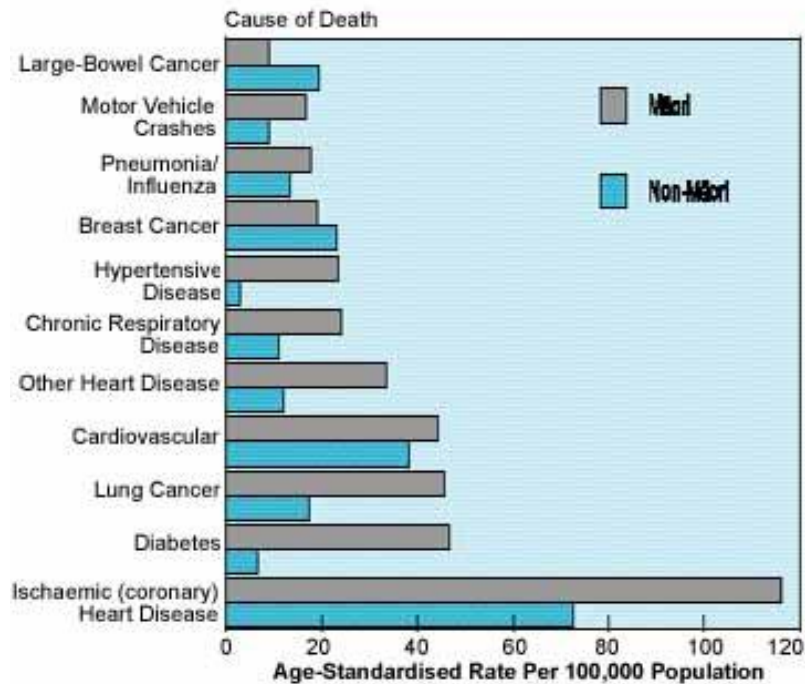
While there have been gains for Māori women there are still gains to be made: Te Puni Kokiri and the Minitatanga Mo Nga Wahine show:

- Māori women are vulnerable to unemployment. In 1996 the unemployment rates for Māori women was 19% compared with 7% for non-Māori women
- Māori women in the labour force continue to be concentrated in low employment growth sectors
- Forty one percent of Māori children aged 0-14 years live in families with an income of less than \$20,000, compared to 20% of non-Māori children (Te Puni Kokiri & Minitatanga mo Nga Wahine, 1999, p. 3)

'Health is one of the most extraordinarily sensitive indicators of the social costs of inequality.' (Kawachi, Kennedy, & Wilkinson, 1999, p. 1). While there have been health gains for Māori women disparities still exist. For example, recent health statistics show:

- Life expectancy for Māori girls at birth has been steadily increasing from 56 in 1952 to 73 in 1992 but remains lower than that for non-Māori girls
- Māori girls under 15 are more likely than non-Māori girls to be admitted to hospital for meningococcal disease, acute respiratory infections, asthma, homicide and injury deliberately inflicted by others.
- Young Māori women are more likely to die from suicide or self-inflicted injury than young Pākehā, but the rate of hospitalisation for suicide or self-inflicted injury is highest for young Pākehā women.
- Māori women's smoking rates are higher than those for men.
- Adult mortality rates, specifically for lung cancer, heart disease and cervical cancer, are considerably higher for Māori women than Pākehā women.
- Māori women are more likely than Māori men or Pākehā women and men to suffer from osteoporosis, diabetes, hypertension, arthritis and most immune disorders (Ministry of Women's Affairs, 2001).

Figure 13: Main causes of death, Māori and non-Māori females, 1994



Source: Mortality and Demographic Data 1994, New Zealand Health Information Service (1997)

As shown in Figure 13 the main causes of death for women in Aotearoa are largely preventable through life style changes and behaviour modification. For example, large bowel cancer can be prevented through eating a healthy diet. Chronic respiratory disease is addressed by providing smoking cessation support and addressing and poverty.

Figure 13 demonstrates the inequalities in health status between Māori and Pākehā. Māori women are worse off than non-Māori for all but large bowel and breast cancer. As already mentioned in Chapter Five initially the inequalities in health were largely attributed to biological and ethnic weaknesses (Durie, 1994c; Lange, 1999; Newell, 1954). In the last two decades, the wider determinants of health, such as social, economic and cultural factors, are now being recognised as influential. For example, struggling to pay for tangi or to manaaki other people has detrimental effects on the

well being of whānau and therefore women (Ministry of Women's Affairs, 2001). However Howden-Chapman & Tobias argue:

Socioeconomic factors do not, however, explain all of the health disparity for Māori and Pacific peoples. Part of the explanation may lie instead in the way our societal arrangements tend to favour the majority population, thus perpetuating inequalities between ethnic groups (Howden-Chapman & Tobias, 1999, p. 162).

Mounting evidence suggest that institutional racism plays a large part in disparities and unless society acknowledges and addresses institutional racism the disparities will continue to exist.(Harris et al., 2006; Robson & Harris, 2007; Te Ropu Rangahau Hauora a Eru Pomare, 2006). Of particular interest to the current study are the disparities that exist for Māori women in relation to cervical cancer.

Cervical cancer and screening services

Cervical cancer is the fifth leading cause of death for Western women globally (Cullins, Wright, Beattie, & Pollack, 1999). For women in developing and colonised countries it remains one of the leading causes of death (Cullins, Wright Jr., Beattie, Pollack, 1999; Hodge, Fredericks, Rodriguez, 1996; Pomare, Keefe-Ormsby, Ormsby, Pearce, Reid, Robson, Watene-Hayden, 1995). Within Aotearoa cervical cancer is the third most common form of cancer for Māori women (Pomare et al., 1995).

There is no known aetiology for cervical cancer but there is evidence to suggest the human papilloma virus (HPV) is a contributor. Recent epidemiology studies show that HPV is a contributor of the greatest majority of cervical dysplasia and there is strong evidence that most cervical cancers are preceded by HPV-induced dysplasia (Lieu, 1996). However, the epidemiology studies do not account for the vast majority of HPV infected women who contract the virus through sexual intercourse and never get cervical cancer. Medical researchers are now trying to figure out why this extremely common and normally harmless infection leads, in a tiny number of cases to cancer. One critical factor seems to be the particular virus involved. At least 70

different strains have been identified so far, with no's 14 and 18 being considered to be the viruses that cause cervical cancer (Lieu, 1996). The HPV is a sexually transmitted disease therefore women who have multiple partners or have a partner who has multiple partners have an increased risk of getting HPV and therefore cervical cancer (Silva, Rosa, Moyses, Afonso, Oliveira, & Cavalcanti, 2009).

While the cause of cervical cancer is not known other risk factors are associated with cervical cancer. These include smoking, long term contraception, women who are not regularly screened, women who have large families, women with a family history of cervical cancer and poverty.

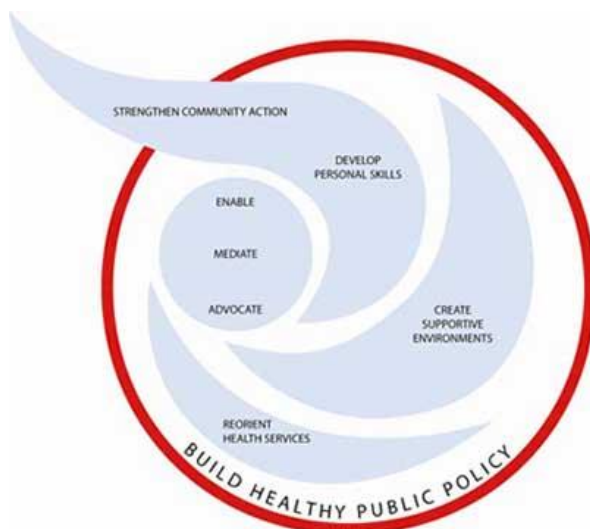
The smoking literature indicates that women who smoke cigarettes are more likely to develop cervical cancer. Smoking facilitates the infection and aids persistence HPV as well as having a direct effect by causing modification of DNA in cervical epithelium (Louie, de Sanjose, Diaz, Castellsague, Herrero, Meijer, Shah, Franceschi, Munoz, & Bosch, 2009). Māori women are more likely to smoke hence the risk for them is much higher than for other ethnicities (Gracey & King, 2009; Silva et al., 2009). Evidence suggests that long-term users (five years or more) of oral contraception double the risk of cervical cancer. The most successful indication of a woman's risk of developing cancer is her screening history (Chamberlain, 1986). Women who are not screened are more likely to get cervical cancer. Within Aotearoa Māori women are the most under screened group. Women who are on immunosuppressants are more likely to develop cervical cancer as they do not have the resistance to fight off infections, such as HPV. The risk of getting cervical cancer is doubled if the woman has had seven or more children or if the woman has a family history (mother, sister) of cervical cancer (Silva et al., 2009). Finally poverty is linked to an increase risk of cervical cancer, probably because these women can not afford health care or optimum diets (Gracey & King, 2009; Lovell, Kearns, & Friesen, 2005). A large number of Māori women live in poverty which may increase the incidence of cervical cancer (Te Puni Kokiri & Minitatanga mo Nga Wahine, 1999). In an endeavour to reduce cervical cancer a number of interventions have been developed.

National Cervical Screening Programme

The underlying focus of the cervical screening programmes is prevention. Generally speaking prevention is about reducing the incidence, duration and impairment of a disease (Heller, Price, Reinharz, Riger, & Wandersman, 1984). Strategies have been implemented to prevent and treat cervical cancer (Cox, 1989; Ministry of Health, 1996; Sadlier, Priest, Peters, Crengle, & Jackson, 2004).

Dominant within the strategies are bio-medical health discourses. The interventions include health education and promotion, smear taking, laboratory services, colposcopy services, national management and co-ordination, regional co-ordination, information management and monitoring and evaluation (Health Funding Authority, 2000; Ministry of Health, 1996). Within Aotearoa, the dominance of Pākehā health discourses increase disparities between Māori and other ethnicities in Aotearoa (Ajwani, Robson, Tobias, & Bonne, 2003; Robson & Harris, 2007). As mentioned in Chapter Five dominant Māori health discourses are holistic, collective and subjective compared to Pākehā health discourses that are reductionalist, individualistic and objective. Endeavouring to prevent cervical cancer from a Pākehā value base is unlikely to address the inequalities that exist between the mortality and morbidity rates for Māori compared to Pākehā (see Figure 14).

Figure 14: The Ottawa Charter



It was the introduction of a public health approach to cervical screening that benefited Māori most. A public health approach involved addressing the wider determinants of health and also the adoption of a health promotion approach. The health promotion approach adopted was the Ottawa Charter (Primary Health Care Directorate, 2009).

Like Māori models of health the Ottawa Charter adopted a holistic approach to health. The Ottawa Charter acknowledged that health was more than the physical and required actions at policy, community and individual levels. The actions included advocacy, re-orientating services, creating supportive environments, developing personal skills and strengthening community actions.

Within the public health sector Māori models of health were acknowledged and utilised, mainly Te Whare Tapa Wha. In an endeavour to support tino rangatiratanga the National Cervical Screening Programme in Aotearoa was Te Whare Tapa Wha. As already mentioned, in 1999 Durie, developed and promoted a health promotion model, Te Pae Mahotanga. The National Cervical Screening Programme has adopted this as one health promotion approach (see Chapter Five). The development and implementation of Māori health promotion models increased Māori responses to cervical screening but disparities continued to still exist.

Another strategy adopted by the Crown was to support Māori provider development (Ministry of Health, 1998b). While it was thought that the establishment of Māori providers would increase access to services for Māori women, which has been proven to be the case, the funding of these services to provide cervical screening services has been tokenistic (Munro, 1990). In 1987, staff from the Ministry of Women's Affairs and Department of Health met with four community groups, which were largely made up of Māori women, to discuss the establishment of cervical screening services. The groups were in Nelson, Kawerau, Wanganui and Kaikohe. When funding for the establishment of the National Cervical Screening Programme was allocated the community groups were quickly allocated \$30,000 and equally as quickly forgotten. The remainder of the allocated \$36,000,000 went into establishing four national cervical screening registers, situated in hospital settings (Munro, 1990). Such resources allocation is remarkable especially as the 1996 National Cervical Screening

Programmes Policy document advocates for cervical screening to meet the needs of Māori women (Ministry of Health, 1996, p. 8).

The establishment of a National Cervical Screening Programme was not a planned activity by Government. Rather it emerged as a consequence of challenge and resistance. In 1983, two women, Sandra Coney and Phillida Bunkle, became aware of research being conducted at National Women's Hospital, in Auckland (Coney, 1988). They discovered that some women, who had carcinoma in situ, were not being treated. These women formed the control group in a research programme being conducted by a gynaecologist although they had not consented to this. Indeed the women believed that the placebo they received were part of the treatment for their cancer. In 1987, Coney and Bunkle decided to go public with their findings and wrote an article for Metro magazine (Coney & Bunkle, 1987). This action triggered a Ministerial enquiry headed by Judge Silvia Cartwright. Her report, completed in 1988, made a number of recommendations, including one calling for the establishment of a national population-based co-ordinated cervical screening programme (see Appendix 8) (Cartwright, 1988). Another motivator for the establishment of the National Cervical Screening Programme was cost. The Crown was feeling the economic pinch of a welfare health system and reducing the health costs was at the forefront of their agenda. During the review a cost-benefit analysis of cervical screening services showed that it was cheaper to spend money on cervical screening than treating women for cervical cancer (Bethwaite, Rayner, & Bethwaite, 1986).

Following international trends, in 1989, it was also recommended that two kinds of register be established, one to provide demographic information about the target population (women between the ages of 20-69 years) and one to provide information about women's cervical screening history (Cox, 1989). As already mentioned, again, in 1989, specific funding was allocated for the establishment and implementation of a National Cervical Screening Programme. The original design of the programme was criticised by Māori, the New Zealand Medical Association, the Cancer Society and activists such as Sandra Coney. These groups argued that not enough consultation

had happened between the interested stakeholders and that primacy was given to the medical component of the programme while minimising Māori, the community and women centred-approaches. Another Ministerial review followed (Adams, 1991; Braun & Gavey, 1999; Coney & Bunkle, 1987; Wanganui Pilot Project, n.d.). Recommendations from this review relevant to Māori included: (a) all aspects of the programme should be developed simultaneously, without focusing on one aspect i.e., the register; (b) money should be held centrally for allocation to Māori initiatives; (c) the development of the programmes should involve local communities so that the programme is understood and accepted by women; (d) a single national co-ordinator should be appointed within the department, and (e) three to five regional Māori co-ordinators (centrally funded) should be appointed in consultation with Iwi (Adams, 1991). These conclusions were obviously meant to support tino rangatiratanga.

While progress has been made in some areas, little has been made in others. For example, while a national co-coordinator was appointed, no regional Māori co-coordinators were appointed. Further, the appointment of a National Māori coordinator arose after repeated pressure from Māori (Māori Cytology Working Group, Undated). At the time the current research was conducted only two Māori providers were funded to provide cervical screening services for the National Cervical Screening Programme. When there were approximately 200 Māori health providers it is of some concern that only two were being funded to provide services for the National Cervical Screening Programme. Regardless in 1990 the National Cervical Screening Programme was launched (Ministry of Health, 1999). Table 16 summarises the key events in the establishment of the National Cervical Screening Programme.

Table 16: Major events influencing the establishment of the NCSP

Year	Events
1983	Sandra Coney and colleagues begin to investigate treatment of women with carcinoma in situ at National Women's hospital
1986	Cost-benefit analysis showed greater expenditure on cervical screening will decrease mortality from cervical cancer
1987	Sandra Coney and Phillida Bunkle go public with an article about the treatment of women with carcinoma in situ at National Women's Hospital by writing an article which was published in Metro A Ministerial Committee established to investigate allegations concerning the treatment of cervical cancer at National Women's Hospital Department of Women's Affairs and Department of Health initiate discussions with four community groups
1988	Cartwright Inquiry completed and recommendations made
1989	Review of recommendations Four community based groups were established and received \$30,000 each, then forgotten \$36 million of health budget allocated to the establishment and implementation of a National Cervical Screening Programme
1990	Launching of National Cervical Screening Programme

(Compiled from Bethwaite, Rayner, & Bethwaite, 1986; Cartwright, 1988; Coney, 1988; Cox, 1989; Ministry of Health, 1996)

Kaupapa Māori analysis

At the core of my thesis is a kaupapa Māori analysis of the 1995 National Cervical Screening Policy document. A kaupapa Māori analysis seeks to explore the policy document for both empirical and normative influences. At a first order or technical analytical and contextual level I am seeking to explore whether there have been any health gains for Māori and whether the normative values underlying the policy targets (objective) are relevant to Māori. At a second order or system and ideological level I seek to determine whether at a normative level the policy goal contributes to Māori women's tino rangatiratanga and society as a whole, whether tino rangatiratanga exists in the policy document, and whether there are any conflicting discourses and if so how these are mediated. The kaupapa Māori analysis begins by providing an overview of the goals, targets and principles under which the National Cervical Screening Programme operates to address Māori women's tino rangatiratanga.

The 1996 National Cervical Screening Programmes Policy

The 1996 National Cervical Screening Programme's Policy document outlines the goal, summary targets and principles under which cervical screening services were to be implemented. The goal was to reduce the incidence of, and mortality and disability from, squamous cell cancer of the cervix. The summary targets relevant to Māori are: (1) to reduce the age standardised death rate from cervical cancer from 10.6 per 100,000 Māori women in the 1989-1993 time period to 7.5 per 100,000 Māori women by the year 2000; and to 5.3 per 100,000 by the year 2005; (2) to reduce the age standardised incidence rate of cervical cancer in Māori women from 29.8 per 100,000 in the 1989-93 time period to below 11.0 per 100,000 by the year 2005; (3) to reduce the percentage of invasive cervical cancer detected beyond stage 1 at the time of detection by the year 2000 to no more than 30 percent. (In 1993, 51 percent of cervical cancer registrations were recorded as detected at Stage 1, 74 percent with staging reported were detected at stage 1 in 1993, and 31 percent had no staging information stated); (4) to increase the proportion of eligible women enrolled on the

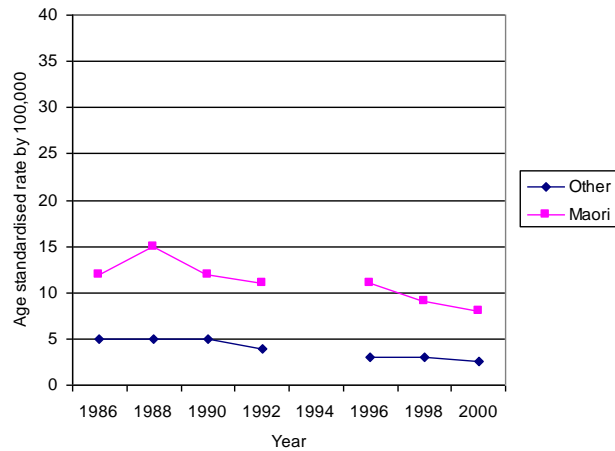
National Cervical Screening Register from 18 percent in 1992 to 75 percent in 1996; (5) to increase the proportion of eligible women enrolled and screened in the previous three years to 85 percent by the year 2000 (Ministry of Health, 1996:1). The principles in the 1996 National Cervical Screening Programme's Policy document include the Treaty of Waitangi, a women's centred approach and the Government's principles for purchase decisions. The Treaty of Waitangi principle argues that the Government is committed to improving Māori health status so that in future Māori have the same opportunity to enjoy at least the same level of health as non-Māori. The key features of this principle is greater participation of Māori at all levels of the health sector, resource allocation priorities that take into account Māori health needs and perspectives and the development of culturally-appropriate practises and procedures including the use of te reo Māori and the incorporation of tikanga Māori. The women centred approach argues that services must be oriented to the needs of women. The Government's principles for purchase include equity, effectiveness, efficiency, safety, acceptability and risk management (see Appendix 5 for full explanation of the Government's principles for purchase).

First order analysis.

A first order kaupapa Māori analysis of the 1996 National Cervical Screening Policy document seeks to demonstrate empirically whether there have been any health gains for Māori and whether the targets reflect Māori womens tino rangatiratanga.

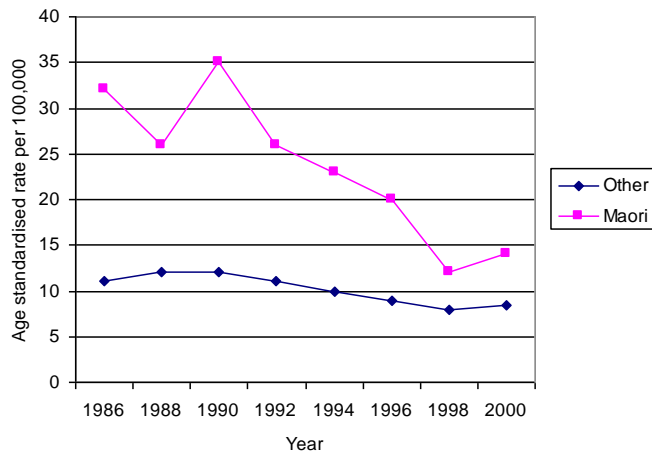
With respect to reducing the death rates from cervical cancer the data empirically demonstrates that the National Cervical Screening Programme was successful in meeting its objective. The death rates for Māori women were reduced from 10.6 per 100,000 in 1989-1993 to 7.5 by the year 2000 (see Figure 15).

Figure 15: Mortality rates of cervical cancer by ethnicity



It is too early to tell whether the National Cervical Screening programme has met the stated outcomes for reducing the age standardised incidence of cervical cancer but the data demonstrates there have been some gains. The age standardised mortality rate for Māori women was 29.8 per 100,000 in 1989-1993 and 14 per 100,000 women in 2000 (see Figure 16).

Figure 16: Morbidity rates of cervical cancer by ethnicity



However the National Cervical Screening Programme fell short of meeting its target for increasing cervical screening enrolments for Māori. While the National Cervical Screening Programme made huge gains by increasing the enrolment rates for Māori from 18% to 61% (adjusted) in 1999 (Whittaker, 1999, p. 24). The enrolment rate fell

short of the 75% stated. Further, the data demonstrated that the Programme also feel short of increasing screening rates for Māori to 85%. The screening rate for Māori women was 46% (adjusted) in 1999 (Whittaker, 1999).

While there have been some health gain for Māori, of concern are the disparities that exist between Māori and other ethnicities. Whittaker demonstrated a large disparity between Māori (61% adjusted¹²) and non-Māori (86% adjusted) enrolment rates on the National Cervical Screening Register (Whittaker, 1999, p. 24 & 68). Whittaker also demonstrated that Māori women's cervical screening rates were lower (46% adjusted) than those for non-Māori women (73% adjusted). Enrolling women onto the National Cervical Screening Register was primarily the responsibility of general practitioners as they did most of the smears. Many general practitioners were resistant to the establishment of the National Cervical Screening Programme therefore some did not actively seek to enrol women. However, general practitioners compliance did not fully account for the lack of enrolments and ethnic differences. Clearly something was amiss. While Māori women are more than twice as likely to get cervical cancer and four times more likely to die from it they are less likely to access cervical screening services (Ministry of Health, 1999; Ratima, Durie, Potaka, & Ratima, 1993; Sadlier, Priest, Peters, Crengle, & Jackson, 2004; Whittaker, 1999).

A first order analysis of the National Cervical Screening Policy document demonstrates that there have been some health gains for Māori women. The analysis also demonstrates that disparities exist for Māori women. Given this a kaupapa Māori analysis shifts its gaze to a second order analysis and examines the policy for systems and ideological discourses.

¹² Women who had hysterectomies for non-malignant reasons were subtracted from the total

Second order analysis.

As already mentioned a second order kaupapa Māori analysis seeks to determine whether the National Cervical Screening Policy document's goal benefits Māori and then society as a whole (systems). A second order analysis also examines the policy document for normative influences within the 1996 National Cervical Screening Policy goal for Māori and society as a whole and then seeks to explore the ideologies that exist in the document and whether any tensions exist between the ideologies and how these are mediated.

At a systems level the 1996 National Cervical Screening policy goal states the National Cervical Screening Programme seeks to 'reduce the incidence of, and mortality and disability from squamous cell cancer of the cervix'. The policy goal reflects bio-medical and epidemiological discourses. The bio-medical discourse is reflected in the goal when it talks about 'squamous cell cancer of the cervix' and the epidemiological discourse when it refers to 'incidence' and 'mortality'. The reduction in the incidence of, and mortality and disability from, squamous cell carcinoma of the cervix will contribute to Māori tino rangatiratanga by reducing the cervical cancer for Māori women and therefore ensuring the continuation of Māori as a nation. Similarly the policy goal benefits Pākehā as well. As the first order analysis demonstrated the policy document benefits Pākehā more than Māori. It is at an ideological level that an explanation for the difference is postulated.

At an ideological level a kaupapa Māori analysis seeks to explore the 1996 National Cervical Screening Policy document for tino rangatiratanga story lines. The tino rangatiratanga story lines were about the Treaty of Waitangi, Māori leadership, Māori provider development and legitimating Māori realities. The analysis demonstrates aspects of tino rangatiratanga exist but it exists counter hegemonically or as resistance to the more dominant bio-medical and epidemiological discourses resulting poor outcomes for Maori. The tensions between the discourses are mediated by kawatanga.

Tino rangatiratanga is a complex, fluid and multi-facted discourse (see Chapter Three and Seven).

Within the 1996 National Cervical Screening Programmes Policy document tino rangatiratanga manifests as Māori leadership, Māori provider development and legitimating Māori realities.

Māori leadership manifests in the guise of the National Kaitiaki Group, Kaihautu Māori and kaimahi Māori. The Crown has established a National Kaitiaki Group. The role of the National Kaitiaki Group is to protect Māori women's cervical screening data. Protection of Māori women's cervical screening data is considered important because of the tapu nature of te whare o te tangata. The establishment of the Group and protection of the data reflects the implementation of the three 'p's (partnership, protection and participation).

An aspect of tino rangatiratanga is the right to enjoy co-operation and dialogue with the Crown. The establishment of the National Kaitiaki Group provided a mechanism through which Māori could dialogue directly with the Crown, in this case the Minister of Health. However, the question arises; does the Group reflect tino rangatiratanga? If as Durie and Parata argue tino rangatiratanga is about the mana and tapu of rangatira then Māori representation on a national body is not tino rangatiratanga (Durie, 1998a; Parata, 1995). Further, if as kaitiaki (Hoani) argue 'true Māori leadership' is iwi leadership at a local level can Māori sitting on a national group be considered tino rangatiratanga in practise. If on the other hand they have been selected by the Crown then it would be considered to be kawanatanga in practise. The Chair of the National Kaitiaki Group is appointed by the Crown.

Another example of Māori leadership is the appointment of a Kaihautu Māori (a national Māori Cervical Screening Coordinator). While being a step toward tino rangatiratanga in practise, again, the selection of the Kaihautu Māori was through normal human resource management practises rather than an iwi selection process. Hence, not true tino rangatiratanga.

The National Cervical Screening Programme also employs a network of kaimahi Māori. Kaimahi Māori are culturally informed people who have networks into the community, and are informed about cervical cancer, cervical screening and the National Cervical Screening Programme. Kaimahi Māori provide health education and promotion services to their respective communities and in some cases provide smears and manage district and regional cervical screening services. Again the selection of kaimahi Māori are through normal human resource management practices. So again is not tino rangatiratanga in practice. However, the kaimahi are selected based on their ability to whakapapa to their respective iwi. Regular meetings between kaimahi Māori and the National Cervical Screening Programme provide a mechanism through which the programme can consult with and provide for Māori women. Recommendations from the kaimahi hui contribute to strategic planning for the National Cervical Screening Programme.

Māori leadership within the National Cervical Screening Programme is about protection rather than true tino rangatiratanga. Hence is about kawanatanga in practice rather than true tino rangatiratanga.

With respect to Māori provider development, the policy document asserts the service will take into account Māori health needs and perspectives and consider the developmental aspects of establishing contracts with new Māori health providers (Ministry of Health, 1996). The policy document also acknowledges that Māori may need more resources than others until their health gains match those of other ethnicities. However, while the policy document asserts kawanatanga ideals in practice the implementation is fraught with tensions where tino rangatiratanga vies for space in a bio-medically and epidemiologically dominated environment. The bio-medical discourse is reflected in resource allocation with most of the funding allocation going to support medical infrastructures (until 2000 all the registers were located in hospital settings) and payment of professionals such as specialists and general practitioners to the detriment of Māori development and lay smear takers and health promotion (Braun & Gavey, 1999; Jeffreys, 2000; Ratima, Durie, Potaka, & Ratima, 1993). In 1996, all of the 14 National Cervical Screening register sites,

situated in the 14 cervical screening programme regions (see Figure 17), were owned and operated by medical professionals and situated in hospitals. While it could be argued Māori organisations are still developing in some areas, Māori organisational infrastructures are well established and have been for a number of years (Wihongi, 1995).

Figure 17: The national cervical screening programmes register sites (1996)



Ministry of Health, 1996, p. 25

At a stretch, one way tino rangatiratanga is actualised within the 1996 National Cervical Screening Policy document is by legitimating Māori diversities. Recognising the diversities is reflected in the 1996 National Cervical Screening Programme's Policy document statement:

All women between the ages of 20-69 years should be offered cervical screening every three years. This includes women of all ethnic groups, lesbians and women with disabilities (Ministry of Health, 1996, p. 10).

To some degree theorists and activists would argue such a statement reflects Article III (ōritetanga) rather than tino rangatiratanga. However, the statement recognises Māori women's diversities such as lesbians and women with different abilities. To fully actualise tino rangatiratanga within this context the policy document would need to acknowledge the range of Māori realities that include; traditional links to te ao Māori, links to te ao Māori and te ao Pākehā, links to te ao Pākehā and finally not having links to either (Durie, 1995a; Durie, 1998b). The policy document would also need to recognise other diversities such socioeconomic status, education, hapū, and iwi diversities. While not identifying these diversities within the policy document the National Cervical Screening Programme endeavours to address these issues. Firstly by providing 'choice' in smear takers (gender, professions, ethnicity) settings (doctors surgeries, hospitals, work place, community organisations, marae and in people's homes), in worldviews (tikanga Māori and tikanga Pākehā), and then by addressing the wider determinants of health through building and maintaining reciprocal collaborative relationships across sectors.

As previously mentioned Māori health discourses focus on maintaining a holistic balance between the spiritual and psychic worlds, the political, the environment, the people, hapū and iwi, Māori society, the past, the future and the present, and between the inanimate and the living (Cunningham, 1998; Davis & Ashton, 2001; Dow, 1999; Durie, 1994c; Durie, 1999; Durie, 2001). The National Cervical Screening

Programme endeavours to address through the adoption of Māori health promotion models. The policy refers to te whare tapa wha (see Chapter 5)¹³.

An issue of contention that comes up for Māori in service delivery has been individualism over collectivism. Services that are focused on individuals are less able to provide services for women from collectivist societies. Research shows that individualistic approaches to service delivery create barriers to access for some people. For example, in a study investigating barriers to access for Māori with disabilities, Ratima and colleagues found that participants found individualistic approaches a barrier (Ratima et al., 1995). The National Cervical Screening Programme recognises that Māori women are generally viewed as part of a collective and that collective is whānau. Traditionally, Māori women's voice was collective and the collective was iwi (Mahuika, 1975; Mikaere, 1995; Parata, 1995). With colonisation and the subsequent socialisation into the worldviews of the Pākehā the collective voice of Māori women is now less likely to be iwi and more likely to be whānau (Mikaere, 1995). In those cases where Māori women's voice is collective women have more power to make changes such as establishing a national body politic and ensuring a Māori coordinator is employed. The individual voice of Māori women tends to be around their own health and often this takes second place to the needs of the whānau (Wihongi, 2000).

The dominance of the bio-medical and epidemiological discourses are not only reflected in resource allocations but also in the language used in the 1996 National Cervical Screening Programme's Policy document. Bio-medical and epidemiological discourses emerge from a positivistic, reductionist and scientific paradigm that dominates the health sector. Bio-medical terms used in the 1996 National Cervical Screening Policy document include such words as squamous cell carcinoma, cancer, uterus, and cervix, words and terms that have been demonstrated to create barriers to access for Maori.

¹³ In National Cervical Screening Programme has since adopted te pae mahutonga as another health promotion model.

While being helpful in the control of communicable diseases, like the bio-medical discourse, the epidemiological discourse it also acts to marginalise and alienate women and minority groups (Māori) through the use of 'blaming language', and by colluding with other dominant discourses such as the bio-medical discourse (Seidal & Vidal, 1997).

Blaming language involves the use of terms such as 'at risk' and 'target groups'. The use of 'at risk' and 'target groups' label, marginalise and alienate women and minority groups by firstly identifying them and then blaming them for the disease (Seidal & Vidal, 1997). For example, cervical cancer 'risk' factors include smoking, long-term use of contraceptives and the sexual behaviour of women and their partners (Chamberlain, 1986; Health Funding Authority, 1999). Such risk factors partially attribute the development of cervical cancer to the individual behaviour of women who get cervical cancer, while underplaying the influence of socio-economics, colonisation, male promiscuity, and the historical and political influences (Albee, 1980; Heller, Price, Reinharz, Riger & Wandersman, 1984; Seidel & Vidal, 1997). Māori women are commonly 'targeted', viewed as at risk and non-compliant (do not have smears). In collusion with other discourses, such as the traditional moral and bio-medical discourses, these groups are then viewed as being 'bad'.

The epidemiological discourse is reflected in the policy document, which refers to 'measuring' the programme, 'computer based information systems' and 'extensive coverage of the eligible population' (Ministry of Health, 1996, p. 4). Measuring the programme involves the gathering of statistical information about 'target groups' (women between the ages of 20-65 years of age) and their cervical screening history. The information is gathered by using a computerised data gathering system and then this is used to 'track' and 'follow up' women to ensure there is extensive coverage of the eligible population (women between the ages of 20-65 years).

In promoting the effectiveness of the national cervical screening register, persuasive language is used to convince women, smear takers, doctors and other stakeholders of the importance of the register (Apthorpe, 1997; Ministry of Health, 1996):

The NCSR [national cervical screening register] records and provides both information to assist individual women and their smear takers with personal health management, and information for monitoring and evaluation... The NCSR complements and backs up existing general practitioners recall systems and registers (Ministry of Health, 1996, p. 3)

International research shows that the use of a register has been instrumental in the reduction of the morbidity (incidence and prevalence) and mortality of cervical cancer. What is underplayed is the controlling influence the register has on women and their smear taking behaviour (Cox, 1989; Miller, 1992; Ministry of Health, 1996). Women who do not choose to have a smear are 'followed up' in various ways and in some cases coerced into having cervical smears (Wihōngī , 2000). The epidemiological information gathered has been helpful in reducing morbidity and mortality rates resulting from cervical cancer by 'tracking' and 'following up' women but it has been less helpful in recruitment of women (Ministry of Health, 1999; Whittaker, 1999).

The language used in the 1996 National Cervical Screening Programmes Policy document reflects how important the register is to the policy makers. For example, the policy document describes how helpful the national cervical screening register will be in 'managing' cervical screening information and acknowledges the register as the 'key' quality, monitoring and evaluation tool for the programme (Ministry of Health, 1996). While this is proving to be the case, some scholars argue it has been at the expense of other aspects of the service such as health promotion and exploring less invasive ways of screening such as a self administered human papilloma virus (HPV) test (Braun & Gavey, 1999; Goldie, Wright, Denny, Kuhn, & Pollack, 2001; Munro, 1990). The self administered HPV test is a simple test involving a swab of vaginal secretions.

It is at the resource allocation level that the influence of the epidemiological discourse can be seen to have been most influential. Approximately 99.7% of the \$36 million dollars was allocated to the establishment and maintenance of the 14 national cervical screening registers (see Figure 17) and supporting the development and provision of bio-medical services (Braun & Gavey, 1999; Munro, 1990).

Barriers to access

Accessing cervical screening services is important if Māori women are to benefit from services offered by the National Cervical Screening Programme. Barriers to access have been identified and include cultural, structural, and personal barriers.

Cultural barriers have been defined as ‘services that are owned, controlled, managed and staffed by non-Māori’ (Ministry of Health, 1998b, p. 32) and structural barriers as:

...health and disability structures [that] contribute to exacerbating the alienation of Māori from participating in the design, development, implementation, management and control of the systems intended to meet their health needs (Ministry of Health, 1998b, p. 32).

Together cultural and structural barriers serve to create barriers that include sexist, racist, and fragmented service delivery, use of exclusionary terms such as medical jargon, not gathering accurate ethnic data, and urbanisation and medicalisation of health services (Ratima, Durie, Potaka, & Ratima, 1993; Whittaker, 1999; Wihongi, 1999). Racist discourses are argued to exist within bio-medical settings and like the epidemiological discourse act to alienate and marginalise some women and some Māori (Fry, Undated; Ministry of Health, 1997; Wihongi, 1999). International and national research links perceived racism to hypertension, low birth rates and in Aotearoa, poor access to services (Jones, 1999; Jones, 2001; McKenzie, 2003; Ministry of Health, 1998b; Ratima et al., 1995; Rua et al., 1998).

Personal barriers for Māori include those barriers relevant to all women and include dislike of having it done, forgetting to have it done, fear of what the results might show, cost, not getting around to it, being embarrassed, because the doctor did not suggest it, because they thought it was not necessary and because they were not sick (Whittaker, 1999). Personal barriers also include those specific to Māori women that emerge from cultural beliefs around te tapu o te whare tangata and whakama (Ratima, Durie, Potaka, & Ratima, 1993; Whittaker, 1999; Wihongi, 1999). For some Māori the womb is considered tapu because it is the house of tomorrow’s people and therefore not to be seen by just anyone. For these women having a cervical smear is

difficult. Another cultural norm of whakama creates barriers to cervical smear taking. Whakama has two common meanings, feeling shy and feeling ashamed.

More recent research in cardiovascular disease argue that an inverse law exists for Māori (Bramley, Hebert, Jackson, & Chassin, 2004; Curtis, Harris, Robson, Reid, Purdie, & Cormack, 2003; New Zealand Guidelines Group, 2003; Sharpe & Wilkins, 2004). While Māori are more than twice as likely to get and die from cardiovascular disease they are less likely to access cardiovascular treatments. Further, cancer research show that Māori are less likely to go to the doctor earlier enough, less likely to be diagnosed early, and less likely to be receive treatment in a timely way (Bramley, Hebert, Jackson, & Chassin, 2004; Curtis et al., 2003; Sharpe & Wilkins, 2004). Similarly Māori women are more likely to get and die from cervical cancer than other ethnicities but less likely to access services. For example, in 1994 the age standardised cervical cancer rates per 100,000 women for Māori were 7.4 compared to Pākehā of 3.

The impacts of racist discourses contribute to the differences in morbidity and mortality rates for indigenous and non-indigenous women globally. For example, the incidence of cervical cancer for Native American Indian women is two and a half times higher than white Americans (Hodge & Rodriguez, 1996). In Australia mortality is significantly higher for Aboriginal women than other Australian women (Mak & Straton, 1993). Similarly, in Aotearoa Māori women are more than twice as likely to get and four times more likely to die from cervical cancer (Sadlier, Priest, Peters, Crengle, & Jackson, 2004).

Summary

Traditionally Māori women's tino rangatiratanga was linked to the gods. The colonisation of Māori cosmology saw Māori women's tino rangatiratanga deconstructed along with Māori cosmological beliefs. In a relatively short period of time Māori women's tino rangatiratanga was relegated to that of the dominant Pākehā view, that of chattels and helper to their male partners (Awatere, 1984). While some

women maintained their tino rangatiratanga and went on to lead their iwi through the treacherous waters of colonisation, most were left to struggle in the hostile environment of a largely Pākehā dominated world (Awatere, 1984; King, 2003).

One of the consequences is that Māori women's health is one of the worst in Aotearoa (Te Puni Kokiri & Minitatanga mo Nga Wahine, 1999). Of relevance to my thesis are the morbidity and mortality rates for cervical cancer. The health of te whare o te tangata is important to tino rangatiratanga as it is the house of humanity, therefore important to the continuation of Māori as a nation and is also the whakapa link to Papatūānuku.

Māori women are more than twice as likely to get cervical cancer and four times more likely to die from it (Sadlier, Priest, Peters, Crengle, & Jackson, 2004). While recent data show that mortality and morbidity rates from cervical cancer has improved since the introduction of the National Cervical Screening Programme there is also evidence to show that Māori women still lag behind other ethnicities (Sadlier, Priest, Peters, Crengle, & Jackson, 2004).

Barriers to access have been identified but in recent years the gap is being attributed to what some call an inverse law. Although Māori are more likely to get and die from cervical cancer they are less likely to access services. Theorist are attributing the difference to racist practises in health service delivery (Harris et al., 2006; Te Ropu Rangahau Hauora a Eru Pomare, 2006; Tobias, Sexton, Mann, & Sharpe, 2006).

The influence of dominant discourses in the development of and implementation of cervical screening policies in Aotearoa are reflected in the decisions made in the establishment and implementation of the National Cervical Screening Programme. If policies are understood to be mechanisms through which the Crown manages society then policies are integral in addressing disparities that exist between Māori and Pākehā in Aotearoa.

While the establishment of the National Cervical Screening Programme was problematic and while the programme did not always know what to do about issues

that arose for Māori, managers within the programme did take the issues raised seriously and endeavoured to address them.

Chapter Nine completes the kaupapa Māori analysis of the 1996 National Cervical Screening Programmes Policy document by providing a thematic analysis of Māori womens experiences of cervical screening servivces. .

Chapter Nine

NGA KORERO O NGA WAHINE TOA

Discussion with women

Ka ora to wahine puapua, ka ora to whānaupuawai, ka ora to hapu puawānanga, ka ora te iwi purotu (the health of the iwi is dependent on the health of the hapu, the health of the hapu is dependent on the health of the whānau, the health of the whānau is dependent on the health of the women) (song by Kataraina Pipi).

Chapter Nine provides the findings and discussions from a thematic analysis of; whanau hui, kanohi ki te kanohi discussions with women who have had a cervical smear and information from a survey questionnaire.

Demographics

A total of twenty-one women participated in this part of the research. Seventeen indicated they were Māori only, three ‘other’ (NZMāori /Irish, NZMāori / European) and one person did not answer this question. Each of the participants had whakapāpa connections to Ngati Porou, Ngapuhi, and/or Rongowhakata. The participants ranged in age from 15-65+ and all had had a cervical smear.

Thematic analysis

The thematic analysis of the findings from discussions with women who have had a cervical smear completes the kaupapa Māori analysis which was begun in Chapter Eight. Chapter Nine completes a second order analysis of the 1996 National Cervical Screening Programmes Policy document by capturing the influence of ideologies on the tino rangatiratanga of women who access cervical screening services. A thematic analysis of whānau hui and the kanohi ki te kanohi discussion was conducted. Four main themes emerged and are presented under the following headings: alienation and

oppression, Kaupapa Māori, practitioner attitudes and gender, and opportunistic smear taking.

Alienation and oppression

The dominant theme that emerged from whānau hui and kanohi ki te kanohi discussions was one of alienation and oppression. Alienation and oppression was linked to the dominance of bio-medical settings (hospitals and doctor's surgeries) and the negative attitudes of the practitioners who women met. For example, over half the women who took part in whānauhui and kanohi ki te kanohi discussions talked about feeling alienated or oppressed because the setting was "cold and sterile" or because their needs as women and Māori were not met (whānau hui 1 and 2). Women talked about the lack of understanding of their realities (low income, unemployed, no transport and no whānau support), lack of respect, and racist and sexist practises displayed by practitioners. Women also talked about practitioners who did not listen or had selective hearing, practitioners who made their decisions for them or recommended options that were unacceptable, practitioners who were rough and insensitive, practitioners who were abusive and practitioners who were intolerant and impatient (whānau hui one, 2, 3, 4, Kiri). For example, Kiri commented:

Yeah I was on the cervical screening programme and I went up to the hospital because I had had an abnormal smear...I was seen by a [Pākehā] doctor...he did a colposcopy and had access to my file and made comments about my medical history...I had just had my first son and umm so saying I also had an abortion that was marked on my file...One of the many comments he made that was detrimental to myself was umm comments such as, cause I wasn't working at the time and obviously had to receive an income so obviously had be on welfare, ummm, that I should count myself fortunate that I should be on the receiving end of this type of treatment given my circumstances...

The circumstance the practitioner was referring to was Kiri's abortion history and her status as an unemployed single parent. Kiri, who had survived a murder attempt by her now ex-partner, found the way and frequency in which the practitioner made reference to her abortion history offensive, and believed the practitioner treated her

badly because she had had an abortion, because she was a single parent and because she was temporarily on a low income. She illustrated this point by commenting:

I had heard from other women [married] that...when they've had a colposcopy they've been given an anaesthetic but I wasn't given anything like that. I was just on the table and he cut it off or cut it out...

Added to this, when she was having her colposcopy she had to take her nine-month old baby with her because she did not have any whānau support or any money to pay a baby sitter. During the procedure she had to put her baby on her chest during which time the practitioner was angry at her son for moving:

He actually made me frightened; he made me frightened for my baby. Here was a baby who couldn't sit still and I had him lying on my chest while, you know, while he was doing my colposcopy...and my baby was being told not to move...I mean how realistic is that?

Kiri believed that:

I didn't matter and my person didn't matter and I didn't have any value and I was a little cog in a big machine and this is what you do with a little cogs...you squash them.

Discrimination on the grounds of gender or marital status is illegal in Aotearoa. Such discriminatory practises illustrate the existence of traditional, Christian and moral discourses, within this bio-medical setting (hospital).

Issues of power and control also existed. Because of his position in society the practitioner (a gynaecologist) had power over Kiri. Specialists are considered experts in their field and have access to information that others do not (Harker, 1979). In Kiri's case the specialist's position also entitled him to access 'private' information about her. He utilised this knowledge to make a moral judgement about her. One of the outcomes was the recommendation that Kiri have a hysterectomy! Kiri believed he made this decision because she was a burden to society and did not deserve to be treated as other "married" women were.

Being told she should have a hysterectomy was the “last straw” and Kiri went back to her general practitioner to ask for a second opinion. Her general practitioner referred her to another gynaecologist. She discovered during this consultation that she did not need to have a hysterectomy and that there were alternative solutions. She still has her uterus today (2001). The outcome could have been different if Kiri was not an informed woman who knew what her rights were. Kiri commented that had she known that the experience with the first practitioner was going to be abhorrent she would have taken her cousin with her.

While Durie argues that ethnocidal policies of the 1990s had been largely minimised by the actions of the Māori Women’s Welfare League, Kiri’s experience shows that the way the cervical screening programme is being implemented can sometimes be profoundly racist and needs serious attention (Durie, 1994c).

The 1996 National Cervical Screening Programmes Policy document postulates that cervical screening services will be ‘women centred’. In some areas women centred services include the provision of child care services (Wihongi, 2000). In Keri’s case, when she was seeing the first specialist, the service was either not available or not offered. In Keri’s case her tino rangatiratanga was not protected neither were her rights as a woman or her rights as a human being. Because the policy document provides choices Keri was able to seek a second opinion and eventually she saw another specialist who provided her with information and other acceptable options.

Yet another example of alienation and oppression was cited by Hana. She recalls going to see a doctor, about a year after being raped. The doctor referred her to a clinic where she was to have had a smear. Hana panicked when the practitioner (Pākehā, female, general practitioner) attempted to insert the speculum. As a lesbian woman who had been raped the insertion of a speculum was re-traumatising. After a number of unsuccessful attempts by the practitioner to insert the speculum, the practitioner asked the nurse to have a talk to her. When this did not work the practitioner decided to administer a mild anaesthetic! Informed consent was not sought because at this stage Hana was unable to take in what was being said. The administration of a mild anaesthetic meant that the practitioner was able to complete

the procedure successfully. The experience left Hana feeling “out of it for days”. Being given an anaesthetic to have a smear seems extreme given that a cervical smear is a simple procedure. Needing to give someone an anaesthetic before doing a smear should have signalled to the practitioner that something was very wrong and further investigation was needed before proceeding. Another option might have been to have referred Hana to a counsellor and reschedule the smear.

Hana recalled another smear taking experience that involved another Pākehā, female general practitioner. In this instance when the doctor had difficulty inserting the speculum she told Hana that Hana had something wrong with her and that the doctor could not “be bothered” with her. Hana did have something wrong with her. She had been raped and needed counselling support. Hana commented during this experience, the doctor was shocked by her reaction to having the speculum inserted and the doctor’s reaction shocked Hana. Hana also commented that she “came out of there feeling like I had just been raped again”. Again the practitioner lacked the skills to address the issues Hana presented with. If a full history had been taken and options discussed Hana may not have felt like she did.

Practitioners are paid to provide cervical screening services and to some extent the responsibility of the experiences cited by women in the current study lies with the National Cervical Screening Programme. The 1996 National Cervical Screening Programme’s Policy document states, ‘to succeed, the screening service must be oriented to the needs of women’ (Ministry of Health, 1996:7). Therefore the National Cervical Screening Programme has a responsibility to ensure practitioners are fully trained. While the practitioners in the current study were medically trained, they appeared to lack the empathy or skills to provide services to women who have experienced a past traumatic event such as rape or attempted murder. All of the practitioners in the previous examples were trained medical professionals and this illustrates the power of the medical profession to capture the cervical screening domain, to the detriment of some of the women who participated in the current study (whānau hui 2 & 4, Kiri). It is not enough to be medically trained. Practitioners must also be skilled enough to know when they are out of their depth and refer on. They

must be aware enough to know when their actions are offensive and they must have highly developed interpersonal skills.

The comments made by Kiri and Hana highlight the need for further auditing of individual practitioners and further training of practitioners, particularly specialists and general practitioners. The auditing process should include women-centred questions such as ‘Did the practitioner offer child care services?’ and ‘Was a full history taken before having a smear?’ and ‘Did the practitioner take into account your individual needs?’ The training needs identified in these examples include history taking, micro counselling skills, and dealing with abuse.

A final example was cited by Rewi (a survivor of child sexual violence) who went to a Pākehā, male general practitioner to have a smear. She commented:

My first smear was done by a male doctor [Pākehā] and it was quite painful. They can be b....well rough those male doctors...It was from then that I decided well...I wouldn't have one for years after that...(whānau hui 4)

It is not always possible to determine whether you are being discriminated on the grounds of gender, employment, race or for some other reason but in the above instance Rewi believed she was treated badly because of her race. Because the practitioner treated her roughly she did not go back to have another smear for fifteen years and then she only went back because she was talked into it by a friend who was Māori, female practitioner working for a Māori provider. Being treated rudely and disrespectfully because they were Māori was a common theme that emerged in discussions with woman who participated in the current study (whānau hui 1, 2, 3 & 4).

While the impact of racism on health has been ignored in the past, recent research links racist practises to the level of well-being in countries such as United States, Australia and now Aotearoa (Ajwani, Robson, Tobias, & Bonne, 2003; Jones, 1999; McIntosh, 2001; Spoonley, 1990). The Ministry of Health and the Ministerial Advisory Committee both acknowledge racist practises affect access to services and

the quality of services provided (Ministerial Advisory Committee, 1988; Ministry of Health, 1998b).

The 1996 National Cervical Screening Programmes Policy document states ‘The Government is committed to improving Māori health status’ (Ministry of Health, 1996:7). Strategies to address this include the recognition of the Treaty of Waitangi as the guiding document of good health for all New Zealanders. The findings from the current study suggest that despite the rhetoric, it is primarily Pākehā New Zealanders who gain the most from the cervical screening policies, especially those who are allocated the resources (Ministry of Health, 1999; Sadlier, Priest, Peters, Crengle, & Jackson, 2004).

While practitioner attitudinal bias exists for Māori women in the current study and this in itself acts as barriers to access, such practises are compounded when the women have a history of child sexual violence, rape and attempted murder. For example, Kiri experienced a murder attempt, Hana rape and Rewi child sexual violence. The relationship between Māori women’s experiences of cervical screening and major life events has not been fully studied and is another research topic.

Māori were not passive in the instances cited. As a result of her experiences Kiri sought a second opinion. Hana searched for an alternative and became a shiatsu practitioner¹⁴. She now teaches women alternative methods of cervical health. Rewi choose not to have a cervical smear again for fifteen years. Other Māori women went on to establish Kaupapa Māori services (whānau hui 2).

Kaupapa Māori

Given the experiences highlighted in the previous section it is not surprising that some women sought alternatives. The second most dominant theme was a Kaupapa Māori theme. The Kaupapa Māori theme comprised of acts of resistance to the dominance of the bio-medical model of health, legitimating Māori healing practises, tikanga Māori and Kaupapa Māori services.

¹⁴ Japanese form of healing

From a discursive perspective, Foucault argues, new discourses emerge as acts of resistance (Foucault, 1977). In the current study the emergence of a Kaupapa Māori theme resulted from resistance to the dominance of the mainstream (bio-medical) services. Women in the current study talked about their experiences when having a smear at a hospital or at a doctor's surgery. For example, one woman commented:

I really got sick of it [going up to the hospital every six months to have a smear]...so I went to my tohunga and ummm went totally alternative, never went back to the hospital and ah so I sit here today (whānau hui 1).

The woman explained while she believed the specialist she saw was “awesome” she got sick of mainstream (bio-medical) settings. She and other women in the study described “mainstream” settings as “cold and sterile”, “invasive”, and “male dominated” (whānau hui 2, 3 and 4). Another woman commented that she found “...that instrument they use, that speculum, is what is really invasive” (whānau hui 4). Finally one woman commented that:

I was young when I started having smears, I was 20, I was 20 when I had my first baby and if my doctor had treated me right I probably would not have lost the baby (whānau hui 1).

While cervical smear taking is not shown to cause miscarriages, in the aforementioned case the woman believed it did and therefore did not have another smear for 20 years. An explanation by the practitioner may have prevented this misunderstanding and meant the women may have gone on to have regular smears.

The resistance to bio-medical services and the emergence of Kaupapa Māori services did not occur in isolation. Challenges to the dominance of the bio-medical model of health had occurred, underground, for many years to re-emerge during the late 1960s-early 1970s Māori resistance movement (Ballard, 1994; Fischer, 1995; Oliver, 1992). A variety of activities occurred at this stage with some Māori refusing to go to medical doctors or Pākehā-owned services and a resurgence of a demand for rongoā and tohungism (whānau hui 2). Within the cervical screening service a certain amount of resistance arose from Māori because they argued that there had been very little consultation with them in the establishment of the service and that their

recommendations were generally ignored or took a long time to be acknowledged (Wanganui Pilot Project, n.d.). Māori received very little money from the cervical screening programme and this had not changed greatly (Adams, 1991; Wanganui Pilot Project, n.d.). In such an environment, services that address Māori women's realities have emerged in spite of the cervical screening programme rather than because of it.

Legitimizing traditional healing practises was another aspect of the Kaupapa Māori theme that emerged from the current study. Traditionally Māori healing practises involved physical and spiritual healing and were holistic in nature. Physical practises included treating common ailments such as boils, and coughs and colds with rongoā (Durie, 1998b; Hiroa, 1958). Spiritual practises included karakia, usually conducted by tohunga, who had specialised knowledge similar to medical doctors. A holistic approach acknowledges the person in the context of their whānau, hapū and iwi and acknowledges the spiritual, psychic and political aspects of health (Durie, 1998b; Hiroa, 1958; Pere, 1991).

Within the current study tohungism, karakia, rongoā and holistic services were some healing options chosen by some women. One woman in the current study had been diagnosed with cervical cancer and had required treatment for it for a number of years. Although she was happy with her mainstream provider the procedures were uncomfortable and painful. She eventually decided that she had had enough and in her own words thought "if this is going to take me then this is what is going to take me". She decided to see a tohunga who prescribed the use of kawakawa and kohekohe. After five months she went back to the specialist for a check and was told she was cancer free. Not surprisingly she is a strong advocate of traditional healing practises.

A preference for holistic treatment was illustrated in a comment made by one woman who described cervical screening services that she and other women had attended:

...nine years ago over in [name of town] I went to [name of service provider] and his wife. It was totally Māori and we had whānau there and that's what made it for me...and now I'm still part of a Māori organisation and that's why I feel secure about going as well...its because I know I'm really being looked after...I suppose it was because we could awahi each other ...it was the way Māori are able to talk to each other. You know it was just the loving environment...so comfortable it was like being at home (whānau hui 4).

Legitimizing Māori healing practises increases accessibility for women in the current study and for one woman had a huge health gain. Purchase of Māori health services has been identified as an option in the 1996 National Cervical Screening Programmes Policy document but these services still exist only on the margins of the cervical screening programme, at the time of writing only two Māori providers were funded to provide cervical screening services.

Critical to the Kaupapa Māori theme was tikanga Māori. Tikanga Māori refers to Māori values and beliefs, which, according to Durie, are critical to Māori well-being (Durie, 1998b). Theorists argue that the imposition of Pākehā worldviews over those of the Māori have had a negative influence on Māori health (Awatere, 1984; Bishop, 1994; Durie, 1998a; Pomare et al., 1995). For example, racist attitudes have resulted in Māori not receiving the same quality of care as Pākehā (Ajwani, Robson, Tobias, & Bonne, 2003). As already mentioned, since the late 1960s and early 1970s Māori resistance movement, Māori have asserted their rights to tino rangatiratanga within the health sector. While little progress was made in this direction until the early 1990's, between 1993 and 1997 the number of Māori health providers increased from 30 to 200 (Te Puni Kokiri, 1998). However, only two were contracted to provide cervical screening services.

Within the current study the importance of tikanga Māori in issues related to cervical screening was highlighted in whānau hui. Common values and beliefs included te

whare to te tangata, tūrangawaewae, whakama, awhi and manaaki and whānaungatanga.

Te whare o te tangata

The reproductive organs or te whare o te tangata are considered tapu. The tapu nature of te whare o te tanga originates from the cultural beliefs that it is the house of tomorrow's people and important for the continuation of Māori as a nation (Royal Commission on Social Policy, 1988). It is through te whare o te tangata that the whakapāpa linkages are continued and some of these go back to the gods or Io matua (Hiroa, 1958; Mahuika, 1975). Traditionally, therefore, women were generally treated with dignity and respect. As the result of colonisation and the imposition of patriarchal systems and values, the tapu nature of te whare o te tangata was lost (Mikaere, 1994; Mikaere, 1995, 1999a, 1999b). The recognition of te whare o te tangata as tapu re-emerged during the Māori women's resistance movement and the emergence of feminism in addressing issues of violence (Pitman, personal communication, June, 1988). Within the cervical screening service, te whare o te tangata was used as a health promotion tool to encourage women to have a cervical smear (Ministry of Health, 1997). However te whare o te tangata has more meaning to women in the current study than a health promotion tool. For example, one commented:

To me that part is sacred [te whare o te tangata] and must be treated with care...[it] has ten atua that sit around [it] to manaaki that area and so it is very tapu (whānau hui 4)

Unlike the bio-medical discourse of health, the Kaupapa Māori theme highlights the importance of the tapu nature of te whare o te tangata and the relationship of this to the well being of Māori women as a whole.

Turangawaewae

Closely linked to te whare o te tangata was tūrangawaewae or Māori links to their tribal lands. The connection between te whare o te tangata and tūrangawaewae relate

to te whare o te tangata being the house of man and tūrangawaewae being the earth mother (papatūānuku) or the original te whare o te tangata. For some Māori the links are very strong. In the current study the importance of tūrangawaewae was illustrated in the discussions women had about where they expected to be buried and where their cervical information should be held. One woman commented that it was important to her to have her smears done in her tribal area and to have her cervical smear information kept within her tribal area as well. In this particular instance this comment was about her right to be counted as a Māori woman and the rights that are hers because of her whakapāpa links to the area. She commented:

...and another thing for me it is about connectedness and relationship... my connections...I don't want it [smear results] to be in a tauwi office - I want it here [Māori provider setting] where it belongs, you know my tūrangawaewae. That's where I'm going to go back to [when I die] so that's where I want it centred (Anna).

While women have spiritual and emotional links to their tūrangawaewae, within Māori society, being able to claim tūrangawaewae status links to recognition of ancestors and current rangatira. Being able to do this is linked to feelings of self esteem and well being (Durie, 1998b; Murchie, 1984).

Whakama

Another value and belief associated with te whare tangata was the notion of whakama. Whakama has two common meanings, feeling shy and feeling ashamed. Within the current study feelings of shyness tended to originate from the notion of tapu and the sacredness of te whare tangata. In these cases women explained that the area was tapu and needed to be treated with respect and gentleness, this manifested as shyness. One woman commented “I would like for people to understand how shy I am and to be careful” (whānau hui one).

With respect to shame, women in the current study linked whakama to feelings of shame because it was linked to sexual inappropriateness. For example one woman commented:

...I was brought up with nobody goes down there...nobody touches that...although there have been those that try...well with my grandmother that was a part that nobody was allowed to touch...and of course my mother spoke to me clearly about sex....and even my step-father said “no man touches down there...(whānau hui 2).

Whakama is considered to be a cultural barrier to accessing cervical screening services for Māori women. Such was the case with women in the current study. However feelings of whakama could be minimised by being treated with respect, by having a smear within a culturally appropriate setting and having access to a Māori.

Awhi and manaaki

Yet other values and beliefs were awhi and manaaki. Awhi refers to being supported and manaaki to showing respect, showing kindness and caring for people. Within the current study awhi and manaaki were key concepts with respect to having a smear. For example, women, in particular younger women, talked about the importance of having their mothers present. This point was illustrated by one rangatahi who expressed shock when she heard one of her friends was going to have a smear and her mother was not with her:

...I went with my friend. She had the smear. She felt everything about it was uncomfortable and she didn't like anything about it. She's really young. I said “Don't you go with your Mum” and she said “no”. I went “ooh not at all”. She made me go in the room with her. She pulled the curtain across...but I was holding her hand (whānau hui 3).

Another woman linked awhi and manaaki with mana and dignity. For example she commented that “awhi and manaaki” was important in service delivery because it related to her “mana Māori and dignity” (whānau hui 4). Mana Māori and dignity relates to feelings of self worth and recognition as a Māori.

Whānaungatanga

Finally, a common value across the range of realities was that of whānaungatanga. Traditionally whānaungatanga meant kinship connections and the reciprocal responsibilities that exist between these kin or the practical implementation of whakapāpa (Ministry of Health, 1998b; Weaver, Nikora, & Moeke-Pickering, 1997). Today the meaning of whānaungatanga has been generalised across sectors and group settings to mean the reciprocal relationships that exist within these groups.

Within the current investigation whānaungatanga manifested in a variety of ways. In some cases it was being able to have whānau present during the cervical screening process. For example, one participant commented:

that's what made the difference for me...it was totally Māori and we had whānau their and that's what made it for me...(whānau hui 4).

In another it was the feelings of connectedness within a Māori provider setting

I suppose it was because we could awahi each other. You know it was totally that way. It was the way we as Māori are able to talk to each other. You know it was just the loving environment...it was comfortable it was like being at home (whānau hui 2 & 4).

Practitioner attitudes and gender

Given the range of Māori realities which existed, within the current study, it is not surprising that some women's experiences of cervical screening by medical practitioners working in bio-medical settings were positive. Typically, in these cases women reported having long and trusting relationships with their practitioners, in one case over sixteen years, and in another over twenty. Women commented:

I've always felt comfortable, Dr F [male, Pākehā] has always done them...and I've always felt comfortable with him and then I changed to a woman doctor [Pākehā] and that was equally as comfortable...(whānau hui 3)

I don't mind my Doctor and I don't mind his nurse...(Kiri)

He was very sensitive in the way he treated me [male, Pākehā, doctor]...(whānau hui 3).

Another woman who had a disability described her experiences:

My nurse and my doctor are really good. They take their time with me, and sometimes it takes two hours to position me on the table. I have to lie on my side and sometimes I have to move because it is uncomfortable and painful (whānau hui one).

Regardless of how long it took the two practitioners did not do the smear until the woman was ready. It seems then that in some cases general practitioners are able to provide services to Māori that are acceptable. The difference between those who do not and those that do are their attitudes and the way they treat women.

Another success factor was the gender of the practitioner. In those cases where women had had initial difficulties with practitioners, changing to a female practitioner increased feelings of comfort and acceptability of the process. For example, in Kiri's case when she sought a second opinion the practitioner she saw was a Pākehā female:

I went to another specialist who fortunately for me was a female doctor and she said to me there is this avenue and this avenue and this avenue before there is the necessity to go, to, to umm go to the lengths they were suggesting...[hysterectomy] (Kiri).

Feeling fortunate to have a female practitioner tends to illustrate the dominance of male practitioners in the cervical screening world. For example, most cervical smear practitioners are general practitioners and most of these are men (New Zealand Health Information Service, 2003). While some changes have been made since 1990, most cervical smear takers are male general practitioners. As cervical screening is a women's issue it would seem appropriate that women would be the most knowledgeable about the service. As explained in Chapter Five and Eight, the capturing of the medical domain by males is reflected in the cervical screening programme which is primarily dominated by male practitioners and in fact the establishment of the National Cervical Screening Programme was driven by male knowledge (Cox, 1989). However in this case the provider was female and provided Keri with other options. In Rewi's case, when she finally had another smear fifteen years later, she also saw a female practitioner in a hospital and described the practitioner as good:

I had a female at the hospital. Ooh she was good, she was good and I've had a female ever since. The lady that did it was talking to you and all that. She was really good, she didn't just put me on the table, she was really good. She just talked to me and showed me the things she was going to do and what she was using and how she was doing it.

Often it is the ability of the provider to accommodate the woman's subject position that mediated the woman's experience of the cervical screening.

Finally most (15) women in the current study preferred to have a female practitioner, usually Māori, but when that option was not available they chose a Pākehā female practitioner.

Opportunistic smear taking

Another theme that emerged from the whānau hui and discussions with women in the current study was opportunistic smear taking. Opportunistic smears are those taken when women see their doctors for something else. They are done in bio-medical settings. For example one rangatahi said when she was in hospital because she had a lump in her genital area the doctor who examined her said “ooh we’ll give you a smear while, while we’re down [here]” (whānau hui 3). In another case, a woman commented that “my doctor usually does mine when I go and see him about something else” (whānau hui 3). In yet another example a woman commented:

I’ve always had it done at the doctor’s and it’s been times when I’ve been like cause I had the loop and they pulled it out and they [did] a smear while they were doing it...the next time I had a miscarriage and they did one then (whānau hui 1).

The woman in the above example did not consider cervical screening important and indicated she would not have one by choice. To a small degree, opportunistic smear taking may be an endeavour to detect cervical cancer in its early stages, within the current context. However

While opportunistic smear taking may reduce the incidence of cervical cancer for Māori women it also takes away their right to make informed decisions.

Opportunistic smear taking highlights the need for more promotional work and for more practitioner training.

Summary

In summary the findings from a Kaupapa Māori analysis of the 1996 National Cervical Screening Programmes Policy document show that the implementation of the policy document was limited in its ability to protect Māori women’s tino rangatiratanga.

Over half the women in the current study indicated that they had experienced some sort of discrimination, gender, employment status, sexual orientation, abortion history, and race. When discrimination was compounded by a history of violence (child sexual violence, rape, attempted murder) women in the current study were traumatised by the event and in some cases choose not to go back again for many years, in one case 20 years, and in other cases chose other methods to maintain their health and included rongoā, reiki and the establishment of kaupapa Māori services.

Based on the experiences of women in my study the National Cervical Screening Programme is not meeting its programmes goal because Māori women's tino rangatiratanga is not being protected. The findings demonstrated the attitudes and behaviours of the smear takers, who were primarily Pākehā specialists and general practitioners, created major access issues for some women.

The principles (ideologies) of the 1996 National Cervical Screening Programmes Policy document acknowledge services for Māori will include culturally-appropriate practises and procedures (Ministry of Health, 1996). Yet Māori women's pathways through the cervical screening services are extremely difficult. In an endeavour to address these issues Māori women have established services that better meet their needs, not as a right but as acts of resistance (whānau hui 2). Further the principles for purchase decisions identified in the 1996 National Cervical Screening Programmes Policy document are equity (addressing...disparities and giving greater weight to Māori... health gains), effectiveness (...addressing and reflecting diverse realities...), safety (...protecting women from avoidable harm, both physical and non-physical.) and acceptability (...recognising Māori aspirations for self management and preferences for services to be provided by Māori) yet the literature and discussions with women who have had a cervical smear demonstrate that in some cases disparities still exist, Māori women's diversity is not being fully addressed, and that Māori women's aspirations for self management are not being fully supported (Ministry of Health, 1996).

However there were instances in the current study where women indicated that the services they had been provided were good and that sometimes specialists and general practitioners do provide an excellent service.

Finally over all for women in the current study it was not the race or gender of the smear taker that was paramount but being treated with respect.

Chapter Ten concludes my thesis and provides a summary of the key findings and how my thesis contributes to the growing knowledge around tino rangatiratanga in health policies and practises.

Chapter Ten

NGA WHAKAOTINGA

Conclusions

Na te kune te pupuke. Na te pupuke te hihiri. Na te hihiri te mahara. Na te mahara te hinengaro. Na te hinengaro te manako. Ka hua te wananga.

From the conception the increase (growth). From the increase the thought. From the rising thought the memory. From the memory the consciousness (mind-heart). From the consciousness the desire. Knowledge became conscious (fruitful).

Māori health has gone from one of the best in the world to one of the worst (Milroy & Mikaere, 1993). To some degree this can be argued to be the result of the signing of the Treaty of Waitangi and the implementation of Article I of Hobson's version. The implementation of Article I of Hobson's version saw wide spread acquisition and assimilation legislation and policies implemented (Durie, 1998a; Durie, 1998b; Gilling & O'Malley, 2000). The acquisition and assimilation policies embedded kawanatanga while marginalising and alienating tino rangatiratanga.

The embedding of kawanatanga saw dominant Crown discourses normalised across the social landscape. Scholars argue dominant Crown discourses were racist, capitalist and patriarchal (Awatere, 1984; Irwin, 1992b; Mikaere, 1994; Mikaere, 1999a). The marginalisation of tino rangatiratanga saw massive land loss and attempts by the Crown to assimilate Māori into the cultural norms of the Pākehā (Awatere, 1984; Durie, 1998b; Fleras & Spoonley, 1999; Gilling & O'Malley, 2000; Walker, 1990). Māori resisted such moves, initially through warfare, passive resistance, oratory and political activity and now through passive resistance, political activity, oratory, strategic alliances and the written word (Durie, 1998a; Kawharu, 1989; King, 1997; Tuhiwai-Smith, 1999; Walker, 1990).

In contemporary Aotearoa tino rangatiratanga is argued to be a site of constructive engagement through which Māori and the Crown can renegotiate relationships

(Durie, 1998a; Fleras & Spoonley, 1999; Kawharu, 1989; King, 1997; Tuhiwai-Smith, 1999; Walker, 1990).

The purpose of my research was to explore the definition of and implementation of tino rangatiratanga in health policies and practises. Firstly by defining tino rangatiratanga and then through a Kaupapa Māori analysis of the 1996 National Cervical Screening Programmes Policy document.

Kaupapa Māori theories

I grounded my research in Kaupapa Māori theories that have at their core tino rangatiratanga (Bishop, 1994; Tuhiwai-Smith & Reid, 2000). Like post-colonialism Kaupapa Māori theories challenge colonisation, racism and patriarchy and are strongly political. Kaupapa Māori theories also legitimate tikanga Māori and seek to emancipate, liberate and empower. Within my research Kaupapa Māori theories is taken to mean the quest for Māori knowledge (wisdoms and truths) through rational inquiry, it is culturally bound knowledge, it is knowledge that normalises Māori cultural values, and challenges colonisation, racism and patriarchy (Bishop, 1994; Pihama, 2001; Rosso & Fair, 2000).

Kaupapa Māori research

Within the research context Kaupapa Māori sought to challenge the dominance of Western methodologies that have served to marginalise and alienate Māori (Bishop, 1994; Pihama, 2001; Tuhiwai-Smith, 1999). Like Kaupapa Māori theories at the core of kaupapa Māori research is tino rangatiratanga. Bishop operationalises tino rangatiratanga as initiation, benefits, representation, legitimisation and accountability (Bishop, 1996). Such an approach asks questions such as, who initiates the research, how is initiated, who benefits, how do they benefit, whose worldviews or ‘voices’ are heard, whose realities are meaningful and given credence, who is the researcher accountable to, and who will own and disseminate the results.

Tuhiwai-Smith operationalises tino rangatiratanga as whakapapa (the way we think and come to know the world), te reo (a window to ways of knowing the world), tikanga (customary practises, obligations and behaviours or the principles which govern the world), rangatiratanga (control over the decision making process), and whānau (cultural ways of organising and supervising the research and gender issues) (Tuhiwai-Smith, 1996).

Within the context of my research Kaupapa Māori tino rangatiratanga was operationalised as representation and reciprocity. Representation challenged the dominance of scientific and positivism in the research process, constructed Māori realities in the text of the research, and recognised diversity and matauranga Māori. Reciprocity was about reciprocal collaborative relationships, tohungatanga, tikanga Māori and rangatiratanga.

The methods I adopted ensured that tikanga Māori was legitimated and my process was safe. Hence, my methods included the establishment of a research whānau and the development of a Kaupapa Māori policy analysing framework.

Critical to the success of research that involves Māori is tika or ethical practise. To ensure my research was ethically safe within the cultural boundaries of tikanga Māori a research whānau was established that included academic and cultural supervisors or experts. Participation in the research whānau was flexible. There were those who were constantly present such as my academic and cultural supervisors. There were those who provided guidance at certain times of my research and these were typically specialists or experts within a given field. For example, when I was data gathering local iwi and Māori leaders were part of my research whānau because they provided access to participants, ensured my processes were tika within their iwi boundaries and ensured the research findings were valid. Once the data gathering process was completed these people, while keeping a watchful eye on my progress, did not meet with me as regularly as my academic and cultural supervisors.

Drawing on Fishcer's practical deliberation framework I developed a Kaupapa Māori analysing tool that enabled an analysis of the 1996 National Cervical Screening

Programme Policy document at four discursive levels, technocratic, contextual, relevance and ideological. The analysing tool asked questions relevant to tino rangatiratanga and included; were there health gains for Māori women, were the health targets (objectives) relevant to Maori, did the policy goal contribute to Māori society and then society as a whole, was tino rangatiratanga reflected in the policy document, were there tensions between tino rangatiratanga and other discourses and if so how were they mediated.

Research findings

The findings from my research showed that tino rangatiratanga is both a cultural norm and a multifaceted and fluid construct. The Kaupapa Māori analysis of the 1996 National Cervical Screening Programmes Policy document demonstrated at technical analytical level the policy is partially addressing Māori tino rangatiratanga. At a contextual, systems and ideological level the analysis demonstrated tino rangatiratanga was only partially addressed because kawanatanga was not being fully implemented by the Crown and because of the dominance of the bio-medical and epidemiological discourses.

Investigating the definition of tino rangatiratanga.

Investigating the definition of tino rangatiratanga highlighted firstly that tino rangatiratanga is a cultural norm and secondly highlighted the complexity of the construct and also its multiplicity in practise.

A cultural norm

Traditionally tino rangatiratanga was about the mana and tapu of rangatira and their ability to whakapapa to the gods. Such a cultural norm still exists today. There are those holders of the knowledge of tino rangatiratanga who still meet to discuss tino rangatiratanga matters, what might be called a national Māori body politic. The holders of the knowledge of tino rangatiratanga are ‘true’ iwi leaders, leaders who have been selected by their iwi to represent them (Hoani). Durie argues that tino rangatiratanga is Māori leadership personified (Durie, 1998a). While this was the case

in the past and to some degree today unlike traditional Māori leadership contemporary Māori leaders do not always need to be rangatira, nor do they need to be able to whakapapa to the gods. In some cases the Māori leaders are leaders who have accomplished professionally so may be cleaners, builders, lawyers, doctors and academics.

Traditionally wahine were rangatira and ariki rangatira (Mahuika, 1975; Mikaere, 1995). My research shows that the process of colonisation and the dominance of patriarchy and racism contributed to the deconstruction of wahine Māori as rangatira and ariki rangatira and reconstructed them as chattels (Awatere, 1984; James & Saville-Smith, 1990; Mikaere, 1995). Such a deconstruction of wahine Māori rangatira contributed to the appalling situations that Māori women experience today, reflected in mortality statistics for a range of ailments such as lung cancer, cardiovascular disease, diabetes, respiratory conditions and cervical cancer (Ministry of Health, 1999; Ministry of Women's Affairs, 2001). Conditions that are largely preventable and are stress related.

Within my findings there was strong 'Māori women as leaders' theme, both wahine and tane and also Māori and Pākehā argued that Māori women were and are leaders. The Māori women as leaders theme was also reflected in discussion with women who have had a cervical smear when they went out a developed services for themselves and also chose alternative solutions to those offered such as ronga, tohungism and reiki.

Complexity and multiplicity

A variety of meaning of tino rangatiratanga emerged from my study. Within the sovereignty discourse tino rangatiratanga ranged from total Māori control over all of Aotearoa to Māori control over decision making. Within the self-determination discourse tino rangatiratanga was about non-interference by the Crown or Government and advancing as Māori into the future. The positive Māori development discourse is about advancing as Māori from the basis of tikanga Māori and developing strategic alliances. What all of the discourses have in common is resistance, reclamation, decolonisation and celebration.

The signing of Hobson's version of the Treaty of Waitangi was critical to tino rangatiratanga because once the Treaty was signed it was Hobson's version that was authoritative and the Crown implemented Article I of Hobson's version while ignoring Article II of either version. In cases where there is ambiguity between treaties, a treaty is to be interpreted against the party drafting it, in this case the Crown (The Waitangi Tribunal, 1989). Such recognition would mean that the Crown can no longer govern without recognition of tino rangatiratanga. While attempts are being made to address the Crown's lack of responsiveness to Article II of either Treaty it has been through major acts of resistance not on any willingness by the Crown. My findings suggest the Crown only has the legal right to make laws for their own people and Māori for Māori. Adopting such a process requires a major shift in power relations and mechanisms need to be developed to facilitate this process. Such processes are being implemented by other indigenous cultures in other parts of the world and include a nation within a nation scenario, and a nation within tribal boundaries. Either options need further development but given our history it is not likely to happen easily or without resistance.

Today tino rangatiratanga is bounded by the laws of the land. Te Tiriti o Waitangi allows the Crown to make laws to govern Aotearoa while supporting and protecting Māori tino rangatiratanga, a far cry from absolute sovereignty.

The policy domain

Within the policy domain tino rangatiratanga is about finding Māori solutions to Māori issues. Typically, within Western society getting a policy issue on the political agenda is vital because getting it on the political agenda means that resources will be allocated for implementation. Within Western society there are mechanisms through which policy issues get on the political agenda. Common is the rationalist approach to policy making and include identifying the problem, getting it on the political agenda, generating solutions and allocating resources.

For Māori, policy issues that are of major importance to us often get on the political agenda through major acts of resistance such as the Land March and Takaparawha. Clearly, Māori policy issues are not taken seriously by the Crown until they have

reached crisis point and get on to the international political agenda as was the case with the Land March. Other mechanisms must be found for the cost of resistance to Māori and Pākehā alike is high.

One mechanism mooted by Durie was a national Māori body politic (Durie, 1998a). Several national Māori body politic were mooted in my research. A Māori government was one such body, parallel development models were also mooted with Māori as one of the parties, there were also sectoral national Māori body politic such as Te kōhanga Reo, Women's Refuge and the Māori Women's Welfare league. . As mentioned earlier other body politics include a nation within a nation body politic and a nation within tribal boundaries approach which has been utilised successfully in Canada. My research showed that while national body politic exist they exist in silo's, represent a sector of society and people sitting on these bodies are not always 'true' Māori representatives. Work is required in deciding what and how a national Māori body politic should be. The findings suggest that those Māori sitting on existing national bodies need to be selected by their hapu and iwi and must be the holders of the knowledge of tino rangatiratanga.

Even with a national Māori body politic the policy areas are huge and are still to be developed. Durie identifies eight dimensions, mana atua, mana tupuna, mana tangata, mana whenua, mana moana, mana tiriti and mana motuhake. Each of the dimensions covers a wide range of issues for Māori and a lot of work. Experts in each of the areas are required.

The practise

In practise tino rangatiratanga is about resistance, reclamation, decolonisation and celebration, resistance to the dominance of Western values of beliefs, reclamation of tikanga Māori that includes a decolonisation process and celebration of success (Durie, 1998a; Henry, 1995; Parata, 1995).

Scholars and kaitiaki in the current study highlight resistance as part of the practise of tino rangatiratanga (Durie, 1998a; Henry, 1995; Parata, 1995). In one case it was resistance to the dominance of Western management models, in another the

dominance of Western medical models and in yet another it was challenging the dominance of Western values such as racism.

Within my research a debate emerged about who could claim tino rangatiratanga, the individual or the collective. In some cases scholars and kaitiaki argued that the individual and the collective could claim tino rangatiratanga (Durie, 1998a; Henry, 1995; Parata, 1995). However, it is my view that individual tino rangatiratanga is more to do with Article III of Te Tiriti of Waitangi and citizenship rights, the same rights as British citizens rather than Article II, tino rangatiratanga.

The strongest theme to emerge from my study was tino rangatiratanga as a collective right and that collective was typically iwi (Durie, 1998a; Henry, 1995; Parata, 1995). Scholars argue if Māori were to move from dependency on the state to independence, then iwi or hapū seem to be the best political vehicle for this (Durie, 1998a; Henry, 1995; Parata, 1995). The debate is ongoing but, if, as some kaitiaki believe, tino rangatiratanga is absolute Māori sovereignty, then tino rangatiratanga is an iwi right.

What the current study showed was, like other indigenous tribes elsewhere in the world, those iwi who were successfully practising tino rangatiratanga had a strong degree of self governance (Cornell, 2000). The degree of self governance was related to having a strong asset base, sustainable management systems, decisions makers who were immersed in te ao Māori, and a certain degree of independence from the Government. In practise, kaitiaki described tino rangatiratanga as services that were owned and operated by iwi and where tikanga Māori was the norm. It was also about struggle, reclamation, decolonisation, and growth and celebration.

Kaupapa Māori Policy Analysis

The Kaupapa Māori analysis of the 1996 National Cervical Screening Programmes Policy document showed that at technical analytical level the policy is not working for Māori, at a contextual level the normative values are bio-medical and epidemiological and therefore barriers to access exist but it is at the ideological level that the reasons for the disparities between Māori and Pākehā are most clearly demonstrated.

At a technical analytical level the implementation of the 1996 National Cervical Screening Programmes Policy demonstrates there are minimum health gains for Māori. The stated morbidity targets for Māori women was met with a reduction from 10.6 per 100,000 in 1989-1993 to 7.5 by the year 2000. While it is too early to determine whether the stated mortality targets will be met there has been a reduction from 29.8 per 100,000 in 1989-1993 and in 2000 it was 14 per 100,000 women. However the stated outcomes for enrolments (75%) and cervical smear taking (85%) were not met for Māori (Whittaker, 1999). Of greater concern is that Māori women are twice as likely as Pākehā to get and four times more likely to die from cervical cancer and yet they are less likely to access the services required (Sadler, Priest, Peters, Crengle, & Jackson, 2004).

Not only do disparities exist but Māori women in my study have also been subjected to abhorrent discrimination by general practitioners and specialists; some of this was due to the woman's perceived employment status, some to gender, some to sexual orientation, some to marital status and some to race. When this was coupled with a history of some sort of violence (physical, emotional or sexual) the cervical screening experience was particularly traumatic. Such treatment led some women not to have another smear for 20 years. In some cases women chose not to have a smear again for many years, in other cases women chose alternatives such as rongoa and reike and in yet other cases women chose to set up Kaupapa Māori services, services that had tikanga Māori as the underlying value base, services that were owned and provided by Māori but also services that utilised cervical screening experts.

Clearly there are mitigating circumstances. A contextual analysis demonstrated that the underlying values of the targets were bio-medical and epidemiological as evidenced by the language used and resource allocation (most of the cervical screening budget went to the development of a national register and paying specialist and other medical specialists as smear takers). The targets set do not take into account Māori women's realities and therefore only partially address Māori women's tino rangatiratanga. To some degree this could be attributed to the dominance of the bio-medical and epidemiological.

At a systems level the 1996 National Cervical Screening Programmes Policy goal demonstrated the underlying bio-medical and epidemiological values reflected contextually are also evidenced at the policy goal level, again these values are shown to create barriers to access for Māori and women.

Policies determine who get what when and how and are influenced by the values and beliefs of the policy makers (Fischer, 1995; Lasswell, 1936; Shore & Wright, 1997). At an ideological level it became clearer that the dominance of the bio-medical and epidemiological discourses in the 1996 National Cervical Screening Programme Policy document resulted in decision being made that not only alienated Māori but also women (Munro, 1990). The decision to establish a national register reflected the dominance of the epidemiological discourse. The decision to base these registers within bio-medical settings to the exclusion of Māori and women centred services reflected the dominance and collusion of the epidemiological and bio-medical discourses. The decision to allocate 93% of the total cervical screening budget to the establishment of the registers, while ignoring the development of Māori and women centred services, was in my opinion, a major oversight by the decision makers especially as one of the outcomes has been major disparities between Māori and other ethnicities and that Māori women are four times more likely to die from cervical cancer than other ethnicities. Such disparities are not only costly to Māori in terms of cultural capital but also to society as a whole in terms of the cost of hospitalising and treating people with cancer.

Existing, counter hegemonically to the bio-medical and epidemiological discourse is tino rangatiratanga. Kaitiaki within the current study argue tino rangatiratanga in practise is about iwi-owned and operated services in which tikanga Māori is the norm. While the 1996 National Cervical Screening Programme's Policy document calls for a focus on purchasing by Māori for Māori services and supports the use Māori health models, in practise this was not fully actualised. In 2000 only two Māori providers were contracted to provide cervical screening services. The employment of Māori to manage cervical screening services within Pākehā settings has been helpful but again limited to the support these people were given. The utilisation of Māori

healing models were utilised within Māori health settings but limited to te whare tapa wha in the policy document. The 1996 policy document also indicated support for Māori to support themselves. Again this did not happen. It is no wonder then that Māori health providers also view tino rangatiratanga as being about struggle and reclamation.

Clearly there are limitations to the implementation of the 1996 National Cervical Screening Programme Policy document in addressing Māori tino rangatiratanga. To a large degree these limitations are the result of the dominance of the bio-medical and epidemiological discourse and the marginalisation of tino rangatiratanga.

However, the National Cervical Screening Programme endeavours to meet its kawanatanga responsibilities through the National Kaitiaki Group (outside of the programme) and the establishment of Kaihautu Māori and Kaimahi Māori. Further, while at times it is difficult for the National Cervical Screening Programme to consult with Māori they do know that they must consult widely and have several mechanisms in place to ensure that the voice of iwi and Māori are heard.

In an endeavour to address Māori women's tino rangatiratanga the policy makers need to be Māori and Māori allies, the people who make resource allocation decisions need to be Māori and Māori allies, the people who deliver the services need to be well informed and trained Māori and Pākehā allies, the systems used to monitor performance need to be based on tikanga Māori.

Finally, it is up to each individual woman to decide whether or not she wants to have a cervical smear. In some cases the psychic trauma is too much, and in other cases some women find that cervical screening is just another form of colonisation and prefer not to comply. If all the barriers to cervical screening have been addressed and Māori women still do not want a smear, then that is tino rangatiratanga in practise.

Limitations

Limitations to the current study included minimal participation by the Ministry of Health, exclusion of the Gisborne cervical screening review and supervision.

Accessing participants at a Ministerial level was problematic. While all policy makers within the cervical screening unit were approached only one was free to participate, the manager of the unit. To some degree this was understandable as the programme was experiencing another serious review following the deaths of women in Tairāwhiti. Given this I was unable to conduct a discourse analysis of findings at this level. However, the information provided by the manager was thought provoking.

In 2001 a major investigation into cervical screening services was conducted in Gisborne. As I had a minor role in this I decided not to include the investigation as part of the current study. However the review of the Gisborne services caused major changes to the health sector and to the delivery of cervical screening services.

Finally while academic supervision is readily available within academia, cultural supervision is not. Initially I sought cultural supervision from outside the University and paid for this myself. Once I received a Health Research Council Scholarship, I was able to use the tikanga allocation to pay my supervisor. In those cases where academia is unable to provide the supervision required funding allocation must be made available to students to get and pay for outside cultural supervision.

Questions/avenues for future research

The definition of tino rangatiratanga was limited to the health sector. While working on the thesis it became apparent that tino rangatiratanga was contextual and may have different meanings and practises for different iwi. Future research could focus on defining tino rangatiratanga from an iwi perspective and an inter iwi perspective. Coming to a common understanding, from an iwi perspective, of what tino rangatiratanga means and what that looks like in practise, as some iwi have already

done, could enable them to move forward into the 21st century from a position of strength. Such research could also provide planning information for all services rather than in this case, just health. Looking at tino rangatiratanga across iwi might provide avenues for developing a sustainable national body politic that provides policy direction for Māori .

The Kaupapa Māori analytical tool was a useful tool for analysing a current health policy and its responsiveness to Māori by defining tino rangatiratanga and then analysing the policy to see if it responded to what tino rangatiratanga was. Utilising the tool to analyse other health policies has the potential to show whether current health policies are addressing Māori health and if not where and why this is happening. Such information could then provide possible solutions. The implementation of the solutions might then contribute to improving Māori health status.

A lot of women have difficulty having cervical smears and reasons given for this include embarrassment, shame, shyness, sacredness of the area, practitioner bias and lack of transport. In some countries, self administered tests are being utilised and found to increase cervical screening. Research into the utilisation of self administered tests in Aotearoa may be useful with the potential of increasing cervical screening and reducing cervical cancer in Māori women.

The literature argues that older women who are traditional in their behaviours are less likely to have a smear. A traditional behaviour scale was initially developed to measure this. However, the numbers in the current study were too small to test for significance and hence the traditional behaviour data was excluded from my research. Another study that focuses mainly on this question might be useful in (a) identifying whether it is true that more “traditional” women avoid having a smear, (b) determining why this is, and (c) developing strategies to address these barriers.

Finally, a finding in the current study was the link between cervical smear taking, violence and practitioner bias. Women told stories of horrific cervical screening experiences. These stories had common story lines – historical violence and

practitioner bias. The link between these two variables are worth further exploration especially as in one case a woman nearly had her womb removed and in other cases women chose not to have a smear again for over 10 years.

Concluding comments

The 1996 National Cervical Screening Programmes Policy document addressed Māori women's tino rangatiratanga in a limited way. The kaupapa Māori analysis demonstrated this was strongly influenced by the dominance of bio-medical and epidemiological discourses and the attitudes of practitioners within these settings.

A kaupapa Māori methodology and the development of a Kaupapa Māori analysing framework legitimated tino rangatiratanga for Māori women. It meant that the barriers to access identified were those told by Māori women; it meant the solutions were also identified by Māori women; and therefore there is a high likelihood health gains may occur if the findings and recommendations of the research can inform health policy development.

The findings from the current research show that Māori women's experiences of cervical screening services are often troubled. Women in the current study told stories of severe discrimination based on marital, employment status, sexual orientation and race. These experiences were compounded when women had a history of violence such as childhood molestation, rape and attempted murder.

However, Māori women come from diverse backgrounds and the ability of the 1996 National Cervical Screening Programme's Policy document to provide a range of choices was helpful for those women who chose to use them. However it was not just about any mainstream service. It was necessary for the practitioner to have had a long history with the woman and it had to be someone whom the woman trusted.

Addressing Māori women's tino rangatiratanga status within health is about improving their health outcomes. It is not enough to recognise the broader determinants of health. Policy makers and health practitioners must develop strategies

and action plans that outline and measure how they will address the determinants of health.

If we do not include tino rangatiratanga in all its complexities in all public policies it is likely that the discrepancies that have been shown to exist will continue to exist. These discrepancies will be costly to Māori and society as a whole, not only fiscally but also in cultural capital.

Māori have been working with the Crown to develop policies and implement services since the signing of Te Tiriti yet disparities still exist and Māori are still dying more often than other ethnicities.

My study demonstrates that these deaths are influenced by the dominance of Crown sovereignty or the limited implementation of kawanatanga, discrimination at practitioner level and personal and cultural barriers. Further, policy development and implementation are strongly influenced by Western values, in the case of my study these bio-medical and epidemiological discourses.

Resistance and demonstration is not an acceptable way to get Māori policies on the political agenda. If tino rangatiratanga is to be fully implemented within policy then a different policy framework is required. It might be a national Māori body politic made of representative from each iwi or waka influencing Crown policies at a national level. It might be a local iwi body politic that makes decisions at a local level through hui a iwi or some such mechanism that then feeds into a national Māori body politic. It might be a parallel development model at a national level with the Crown and Māori begin equal partners. Which ever mechanism is used Māori must influence policy development and resource allocation or we will continue to die

Overall I believe that if policies are to benefit Māori then Māori need to move away from dependency on the state, they need to make their own policies to address their own policy issues. Tikanga Māori needs to be reflected in the development, implementation and monitoring of policies. Further Māori must find ways of becoming financially independent through Tiriti claims, wise investments, business development, and intergenerational exchange of information. Strategic alliances are

important both nationally and internationally. A mechanism through which these strategies might be achieved is a Nation within a Nation mechanism where Māori make decisions for Māori and the Crown making decisions for Pākehā.

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APPENDICES

Appendix 1

He Wakaputanga o te Rangatiratanga o Nu Tirene

HE WAKAPUTANGA O TE RANGATIRATANGA O NU TIRENE.

1. KO MATOU, ko nga tino Rangatira o nga iwi o NU TIRENE i raro mai o Haurake, kua oti nei te huihui i Waitangi, i Tokirau, i te ra 28 o Oketopa, 1835. Ka wakatapu i te Rangatiratanga o to matou wenua; a ka meatia ka wakatapuina e matou he Wenua Rangatira, kia huaina, "KO TE WAKAMINENGA O NGA HAPU O NU TIRENE."

2. Ko te Kingitanga, ko te mana i te wenua o te wakaminenga o Nu Tirene, ka meatia nei kei nga tino Rangatira anake i to matou huihuinga; a ka mea hoki, e kore e tukua e matou te wakarite ture ki te tahi hunga ke atu, me te tahi Kawanatanga hoki kia meatia i te wenua o te wakaminenga o Nu Tirene, ko nga tangata anake e meatia nei e matou, e wakarite ana ki te ritenga o o matou ture e meatia nei e matou i to matou huihuinga.

3. Ko matou, ko nga tino Rangatira, ka mea nei, kia huihui ki te runanga ki Waitangi a te Ngauru i tenei tau i tenei tau, ki te wakarite ture, kia tika ai te wakawakanga, kia mau pu te rongu, kia mutu te he, kia tika te hokohoko. A ka mea hoki ki nga tau iwi o runga, kia wakarerea te wawai, kia mahara ai ki te wakaoranga o to matou wenua, a kia uru ratou ki te wakaminenga o Nu Tirene.

4. Ka mea matou, kia tuhituhia he pukapuka, ki te ritenga o tenei o to matou wakatupanga nei, ki te Kingi o Ingarani, hei kawe atu i to matou aroha; nana hoki i wakaac ki te Kara mo matou. A no te mea ka atawai matou, ka tiaki i nga Pakeha e noho nei i uta, e rere mai ana ki te hokohoko, koia ka mea ai matou ki te Kingi kia waiho hei Matua ki a matou i to matou tamarikitanga, kei wakakahoretia to matou Rangatiratanga.

Kua wakaaetia katoatia e matou i tenei ra i te 28 o Oketopa 1835, ki te aroaro o te Rehirenete o te Kingi o Ingarani.

KO PAERATA, no te Patu Koraha.
KO URURUA, no te Taha Wai.
KO HARE HONGI.
KO HEMI KEPA TUPE, no te Uripotete.
KO WAREFOAKA, no te Hikutu.
KO TITORE, no nga te Ngenene.
KO MOKA, no te Patu Heke.
KO WARERAHI.
KO REWA.
KO WAI, no Ngaitewake.
KO REWETI ATUA HAERE, no nga te Tau Tahi.
KO AWA.
KO WIREMU IETI TAUNUI, no te Wiu.
KO TENANA, no nga te Kuta.
KO PI, no te Mahurehure.
KO KAUA, no te Herepuka.

KO TAREHA, no nga te Rehia.
KO KAWITI, no nga te Hine.
KO PUMUKA, no te Rorea.
KO KEKEAO, no nga te Matakere.
KO TE KAMARA, no nga te Kawa.
KO POMARE, no te Wanau Pane.
KO WIWIA, no te Kapo Tahi.
KO TE TAO, no te Kai Mata.
KO MARUPU, no te Waduu Rongu.
KO KOPIRI, no te Uritanewa.
KO WARAU, no nga te Tokawero.
KO NGRRE, no te Urikapana.
KO MONTARA, no nga te Korokoro.
KO HIAMOE, no te Uru o Ngongo.
KO PUKUTUTU, no te Uri o te Hawato.

Ko ERUERA PARE, te Kai Tuhituhi.

Ko matou, ko nga Rangatira, ahakoa kihai i tae ki te huihuinga nei, i te nuinga o te Waipuke, i te aha ranei, ka wakase katoa ki te wakatupanga Rangatiratanga o Nu Tirene, a ka uru ki roto ki te wakaminenga.

KO NENE.
KO HUUU.
KO TONA.

KO PANAKAREAO.
KO KIWIKIWI.
KO TE TIRARAU.

He mea ta i te Perchi o nga Mihanere o te Hahi o Ingarani, i Paikia.

A Declaration of the Independence of New Zealand

1. We, the hereditary chiefs and heads of the tribes of the Northern parts of New Zealand, being assembled at Waitangi, in the Bay of Islands, on this 28th day of October, 1835, declare the Independence of our country, which is hereby constituted and declared to be an Independent State, under the designation of The United Tribes of New Zealand.

2. All sovereign power and authority within the territories of the United Tribes of New Zealand is hereby declared to reside entirely and exclusively in the hereditary chiefs and heads of tribes in their collective capacity, who also declare that they will not permit any legislative authority separate from themselves in their collective capacity to exist, nor any function of government to be exercised within the said territories, unless by persons appointed by them, and acting under the authority of laws regularly enacted by them in Congress assembled.

3. The hereditary chiefs and heads of tribes agree to meet in Congress at Waitangi in the autumn of each year, for the purpose of framing laws for the dispensation of justice, the preservation of peace and good order, and the regulation of trade; and they cordially invite the Southern tribes to lay aside their private animosities and to consult the safety and welfare of our common country, by joining the Confederation of the United Tribes.

4. They also agree to send a copy of this Declaration to His Majesty the King of England, to thank him for his acknowledgement of their flag; and in return for the friendship and protection they have shown, and are prepared to show, to such of his subjects as have settled in their country, or resorted to its shores for the purposes of trade, they entreat that he will continue to be the parent of their infant State, and that he will become its Protector from all attempts upon its independence.

Agreed to unanimously on this 28th day of October, 1835, in the presence of His Britannic Majesty's Resident.

[Here follows the signatures or marks of thirty-five Hereditary chiefs or Heads of tribes, which form a fair representation of the tribes of New Zealand from the North Cape to the latitude of the River Thames.]

English witnesses

(Signed) Henry Williams, Missionary, C.M.S.

George Clarke, C.M.S.

James C. Clendon, Merchant.

Gilbert Mair, Merchant.

I certify that the above is a correct copy of the Declaration of the Chiefs, according to the translation of Missionaries who have resided ten years and upwards in the country; and it is transmitted to His Most Gracious Majesty the King of England, at the unanimous request of the chiefs.

(Signed) JAMES BUSBY,

British Resident at New Zealand.

Appendix 2

Versions of the Te Tiriti o Waitangi

THE ENGLISH AND MĀORI VERSIONS OF TE TIRITI
An analysis by Professor I H Kawharu

THE ENGLISH VERSION

(The English text of the Treaty)

Her Majesty Victoria Queen of the United Kingdom of Great Britain and Ireland regarding with Her Royal Favour the Native Chiefs and Tribes of New Zealand and anxious to protect their just Rights and Property and to secure to them the enjoyment of Peace and Good Order has deemed it necessary in consequence of the great number of Her Majesty's Subjects who have already settled in New Zealand and the rapid extension of Emigration both from Europe and Australia which is still in progress to constitute and appoint a functionary properly authorized to treat with the Aborigines of New Zealand for the recognition of Her Majesty's Sovereign authority over the whole or any part of those islands.

Her Majesty therefore being desirous to establish a settled form of Civil Government with a view to avert the evil consequences which must result from the absence of the necessary Laws and Institutions alike to the native population and to Her subjects has been graciously pleased to empower and to authorize "me William Hobson a Captain" in Her Majesty's Royal Navy Consul and Lieutenant Governor of such parts of New Zealand as may be or hereafter shall be ceded to Her Majesty to invite the confederated and independent Chiefs of New Zealand to concur in the following Articles and Conditions.

ARTICLE THE FIRST

The Chiefs of the Confederation of the United Tribes of New Zealand and the separate and independent Chiefs who have not become members of the Confederation cede to Her Majesty the Queen of England absolutely and without reservation all the rights and powers of Sovereignty which the said Confederation or Individual Chiefs respectively exercise or possess, or may be supposed to exercise or to possess, over their respective Territories as the sole Sovereigns thereof.

ARTICLE THE SECOND

Her Majesty the Queen of England confirms and guarantees to the Chiefs and Tribes of New Zealand and to the respective families and individuals thereof the full exclusive and undisturbed possession of their Lands and Estates Forests Fisheries and other properties which they may collectively or individually possess so long as it is their wish and desire to retain the same in their possession; but the Chiefs of the United Tribes and the individual Chiefs yield to Her Majesty the exclusive right of Pre-emption over such lands as the proprietors thereof may be disposed to alienate at such prices as may be agreed upon between the respective Proprietors and persons appointed by Her Majesty to treat with them in that behalf.

ARTICLE THE THIRD

In consideration thereof Her Majesty the Queen of England extends to the Natives of New Zealand Her royal protection and imparts to them all the Rights and Privileges of British Subjects.

[Signed] W Hobson Lieutenant Governor

Now therefore We the Chiefs of the Confederation of the United Tribes of New Zealand being assembled in Congress at Victoria in Waitangi and We the Separate and Independent Chiefs of New Zealand claiming authority over the Tribes and Territories which are specified after our respective names, having been made fully to understand the Provisions of the foregoing Treaty, accept and enter into the same in the full spirit and meaning thereof in witness of which we have attached our signatures or marks at the places and the dates respectively specified
Done at Waitangi this Sixth day of February in the year of Our Lord one thousand eight hundred and forty.

TIRITI O WAITANGI 1840

(The Māori text of the Treaty)

Ko Wikitoria te Kuini o Ingarani i tana mahara atawai ki nga Rangatira me nga Hapū o Nu Tirani i tana hiahia hoki kia tohungia ki a rātou o rātou rangatiratanga me to rātou wenua, a kia mau tonu hoki te Rongo ki a rātou me te Atanoho hoki kua wakaaro ia he mea tika kia tukua mai tetahi Rangatira—hei kai wakarite ki nga Tangata Māori; o Nu Tirani—kia wakaetia e nga Rangatira Māori; te Kāwanatanga o te Kuini ki nga wahikatoa o te Wenua nei me nga Motu—na te mea hoki he tokomaha ke nga tangata o tona Iwi Kua noho ki tēnei wenua, a e haere mai nei. Na ko te Kuini e hiahia ana kia wakaritea te Kāwanatanga kia kaua ai nga kino e puta mai ki te tangata Māori ki te Pākehā e noho ture kore ana. Na, kua pai te Kuini kia tukua a hau a Wiremu Hopihona he Kapitana i te Roiara Nawi hei Kawana mo nga wahi katoa o Nu Tirani e tukua aianeī, amoa atu ki te Kuini, e mea atu ana ia ki nga Rangatira o te wakaminenga o nga hapū o Nu Tirani me era Rangatira atu enei ture ka korerotia nei.

KO TE TUATAHI

Ko nga Rangatira o te wakaminenga me nga Rangatira katoa hoki ki hai i uru ki taua wakaminenga ka tuku rawa atu ki te Kuini o Ingarani ake tonu atu—te Kāwanatanga katoa o rātou wenua.

KO TE TUARUA

Ko te Kuini o Ingarani ka wakarite ka wakaae ki nga Rangatira ki nga hapū—ki nga tangata katoa o Nu Tirani te tino rangatiratanga o rātou wenua o rātou kainga me o rātou taonga katoa. Otiia ko nga Rangatira o te wakaminenga me nga Rangatira katoa atu ka tuku ki te Kuini te hokonga o era wahi wenua e pai ai te tangata nona te Wenua—ki te ritenga o te utu e wakaritea ai e rātou ko te kai hoko e meatia nei e te Kuini hei kai hoko mona.

KO TE TUATORU

Hei wakaritenga mai hoki tēnei mo te wakaaetanga ki te Kāwanatanga o te Kuini—
Ka tiakina e te Kuini o Ingarani nga tangata Māori; katoa o Nu Tirani ka tukua ki a
rātou nga tikanga katoa rite tahi ki ana mea ki nga tangata o Ingarani.

[signed] William Hobson Consul & Lieutenant Governor

Na ko matou ko nga Rangatira o te Wakaminenga o nga hapū o Nu Tirani ka huihui
nei ki Waitangi ko matou hoki ko nga Rangatira o Nu Tirani ka kite nei i te ritenga o
enei kupu, ka tangohia ka wakaaetia katoatia e matou, koia ka tohungia ai o matou
ingoa o matou tohu.

Ka meatia tēnei ki Waitangi i te ono o nga ra o Pepueri i te tau kotahi mano, e waru
rau e wa te kau o to tatou Ariki.

TREATY OF WAITANGI 1840

[Translation of the Māori text of the Treaty, by Prof. Sir Hugh Kawharu, used with
permission]

Victoria, the Queen of England, in her concern to protect the chiefs and the sub-tribes
of New Zealand and in her desire to preserve their chieftainship (1) and their lands to
them and to maintain peace (2) and good order considers it just to appoint an
administrator (3) one who will negotiate with the people of New Zealand to the end
that their chiefs will agree to the Queen's Government being established over all parts
of this land and (adjoining) islands (4) and also because there are many of her
subjects already living on this land and others yet to come. So the Queen desires to
establish a government so that no evil will come to Māori and European living in a
state of lawlessness. So the Queen has appointed "me, William Hobson a Captain" in
the Royal Navy to be Governor for all parts of New Zealand (both those) shortly to be
received by the Queen and (those) to be received hereafter and presents (5) to the
chiefs of the Confederation chiefs of the sub-tribes of New Zealand and other chiefs
these laws set out here.

THE FIRST

The Chiefs of the Confederation and all the Chiefs who have not joined that
Confederation give absolutely to the Queen of England for ever the complete
government (6) over their land.

THE SECOND

The Queen of England agrees to protect the chiefs, the sub-tribes and all the people of
New Zealand in the unqualified exercise (7) of their chieftainship over their lands,
villages and all their treasures (8). But on the other hand the Chiefs of the
Confederation and all the Chiefs will sell (9) land to the Queen at a price agreed to by
the person owning it and by the person buying it (the latter being) appointed by the
Queen as her purchase agent.

THE THIRD

For this agreed arrangement therefore concerning the Government of the Queen, the
Queen of England will protect all the ordinary people of New Zealand and will give
them the same rights and duties (10) of citizenship as the people of England (11).

[signed] William Hobson Consul & Lieut. Governor

So we, the Chiefs of the Confederation of the sub-tribes of New Zealand meeting here at Waitangi having seen the shape of these words which we accept and agree to record our names and our marks thus.

Was done at Waitangi on the sixth of February in the year of our Lord 1840.

Footnotes

(1) "Chieftainship": this concept has to be understood in the context of Māori social and political organization as at 1840. The accepted approximation today is "trusteeship".

(2) "Peace": Māori "Rongo", seemingly a missionary usage (rongo - to hear i.e. hear the "Word" - the "message" of peace and goodwill, etc).

(3) Literally "Chief" ("Rangatira") here is of course ambiguous. Clearly a European could not be a Māori, but the word could well have implied a trustee-like role rather than that of a mere "functionary". Māori speeches at Waitangi in 1840 refer to Hobson being or becoming a "father" for the Māori people. Certainly this attitude has been held towards the person of the Crown down to the present day - hence the continued expectations and commitments entailed in the Treaty.

(4) "Islands" i.e. coastal, not of the Pacific.

(5) Literally "making" i.e. "offering" or "saying" - but not "inviting to concur".

(6) "Government": "kāwanatanga". There could be no possibility of the Māori signatories having any understanding of government in the sense of "sovereignty" i.e. any understanding on the basis of experience or cultural precedent.

(7) "Unqualified exercise" of the chieftainship - would emphasise to a chief the Queen's intention to give them complete control according to their customs. "Tino" has the connotation of "quintessential".

(8) "Treasures": "taonga". As submissions to the Waitangi Tribunal concerning the Māori language have made clear, "taonga" refers to all dimensions of a tribal group's estate, material and non-material heirlooms and wahi tapu (sacred places), ancestral lore and whakapapa (genealogies), etc.

(9) Māori "hokonga", literally "sale and purchase". Hoko means to buy or sell.

(10) "Rights and duties": Māori " at Waitangi in 1840 refer to Hobson being or becoming a "father" for the Māori people. Certainly this attitude has been held towards the person of the Crown down to the present day - hence the continued expectations and commitments entailed in the Treaty.

(11) There is, however, a more profound problem about "tikanga". There is a real sense here of the Queen "protecting" (i.e. allowing the preservation of) the Māori people's tikanga (i.e. customs) since no Māori could have had any understanding whatever of British tikanga (i.e. rights and duties of British subjects.) This, then, reinforces the guarantees in Article 2.

Appendix 3

The New Zealand Public Health and Disability Act 2000

THE NEW ZEALAND PUBLIC HEALTH AND DISABILITY ACT 2000

Commenced: 1 January 2001

1 Title

This Act is the New Zealand Public Health and Disability Act 2000.

Part 1

Preliminary provisions

2 Commencement

(1) Sections 8, 106, and 114 come into force on the day after the date on which this Act receives the Royal assent.

(2) The rest of this Act comes into force on 1 January 2001

3 Purpose

(1) The purpose of this Act is to provide for the public funding and provision of personal health services, public health services, and disability support services, and to establish new publicly-owned health and disability organisations, in order to pursue the following objectives:

- (a) to achieve for New Zealanders---
 - (i) the improvement, promotion, and protection of their health:
 - (ii) the promotion of the inclusion and participation in society and independence of people with disabilities:
 - (iii) the best care or support for those in need of services:
- (b) to reduce health disparities by improving the health outcomes of Māori and other population groups:
- (c) to provide a community voice in matters relating to personal health services, public health services, and disability support services---
 - (i) by providing for elected board members of DHBs:
 - (ii) by providing for board meetings and certain committee meetings to be open to the public:
 - (iii) by providing for consultation on strategic planning:
- (d) to facilitate access to, and the dissemination of information to deliver, appropriate, effective, and timely health services, public health services and programmes, both for the protection and the promotion of public health, and disability support services.

(2) The objectives stated in subsection (1) are to be pursued to the extent that they are reasonably achievable within the funding provided.

(3) To avoid any doubt, nothing in this Act---

- (a) entitles a person to preferential access to services on the basis of race; or
- (b) limits section 73 of the Human Rights Act 1993 (which relates to measures to ensure equality).

(4) In giving effect to the purposes set out in subsection (1), the Crown and DHBs must endeavour to promote the integration of all health services, especially primary and secondary services.

(5) In giving effect to the purposes set out in subsection (1), the Crown and DHBs must endeavour to provide for health services to be organised at either a local, regional, or national level depending on the optimum arrangement for the most effective delivery of properly co-ordinated health services.

4 Treaty of Waitangi

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

5 Outline

(1) In general terms, this Act relates to, and reorganises, the public health and disability sector.

(2) Ministerial responsibilities (Part 2) include---

- (a) determining health and disability strategies (section 8):
- (b) negotiating and entering into agreements under which the Crown provides a person money in return for the person providing or arranging for the provision of health services or disability support services (section 10):
- (c) establishing and appointing committees (section 11), including---
 - (i) a national advisory committee on health and disability (section 13):
 - (ii) a health workforce advisory committee (section 15):
 - (iii) a national advisory committee on health and disability support services ethics (section 16):
 - (iv) mortality review committees (section 18 and Schedule 5).

(3) District Health Boards (DHBs) are established (Part 3 and Schedules 1 to 3), and take over functions like those of Hospital and Health Services (HHSs), which are dissolved (Part 7). DHBs---

- (a) have boards that include members elected by the community and

representation of Maori:

- (b) will provide, or fund the provision of, health services and disability support services:
- (c) have the objective of reducing health disparities by improving health outcomes for Māori and other New Zealanders:

- (d) are statutory corporations rather than companies:
- (e) are accountable in a number of ways (sections 37 to 43), for example, through annual plans agreed with the Minister of Health, and statements of intent.

(4) The board of each DHB must have 3 permanent advisory committees (the community and public health advisory committee, disability support advisory committee, and hospital advisory committee (sections 34 to 36 and Schedule 4)), but may also establish other committees (Schedule 3---clause 38(1)).

(5) A statutory corporation called the Pharmaceutical Management Agency (Pharmac) is established (Part 4---sections 46 to 53, and sections 61 to 69, and Schedule 6), and takes over functions relating to the pharmaceutical schedule from the company called Pharmaceutical Management Agency Limited, which is dissolved (Part 7).

(6) A statutory corporation called the New Zealand Blood Service (NZBS) is established (Part 4---sections 54 to 56, and sections 61 to 69, and Schedule 6), and takes over functions relating to blood and controlled human substances from the company called New Zealand Blood Service Limited, which is dissolved (Part 7).

(7) A statutory corporation called the Residual Health Management Unit (RHMU) is continued (Part 4---sections 57 to 59, and sections 61 to 69, and Schedule 6), and continues to have functions (including the management of certain public health and disability sector assets and liabilities) given to it under any enactment or by the Minister of Health.

(8) Inquiry boards may be appointed by the Minister of Health to conduct an inquiry into, and report to the Minister on, matters like the funding or provision of health services or disability support services, or the management of any publicly-owned health and disability organisation (Part 5---sections 72 to 86).

(9) The Health Funding Authority (HFA) is dissolved, and its functions, employees, and assets and liabilities transferred to the Crown, acting through the Ministry of Health (Part 7). However, funding of the provision of health services or disability support services may be further devolved under this Act.

(10) Subsections (1) to (9) are only a guide to the general scheme and effect of this Act.

6 Interpretation

(1) In this Act, unless the context otherwise requires,---

annual plan means an annual plan of a publicly-owned health and disability organisation under section 39 or section 64

board, in relation to a publicly-owned health and disability organisation, means the members of the board of the organisation acting together as a board

board committee, in relation to the board of a DHB, means the community and public health advisory committee, disability support advisory committee, or hospital advisory committee, and any other committee of the board appointed under clause 38(1) of Schedule 3

board member, in relation to a publicly-owned health and disability organisation, means a member of the board of that organization community and public health advisory committee

conflict of interest, in relation to a person and a publicly-owned health and disability organisation, includes---

- (a) the person's interest in a transaction (within the meaning of subsection (2)) of the publicly-owned health and disability organisation; and
- (b) the person's interest that would, if the person were a member of the board of the publicly-owned health and disability organisation or a member of a committee of that board or a delegate of that board, be an interest in a transaction (within the meaning of subsection (2)) of the publicly-owned health and disability organisation; and
- (c) to avoid any doubt, the employment or engagement of the person, or of the person's spouse, as an employee or contractor of the publicly-owned health and disability organisation

Crown means Her Majesty the Queen in right of New Zealand

Crown funding agreement has the meaning given to it by section 10

DHB means an organisation established as a DHB by or under section 19

Director-General means the chief executive or acting chief executive under the State Sector Act 1988 of the Ministry of Health

disability support advisory committee means a committee established under section 35

disability support services includes goods, services, and facilities---

- (a) provided to people with disabilities for their care or support or to promote their inclusion and participation in society, and independence; or
- (b) provided for purposes related or incidental to the care or support of people with disabilities or to the promotion of the inclusion and participation in society, and independence of such people

district strategic plan means a plan of a DHB determined under section 38 covering a period of at least 5, and not more than 10, years

eligible people means people who are eligible to receive services funded under this Act, as specified by the Minister in a direction issued under section 32

good employer means an employer who operates a personnel policy containing provisions

generally accepted as necessary for the fair and proper treatment of employees in all aspects of their employment, including provisions requiring---

- (a) good and safe working conditions; and
- (b) an equal employment opportunities programme; and
- (c) the impartial selection of suitably qualified persons for appointment; and
- (d) opportunities for the enhancement of the abilities of individual employees; and
- (e) recognition of---
 - (i) the aims and aspirations of Maori; and
 - (ii) the employment requirements of Maori; and
 - (iii) the need for greater involvement of Māori as employees of the employer; and
- (f) recognition of the aims and aspirations, and the cultural differences, of ethnic or minority groups; and
- (g) recognition of the employment requirements of women; and
- (h) recognition of the employment requirements of persons with disabilities

health services means personal health services and public health services

hospital advisory committee means a committee established under section 36

inquiry board has the meaning specified in section 72(1)

Maori, in sections 29(4), 34, 35, and 36, and clause 38(2) of Schedule 3, means a person of the Māori race of New Zealand, and includes any descendant of such a person

Minister means the Minister of Health

Ministry of Health means the department of the Public Service referred to by that name

monitor, in relation to a Crown funding agreement and in relation to the functions specified in section 23(1)(i) and in section 25,---

- (a) means to analyse on the basis of information provided under any relevant agreement and any other relevant substantiated information; and
- (b) includes assessing the timeliness of provision of information required to be provided under any agreement

NZBS means the New Zealand Blood Service established by section 54

New Zealand disability strategy means a strategy referred to in section 8(2)

New Zealand health strategy means a strategy referred to in section 8(1)

personal health means the health of an individual

personal health services means goods, services, and facilities provided to an individual for the purpose of improving or protecting the health of that individual, whether or not they are also provided for another purpose; and includes goods, services, and facilities provided for related or incidental purposes

Pharmac means the Pharmaceutical Management Agency established by section 46

pharmaceutical means a medicine, therapeutic medical device, or related product or related thing

pharmaceutical schedule means the list of pharmaceuticals for the time being in force that states, in respect of each pharmaceutical, the subsidy that the Crown intends to provide for the supply of that pharmaceutical to a person who is eligible for the subsidy

provider means a person who provides, or arranges the provision of, services

public health means the health of all of---

- (a) the people of New Zealand; or
- (b) a community or section of such people

publicly-owned health and disability organisation means a DHB, Pharmac, NZBS, and RHMU

public health services means goods, services, and facilities provided for the purpose of improving, promoting, or protecting public health or preventing population-wide disease, disability, or injury; and includes---

- (a) regulatory functions relating to health or disability matters; and
- (b) health protection and health promotion services; and
- (c) goods, services, and facilities provided for related or incidental functions or purposes

publicly available, in relation to a document, means that the document is promptly provided on request by any person on payment of a charge, if any, that is reasonable

resident population, in relation to a DHB, means the eligible people residing in the geographical area of the DHB (as specified in Schedule 1)

RHMU means the Residual Health Management Unit continued by section 57

service agreement has the meaning given to it by section 25

services means health services and disability support services

sitting day means a sitting day of the House of Representatives

spouse includes a de facto partner of either sex

statement of intent means a statement of intent prepared in accordance with the Public Finance Act 1989 and section 42 or section 67

subsidiary has the same meaning as in sections 5 to 8 of the Companies Act 1993; and, in relation to a publicly-owned health and disability organisation, includes a Crown entity, within the meaning of the Public Finance Act 1989, in which the publicly-owned health and disability organisation holds an interest

transaction, in relation to a publicly-owned health and disability organisation, means--

- (a) the exercise or performance of a function, duty, or power of the publicly-owned health and disability organisation; or
- (b) an arrangement, agreement, or contract to which the publicly-owned health and disability organisation is a party; or
- (c) a proposal that the publicly-owned health and disability organisation enter into an arrangement, agreement, or contract.

(2) For the purposes of this Act, a person who is a member of a board of a publicly-owned health and disability organisation or a member of a committee of such a board or a delegate of such a board is interested in a transaction of the

publicly-owned health and disability organisation if, and only if, the board member or the member of the committee or the delegate---

- (a) is a party to, or will derive a material financial benefit from, the transaction; or
- (b) has a material financial interest in another party to the transaction; or
- (c) is a director, member, officer, or trustee of another party to, or person who will or may derive a material financial benefit from, the transaction, not being a party or person that is---
 - (i) the Crown; or
 - (ii) a publicly-owned health and disability organisation; or
 - (iii) a body corporate that is wholly owned by 1 or more publicly-owned health and disability organisations; or
- (d) is the parent, child, or spouse of another party to, or person who will or may derive a material financial benefit from, the transaction; or
- (e) is otherwise directly or indirectly materially interested in the transaction.

7 Act to bind the Crown

This Act binds the Crown.

PART 2

Responsibilities of Minister

8 Health and disability strategies

- (1) The Minister must determine a strategy for health services, called the New Zealand health strategy, to provide the framework for the Government's overall direction of the health sector in improving the health of people and communities; and the Minister may amend or replace that strategy at any time.
- (2) The Minister of the Crown who is responsible for disability issues must determine a strategy for disability support services, called the New Zealand disability strategy, to provide the framework for the Government's overall direction of the disability sector in improving disability support services; and may amend or replace that strategy at any time.
- (3) Before determining the New Zealand health strategy or the New Zealand disability strategy, or amending or replacing either of them, the relevant Minister must consult any organisations and individuals that the Minister considers appropriate.
- (4) The relevant Minister must in each year report on progress in implementing the New Zealand health strategy or the New Zealand disability strategy, as the case may require.

(5) The relevant Minister must make publicly available, and present to the House of Representatives, a copy of any strategy, amendment, replacement, or report as soon as practicable after the strategy, amendment, replacement, or report has been determined or made under this section.

9 Strategies for standards and quality assurance programmes

(1) The Minister must, as soon as reasonably practicable after the commencement of this section, determine a strategy for the development and use of---

- (a) nationally consistent standards and quality assurance programmes for health services and consumer safety; and
- (b) nationally consistent performance monitoring of health services and consumer safety against those standards and programmes.

(2) Before determining the strategy, or amending or replacing it, the Minister must consult any organisations that the Minister considers appropriate.

(3) The Minister must in each year report on progress in implementing the strategy.

(4) The Minister must make publicly available, and present to the House of Representatives, a copy of any strategy, amendment, replacement, or report as soon as practicable after the strategy, amendment, replacement, or report has been determined or made.

10 Crown funding agreements

(1) In this Act, Crown funding agreement means an agreement that the Crown enters into with any person, under which the Crown agrees to provide money in return for the person providing, or arranging for the provision of, services specified in the agreement.

(2) The Minister may, on behalf of the Crown,---

- (a) negotiate and enter into a Crown funding agreement containing any terms and conditions that may be agreed; and
- (b) negotiate and enter into an agreement that amends a Crown funding agreement; and
- (c) monitor performance under a Crown funding agreement.

(3) Except to the extent that the Minister determines by written notice to the Ministry of Health, the Ministry of Health may exercise the Minister's powers under subsection (2) on the Minister's behalf.

(4) Nothing in this section limits section 39 or section 64 or any other enactment, or any powers that the Minister or the Crown has under any enactment or rule of law.

(5) As soon as practicable after giving a notice under subsection (3), the Minister must publish a copy of the notice in the Gazette.

11 Ministerial committees

(1) The Minister may by written notice---

- (a) establish any committee that the Minister considers necessary or desirable for any purpose relating to this Act or its administration or to any services; and
- (b) appoint any person to be a member or chairperson of the committee; and
- (c) terminate the committee or the appointment of a member or chairperson of the committee.

(2) Every committee established under this section (other than the committees referred to in sections 13 to 18) has the functions that the Minister determines by written notice to the committee.

(3) Every committee established under this section---

- (a) consists of such members as the Minister determines; and
- (b) may, subject to any written directions that the Minister gives to the committee, regulate its procedure in any manner that the committee thinks fit.

(4) Each member of a committee established under this section is appointed on any terms and conditions (including terms and conditions as to remuneration and travelling allowances and expenses) that the Minister determines by written notice to the member.

(5) Nothing in this section or in sections 13 to 18 limits any powers that the Minister has under any other enactment or rule of law.

12 Information about committees to be made public

(1) As soon as practicable---

- (a) after giving a notice establishing any committee under section 11, the Minister must present to the House of Representatives a copy of the notice that includes or has attached to it the following information:
 - (i) the name of the committee; and

- (ii) the number of members of the committee:
- (b) after giving a notice appointing any person to be a member or chairperson of a committee established under section 11, the Minister must present to the House of Representatives a copy of the notice that includes or has attached to it the following information:
 - (i) the name of the chairperson of the committee; and
 - (ii) the names of the members of that committee.

(2) As soon as practicable after giving a notice terminating any committee established under section 11, the Minister must present to the House of Representatives a copy of the notice that includes or has attached to it the following information:

- (a) the name of the committee terminated; and
- (b) the reason or reasons for the termination of the committee.

(3) As soon as practicable after giving a notice under section 11(2) determining a function of a committee established under section 11, the Minister must present to the House of Representatives a copy of the notice that includes or has attached to it the following information:

- (a) the functions of the committee; and
- (b) any other terms of reference or directions (other than directions as to procedure).

(4) As soon as practicable after giving, under section 11(3)(b), a written direction as to the procedure of a committee established under section 11, the Minister must present to the House of Representatives a copy of the direction.

(5) In every annual report of the Ministry of Health, the Ministry must---

- (a) give the following information in respect of every committee established under section 11:
 - (i) the name of the committee;
 - (ii) the name of the chairperson of the committee;
 - (iii) the name of every member of the committee; and
- (b) indicate whether there is a committee established under section 11 that has not reported to the Minister in the year to which the report relates.

13 National advisory committee on health and disability

(1) The Minister may appoint a committee established under section 11, to be known as the national advisory committee on health and disability, to advise the Minister on---

- (a) the kinds, and relative priorities, of public health services, personal health services, and disability support services that should, in the committee's opinion, be publicly funded; and
- (b) other matters relating to public health, including---
 - (i) personal health matters relating to public health; and
 - (ii) regulatory matters relating to public health; and
- (c) any other matters that the Minister specifies by notice to the committee.

(2) The advice given by the committee to the Minister under subsection (1) is to be formulated after consultation by the committee with any members of the public, persons involved in the provision of services, and other persons that the committee considers appropriate.

(3) The committee must, at least once each year, deliver to the Minister a report setting out its advice on the matters referred to in subsection (1)(a) and (b).

(4) As soon as practicable after giving a notice under subsection (1)(c) or receiving a report under subsection (3), the Minister must present a copy of the notice or report to the House of Representatives.

14 Public health advisory committee

(1) The national advisory committee on health and disability must establish a committee called the public health advisory committee to provide independent advice to the Minister and to the national advisory committee on health and disability on the following matters:

- (a) public health issues, including factors underlying the health of people and communities;
- (b) the promotion of public health;
- (c) the monitoring of public health;
- (d) any other matters the national advisory committee on health and disability specifies by notice to the committee.

(2) The advice given by the public health advisory committee is to be formulated after consultation by the committee with any interested organisation or individual that the committee considers appropriate.

(3) The Minister must make publicly available, and present to the House of Representatives, a copy of any advice given by the public health advisory committee.

15 Health workforce advisory committee

(1) The Minister may appoint a committee established under section 11 to advise the Minister on health workforce issues that the Minister specifies by notice to the committee.

(2) The advice given by the committee to the Minister under subsection (1) is to be formulated after consultation by the committee with persons involved in the provision of services and any other persons that the committee considers appropriate.

(3) As soon as practicable after giving a notice under subsection (1), the Minister must present a copy of the notice to the House of Representatives.

(4) The committee must, at least once a year, deliver to the Minister a report setting out its advice on the matters referred to it under subsection (1).

(5) As soon as practicable after receiving a report under subsection (4), the Minister must present a copy of the report to the House of Representatives

16 National advisory committee on health and disability support services ethics

(1) The Minister must, by written notice, appoint a national advisory committee on the ethics governing health and disability support services for the purpose of obtaining advice on ethical issues of national significance in respect of any health and disability matters (including research and health services).

(2) The national advisory committee appointed under subsection (1) must determine nationally consistent ethical standards across the health sector and provide scrutiny for national health research and health services.

(3) For the purpose of obtaining advice on specific ethical issues of national, regional, or public significance in respect of any health or disability matters, the Minister may, by written notice, appoint any 1 or more of the following committees:

- (a) 1 or more committees established under section 11:
- (b) the ethics committee of the Health Research Council established under section 24 of the Health Research Council Act 1990--- to consider matters specified by the Minister and to report to the Minister or a person specified by the Minister.

(4) Before a committee appointed under subsection (1) or subsection (3) gives advice, the committee must consult with any members of the public, persons involved in the

funding or provision of services, and other persons that the committee considers appropriate.

(5) As soon as practicable after giving a notice under subsection (1) or subsection (3), the Minister must present a copy of the notice to the House of Representatives.

(6) Any committee appointed under this section must, at least once a year, deliver to the Minister a report setting out its activities and summarising its advice on the matters referred to it under this section.

(7) As soon as practicable after receiving a report under subsection (6), the Minister must present a copy of the report to the House of Representatives.

17 National health epidemiology and quality assurance advisory committee

(1) The Minister must appoint a committee established under section 11 to advise the Minister on any health epidemiology and quality assurance matters.

(2) The advice given by the committee to the Minister under subsection (1) is to be formulated after consultation by the committee with DHBs and other persons involved in the provision of services and any other persons that the committee considers appropriate.

(3) The advice from the committee to the Minister may deal with any health epidemiology and quality assurance matter, but must specifically deal with morbidity and mortality issues concerning the following sectors:

- (a) perinatal:
- (b) infant:
- (c) child and adolescent.

(4) The Minister may, by written notice to the committee from time to time, direct the committee to provide advice to the Minister on the matter specified in that notice.

(5) The committee, in providing advice to the Minister, must ensure, to the maximum extent practicable, that there is national co-ordination in the reporting of relevant health epidemiology and quality assurance matters and that there is a capacity to improve health outcomes through quality assurance programmes directed to clinical providers.

(6) In carrying out its functions under subsection (1), the committee must consider all reports from any mortality review committees established under section 18, and provide advice to the Minister as to appropriate quality assurance programmes to institute, and to respond to those and other relevant reports.

(7) The committee must, at least once each year, deliver to the Minister a report setting out its advice on the matters referred to in subsections (1) to (6).

(8) As soon as practicable after giving notice or receiving a report under this section, the Minister must present a copy of that notice or report to the House of Representatives.

18 Mortality review committees

(1) The Minister may appoint 1 or more committees established under section 11 to carry out any of the following functions that the Minister specifies by notice to the committee:

- (a) to review and report to the Minister or 1 or more other specified committees on specified classes of deaths of persons, or deaths of persons of specified classes, with a view to reducing the numbers of deaths of those classes or persons, and to continuous quality improvement through the promotion of ongoing quality assurance programmes;
- (b) to advise on any other matters related to mortality that the Minister specifies in the notice.

(2) A committee appointed under subsection (1) must develop strategic plans and methodologies that---

- (a) are designed to reduce morbidity and mortality; and
- (b) are relevant to the committee's functions.

(3) A committee appointed under subsection (1) must, at least annually, provide the Minister with a report on its progress in carrying out its functions; and the Ministry of Health must include each such report in the Ministry's next annual report.

(4) As soon as practicable after appointing a committee under subsection (1), or receiving a report or advice from such a committee, the Minister must present to the House of Representatives a copy of the appointment, report, or advice.

(5) The provisions of Schedule 5 apply in relation to a committee appointed under subsection (1).

(6) Every person who fails, without reasonable excuse, to comply with a requirement imposed under Schedule 5 by the chairperson of a committee appointed under subsection (1) commits an offence and is liable to a fine not exceeding \$10,000.

(7) Every person who discloses information contrary to Schedule 5 commits an offence and is liable on summary conviction to a fine not exceeding \$10,000.

(8) Any member of a registered occupational profession who commits an offence under subsection (6) or subsection (7) is liable to any disciplinary proceedings of that

profession in respect of the offence, whether or not he or she is fined under that subsection.

PART 3

District Health Boards

19 Establishment of DHBs

(1) This section establishes each of the organisations named in column 1 of Schedule 1 as a DHB in respect of the geographical area specified in that schedule for the organisation.

(2) Schedule 1 may be amended by Order in Council.

(3) The Governor-General may, by Order in Council, divide any geographical area specified in Schedule 1 for a DHB into 2 or more constituencies, and determine---

- (a) the boundaries of each constituency, whether by reference to a current or former local government unit or otherwise; and
- (b) the number of members of the board of the DHB that are to be elected by the electors of each constituency.

(4) An Order in Council under this section may not take effect in the period commencing after 30 April in a year in which triennial elections under the Local Elections and Polls Act 1976 are to be held and ending with the close of the 58th day after polling day appointed for those elections if the Order---

- (a) alters a geographical area specified in Schedule 1; or
- (b) divides such an area into constituencies; or
- (c) alters a constituency; or
- (d) changes the number of members to be elected by the electors of a constituency.

(5) With the written permission of the Minister, a DHB may adopt an operating name that is different from the name of the DHB specified in Schedule 1.

20 Process for restructuring geographical areas of DHBs

(1) Whenever, at any time after 31 December 2001, the Minister or 1 or more DHBs or any other person proposes to alter the geographical area of any DHB, the Minister, or DHBs, or other person must consult with the public in the area affected.

(2) The consultation under subsection (1) must include---

- (a) producing a discussion document explaining the proposed change, and

including a discussion of any advantages or disadvantages that may flow from the implementation of the proposal; and

- (b) giving the public in the area affected and in other parts of New Zealand that may be affected an opportunity to make submissions on the proposal.

(3) Before the proposal is finalised, the person who issued the discussion document must---

- (a) fully consider any submissions received in response to the document; and
- (b) publish in any affected area an analysis of the submissions and the person's conclusions and recommendations on the proposal.

(4) A person (other than the Minister) who prepares a discussion document or publishes a report of the kind referred to in subsection (3) must deliver a copy of the discussion document or the report to the Minister, as soon as practicable after the preparation of the document or report.

(5) As soon as practicable after issuing or receiving a copy of a discussion document or report under this section, the Minister must present to the House of Representatives a copy of the document or report.

(6) No Order in Council that alters the geographical area of a DHB may be made under section 19 unless the requirements of this section have been followed.

21 Body corporate status and powers

(1) Each DHB is a body corporate owned by the Crown with perpetual succession.

(2) Except as provided in sections 24, 25(2), and 28 and clauses 43, 45, and 46 of Schedule 3, each DHB has full rights, powers, and privilege

22 Objectives of DHBs

(1) Every DHB has the following objectives:

- (a) to improve, promote, and protect the health of people and communities:
- (b) to promote the integration of health services, especially primary and secondary health services:
- (c) to promote effective care or support for those in need of personal health services or disability support services:
- (d) to promote the inclusion and participation in society and

independence of people with disabilities:

- (e) to reduce health disparities by improving health outcomes for Maori and other population groups:
- (f) to reduce, with a view to eliminating, health outcome disparities between various population groups within New Zealand by developing and implementing, in consultation with the groups concerned, services and programmes designed to raise their health outcomes to those of other New Zealanders:
- (g) to exhibit a sense of social responsibility by having regard to the interests of the people to whom it provides, or for whom it arranges the provision of, services:
- (h) to foster community participation in health improvement, and in planning for the provision of services and for significant changes to the provision of services:
- (i) to uphold the ethical and quality standards commonly expected of providers of services and of public sector organisations:
- (j) to exhibit a sense of environmental responsibility by having regard to the environmental implications of its operations:
- (k) to be a good employer.

(2) Each DHB must pursue its objectives in accordance with its district strategic plan, its annual plan, its statement of intent, and any directions or requirements given to it by the Minister under section 32 or section 33.

23 Functions of DHBs

(1) For the purpose of pursuing its objectives, each DHB has the following functions:

- (a) to ensure the provision of services for its resident population and for other people as specified in its Crown funding agreement:
- (b) to actively investigate, facilitate, sponsor, and develop co-operative and collaborative arrangements with persons in the health and disability sector or in any other sector to improve, promote, and protect the health of people, and to promote the inclusion and participation in society and independence of people with disabilities:
- (c) to issue relevant information to the resident population, persons in the health and disability sector, and persons in any other sector working to improve, promote, and protect the health of people for the purposes of paragraphs (a) and (b):
- (d) to establish and maintain processes to enable Māori to participate in, and contribute to, strategies for Māori health improvement:
- (e) to continue to foster the development of Māori capacity for participating in the health and disability sector and for providing for the needs of Maori:
- (f) to provide relevant information to Māori for the purposes of paragraphs (d) and (e):
- (f) to regularly investigate, assess, and monitor the health status of its resident

population, any factors that the DHB believes may adversely affect the health status of that population, and the needs of that population for services:

- (h) to promote the reduction of adverse social and environmental effects on the health of people and communities:
- (i) to monitor the delivery and performance of services by it and by persons engaged by it to provide or arrange for the provision of services:
- (j) to participate, where appropriate, in the training of health professionals and other workers in the health and disability sector:
- (k) to provide information to the Minister for the purposes of policy development, planning, and monitoring in relation to the performance of the DHB and to the health and disability support needs of New Zealanders:
- (l) to provide, or arrange for the provision of, services on behalf of the Crown or any Crown entity within the meaning of the Public Finance Act 1989:
- (m) to collaborate with pre-schools and schools within its geographical area on the fostering of health promotion and on disease prevention programmes:
- (n) to perform any other functions it is for the time being given by or under any enactment, or authorised to perform by the Minister by written notice to the board of the DHB after consultation with it.

(2) The Minister must, as soon as practicable after giving a notice to a DHB under subsection (1)(n), publish in the Gazette, and present to the House of Representatives, a copy of the notice.

(3) Subsection (1)(c), (f), and (k) is subject to the Privacy Act 1993.

(4) Subsection (1)(c) and (f) does not require a DHB to provide any information that could properly be withheld under the Official Information Act 1982, if a request for that information were made under that Act.

(5) A DHB that, in reliance on subsection (4), decides not to provide relevant information must advise the persons concerned of that decision.

(6) To avoid any doubt, subsection (1)(d) does not limit the capacity of a DHB to establish and maintain processes to enable other population groups to participate in, and contribute to, strategies for the improvement of the health of those groups.

(7) In performing any of its functions in relation to the supply of pharmaceuticals, a DHB must not act inconsistently with the pharmaceutical schedule.

24 Co-operative agreements and arrangements

(1) Except as provided in subsection (2), for the purpose of performing its function under section 23(1)(b), a DHB may enter into a co-operative agreement or arrangement with any person (whether or not that person is involved in the health sector) in order to---

- (a) assist the DHB to meet its objectives set out in section 22; or
- (b) enhance health or disability outcomes for people; or
- (c) enhance efficiencies in the health sector.

(2) A DHB may not enter into a co-operative agreement or arrangement under subsection (1) unless,---

- (a) if the consent of the Minister or authority by regulations is required for that agreement or arrangement by section 28, that consent or authority exists; or
- (b) in any other case, the DHB is authorised to enter into the agreement or arrangement by its district strategic plan or annual plan, or by the Minister.

(3) Any authority given by the Minister for the purposes of subsection (2) may be given subject to any conditions the Minister specifies.

(4) The Minister must, within 6 months of the commencement of this section, produce guidelines to be followed by DHBs in establishing co-operative agreements or arrangements under subsection (1) so that DHBs follow processes that are fully transparent and designed to ensure that DHBs accomplish their objectives in ways that---

- (a) take full account of all issues concerned; and
- (b) are effective and efficient so as to maximise the benefit to the public or group whom the agreements or arrangements are intended to benefit.

(5) In determining whether or not to enter into co-operative agreements or arrangements under subsection (1), DHBs must comply fully with any guidelines issued under subsection (4).

(6) As soon as practicable after issuing the guidelines for DHBs under subsection (4), the Minister must present to the House of Representatives a copy of those guidelines.

25 Service agreements

(1) In this Act, service agreement means an agreement under which 1 or more DHBs agree to provide money to a person in return for the person providing services or arranging for the provision of services.

(2) A DHB may, if permitted to do so by its annual plan and in accordance with that plan,---

- (a) negotiate and enter into service agreements containing any terms and conditions that may be agreed; and
- (b) negotiate and enter into agreements to amend service agreements.

(3) A DHB that has entered into a service agreement must monitor the performance under that agreement of the other parties to that agreement.

26 Role of board

(1) All decisions relating to the operation of a DHB are to be made by or under the authority of its board.

(2) The board of a DHB has all powers necessary for the governance and management of the DHB.

(3) The board of a DHB must delegate to the chief executive of the DHB, under clause 39 of Schedule 3, the power to make decisions on management matters relating to the DHB, but any such delegation may be made on such terms and conditions as the board thinks fit.

(4) This section does not limit clause 44 of Schedule 3.

27 Duties of board members

(1) A board member of a DHB, when exercising powers or performing duties as a board member, must act---

- (a) in good faith; and
- (b) with reasonable care, diligence, and skill; and
- (c) with honesty and integrity; and
- (d) in accordance with any code of conduct that applies to Crown entities.

(2) The board of a DHB---

- (a) must ensure that the DHB acts in a manner consistent with the

functions of the DHB, and with the DHB's district strategic plan, annual plan, statement of intent, and any directions or requirements given under section 32 or section 33:

- (b) must not act, or agree to the DHB or any subsidiary of the DHB acting, in a manner that contravenes this Act or any other Act:
- (c) must ensure that the activities of the entity, and those of its subsidiaries, are conducted efficiently and effectively and in a manner consistent with the spirit of service to the public:

28 Shares in bodies corporate or interests in associations

(1) Except with the consent of the Minister or in accordance with regulations made under this Act, no DHB may---

- (a) hold any shares or interests in a body corporate or in a partnership, joint venture, or other association of persons; or
- (b) settle, or be or appoint a trustee of, a trust.

(2) The Minister's consent under subsection (1) may be given subject to any conditions the Minister specifies.

29 Membership of boards

(1) The board of each DHB consists of---

- (a) 7 members elected in accordance with Schedule 2; and
- (b) up to 4 members appointed by the Minister by notice in the Gazette.

(2) If, at an election of members of a board of a DHB, fewer than 7 members are elected or no members are elected, the Minister may, by notice in the Gazette, appoint persons who were eligible to stand in that election to fill the vacant elected member positions, and the persons so appointed hold office in all respects as if they had been elected under this Act.

(3) Where a vacancy occurs in an elective position on a board, the Minister may, by notice in the Gazette, appoint a person for the remainder of the term of office of the person who vacated office, and the provisions of this Act applying to elected members apply to the person so appointed.

(4) In making appointments to a board, the Minister must endeavour to ensure that---

- (a) Māori membership of the board is proportional to the number of Maori in the DHB's resident population (as estimated by Statistics New Zealand); and
- (b) in any event, there are at least 2 Māori members of the board.

(5) Any member appointed to a board by the Minister must be a person who, in the opinion of the Minister, will assist the DHB to carry out its functions and achieve its objectives.

(6) Before the Minister appoints a person to the board of a DHB, the person must give the Minister a statement completed by the person in good faith that---

- (a) discloses any conflicts of interest that the person has with the DHB as at the date on which the statement is completed, or states that the person has no such conflicts of interest as at that date; and
- (b) discloses any such conflicts of interest that the person believes are likely to arise in future, or states that the person does not believe that any such conflicts are likely to arise in future.

30 Crown monitors to sit on boards

(1) If the Minister considers that it is desirable to do so for the purpose of assisting in improving the performance of a DHB, the Minister may appoint 1 or more persons (in this section called Crown monitors) in relation to that DHB.

(2) A board of a DHB must---

- (a) permit each Crown monitor appointed by the Minister in relation to the DHB to attend any meeting of the board; and
- (b) provide the Crown monitor with copies of all notices, documents, and other information that is provided to board members.

(3) The functions of a Crown monitor are to---

- (a) observe the decision-making processes, and the decisions of the board;
- (b) assist the board in understanding the policies and wishes of the Government so that they can be appropriately reflected in board decisions;
- (c) advise the Minister on any matters relating to the DHB, the board, or its performance.

- (4) The appointment of a person as a Crown monitor is on terms and conditions agreed between the Minister and the person.
- (5) A Crown monitor may provide to the Minister any information that the Crown monitor obtains in the course of acting as such.
- (6) Subsection (5) is subject to the Privacy Act 1993

31 Replacement of board by commissioner

- (1) Where the Minister is seriously dissatisfied with the performance of a board of a DHB, the Minister may, by written notice to the board and the commissioner, dismiss all members of the board and replace the board with a commissioner.
- (2) Where the Minister replaces a board with a commissioner, the commissioner has all the functions, duties, powers, and protections of the board and of a member of the board except that---
- (a) clauses 14 to 35 of Schedule 3 do not apply to a commissioner; and
 - (b) where the commissioner has an interest of the kind described in section 6(2), the commissioner must make the required disclosure to the Minister, and the Minister, under clause 37 of that schedule, must notify any waiver or modification of clause 36(2) of that schedule to the commissioner.
- (3) A commissioner may appoint, on any terms and conditions that may be agreed, up to 3 deputy commissioners, each of whom must be a person who would be eligible to be appointed by the Minister to a board of a DHB.
- (4) The Minister may at any time, by written notice, dismiss a commissioner from office, and a commissioner may at any time, by written notice, dismiss a deputy commissioner from office with the agreement of the Minister.
- (5) All the provisions of this Act that apply to appointed members of a board apply, with any necessary modifications, to a commissioner and a deputy commissioner.
- (6) A commissioner and any deputy commissioner hold office only until the persons elected at the next election of members of boards take office as board members.

32 Minister may give directions

- (1) The Minister may, by written notice to a DHB, give the DHB any directions relating to government policy that---

- (a) the Minister considers necessary or expedient in relation to any matter relating to the DHB; and
 - (b) are consistent with the objectives and functions of the DHB.
- (2) A DHB must comply with any directions given.
- (3) No direction given under subsection (1) may require the supply to any person of any information relating to an individual that would enable the identification of the individual.
- (4) Before giving any direction under subsection (1), the Minister must consult the board of the DHB and must take into account the objectives of the DHB under section 22.
- (5) A direction must not be given under this section if it would more appropriately be given under section 33.
- (6) As soon as practicable after giving a notice under subsection (1), the Minister must publish in the Gazette, and present to the House of Representatives, a copy of the notice.

33 Minister may require provision of services

- (1) The Minister may, from time to time, by written notice to a DHB, require the DHB to provide or arrange for the provision of any services that are specified in the notice, but the notice may not---
- (a) require the supply of services to any named individuals or organisations; or
 - (b) require the supply of services by any named individuals or organisations (other than any DHB); or
 - (c) specify the price for any services.
- (2) Before giving the notice, the Minister must---
- (a) have regard to section 22 and section 23, the New Zealand health strategy, the New Zealand disability strategy, and the district strategic plan of the DHB; and
 - (b) consult the board of the DHB as to the services that are to be required to be provided or arranged, and the cost and funding of those services.
- (3) As soon as practicable after giving the notice, the Minister must

publish in the Gazette, and present to the House of Representatives, a copy of the notice.

Committees

34 Community and public health advisory committees

The board of a DHB must, within 3 months of the commencement of this Act, establish a committee, to advise on health improvement measures, called the community and public health advisory committee, and must provide for Māori representation on the committee

35 Disability support advisory committees

The board of a DHB must, within 3 months of the commencement of this Act, establish a committee, to advise on disability issues, called the disability support advisory committee, and must provide for Māori representation on the committee

36 Hospital advisory committees

The board of a DHB must, within 3 months of the commencement of this Act, establish a committee, to advise on matters relating to hospitals, called the hospital advisory committee, and must provide for Māori representation on the committee.

Accountability of DHBs

37 Responsibility of board

For the avoidance of doubt, a DHB is responsible to the Minister in the manner set out in the Public Finance Act 1989.

38 District strategic plans

- (1) Each DHB must,---
 - (a) as soon as practicable after the commencement of this Act, determine a district strategic plan for fulfilling its objectives and functions during a period of 5 to 10 years from the date of its determination; and
 - (b) determine a replacement district strategic plan before its current plan expires; and
 - (c) review its current district strategic plan at least once every 3 years.

- (2) A DHB may amend or replace a district strategic plan at any time.
- (3) Before a DHB determines or makes a significant amendment to a district strategic plan, it must---
- (a) assess the health status of that population, any factors that the DHB believes may adversely affect the health status of that population, the needs of that population for services, and the contributions that those services are intended to make towards the health outcomes and health status sought for that population; and
 - (b) prepare a draft plan or amendment and consult its resident population on that draft; and
 - (c) obtain the Minister's consent to the plan or amendment.
- (4) The standard for any consultation required by subsection (3)(b) may not be lower than the standard required by section 716A of the Local Government Act 1974 for local authorities; and for the purposes of this subsection, that section applies, with all necessary modifications, as if the DHB concerned were a local authority.
- (5) Despite subsection (3), a DHB may determine its first district strategic plan without complying with paragraph (a) of that subsection.
- (6) A district strategic plan of a DHB must reflect the overall direction set out in, and not be inconsistent with, the New Zealand health strategy and
- (7) A DHB must make publicly available copies of its current district strategic plan and any amendments to it.

39 District annual plans

- (1) The Minister and DHB must agree on an annual plan of the DHB for each financial year beginning on or after 1 July 2001.
- (2) The annual plan of a DHB for a financial year must,---
- (a) if the Minister so requires by written notice to the DHB, be in a form specified by the Minister in the notice:
 - (b) except to the extent to which the information is included in the DHB's statement of intent for that year, include the following information:
 - (i) the intended outputs of the DHB for that year, and how they relate to the DHB's district strategic plan:
 - (ii) the funding proposed for those intended outputs:
 - (c) include the expected performance of the DHB's hospital and related services during the year, and the amount of any capital investment expected to be required:
 - (d) contain, in respect of that year, forecasts that provide information about the matters specified in paragraphs (a) to (c), (i), and (j) of section 41(2) of the Public Finance Act 1989:

- (e) have attached a copy of the DHB's completed statement of intent and Crown funding agreement for that year.
- (3) Every annual plan of a DHB must be signed by the Minister and the DHB.
- (4) Each DHB must make its annual plan publicly available as soon as reasonably practicable after it has been signed by the Minister and the DHB.
- (5) If for any reason the statement of intent under the Public Finance Act 1989 or Crown funding agreement of a DHB has not been finalised in sufficient time to attach a copy of it to the DHB's annual plan, the DHB must specify in the plan that the statement of intent or Crown funding agreement was not included for that reason, but that the statement of intent or Crown funding agreement will be made publicly available as soon as is practicable in the circumstances.
- (6) A DHB, in making its annual plan publicly available, may omit any information that may properly be withheld under the Official Information Act 1982, if a request for that information were made under that Act.
- (7) A DHB that, in reliance on subsection (6), omits any information from its annual plan must, in that annual plan,---
- (a) state that information has been omitted; and
 - (b) indicate the general nature of the omitted information; and
 - (c) give the DHB's reasons for omitting the information.
- (8) An annual plan, statement of intent, or Crown funding agreement of a DHB must not be inconsistent with the DHB's district strategic plan.

40 Consultation on proposed changes to annual plan

As soon as reasonably practicable after proposing a significant change to policies, outputs, or funding for outputs stated in its most recent annual plan, a DHB must consult its resident population about the proposed change.

Financial provisions

41 DHBs to operate in financially responsible manner

Every DHB must operate in a financially responsible manner and, for this purpose, must---

- (a) endeavour to maintain its long-term financial viability; and
- (b) endeavour to cover all its annual costs (including the cost of capital) from its net annual income; and
- (c) endeavour to act as a successful going concern; and
- (d) prudently manage its assets and liabilities

42 Application of Public Finance Act 1989

(1) Every DHB is a Crown entity for the purposes of the Public Finance Act 1989 and, in particular, each DHB must prepare statements of intent, annual financial statements, and annual reports in accordance with that Act and regulations made under section 92(1)(d) of this Act.

(2) Without limiting sections 41C to 41H of the Public Finance Act 1989, every statement of intent of a DHB must include provisions stating the procedure for any disposal of land transferred to, or vested in, the DHB under the Health Sector (Transfers) Act 1993.

(3) Without limiting section 41I of the Public Finance Act 1989, every annual report of a DHB must contain---

- (a) a summary of those provisions of the personnel policy operated by the board that the board considers will assist it in meeting its objective under section 22(1)(k) of being a good employer; and
- (b) a report on the extent to which the DHB has met its other objectives under section 22; and
- (c) a report on the performance of the hospital and related services it owns, including the amount of any capital investment made or required; and
- (d) a statement of any fees (including consultancy fees) received by board members in any capacity from the DHB or any of its subsidiaries; and
- (e) a statement of the number of employees or former employees of the DHB or any subsidiaries of the DHB who, during the accounting period, received remuneration and any other benefits in their capacity as employees,

the value of which was or exceeded \$100,000 per annum, and showing the number of such employees or former employees in brackets of \$10,000; and

- (f) a statement of the number of former employees of the DHB or any subsidiary of the DHB who, during the accounting period, received payments in respect of the termination of their employment with the DHB or the subsidiary, as the case may be, and showing the amount of every such payment; and
- (g) the names of any bodies corporate, partnerships, joint ventures, or other associations of persons, or trusts with which the DHB is involved in accordance with section 28(1) or any other provision of this Act; and
- (h) a list of all shares or interests held in bodies corporate, partnerships, joint ventures, or other associations of persons, or trusts named in accordance with paragraph (g); and
- (i) a statement of how the DHB has given effect and intends to give effect to its functions specified in section 23(1)(b) to (e).

43 Auditor

The Audit Office is the auditor of each DHB and any subsidiary of the DHB and, in relation to each DHB and each such subsidiary, has and may exercise all the functions, duties, and powers that the Audit Office has under the Public Finance Act 1977 in respect of money, stores, and resources of a local authority.

Miscellaneous

44 Provision of information

(1) Without limiting section 45B of the Public Finance Act 1989, the Minister of Finance may, by written notice, require any DHB to supply to that Minister or any other person or class of persons that the Minister specifies, any economic or financial forecasts or other economic or financial information relating to the DHB or any or all of its subsidiaries that the Minister specifies in the notice, and the DHB must comply with the requirement.

(2) The Minister of Health may, by written notice, require any DHB to supply to the Minister, at a specified time or times or at specified intervals, any information that the Minister requires that relates to any aspect of the operations of the DHB or any or all of its subsidiaries, and the DHB must comply with the requirement.

(3) No requirement of the Minister under this section may require the supply

of any information that would infringe the privacy of any natural person or deceased natural person, unless the person (or a representative of the deceased person) has consented to the supply.

45 Other provisions in schedules

- (1) Schedules 2 and 3 apply in respect of DHBs.
- (2) Schedule 4 applies to each community and public health advisory committee, disability support advisory committee, and hospital advisory committee.

PART 4 OTHER PUBLICLY OWNED HEALTH AND DISABILITY ORGANISATIONS

46 Pharmac

- (1) An organisation called the Pharmaceutical Management Agency (“Pharmac”) is established.
- (2) Pharmac is a Crown entity for the purposes of section [7](#) of the Crown Entities Act 2004.
- (3) The [Crown Entities Act 2004](#) applies to Pharmac except to the extent that this Act expressly provides otherwise.
- (4) Pharmac is owned by the Crown.

47 Objectives of Pharmac

The objectives of Pharmac are—

- (a) to secure for eligible people in need of pharmaceuticals, the best health outcomes that are reasonably achievable from pharmaceutical treatment and from within the amount of funding provided; and
- (b) any other objectives it is given by or under any enactment, or authorised to perform by the Minister by written notice to the board of Pharmac after consultation with it.

48 Functions of Pharmac

The functions of Pharmac are to perform the following within the amount of funding provided to it and in accordance with its statement of intent (including the statement of forecast service performance) and (subject to section [65](#)) any directions given under the [Crown Entities Act 2004](#):

- (a) to maintain and manage a pharmaceutical schedule that applies

consistently throughout New Zealand, including determining eligibility and criteria for the provision of subsidies:

- (b) to manage incidental matters arising out of paragraph (a), including in exceptional circumstances providing for subsidies for the supply of pharmaceuticals not on the pharmaceutical schedule:
- (c) to engage as it sees fit, but within its operational budget, in research to meet the objectives set out in section 47(a):
- (d) to promote the responsible use of pharmaceuticals:
- (e) any other functions it is for the time being given by or under any enactment, or authorised to perform by the Minister by written notice to the board of Pharmac after consultation with it.

49 Pharmac to consult in implementing objectives and carrying out functions

In carrying out its functions under section 48, Pharmac must, when it considers it appropriate to do so,—

- (a) consult on matters that relate to the management of pharmaceutical expenditure with any sections of the public, groups, or individuals that, in the view of Pharmac, may be affected by decisions on those matters; and
- (b) take measures to inform the public, groups, and individuals of Pharmac's decisions concerning the pharmaceutical schedule.

50 Board of Pharmac to establish advisory committees

(1) The board of Pharmac must establish the following advisory committees under clause 14(1)(a) of Schedule 5 of the Crown Entities Act 2004:

- (a) a pharmacology and therapeutics advisory committee to provide objective advice to Pharmac on pharmaceuticals and their benefits:
- (b) a consumer advisory committee to provide input from a consumer or patient point of view.

(2) Repealed.

(3) Repealed.

(4) Despite clause 14(1)(a) of Schedule 5 of the Crown Entities Act 2004, the members of the pharmacology and therapeutics advisory committee are appointed by the Director-General in consultation with the board of Pharmac.

51 Publication of notices

The Minister must, as soon as practicable after giving a notice under section [47](#) or section [48](#), publish in the *Gazette*, and present to the House of Representatives, a copy of the notice.

52 Membership of board

(1) The board of Pharmac consists of up to 6 members appointed under section [28](#) of the Crown Entities Act 2004.

(2) Repealed.

(3) Repealed.

53 Exemption from Part 2 of Commerce Act 1986

(1) In this section, unless the context otherwise requires,—

agreement—(a) includes any agreement, arrangement, contract, covenant, deed, or understanding, whether oral or written, whether express or implied, and whether or not enforceable at law; and

(b) without limiting the generality of paragraph (a), includes any contract of service and any agreement, arrangement, contract, covenant, or deed, creating or evidencing a trust

pharmaceuticals means substances or things that are medicines, therapeutic medical devices, or products or things related to pharmaceuticals.

(2) It is declared that nothing in Part [2](#) of the Commerce Act 1986 applies to—

(a) any agreement to which Pharmac is a party and that relates to pharmaceuticals for which full or part-payments may be made from money appropriated under the [Public Finance Act 1989](#); or

(b) any act, matter, or thing, done by any person for the purposes of entering into such an agreement; or

(c) any act, matter, or thing, done by any person to give effect to such an agreement.

New Zealand Blood Service

54 NZBS

(1) An organisation called the New Zealand Blood Service (**NZBS**) is established.

(2) NZBS is a Crown entity for the purposes of section [7](#) of the Crown Entities Act 2004.

(3) The [Crown Entities Act 2004](#) applies to NZBS except to the extent that this Act expressly provides otherwise.

(4) NZBS is owned by the Crown.

55 Functions of NZBS

(1) The functions of NZBS are—

- (a) to manage the donation, collection, processing, and supply of blood, controlled human substances, and related or incidental matters, in accordance with its [statement of intent (including the statement of forecast service performance) and (subject to section [65](#)) any directions given under the [Crown Entities Act 2004](#)]; and
- (b) if it is an appointed entity (as defined in section [92A](#) of the Health Act 1956), to perform the functions for which it is for the time being responsible under section [92H](#) of that Act; and
- (c) to undertake any other functions it is for the time being given by or under any enactment, or authorised to perform by the Minister by written notice to the board of NZBS after consultation with it, in accordance with its statement of intent (including the statement of forecast service performance) and (subject to section [65](#)) any directions given under the [Crown Entities Act 2004](#)].

(2) The Minister must, as soon as practicable after giving a notice under subsection [\(1\)](#), publish in the *Gazette*, and present to the House of Representatives, a copy of the notice.

(3) In this section, **blood** and **controlled human substance** have the same meaning as in Part [3A](#) of the Health Act 1956.

56 Membership of board

(1) The board of NZBS consists of up to 7 members [appointed under section [28](#) of the Crown Entities Act 2004].

(2) Repealed.

(3) Repealed.

Crown Health Financing Agency

57 CHFA

(1) The body corporate established by section [16](#) of the Health Sector (Transfers) Act 1993 is continued under the name of the Crown Health Financing Agency (“CHFA”).

(2) CHFA is a Crown entity for the purposes of section [7](#) of the Crown Entities Act 2004.

(3) The [Crown Entities Act 2004](#) applies to CHFA except to the extent that this Act expressly provides otherwise.

(4) CHFA is owned by the Crown.

58 Functions of [CHFA]

(1) The functions of CHFA are to undertake the following in accordance with its statement of intent (including the statement of forecast service performance) and any directions given under the [Crown Entities Act 2004](#):

- (a) any functions that are given to it by or under any enactment (whether before or after the commencement of this Act);
- (b) any other functions it is authorised to perform by the Minister by written notice to the board of CHFA after consultation with it.

(2) The Minister must, as soon as practicable after giving a notice under subsection [\(1\)](#), publish in the *Gazette*, and present to the House of Representatives, a copy of the notice.

59 Membership of board

(1) The board of CHFA consists of up to 5 members appointed under section [28](#) of the Crown Entities Act 2004.

(2) Repealed.

(3) Repealed.

(4) Each director of CHFA who holds office as such at the time of the commencement of this section continues in office as a member of the board of CHFA for the remainder of his or her existing term.

(5) Repealed.

(6) Repealed.

Other provisions

60 Interpretation

In sections [61](#) to [69](#), **organisation** means each of the following organizations

- (a) Pharmac:
- (b) NZBS:
- (c) CHFA.

61 Role of Board

The board of an organisation has the role set out in section [25](#) of the Crown Entities Act 2004.

62 Duties of board members (Repealed)

63 Shares in bodies corporate or interests in associations (Repealed)

64 Annual plans (Repealed)

65 [Restrictions on directions by Minister]

(1) Repealed.

(2) Repealed.

(3) No direction may be given to Pharmac under section [103](#) of the Crown Entities Act 2004 that would—

- (a) require Pharmac to purchase a pharmaceutical from a particular source or at a particular price; or
- (b) provide any pharmaceutical or pharmaceutical subsidy or other benefit to a named individual.

(4) No direction under section [103](#) of the Crown Entities Act 2004 may be issued to NZBS unless it concerns—

- (a) Repealed.
- (b) protecting the gift status, donation, collection, processing, and supply of blood or controlled human substances (within the meaning of Part [3A](#) of the Health Act 1956); or
- (c) withdrawal of contaminated blood or contaminated controlled human substances from supply.

(4A) Despite anything in the [Crown Entities Act 2004](#), subsection [\(4\)](#) does not limit—

- (a) the ability of the Minister to direct NZBS under section [147](#) of that Act;
or
- (b) section [107](#) of that Act.

(5) Repealed.

(6) Directions given under section [20](#) of the Health Reforms (Transitional Provisions) Act 1993 to RHMU are deemed to be directions given under section [103](#) of the Crown Entities Act 2004.

66 Pharmac, NZBS, and [CHFA] to operate in financially responsible manner

(1) Every organisation must operate in a financially responsible manner and for this purpose must—

- (a) Repealed.
- (b) endeavour to cover all its annual costs (including the cost of capital) from its net annual income; and
- (c) Repealed.
- (d) Repealed.

(2) This section does not limit section [51](#) of the Crown Entities Act 2004.

67 Accountability documents under Crown Entities Act 2004

The statements of intent, annual financial statements, and annual reports of an organisation under the [Crown Entities Act 2004](#) must comply with any regulations made under section [92\(1\)\(d\)](#) of this Act.

68 Auditor (Repealed)

69 Provision of information

(1) Without limiting section [133\(2\)](#) of the Crown Entities Act 2004, the Minister of Finance may from time to time, by written notice, require any organisation to supply to that Minister, or any other person or class of persons that the Minister specifies, any economic or financial forecasts or other economic or financial information relating to the organisation or any or all of its Crown entity subsidiaries that the Minister specifies in the notice, and the organisation must comply with the requirement.

(2) Repealed.

(3) No requirement of the Minister under this section may require the supply of any information that would infringe the privacy of any natural person or deceased natural

person, unless the person (or a representative of the deceased person) has consented to the supply.

(4) Subsection (3) applies despite section 134 of the Crown Entities Act 2004.

70 Further provisions

The provisions set out in Schedule 6 apply in respect of Pharmac, NZBS, and CHFA.

PART 5 INQUIRES

Inquiries and investigations under [Commissions of Inquiry Act 1908](#)

71 Minister may appoint Commission under [Commissions of Inquiry Act 1908](#) to conduct inquiry or investigation

(1) The Minister may appoint 1 or more persons as a Commission under the [Commissions of Inquiry Act 1908](#) to conduct an inquiry or investigation into, and report to the Minister on, 1 or more of the following:

- (a) the funding or provision of health services, disability support services, or both;
- (b) the management of any publicly-owned health and disability organisation;
- (c) a complaint or matter that arises or may arise under this Act or out of the administration of this Act.

(2) Any appointment under subsection (1) may be made subject to any terms and conditions (being terms and conditions not inconsistent with any enactment) the Minister determines.

(3) Sections 11 and 12 of the [Commissions of Inquiry Act 1908](#) (which relate to costs) do not apply to any Commission appointed under subsection (1).

(4) There may be paid out of money appropriated by Parliament for the purpose to any person or persons appointed under subsection (1)

- (a) remuneration not within paragraph (b) for services as a member at a rate and of a kind determined by the Minister in accordance with the fees framework; and
- (b) reimbursement for actual and reasonable travelling and other expenses incurred in carrying out his or her office as a member.

(4) For the purposes of subsection (4), **fees framework** means the framework determined by the Government from time to time for the classification and remuneration of statutory and other bodies in which the Crown has an interest.

(5) Any Commission appointed under subsection (1) may regulate its procedure in any manner (being a manner not inconsistent with any enactment or with any terms and conditions determined under subsection (2)) it thinks fit.

(6) Nothing in this section limits any powers that the Minister has under any enactment or rule of law.

Compare: 1993 No 22 s 47

Special health inquiries

72 Minister may appoint inquiry board to conduct special health inquiry

(1) The Minister may appoint a person or persons (an **inquiry board**) to conduct an inquiry into, and report to the Minister on, 1 or more of the following:

- (a) the funding or provision of health services, disability support services, or both;
- (b) the management of any publicly-owned health and disability organisation;
- (c) a complaint or matter that arises or may arise under this Act or out of the administration of this Act.

(2) For the purposes of subsection (1)(a), the services need not be or have been funded or provided—

- (a) under this Act; or
- (b) after the commencement of this section.

(3) The Director-General may, without further authority than this subsection, exercise the Minister's powers under subsection (1) in relation to a proposed inquiry, and, if the Director-General does so, then, in relation to the inquiry, it is only the Director-General who—

- (a) may exercise the Minister's powers under sections 73 to 75; and
- (b) must perform the Minister's duties under those sections.

(4) The Director-General must not exercise the Minister's powers under sections 73 to 75, and perform the Minister's duties under those sections, in accordance with subsection (3), unless the Director-General has first consulted the Minister about the Director-General doing so.

(5) Nothing in this section, or sections 73 to 75, limits any powers that the Minister, or the Director-General, has under any other enactment or rule of law.

73 Consultation required before inquiry board appointed to inquire into certain matters

(1) Subsection

[\(2\)](#) applies if the Minister proposes to appoint an inquiry board under section [72\(1\)](#) to inquire into a matter—

- (a) that is being investigated by the Health and Disability Commissioner; or
- (b) that is the subject of proceedings—
 - (i) that relate to an alleged breach of the Code of Health and Disability Services Consumers' Rights; and
 - (ii) that are known to the Health and Disability Commissioner; or
- (c) that includes a complaint—
 - (i) that is made against, or that directly involves, a [health practitioner] (within the meaning of section [4](#) of the Health and Disability Commissioner Act 1994); and
 - (ii) that is the subject of proceedings before the appropriate health professional body (within the meaning of section [38\(2\)](#) of that Act).

(2) If this subsection applies, the Minister must, before appointing the inquiry board, consult the Health and Disability Commissioner or, as the case requires, the appropriate health professional body, on the proposed appointment.

(3) If the Minister proposes to appoint an inquiry board under section [72\(1\)](#) to inquire into a matter in which the Ministry of Health is, or was, or may be, or may have been, involved, the Minister must seek advice on the proposed appointment from any adviser independent from the Ministry of Health (for example, the Solicitor-General) the Minister thinks fit.

74 Discussion required before inquiry board appointed

Before appointing an inquiry board under section [72\(1\)](#), the Minister must select a person as prospective sole or principal member of the proposed inquiry board, and discuss with the person—

- (a) the content of the terms of reference for the proposed inquiry (including the time by which the inquiry board must finally report); and
- (b) whether the inquiry should be conducted in an inquisitorial or in an adversarial manner, and any other instructions as to procedure to be given under section [75\(3\)\(b\)](#); and
- (c) the terms and conditions of appointment of the sole or principal member of the proposed inquiry board; and
- (d) whether the inquiry board needs any additional member (or additional members) and, if so, who might be appointed as an additional member (or as additional members) of the inquiry board; and

- (e) the support personnel, resources, and services that the proposed inquiry board is likely to need to be able to conduct the inquiry in accordance with—
 - (i) the instructions proposed to be given under section [75\(3\)\(b\)](#);
and
 - (ii) the requirements stated in sections [78](#) and [79](#).

75 Establishment and alteration of inquiry

(1) After the discussions referred to in section [74](#), the Minister may, under section [72\(1\)](#), appoint a person as sole or principal member of the inquiry board on mutually acceptable terms and conditions.

(2) If, after the discussions referred to in section [74](#), the Minister considers an inquiry board needs a member or members in addition to the sole or principal member, the Minister may, under section [72\(1\)](#), appoint any person or persons as an additional member or as additional members of the inquiry board on mutually acceptable terms and conditions.

(3) On appointing an inquiry board for an inquiry under section [72\(1\)](#), the Minister must—

- (a) set the terms of reference for the inquiry (including the time by which the inquiry board must finally report); and
- (b) give the following procedural instructions that the inquiry board (and its support personnel) must, together with the procedural requirements stated in sections [78](#) and [79](#), apply and follow during the inquiry:
 - (i) an instruction referred to in section [77\(a\)](#); and
 - (ii) an instruction referred to in section [77\(g\)](#) if (and only if)
 - (a) the instruction referred to in section [77\(a\)](#) given by the Minister is that the inquiry be conducted in an inquisitorial manner; and
 - (b) the Minister thinks fit to give an instruction referred to in section [77\(g\)](#); and
 - (iii) any other instruction or instructions referred to in section [77](#) that the Minister thinks fit to give.

(4) In any inquiry the Minister may, at any time after appointing the inquiry board,—

- (a) alter the inquiry board (including the sole or principal member) appointed;
- (b) alter the terms of reference set (including the time by which the inquiry board must finally report);
- (c) add, to the instructions already given to the inquiry board under subsection [\(3\)\(b\)](#), further instructions referred to in any paragraph (except paragraph [\(a\)](#) or paragraph [\(g\)](#)) of section 77.

76 Protection of inquiry board

No member of an inquiry board (or of the support personnel for an inquiry board) has any civil liability for anything the member does or says or reports, or omits to do or say or report, in good faith in pursuance or intended pursuance of his or her duties as a member of the inquiry board (or of the support personnel for the inquiry board).

Compare: 1908 No 25 s [3](#)

77 Instructions as to procedure

The instructions referred to in section [75\(3\)\(b\)](#) are—

- (a) that the inquiry be conducted in an inquisitorial or in an adversarial manner:
- (b) that the inquiry be conducted efficiently and with as much expedition as is possible, while retaining procedural flexibility:
- (c) that the inquiry board avoid unnecessary formality:
- (d) that, to the extent reasonably possible, costs of the inquiry be kept within reasonable bounds:
- (e) that the inquiry board recognise tikanga Māori where appropriate:
- (f) that the inquiry board receive any evidence written or spoken in Māori (but the fact that this instruction has, or has not, been given to the inquiry board is not to affect the application (if any) of the [Māori Language Act 1987](#) in proceedings before the inquiry board):
- (g) that the questioning of witnesses (other than by the inquiry board or its support personnel) be available only if—
 - (i) a person's interests may be adversely affected by evidence or a statement of a witness or, and in exceptional circumstances only, a refusal to allow questioning would otherwise contravene natural justice; and
 - (ii) No other procedure would protect adequately the person's interests or avoid the other contravention of natural justice:
- (h) that the inquiry board hold public hearings in places specified by the Minister, subject to the inquiry board's powers under section [79](#) to hold hearings in private and prohibit publication or disclosure of proceedings:
 - (i) that witnesses who give information in a hearing be given a transcript of the hearing relating to the information and a reasonable chance to clarify the information or to provide any relevant further information:
- (j) that the inquiry board have the powers under section [82](#) to investigate and the power under section [83](#) to summon witnesses.

78 Further requirements as to procedure

In any inquiry, the inquiry board must—

- (a) give witnesses notice before a hearing of matters in respect of which they will be asked questions in the hearing:
- (b) give persons who are the subject of damaging or adverse allegations a reasonable chance to respond to those allegations:
- (c) draw to a person's attention any proposed criticisms by the inquiry board of the person, so that the person has a reasonable chance to respond to those criticisms.

79 Inquiry hearings and evidence generally to be public

(1) Each hearing an inquiry board conducts for the purposes of its inquiry must be held in public.

(2) Subsection [\(1\)](#) is subject to subsections [\(3\)](#) to [\(5\)](#).

(3) An inquiry board that considers it proper to do so after having had regard to the interests of any person and to the public interest may—

- (a) hold all or any part of a hearing in private:
- (b) make an order prohibiting the publication or disclosure of any report or account of all or any part of the proceedings before it, whether held in public or in private:
- (c) make an order prohibiting the publication or disclosure of all or any part of any evidence given, or any books, papers, documents, or records produced, at any hearing.

(4) An inquiry board may make an order under subsection [\(3\)\(b\)](#) or [\(c\)](#) on its own

(5) If an inquiry board makes an order under subsection [\(3\)](#), the inquiry board must state in the order—

- (a) the inquiry board's reasons for making the order; and
- (b) in the case of an order made under subsection [\(3\)\(b\)](#) or [\(c\)](#), the time (if any) at which, or the circumstances (if any) in which, the order ceases to have effect.

(6) If an inquiry board makes an order, under subsection [\(3\)\(b\)](#) or [\(c\)](#), in respect of information, that information must not while that order has effect be made available under any of the [Local Government Official Information and Meetings Act 1987](#), the [Official Information Act 1982](#), or the [Privacy Act 1993](#).

(7) An inquiry board may at any time deliberate in private as to its decision on any matter or question arising in the course of the inquiry.

(8) Nothing in this section prevents an inquiry board from at any time seeking information or questioning people outside a hearing as to where information relevant to the inquiry might be obtained.

80 Supplementary procedure

In any inquiry, the inquiry board may adopt further procedures for the inquiry that are not inconsistent with—

- (a) instructions given under subsections [\(3\)\(b\)](#) and [\(4\)\(c\)](#) of section 75:
- (b) the requirements stated in sections [78](#) and [79](#).

81 Evidence

(1) An inquiry board may receive as evidence any statement, document, information, or matter that, in the inquiry team's opinion, may help it meet its terms of reference, whether or not the statement, document, information, or matter would be

(2) An inquiry board may take evidence on oath.

(3) An inquiry board may permit a person appearing as a witness before it to give evidence by tendering a written statement and, if the inquiry board thinks fit, verifying it by oath.

Compare: 1908 No 25 s [4B](#)

82 Powers to investigate

(1) If the Minister has given an inquiry board an instruction referred to in section [77\(j\)](#) then, for the purposes of its inquiry, the inquiry board or any person authorised by it in writing to do so may—

- (a) inspect and examine any books, papers, documents, records, or things (for example, medical equipment, parts of or substances from a human body, or specimens):
- (b) require any person to produce for examination any books, papers, documents, records, or things (for example, medical equipment, parts of or substances from a human body, or specimens) in the person's possession or control, and to allow copies of or extracts from any of those books, papers, documents, or records to be made:
- (c) require any person to give, in a form approved by or acceptable to the inquiry board, any information or particulars it requires, and any copies

of or extracts from any books, papers, documents, or records referred to in paragraph [\(b\)](#).

(2) The inquiry board may, if it thinks fit, require that any written information or particulars or any copies or extracts given under this section be verified by statutory declaration or another means the inquiry board identifies.

(3) Every person has the same privileges in relation to the giving of information to the inquiry board, the answering of questions put by the inquiry board, and the production of books, papers, documents, records, and things to the inquiry board, as witnesses have in courts of law.

Compare: 1908 No 25 s [4C](#)

83 Power to summon witnesses

(1) If the Minister has given an inquiry board an instruction referred to in section [77\(j\)](#) then, for the purposes of its inquiry, the inquiry board may issue a summons requiring any person to—

- (a) attend and give evidence; and
- (b) produce any books, papers, documents, records, or things in the person's possession or control that are relevant to the subject of the inquiry.

(2) A witness is not required to attend and give evidence or produce any things in accordance with a summons issued under subsection [\(1\)](#) unless, at the time of the service of the summons or at some other reasonable time before the day on which the attendance of the witness would, apart from this subsection, be required, there is tendered or paid to the witness a sum in respect of the witness' allowances and travelling expenses in accordance with the scale prescribed for the time being by regulations made under the [Summary Proceedings Act 1957](#).

(3) The summons must be in writing and state the place and time at which the witness is required to attend.

(4) The inquiry board may issue a summons on its own initiative or an application by any person for the purpose.

(5) The power to issue the summons may be exercised by—

- (a) the sole or principal member of the inquiry board; or
- (b) any other member of the inquiry board purporting to act by direction or with the authority of the principal member of the inquiry board.

Compare: 1908 No 25 s [4D](#)

84 Service of summons

(1) A summons to a witness may be served by—

- (a) delivering it to the witness; or
- (b) leaving it at the witness' usual place of residence; or
- (c) posting it by registered post addressed to the witness at the witness' usual place of residence.

(2) The summons must be served at least 10 days before the day on which the attendance of the witness is required.

(3) A summons served under subsection [\(1\)\(c\)](#) must be treated as having been served at the time when the letter would be delivered in the ordinary course of post.

Compare: 1908 No 25 s [5](#)

85 Protection of witnesses

Every witness giving evidence, and every counsel or agent or other person appearing, before an inquiry board, has the same privileges and immunities as witnesses and counsel in courts of law.

Compare: 1908 No 25 s [6](#)

86 Offences

(1) Every person commits an offence who, after being summoned to attend to give evidence before an inquiry board or to produce to it any books, papers, documents, records, or things, without sufficient cause,—

- (a) fails to attend in accordance with the summons; or
- (b) refuses to be sworn or to give evidence, or having been sworn refuses to answer any question that the person is lawfully required by the inquiry board or any member of it to answer concerning the subject of the inquiry; or
- (c) fails to produce any such book, paper, document, record, or thing.

(2) Every person commits an offence who without lawful excuse contravenes any order made by an inquiry board under section [79\(3\)\(b\)](#) or [\(c\)](#).

(3) Every person commits an offence who—

- (a) wilfully obstructs or hinders an inquiry board or any member of it or any authorised person in any inspection or examination of books, papers, documents, records, or things, under section [82\(1\)\(a\)](#); or

- (b) without sufficient cause, fails to comply with any requirement of an inquiry board or any authorised person made under section [82\(1\)\(b\)](#) or [\(c\)](#).

(4) Every person commits an offence who wilfully interrupts or obstructs any hearing conducted by an inquiry board.

(5) Every person who commits an offence against this section is liable on summary conviction to a fine not exceeding \$10,000.

Compare: 1908 No 25 s [9\(1\)-\(3\)](#)

PART 6 MISCELLANEOUS PROVISIONS

87 Saving of certain transactions

The validity or enforceability of any deed, agreement, right, or obligation entered into, or incurred by, the Crown or a publicly-owned health and disability organisation is not affected by a failure by the Crown or the organisation to comply with

- (a) any provision in sections [3](#), [4](#), or [8](#), or Parts [3](#) and [4](#); or
- (b) any regulations made under section [92\(1\)\(e\)](#); or
- (c) any provision of Schedules [3](#) to [6](#); or
- (d) any provision in any statement of intent or district strategic plan or annual plan; or
- (e) any direction or requirement given under this Act or any other Act.

88 Arrangements relating to payments

(1) Where the Crown or a DHB gives notice of the terms and conditions on which the Crown or the DHB will make a payment to any person or persons, and, after notice is given, such a payment is accepted by any such person from the Crown or DHB, then—

- (a) acceptance by the person of the payment constitutes acceptance by the person of the terms and conditions; and
- (b) compliance by the person with the terms and conditions may be enforced by the Crown or DHB (as the case may be) as if the person had signed a deed under which the person agreed to the terms and conditions.

(2) Any terms and conditions of which notice is given under subsection [\(1\)](#), unless they expressly provide otherwise, are deemed to include a provision to the effect that 12 weeks' notice must be given of any amendment or revocation of the terms and conditions.

(3) Every notice, and every amendment or revocation of a notice, must be published in the *Gazette* before the notice, amendment, or revocation takes effect; and, as soon as practicable, the Minister must present a copy to the House of Representatives.

(4) No notice may be issued under this section that would bind Pharmac or NZBS.

89 Principles of national consistency applicable to notices under section

(1) The principles stated in subsection (2) apply to the Crown and to a DHB whenever the Crown or a DHB proposes to issue a notice under section 88.

(2) The principles are—

- (a) that it is desirable to maintain national consistency in the terms and conditions set in respect of the same or substantially the same services; but
- (b) that it needs to be recognised that there are circumstances when there is good reason to depart from terms and conditions set in respect of the same or substantially the same services, including, without limitation,—
 - (i) special circumstances relating to a geographical area; or
 - (ii) the need to adjust the amounts payable for services; or
 - (iii) the need to update standards set for services.

(3) A DHB may not issue a notice under section 88 without the written approval of the Minister if the proposed notice—

- (a) relates to services in respect of which the DHB has not previously issued a notice; or
- (b) sets terms and conditions in respect of particular services that depart from terms and conditions set out in an existing notice in respect of the same or substantially the same services; or
- (c) differentiates between persons or classes of person accepting payment under section 88.

(4) The Minister's approval may be given subject to any conditions the Minister specifies.

(5) Any notice under section 88 that departs from an existing notice in the manner referred to in subsection (3)(b) or differentiates in the manner referred to in subsection (3)(c) must include a statement of the reasons for the departure or differentiation.

(6) In this section, **existing notice** means a notice issued under section 88, or continued by section 112(3), that is for the time being in force.

(7) The Minister must present to the House of Representatives a copy of any approval given under this section.

90 Exclusion of liability

(1) A member of a board, or of a committee of a board, of a publicly-owned health and disability organisation is not liable for any liability, or act or omission, of the organisation.

(2) A member of a board, or of a committee of a board, of a publicly-owned health and disability organisation is not liable to the organisation for any act or omission done or omitted in his or her capacity as a member, if he or she acted in good faith, and with reasonable care, in pursuance of the functions of the organisation.

(2A) Section [59\(3\)](#) of the Crown Entities Act 2004 (which provides that a statutory entity may bring an action against a member for breach of an individual duty) does not apply to a member of a publicly-owned health and disability organisation, unless it is shown by that publicly-owned health and disability organisation that the person did not act with good faith, or with reasonable care.

(3) Every member of the board, or of any committee of the board, of a publicly-owned health and disability organisation is indemnified by the organisation—

- (a) for costs and damages for any civil liability arising from any action brought by a third party in respect of any act or omission done or omitted in his or her capacity as a member, if he or she acted in good faith, and with reasonable care, in pursuance of the functions of the organisation; and
- (b) for costs arising from any successfully defended criminal proceeding in relation to any such act or omission.

(4) A member of a committee established or appointed under Part [2](#) is not liable for any act or omission done or omitted in his or her capacity as a member, if he or she acted in good faith, and with reasonable care, in pursuance of the functions of the committee.

(5) Sections [120](#) to [126](#) of the Crown Entities Act 2004 do not apply to a publicly-owned health and disability organisation, members of the board or a committee of the board of a publicly-owned health and disability organisation, or office holders or employees of a publicly-owned health and disability organisation.

91 No compensation for loss of office

Neither the Crown nor any publicly-owned health and disability organisation may make any payment to, or otherwise compensate, any person in respect of the person ceasing for any reason to hold any office established by or under this Act.

92 Regulations

(1) The Governor-General may, by Order in Council, make regulations for all or any of the following purposes:

- (a) imposing restrictions and requirements relating to ... reinsurance, service agreements, and notices under section [88](#);
- (b) specifying the circumstances in which a person may lend money to a DHB:.
- (c) specifying any class of shares or interests that, and any conditions on which, DHBs may—
 - (i) hold in a body corporate or in a partnership, joint venture, or other association of persons; or
 - (ii) settle, or be or appoint a trustee of, a trust:
- (d) specifying the form of any document of the kind referred to in section [42](#) or section [67](#), and specifying matters to be stated in any such document in addition to those required by those sections or [the [Crown Entities Act 2004](#)]:
- (e) imposing procedural requirements in relation to any consultation required by or under this Act, not being requirements that are inconsistent with any provision of this Act:
- (f) specifying kinds of information for the purposes of clause [49](#) of Schedule 3:
- (g) Repealed.
- (h) Repealed.
- (i) prescribing standard provisions that are to be regarded as being included in all Crown funding agreements between the Crown and DHBs:
- (j) providing for any other matters contemplated by this Act or necessary for its administration or necessary for giving it full effect.

(2) The Governor-General may, by Order in Council made on the recommendation of the Minister, make regulations prescribing rules by which disputes or differences between any one or more publicly-owned health and disability organisations or providers of services or other persons may be mediated or arbitrated with the agreement of the persons concerned.

(3) The Governor-General may, by Order in Council, make regulations for all or any of the following purposes:

- (a) providing for the issue of entitlement cards (including cards that may record information of any description that is capable of being read or processed by a computer, but not including cards that are themselves capable of processing information) to various classes of persons or the continuation of use of such cards issued under the [Health Entitlement Cards Regulations 1993](#):
- (b) prescribing the classes of persons eligible to be issued with the cards:
- (c) prescribing and regulating the use of the cards, including (but not limited to)—
 - (i) their use to obtain any payment or exemption from payment for health services or disability support services supplied to the holder of a card, or his or her dependent spouse or partner or child:

- (ii) specifying time limits on the validity of the cards:
- (iii) requiring holders to return the cards to the Ministry of Health:
- (iv) any other conditions relating to their use:
- (d) providing for reviews or appeals, or both, of any decisions made under any regulations authorised by paragraphs (a) to (c):
- (e) prescribing offences relating to the improper use of the cards and the fines (not exceeding \$10,000) that may be imposed in respect of any such offences.

(4) The [Health Entitlement Card Regulations 1993](#) are deemed to have been made under subsection (3) and may be amended or revoked accordingly.

PART 7 TRANSITIONAL AND CONSEQUENTIAL PROVISIONS

93 Interpretation

In this Part, unless the context otherwise requires,—

assets has the same meaning as in section [2\(1\)](#) of the Health Sector (Transfers) Act 1993

dissolved entity means any of the following:

- (a) the Health Funding Authority:
- (b) any hospital and health service:
- (c) New Zealand Blood Service Limited:
- (d) Pharmaceutical Management Agency Limited

Health Funding Authority means the authority continued by section [32\(1\)](#) (as in force immediately before the commencement of this section) of the [Health and Disability Services Act 1993](#)

hospital and health service means every company formed and registered in accordance with section [37](#) of the Health and Disability Services Act 1993

liabilities has the same meaning as in section [2\(1\)](#) of the Health Sector (Transfers) Act 1993

New Zealand Blood Service Limited means the hospital and health service incorporated with the name New Zealand Blood Service Limited

Pharmaceutical Management Agency Limited means the company incorporated under the [Companies Act 1993](#) with the name Pharmaceutical Management Agency Limited

transfer has the same meaning as in section [2\(1\)](#) of the Health Sector (Transfers) Act 1993.

Assets and liabilities of dissolved entities to vest in publicly-owned health and disability organizations

94 Health Funding Authority dissolved and assets and liabilities vested in the Crown

(1) The Health Funding Authority is dissolved.

(2) No person who, immediately before the commencement of this section, held office as a director of the Health Funding Authority is entitled to compensation for loss of the office.

(3) On the commencement of this section, the assets and liabilities of the Health Funding Authority vest in the Crown (acting, in the case of any shares vested, through the Minister and, in the case of any other assets or liabilities vested, through the Ministry of Health).

95 Hospital and health services dissolved and assets and liabilities vested in DHBs

(1) Every hospital and health service is dissolved.

(2) No person who, immediately before the commencement of this section, held office as a director of a hospital and health service is entitled to compensation for loss of the office.

(3) Except as provided in subsection (4), on the commencement of this section, the assets and liabilities of each hospital and health service (other than New Zealand Blood Service Limited) vest in the DHB whose name is shown opposite the name of the hospital and health service in column 2 of Schedule 7.

(4) The assets and liabilities vested by subsection (3) do not include rights or obligations under any contract of service under which a person was, before the commencement of this section, employed as the chief executive of a hospital and health service.

(5) The Registrar of Companies must remove from the register of companies kept under section 360(1)(a) of the Companies Act 1993 the name of every hospital and health service.

96 Assets and liabilities of New Zealand Blood Service Limited vested in NZBS

On the commencement of this section, the assets and liabilities of New Zealand Blood Service Limited vest in NZBS.

97 Former directors of New Zealand Blood Service Limited to be transitional members of NZBS

(1) Every person who, on the date immediately before the commencement of this section, held office as a director of New Zealand Blood Service Limited is to be taken to have been appointed under section 56 as a member of the board of NZBS for the period that, as at the close of that date, represents the remainder of the person's term as a director of New Zealand Blood Service Limited.

(2) Within 28 days after the commencement of this section, every member continuing in office under subsection (1) must give the Minister the statement required to be completed by section 56(2), and that subsection applies to the member as if he or she were to be appointed as a member of the board of NZBS on the 29th day after that commencement.

(3) If on the 29th day after the commencement of this section a member affected by subsection (1) has failed to comply with subsection (2), the member ceases to be a member of the board of NZBS on that day.

98 Pharmaceutical Management Agency Limited dissolved and assets and liabilities vested in Pharmac

(1) Pharmaceutical Management Agency Limited is dissolved.

(2) No person who, immediately before the commencement of this section, held office as a director of Pharmaceutical Management Agency Limited is entitled to compensation for loss of the office.

(3) On the commencement of this section, the assets and liabilities of the Pharmaceutical Management Agency Limited vest in Pharmac.

(4) The Registrar of Companies must remove from the register of companies kept under section 360(1)(a) of the Companies Act 1993 the name of Pharmaceutical Management Agency Limited.

99 Former directors of Pharmaceutical Management Agency Limited to be transitional members of board of Pharmac

(1) Every person who, immediately before the commencement of this section, held office as a director of Pharmaceutical Management Agency Limited is to be taken to have been appointed under section 52 as a member of the board of Pharmac for the period that, as at the close of that date, represents the remainder of the person's term as a director of Pharmaceutical Management Agency Limited.

(2) Within 28 days after the commencement of this section, every member continuing in office under subsection (1) must give the Minister the statement required to be

completed by section [52\(2\)](#), and that subsection applies to the member as if he or she were to be appointed as a member of the board of Pharmac on the 29th day after that commencement.

(3) If on the 29th day after the commencement of this section a member affected by subsection [\(1\)](#) has failed to comply with subsection [\(2\)](#), the member ceases to be a member of the board of Pharmac on that day.

100 Health Sector (Transfers) Act 1993 to apply to vestings under this Act

(1) Section [6](#), sections [8](#) to [14](#), and Schedule [1](#) of the Health Sector (Transfers) Act 1993 apply to the vestings effected by sections [94](#) to [96](#) and section [98](#) as if—

- (a) each vesting had been effected under section [5](#) of that Act; and
- (b) each dissolved entity were a transferor within the meaning of that Act.

(2) For the purposes of the [Government Superannuation Fund Act 1956](#), a person who, as a result of any of the vestings by sections [94](#) to [96](#) and section [98](#) becomes an employee of a transferee and who, immediately before becoming such an employee, was an officer or employee of a dissolved entity and a contributor to the Government Superannuation Fund under that Act is, so long as that person continues to be employed by a transferee,—

- (a) to be taken to be employed in the Government service; and
- (b) that Act applies to that person as if service with the transferee were Government service.

(3) Subject to the [Government Superannuation Fund Act 1956](#), nothing in subsection [\(2\)](#) entitles any such person to become a contributor to the Government Superannuation Fund after that person has ceased to be a contributor.

(4) For the purposes of applying the [Government Superannuation Fund Act 1956](#), in accordance with subsection [\(2\)](#), to a person who is in the service of a transferee and is a contributor to the Government Superannuation Fund, the term **controlling authority**, in relation to that person, means the chief executive of the transferee.

101 Modifications of Health Sector (Transfers) Act 1993 in respect of former employees of dissolved entities and certain employees of Ministry of Health

(1) Section [13](#) of the Health Sector (Transfers) Act 1993 applies to any person who, at any time in the period commencing on 1 April 2000 and ending with the commencement of this section, was an employee of a dissolved entity as if—

- (a) in subsection [\(1\)](#) of that section there were inserted, before the words “an employee of a transferor”, the words “on or after 1 April 2000”;
- (b) in subsection [\(2\)](#) of that section there were inserted, before the words “an employee of a transferor”, the words “on or after 1 August 2000”;
- (c) in subsection [\(2\)](#) of that section there were substituted for the expression “9 months”, the expression “3 months”:

(d) in subsection [\(6\)](#) of that section there were substituted for the words “31st day of December 1994”, the words “commencement of section 101 of the New Zealand Public Health and Disability Act 2000”.

(2) For the purposes of subsection [\(1\)](#), every dissolved entity is to be taken to be a transferor as well as a transferee within the meaning of the [Health Sector \(Transfers\) Act 1993](#).

(3) Before 31 December 2002, the Director-General may give notice to any employee of the Director-General that the employee may, through the operation of section [4](#) or section [5](#) of the Health Sector (Transfers) Act 1993, become an employee of a DHB or of a subsidiary of a DHB.

(4) From the date of a notice given to an employee under subsection [\(3\)](#), the [Health Sector \(Transfers\) Act 1993](#) applies to the employee as if—

(a) in section [13\(2\)](#) there were substituted for the expression “9 months”, the expression “3 months”:

(b) in section [13\(6\)](#) there were substituted for the words “the 31st day of December 1994”, the expression “31 December 2002”:

(c) in section [15\(1\)](#) there were substituted for the words “the 31st day of March 1994”, the expression “31 December 2002”.

102 References to dissolved entities to be references to their successors

As from the commencement of this section, unless the context otherwise requires, every reference in any notice or document—

(a) to the Health Funding Authority must be read as a reference to the Crown (acting, in the case of any shares formerly held by the Health Funding Authority, through the Minister and, in any other case, through the Ministry of Health):

(b) to a hospital and health service (other than New Zealand Blood Service Limited) must be read as a reference to the DHB in whom the assets and liabilities of the hospital and health service are vested by section [95](#):

(c) to New Zealand Blood Service Limited must be read as a reference to NZBS:

(d) to the Pharmaceutical Management Agency Limited must be read as a reference to Pharmac.

103 Persons in whom assets and liabilities vested deemed dissolved entities for certain purposes

Every person in whom the assets and liabilities of a dissolved entity are vested by any of sections [94](#) to [96](#) and [98](#) is deemed to be the dissolved entity for the purposes of any requirement or entitlement under—

- (a) the [Goods and Services Tax Act 1985](#); or
- (b) any enactment or accounting practice relating to accounting records or financial statements.

Transitional provisions relating to annual reports and financial statements of dissolved entities

104 Meaning of final report

In section [105](#), **final report**, in relation to a dissolved entity, means—

- (a) a report setting out the information specified in section [41I](#) of the Public Finance Act 1989 in relation to the dissolved entity's operations for the period beginning on 1 July 2000 and ending with the close of the day immediately before the commencement of this section; and
- (b) the dissolved entity's financial statements for that period, which—
 - (i) set out the information specified in section [41](#) of the Public Finance Act 1989; and
 - (ii) are accompanied by an audit opinion prepared by the Audit Office in accordance with section [43](#) of that Act.

105 Final reports of dissolved entities

(1) As soon as reasonably practicable after the commencement of this section, the Minister must receive—

- (a) from the Director-General the final report of the Health Funding Authority;
- (b) from each DHB the final report of the hospital and health service whose assets and liabilities are vested in the DHB by section [95](#);
- (c) from NZBS the final report of New Zealand Blood Service Limited;
- (d) from Pharmac the final report of the Pharmaceutical Management Agency Limited.

(2) As soon as practicable after receiving each final report, the Minister must present the report to the House of Representatives.

All positions on boards of DHBs filled by appointment until first elections

106 Transitional board members

(1) In the period commencing with the commencement of this section and ending with the first elections of members of boards of DHBs, the Minister may appoint up to 11 members to the board of each DHB (whether that DHB has been, or is to be, established) to hold the positions that are, after those elections, to be held by elected and appointed members.

(2) The provisions of this Act that apply to appointed members of DHBs apply to members appointed under subsection (1), except that—

- (a) the appointment of such a member (whether as member, chairperson, or deputy chairperson) must be made by written notice to the member, and need not be notified in the *Gazette*; and
- (b) such a member need not complete the statement under section 29(6) before his or her appointment, but must complete that statement before the 29th day after his or her appointment; and
- (c) if such members hold a meeting of a board of a DHB before 1 February 2001, clauses 16 to 24, 28 and 31 to 35 of Schedule 3 do not apply to that meeting.

(3) As soon as practicable after the commencement of this section, the Minister must make appointments under subsection (1) to enable each DHB to operate on and from 1 January 2001.

(4) For the purpose of enabling a DHB to operate on and from 1 January 2001, the members appointed under subsection (1) in respect of a DHB may, before that date, exercise or perform any duty, power, or function of the board of the DHB.

(5) A record of every meeting of the board of a DHB held in accordance with subsection (2)(c) and of every decision taken in respect of the board of a DHB under subsection (4) must be tabled at the first meeting of the board that is publicly notified under clause 16 of Schedule 3.

(6) Despite subsection (2), when the first elected members of a board of a DHB come into office, every member appointed under subsection (1) ceases to be a member of the board.

Amendments to other Acts

107 Amendments to Commerce Act 1986

(1) Section 2(7) of the Commerce Act 1986 is amended by inserting, after paragraph (b), the following paragraph: (ba) both of them are entities referred to by any of the paragraphs (other than paragraph (e)) of the definition of ‘transferor’ in section 2(1) of the Health Sector (Transfers) Act 1993; or.”

(2) Section 2(7A) of the Commerce Act 1986 is amended by omitting the expression “subsection (7)”, and substituting the expression “subsection (7)(a) and (b)”.

108 Amendments to State Sector Act 1988

Section 2 of the State Sector Act 1988 is amended—

- (a) by repealing the definition of “Health service”:

(b) by omitting from paragraph (b) of the definition of “State Services” the words “and the Health service”.

109 Amendment to Mental Health Commission Act 1998

Section [13](#) of the Mental Health Commission Act 1998 is amended by repealing subsections [\(1\)](#) and [\(2\)](#), and substituting the following subsections:

“(1) This Act expires at 5 pm on 31 August 2004.

“(2) The Governor-General may by Order in Council, on the recommendation of the Minister, specify a later date in substitution for the date specified in subsection (1), but such substituted date may not be later than 31 August 2007.”

Consequential repeals, revocations, and amendments

110 Consequential repeals and revocations

(1) The following Acts are repealed:

- (a) [Health and Disability Services Act 1993](#) (1993 No 22):
- (b) [Maternal Mortality Research Act 1968](#) (1968 No 26).

(2) The instruments specified in Schedule [8](#) are revoked.

111 Consequential amendments

(1) The Acts specified in Schedule [9](#) are amended in the manner indicated in that schedule.

(2) The regulations specified in Schedule [10](#) are amended in the manner indicated in that schedule.

112 Saving

(1) The direction concerning the eligibility of persons for Crown-funded services given to the Health Funding Authority under section [25](#) of the Health and Disability Services Act 1993, and in force immediately before the commencement of this section, is deemed to have been given, under section [32](#), to every DHB.

(2) The Minister may at any time amend or revoke the direction referred to in subsection [\(1\)](#) by issuing a direction under section [32](#).

(3) Every notice given, under section [51](#) of the Health and Disability Services Act 1993, and in force immediately before the commencement of this section, continues in force as if the notice had been given by the Crown under section [88](#).

(4) The Crown (acting through the Ministry of Health) may at any time amend or revoke a notice referred to in subsection (3) by issuing a notice under section 88.

(5) Despite sections 28 and 63, during the period of 1 year ending after the commencement of this section, a publicly-owned health and disability organisation may—

(a) hold any shares or interests in a body corporate or in a partnership, joint venture, or other association of persons if those shares or interests were vested in the organisation by this Act; and

(b) be the trustee of a trust if the office as trustee was vested in the organisation by this Act.

(6) On the expiry of the period referred to in subsection (5), no organisation may continue to hold such shares or interests or be such a trustee without the consent of the Minister, given in accordance with section 28 or section 63, as the case may require.

Appropriations for purposes of Act

113 Interim authority of Crown to incur liabilities

(1) Liabilities of up to a total of \$1,200,000,000 may, during the 2000/01 year, be incurred in advance of appropriation in relation to Vote Health to provide the capital injections required to establish the District Health Boards.

(2) All liabilities incurred under this section must be charged in the manner to be specified in an Appropriation Act for the 2000/01 year and, until the coming into force of the Appropriation Act in which that manner is specified, may be incurred during the 2000/01 year as if they had been incurred in accordance with 1 of the separate appropriations specified in section 4(3) of the Public Finance Act 1989.

Transitional provisions relating to New Zealand health strategy and New Zealand disability strategy

114 Consultation for first New Zealand health strategy and first New Zealand disability strategy

(1) The consultation undertaken, before the commencement of this section, by the Minister on proposals for a New Zealand health strategy is to be taken to be consultation for the purposes of section 8(3) for the first New Zealand health strategy determined after the commencement of this section.

(2) The consultation undertaken, before the commencement of this section, by the Minister of the Crown who is responsible for disability issues on proposals for a New Zealand disability strategy is to be taken to be consultation for the purposes of section

[8\(3\)](#) for the first New Zealand disability strategy determined after the commencement of this section.

FIRST: DHBs and their geographical areas

Schedule 1 s 19(1)

DHBs and their geographical areas

Organisation	Representative geographical area based on territorial authority and ward boundaries
Northland DHB	Far North District, Whangarei District, Kaipara District
Waitemata DHB	North Shore City, Rodney District, Waitakere City
Auckland DHB	Auckland City
Counties Manukau DHB	Manukau City, Papakura District, Franklin District
Waikato DHB	Hauraki District, Thames-Coromandel District, Waikato District, Waipa District, Hamilton City, South Waikato District, Matamata-Piako District, Otorohanga District, Waitomo District, Ruapehu District (Ohura, Taumarunui and National Park Wards only)
Lakes DHB	Taupo District, Rotorua District
Bay of Plenty DHB	Tauranga District, Western Bay of Plenty District, Whakatane District, Kawerau District, Opotiki District
Tairāwhiti DHB	Gisborne District
Taranaki DHB	New Plymouth District, Stratford District, South Taranaki District
Hawke's Bay DHB	Wairoa District, Hastings District, Napier City, Central Hawkes Bay District, Chatham Islands Territory
Whanganui DHB	Wanganui District, Rangitikei District, Ruapehu District (Waiouru and Waimarino Wards only)
MidCentral DHB	Manawatu District, Palmerston North City, Tararua District, Horowhenua District, Kapiti Coast District (Otaki Ward only)
Hutt DHB	Upper Hutt City, Lower Hutt City

Capital and Coast DHB	Kapiti Coast District (Paraparaumu, Waikanae and Paekakariki-Raumati Wards only), Porirua City, Wellington City
Wairarapa DHB	Masterton District, Carterton District, South Wairarapa District
Nelson Marlborough DHB	Tasman District, Nelson City, Marlborough District
West Coast DHB	Buller District, Grey District, Westland District
Canterbury DHB	Kaikoura District, Hurunui District, Waimakariri District, Banks Peninsula District, Selwyn District, Christchurch City, Ashburton District
South Canterbury DHB	Timaru District, Mackenzie District, Waimate District
Otago DHB	Waitaki District, Queenstown-Lakes District (Wanaka Ward only), Central Otago District, Dunedin City, Clutha District
Southland DHB	Southland District, Gore District, Invercargill City, Queenstown-Lakes District (Arrowtown and Queenstown Wakatipu Wards only)

SECOND: Membership of boards: Election and appointment of members, and effect of boundary changes on membership

1 Interpretation

Purpose of this schedule

2 Purpose

Electors and candidates

3 Residential qualification for electors

4 Qualification for candidates

5 Candidates not to stand for more than 1 district

6 Candidate to declare conflicts of interest

7 Employees of DHBs may stand for elections

Application of Local Elections and Polls Act 1976

8 Elections governed by Local Elections and Polls Act 1976

9 Timing of elections

10 No by-elections

Rolls for election

11 Rolls for election

Conduct of election

12 Postal voting

Cost of elections

13 Cost to be borne by DHB

When members come into office

14 When elected members come into office

15 When appointed members come into office

Appointment to boards of newly created DHBs

16 Appointment of new DHB

Persons who may not be members of boards

17 Certain persons disqualified from membership

Effect of boundary changes

18 Reorganisation of districts

19 Other alterations of districts

20 Inquiries by Local Government Commission

1 Interpretation

In this schedule, unless the context otherwise requires,--- constituency, in relation to a DHB, means,---

- (a) if the district of the DHB has been divided into constituencies by an Order in Council under section 19, each such constituency; and
 - (b) if the district of the DHB has not been divided in that way, the district of the DHB district, in relation to a DHB, means the geographical area specified opposite to that board in column 2 of Schedule 1
- election of a DHB means an election to elect the elective members of the board of a DHB elector means an elector at an election of a DHB territorial authority has the same meaning as in section 2(1) of the Local Government Act 1974; but does not include the Minister of Local Government triennial general election means a triennial general election held under the Local Elections and Polls Act 1976.

2 Purpose

This schedule has the following purposes:

- (a) to state the qualifications of electors and candidates at DHB elections:
- (b) to apply, with certain modifications, the legislation governing the election of local authorities to DHB elections:
- (c) to link DHB elections to the triennial local authority elections so as to maximise voter participation at DHB elections through effective co-operation between DHBs and territorial authorities:
- (d) to provide for mechanisms relating to the membership and constitution of the boards of DHBs.

3 Residential qualification for electors

A person who is lawfully registered as a parliamentary elector under the Electoral Act 1993 in respect of an address that is within the constituency of a DHB is qualified to be an elector of that constituency at an election of the DHB.

4 Qualification for candidates

A person may be a candidate at an election of a DHB if the person---

- (a) is qualified to be a parliamentary elector; and
- (b) is not disqualified by clause 17.

5 Candidates not to stand for more than 1 district

(1) A person may not at any elections of DHBs held in conjunction with a triennial general election be a candidate for more than 1 district or more than 1 constituency.

(2) If a person is nominated in contravention of subclause (1), every nomination is void, if made with the person's consent.

6 Candidate to declare conflicts of interest

When a candidate gives the responsible Returning Officer notice of the candidate's consent to being nominated as a candidate, the candidate must also give the Returning Officer a statement completed by the candidate in good faith that---

- (a) discloses any conflicts of interest that the candidate has with the DHB as at the date of the candidate's notice of consent, or states that the

- candidate has no such conflicts of interest as at that date; and
- (b) discloses any such conflicts of interest that the candidate believes are likely to arise in future, or states that the candidate does not believe that any such conflicts of interest are likely to arise in future.

7 Employees of DHBs may stand for elections

A person is not prevented from being elected as a member of a DHB simply because the person is an employee of the DHB.

Application of Local Elections and Polls Act 1976

8 Elections governed by Local Elections and Polls Act 1976

- (1) The provisions of the Local Elections and Polls Act 1976 apply, with all necessary modifications, to every election of a DHB.
- (2) Subclause (1) is subject to the provisions of this Act and to any regulations made under this Act.

9 Timing of elections

- (1) The elections of DHBs must be held in conjunction with every triennial general election.
- (2) For the purposes of subclause (1), the first triennial general election is the one to be held in 2001.

10 No by-elections

No by-election or poll may be held under the Local Elections and Polls Act 1976 for the purpose of electing a member to a board.

Rolls for election

11 Rolls for election

- (1) If the district of a DHB is situated wholly within the district of any territorial authority, the roll of residential electors for that part of the territorial authority's district that is the same as the DHB's district is the roll of electors for the election of the DHB.

(2) In any other case, the rolls of residential electors or relevant parts of those rolls, as the case may require, in respect of the districts of the territorial authorities that are situated wholly or partly within the district of a DHB are the rolls of electors for the election of the DHB.

(3) The principal administrative officer of every territorial authority whose district is situated wholly or partly within the district of a DHB must indicate on the roll of residential electors for the district of that territorial authority, by appropriate words, abbreviations, or marks, the names of the persons entitled to vote at the election of the DHB; and if the district of the DHB has, by an Order in Council under section 19, been divided into constituencies, that officer must also indicate the constituency in respect of which those persons may vote at that election.

Conduct of election

12 Postal voting

(1) Every election of a DHB must be conducted by postal vote.

(2) Part III of the Local Elections and Polls Act 1976 applies, with all necessary modifications, to every election of a DHB as if the DHB concerned had determined, under section 66(1) of that Act, that the election be conducted by postal vote.

(3) Every returning officer must include in the papers that are sent to electors a copy of the statement relating to conflicts of interest provided to the returning officer by each candidate under clause 6.

(4) This clause is subject to any regulations made under this Act.

Cost of elections

13 Cost to be borne by DHB

The costs incurred by every territorial authority in conducting an election of a DHB must be borne and paid for by the DHB.

When members come into office

14 When elected members come into office

Despite anything in section 6 of the Local Elections and Polls Act 1976, every person who is elected as a member of a board at an election of a DHB comes into office on the 58th day after polling day.

15 When appointed members come into office

Every appointed member comes into office on the date specified for that purpose in the notice appointing the member or, if no date is specified in the notice, from the date on which the notice is published in the Gazette.

Appointment to boards of newly created DHBs

16 Appointment of new DHB

(1) If an Order in Council made under section 19(2) creates a new DHB by adding it to Schedule 1, the Minister may appoint persons to hold positions on the board of that DHB that would otherwise be held by elected members.

(2) Section 29(2) applies with any necessary modifications to an appointment made under subclause (1).

(3) Persons appointed under subclause (1) hold office until the 58th day after polling day for the next election of the DHB (subject to clauses 7 and 8 of Schedule 3).

(4) To avoid any doubt, for the purposes of subclause (1), the renaming of a DHB is not the creation of a new DHB.

Persons who may not be members of boards

17 Certain persons disqualified from membership

(1) None of the following persons may be elected or appointed as a member of a board, or appointed as a member of a board committee, of a DHB:

- (a) a person who has been convicted of an offence punishable by imprisonment for a term of 2 years or more, and who has not obtained a pardon, or served the sentence or otherwise suffered the penalty imposed:
- (b) a person who is subject to a sentence of imprisonment for an offence punishable by a term of imprisonment of less than 2 years:
- (c) a person who is subject to an order made under any of sections 10, 11, 12, and 30 of the Protection of Personal and Property Rights Act 1988, or whose property is managed by a trustee corporation under section 32 of that Act:
- (d) a person who is an undischarged bankrupt:
- (e) a person who has, since the date on which members of boards elected at the immediately preceding triennial general election came into office, been removed as a member of a board for any reason specified

in clause 9(c) or (e) of Schedule 3:

- (f) a person who has failed to declare a material conflict of interest before accepting nomination as candidate for an election of a DHB held in conjunction with the immediately preceding triennial general election.

(2) In addition to the grounds specified in subclause (1), a person may not be elected as a member of a board if the person is incapable of being elected as a member of a local authority because of section 112 of the Local Elections and Polls Act 1976.

Effect of boundary changes

18 Reorganisation of districts

(1) In this clause, Order in Council is a reference to an Order in Council made under section 19(2).

(2) If an Order in Council abolishes 2 or more DHBs and constitutes a new DHB whose district consists of the districts of the abolished DHBs, the boards of the abolished DHBs are united into a new board (a united board).

(3) If an Order in Council dissolves or divides 1 DHB by transferring its district in whole or in part to the districts of 1 or more other DHBs, the Minister may, at the time that the Order takes effect, assign any member of the board of the dissolved or divided DHB to any board (an augmented board) of those other DHBs.

(4) Throughout the relevant period specified in subclause (7), a united board consists of all the currently elected and appointed members of each board of the abolished DHBs (even if the total number of those members exceeds 11).

(5) Throughout the relevant period specified in subclause (7), the members of an augmented board include the member or members assigned to it under subclause (3) (even if the total number of those members exceeds 11).

(6) The provisions of Schedule 3 continue to apply, with any necessary modifications, to every united board and to every augmented board.

(7) The relevant period referred to in subclause (4) and subclause (5) commences on the date that the Order in Council takes effect and ends with the close of the 58th day after polling day for the next elections of DHBs.

19 Other alterations of districts

The membership of a board is not affected by---

- (a) an alteration of the district or the constituency of the DHB made by an Order in Council under section 19 (other than a reorganisation of districts described in clause 18); or

- (b) the abolition or alteration of any local government area or ward specified in column 2 of Schedule 1.

20 Inquiries by Local Government Commission

If at any time the Minister is of the opinion that for the purposes of this Act an inquiry should be made into any question relating to the union, reconstitution, or alteration of the boundaries of any district or constituency of a DHB, the Minister may request the Minister of Local Government to refer the question to the Local Government Commission for inquiry and report.
Compare: 1983 No 134 s 8E

THIRD: Provisions applying to DHBs and their boards

Schedule 3 s 45(1)

Provisions applying to DHBs and their boards

Interpretation

- 1 Interpretation

Members

- 2 Appointed members
- 3 Elected members
- 4 Terms or conditions of office, and remuneration
- 5 Training relating to members' obligations and duties
- 6 Resignation
- 7 Vacation of office
- 8 Removal from office
- 9 Reasons for removal of elected members

Chairperson and deputy chairperson

- 10 Chairperson and deputy chairperson
- 11 Resignation
- 12 Vacation of office
- 13 Removal from office

Teleconferences

- 14 Teleconferences
- 15 Further provisions relating to teleconferences

Notice of meetings

- 16 Meetings of boards to be publicly notified
- 17 Meetings not publicly notified in accordance with clause 16
- 18 Members to be notified of meetings

Information relating to meetings

- 19 Availability of agendas and reports
- 20 Availability of agendas and reports in special circumstances
- 21 Public may inspect or request copies of minutes of meeting
- 22 Public notification of resolution at emergency meeting
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1 Interpretation

In this schedule, unless the context otherwise requires,---

district, in relation to a DHB, means the geographical area opposite to the DHB in column 2 of Schedule 1

meeting, in relation to a board, means any annual, biennial, triennial, ordinary, special, or emergency meeting of the board at which resolutions or decisions of the board are made

minutes, in relation to a meeting of a board, means any record of the meeting
publicly notify, in relation to a board of a DHB, means to give the resident population of the DHB notice by advertisements in 1 or more newspapers circulating in the district of the DHB, or by advertisements of that kind and any 1 or more of the following means:

- (a) printed placards affixed to public places in that district:
- (b) radio or television broadcasts:
- (c) notices available on the Internet, or given by any other electronic means.

Compare: 1987 No 174 ss 2(1), 45

Members

2 Appointed members

Appointed members of the board of a DHB---

- (a) must be appointed for 3 years or a shorter period:
- (b) are eligible for reappointment unless they have held office for 6 consecutive years, in which case they must not be reappointed immediately unless the Minister consents in writing to them being re-

- appointed immediately and holding office consecutively for longer than 6 years but not exceeding 9 years:
- (c) may also hold office as appointed members of the board of 1 or more other DHBs.

3 Elected members

Elected members of the board of a DHB,---

- (a) if they have not ceased to hold that office earlier and are not re-elected in the next triennial election of members of boards, cease to hold that office when the members elected in that election come into office:
- (b) are not to hold office as an elected or appointed member of the board of any other DHB.

**4 Terms or conditions of office, and remuneration **

Members of a board---

- (a) have the terms or conditions of office, consistent with this Act, that the Minister determines:
- (b) are remunerated as the Minister determines.

5 Training relating to members' obligations and duties

(1) A board that has elected or appointed to it a member or members not already familiar with the obligations and duties of a member of a board, Māori health issues, Treaty of Waitangi issues, or Māori groups or organisations in the district of the DHB concerned must fund and, to the extent practicable, ensure the member or members undertake and complete, training approved by the Minister relating to whichever of those matters the member or members are not familiar with.

(2) Any such board must keep an up-to-date record of the following matters:

- (a) the name of each member of the board:
- (b) the date on which each member of the board most recently came into office as a member of the board:
- (c) any familiarity each member of the board has at that date with the obligations and duties of a member of a board, Māori health issues, Treaty of Waitangi issues, and Māori groups or organisations in the district of the DHB concerned:
- (d) the nature of the training (if any) the board is required by subclause (1) to fund and, to the extent practicable, have any of its members undertake and complete:
- (e) the date that training was completed or, if it is still in progress, the date on which it started and the date by which it is expected to have been completed or, if it has not yet started, the date on which it is expected to start.

(3) A board asked by the Minister to give him or her a copy of the record must comply with that request as soon as practicable, and no later than 5 working days after the request.

6 Resignation

A member of a board may resign that office by notice in writing to the Minister and the board stating the date on which the resignation takes effect.

7 Vacation of office

(1) A member of a board ceases to hold that office if---

- (a) he or she is an appointed member of the board and the period of his or her appointment as such expires; or
- (b) he or she dies; or
- (c) the DHB to which the board relates is disestablished by an Order in Council made under section 19(2).

(2) For the purposes of subclause (1)(c), a DHB is not disestablished just because it---

- (a) is renamed; or
- (b) is involved in a reorganisation of districts (as described in clause 18 of Schedule 2); or
- (c) has its district altered (as described in clause 19 of Schedule 2).

(3) Subclause (1) overrides any deed or agreement, but does not limit section 31 (replacement of board by commissioner).

8 Removal from office

(1) The Minister may remove a member of a board from that office by notice in the Gazette stating the date on which the removal takes effect but, if the member is an elected member of the board,---

- (a) only if the Minister has first consulted the member, and the board, about the removal; and
- (b) only for a reason stated in clause 9.

(2) Subclause (1) overrides any deed or agreement.

9 Reasons for removal of elected members

The reasons referred to in clause 8(1)(b) are---

- (a) that, if an election of members of the board were held immediately, the member would be disqualified from that election for a reason stated in

clause 17 of Schedule 2 (other than the reasons stated in clause 17(1)(e) and (f) of that schedule):

- (b) that the Minister is satisfied that the member failed to declare an interest in circumstances where clause 6 of Schedule 2, or clause 36, required the member to do so:
- (c) that the Minister is satisfied that the integrity of the board, or of the DHB to which the board relates, has been seriously compromised because the member---
 - (i) has neglected his or her duties as a member of the board; or
 - (ii) has failed to perform his or her duties under this Act:
- (d) that the member has, without permission from the board or Minister and without any reasonable excuse, been absent from 4 consecutive meetings of the board:
- (e) that the member has breached any of the obligations and duties of a board member that applied to the member.

10 Chairperson and deputy chairperson

(1) The Minister must, by notice in the Gazette, appoint 1 member from the elected or appointed members of the board as chairperson of the board, and another as deputy chairperson of the board.

(2) The notice---

- (a) may be the same notice as the notice under section 29 appointing the member; and
- (b) must state the period (starting at or after the time the member comes into that office, and ending at or before the time he or she must cease to be a member) for which the member is appointed chairperson or deputy chairperson and the date on which he or she comes into that office.

(3) A member appointed chairperson or deputy chairperson and whose appointment as such has expired---

- (a) continues in that office until his or her successor is appointed; and
- (b) is eligible for reappointment to that office so long as he or she continues to be a member of the board.

11 Resignation

(1) A chairperson or deputy chairperson may resign from that office by written notice to the Minister and board stating the date on which the resignation takes effect.

(2) A chairperson or deputy chairperson who resigns from that office continues to be a member of the board unless he or she also resigns from that office, under clause 6.

12 Vacation of office

- (1) A chairperson or deputy chairperson ceases to hold that office if he or she ceases to be a member of the board.
- (2) A deputy chairperson ceases to hold that office if he or she is appointed chairperson of the board.
- (3) Subclauses (1) and (2) override any deed or agreement, but do not limit section 31 (replacement of board by commissioner).

13 Removal from office

- (1) A chairperson or deputy chairperson may be removed from that office by the Minister by notice in the Gazette stating the date on which the removal takes effect, but only if the Minister has first consulted the chairperson or deputy chairperson, and board, about the removal.
- (2) Subclause (1) overrides any deed or agreement.
- (3) A chairperson or deputy chairperson removed from that office continues to be a member of the board unless also removed from that office, under clause 8(1).

14 Teleconferences

- (1) A number of members of a board (being a number not less than the quorum provided by clause 25) may, whether or not any member or members of the board are out of New Zealand, have a teleconference by contemporaneous linking together by telephone or other means of communication, if the requirements in subclauses (2) to (4) are satisfied.
- (2) In any teleconference, no resolution of the board may be voted on, and no decision of the board may be made.
- (3) Notice of any teleconference must, before the teleconference, have been given by telephone or other means of communication to every member of the board.
- (4) Each member taking part in a teleconference by telephone or other means of communication must, wherever practicable,---
 - (a) be linked by telephone or such other means for the purposes of the teleconference; and
 - (b) at the start of the teleconference acknowledge, to all the other members taking part, the member's participation in the teleconference; and

- (c) be able, throughout the teleconference, to hear each of the other members taking part.

15 Further provisions relating to teleconferences

- (1) Each teleconference must have a presiding member, to be determined in accordance with clause 27.
- (2) A member must not leave a teleconference by disconnecting his or her telephone or other means of communication unless he or she has first obtained permission to do so from the member presiding in the teleconference.
- (3) A member who, at the start of a teleconference acknowledged, to all the other members taking part, the member's participation in the teleconference, must be treated as having taken part, and as having formed part of the quorum, in all of the teleconference before the member who presided in it expressly permitted the member to leave it.
- (4) A written record of a teleconference must be made by the member who presided in it, and any such written record that is certified correct by that member is sufficient evidence of it and that it complied with this clause and clause 14(1), unless the contrary is proved.

16 Meetings of boards to be publicly notified

- (1) Each board must, not more than 14 days and not less than 5 days before the end of each month, publicly notify a list of all meetings of that board scheduled to be held in the following month, together with the dates on which, and the times and places at which, the meetings are to be held.
- (2) However, if a meeting of a board is to be held on or after the 21st day of any month, the board may, instead of publicly notifying the meeting under subclause (1), publicly notify the meeting not more than 10 nor less than 5 working days before the day on which the meeting is to be held.
- (3) If a special meeting of a board is called and notice of the meeting cannot be given in the manner required or permitted by this clause, the board must publicly notify or otherwise advertise the meeting, and the general nature of business to be transacted at the meeting, as soon as practicable before the meeting is to be held.
- (4) If an emergency meeting of a board is called and notice of the meeting cannot be given in the manner required or permitted by this clause for a scheduled or special meeting, the board or member of the board calling the meeting must give any public notice of the meeting and the business to be transacted at the meeting that is reasonable in the circumstances.
Compare: 1987 No 174 s 46(1)-(4)

17 Meetings not publicly notified in accordance with clause 16

(1) No meeting of a board is invalid just because it was not publicly notified in accordance with clause 16.

(2) If a board becomes aware that any meeting of the board has not been publicly notified in accordance with clause 16, the board must, as soon as practicable, give public notice that the meeting was not so notified, and must, in that notice,---

- (a) state the general nature of the business transacted at the meeting; and
- (b) give the reasons why the meeting was not so notified.

Compare: 1987 No 174 s 46(5), (6)

18 Members to be notified of meetings

(1) The chairperson must ensure that each member of a board is given notice of a meeting of the board as early as practicable before the meeting is to be held.

(2) The notice must be written, and may be given by delivery or by electronic transmission (for example, by fax or e-mail).

(3) For the purposes of subclause (1), it is enough if the chairperson made all reasonable efforts to ensure each member was given the notice by the time required under that subclause.

Information relating to meetings

19 Availability of agendas and reports

(1) Any member of the public may, without payment of any fee, inspect, during normal office hours, within a period of at least 2 working days before every meeting of a board, all agendas and associated reports circulated to members of the board and relating to the meeting.

(2) The board must, from time to time, authorise a person to act for it for the purposes of this subclause, and that person---

- (a) may exclude from the reports made available any reports or items

from reports he or she reasonably expects the meeting to discuss with the public excluded; and

- (b) must indicate on each agenda items he or she reasonably expects the meeting to discuss with the public excluded.
- (3) The agendas must be available for inspection at a place or places within the district, and must be accompanied by either---
 - (a) the associated reports; or
 - (b) a notice specifying the place or places at which the associated reports may be inspected.

(4) The associated reports must be available for inspection at a place or places within the district.

(5) Any member of the public may take notes from any agenda or report inspected by that member of the public.

(6) Every member of the public who inspects an agenda or report made available under this clause and requests a copy of all or any part of any such agenda or report must, if he or she tenders an amount that represents the reasonable costs of making one available, be given such a copy as soon as practicable.

(7) This clause is subject to clause 20.

Compare: 1987 No 174 s 46A(1)-(5), (8)-(9)

20 Availability of agendas and reports in special circumstances

(1) If a meeting is an emergency meeting or a special meeting called pursuant to a resolution of the board, the agenda and any associated reports must be made available as soon as is reasonable in the circumstances.

(2) The board must, from time to time, authorise a person to act for it for the purposes of this subclause, and that person---

- (a) may exclude from the reports made available any reports or items from reports that the meeting discussed with the public excluded; and
- (b) must indicate on each agenda items the meeting discussed with the public excluded.

Compare: 1987 No 174 s 46A(6), (8)-(9)

21 Public may inspect or request copies of minutes of meeting

(1) Any member of the public may, within a reasonable time after any meeting of a board, without payment of any fee and during normal office hours, inspect the minutes of the meeting or any part of it, unless it was a meeting or part of a meeting from which the public was excluded.

(2) The minutes must be available for inspection at a place or places within the district.

(3) Any member of the public may take notes from any minutes inspected by that member of the public.

(4) Every member of the public inspecting any such minutes who requests a copy of all or any part of those minutes must, if he or she tenders an amount equal to the reasonable costs of making one available, be given such a copy.

(5) If any person requests a copy of the minutes of any meeting or part of a meeting from which the public was excluded, the board must deal with the request as follows:

- (a) if it is made by or on behalf of a natural person, and is for access to any personal information that is about that person, as if it were a request made under subclause (1)(b) of principle 6 of the Privacy Act 1993:
- (b) in any other case, as if it were a request for access to official information made under the Official Information Act 1982.

Compare: 1987 No 174 s 51

22 Public notification of resolution at emergency meeting

If a resolution is passed at an emergency meeting of a board, the board must publicly notify the resolution as soon as practicable, unless it was passed at a meeting or part of a meeting from which the public was excluded.

Compare: 1987 No 174 s 51A

23 Defamatory matter in copy of agenda or additional particulars supplied to public or in minutes of meeting

(1) This clause applies if all or any part of a meeting of any board is open to the public, and---

- (a) a copy of the agenda for the meeting, with or without further statements or particulars for the purpose of indicating the nature of any item included in the agenda, is supplied to a member of the public; or
- (b) the minutes of the meeting or part are produced, for inspection, to any member of the public, or a copy of them is given to any member of the public.

(2) The publication, in that way, of any defamatory matter in the agenda, or in the further statements or particulars, or in the minutes, is privileged.

(3) This clause does not apply if, in any proceedings for defamation in respect of that publication, the plaintiff proves that, in publishing the matter, the defendant was predominantly motivated by ill will towards the plaintiff, or otherwise took improper advantage of the occasion of publication.

Compare: 1987 No 174 s 52

24 Oral statements at meetings privileged

(1) Any oral statement made at any meeting of a board in accordance with the rules that have been adopted by the board for the guidance and order of its meetings is privileged.

(2) This clause does not apply if, in any proceedings for defamation in respect of the statement, the plaintiff proves that, in making the statement, the defendant was predominantly motivated by ill will towards the plaintiff, or otherwise took improper advantage of the occasion of publication.

(3) The privilege conferred by this clause is in addition to and not in substitution for or derogation of any other privilege, whether absolute or qualified, that applies, by virtue of any other enactment or rule of law, to meetings of any board.

Compare: 1987 No 174 s 53

Procedure at meetings

25 Quorum

(1) No authority, power, or discretion of a board can be exercised, and no business of a board can be transacted, at any meeting of the board, unless the quorum of members of the board is present at the meeting.

(2) The quorum of members of a board is,---

- (a) if the total number of members of the board is an even number, half that number; but
- (b) if the total number of members of the board is an odd number, a majority of the members.

(3) Despite subclause (2), the Minister may, by written notice to all members of a board given before a certain meeting or meetings of the board, or before any meetings of the board within a certain period, set a quorum other than that in subclause (2) for the meeting or meetings of the board, if---

- (a) a member of the board gives the Minister a written statement of reasons why the Minister should do so; and
- (b) the Minister considers that those reasons are good reasons and is satisfied that those reasons exist in fact.

(4) For the purposes of subclause (3), it is enough if the Minister made all reasonable efforts to give all members the notice before the meeting or meetings.

26 Further provisions relating to quorum

For the purposes of subclauses (2) and (3) of clause 25,---

- (a) a member who has declared an interest under clause 36 in relation to a transaction must not, for the purposes of that transaction, be counted, unless the Minister has waived or modified the application of clause 36(2); and
- (b) vacancies in the appointed membership of the board because the Minister has appointed fewer than the maximum number of members the Minister may appoint under section 29(1)(b), must not be counted; and
- (c) vacancies in the elected membership of the board after an election of members of a board, or members the Minister appoints under section 29(2) to fill those vacancies, must not be counted; and
- (d) it does not matter that 1 or more vacancies have occurred in the

elected membership of the board and the Minister has not yet filled them by appointing 1 or more replacement members under section 29(3).

27 Presiding member

- (1) At each meeting of a board the chairperson of the board presides, if he or she is present and willing to do so.
- (2) If the chairperson of a board is not present or willing to preside at a meeting of the board, the deputy chairperson of the board presides, if he or she is present and willing to do so.
- (3) If neither the chairperson nor the deputy chairperson of a board is present and willing to preside at a meeting of the board, the members present at the meeting must elect a member who is present to preside at the meeting.

28 Dealing with items not on agenda for meeting

- (1) If an item is not on the agenda for a meeting of a board, that item may be dealt with at the meeting if the board by resolution so decides, and the presiding member explains at the meeting, at a time when it is open to the public,---
 - (a) the reason why the item is not on the agenda; and
 - (b) the reason why the discussion of the item cannot be delayed until a later meeting.
- (2) Despite subclause (1), if an item is not on the agenda for a meeting of a board,---
 - (a) the item may be discussed at the meeting if---
 - (i) the item is a minor matter relating to the general business of the board; and
 - (ii) the presiding member explains at the beginning of the meeting, at a time when it is open to the public, that the item will be discussed at the meeting; but
 - (b) No resolution, decision, or recommendation may be made in respect of the item except to refer the item to a later meeting of the board for further discussion.

Compare: 1987 No 174 s 46A(7), (7A)

29 Voting

- (1) All questions arising at any meeting of a board must be decided by a majority of the votes cast by the members present.
- (2) If a vote is tied, the member presiding at the meeting has no second or

casting vote, and the question is negatived.

30 Supplementary procedure

A board may regulate its procedure, at its meetings and otherwise, in any manner not inconsistent with this Act it thinks fit.

Admission of public

31 Admission of public

Except as provided in clauses 32 to 35, every meeting of a board must be open to the public.

Compare: 1987 No 174 s 47

32 Right of board to exclude public

A board may by resolution exclude the public from the whole or any part of any meeting of the board only on 1 or more of the following grounds:

- (a) that the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982:
- (b) that the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information the public disclosure of which would---
 - (i) be contrary to the provisions of a specified enactment; or
 - (ii) constitute contempt of court or of the House of Representatives:
- (c) that the purpose of the whole or the relevant part of the meeting is to consider a recommendation of an Ombudsman made under section 30(1) or section 35(2) of the Official Information Act 1982 to the board:
- (d) that the purpose of the whole or the relevant part of the meeting is to consider a communication from the Privacy Commissioner arising out of an investigation under Part VIII of the Privacy Act 1993:

- (e) that the exclusion of the public from the whole or the relevant part of the meeting is necessary to enable the board to deliberate in private on a decision or recommendation as to whether any of the grounds in paragraphs (a) to (d) are established in relation to all or any part of any meeting of the board.

Compare: 1987 No 174 s 48(1)

33 Resolution excluding public

(1) Every resolution excluding the public from any meeting of a board must state---

- (a) the general subject of each matter to be considered while the public is excluded; and
- (b) the reason for the passing of that resolution in relation to that matter, including, where that resolution is passed in reliance on clause 32(a), the particular interest or interests protected by section 6 or section 7 or section 9 of the Official Information Act 1982 which would be prejudiced by the holding of the whole or the relevant part of the meeting in public; and
- (c) the grounds on which that resolution is based (being 1 or more of the grounds stated in clause 32).

(2) Every resolution to exclude the public must be put at a time when the meeting is open to the public, and the text of that resolution (or copies of it) must---

- (a) be available to any member of the public who is present; and
- (b) form part of the minutes of the board.

(3) A resolution to exclude the public may also provide for a specified person or persons to remain after the public has been excluded if that person, or those persons, has or have, in the board's opinion, knowledge that will help it.

(4) If a board resolves that a person or persons may remain after the public has been excluded, the resolution must state---

- (a) the knowledge possessed by that person or those persons that will be helpful in relation to the matter to be discussed; and
- (b) how it is relevant to that matter.

(5) The person or persons must not disclose to anyone not present at the meeting while the public was excluded and the person or persons remained any information that the person or persons became aware of only at the meeting while the public was excluded and the person or persons remained.

Compare: 1987 No 174 s 48(3)-(6)

34 Provisions applying when meeting open to public

The following provisions apply when all or any part of a meeting of a board is required by this schedule to be open to the public:

- (a) for the purposes of this schedule, genuine members of the news media must be treated as members of the public, and are entitled to attend any meeting or any part of a meeting for the purpose of reporting it for any news media:
- (b) if the agenda for any meeting is copied by any means for use by members of a board, that board must also cause to be made any additional copies of the agenda that in that board's opinion may be necessary to ensure there is an adequate supply for any persons requesting copies under paragraph (c):
- (c) any member of the public who attends a meeting of a board and requests a copy of the agenda must, if he or she tenders an amount equal to the reasonable costs of making one available, be given (and may take away with him or her) any spare copy of the agenda:
- (d) copies of the agenda supplied for members of the public as provided in paragraph (b) must include any further statements or particulars necessary to indicate the nature of any items included in the agenda, unless that item refers to any matter to be considered by the board when the meeting is not likely to be open to the public.

Compare: 1987 No 174 s 49

35 Maintenance of order

- (1) At any meeting of any board the presiding member of the board may require a member of the public attending the meeting to leave it if the presiding member believes on reasonable grounds that, if the member of the public is permitted to remain, the behaviour of the member of the public is likely to prejudice, or to continue to prejudice, the orderly conduct of the meeting.
- (2) At the request of the presiding member, a member of the police, or officer or employee of the DHB concerned may remove or, as the case requires, exclude a member of the public from a meeting of a board if the member of the public has been required under this clause to leave the meeting but---
 - (a) refuses or fails to leave it; or
 - (b) having left it, attempts to re-enter it without the permission of the presiding member.

Compare: 1987 No 174 s 50

Disclosure of members' interests

36 Disclosure of interests

- (1) A member of a board of a DHB who is interested in a transaction of the DHB must, as soon as practicable after the relevant facts have come to the member's knowledge, disclose the nature of the interest to the board.
- (2) A member of a board who makes a disclosure under this clause must not (unless subclause (4) applies, or the Minister, by a waiver or modification of the application of this subclause under clause 37, permits)---
 - (a) take part, after the disclosure in any deliberation or decision of the board relating to the transaction; or
 - (b) be included in the quorum required by clause 25 for any such deliberation or decision.
- (3) A disclosure under this clause must be recorded in the minutes of the next meeting of the board concerned and entered in a separate interests register maintained for the purpose.
- (4) However, a member of the board who makes a disclosure under this clause may take part in any deliberation (but not any decision) of the board relating to the transaction concerned if a majority of the other members of the board permits the member to do so.
- (5) If subclause (4) applies, the board must record in the minutes of its next meeting---
 - (a) the permission and the majority's reasons for giving it; and
 - (b) what the member says in any deliberation of the board relating to the transaction concerned.
- (6) Every member of a board of a DHB must ensure that---
 - (a) the statement completed by the member under section 29(6) or clause 6 of Schedule 2 is incorporated in the interests register maintained under subclause (3); and
 - (b) any relevant change in the member's circumstances affecting a matter disclosed in that statement is entered in that register as soon as practicable after the change occurs.

37 Minister may waive or modify application of clause 36(2)

(1) The Minister may, if satisfied it is in the public interest, or the interests of the DHB concerned, to do so, waive or modify the application of all or any part of clause 36(2) in respect of---

- (a) any particular member of a board:
- (b) any transaction, or class of transaction.

(2) The Minister must effect any waiver or modification under subclause (1) by written notice to the board, and may make the waiver or modification subject to any conditions the Minister thinks fit.

(3) The Minister must present to the House of Representatives a copy of any such notice within 12 sitting days after the date on which the Minister issues the notice.

Committees

38 Committees

(1) A board of a DHB may---

- (a) establish 1 or more committees of the board for a particular purpose or purposes:
- (b) appoint, as members of a committee of the board, or as the chairperson or deputy chairperson of any such committee, either members of the board, or other persons, or both:
- (c) dismiss any member, or chairperson, or deputy chairperson, of a committee of the board:
- (d) dissolve any committee of the board.

(2) In making appointments to a committee of a board, the board must endeavour, where appropriate, to ensure representation of Māori on the committee.

(3) If a board of a DHB dismisses any member, or chairperson, or deputy chairperson, of a committee of the board, under subclause (1)(c), the board must, on or as soon as reasonably practicable after the dismissal, give that person a written statement of the board's reasons for the dismissal.

(4) A board may regulate the procedure of each committee of the board in any manner not inconsistent with this Act the board thinks fit.

(5) If meetings of a committee of a board involve making decisions or resolutions on behalf of the board, clauses 16 to 24, 28, and 31 to apply to those meetings as if the committee were the board.

(6) Before a board of a DHB appoints a person who is not a member of the board to a committee of the board, the person must give the board a statement completed by the person in good faith that---

- (a) discloses any conflicts of interest that the person has with the DHB as at the date on which the statement is completed, or states that the person has no such conflicts of interest as at that date; and
- (b) discloses any such conflicts of interest that the person believes are likely to arise in future, or states that the person does not believe that any such conflicts are likely to arise in future.

(7) Nothing in this clause applies in respect of the community and public health advisory committee, or disability support advisory committee, or hospital advisory committee, of the board of any DHB.

(8) Clauses 38 and 39 of Schedule 4 apply to every committee established under this clause.

39 Delegations

(1) Every board must,---

- (a) as soon as practicable after the commencement of this clause, formulate a policy for the exercise of its powers of delegation under this clause:
- (b) keep the policy under review, and amend or replace the policy as it considers appropriate:
- (c) make the policy formulated, and any amendments to or replacements of the policy, publicly available.

(2) A formulation, amendment, or replacement under subclause (1) does not come into force unless it has been approved by the Minister, and the Minister may give his or her approval subject to any conditions the Minister specifies.

(3) When a policy referred to in subclause (1) is in force, every exercise by the board of a power of delegation under this clause must comply with that policy.

(4) A board may, by written notice to a committee of the board, delegate to that committee any of the functions, duties, or powers, of the board, or of the DHB concerned.

(5) A board may, by written notice to any member of the board or employee of the DHB concerned, or person or class of persons approved by the Minister for the purpose, delegate to that member, employee, person, or class of persons any of the functions, duties, or powers, of the board, or of the DHB concerned.

(6) A delegation of a function, duty, or power under this clause---

- (a) is revocable at will;
 - (b) does not prevent the board or DHB concerned from performing the function or duty, or exercising the power.
- (7) A delegation under subclause (5)---
- (a) may be to any named person or to any member of a specified class of persons; and
 - (b) if made to a specified class of persons is, unless it provides otherwise, to each member of the class for the time being, even though the membership of the class has changed since the delegation was made.
- (8) A person who on any day is to perform a function, or duty, or exercise a power, delegated under subclause (5)---
- (a) must, before performing the function or duty or exercising the power, consider whether or not he or she has (or, as the case requires, will have) on that day any conflicts of interest with the DHB; and
 - (b) if the person has (or will have) any such conflicts of interest, must give the board a statement completed by the person in good faith that discloses those conflicts of interest, together with any such conflicts of interest the person believes are likely to arise in future; and
 - (c) if the person has (or will have) no such conflicts of interest, must be treated for the purposes of subclause (9) as if he or she had given the board a statement completed by the person in good faith that states that the person has (or will have) no such conflicts of interest on that day.
- (9) A delegate who has completed a statement under subclause (8) must inform the board of any relevant change in the delegate's circumstances affecting a matter disclosed in that statement, as soon as practicable after the change occurs.

40 Effect of delegation

- (1) If a function, duty, or power of a board or of the DHB concerned is delegated under a delegation under clause 39, the delegate---
- (a) may, unless the delegation provides otherwise, perform the function or duty, or exercise the power, in the same manner, subject to the same restrictions, and with the same effect, as if the delegate were the board, or the DHB concerned; but
 - (b) may not delegate the function, duty, or power, except in accordance with the provisions of the delegation or with the written consent of the board.
- (2) A delegate under clause 39(5) who is interested in a transaction of

the DHB concerned may not perform a function or duty, or exercise a power, under the delegation, if the function, duty, or power relates to the transaction.

(3) Subclause (2) does not apply if the board of the DHB gives its prior written consent to the delegate performing the function or duty, or exercising the power, even though the function, duty, or power relates to the transaction.

(4) Nothing in this clause requires any delegate under clause 39(5) to hold a public meeting.

(5) Every delegate who purports to perform a function or duty, or exercise a power, under a delegation under clause 39 is presumed to do so in accordance with that delegation, unless the contrary is proved.

41 Seal

(1) A board of a DHB may adopt a common seal of the DHB in any form the board decides.

(2) If a board of a DHB adopts a seal of the DHB,---

(a) the board must provide for the safe custody of the seal; and

(b) the seal may be used only under the authority of a resolution of the board, or of a committee of the board authorised in that behalf.

(3) Every document to which any seal of a DHB is affixed must be signed by 2 people who are---

(a) members of the board of the DHB; or

(b) people appointed by that board to sign that document, or documents of that kind.

(4) A document to which the seal of a DHB appears to have been affixed must be treated as a document to which that seal has been affixed, unless the contrary is proved.

42 Contracts and other enforceable obligations

(1) A contract or other enforceable obligation may be entered into by a DHB as stated in subclauses (2) to (4).

(2) An obligation which, if entered into by a natural person would be required to be by deed, must be entered into on behalf of the DHB in writing under---

- (a) any common seal of the DHB, in accordance with clause 41; or
- (b) the witnessed signatures of 2 people of the kind described in clause 41(3).

(3) An obligation which, if entered into by a natural person would be required to be in writing, may be entered into on behalf of the DHB in writing by a person acting under the express or implied authority of the DHB.

(4) An obligation which, if entered into by a natural person would not be required to be in writing, may be entered into on behalf of the DHB orally by a person acting under the express or implied authority of the DHB.

(5) Despite subclause (2), no obligation entered into by or on behalf of the DHB, under the authority of a general or specific resolution of the board of the DHB, is invalid just because it was not entered into in accordance with subclause (2).

(6) Subclauses (3) and (4) do not prevent an obligation being entered into by a DHB in the manner stated in subclause (2).

(7) This clause does not limit clause 43 or subclause (2) or (4) of clause 44.

43 Dealings with land

(1) No DHB may sell, exchange, mortgage, or charge land without the prior written approval of the Minister.

(2) No DHB may grant a lease or licence for a term of more than 5 years over land without the prior written approval of the Minister.

(3) For the purposes of subclause (2), the term of a lease or licence includes any period (or, if the lease or licence provides for more than 1 such period, the total period) for which any person is entitled to have the lease or licence renewed.

(4) Before approving the sale or exchange of any land under subclause (1), the Minister must be satisfied that---

- (a) the DHB concerned is, as a result of consultations with its resident population, aware of the views within the population about the proposed sale or exchange; and
- (b) the sale or exchange of the land will assist the DHB to meet its objectives under section 22; and
- (c) the DHB will comply with any applicable requirement under subclause (5).

(5) Every DHB must use the proceeds of a sale of land, and any payments received in connection with an exchange of land, for the purchase, improvement, or extension of publicly-owned facilities for health purposes unless the Minister, by written notice to the DHB, approves a different use of the proceeds or payments.

(6) Any approval under this clause may be subject to any conditions the Minister specifies, and may be given in respect of any land of a class the Minister specifies.

(7) A DHB that receives a written approval under this clause must, as soon as practicable, table the approval at a meeting of the DHB.

(8) In this clause, DHB includes a subsidiary of a DHB.

(9) To avoid any doubt, the matters to which the Minister may have regard in giving an approval under subclause (2) in relation to any land include the question of the application to the land of clause 3 of the First Schedule of the Health Sector (Transfers) Act 1993.

44 Employees of DHBs

(1) The terms and conditions of employment of a chief executive of a DHB appointed by its board are to be determined by agreement between the board and the chief executive, except that the board must not finalise those terms and conditions, or agree to any amendments to any or all of those terms and conditions once they have been finalised, without first obtaining the consent of the State Services Commissioner.

(2) The individual for the time being acting in the position of chief executive of a DHB may enter into a collective agreement on behalf of the DHB with any or all employees of the DHB, except that that individual must not finalise any such collective agreement without first consulting the Director-General on the terms and conditions of any such collective agreement.

(3) The Governor-General may, by Order in Council,---

- (a) exempt any DHB, or any DHB specified in the order, from the requirement to consult in subclause (2); or
- (b) revoke any order made under paragraph (a) in order to end an exemption from that requirement for the DHBs or DHB concerned.

(4) In respect of any DHB, matters relating to decisions on individual employees (for example, relating to the appointment, promotion, demotion, transfer, personal grievances, disciplining, or cessation of employment, of an employee) are the independent responsibility of the individual for the time

being acting as chief executive of that DHB, without any interference from the board of the DHB or from committees of the board (or from members of the board or of committees of the board).

Compare: 1993 No 22 s 43(1)-(3)

Borrowing and investment

45 Borrowing

(1) A DHB must not raise a loan and no person may lend money to a DHB, except in accordance with regulations made under this Act or with the consent of the Minister of Finance.

(2) In this clause, raising a loan has the same meaning as in section 2(1) of the Public Finance Act 1989.

(3) In this clause, DHB includes a subsidiary of a DHB.

46 Investment

(1) A DHB that has any money not immediately required for expenditure by the DHB may invest that money only---

- (a) on deposit with any bank in New Zealand, or any bank outside New Zealand approved by the Minister of Finance for the purpose; or
- (b) in any security issued by any bank in New Zealand; or
- (c) in any public security; or
- (d) in any other security of a class specified in regulations made under this Act, or approved by the Minister of Finance, for the purposes of this paragraph.

(2) In this clause, bank and public security have the same meanings as in section 2(1) of the Public Finance Act 1989.

(3) A DHB may sell, or convert into money, any such securities.

(4) In this clause, DHB includes a subsidiary of a DHB.

47 Tax status

(1) For the purposes of the Inland Revenue Acts, each DHB is a public authority.

(2) In this clause, Inland Revenue Acts has the same meaning as in section 3(1) of the Tax Administration Act 1994.

Address for service

48 Address for service

The address for service in respect of a DHB is the address of the head office of the DHB.

49 Archives Act 1957 to apply

The Archives Act 1957 applies to information held by DHBs that is of a kind specified by regulations made under this Act.

FOURTH: Provisions applying to community and public health advisory committees, disability support advisory committees, and hospital advisory committees

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1 Interpretation

In this schedule, unless the context otherwise requires,---

board, in relation to a committee, means the board that established the committee, being the board of a DHB

committee means the community and public health advisory committee, disability support advisory committee, or hospital advisory committee, of the board

district, in relation to a committee of the board of a DHB, means the geographical area opposite to the DHB in column 2 of Schedule 1

meeting, in relation to a committee, means any annual, biennial, triennial, ordinary, special, or emergency meeting of the committee at which resolutions or decisions of the committee are made

minutes, in relation to a meeting of a committee, means any record of the meeting

publicly notify, in relation to a committee of the board of a DHB, means to give the resident population of the DHB notice by advertisements in 1 or more newspapers circulating in the district of the DHB, or by advertisements of that kind and any 1 or more of the following means:

- (a) printed placards affixed to public places in that district:
- (b) radio or television broadcasts:
- (c) notices available on the Internet, or given by any other electronic means.

Compare: 1987 No 174 ss 2(1), 45

2 Functions of community and public health advisory committees

(1) The functions of the community and public health advisory committee of the board of a DHB are to give the board advice on---

- (a) the needs, and any factors that the committee believes may adversely affect the health status, of the resident population of the DHB; and
- (b) priorities for use of the health funding provided.

(2) The aim of a community and public health advisory committee's advice must be to ensure that the following maximise the overall health gain for the population the committee serves:

- (a) all service interventions the DHB has provided or funded or could provide or fund for that population:
- (b) all policies the DHB has adopted or could adopt for that population.

(3) A community and public health advisory committee's advice may not be inconsistent with the New Zealand health strategy.

3 Functions of disability support advisory committees

(1) The functions of the disability support advisory committee of the board of a DHB are to give the board advice on---

- (a) the disability support needs of the resident population of the DHB; and
- (b) priorities for use of the disability support funding provided.

(2) The aim of a disability support advisory committee's advice must be to ensure that the following promote the inclusion and participation in society, and maximise the independence, of the people with disabilities within the DHB's resident population:

- (a) the kinds of disability support services the DHB has provided or funded or could provide or fund for those people;
- (b) all policies the DHB has adopted or could adopt for those people.

(3) A disability support advisory committee's advice may not be inconsistent with the New Zealand disability strategy.

4 Functions of hospital advisory committees

The functions of the hospital advisory committee of the board of a DHB are to---

- (a) monitor the financial and operational performance of the hospitals (and related services) of the DHB; and
- (b) assess strategic issues relating to the provision of hospital services by or through the DHB; and
- (c) give the board advice and recommendations on that monitoring and that assessment.

Other functions

5 Committees may be given other functions by Order in Council

(1) In addition to the functions specified in clauses 2 to 4, a committee has such functions as are specified as functions of the committee, or of committees of the class to which the committee belongs, by the Governor-General by Order in Council on the recommendation of the Minister.

(2) Before making a recommendation for the purposes of subclause (1), the Minister must consult with such persons as the Minister considers appropriate.

6 Members

(1) Members of the committee---

- (a) must each be appointed by the board by notice in writing to the member for a term, not exceeding 3 years, stated in the notice together with the date on which the member comes into office;
- (b) are eligible for reappointment.

(2) A person who is a member of a board of a publicly-owned health and disability organisation may not be appointed as a member of a committee that regularly advises, or is likely regularly to advise, on matters relating to transactions of a kind in which the person is interested.

(3) Before the board of a DHB appoints a person who is not a member of that board to a committee, the person must give the board a statement completed by the person in good faith that---

- (a) discloses any conflicts of interest that the person has with the DHB as at the date on which the statement is completed, or states that the person has no such conflicts of interest as at that date; and
- (b) discloses any such conflicts of interest that the person believes are likely to arise in future, or states that the person does not believe that any such conflicts are likely to arise in future.

7 Terms or conditions of office, and remuneration

Members of the committee---

- (a) have the terms or conditions of office, consistent with this Act, that the board determines; and
- (b) are remunerated as the Minister determines.

8 Resignation

A member of the committee may resign from that office by notice in writing to the committee and board stating the date on which the resignation takes effect.

9 Vacation of office

(1) A member of the committee ceases to hold that office if---

- (a) the period of his or her appointment expires; or
- (b) he or she dies; or
- (c) the DHB to which the board relates is disestablished by an Order in

Council made under section 19(2).

(2) For the purposes of subclause (1)(c), a DHB is not disestablished just because it ---

- (a) is renamed; or
- (b) is involved in a reorganisation of districts (as described in clause 18 of Schedule 2); or
- (c) has its district altered (as described in clause 19 of Schedule 2).

(3) Subclause (1) overrides any deed or agreement.

10 Removal from office

(1) A member of the committee may be removed from that office by the board by notice in writing to the member and committee stating the board's reasons for the removal and the date on which the removal takes effect.

(2) A board may exercise the power under subclause (1) only if it has first consulted the member, and committee, about the removal.

(3) Subclauses (1) and (2) override any deed or agreement.

11 Chairperson and deputy chairperson

(1) A board---

- (a) must appoint a member of the committee as chairperson of the committee; and
- (b) may appoint another member of the committee as deputy chairperson of the committee.

(2) The appointment must be by notice in writing to the member and committee that---

- (a) may be the same notice as the notice under clause 6(1)(a) appointing the member; and
- (b) must state the period (starting at or after the time the member comes into that office, and ending at or before the time he or she must cease to be a member) for which the member is appointed chairperson or deputy chairperson and the date on which he or she comes into that office.

(3) A member appointed chairperson or deputy chairperson and whose appointment as such has expired---

- (a) continues in that office until his or her successor is appointed; and
- (b) is eligible for reappointment to that office so long as he or she continues to be a member of the committee.

12 Resignation

A chairperson or deputy chairperson of the committee---

- (a) may resign from that office by notice in writing to the committee and board stating the date on which the resignation takes effect; but
- (b) if he or she does so, continues to be a member of the committee unless he or she also resigns from that office, under clause 8.

13 Vacation of office

(1) A chairperson or deputy chairperson of the committee ceases to hold that office if he or she ceases to be a member of the committee.

(2) A deputy chairperson of the committee ceases to hold that office if he or she is appointed chairperson of the committee.

(3) Subclauses (1) and (2) override any deed or agreement.

14 Removal from office

(1) A chairperson or deputy chairperson of the committee may be removed from that office by the board by notice in writing to the chairperson or, as the case requires, deputy chairperson, and committee stating the board's reasons for the removal and the date on which the removal takes effect.

(2) A board may exercise the power under subclause (1) only if it has first consulted the chairperson or, as the case requires, deputy chairperson, and committee, about the removal.

(3) Subclauses (1) and (2) override any deed or agreement.

(4) A chairperson or deputy chairperson removed from that office continues to be a member of the committee unless also removed from that office, under clause 10(1).

15 Board to notify Minister of appointments, etc

(1) The board must give the Minister notice of any appointment, resignation, vacation of office, or removal from office, of any chairperson, deputy chairperson, or member of a committee, under any of clauses 6, or 8 to 14.

(2) The notice must be in writing and given as soon as practicable, and no later than 10 working days, after the board becomes aware of the appointment, resignation, vacation of office, or removal from office.

16 Teleconferences

(1) A number of members of a committee (being a number not less than the quorum provided by clause 27) may, whether or not any member or members of the committee are out of New Zealand, have a teleconference by contemporaneous linking together by telephone or other means of communication, if the requirements in subclauses (2) to (4) are satisfied.

(2) In any teleconference, no resolution of the committee may be voted on, and no decision of the committee may be made.

(3) Notice of any teleconference must, before the teleconference, have been given by telephone or other means of communication to every member of the committee.

(4) Each member taking part in a teleconference by telephone or other means of communication must, wherever practicable,---

- (a) be linked by telephone or such other means for the purposes of the teleconference; and
- (b) at the start of the teleconference acknowledge, to all the other members taking part, the member's participation in the teleconference; and
- (c) be able, throughout the teleconference, to hear each of the other members taking part.

17 Further provisions relating to teleconferences

(1) Each teleconference must have a presiding member, to be determined in accordance with clause 29.

(2) A member must not leave a teleconference by disconnecting his or her telephone or other means of communication unless he or she has first obtained permission to do so from the member presiding in the teleconference.

(3) A member who, at the start of a teleconference acknowledged, to all the other members taking part, the member's participation in the teleconference, must be treated as having taken part, and as having formed part of the quorum, in all of the teleconference before the member who presided in it expressly permitted the member to leave it.

(4) A written record of a teleconference must be made by the member who presided in it and, if certified correct by that member, is sufficient

evidence of it and that it complied with this clause and clause 16(1), unless the contrary is proved.

Notice of meetings

18 Meetings of committees to be publicly notified

- (1) Each committee must, not more than 14 days and not less than 5 days before the end of each month, publicly notify a list of all meetings of the committee scheduled to be held in the following month, together with the dates on which, and the times and places at which, the meetings are to be held.
- (2) However, if a meeting of a committee is to be held on or after the 21st day of any month, the committee may, instead of publicly notifying the meeting under subclause (1), publicly notify the meeting not more than 10 nor less than 5 working days before the day on which the meeting is to be held.
- (3) If a special meeting of a committee is called and notice of the meeting cannot be given in the manner required or permitted by this clause, the committee must publicly notify or otherwise advertise the meeting, and the general nature of business to be transacted at the meeting, as soon as practicable before the meeting is to be held.
- (4) If an emergency meeting of a committee is called and notice of the meeting cannot be given in the manner required or permitted by this clause for a scheduled or special meeting, the committee or member of the committee calling the meeting must give any public notice of the meeting and the business to be transacted at the meeting that is reasonable in the circumstances.

Compare: 1987 No 174 s 46(1)-(4)

19 Meetings not publicly notified in accordance with clause 18

- (1) No meeting of a committee is invalid just because it was not publicly notified in accordance with clause 18.
- (2) If a committee becomes aware that any meeting of the committee has not been publicly notified in accordance with clause 18, the committee must, as soon as practicable, give public notice that the meeting was not so notified, and must, in that notice,---
 - (a) state the general nature of the business transacted at the meeting;
and
 - (b) give the reasons why the meeting was not so notified.

Compare: 1987 No 174 s 46(5), (6)

20 Members to be notified of meetings

(1) The chairperson must ensure that each member of a committee is given notice of a meeting of the committee as early as practicable before the meeting is to be held.

(2) The notice must be written, and may be given by delivery or by electronic transmission (for example, by fax or e-mail).

(3) For the purposes of subclause (1), it is enough if the chairperson made all reasonable efforts to ensure each member was given the notice by the time required under that subclause.

Information relating to meetings

21 Availability of agendas and reports

(1) Any member of the public may, without payment of any fee, inspect, during normal office hours, within a period of at least 2 working days before every meeting of a committee, all agendas and associated reports circulated to members of the committee and relating to the meeting.

(2) The committee must, from time to time, authorise a person to act for it for the purposes of this subclause, and that person---

- (a) may exclude from the reports made available any reports or items from reports he or she reasonably expects the meeting to discuss with the public excluded; and
- (b) must indicate on each agenda items he or she reasonably expects the meeting to discuss with the public excluded.

(3) The agendas must be available for inspection at a place or places within the district, and must be accompanied by either---

- (a) the associated reports; or
- (b) a notice specifying the place or places at which the associated reports may be inspected.

(4) The associated reports must be available for inspection at a place or places within the district.

(5) Any member of the public may take notes from any agenda or report inspected by that member of the public.

(6) Every member of the public who inspects an agenda or report made available under this clause and requests a copy of all or any part of any such

agenda or report must, if he or she tenders an amount that represents the reasonable costs of making one available, be given such a copy as soon as practicable.

(7) This clause is subject to clause 22.

Compare: 1987 No 174 s 46A(1)-(5), (8)-(9)

22 Availability of agendas and reports in special circumstances

(1) If a meeting is an emergency meeting or a special meeting called pursuant to a resolution of the committee, the agenda and any associated reports must be made available as soon as is reasonable in the circumstances.

(2) The committee must, from time to time, authorise a person to act for it for the purposes of this subclause, and that person---

- (a) may exclude from the reports made available any reports or items from reports that the meeting discussed with the public excluded; and
- (b) must indicate on each agenda items the meeting discussed with the public excluded.

Compare: 1987 No 174 s 46A(6), (8)-(9)

23 Public may inspect or request copies of minutes of meeting

(1) Any member of the public may, within a reasonable time after any meeting of a committee, without payment of any fee and during normal office hours, inspect the minutes of the meeting or any part of it, unless it was a meeting or part of a meeting from which the public was excluded.

(2) The minutes must be available for inspection at a place or places within the district.

(3) Any member of the public may take notes from any minutes inspected by that member of the public.

(4) Every member of the public inspecting any such minutes who requests a copy of all or any part of those minutes must, if he or she tenders an amount equal to the reasonable costs of making one available, be given such a copy.

(5) If any person requests a copy of the minutes of any meeting or part of a meeting from which the public was excluded, the committee must deal with the request as follows:

- (a) if it is made by or on behalf of a natural person, and is for access to any personal information that is about that person, as if it were a request

made under subclause (1)(b) of principle 6 of the Privacy Act 1993:

- (b) in any other case, as if it were a request for access to official information made under the Official Information Act 1982.

Compare: 1987 No 174 s 51

24 Public notification of resolution at emergency meeting

If a resolution is passed at an emergency meeting of a committee, the committee must publicly notify the resolution as soon as practicable, unless it was passed at a meeting or part of a meeting from which the public was excluded.

Compare: 1987 No 174 s 51A

25 Defamatory matter in copy of agenda or additional particulars supplied to public or in minutes of meeting

- (1) This clause applies if all or any part of a meeting of any committee is open to the public, and--
 - (a) a copy of the agenda for the meeting, with or without further statements or particulars for the purpose of indicating the nature of any item included in the agenda, is supplied to a member of the public; or
 - (b) the minutes of the meeting or part are produced, for inspection, to any member of the public, or a copy of them is given to any member of the public.
- (2) The publication, in that way, of any defamatory matter in the agenda, or in the further statements or particulars, or in the minutes, is privileged.
- (3) This clause does not apply if, in any proceedings for defamation in respect of that publication, the plaintiff proves that, in publishing the matter, the defendant was predominantly motivated by ill will towards the plaintiff, or otherwise took improper advantage of the occasion of publication.

Compare: 1987 No 174 s 52

26 Oral statements at meetings privileged

- (1) Any oral statement made at any meeting of a committee in accordance with the rules that have been adopted by the committee for the guidance and order of its meetings is privileged.
- (2) This clause does not apply if, in any proceedings for defamation in

respect of the statement, the plaintiff proves that, in making the statement, the defendant was predominantly motivated by ill will towards the plaintiff, or otherwise took improper advantage of the occasion of publication.

(3) The privilege conferred by this clause is in addition to and not in substitution for or derogation of any other privilege, whether absolute or qualified, that applies, by virtue of any other enactment or rule of law, to the meetings of any committee.

Compare: 1987 No 174 s 53

Procedure at meetings

27 Quorum

(1) No authority, power, or discretion of a committee can be exercised, and no business of a committee can be transacted, at any meeting of the committee, unless the quorum of members of the committee is present at the meeting.

(2) The quorum of members of a committee is,---

- (a) if the total number of members of the committee is an even number, half that number; but
- (b) if the total number of members of the committee is an odd number, a majority of the members.

(3) Despite subclause (2), the board may, by written notice to all members of a committee given before a certain meeting or meetings of the committee, or before any meetings of the committee within a certain period, set a quorum other than that in subclause (2) for the meeting or meetings of the committee, if---

- (a) a member of the committee gives the board a written statement of reasons why the board should do so; and
- (b) the board considers that those reasons are good reasons and is satisfied that those reasons exist in fact.

28 Further provisions relating to quorum

(1) For the purposes of clause 27(3), it is enough if the board made all reasonable efforts to give all members of the committee the notice before the meeting or meetings.

(2) For the purposes of clause 27(2) and (3), a member who has declared an interest under clause 38 in relation to a transaction must not, for the purposes of that transaction, be counted, unless the board has waived or modified the application of clause 38(2).

29 Presiding member

- (1) At each meeting of a committee the chairperson of the committee presides, if he or she is present and willing to do so.
- (2) If the chairperson of a committee is not present or willing to preside at a meeting of the committee and there is a deputy chairperson of the committee, the deputy chairperson presides, if he or she is present and willing to do so.
- (3) If neither subclause (1) nor subclause (2) applies, the members present at the meeting must elect a member who is present to preside at the meeting.

30 Dealing with items not on agenda for meeting

- (1) If an item is not on the agenda for a meeting of a committee, that item may be dealt with at the meeting if the committee by resolution so decides, and the presiding member explains at the meeting, at a time when it is open to the public,---
 - (a) the reason why the item is not on the agenda; and
 - (b) the reason why the discussion of the item cannot be delayed until a later meeting.
- (2) Despite subclause (1), if an item is not on the agenda for a meeting of a committee,---
 - (a) the item may be discussed at the meeting if---
 - (i) the item is a minor matter relating to the general business of the committee; and
 - (ii) the presiding member explains at the beginning of the meeting, at a time when it is open to the public, that the item will be discussed at the meeting; but
 - (b) No resolution, decision, or recommendation may be made in respect of the item except to refer the item to a later meeting of the committee for further discussion.

Compare: 1987 No 174 s 46A(7), (7A)

31 Voting

- (1) All questions arising at any meeting of a committee must be decided by a majority of the votes cast by the members present.
- (2) If a vote is tied, the member presiding at the meeting has no second or casting vote, and the question is negated.

32 Supplementary procedure

A committee may regulate its procedure, at its meetings and otherwise, in any manner not inconsistent with this Act it thinks fit.

33 Admission of public

Except as provided in clauses 34 to 37, every meeting of a committee must be open to the public.

Compare: 1987 No 174 s 47

34 Right of committee to exclude public

A committee may by resolution exclude the public from the whole or any part of any meeting of the committee only on 1 or more of the following grounds:

- (a) that the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982:
- (b) that the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information the public disclosure of which would---
 - (i) be contrary to the provisions of a specified enactment; or
 - (ii) constitute contempt of court or of the House of Representatives:
- (c) that the purpose of the whole or the relevant part of the meeting is to consider a recommendation of an Ombudsman made under section 30(1) or section 35(2) of the Official Information Act 1982 to the committee:
- (d) that the purpose of the whole or the relevant part of the meeting is to consider a communication from the Privacy Commissioner arising out of an investigation under Part VIII of the Privacy Act 1993 to the committee:
- (e) that the exclusion of the public from the whole or the relevant part of the meeting is necessary to enable the committee to deliberate in private on a decision or recommendation as to whether any of the grounds in paragraphs

(a) to (d) are established in relation to all or any part of any meeting of the committee.

Compare: 1987 No 174 s 48(1)

35 Resolution excluding public

(1) Every resolution excluding the public from any meeting of a committee

must state---

- (a) the general subject of each matter to be considered while the public is excluded; and
- (b) the reason for the passing of that resolution in relation to that matter, including, where that resolution is passed in reliance on clause 34(a), the particular interest or interests protected by section 6 or section 7 or section 9 of the Official Information Act 1982 which would be prejudiced by the holding of the whole or the relevant part of the meeting in public; and
- (c) the grounds on which that resolution is based (being 1 or more of the grounds stated in clause 34).

(2) Every resolution to exclude the public must be put at a time when the meeting is open to the public, and the text of that resolution (or copies of it) must---

- (a) be available to any member of the public who is present; and
- (b) form part of the minutes of the committee.

(3) A resolution to exclude the public may also provide for a specified person or persons to remain after the public has been excluded if that person, or those persons, has or have, in the committee's opinion, knowledge that will help it.

(4) If a committee resolves that a person or persons may remain after the public has been excluded, the resolution must state---

- (a) the knowledge possessed by that person or those persons that will be helpful in relation to the matter to be discussed; and
- (b) how it is relevant to that matter.

(5) The person or persons must not disclose to anyone not present at the meeting while the public was excluded and the person or persons remained any information that the person or persons became aware of only at the meeting while the public was excluded and the person or persons remained.

Compare: 1987 No 174 s 48(3)-(6)

36 Provisions applying when meeting open to public

The following provisions apply when all or any part of a meeting of a committee is required by this Schedule to be open to the public:

- (a) for the purposes of this Schedule, genuine members of the news media must be treated as members of the public, and are entitled to attend any meeting or any part of a meeting for the purpose of reporting the meeting for any news media;
- (b) if the agenda for any meeting is copied by any means for use by

members of a committee, that committee must also cause to be made any additional copies of the agenda that in that committee's opinion may be necessary to ensure there is an adequate supply for any persons requesting copies under paragraph (c):

- (c) any member of the public who attends a meeting of a committee and requests a copy of the agenda must, if he or she tenders an amount equal to the reasonable costs of making one available, be given (and may take away with him or her) any spare copy of the agenda:
- (d) copies of the agenda supplied for members of the public as provided in paragraph (b) must include any further statements or particulars necessary to indicate the nature of any items included in the agenda, unless that item refers to any matter to be considered by the committee when the meeting is not likely to be open to the public.

Compare: 1987 No 174 s 49

37 Maintenance of order

(1) At any meeting of any committee the presiding member of the committee may require a member of the public attending the meeting to leave it if the presiding member believes on reasonable grounds that, if the member of the public is permitted to remain, the behaviour of the member of the public is likely to prejudice, or to continue to prejudice, the orderly conduct of the meeting.

(2) At the request of the presiding member, a member of the police, or officer or employee of the committee may remove or, as the case requires, exclude a member of the public from a meeting of a committee if the member of the public has been required under this clause to leave the meeting but---

- (a) refuses or fails to leave it; or
- (b) having left it, attempts to re-enter it without the permission of the presiding member.

Compare: 1987 No 174 s 50

Disclosure of members' interests

38 Disclosure of interests

(1) A member of a committee who is interested in a transaction of the DHB must, as soon as practicable after the relevant facts have come to the member's knowledge, disclose the nature of the interest to the committee.

(2) A member of a committee who makes a disclosure under this clause must

not (unless subclause (4) applies, or the board, by a waiver or modification of the application of this subclause under clause 39, permits)---

- (a) take part, after the disclosure, in any deliberation or decision of the committee relating to the transaction; or
- (b) be included in the quorum required by clause 27 for any such deliberation or decision.

(3) A disclosure under this clause must be recorded in the minutes of the next meeting of the committee concerned and entered in a separate interests register maintained for the purpose.

(4) However, a member of the committee who makes a disclosure under this clause may take part in any deliberation (but not any decision) of the committee relating to the transaction concerned if a majority of the other members of the committee permits the member to do so.

(5) If subclause (4) applies, the committee must record in the minutes of its next meeting---

- (a) the permission and the majority's reasons for giving it; and
- (b) what the member says in any deliberation of the committee relating to the transaction concerned.

(6) Every member of a committee who has completed a statement under clause 38(6) of Schedule 3 or clause 6(3) must ensure that---

- (a) the statement is incorporated in the interests register maintained under subclause (3); and
- (b) any relevant change in the member's circumstances affecting a matter disclosed in that statement is entered in that register as soon as practicable after the change occurs.

(7) In this clause and clause 39, committee includes a committee established under clause 38 of Schedule 3.

39 Board may waive or modify application of clause 38(2)

(1) The board may, if satisfied it is in the public interest, or the interests of the DHB concerned, to do so, waive or modify the application of all or any part of clause 38(2) in respect of---

- (a) any particular member of a committee;
- (b) any transaction, or class of transaction.

(2) The board must effect any waiver or modification under subclause (1) by written notice to the committee, and may make the waiver or modification subject to any conditions the board thinks fit.

(3) The board must give the Minister a copy of any such notice within 10 working days after the date on which the board issues the notice.

FIFTH: Provisions applying to mortality review committees

Schedule 5 s 18(5)

Provisions applying to mortality review committees

1 Interpretation

2 Chairperson may require person to give information

Production, disclosure, and recording of information

3 Meaning of information

4 Prohibitions on production, disclosure, and recording of information

5 Exceptions to prohibitions

6 Minister may authorise disclosure of information

7 Supplementary procedure

1 Interpretation

In this schedule, unless the context otherwise requires,---

document has the same meaning as in section 2(1) of the Official Information Act 1982

judicial proceeding means a proceeding that is judicial within the meaning of section 108 of the Crimes Act 1961

ministerial authority means an authority---

- (a) given by the Minister under clause 6(1); and
- (b) in force for the time being serious offence means an offence punishable by imprisonment for a term of 2 years or more.

Compare: 1995 No 95 s 66

2 Chairperson may require person to give information

(1) If a mortality review committee gives its chairperson, or an agent the committee appoints for the purpose, authority in writing to do so, the chairperson or agent may, by notice in writing to any person, require the person to give the committee information in the person's possession, or under the person's control, and relevant to the performance by the committee of any of its functions.

(2) Examples of the information the chairperson or agent may require are---

- (a) patient records, clinical advice, and related information:
- (b) answers to questions posed by the chairperson in the notice, and that the person is able to answer:
- (c) information that became known solely as a result of a declared quality assurance activity, within the meaning of Part VI of the Medical Practitioners Act 1995.

(3) The person must take all reasonable steps to comply with the notice.
Production, disclosure, and recording of information

3 Meaning of information

In clauses 4 to 6, information means any information---

- (a) that is personal information within the meaning of section 2(1) of the Privacy Act 1993; and
- (b) that became known to any member or executive officer or agent of a mortality review committee only because of the committee's functions being carried out (for example, because it is contained in a document created, and made available to the member or executive officer or agent, only because of those functions being carried out), whether or not the carrying out of those functions is completed.

4 Prohibitions on production, disclosure, and recording of information

(1) A member or executive officer or agent of a mortality review committee must not produce or disclose information to another person or in any judicial proceeding, or make any record of it, unless the production, disclosure, or record, is---

- (a) for the purposes of carrying out the committee's functions; or
- (b) in accordance with an exception stated in clause 5; or
- (c) in accordance with a ministerial authority.

(2) In any judicial proceeding, a member or executive officer or agent of a mortality review committee must not be required to produce information if under subclause (1) he or she is prohibited from doing so.

Compare: 1995 No 95 s 70

5 Exceptions to prohibitions

Clause 4 does not prohibit---

- (a) the production, disclosure, or recording of information if the information does not identify, either expressly or by implication, any particular individual:
- (b) the disclosure of information---
 - (i) with the consent of every person who would be directly or indirectly identified by the disclosure:
 - (ii) to the Minister, or a person authorised by the Minister, for the purpose of enabling the Minister to decide whether or not to issue a ministerial authority:
 - (iii) for the purposes of the prosecution of an offence against section 18(7) (disclosure of information contrary to this Schedule).

Compare: 1995 No 95 s 71

6 Minister may authorise disclosure of information

(1) If the Minister is satisfied that information relates to conduct (whenever occurring) that constitutes or may constitute a serious offence, the Minister may, by notice in writing signed by the Minister, give a ministerial authority authorising the disclosure of the information, in the manner, and subject to any conditions, specified in the notice, for 1 or more of the following purposes:

- (a) for the purposes of the investigation and prosecution of offences:
- (b) for the purposes of a Royal Commission, or a commission of inquiry appointed by an Order in Council made under the Commissions of Inquiry Act 1908.

(2) However, a ministerial authority may be given for information of a non-factual nature (for example, expressions of opinion) only if that information consists only of matter contained in a report or advice prepared by the mortality review committee.

(3) The Minister may at any time---

- (a) revoke a ministerial authority; or
- (b) revoke, amend, or add to any condition or conditions to which a

ministerial authority is subject.

(4) A ministerial authority authorising the disclosure of information does not of itself---

- (a) require the disclosure of that information; or
- (b) create a duty to disclose that information.

Compare: 1995 No 95 s 72

7 Supplementary procedure

A mortality review committee may regulate its procedure, at its meetings and otherwise, in any manner not inconsistent with this Act it thinks fit.

Appendix 4

**Information sheet, discussion schedule and consent form for kanohi
ki te kanohi discussions with kaitiaki**

INFORMATION SHEET

63 Jellicoe Drive
Hamilton
Phone (07) 858 2313
Email: helen.wihongi@xtra.co.nz

9th August 2003

Kia Ora person's name

I am writing to ask if you would be willing to participate in my doctoral research. The purpose of my research is to explore the definitions and implementation of tino rangatiratanga in health policies and practises. My objectives are to

- define tino rangatiratanga
- examine how tino rangatiratanga is expressed in government, government agency and service provider policies
- determine how tino rangatiratanga is expressed in health practise

In relation to objectives bullet point one and three I am seeking to interview people who are knowledgeable about tino rangatiratanga in health services and/or in cervical screening.

If you agree to participate in this research, I will seek to protect your anonymity by not referring to you by name and by collectively analysing data. However, as some of you occupy certain positions or are high profile people it may be possible for people to identify you. Your individual findings from the interviews will be returned to you to provide you with an opportunity to change or remove anything that has been said. Collective findings from all the interviews will also be returned to you to provide another opportunity for comments. If during the period of writing up of the findings (the time during which the tapes are transcribed and written up), you decide you no longer want to participate, all findings related to anything you have said will be removed from the research. After the collective findings have been written up it will be difficult to remove your individual findings so the option to withdraw will no longer exist.

I have received ethical approval for this research from the Research and Ethics Committee in the Psychology Department at the University of Waikato.

Funding for my research has come from Te Runanga O Ngati Porou, the Māori Health Research Council, the Māori Education Foundation and the University of Waikato.

If you have any questions about this research you may contact my supervisors.

Dr Neville Robertson at 838 4466 ext. 8300, email scorpio@waikato.ac.nz

Dr Priya Kurian at 838 4466 ext. 6109 email pkurian@waikato.ac.nz or

Professor Jane Ritchie at 838 4466 ext. 8402 email psyc0123.@waikato.ac.nz

If you are willing to participate please contact me at 0800 858 231 or email me at helen.wihongi@xtra.co.nz to arrange a time and venue

Thank you for your consideration

Helen Wihongi

Doctoral Student

The Department of Psychology

The University of Waikato

DISCUSSION SCHEDULE

- 1 What is your understanding of (tino) rangatiratanga?
Prompts
For
Individual
Iwi
Urban Māori
Māori organisations
National bodies
Cross-cultural
In relation to:
Colonisation/decolonisation
Sovereignty
Self-determination
Māori development
- 2 Is there a place for (tino) rangatiratanga in service policy?
If YES, how?
Prompts
How are or should these decisions be made?
Iwi
Māori
Pan-tribal
Pākehā
Government
Women
Who is or would benefit?
(as above)
- 3 Is there a place for (tino) rangatiratanga in service delivery?
If YES, what shape does or could this take?
Prompts
Implementation
Iwi
Māori organisations
Pan-tribal organisations
Mainstream organisations
Relationships
Leadership
By Māori for Māori
Who benefits?
How do they benefit?
Are there any limitations?
If YES how could these limitations be addressed?
If NO why?

Thank you your participation. Just before we finish is there anything else you would like to comment on?

University of Waikato
Psychology Department
CONSENT FORM

PARTICIPANT'S COPY

Research Project: _____

Name of Researcher: _____

Name of Supervisor (if applicable): _____

I have received an information sheet about this research project or the researcher has explained the study to me. I have had the chance to ask any questions and discuss my participation with other people. Any questions have been answered to my satisfaction.

I agree to participate in this research project and I understand that I may withdraw at any time. If I have any concerns about this project, I may contact the convenor of the Research and Ethics Committee.

Participant's

Name: _____ Signature: _____ Date: _____

=====
University of Waikato
Psychology Department
CONSENT FORM

RESEARCHER'S COPY

Research Project: _____

Name of Researcher: _____

Name of Supervisor (if applicable): _____

I have received an information sheet about this research project or the researcher has explained the study to me. I have had the chance to ask any questions and discuss my participation with other people. Any questions have been answered to my satisfaction.

I agree to participate in this research project and I understand that I may withdraw at any time. If I have any concerns about this project, I may contact the convenor of the Research and Ethics Committee.

Participant's Name: _____ Signature: _____

Date: _____

Appendix 5

The 1996 National Cervical Screening Programme Policy document

*National
Cervical Screening
Programme*



POLICY

MINISTRY OF HEALTH

ISBN: 0-478-09451-5

Published with the permission of the Director-General of Health

JUNE 1996



FOREWORD

I am very pleased to present the *National Cervical Screening Programme Policy*. This document is the first major review of the policy since the National Cervical Screening Programme's inception in 1990. It reflects the successful implementation of the National Cervical Screening Programme through major health sector reforms. The Government is committed to improving the health status of New Zealand women by reducing the number of deaths from, and incidence of, cervical cancer.

This policy was developed in consultation with purchasers, providers and consumers of cervical screening services. The Policy Advisory Group met in 1994 to begin reviewing the 1991 National Policy and oversee the consultation process. Included in the Advisory Group were representatives of Māori, Pacific Islands women, laboratories, women's groups, purchasers, providers and the ministerial advisory committee.

Over 75 submissions have been received from interested parties and key players during the consultation processes. Some submissions identified work outside the scope of this policy review. Several submissions suggested two documents be produced: one outlining the strategic policy direction for the delivery of cervical screening services in New Zealand; the other detailing operational guidelines of the National Cervical Screening Programme.

Several submissions made comments about developing further goals and targets for the National Cervical Screening Programme. Current targets were developed with input from statisticians and an epidemiologist, and were based on available data from the National Cervical Screening Register. However, there is room for further development and refinement of targets and indicators. An evaluation plan is also being developed for the National Cervical Screening Programme.

I am very pleased with the progress of the National Cervical Screening Programme. Enrolments of women in the programme have exceeded expectations with 75 percent of eligible women enrolled at the end of May 1996. This goal was set by the then Public Health Commission in 1994 to *increase the proportion of eligible women enrolled on the Register to 75 percent by the year 1996 and to 85 percent by the year 2000.*

I am sure that this document will provide valuable information for purchasers and providers alike for the effective management, co-ordination and ongoing success of the National Cervical Screening Programme.

Hon Katherine O'Regan
ASSOCIATE MINISTER OF HEALTH

June 1996



ACKNOWLEDGEMENTS

I would like to acknowledge the many people who have assisted and encouraged the National Cervical Screening Unit during the different stages of the review of this policy. Many individuals and organisations shared their ideas, advice and knowledge by way of submissions to two draft documents. In particular I thank the Policy Advisory Group who began the review process in 1994.

Thanks are due to the numerous people whose knowledge has contributed to the development and implementation of the National Cervical Screening Programme (NCSP) including health educators, health promoters, lay smear takers, nurses, midwives, general practitioners, obstetricians and gynaecologists, pathologists, cytologists, cyto-screeners, policy makers, managers and computer experts. Adopting a co-ordinated approach has played a vital role in the success of the NCSP by providing linkages between the many component parts of the screening pathway

I appreciate the commitment and assistance given to me by my colleagues in the Ministry of Health, especially Penny Ehrhardt, Anna Fenwick, Sandra Matcham, Marianne Linton and Maria Rangiawha.

I am also grateful to Brian Cox for his assistance with the development and revision of the targets.

Most importantly I thank the many women who have participated and enrolled with the NCSP, who, I hope, will ultimately benefit from the knowledge gained, as will all women.



Teenah Handiside
NATIONAL CO-ORDINATOR
National Cervical Screening Programme



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GOAL, STRATEGY STATEMENT AND SUMMARY OF TARGETS

Goal

To reduce the incidence of, and mortality and disability from, squamous cell cancer of the cervix.

Strategy Statement

To ensure that the National Cervical Screening Programme is an effective and efficient cervical screening programme and that it is an integral part of the New Zealand health service.

Summary of Targets

MORTALITY

To reduce the age-standardised death rate from cervical cancer from 4.2 per 100 000 women in the 1989–93 time period to below 3.5 per 100 000 by the year 2005.

MĀORI MORTALITY

To reduce the age-standardised death rate from cervical cancer from 10.6 per 100 000 Māori women in the 1989–93 time period to 7.5 per 100 000 Māori women by the year 2000; and to 5.3 per 100 000 or less by 2005.

INCIDENCE

To reduce the age-standardised incidence rate of cervical cancer in women from 12.0 per 100 000 women in the 1989–93 time period to below 8.6 per 100 000 by the year 2005.

MĀORI INCIDENCE

To reduce the age-standardised incidence rate of cervical cancer in Māori women from 29.8 per 100 000 Māori women in the 1989–93 time period to below 11.0 per 100 000 by the year 2005.

EARLY DETECTION

No more than 30 percent of invasive cervical cancers detected should be beyond Stage 1 at the time of detection by the year 2000. In 1993, 51 percent of cervical cancer registrations were recorded as detected at Stage 1 (74 percent with staging reported were detected at Stage 1 in 1993, and 31 percent had no staging information stated).

ENROLMENTS

To increase the proportion of eligible women enrolled on the National Cervical Screening Register from 18 percent in 1992 to 75 percent in 1996.

To increase the proportion of eligible women enrolled and screened in the previous three years to 85 percent by the year 2000.

1 BACKGROUND

In 1994 the Ministry of Health began a review of the *Government Policy for National Cervical Screening* (Department of Health 1991a). The current document is a result of submissions from a wide range of groups, including the National Policy Advisory Group, and reflects increased emphasis on monitoring and evaluation.

The need for a population-based cervical screening programme was first identified in 1984, prompting the formation of a working group in 1985 to make recommendations on routine cervical screening for New Zealand.

In August 1988 Dame Silvia Cartwright released *The Report of the Committee of Inquiry into Allegations Concerning the Treatment of Cervical Cancer at National Women's Hospital and into Other Related Matters (1988)*, recommending the urgent establishment of a national population-based cervical screening programme.

Specific funding was allocated for the National Cervical Screening Programme (NCSP) in 1989 and pilot register projects were begun by the Wanganui and Marlborough Area Health Boards. The NCSP was launched nationally in 1990. An expert group with wide representation, including consumer groups, Māori, and health professional organisations advised on the development of policy and establishment issues.

In 1991 the then Department of Health produced the *Government Policy for National Cervical Screening* based on policy advice from the expert group. In September 1993 the policy document was revised to reflect the structural changes to the health sector (Ministry of Health 1993).

The NCSP is the first national population-based cancer screening programme in New Zealand. National co-ordination and leadership of the NCSP and management of the National Cervical Screening Register (NCSR) are provided by a unit within the Ministry of Health. The Ministry of Health appointed a kuia for the NCSP in 1993. A position of National Māori Co-ordinator was established in 1994 in response to repeated requests from Māori women. This has now become the Kaihautū Māori, Te Whare Tangata, National Co-ordinator Māori (Cervical Screening and Sexual and Reproductive Health) position and is located outside the NCSP unit in He Kākano Oranga (Māori Public Health Policy Section) in the Ministry of Health. The NCSP is delivered by a range of providers including general practitioners, nurse and lay smertakers, health educators and laboratories. Local co-ordination of the NCSP and delivery of the NCSR are provided from 14 sites around the country, based on the old area health board boundaries.

The NCSR is the key management tool of the NCSP. It is a stand-alone system, which means it is not linked to any other computer system. The NCSR records and provides both information to assist individual women and their smertakers with personal health management, and information for monitoring and evaluation. It forms a communication link between a woman, her general practitioner or other smertaker, and the laboratory and

treatment services, and enables tracking of women moving from one part of the country to another. The NCSR complements and backs up existing general practitioner recall systems and registers. It enables population coverage to be monitored and provides information for quality assurance and evaluation.

Initially enrolment in the NCSR was restricted to those women indicating in writing that they wished to be part of the NCSP. In July 1993, a legislative change allowed for the inclusion on the NCSR of all women who did not object, and for the inclusion of cervical histology test results as well as cytology on the NCSR.

The NCSR is currently implemented as fourteen local registers using common software with national management and support. The local sites maintain and operate a register for women in their area. The local registers are being linked to a national centrally-located register during 1996.

As with previous documents, the current policy for the NCSP has been developed to ensure that the programme has clearly defined goals, is broadly consistent throughout New Zealand, and that its effectiveness can be monitored nationally. The policy determines the parameters of the NCSP and, by adding detail to the Government's policy guidelines for regional health authorities (RHAs) (Minister of Health 1995), it provides guidance for them in purchasing services. While it provides national direction to ensure national consistency, the policy also enables local flexibility where desirable.

In its initial phase the NCSP focused on policy development, structural and organisation issues, the development of standards, the enhancement of services and the enrolment of women. More recently, emphasis has been given to adjusting the NCSP to the new structures of the reformed health services, and increasing enrolments. In future the NCSP must concentrate on attracting unscreened and underscreened women, especially in priority groups, as well as retaining women already screened. It must monitor the rescreening interval, identify patterns of and reasons for short interval rescreening and develop ways to reduce short interval rescreening. Monitoring quality assurance for all stages of cervical screening will also be a priority.

This policy briefly describes the reasons for, and background to, the NCSP. It sets out the goals, objectives and principles of the NCSP. It defines the policy for each stage of the 'screening pathway' from identifying and reaching women in the eligible population on a regular basis to smearing services, laboratory services, services for the management of women with abnormal smears, and monitoring and evaluation.

The policy incorporates the 'Cervical Screening Recommendations' (Paul et al 1991) and the *National Consensus on a Treatment Protocol for the Management of Abnormal Smears* (Department of Health 1992). These two documents are being reviewed in 1996. The 'Cervical Screening Recommendations' are unlikely to change significantly (G Turner, personal communication 23 May 1996). If changes are made to either of these documents then the new standards set out in them should be adhered to.

2 CERVICAL SCREENING AND CERVICAL CANCER

2.1 Qualities of Successful Screening Programmes

Countries and communities which have made the most impact on reducing the incidence rates of and death rates from cervical cancer, such as Iceland, Finland, Sweden and British Columbia in Canada, have an organised approach to cervical screening.

Well organised cervical cancer screening programmes can significantly reduce the incidence and mortality from the disease in a country. A reduction of at least 60% in incidence and mortality from the disease baseline is possible, the theoretical maximum being of the order of 90%. To be most effective, these programmes must be planned in accordance with the established principles for national cancer control programmes (Miller 1992).

Thus, the establishment and maintenance of a nationally co-ordinated approach to cervical screening is crucial to controlling and reducing cervical cancer in New Zealand. It is estimated that if the results of overseas communities with organised programmes are replicated in New Zealand, the NCSP has the potential over a 10 year period to reduce the incidence of cervical cancer by 70 percent and the number of deaths of New Zealand women from cervical cancer by 65 percent (Cox 1989).

The key organisational requirements identified by the World Health Organization (Lunt 1984) for a successful programme include:

- ✦ a central office or individual responsible for planning, co-ordinating and evaluating the programme
- ✦ an agreed policy and set of objectives for the programme, against which to measure the programme
- ✦ computer-based information systems
- ✦ extensive continuing coverage of the eligible population
- ✦ quality control of both smearing and smear reading
- ✦ measures to ensure that women with abnormal smears are followed up and treated.

2.2 Incidence and Mortality in New Zealand

Each year, about 250 cases of cervical cancer are diagnosed and about 100 women die from invasive cancer of the cervix. Based on these figures, about one in 97 women can expect to develop cancer of the cervix before the age of 75 years (PHC 1995a).

Women aged 40 years and over have a higher incidence and death rate than younger women. The overall incidence rate for Māori women (29.9 per 100 000 women) is more than twice that of non-Māori women (11.8 per 100 000). The incidence rate for Māori women is also high when compared with women in other countries. Mortality rates for Māori women are also higher than for New Zealand women as a whole (PHC 1995a). Although reliable figures are unavailable for Pacific Islands women, indications are that incidence rates could be even higher than those for Māori women (Cox and Skegg 1989). The data do not, however, indicate higher mortality rates among Pacific Islands women than for New Zealand women as a whole (Bathgate et al 1994).

2.3 Possible Causes of Cervical Cancer and Risk Factors

The causes of cervical cancer are uncertain, although a number of factors relating mainly to the sexual background of the woman and her partners appear to be relevant. There is evidence that certain types of human papilloma virus (HPV) are necessary but not sufficient as pre-conditions for cervical cancer. Cigarette smoking and oral contraceptive use may also be associated with developing cervical cancer, although the latter may be linked to behaviour (Miller 1992).

As these risk factors are insufficiently precise to define a specific high-risk group, screening should be offered to all women in the eligible population (20–69 years). Furthermore, more frequent screening is not recommended for women regarded as being at higher risk of cervical cancer. There is no evidence that the disease in women who may be at higher risk has a shorter duration of the preinvasive phase (Paul et al 1991). Thus, there is no real benefit to be gained from screening women more frequently or from referring to clinical or behavioural risk in advising screening. Furthermore, experience with cervical screening programmes has shown that undue emphasis on the sexually transmitted aspects has adverse consequences for recruitment of women (Straton 1994).

Studies have shown that the most useful indication of a woman's risk of developing cervical cancer is her screening history (Chamberlain 1986). The women most likely to develop cervical cancer are those unlikely to have been

regularly screened (MacLean et al 1985; Skegg et al 1985; Paul et al 1991). Thus a woman's screening history is the most useful indicator of her risk of developing cervical cancer.

2.4 Future Predictions for New Zealand in the Absence of a Cervical Screening Programme

Without effective cervical screening, cervical cancer mortality and incidence can be expected to increase (Cox 1995). The risk of developing cervical cancer has increased very rapidly in cohorts of women born since the 1930s. It has been estimated that a woman born in 1957 may have over three times the risk of dying of cervical cancer than a woman born around 1932 (Cox and Skegg 1986). Projections have been made that without an organised screening programme up to 500 women may develop cervical cancer and 150 women die of it each year before the turn of the century. The cervical cancer incidence and death rates can be expected to increase by about 45 percent and 20 percent respectively by the year 2005 in the absence of an effective cervical screening programme (Cox 1989).

2.5 Cervical Screening

Precursors of squamous cell cancer of the cervix (which represents 85 percent of all invasive cervical cancer) can be detected by screening. This involves testing cells from the cervixes of asymptomatic women for pre-cancerous abnormalities and early invasive cervical cancer. If these abnormalities are detected, they can be readily treated. The success rate for adequate treatment of pre-cancers is 98–100 percent (Sharp and Cordiner 1985). Thus, cervical cancer, unlike most cancers, is largely preventable through regular screening. Cervical screening has proved to be the major strategy to achieve a significant reduction in the incidence of and mortality from cervical cancer (Miller 1992).

Improved cervical screening over the past five to ten years may be expected to reduce mortality by about 7.5 percent from that expected for the 1992–96 time period and a further 15 percent for successive years thereafter (Cox 1995).

- extensive consultation
- ensuring participation in the decision-making, planning, provision and monitoring of services
- ☛ resource allocation priorities which take account of Māori health needs and perspectives. Purchasers should consider the developmental aspects of establishing contracts with new Māori health service providers
- ☛ the development of culturally-appropriate practices and procedures as an integral requirement in the purchase and provision of health services. Māori concepts of health and wellbeing are holistic in contrast with the traditional western model in which the physical aspects of health and sickness are emphasised. This is a key consideration in developing the purchasing strategies to address both Māori and non-Māori health needs. The Whare Tapa Whā (four cornerstones of health) model provides one model for viewing Māori health (Durie 1994). The cornerstones are:
 - Taha Whānau — the well-being of the family and extended family
 - Taha Tinana — the physical elements of the body and the environment
 - Taha Hinengaro — mental and emotional health
 - Taha Wairua — spiritual health (PHC 1995b).

All of these are embraced by te reo (the language) and tikanga (cultural traditions) which are crucial factors in determining Māori health and wellbeing.

2.6.2 A WOMEN-CENTRED APPROACH TO ALL ASPECTS OF THE PROGRAMME

For a cervical screening programme to succeed, the screening service must be oriented to the needs of the women using it, but initiated by providers (Eardley et al 1985; Haran et al 1986). The service must acknowledge and meet women's needs and remove any barriers to their participation. In its planning the NCSP should take into account the range of factors identified by women.

2.6.3 THE GOVERNMENT'S PRINCIPLES FOR PURCHASE DECISIONS

The Government has adopted six principles to be applied by RHAs in all their purchase decisions for health and disability services. Applied to the NCSP, these are:

- ☛ **equity** in the distribution of services in relation to women's needs and in terms of their ability to benefit from services, including increasing access to services for Māori and Pacific Islands women, decreasing disparities in health status between these groups and Pākehā, and giving greater weight to Māori and Pacific Islands health gains

Targets

MORTALITY

To reduce the age-standardised death rate from cervical cancer from 4.2 per 100 000 women in the 1989–93 time period to below 3.5 per 100 000 by the year 2005.

MĀORI MORTALITY

To reduce the age-standardised death rate from cervical cancer from 10.6 per 100 000 Māori women in the 1989–93 time period to 7.5 per 100 000 Māori women by the year 2000; and to 5.3 per 100 000 or less by 2005.

INCIDENCE

To reduce the age-standardised incidence rate of cervical cancer in women from 12.0 per 100 000 women in the 1989–93 time period to below 8.6 per 100 000 by the year 2005.

MĀORI INCIDENCE

To reduce the age-standardised incidence rate of cervical cancer in Māori women from 29.8 per 100 000 Māori women in the 1989–93 time period to below 11.0 per 100 000 by the year 2005.

EARLY DETECTION

No more than 30 percent of invasive cervical cancers detected should be beyond Stage 1 at the time of detection by the year 2000. In 1993, 51 percent of cervical cancer registrations were recorded as detected at Stage 1 (74 percent with staging reported were detected at Stage 1 in 1993, and 31 percent had no staging information stated).

2.6 Principles of the NCSP

The principles underpinning the planning, purchase and operation of the NCSP are as follows.

2.6.1 THE TREATY OF WAITANGI

The Government is committed to improving Māori health status so that in future Māori have the opportunity to enjoy at least the same level of health as non-Māori. General policy directions for Māori health are set out in the Government document *Whāia te ora mō te iwi* (Minister of Health 1993). The key features are:

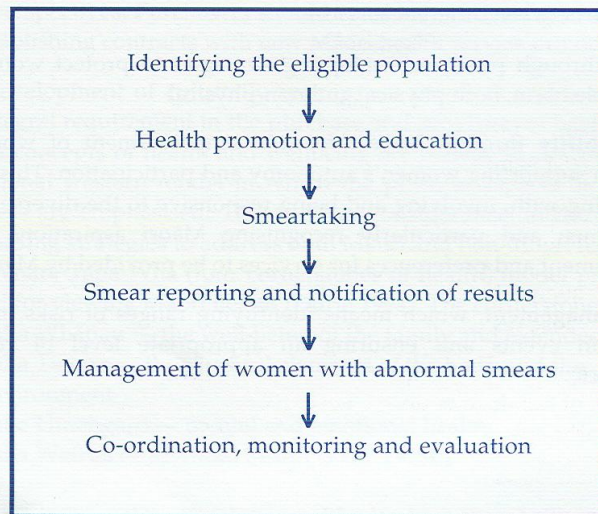
- ☛ greater participation of Māori at all levels of the health sector. This requires:
 - good employer personnel policies

NATIONAL CERVICAL SCREENING PROGRAMME POLICY

- ✦ **effectiveness** to ensure that services result in better health outcomes. This includes identifying, addressing and reflecting diverse realities of all women, in the planning, design and purchasing of the NCSP
- ✦ **efficiency** in recognising that resources are limited and choices have to be made between different services
- ✦ **safety** through purchasers adopting strategies to protect women from avoidable harm, both physical and non-physical
- ✦ **acceptability** through respect for and empowerment of women and through supporting women's autonomy and participation. This includes consulting with, involving and being responsive to the diverse needs of all women and particularly recognising Māori aspirations for self-management and preferences for services to be provided by Māori
- ✦ **risk management**, which means identifying ranges of risks, managing uncertain events and ensuring an appropriate level of control of resources.

3 THE SCREENING PATHWAY

It is useful to consider the organisation of cervical screening in terms of a 'screening pathway', with the following stages:



3.1 Identifying the Eligible Population

3.1.1 WHO SHOULD BE SCREENED?

The eligible population is women aged 20–69 years, excluding those who have had a total hysterectomy for a benign condition with a previously normal screening history. Women outside the eligible population who have smears are included on the NCSR, but the focus of the NCSP is the eligible population of women.

Women should be offered cervical screening in line with the 'Cervical Screening Recommendations' (Paul et al 1991), in particular:

- ☛ all women between the ages of 20–69 years should be offered cervical screening every three years. This includes women of all ethnic groups, lesbians and women with disabilities. All of these women are to be encouraged to be part of the NCSP. Twenty years is the age for starting routine screening as this is just before the first cases of invasive cancer occur. In New Zealand these occur in the 20–24 age group. From 1982–86 on average only two cases per year were diagnosed under the age of 25
- ☛ any woman who has never had intercourse or who has had a hysterectomy with complete removal of the cervical epithelium for a benign condition and consistently normal previous smears need not be screened

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- ☛ women should have a second smear after one year if they have never had a smear before or if more than five years have passed since their last smear. After two negative smears, screening should be repeated every three years
- ☛ women presenting with symptoms or signs suggestive of invasive cancer should have a smear taken as part of the appropriate gynaecological examination irrespective of their screening history. They should, however, be referred for gynaecological assessment irrespective of the smear result. The cervical smear may be unreliable as a diagnostic test where cancer symptoms are present
- ☛ once a woman has been found to have Cervical Intraepithelial Neoplasia (CIN), follow-up should include annual screening
- ☛ more frequent than three-yearly screening is not recommended for women whose results have always been normal
- ☛ women regarded as being at higher risk of cervical cancer because of the presence of risk factors do not need to be screened more frequently than three yearly.

Target

ENROLMENTS

To increase the proportion of eligible women enrolled on the National Cervical Screening Register from 18 percent in 1992 to 75 percent in 1996.

To increase the proportion of eligible women enrolled and screened in the previous three years to 85 percent by the year 2000.

3.1.2 PRIORITY GROUPS

Women who have never had a smear or whose smear history is outdated

The recruitment focus of the NCSP is on women who have never had a smear or whose previous smear was more than three years ago.

A national omnibus survey conducted by the National Research Bureau (NRB) in 1989 showed that 77 percent of women 20–64 years who responded reported having had a smear test in the previous three years. Screening coverage, however, was unevenly spread, with Pākehā women being more likely to be screened than Māori women. In the NRB survey, 80 percent of Pākehā women reported having had a smear test in the past three years compared with 71 percent of Māori women. This survey had a low response rate and it is likely that the actual percentage of women with up-to-date screening history would have been much lower than these figures

suggest. No reliable information was available on Pacific Islands women.

Screening rates fell with age. Younger women were more likely to be having regular smears than older women. Women up to 50 years of age reported higher levels of screening, at around 80 percent. Women aged 50–64 years had a rate of 63 percent and women 60–64 years a level of 50 percent. For women 65–69 years of age the screening level was even lower, at 25 percent. Sixteen percent of women aged 55–69 years reported never having had a smear test.

The National Cervical Screening Programme Second Statistical Report: Analysis of data to 30 June 1994 (Ministry of Health 1995) shows that women over 35 years were not enrolling on the NCSP in as large numbers as younger women. From a peak of over 50 percent of women aged 30–34 years enrolled on the NCSR, enrolments dropped rapidly. Less than 20 percent of women aged 65–69 years were enrolled.

Special efforts and initiatives are to be directed at three priority groups: mid-life and older women, Māori women and Pacific Islands women.

AREAS FOR FURTHER DEVELOPMENT

Evaluation is required of the up-take of cervical screening by other sub-populations of women who appear to experience barriers in accessing cervical screening, such as lesbians (MacBride-Stewart 1996; Peteros and Miller 1988; Trippet and Bain 1992; Smith et al 1985), sexual abuse survivors, women with disabilities and Asian women. Appropriate health promotion strategies should be instituted for sub-populations which appear unlikely to reach 85 percent enrolment by the year 2000.

Mid-life and older women

There were approximately 622 431 women aged 35–69 years in New Zealand at the 1991 census.

About 80 percent of women who die from cervical cancer and about 70 percent of women who develop the disease are 40 or more years of age (Cox 1989). Despite their greater risk, women over 40 have lower rates of enrolment on the NCSP than women aged 20–39 years (Ministry of Health 1995).

Mid-life and older women are a diverse group which is likely to be difficult to reach. They represent many ethnicities and belief systems.

Possible barriers to mid-life and older women's participation in cervical screening include:

- ☛ a misconception among women and providers that mid-life and older women do not need cervical screening
- ☛ less frequent attendance at general practitioners for sexual and reproductive health matters

- ☛ embarrassment
- ☛ less time for health matters because of paid and unpaid work commitments.

A greater proportion of mid-life and older women may have had a total hysterectomy for a benign condition with a previously normal screening history, and so will not require screening (Paul et al 1991). Other women who have had hysterectomies may not be aware of their need for continued screening.

AREAS FOR FURTHER DEVELOPMENT

Further investigation of the barriers to mid-life and older women's participation in cervical screening and the identification of strategies to overcome these barriers is required.

Māori women

At the 1991 census there were approximately 111 819 Māori women aged 20–69 years in New Zealand.

The incidence of cervical cancer in Māori women is high when compared with non-Māori women in New Zealand and internationally (Ministry of Health 1995).

Cervical screening for Māori women is based on the Crown's Māori policy objectives, set out in *Whāia te ora mō te iwi* (Minister of Health 1992), and the principles of the Treaty of Waitangi.

Cervical screening is only one of a number of major health and social issues facing Māori women. The health of the woman and her whole family is important, not just the health of her cervix. Community development strategies will best meet the need for a holistic approach to Māori women's health.

Cervical screening must be offered to Māori women in ways that they find acceptable, accessible and affordable if it is to be successful in reducing Māori mortality and morbidity from cervical cancer. This will involve creating working partnerships, encouraging participation and providing choice to ensure equity.

The aim is to achieve equity of outcome for Māori women in terms of cervical screening. This may involve a higher allocation of resources. More work will be required to inform Māori women of the benefits of the programme, and to provide a screening service that meets the needs of Māori women. Bringing about the willing participation of Māori women is a process which will involve every aspect of the NCSP.

Māori are not a homogeneous population group. A range of services needs to be purchased to provide for age and sex, as well as rural, urban and socio-economic groups. Also, hapū, iwi and Māori community-based groups need to be acknowledged as structures whose ability and capacity to respond to

and participate in the provision of services will be various and diverse (Minister of Health 1995).

While many Māori women may wish to use the services of mainstream health care providers, not all will want to do so. Increasing Māori utilisation of primary health care services will increase Māori access to cervical screening. There needs to be a choice so that Māori women can decide which type of service they will use. To promote choice, Māori women need access to training as smertakers and educators.

The Ministry of Health has a Kaihautū Māori, Te Whare Tangata, National Co-ordinator Māori (Cervical Screening and Sexual Reproductive Health) who gives leadership to Māori aspects of the NCSP. She works in partnership with the National Co-ordinator to jointly provide leadership and co-ordination and liaison of the NCSP.

National kaimahi (Māori cervical screening co-ordinators, educators and smertakers) hui are held at least annually for Māori working in the NCSP to consider policy and operational issues to improve the effectiveness of the NCSP for Māori women. This provides an opportunity for kaimahi to make recommendations to the NCSP on how best to meet Māori needs and enhance Māori wellbeing.

National health education resources for Māori have been developed.

RHAs are to purchase locally co-ordinated health education, promotion and smertaking services for Māori women and their whānau in a way which acknowledges holistic Māori concepts of health. Māori women are, where feasible, to have access to educators and cervical smertakers who are Māori women. Follow-up services, such as colposcopy, are to be provided in a culturally appropriate manner.

NATIONAL KAITIAKI GROUP

Māori women's summary data stored on the NCSR are given special protection by a National Kaitiaki Group who are appointed under the Health (Cervical Screening (Kaitiaki)) Regulations 1995 to oversee the release of this data (see Appendix 3). The National Kaitiaki Group was established in response to concerns from some Māori women to ensure that they retained protection and control of their summary data. An interim Kaitiaki group fulfilled this function from 1993 until the Regulations came into force in 1995.

AREAS FOR FURTHER DEVELOPMENT

Indices to measure the provision of the NCSP for Māori should be developed.

Pacific Islands Women

At the 1991 census there were approximately 41 862 Pacific Islands women aged 20–69 years in New Zealand.

There are indications that Pacific Islands women have significantly higher rates of cervical cancer than other women (Cox 1989; Gray et al 1989; Cox and Skegg 1989).

Pacific Islands women include those from Samoa, Cook Islands, Niue, Tonga, Fiji and Tokelau, the Melanesian countries of Papua New Guinea, Vanuatu, Solomon Islands and Kiribati, and New Zealand-born Pacific Islands women. Each island group has a unique language, customs, values and traditions; each approaches situations differently, and has different interpretations of concepts, principles, and assumptions. The needs of these different groups overlap but they are not identical.

The cultural diversity of Pacific Islands women means that to be effective the design and delivery of cervical screening programmes and services must involve comprehensive consultation with representatives of all the major Pacific Islands groups.

To meet the goals of the NCSP for Pacific Islands women, the screening service must be provided in a culturally appropriate manner. Health services must recognise barriers that exist for Pacific Islands women which may include economic and language barriers, lack of knowledge about services, inappropriate health promotion programmes, and cultural values such as shyness and deference to authority (Bailey 1990). Recognising these barriers, service providers should take care to design promotional programmes and deliver services that are culturally appropriate.

For health services to be effective, they must be acceptable to the people who use them. For Pacific Islands people, health is a state of complete physical, mental, social, spiritual, cultural and family wellbeing. The screening service should be developed within such a holistic context and should be people oriented rather than problem oriented (Bailey 1990).

A National Pacific Islands Cervical Screening Conference is held annually to provide a forum to present reports from the representatives on national committees, and an opportunity for all involved in the programme to make recommendations to the NCSP. The NCSP is developing competencies for Pacific Islands educators. There is the opportunity for the NCSP to link holistically with other programmes to address cultural issues impacting upon Pacific Islands women's sexual health.

In recognition of the particular cultural beliefs about the sanctity and integrity of the lives of Pacific Islands women and the sensitive nature of cervical screening, an Interim Pacific Data Management Group has been established to protect and oversee the release of Pacific women's summary data from the NCSR. A policy and process for the management of Pacific Islands summary data on the NCSR are being developed with the assistance of the Interim Pacific Data Management Group.

National health education resources for Pacific Islands women have been developed by the Public Health Commission in consultation with an advisory group nominated by the Pacific Islands conference.

RHAs purchase locally co-ordinated health education, promotion and smearthaking services for Pacific Islands women.

To promote choice, Pacific Islands women need access to training as smearthakers and educators. Pacific Islands women are, where feasible, to have access to educators and cervical smearthakers who are Pacific Islands

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Medical smertakers

In New Zealand, most smears are taken by general practitioners. The NCSR records information which allows monitoring of the categories of smertakers (general practitioner, nurse, midwife, lay, medical specialist) and quality of smertaking.

AREAS FOR FURTHER DEVELOPMENT

Standards of competency for medical smertakers should be developed.

Non-medical smertakers

- ✦ All non-medical smertakers who independently access laboratory services are expected to meet the Training Guidelines and Standards of Competency for Smear Takers (Department of Health 1991b).
- ✦ Medical Officers of Health are responsible for the certification and continuing evaluation of non-medical smertakers so that they can access laboratory services.

Midwives are able to take smears from women in the course of pregnancy care. To take smears from other women they are required to meet the criteria for non-medical smertakers.

All smertakers should:

- ✦ deliver cervical screening services by actively offering screening on a regular basis to individual women. Screening should be accompanied by a full explanation of its purpose and the procedure in a language easily understood by the women (Grace 1985)
- ✦ ensure that they have the informed consent of the woman before taking a smear
- ✦ ensure that, before a specimen is forwarded to a laboratory for analysis, the woman is informed that unless she objects, a report on the test will be included on the NCSR
- ✦ discuss the NCSP with women having smears and provide women with the written information sheet from the NCSP enrolment form
- ✦ when enrolling women in the NCSP, discuss with them:
 - the purpose for which the information is collected (that is, to help ensure women with abnormal smears are identified, informed and referred for treatment; to provide information about past cervical smear tests to laboratories to assist them in interpreting smears and making recommendations on treatment; to monitor the quality of

younger women or those who are currently heterosexually active. The NCSP will also examine ways to promote primary prevention and health education to young women.

When it is shown that barriers exist for other sub-populations, such as lesbians, women who have been sexually abused, women with disabilities and Asian women, health promotion strategies should be developed to address these barriers.

Information must be technically accurate, educationally and culturally appropriate and available in appropriate languages for women to make an informed choice on having a cervical smear and enrolment on the NCSR.

AREAS FOR FURTHER DEVELOPMENT

In addition to education and information, other effective strategies for women and health professionals should be identified and implemented to increase the number of eligible women being offered screening.

Monitoring effectiveness of health promotion

The NCSR is able to generate reports on numbers of enrolments by age and area to help identify groups of under-screened women for whom health promotion initiatives are needed and to assist in monitoring the effectiveness of health promotion. The Health (Cervical Screening (Kaitiaki)) Regulations 1995 require that Māori women's summary data on the NCSR be released only with the approval of the National Kaitiaki Group. Pacific Islands women's summary data on the NCSR is currently released only if approved by the Interim Pacific Data Management Group. Approval from these groups will be sought for the release of data to enable monitoring of the effectiveness of health promotion for Māori and Pacific Islands women.

3.3 Smarttaking

3.3.1 WHO SHOULD TAKE THE SMEAR?

Smarttaking must be provided in a way which is acceptable to women. Where feasible, all women should have access to a smarttaker of their choice. Women should have access to female smarttakers. It is desirable that women, particularly those who are reluctant to present for smears, have access to certificated nurse smarttakers as this may offer the possibility of lower costs and greater flexibility in providing screening. It is desirable that women have access to a smarttaker of their cultural group, if they wish. Māori women are, where feasible, to have access to cervical smarttakers who are Māori women.

Women are not to be charged for any services in relation to cervical screening other than smarttaking. Some smarttaking services are provided free of charge to women in priority groups.

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- smear-taking and smear-reading services; and to help identify groups of women who are/are not being screened)
 - the authorisation under which the information is collected
 - who will have access to the information
- ☛ ensure that sufficient information is collected and provided to the NCSP to meet its minimum data requirements and to enable women to be enrolled and recalled according to the NCSP policy and protocols. This includes full name, date of birth, address and smear history, as well as asking women to self identify their ethnicity, which is recorded for monitoring purposes
- ☛ ensure that where a woman objects to a report on her smear test being forwarded to the NCSP, a written notice for the objection accompanies the specimen to the laboratory, an acknowledgment of her objection is given to the woman and a copy filed in her medical records
- ☛ inform women of the result of their smear test
- ☛ have an 80 percent smear adequacy rate. That is, 80 percent of smears should be satisfactory for evaluation (except where this cannot be met for reasons outside the smearer's control)
- ☛ not take smears outside of the 'Cervical Screening Recommendations' (Paul et al 1991), except on women, whatever their age, who present with symptoms or signs of cervical cancer
- ☛ provide services in a manner which complies with the Code of Health and Disability Services Consumers' Rights.

NCSP REPORTS TO SMEARTAKERS

Where requested, local NCSP sites will send smeartakers reports on women's smear history. The local NCSP sites will send annual reports to smeartakers on the quality of smear tests, and inform smeartakers more often if they are below the adequacy rate. The NCSP sends all smeartakers recall lists of those women overdue for a smear at least every three months. Local sites will consider requests from individual smeartakers for recall lists of women who are due for a smear.

3.4 Smear Reporting and Notification of Results

3.4.1 LABORATORY SERVICES

Laboratories are required to:

- ✦ provide efficient and accurate services for processing and examining cervical smears (including cytological and histological cervical smear tests) and report results to smertakers within five working days
- ✦ forward cytology results (except those accompanied by written notice of objection) to the NCSR in the agreed codes and electronic format (within 10 working days of receipt of specimen). This should be accompanied by the NCSP or laboratory form containing the information necessary to enrol the woman (full name, date of birth, address, previous smear history and stated ethnicity)
- ✦ forward histology results (except those accompanied by written notice of objection) to the NCSR in the agreed codes and electronic format (within 20 working days of receipt of specimen). This should be accompanied by the NCSP or laboratory form containing the information necessary to enrol the woman (full name, date of birth, address, previous smear history and stated ethnicity).

The NCSP will provide reports of the woman's previous smear history to assist laboratories reading smears. The NCSP will also provide laboratories with an analysis of their own results in comparison to a national average on an annual basis for quality assurance purposes.

3.4.2 QUALITY CONTROL MEASURES FOR GYNAECOLOGICAL CYTOLOGY SCREENERs

To be eligible for reimbursement for reading smears, laboratories providing services for cervical cytology and histology are required to be accredited with the Testing Laboratory Registration Council of New Zealand (TELARC) or an equivalent accreditation authority.

Cytology laboratories approved by TELARC must have policies and practices which assure the quality of smear reading. They must define staff responsibilities and laboratory procedures, appoint appropriately qualified and experienced staff and ensure high quality, accurate reporting systems using the Bethesda coding system for cytology and the SNOMED system for histology results. Laboratories are required to have quality control systems which can identify potential sources of error in the laboratory's operation and implement controls to detect and minimise errors.

Laboratories must have quality control mechanisms to minimise the

incidence of false negative and false positive results. Laboratories are required to participate to a satisfactory standard in an external quality assurance programme such as the Royal College of Pathologists' quality assurance programme, or an alternative which meets TELARC standards. They must also have an internal quality control programme which meets TELARC standards.

In future, laboratories will be required to meet the National Quality and Service Standards for Medical Testing Laboratories (under development).

The NCSP will monitor technological developments which may improve performance and accuracy in screening for cervical abnormalities.

3.4.3 PRIVACY AND CONFIDENTIALITY OF PERSONAL INFORMATION STORED ON THE NCSR

The following safeguards and protocols protect the information held on the NCSR:

- ✦ access to information on the NCSR is governed by the provisions of the Health Act 1956 Section 74 (see Appendix 3), the Privacy Act 1993, and codes of practice
- ✦ the NCSR National Security Protocol (Matcham 1995) maintains the integrity of NCSR data in terms of its quality existence and privacy
- ✦ access to Māori women's summary data is governed by the provisions of the Health (Cervical Screening (Kaitiaki)) Regulations 1995
- ✦ access to Pacific Islands women's aggregate data is currently determined by the Interim Pacific Data Management Group
- ✦ records must be protected by adequate security safeguards against loss, or unauthorised access, use, modification, or disclosure
- ✦ procedures for women seeking access to their own personal information on the NCSR must be consistent with the requirements of the Official Information Act 1987, and the Privacy Act 1993.

3.4.4 LETTERS TO WOMEN WHOSE CYTOLOGICAL SMEAR RESULTS ARE SENT TO THE NCSR

The NCSP sends an initial letter to women having their smear result sent to the NCSR for the first time. This meets privacy requirements by advising women of what information is held about them and where it is stored, and to give them the opportunity to check their enrolment details. The NCSP sends a letter as failsafe to all women who have a smear result which is not completely normal.

Local NCSP sites must send an initial letter to women having their smear result sent to the NCSR for the first time within five working days of receipt of a normal smear result. If the result is not completely normal, the letter

should be held to give the smearer the opportunity to inform the woman. It should, however, be sent within 20 working days of receipt of the smear test result.

The initial letter must:

- ✦ confirm personal details held on NCSR, that is, the woman's name, address, telephone number, National Health Index (NHI) number, date of birth and ethnicity
- ✦ provide an opportunity to check accuracy of personal details
- ✦ include results of the smear test
- ✦ provide advice on when the woman should have her next smear.

A nationally approved pamphlet explaining the meaning of the smear test result will be sent with the letter to each woman whose smear result is not completely normal.

Local NCSP sites will send a letter to women who are at least three months overdue for a cervical smear, to remind them to have their smear.

There will be national consistency with regards to the letters and reports produced by the NCSR.

3.5 Management of Women with Abnormal Smears

It is the smearer's responsibility to ensure that women who have not completely normal smear results are informed within 10 working days of the smear being taken and offered appropriate follow-up. The NCSP is a back-up to smearers' own systems.

Women are entitled to receive follow-up and treatment in a manner which complies with the Code of Health and Disability Services Consumer's Rights.

Smearers should inform the NCSP when a woman is referred for treatment. This is to ensure that women do not receive correspondence from the NCSP or appear on any recall lists as a result of diagnostic smears during treatment ('sign-out'). The local NCSP will follow up:

- ✦ all women with a high grade lesion who have been 'signed out' for more than four weeks and for whom no smear or histology report has been received
- ✦ all women with low grade lesions who have been 'signed out' for more than six months and for whom no smear or histology report has been received.

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Smertakers should inform the NCSP when a woman has finished treatment.

Local NCSP sites will identify those women for whom they do not receive notification of completion of treatment within one year of commencement of treatment by a specialist, and check whether those women are still receiving treatment.

Procedures for following up less than normal smears are set out in the *National Consensus on a Treatment Protocol for the Management of Abnormal Smears* (Department of Health 1992). This includes the maximum waiting times for women referred to colposcopy, namely:

- ☛ women in whom there is a clinical suspicion of invasive carcinoma, and women in whom the smear is suspicious of invasive disease should receive colposcopy within one week of referral
- ☛ women who have high grade squamous intraepithelial lesions and no symptoms should receive colposcopy within one month of referral
- ☛ women in whom there is a low grade squamous intraepithelial lesion apparent in consecutive smears, or persistence of atypia of uncertain significance, should receive colposcopy within three to six months of referral.

The *National Consensus on a Treatment Protocol for the Management of Abnormal Smears* (Department of Health 1992) is being reviewed in 1996. If changes are made to it, women are to receive follow-up in line with the revised protocol.

Local NCSP sites will send reports regularly to smertakers listing:

- ☛ women currently undergoing treatment
- ☛ women with abnormal results who have not been referred for diagnosis and treatment.

3.5.1 CERVICAL HISTOLOGY

Medical practitioners taking cervical histology specimens from women should:

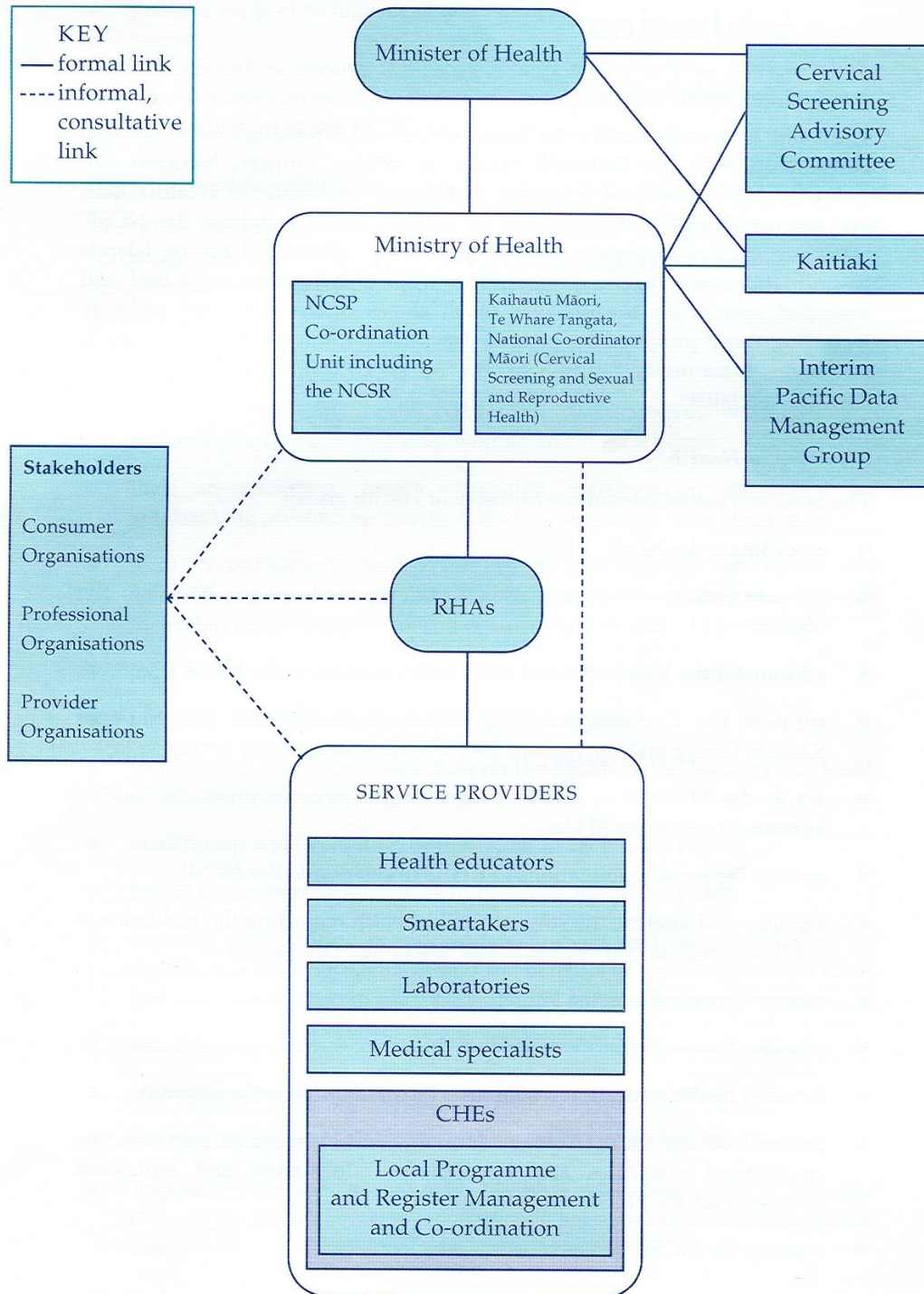
- ☛ ensure that they have the informed consent of the women to take the specimen
- ☛ ensure that, before a histology specimen is forwarded to a laboratory for analysis, the woman is informed that unless she objects, a report on the test will be included on the NCSR
- ☛ discuss the NCSP with women having histology specimens taken and provide women with the written information sheet from the NCSP enrolment form

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- ✿ when enrolling women in the NCSP, discuss with them:
 - the purpose for which the information is collected (that is, to help ensure women with abnormal smears are identified, informed and referred for treatment; to provide information about past cervical smear tests to laboratories to assist them in interpreting smears and making recommendations on treatment; to monitor the quality of smearing and smear-reading services; and to help identify groups of women who are/are not being screened)
 - the authorisation under which the information is collected
 - who will have access to the information
- ✿ ensure that sufficient information is collected and provided to the NCSP to meet its minimum data requirements and to enable women to be enrolled according to the NCSP policy and protocols. This includes full name, date of birth, address and previous smear history, as well as asking women to self identify their ethnicity, which is recorded for monitoring purposes
- ✿ ensure that where a woman objects to the report on the histology specimen being forwarded to the NCSP, written notice for the objection accompanies the specimen to the laboratory, and an acknowledgment of her objection is given to the woman and a copy filed in her medical records.

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DIAGRAM OF RELATIONSHIPS



3.6 Co-ordination, Monitoring and Evaluation

3.6.1 CO-ORDINATION

The NCSP is co-ordinated by the National Cervical Screening Co-ordinator in partnership with the Kaihautū Māori, Te Whare Tangata, National Co-ordinator Māori (Cervical Screening and Sexual Reproductive Health). Both are employed within the Ministry of Health. RHAs purchase the NCSP, including local management and co-ordination, Māori and Pacific Islands co-ordination, and health services. The NCSP provides an organised and managed system for the delivery of all stages of the screening pathway including those provided by general practitioners, nurses, lay smertakers, midwives, community health workers, health educators, pathologists and medical specialists.

Ministry of Health

The main responsibilities of the Ministry of Health are to:

- ✦ co-ordinate the NCSP
- ✦ provide policy advice on national policy aspects of the NCSP to the Minister of Health
- ✦ administer the legislation and regulations relating to the NCSP
- ✦ support the Cervical Screening Advisory Committee, the National Kaitiaki Group and the Interim Pacific Data Management Group
- ✦ act as the Minister of Health's agent in the negotiation of the funding agreements with the RHAs
- ✦ specify the service obligations to RHAs in relation to the NCSP
- ✦ monitor and analyse the state of public health regarding the incidence of cervical cancer in New Zealand and associated risk factors
- ✦ monitor and evaluate the NCSP
- ✦ monitor the performance of RHAs
- ✦ develop health education resources which articulate national policy
- ✦ provide advice to RHAs regarding the development of cost-effective recruitment strategies and appropriate information and education strategies for the NCSP
- ✦ manage the NCSR

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- ☛ liaise and provide advice to local areas
- ☛ provide support to register sites.

The Cervical Screening Advisory Committee provides advice to the Minister of Health on strategic and operational policy development, monitoring and evaluation of the NCSP.

Regional health authorities

The RHA funding agreements set out the Service Obligation for Cervical Screening (see Appendix 4). RHAs purchase cervical screening services according to Section 74A of the Health Act and this policy. This should include:

- ☛ local management and co-ordination of the NCSP
- ☛ local co-ordination, health education, participation strategies and smearing services for Māori women and their whānau
- ☛ local co-ordination, health education, participation strategies and smearing services for Pacific Islands women and their families
- ☛ local co-ordination, health education, participation strategies and smearing services for other sub-populations of women who are identified as having low rates of participation in cervical screening
- ☛ local maintenance and operation of the NCSR
- ☛ meeting cervical screening targets in each region
- ☛ provision of non-identifiable data on the NCSR to the Ministry of Health as required for monitoring and evaluation
- ☛ monitoring and evaluation of the NCSP in each RHA region
- ☛ health promotion programmes in line with the NCSP policy
- ☛ focusing the attention of individuals, families and communities on the significance of cervical cancer and the benefits of enrolling on the NCSR, and encouraging community participation in these issues
- ☛ training programmes for health professionals and lay smearers
- ☛ laboratory diagnostic services
- ☛ treatment services in the regions to meet the requirements of the NCSP
- ☛ colposcopy services in line with the *National Consensus on a Treatment Protocol for the Management of Abnormal Smears* (Department of Health 1992).

3.6.2 MONITORING AND EVALUATION

The Ministry of Health is responsible for ensuring that the NCSP is monitored and evaluated nationally. It is responsible for ensuring that any necessary response is made to information obtained from the NCSR, performance indicators, routine or other analysis. It is the Ministry of Health's role to make sure that progress towards achieving the goal and objectives of the NCSP is evaluated and fed back to providers and the community. To ensure this is achieved, the Ministry of Health is beginning an evaluation of the NCSP in the 1996/97 year. This will include evaluation of the NCSP's provision to priority groups and other sub-populations, evaluation of the NCSP's acceptability to consumers, and evaluation of expenditure on the NCSP.

The NCSP is unique in that the NCSR, which is located in the Ministry of Health, contains much of the information for effective monitoring and evaluation.

The effectiveness of the NCSP will be judged ultimately in terms of the incidence of and rates of deaths from cervical cancer. There will be considerable lag, however, before the impact of changes in cervical screening are reflected in lowered incidence and mortality rates. Data collection and analysis of interim measures are carried out for quality assurance of service delivery, comparative assessment of providers and monitoring and evaluation of processes and outcomes along the screening pathway. To ensure cost-effectiveness of monitoring and evaluation, the amount of data collected should be the absolute minimum to adequately address the relevant issues (Cervical Screening Advisory Committee 1994).

Annual statistical report

The Ministry of Health produces an annual statistical report on the NCSP to provide data to assist with the monitoring and evaluation of each stage of the screening pathway, including:

- ✦ progress on NCSP targets
- ✦ enrolment numbers, including number of smears taken, and the proportion of the eligible population on the NCSR
- ✦ reported screening history of women at time of enrolment
- ✦ demographic characteristics of women who can no longer be contacted
- ✦ demographic characteristics of women on the NCSR in comparison to the eligible population
- ✦ smear volumes and screening frequency
- ✦ adequacy of cervical smearing

- ☛ cervical cytology, including the proportion of abnormalities detected as low-grade intraepithelial lesions
- ☛ histology reports
- ☛ cytological quality and reporting
- ☛ a report on the numbers of women who opted off the register after enrolment.

Monitoring processes to be developed

The Ministry of Health will work to develop processes to monitor and evaluate the following:

- ☛ the proportion of patients with abnormal cytology who have been followed through to diagnosis
- ☛ the screening history of all women developing cervical cancer, to be done on an ongoing basis, including reassessing previous smears
- ☛ the proportion of smears taken outside the guidelines (that is, roughly one smear every three years per woman aged 20–69 years and follow-up smears for each abnormal and unsatisfactory smear). This should not exceed 10 percent
- ☛ variations in laboratory reporting practice
- ☛ sensitivity of smears in detecting abnormalities
- ☛ specificity of smears in detecting abnormalities
- ☛ whether the invasive cervical cancers which are found were detected at regular screening or by another method.

Further specific standards and appropriate review periods will be developed by the Ministry of Health. Consideration will be given to World Health Organization measures (Lunt 1984), Europe Against Cancer Programme measures (Coleman et al 1993) and other performance measures not yet included. Implementation of these monitoring processes will enable comparison to be made with accepted international standards for cervical screening programmes.

Regional monitoring and evaluation

RHAs are to monitor and evaluate the quality of services they purchase, and provide information to the Ministry of Health as set out in the Funding Agreements for national monitoring and evaluation of the NCSP. They should monitor and evaluate as appropriate expenditure, health promotion, smear taking and smear reading services, performance of the NCSR and provision of colposcopy and treatment services in their regions.

APPENDIX 1

National Policy Advisory Group

Members

<i>Sheila Alexander</i>	New Zealand <u>Nurses' Organisation</u>
<i>Doreen Arapai</i>	Pacific Islands women's perspectives
<i>Sandra Coney</i>	Federation of Women's Health Councils Aotearoa New Zealand
<i>Sue Dahl</i>	National Co-ordinator, Cervical Screening Programme-until 1994; 1994 onwards: <i>Teenah Handiside</i>
<i>Allison Handley</i>	Regional Health Authorities — until 1995
<i>Connie Hassan</i>	Māori women's perspectives
<i>Dr David Kitchen</i>	New Zealand College of Obstetricians and Gynaecologists
<i>Dr Maree Leonard</i>	Cervical Screening Advisory Committee — appointed 1995
<i>Cynthia Maling</i>	Public Health Commission — until 1995
<i>Betsy Marshall</i>	Cervical Screening Advisory Committee
<i>Heather Marunui</i>	Māori Women's Welfare League
<i>Karen McCarthy</i>	Cervical Screening Programme Managers — until 1995; 1995 onwards: <i>Susan Bramley</i>
<i>Dr Aine McCoy</i>	New Zealand <u>Medical Association</u>
<i>Dr Branko Sijnja</i>	New Zealand <u>General Practitioners'</u> Association
<i>Iva Singsam</i>	Pacific Islands women's perspectives
<i>Dr Clint Teague</i>	Cervical Screening <u>Laboratory</u> Advisory Committee, previously Cytology Advisory Liaison Committee
<i>Dr Tessa Turnbull</i>	Royal New Zealand College of General <u>Practitioners</u> ✓

APPENDIX 2

Submissions Received

Allan-Moetaua, Anne. Wellington Cervical Screening Programme Pacific Islands Co-ordinator

Anderson, Maureen E; Roberts, Tris; Pearson, Heather; Courtenay, Helen. Hamilton

Arapai, Doreen. National Policy Advisory Group
Auckland Cervical Screening Programme
Auckland Cervical Screening Working Party
Cancer Society of New Zealand Inc.
Central Regional Health Authority. Wellington
Cervical Screening Advisory Committee
Cervical Screening Programme Local Managers

Chambers, Helen. Marlborough

College of Nurses. Aotearoa New Zealand

Consumer/Smear takers Group. Southland

Cox, Brian. Department of Preventive and Social Medicine, University of Otago, Dunedin

Cytology Advisory Liaison Committee

Green, Terri. Christchurch

Health Care Hawkes Bay

Health Services for Women, Cervical Smear Clinic, Palmerston North

Health Waikato Cervical Screening Programme General Practitioner and Practice Nurse Advisory Group

Healthcare Otago Limited. Dunedin

Healthlink South. Christchurch

Jones, R W. Obstetrician and Gynaecologist, National Women's Hospital, Auckland

Kitchen, D H. Obstetrician and Gynaecologist, Health Waikato, Hamilton

Manawatu-Wanganui Cervical Screening Programme. MidCentral Health

Māori Women's Welfare League Inc.

Matcham, Peter. Wellington

McBride-Stewart, Sara. Department of Psychology, University of Waikato

Midland Regional Health Authority

Ministry of Pacific Island Affairs

NATIONAL CERVICAL SCREENING PROGRAMME POLICY

Ministry of Women's Affairs
Ministry of Youth Affairs
National Council of Women, Auckland Branch Sub-Committee on Health
National Council of Women
New Zealand College of Midwives
New Zealand Family Planning Association
New Zealand Family Planning Association, Southern Region
New Zealand General Practitioners' Association
New Zealand Medical Association
New Zealand Nurses' Organisation
New Zealand Society of Pathologists and Royal College of Pathologists of
Australasia, New Zealand Regional Committee
North Health
O'Brien, Puti Puti. Te Teko
Otago Cervical Screening Advisory Committee. Healthcare Otago Limited
Otago Cervical Screening Programme. Health Care Otago Limited
Otaki Women's Health Group. Otaki
Palmerston North Women's Health Collective Inc.
Patients' Rights. Christchurch
Paul, Charlotte. Associate Professor of Epidemiology, Department of
Preventive and Social Medicine, University of Otago
Public Health Commission
Royal New Zealand College of General Practitioners
Royal New Zealand College of Obstetricians and Gynaecologists
Salmond, Clare. Department of Public Health, Wellington School of Medicine,
Wellington
Singsam, Iva. National Policy Advisory Group
Southland Cervical Screening Programme. Southern Health
Southland Cervical Screening Programme, Providers' Consultative Group
Straton, Judy. Senior Lecturer, Department of Public Health, University of
Western Australia
Te Puni Kōkiri
Vaine Inter-Pacific. Palmerston North
Whata, Ngaire. Korowai Aroha, Rotorua
Women's Health Action, Federation of Women's Health Council of
New Zealand Aotearoa and Auckland Women's Health Council
Women's Health and Information Support and Education (WHISE).
Hamilton

APPENDIX 3

Legislation

I THE HEALTH ACT 1956

74A. National Cervical Screening Register

(1) In this section,—

“Cervical smear test” means any test or the taking of any cytological or histological specimen to determine the presence in the cervix of any woman of a cancer or non-invasive, pre-cancerous lesion:

“Register” means the National Cervical Screening Register maintained by the Ministry of Health or by a person who is appointed by the Director-General for this purpose.

(2) Every person who, for the purposes of a cervical smear test, takes a specimen from a woman shall—

(a) Ensure that, before the specimen is forwarded to a laboratory for analysis, the woman is informed that, unless she objects, a report on the test will be forwarded for inclusion in the register; and

(b) If aware that the woman objects to a report on the test being forwarded for inclusion in the register, ensure that—

(i) A written acknowledgment of the objection is given to the woman; and

(ii) The specimen is accompanied by a written notice of the objection.

(3) The person in charge of a laboratory where a specimen from a cervical smear test is analysed—

(a) Must not allow a report of the results of the test to be forwarded for inclusion in the register if the specimen was accompanied by a written notice of objection under subsection (2) of this section; but

(b) In every other case, must cause such a report to be forwarded for inclusion in the register.

(4) Cervical smear test information held by any area health board on the day before the day on which this section comes into force shall, if the Director-General so requests, be forthwith forwarded for inclusion in the register by the holder of the information at the date of the request.

(5) No person may disclose information on the register that identifies a woman, unless the information is disclosed—

(a) With the consent of the woman; or

(b) To a medical practitioner who has been engaged by the woman and who is seeking information to assist in diagnosis or treatment or to determine when the woman should next have a cervical smear test; or

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- (c) For the purpose of enabling positive results from a cervical smear test to be followed up; or
 - (d) For the purpose of enabling reminder notices to be sent to women whose names appear in the register and who are due for another cervical smear test; or
 - (e) For the purpose of giving access to the register in accordance with regulations made under subsection (7) (a) of this section to persons studying cancer; or
 - (f) [Subject to any regulations made under subsection (7) (b) of this section] for the purpose of enabling the compilation and publication of statistics that do not enable the identification of the women to whom those statistics relate.
- (6) All information on the register that identifies a woman shall be removed from the register if the woman so requests in writing.
- (7) Regulations made be made under this Act for any one or more of the following purposes:
- (a) Regulating access to the register by persons studying cancer;
 - (b) Prohibiting the disclosure, under subsection (5) (f) of this section, of information that relates to any class or classes of women specified in the regulations, including prohibiting the disclosure of such information without the approval of any person or group of persons or body or organisation specified in the regulations;
 - (c) Specifying the obligations of the person who maintains the register to women named on the register;
 - (d) Regulating the use, disclosure, and publication of information from the register;
 - (e) Prohibiting the use, disclosure, and publication of information from the register where the information relates to any class or classes of women specified in the regulations, including prohibiting the use, disclosure, and publication of such information without the approval of any person or group of persons or body or organisation specified in the regulations;
 - (f) Providing for the establishment, appointment, procedures, and powers of any person or group of persons or body or organisation established to make decisions relating to the matters referred to in paragraph (e) of this subsection.
- (8) Every person who fails to comply with the requirements of this section, or any regulations made under this section, commits an offence against this Act.

II THE HEALTH (CERVICAL SCREENING (KAITIAKI)) REGULATIONS 1995

1. Title and commencement

- (1) These regulations may be cited as the Health (Cervical Screening (Kaitiaki)) Regulations 1995.
- (2) These regulations shall come into force on the 1st day of April 1995.

2. Interpretation

- (1) In these regulations, unless the context otherwise requires,—
 - “The Act” means the Health Act 1956;
 - “National Kaitiaki Group” or “Group” means the group established pursuant to regulation 6 of these regulations;
 - “Protected information” means information that—
 - (a) Is on or from the Register; and
 - (b) Identifies the woman or women to whom the information relates as being Maori;
 - “Register” means the National Cervical Screening Register maintained by the Ministry of Health or by a person who is appointed by the Director-General for this purpose.
- (2) Where any expression used in these regulations is not defined in these regulations but is defined in the Act, that expression shall, unless the context otherwise requires, have, in these regulations, the meaning given to it in the Act.

3. Restrictions on disclosure, use, and publication of protected information

- (1) No person shall disclose, under section 74A (5) (f) of the Act, any protected information unless the information is disclosed with the approval of the Group granted under regulation 5 of these regulations.
- (2) No person shall disclose or use or publish any protected information (being protected information that does not enable the identification of the woman or women to whom the information relates) unless the information is disclosed or used or published with the approval of the Group granted under regulation 5 of these regulations.

4. Applications for approval

- (1) Every application for the approval of the Group to disclose or use or publish protected information —
 - (a) Shall be made in writing to the Director-General; and
 - (b) Shall be forwarded as soon as practicable by the Director-General to the convenor of the Group.
- (2) Every such application shall specify—
 - (a) The reasons why the protected information to which the application relates is sought; and
 - (b) The reasons why it is necessary for the information to identify the

Group shall hold office for such term (not exceeding 3 years) as the Minister shall specify in the instrument appointing the member.

- (4) Every member of the Group shall be eligible for reappointment from time to time.
- (5) Subject to these regulations, every member of the Group shall be appointed on such terms and conditions as the Minister thinks fit.

8. Convenor

- (1) The Minister shall from time to time appoint a member of the Group to be the convenor of the Group.
- (2) Subject to subclause (3) of this regulation and to regulation 9 of these regulations, any person who is appointed as the convenor of the Group shall hold that office until that person's current term of office as a member of the Group expires (whether or not that person is subsequently reappointed as a member of the Group).
- (3) Any person who is appointed as the convenor of the Group—
 - (a) May at any time be removed from office as convenor by the Minister by notice in writing to that person:
 - (b) May at any time resign that person's office as convenor by notice in writing addressed to the Minister.
- (4) Any member of the Group may from time to time be reappointed as the convenor of the Group.

9. Vacation of office

- (1) Any member of the Group may at any time be removed from office by the Minister by notice in writing to the member and to the convenor of the Group.
- (2) Any member of the Group may at any time resign that person's office by notice in writing addressed to the Minister.
- (3) Where the term for which a person who has been appointed to be a member of the Group expires, that person, unless sooner vacating or removed from office, shall continue to hold office, by virtue of the appointment for the term that has expired, until—
 - (a) That person is reappointed; or
 - (b) A successor to that person is appointed; or
 - (c) That person is informed in writing by the Minister that that person is not to be reappointed and is not to hold office until a successor is appointed.
- (4) No act or proceeding of the Group or of any person acting as a member of the Group shall be invalidated because there was a vacancy in the membership of the Group at the time of the act or proceeding, or because of the subsequent discovery that there was a defect in the appointment of any person so acting, or that the person was incapable of being, or had ceased to be, such a member.

woman or women to whom the information relates as being Maori;
and

- (c) Where it is proposed to use the information for research,—
 - (i) The purposes of the research; and
 - (ii) How the results of the research will be used.

5. Decisions on applications for approval

- (1) Where an application made under regulation 4 of these regulations is received by the convenor of the Group, the Group shall consider the application as soon as reasonably practicable, and shall determine, in accordance with subclause (3) of this regulation, whether or not to grant the approval.
- (2) Any approval granted under this regulation may be granted either unconditionally or subject to such conditions as the Group thinks fit.
- (3) In determining whether or not to grant an approval under this regulation, and in determining what conditions (if any) should be imposed on any such approval, the Group shall have regard to the following matters:
 - (a) The principle of the sanctity of Te Whare Tangata;
 - (b) The need for culturally appropriate protection for the taonga of protected information;
 - (c) The need to ensure that protected information is used for the benefit of Maori women.
- (4) As soon as reasonably practicable after determining an application under this regulation, the convenor of the Group shall notify the Director-General in writing of the Group's decision and of the reasons for the decision.
- (5) The Director-General shall as soon as reasonably practicable inform the applicant of the Group's decision and of the reasons for the decision.

6. National Kaitiaki Group

- (1) The Minister shall establish a group called the National Kaitiaki Group.
- (2) The function of the Group shall be to consider applications under these regulations for approval to disclose or use or publish protected information and to grant approval for such disclosure or use or publication in appropriate cases.

7. Membership of Group

- (1) The Group shall consist of not fewer than 3 and not more than 6 members.
- (2) The members of the Group shall be appointed by the Minister after consultation with —
 - (a) The Minister of Maori Affairs; and
 - (b) The Minister of Women's Affairs; and
 - (c) Such other persons as the Minister considers appropriate in any particular case.
- (3) Unless sooner vacating or removed from office, every member of the

10. Procedure and servicing

- (1) Except as provided in these regulations, the Group may regulate its procedure in such manner as it thinks fit.
- (2) The Crown (acting through the Ministry of Health) shall provide such secretarial and other services to the Group as the Minister from time to time determines.

11. Offences - Every person commits an offence and is liable on summary conviction to a fine not exceeding \$500 who, without lawful excuse,—

- (a) In contravention of regulation 3 (1) of these regulations, discloses, under section 74A (5) (f) of the Act, any protected information without the approval of the Group; or
- (b) In contravention of regulation 3 (2) of these regulations, discloses or uses or publishes any protected information without the approval of the Group; or
- (c) Contravenes or fails to comply with any condition imposed on any approval granted under regulation 5 of these regulations.

EXPLANATORY NOTE

This note is not part of the regulations, but is intended to indicate their general effect.

These regulations, which come into force on 1 April 1995, relate to the disclosure, use, and publication of information that is contained on the National Cervical Screening Register and that relates to Māori women.

The regulations prohibit the disclosure, use, and publication of such information without the approval of a National Kaitiaki Group, which is to be appointed by the Minister of Health.

Issued under the authority of the Acts and Regulations Publication Act 1989.

Date of notification in Gazette: 2 March 1995.

These regulations are administered in the Ministry of Health.

APPENDIX 4

Service Obligation for Cervical Screening

SERVICES TO BE PURCHASED

RHAs are to purchase locally managed and co-ordinated cervical screening services in accordance with section 74A of the Health Act 1956 and the Government's policy for National Cervical Screening, including:

- ✦ health education and promotion for individuals and families regarding cervical cancer
- ✦ cervical smear-taking services
- ✦ laboratory diagnostic services
- ✦ colposcopy and treatment services
- ✦ maintenance and operation of the National Cervical Screening Register.

RHAs should particularly target groups of:

- ✦ women who have never had a smear
- ✦ women whose smear history is outdated
- ✦ Māori women
- ✦ Pacific Islands women
- ✦ midlife and older women 35-69 years.

TERMS OF ACCESS

The terms of access for primary care, primary diagnostic and therapeutic support services and secondary medical and surgical services apply where relevant to cervical screening services. In addition, the following specific requirements apply:

AVAILABILITY: TIME

RHAs are to ensure that eligible women have access to colposcopy services in line with the Government policy for National Cervical Screening and associated standards. Procedures for following-up less than normal smears are set out in the *National Consensus on a Treatment Protocol for the Management of Abnormal Smears*.

NATIONAL CERVICAL SCREENING PROGRAMME POLICY

This includes the maximum waiting times for women referred for colposcopy. Namely:

- ✦ women in whom there is a clinical suspicion of invasive carcinoma, and women in whom the smear suggests invasive disease should receive colposcopy within one week of referral
- ✦ women who have high grade squamous intraepithelial lesions and no symptoms should receive colposcopy within one month of referral
- ✦ women in whom there is a low grade squamous intraepithelial lesion in consequent smears or persistence of atypia of uncertain significance should receive colposcopy within six months of referral.

CULTURAL EFFECTIVENESS

Māori Requirements

RHAs are to purchase locally co-ordinated health education, promotion and smear-taking services for Māori women and their whānau.

Māori women are, where feasible, to have access to educators and cervical smear-takers who are Māori women.

OTHER CULTURAL EFFECTIVENESS REQUIREMENTS

Pacific Islands People Requirements

RHAs are to purchase locally co-ordinated health education, promotion and smear-taking services for Pacific Islands women.

Pacific Islands women are, where feasible, to have access to educators and cervical smear-takers who are Pacific Islands women.

WOMEN

RHAs should involve women from the target groups in the development of services. Women are, where feasible, to have access to smear-takers who are women.

SAFETY AND QUALITY STANDARDS

Laboratories

RHAs must ensure that all laboratories providing cervical cytology and histology services are registered with the Testing Laboratory Registration Council of New Zealand or an equivalent accreditation programme.

SMEAR-TAKERS

Smear-takers accessing laboratory diagnostic services who are not medically qualified must be approved by the Medical Officer of Health as outlined in the *Standards for Competency for Smear Takers*, Department of Health, 1991.

OTHER REQUIREMENTS

National Cervical Screening Programme

RHAs are to ensure the National Cervical Screening Register (NCSR) system is purchased on a basis that is consistent with it being a key management tool for both the local and national operation of the National Cervical Screening Programme.

RHAs should purchase services to maintain the existing local operational structure of both the programme and the register. This includes:

- ✦ local management and co-ordination
- ✦ functional relationships between local programmes and the national co-ordinators
- ✦ operation and maintenance of existing register services and sites solely for the purpose of meeting NCSP objectives
- ✦ provision of non-identifiable data stored on the NCSR to the Ministry of Health, as and when reasonably required by the Ministry of Health
- ✦ co-operation with the Ministry of Health regarding the re-configuration of site registers and linking with a central register including the purchase of the network.

LABORATORIES

RHAs are to ensure their purchase arrangements for laboratory services for cervical cytology and histology reflect the requirements that all laboratories servicing the National Cervical Screening Programme:

- ✦ forward cervical cytology and histology test results (not accompanied by written notice of objection) to the National Cervical Screening Register in the agreed codes and electronic format
- ✦ forward electronically to the National Cervical Screening Register the results of cervical cytology within 10 working days of the test being taken.

The results from cervical histology should be forwarded electronically to the National Cervical Screening Register within 20 days of being taken.

GLOSSARY

Definitions taken from Adams 1991; Dyson 1986; Department of Health 1992; R Jones (correspondence May 1996); Kurman and Solomon 1994; Landau 1986; and *The Report of the Committee of Inquiry into Allegations Concerning the Treatment of Cervical Cancer at National Women's Hospital and into Other Related Matters* (1988).

Atypia of uncertain significance - Minor epithelial cell changes whose nature is uncertain but which may result from inflammation and repair processes, human papilloma virus (HPV) effect or minor squamous or glandular intraepithelial neoplasia.

Bethesda system - A system for cervical/vaginal cytologic diagnoses, developed at the National Cancer Institute (NCI)-sponsored workshop in December 1988 to provide uniform diagnostic terminology that would facilitate communication between the laboratory and the clinician. Reports include a descriptive diagnosis and an evaluation of specimen adequacy.

Cervical smear - A technique used to detect precursors of cervical cancer. The test is based on the examination of cells which are removed from the cervix and examined under a microscope.

Cervical intraepithelial neoplasia (CIN) - This is the modern terminology for the premalignant changes found either by cervical screening or by histology. The degree of abnormality ranges from CIN 1 (mild) to CIN 3 (severe). CIN is nearly always symptomless.

Colposcopy - A diagnostic examination of the vagina and cervix or neck of the womb using a colposcope (a lighted magnifying instrument resembling a small mounted pair of binoculars), to examine the vaginal walls and cervix for abnormal cells. Is often combined with cervical biopsy.

Coverage - The number, percentage, or proportion of eligible women reached by a programme.

Cytology - The study of cells using a microscope. Used in cervical screening to detect cancer or cell changes which may be precursors of cancer.

Diagnostic smear - A smear taken outside the normal screening interval as part of the diagnostic assessment of a woman who has signs or symptoms possibly indicative of cervical cancer.

Dysplasia - Abnormal cell growth.

- Eligible women** - For the purposes of cervical screening, all women aged 20–69, years who have not had hysterectomy surgery for a benign condition and have a previously normal screening history.
- High grade lesion / High grade squamous intraepithelial lesion** - A cytological diagnosis encompassing CIN 2 and CIN 3 (moderate dysplasia, severe dysplasia and carcinoma in situ).
- Histology** - The microscopic study of the minute structure and composition of tissues.
- Hui** - Generic term for Māori gathering, meeting or conference (typically held on a marae) and organised according to Māori protocol.
- Hysterectomy** - Removal of the uterus (womb). The operation may be recommended for persistent or recurrent CIN. Radical hysterectomy is performed in certain cases of early invasive cervical cancer. In a total hysterectomy the uterus and cervix are both removed and in a subtotal hysterectomy the cervix remains - so that regular smears are still necessary.
- Incidence** - The number of new cases that occur in a given period in a specified population.
- Invasive cancer of the cervix (Invasive carcinoma)** - Condition where cancerous cells spread beyond the surface epithelium into the underlying tissues. It is diagnosed by clinical examination with biopsy in women who present with abnormal bleeding and discharge. The cervical smear is not a reliable method of diagnosing cervical cancer. Classified in four stages, from Stage I where the cancer has not spread beyond the cervix, to Stage IV where it has extended beyond the pelvis. Early stage disease may be treated by an extended hysterectomy (involving the upper vagina and lymph nodes) or by radiation therapy.
- Kaimahi** - Māori cervical screening co-ordinators, educators and smear-takers.
- Kaitiaki** - Caregivers or guardians. The National Kaitiaki Group refers to the group set up to oversee the disclosure, use, and publication of Māori women's summary data held on the NCSR under the Health (Cervical Screening (Kaitiaki)) Regulation 1995.
- Kuia** - Old woman, grandmother, other elderly female relative. Appointed by the NCSP in recognition of the special status of Māori women.
- Lay smearthakers** - Smearthakers without a formal medical, nursing, or midwifery qualification.
- Low grade lesion / Low grade squamous intraepithelial lesion** - A cytological diagnosis encompassing the changes previously described as HPV infection and or CIN 1 (mild dysplasia).

- Management** - The complete care of a patient including advice, information, treatment and follow-up treatment or monitoring of a condition.
- Medical smertakers** - Medical practitioner who takes cervical smears.
- Mortality** - The number of deaths from a specified disease which are diagnosed or reported during a defined period of time in a given population.
- National Health Index Number** - A unique identifier allotted to persons who have contact with the public hospital services.
- Non-medical smertakers** - All other categories of smertakers: nurses (registered and enrolled), midwives, and lay smertakers. Non-medical smertakers include both practice nurses and nurses working independently in the community.
- Sensitivity** - The probability of a positive test result in the presence of the abnormality for which the test is designed to detect. It is equal to the number of true positives divided by the sum of true positives and false negatives, multiplied by 100.
- SNOMED** - A coding system for recording histological diagnosis.
- Specificity** - The ability of a screening test to correctly identify a person who is free of abnormality. If d is the number of persons tested who are both free of the condition and negative on screening, and b is those free of the condition but positive on screening, the specificity of the screening test is defined as $d/(b+d)$.
- Squamous cell carcinoma** - The most common form of cervical cancer arising from squamous cells in the epithelium (tissue which lines the vagina and the outer layer of the cervix).
- Whānau** - Relationships that have links to a common ancestor. Nuclear or wider family.
- Te Whare Tangata** - The womb or uterus. Literally 'the house of people'. The cervix is considered the gateway to Te Whare Tangata.
- Unsatisfactory smears** - A smear that cannot be reported on by the laboratory.
- WHO** - World Health Organization of the United Nations.

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Appendix 6

Information sheet, discussion schedule, questionnaire and consent form for women who use cervical screening services

INFORMATION SHEET

Nga mihi ki a koe,

Ko Herena Wihongi au, no Tolaga Bay. Ko Ngati Porou, ko Rongowhakata, ko Te Aitanga a Mahaki, ko Te Whānau a Apanui, ko Nga Puhi oku Iwi. Tēnā koe.

I am conducting research about Māori women and cervical screening as part of my doctoral studies at Waikato University. The objectives of my research are to:

- define tino rangatiratanga
- examine how tino rangatiratanga is expressed in government, government agency and service provider policies
- determine how tino rangatiratanga is expressed in service delivery.

To contribute to objective bullet point three I am interested in discussing your views and experiences about cervical screening. The discussion/whānau hui will be loosely guided by several questions (see attachment). Your participation in the research is entirely voluntary and you have the right to withdraw from the research at any time. However the information gathered will remain confidential and will only be used for the purposes for which it has been gathered.

If you would be interested in participating in this research please indicate by signing the attached consent form.

If you have any questions now or in the future you may contact me at:

63 Jellicoe Drive, HAMILTON. Phone/fax: (70) 858 2313. Email: hrh@xtra.co.nz

OR

Dr Neville Robertson, Department of Psychology, The University of Waikato, HAMILTON. Phone (07) 856 2889. Email: scorpio@waikato.ac.nz

Professor Russell Bishop, Department of Education, The University of Waikato, HAMILTON. Phone (07) 856 2889. Email: rbishop@waikato.ac.nz

Professor Jane Ritchie, Department of Psychology, The University of Waikato, HAMILTON. Phone (07) 856 2889. Email: j.ritchie@waikato.ac.nz

DISCUSSION SCHEDULE

Question 1): What is your understanding of cervical smear test or cervical screening?

What does it involve?

Who would you prefer to do it (DR, nurse, community worker, Māori, non-Māori, other)

Where would you prefer to have it done?

Who would you prefer to hold your cervical screening information? (national data base, iwi data base, self, Dr, smear taker, other)

Question 2): Where does cervical screening fit in your life?
How important is it?

Question 3): Is having a cervical smear something you are comfortable with?
If **YES** in what way

If **NO** why not

Question 4): In a perfect world how would you like cervical screening to be done/delivered?

Question 5): Are Māori cultural values and beliefs important to you in service delivery?

Question 6): Is there anything you would like to comment on before we finish?

Semi Structured Questionnaire

PERSONAL INFORMATION

Question 1): Which ethnic group(s) do you belong to?
(Please tick as many as you wish)

- NZ European or Pākehā
- NZ Māori
- Other European (English, Dutch, Australian, Scottish, Irish or other)
- Samoan
- Cook Island Māori
- Niuean
- Chinese
- Indian
- Other (such as Fijian, Korean, other European) please identify:

Question 2): What age bracket would you fit into? (*please tick the appropriate box*)

- 15-25 years
- 26-35 years
- 36-45 years
- 46-55 years
- 56-65 years
- 66 +

Question 3): Have you ever had a smear?

- Yes
- No

If **YES** when was the last time you had a smear? (*please tick the appropriate box*)

- Within the last six months?
- Within the last year?
- Within the last two years?
- Within the last three years?
- Over three years ago?

CULTURAL INFORMATION

Question 1): Do you identify with an Iwi?

- Yes No

If **YES** what is/are they?

Question 2): Do you identify with a hapū?

- Yes No

If **YES** which one/s is/are it/they?

Question 3): How important is living in your tribal area to you? (please circle one)

- not very important somewhat unimportant neutral
 somewhat important very important

Question 4); How important is living near whānau to you? (please circle one)

- not very important somewhat unimportant neutral
 somewhat important very important

Question 5): My friends are (please circle one)

- all non-Māori mostly non-Māori both Māori and non-Māori
 mostly Māori all Māori

Question 6): Do you speak te reo Māori (please circle one)

- not at all rarely occasionally very often frequently

Question 7): Are you involved in Māori community activities (ie Te Kohanga Reo, Kura Kaupapa Māori, kapa haka, sports activities, church, kite making, other cultural activities) (please circle one)

- not at all rarely occasionally very often frequently

Question 8): Do you eat traditional Māori food (kaimoana, puha, hāngi, etc) (please circle one)

- not at all rarely occasionally very often frequently

CERVICAL SCREENING INFORMATION

Question 1): Do you know what a cervical smear test is? (please tick one)

- Yes No

If **YES** please explain

Question 2): If you needed a smear who would you prefer to do it for you? (please tick one)

	Māori	Pākehā
Doctor	<input type="checkbox"/>	<input type="checkbox"/>
Nurse	<input type="checkbox"/>	<input type="checkbox"/>
Lay smear taker	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify)	<input type="checkbox"/>	<input type="checkbox"/>

Question 3): Where would you prefer to have it done? (please tick one)

- Marae
 Doctors surgery
 Home
 Other (please specify)

Question 4); How important is having a smear to you? (please tick one)

- not important
 somewhat unimportant
 neutral
 somewhat important
 very important

Question 5): Is having a smear comfortable for you? (please tick one)

- Yes No

If **YES** please explain

If NO please explain

Question 6): In a perfect world how would a perfect cervical screening service look like to you?

Question 7): Is there anything else you would like to comment on before we finish.

CONSENT FORM

Research Project: Discursive interactions – tino rangatiratanga in health policies and services

Name of researcher: Helen Wihongi

I have received an information sheet about this research project and the researcher has explained the project to me. I have had the chance to ask questions and discuss my participation with other people. Any questions have been answered to my satisfaction.

I agree to participate in this research project and I understand that I may withdraw at any time. If I have concerns about this project, I may contact the convenor or the Research and Ethics Committee (Waikato University)

Name: _____ Signature: _____
Date: _____

Research Project: Discursive interactions - tino rangatiratanga in health policies and services

Name of researcher: Helen Wihongi

I have received an information sheet about this research project and the researcher has explained the project to me. I have had the chance to ask questions and discuss my participation with other people. Any questions have been answered to my satisfaction.

I agree to participate in this research project and I understand that I may withdraw at any time. If I have concerns about this project, I may contact the convenor or the Research and Ethics Committee (Waikato University)

Name: _____ Signature: _____
Date: _____

Appendix 7

Regional ethical application form

**NATIONAL APPLICATION FORM FOR ETHICAL
APPROVAL OF A RESEARCH PROJECT**

Protocol number
and date received
(for office use
only)

Part 1 : Basic Information

1. Full project title

2. Short project title (lay title)

3. Principal Investigator's name and position

4. Address of Principal Investigator

	Work phone No.	
	Emergency No.*	
	Fax	
	E-mail	

5. Principal investigator's qualifications and experience in past 5 years (relevant to proposed research)

6. Co-investigators' name(s), qualifications and position(s) and, if more than one locality, Principal Investigator at **each** locality

A

B

C	
D	
E	
F	
G	

7.1 Address of A above

	Work phone No.	
	Emergency No.*	
	Fax	
	E-mail	

7.2 Address of B above

	Work phone No.	
	Emergency No.*	
	Fax	
	E-mail	

7.3 Address of C above

	Work phone No.	
	Emergency No.*	
	Fax	
	E-mail	

7.4 Address of D above

	Work phone No.	
	Emergency No.*	
	Fax	
	E-mail	

7.5 Address of E above

	Work phone No.	
	Emergency No.*	
	Fax	
	E-mail	

7.6 Address of F above

	Work phone No.	
	Emergency No.*	
	Fax	
	E-mail	

7.7 Address of G above

	Work phone No.	
	Emergency No.*	
	Fax	
	E-mail	

(* option for Committee's information only)

8. Where this is supervised work

8.1 Supervisor's name

Position

Day time phone number

8.2 Signature of supervisor (where relevant)

Declaration: I take responsibility for all ethical aspects of the project

--

9. Is this a Multi-Region application

(includes a national study using a national database)

 Yes No

10. Is more than one Locality Organisation Involved

If 'yes', list the name and address of each Locality Organisation involved and complete the locality assessment approval in Part 4 (refer to Guidelines)

 Yes No

--

11. I wish the protocol to be heard in a closed Meeting

If the answer is yes, provide reason why you wish it to be heard in a closed meeting

 Yes No

--

12. If the study is based, in part or in full, overseas, which countries are involved?

--

13. Has ethics committee approval overseas been sought or obtained? (attach if available)

--

14. Human Tissue – Does the project involve collection or use of human tissue?

If yes, complete Part 5

 Yes No

15. Gene Studies – Does this research involve any gene or genetic studies? If yes, complete Part 6

 Yes No

16. Consent - Are all participants able to consent themselves?

 Yes No

If **no**, complete section 7

17. Summary

Give a brief summary of the study (not more than 200 words, in lay language)

18. Proposed starting date (dd/mm/yy)

19. Proposed finishing date (dd/mm/yy)

20. Duration of project (mm/yy)

21. Proposed final report date (mm/yy)

Part 2 : Ethical Principles

A. VALIDITY OF RESEARCH

(Operational Standard

Paragraphs 53-59)

SCIENTIFIC BASIS

A1. Aims of Project

A1.1 What is the hypothesis/research question(s)? (state briefly)

A1.2 What are the specific aims of the project?

A2. Scientific Background of the Research

Has this project been scientifically assessed by independent review?

Yes

No

If **yes**, by whom? (name and position)

A copy of the report should also be attached

If **no**, is it intended to have the project scientifically assessed, and by whom?

Describe the scientific basis of the project (300 words maximum). Where this space is inadequate, continue on a separate sheet of paper. *Do not* delete page breaks or renumber pages.



A3. Study Design

A3.1 Describe the study design. Where this space is inadequate, continue on a separate sheet of paper. *Do not* delete page breaks or renumber pages.

A3.2 Is the method of analysis : quantitative or qualitative?

If the method of analysis is qualitative, go to question 3.3

If the method of analysis is **wholly or partly quantitative**, complete the following :

A3.2.1 Describe the statistical method that will be used

A3.2.2 Has specialist statistical advice been obtained? Yes No

If **yes**, from whom?

(A brief statistical report should be included if appropriate)

A3.3 If the method of analysis is **wholly or partly qualitative**, specify the method.

Why is this method appropriate? If interviews are to be used include the general areas around which they will be based. Copies of any questionnaires that will be used should be appended.

A4. Participants

A4.1 How many participants is it intended to recruit? (Include details for each locality organisation)

A4.2 If randomisation is used, explain how this will be done

A5. Expected outcomes or impacts of research

A5.1 What is the potential significance of this project for improved health outcomes?

A5.2 What is the potential significance of this project for the advancement of knowledge?

A5.3 What steps will be taken to disseminate the research results?

A6. Publication of Results

Will any restriction be placed on publication of results? Yes No

If **yes**, please supply details

--

A7. Budget

A7.1 How will the project be funded?

--

A7.2 Does the researcher, the host department, the host institution or the locality organisation, have any financial interest in the outcome of this research? If “yes”, please give details.

--

A8. Incentive Payments - before completing this question, have you read the relevant section in the Guidelines for Completing the National Application Form? Yes No

A8.1. Will the researcher, the host department, the host institution, the locality organisation or any individual/organisation who recruits participants into studies but who will not be involved in the research as investigators receive payment (in money or kind) or reward in connection with this project – including any payment (in money or kind) or reward for recruiting participants into the project?

Yes No

Note: Details about any payment (in money or kind) or reward made to **participants** recruited into the project are to be provided in Question E10.

A8.2 If “yes” to 8.1, please provide details.

Will the payment or reward be made directly to the researcher or to an audited research account or cost centre?

Will the payment or reward be for early or

complete recruitment of a specified number of participants?

What will be the amount of the payment or reward (indicate whether this will be per patient or lump sum)?

B. Minimisation of Harm

(Operational Standard

Paragraphs 60-68)

B1. How many visits/admissions of participants will this project involve? Give also an estimate of total time involved for participants.

B2. Who will carry out the research procedures?

B3. What other research studies is the lead investigator currently involved with?

B4. Where will the research procedures take place?

B5. Give a justification for the number of research participants proposed, using appropriate power calculations.

B6. Are participants in clinical trials to be provided with a card confirming their participation, medication

and contact phone number of the principal investigator?

Yes

No

B7. Is it intended to inform the participant's GP of individual results of the investigations, and their

participation, if the participant consents?

Yes

No

If **no**, outline the reasons

B8. How do the research procedures differ from standard treatment procedures?

B9. What are the benefits to research participants of taking part?

B10. Briefly describe the inclusion/exclusion criteria and include the relevant page number(s) of the protocol or investigator's brochure.

B11. Describe any methods for obtaining information. Attach questionnaires and interview guidelines

(If NHI information is used, see Guidelines)

B12. What are the physical or psychological risks, or side effects to participants or third parties? Describe what action will be taken to minimise any such risks or side effects.

B13. What facilities/procedures and personnel are there for dealing with emergencies?

B14. What arrangements will be made for monitoring and detecting adverse outcomes?

B15. Is the trial being reviewed by a data safety monitoring board? Yes No

If yes, who is the funder of the HRC Sponsor
DSMB?

B16. What are the criteria for terminating the study?

B17. Will any potential toxins, mutagens or teratogens be used? Yes No

If **yes**, specify and outline the justification for their use

B18. Will any radiation or radioactive substances be used? Yes No

Note: If any form of radiation is being used please answer the following. If no, go to question B19

B18.1 Under whose license is the radiation being used?

B18.2 Has the National Radiation Laboratory (NRL) risk assessment been completed?

Yes No

If **yes**, please enclose a copy of the risk assessment, and the contact name and phone number

If **no**, please explain why

B19. Will any drugs be administered for the purposes of this study? Yes No

If **yes** is SCOTT approval required? Yes No

Has SCOTT approval been given? (please attach) Yes No

B20. Does the study involve the use of healthcare resources?

s
 Yes No

If **yes**, please specify:

B21. What effect will this use of resources have on waiting list times for patients ie., for diagnostic tests or for standard treatments?

C. Compensation for Harm Suffered by Participants (*Operational Std Paragraphs 83-91*)

(refer to Appendix 3 of the Guidelines)

Is this a clinical trial under accident compensation legislation (see form guidelines)

Yes No

If **no**, go to question D. If **yes**, please answer the following:

C1. Is the trial being carried out principally for the benefit of a manufacturer or distributor of the drug

or item in respect of which the trial is taking place?

Yes No

(a) If the answer to 1 is **yes**, please complete **Statutory Declaration Form B** and answer questions C2, C3, C4 and C5.

(b) If the answer to 1 is **no** please complete **Statutory Declaration Form A** and go to question D.

C2. What type of injury/adverse consequence resulting from participation in the trial has the manufacturer

or distributor undertaken to cover? (please tick the appropriate box/es)

Yes **No**

- (a) any injury (mental or physical)
- (b) only serious or disabling injuries.
- (c) only physical injuries

Yes **No**

- (d) only physical injuries resulting from the trial drug or item, but not from any other aspect of the trial
- (e) physical and mental injury resulting from the trial drug or item, but not from any other aspect of the trial.

(f) any other qualification (explain)

C3. What type of compensation has manufacturer or distributor

Yes **No**

agreed to pay?

- (a) medical expenses
- (b) pain and suffering
- (c) loss of earnings
- (d) loss of earning capacity
- (e) loss of potential earnings
- (f) any other financial loss or expenses
- (g) funeral costs
- (h) dependants' allowances

C4. Exclusion clauses:

(a) Has the manufacturer or distributor limited or excluded liability if the injury is attributable to the negligence of someone other than the manufacturer or distributor? (such as negligence by the investigator, research staff, the hospital or institution, or the participant).

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

(b) Has the manufacturer or distributor limited or excluded liability if the injury resulted from a deviation from the study protocol by someone other than the manufacturer or distributor?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

(c) Is company liability limited in any other way?

If yes, please specify

C5. Is the manufacturer/distributor's agreement to provide compensation in accordance with the RMI

Guidelines attached?

Yes No

D. Privacy and Confidentiality
44-49)

(Operational Standard Paragraphs

D1. How will potential participants be identified?

D2. How will participants be recruited?
(e.g. advertisements, notices)

D3. Where will potential participants be approached? (e.g. outpatient clinic)

If appropriate, describe by type

(eg students)

D4. Who will make the initial approach to

potential participants?

D5. How will data including audio and video tapes, be handled and stored to safeguard confidentiality (both during and after completion of the research project)?

D6. What will be done with the raw data when the study is finished?

D7. How long will the data from the study be kept and who will be responsible for its safe keeping?

D8. Who will have access to the raw data and/or clinical records during, or after, the study?

D9. Describe any arrangements to make results available to participants, including whether they will be offered their audio tapes or videos.

E. Informed Consent
28-43)

(Operational Standard Paragraphs

Consent should be obtained in writing, unless there are good reasons to the contrary. If consent is not to be obtained in writing the justification should be given and the circumstances under which consent is obtained should be recorded. Attach a copy of the information sheet and consent form.

E1. By whom, and how, will the project be explained to potential participants?

E2. When and where will the explanation be given?

E3. Will a competent interpreter be available, if required?

E4. How much time will be allowed for the potential participant to decide about taking part?

E5. In what form (written, or oral) will consent be obtained? If oral consent only, state reasons.

E6. If recordings are made, will participants be offered the opportunity to edit the transcripts of the recordings?

Yes No

E7. Will data or other information be stored for use in a different study for which ethics committee

approval would be required?

Yes No

If **yes**, explain
how

E8. Is there any special relationship between the participants and the researchers? e.g. doctor/patient, student/teacher

E9. Will there be any financial cost to the participant, e.g. travel and parking costs? If so, will such cost be reimbursed? (refer to Guidelines)

E10. Will any payments be made to participants or will they gain materially in other ways from participating in this project?

Yes No

If **yes**, please supply details

F. Cultural and Social Responsibility
73-82)

(Operational Standard Paragraphs

F1. Will the study drug/treatment continue to be available to the participant after the study ends?

Yes No

If **yes**, will there be a cost, and how will this be met?

What will happen to participants on a placebo arm?

Note: This needs to be included in the Information Sheet.

F2. Have you read the HRC booklet, Guidelines for Researchers on Health Research Involving Māori ”?

Yes No

F3. Does the proposed research project impact on Māoripeople in any way?

Yes No

F3.1 Explain how the intended research process is consistent with the provisions of the Treaty of Waitangi.

F3.2 Identify the group(s) with whom consultation has taken place, and attach evidence of their support.

F3.3 Describe the consultation process that has been undertaken **prior** to the project's development

F3.4 Describe any ongoing involvement the group(s) consulted have in the project

F3.5 Describe how information will be disseminated to participants and the group(s) consulted at the end of the project

F4. Are there any aspects of the research which might raise specific cultural issues that are not noted in

Questions F3.1-F3.5 (eg for Pacific or Asian populations?)

Yes

No

If **yes**, please explain

F4.1 What ethnic or cultural group(s) does your research involve?

F4.2 Describe what consultation has taken place with the group(s) prior to the project's development

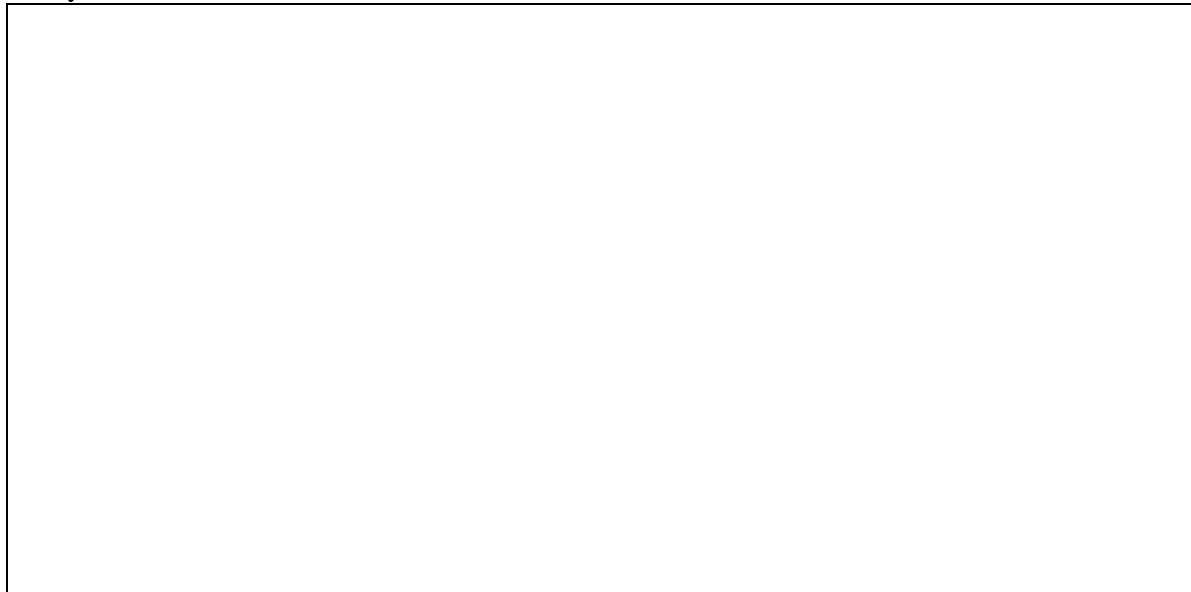
F4.3 Identify the group(s) with whom consultation has taken place and attach evidence of their support

F4.4 Describe any ongoing involvement the group(s) consulted have in the project

F4.5 Describe how you intend to disseminate information to participants and the group(s) consulted at the end of the project

Part 3 : General

Describe and discuss any ethical issues arising from this project, other than those already dealt with in your answers?



Thank you for your assistance in helping us assess your project fully

Please now complete:

the declarations (Part 4)

a Registered Drug Form (if applicable)

Form A or B relating to accident compensation

Attach :

Refer to page 3 of the Guidelines to ensure all relevant documents are attached

Part 4 : Declarations

Full Project Title :

Short Project Title :

1. Declaration by Principal Investigator

The information supplied in this application is, to the best of my knowledge and belief, accurate. I have considered the ethical issues involved in this research and believe that I have adequately addressed them in this application. I understand that if the protocol for this research changes in any way I must inform the Ethics Committee.

NAME OF PRINCIPAL INVESTIGATOR (PLEASE PRINT):

SIGNATURE OF PRINCIPAL INVESTIGATOR:

DATE:

2. Declaration by Head of Department in which the Principal Investigator is located or appropriate Dean or other Senior Manager

I have read the application and it is appropriate for this research to be conducted in this department I give my consent for the application to be forwarded to the Ethics Committee.

NAME AND DESIGNATION (PLEASE PRINT):

SIGNATURE:

INSTITUTION:

DATE:

DESIGNATION:

Where the head of department is also one of the investigators, the head of department declaration must be signed by the appropriate Dean, or other senior manager.

If the application is for a student project, the supervisor should sign here.

3. Locality Organisation Approval

Locality Organisation Approval is being sought / is attached from the following locations :

STATUTORY DECLARATION:

I _____ (name, of town/city) _____
solemnly and sincerely declare that as director of the proposed research, the proposed study is not conducted principally for the benefit of the manufacturer or distributor of the medicine or item in respect of which the trial is carried out.

And I make this solemn declaration conscientiously believing the same to be true and by virtue of the Oaths and Declarations Act 1957.

Name (please print) Signature this day of

before me

Name (please print) Signature

A Justice of the Peace, or
A Solicitor of the High Court
or other person authorised to take a statutory declaration.

Warning: Please note that it is an offence under part VI subsection 111 the Crimes Act 1961 to make a false statutory declaration.

Note: Applicants conducting a research study which is conducted principally for the benefit of the manufacturer or distributor of the medicine or item in respect of which the trial is carried out should complete Form B.

**FORM B
DECLARATION OF PROVISION OF COMPENSATION FOR INJURY FOR
PARTICIPANTS IN A
RESEARCH STUDY FOR A PHARMACEUTICAL COMPANY OR ANY
OTHER
COMPANY INVOLVED IN HEALTH RESEARCH**

Instructions: This form is to be completed and the statutory declaration signed by the applicant.

It should be forwarded to the appropriate Ethics Committee together with the documents seeking ethical approval for the proposed study and appropriate assurance from the pharmaceutical company or any other company involved in health research.

The information provided must be sufficiently detailed to enable the Ethics Committee to be satisfied

that:

the proposed research is conducted principally for the benefit of the manufacturer or distributor of

the medicine or item in respect of which the research is carried out;

participants in the proposed research project will receive an acceptable level of compensation from

a Pharmaceutical Company or any other company involved in health research in the event of injury

to participants resulting from their involvement in the proposed research study.

DETAILS OF PROPOSED RESEARCH STUDY

Title of research project:

Name of Research Director/Investigator:

Location of proposed study:

Number of participants:

Organisations providing support (\$ or "in kind") for the direct and indirect costs of the research.

Please provide names of organisations and the type of support provided.

Relationship of proposed research to the pharmaceutical industry or other company involved in health research. Please describe the involvement of industry in your proposed research, and provide details of support to be received from them.

Details of Compensation to be provided to participants in the event of injury.

Documents signed by the sponsoring Pharmaceutical Company or other company

involved in health research must be attached.

STATUTORY DECLARATION:

I _____ (name, of town/city) _____
solemnly and sincerely declare that as director of the proposed research, the proposed study is conducted principally for the benefit of the manufacturer or distributor of the medicine or item in respect of which the trial is carried out, and that in the event of injury arising from their participation in the research, an appropriate level of compensation, in line with the *New Zealand Researched Medicines Industry Guidelines on Clinical Trials - Compensation for injury resulting from Participation in Industry Sponsored Clinical Trials*, will be provided by _____ (name of Pharmaceutical Company or another company involved in the research project) as detailed in the attached documents.

And I make this solemn declaration conscientiously believing the same to be true and by virtue of the Oaths and Declarations Act 1957.

Name (please print) Signature this day of

before me

Name (please print) Signature
A Justice of the Peace, or
A Solicitor of the High Court
or other person authorised to take a statutory declaration.

Warning: Please note that it is an offence under part VI subsection 111 of the Crimes Act 1961 to make a false statutory declaration.

Note: Applicants conducting a research study which is not conducted principally for the benefit of the manufacturer or distributor of the medicine or item in respect of which the research is carried out should complete Form A

Registered Drug Form (*refer question B19*)

**INFORMATION REQUIRED FOR TRIALS INVOLVING
ADMINISTRATION OF DRUGS CURRENTLY REGISTERED IN NEW
ZEALAND.**

Trade name of drug:

Chemical name of drug

Pharmacological class:

Brief details of any special features:

(E.g., long half life, receptor selectivity)

Recommended dose range:

Form of administration in the study:

Known or possible interactions with non-trial drugs the participants may be taking:

Side effects and adverse reactions:

Appendix 8

Cartwright's recommendations

A SUMMARY OF FINDINGS AND RECOMMENDATIONS

TERM OF REFERENCE ONE

Whether, as alleged in the 'Metro' article, there was a failure adequately to treat cervical carcinoma in situ (CIS) at the National Women's Hospital, and if so, the reasons for that failure and the period for which that failure existed.

1.a **Adequate treatment** of carcinoma in situ is that which is based on generally accepted treatment together with evidence of eradication of the disease. The aim of treatment from the mid-1950s to the present has always been to achieve this, and where there has been a recurrence of the disease, to repeat the treatment. By this standard, there has been a failure adequately to treat a number of patients with cervical CIS at the National Women's Hospital. The outcome of treatment for the majority of women has been adequate, although a significant number were not managed by generally accepted standards over a period of years. For a minority of women, their management resulted in persisting disease, the development of invasive cancer and, in some cases, death.

Follow-up. Any woman who has received a diagnosis of CIS must be treated with the aim of eradicating the disease and must have her condition monitored for life, initially by the hospital or gynaecologist who is responsible for her management and then, when appropriate, by the general practitioner of her choice. These women must be advised of the nature of their condition and of their responsibility to ensure that they have regular smear tests and examinations.

Their general practitioners must be given the same information. Forms currently used for follow-up need redrafting so that the patient and/or her general practitioner receives and sends accurate information.

1.b The reasons for this failure to treat adequately were:

- (i) The implementation of the procedures advocated in the 1966 trial.
- (ii) Failure to recognise the dangers for patients when procedures were adopted which did not comply with generally accepted standards of treatment at that time.
- (iii) Failure to evaluate adequately the risks to patients if the hypothesis on which the 1966 trial was based (that carcinoma in situ is not a pre-malignant disease) was in correct.
- (iv) Failure to note the rising incidence of invasive cancer among the patients included in the trial; and failure to stop the trial and treat the patients as soon as cogent evidence of this risk began to emerge.
- (v) Failure on the part of some colleagues and the administration to impinge on clinical freedom and act decisively in the interests of patients' safety.
- (vi) Failure to take account of the patients' cultural, social and emotional needs, as well as their physical symptoms of disease, in planning a trial that would lead in some cases to many years of monitoring without definitive treatment.
- (vii) Failure to ensure that specialist staff worked as a diagnostic and clinical team.
- (viii) Mediocrity of standards and care in some clinical areas and, in particular, in the standard of information offered to patients.

1.c The period for which that failure existed began in the mid-1950s, rising to a peak in the late 1960s and early 1970s, and diminishing from that point. There are still cases to be found where there is inadequate treatment or management.

TERM OF REFERENCE TWO

Whether, as alleged in the 'Metro article, a research programme into the natural history of CIS of the genital tract was conducted at the National Women's Hospital and, if so:

a) Whether it was approved by any person or body before it was instituted or while it was underway; and

b) Whether patients examined or treated in the course of the programme were aware that they were participants in a research programme?

c) Whether any expressions of concern about the programme were considered and investigated at the time, and if so, by whom?

2.a There was one major research trial (known in this report as the 1966 trial) into the natural history of carcinoma in situ of the genital tract, and some supplementary trials, namely, vaginal swabs in neonatal (newborn) female infants and a study of the histology of fetal cervixes from aborted and stillborn infants.

The 1966 trial was discussed and informally approved by the Senior Medical Staff and then formally approved by the Hospital Medical Committee on 20 June 1966.

The supplementary trial v/which involved vaginal swabs of newborn babies was approved by a full staff meeting at National Women's Hospital on 21 October 1963. The other supplementary study on the histology of fetal cervixes was not formally approved.

2.b The great majority of patients did not know, except intuitively, that they were participants in the 1966 trial. The formal consent of the parents of the 2244 newborn babies who were swabbed was not sought. No formal consent from parents, or scientific or ethical assessment, was sought for the study of fetal cervixes.

2.c From 1966 to 1987 there were many and varied expressions of concern about the 1966 trial, both within New Zealand and overseas. The trial was reviewed by the Hospital Medical Committee in 1975, but not formally ended. Some health professionals expressed concern about the vaginal swabbing of newborn babies. That study was abandoned shortly after it began in 1963. However, the taking of vaginal swabs continued until 1966. The study of fetal cervixes began in 1964 and was abandoned around 1967. I have no evidence that any concern was expressed about this study.

TERM OF REFERENCE THREE

Whether there is a need to contact women who have been referred to or treated for CIS at the National Women's Hospital with a view to providing further advice or treatment or both to them?

3.a The names of 123 women who have been reported to the Minister of Health starting in September 1987 and concluding in June 1988. This list included some women with micro invasive disease. Suggestions to assist follow-up treatment or

advice have been made. They include recommendations concerning cultural, social, emotional and medical matters. I have reported that a special duty is owed to these women who must be offered optimal management.

TERM OF REFERENCE FOUR

Whether the procedures observed at the National Women's Hospital for the approval of research and/or treatment and for its surveillance are adequate, and, in particular, whether they ensure that the rights of patients are protected?

4.a Procedures observed at National Women's Hospital for the approval of research.

The Ethical Committee at National Women's Hospital has operated for over 10 years. Most research conducted at the Hospital during that period would have been assessed by it. Many projects funded by independent groups will also have received ethical approval from that Committee. In the main, those projects will have been scientifically assessed independently of the Ethical Committee. Projects not so funded, appear not to have received adequate scientific assessment in all cases, and the Ethical Committee lacks proper procedures for ensuring that this is undertaken. The Committee has a poor record for ensuring that informed consent to inclusion in a trial is properly sought, and lacks the appearance of impartiality. Although it has recently increased its lay representation, it is heavily weighted with medically trained personnel. The Committee appears to have a limited understanding of ethical principles and their application to research projects.

4.b Procedures observed for the approval of treatment.

New treatment procedures are not systematically reviewed by the Ethical Committee but will be considered if put to it. Treatment protocols in gynaecological malignancy have not been developed systematically by the Hospital Medical Committee.

4.c Procedures for surveillance of research or treatment.

- (i) Research: Few approved projects appear to be reviewed by the Ethical Committee. The publication of results is not encouraged or enforced.
- (ii) Treatment: Peer review is almost non-existent except at an informal level. The Tumour Panel discusses difficult or unusual cases, but there is little other systematic, ongoing review of treatment.

4.d The rights of patients.

The lack of the systematic seeking of consent to inclusion in research or treatment (except for operative procedures) and the inadequate procedures for approval and surveillance of research and treatment, pose a serious risk to patients' rights.

TERM OF REFERENCE FIVE

What steps, if any, need to be taken to improve the protection of patients in respect of whom research and/or treatment is conducted at the National Women's Hospital?

5.a Treatment

(i) Treatment protocols for gynaecological disease should be developed and maintained. These protocols will provide the basis for communicating information to various health professionals and for verbal communication with patients.

Visual and written material should be prepared using the protocol as the starting point. This material will help the patient understand the need for screening for disease, the nature of her condition and the procedures she will be offered in managing it.

(ii) Significant shifts in treatment or management of gynaecological malignancy should receive both ethical and scientific assessment and approval.

(iii) In-hospital audit procedures should be encouraged and external audit of clinical standards seriously considered. Quality assurance programmes involving the patient should be developed.

5.b Research

(1) Scientific assessment of in-hospital research projects and ethical assessment for all research projects must be developed to meet modern standards. National Women's Hospital has not succeeded in developing and maintaining scientific and ethical standards and in achieving impartiality. The Auckland Hospital Board (or Area Health Board), under the supervision of the Director-General of Health, should develop one or more ethical committees for assessment of all research projects in its institutions, The Ethical Committee at National Women's Hospital should be disbanded.

(ii) General information on therapeutic or non-therapeutic research should be offered to all patients whose permission is sought for inclusion in a trial. Their written consent must be sought on all occasions when interventionist clinical or no therapeutic research is planned, The consent of the guardian or guardians of any child to be included in similar trials must be obtained.

Information should be available in the first language of the person whose permission is sought, and adequate time provided to allow consideration or consultation with whānau or family. The patient advocate must be advised of all patients whose consent is being sought for inclusion in a trial.

5.c The system for protecting patients involved in research and/or treatment at National Women's Hospital has failed in significant areas. A system focused on the protection of patients and independent of the Hospital should be set in place.

(i) The patient or her near relatives should have access to:

(a) an advocate in the Hospital whose only duty is to protect her and to ensure that she receives full information and the opportunity to consent to all procedures in which she will be involved;

(b) the Medical Superintendent, as at present;

(c) a Committee of the elected representatives of the Auckland Hospital Board (or Area Health Board) and to the Board administration when she is concerned about a lack of information or has other concerns or grievances;

(d) the disciplinary body established pursuant to the Medical Practitioners Act 1968;
(e) a Health Commissioner appointed under the Human Rights Commission Act 1977.

(ii) A patient advocate responsible to the Director-General of Health should be employed at National Women's Hospital

(a) to ensure that patients who are included in research or teaching, or undergoing treatment, are protected;

(b) to help develop material for the information or, where appropriate, for the education of patients; and

(c) to provide the patient with a means of obtaining more information.

The patient advocate need not be employed full-time at National Women's Hospital. She should be an independent and powerful advocate for the patient. Her reports to the Director-General of Health should also be given to the Health Commissioner and to the Auckland Hospital Board. She should have the power to refer complaints to the disciplinary body established pursuant to the Medical Practitioners Act 1968, to a Health Commissioner, or to the Hospital Board on behalf of a particular patient or class of patients. Before research involving patients is undertaken she must be informed of those who are to be included and afforded the opportunity to comment. Where possible, she should be a member of the ethical committee which assesses projects involving patients of National Women's Hospital.

(iii) **The Board.** Elected representatives to the Auckland Hospital Board (or Area Health Board) should take greater responsibility for the patients' welfare. They should ensure that the duty to safeguard the patients' health is the administration's paramount consideration at all times. The administrative and elected representatives of the Board should receive reports from time to time from the patient advocate and from the ethical committee assessing research at National Women's Hospital. Where appropriate, a sub-committee of elected representatives should have the power to seek further information from the ethical committee.

(iv) **The Human Rights Commission Act 1977** should be amended to provide for a statement of patients' rights and to provide for the appointment of a Health Commissioner. The Commissioner's role would include

- (a) negotiation and mediation of complaints and grievances by patients;
- (b) heightening the professionals' understanding of patients' rights;
- (c) the entitlement to seek a ruling or sanctions from the Equal Opportunities Tribunal on behalf of a patient or class of patients.

The Commissioner should have the power to accept complaints from, or refer complaints to the patient advocate or the Board. The Commissioner should have access to the disciplinary procedures pursuant to the Medical Practitioners Act 1968. Adequate resources to service the increased work of the Human Rights Commission should be provided.

(v) **The Director-General of Health** should

- (a) continue to give urgent consideration to the improvement of ethical standards in National Women's Hospital;
- (b) monitor progress and encourage improvements in ethical committees by heightening the awareness of the importance of strong ethical principles in research and new treatment or management;
- (c) ensure that the patient advocate role is reviewed and developed and that her independence from the administrative structures of the hospital is maintained at all times;
- (d) ensure that lay representation on the ethical committee approximates one half of the membership; and
- (e) encourage the development of better procedures for scientific and ethical assessment.

(vi) **The University of Auckland** should

- (a) improve the teaching of ethical principles and communication skills at all levels of the medical degree;

(b) take some responsibility for encouraging community debate on medical ethical topics;

- (c) ensure that academic staff members are encouraged to take part in ethical or scientific assessment committees;
- (d) ensure that properly planned research is conducted at National Women's Hospital;
- (e) acknowledge that the paramount consideration in teaching or research which involves patients is the welfare of those patients.

TERM OF REFERENCE SIX

Whether patients at the National Women's Hospital are properly informed of the treatment and options available to them and, if not, the steps that need to be taken to see that they are?

6.a Patients have not always been properly informed of the treatment and options available to them.

6.b Steps that need to be taken:

(i) There must be greatly improved communication with all patients and improved information available in the first language of those attending the Hospital for inpatient or out-patient treatment or management. Interpreters must be provided wherever possible. Development of visual formats to present information will greatly enhance communication with patients.

(ii) Prior written consent must be sought from patients

(a) for all procedures conducted under anaesthetic, be they for the benefit of that patient and/or for teaching purposes. No more than two students (present with the patient's consent) may participate in a vaginal examination on an individual patient;

(b) for significant departures from generally accepted treatment of gynaecological malignancy.

A written record should be maintained of a patient's refusal to undergo a recommended procedure, or of her choice from among options for treatment (based on generally accepted management procedures) and particularly where there are significant risks or benefits to her. Except in cases of serious emergency, the patient's autonomy and the right to participate in decisions concerning her treatment or management must be honoured.

(iii) Except in an emergency, verbal consent for procedures or a management programme should be sought from conscious patients after adequate information has been provided.

(iv) A statement of the patient's rights, including the right to have her consent sought to any vaginal examination or other invasive procedure under anaesthetic, should be enacted in an amendment to the Human Rights Commission Act 1977.

(v) Full information on patients' rights and responsibilities should be freely available to all patients of National Women's Hospital.

(vi) Sanctions including disciplinary measures should be set in place for failure on the part of a health professional to comply with these obligations to patients.

TERM OF REFERENCE SEVEN

7.a What training has been and is being given at the National Women's Hospital to medical students and medical practitioners in relation to the proper detection and treatment of cervical cancer and pre-cancerous conditions of the genital tract?

Teaching on gynaecological malignancy has largely been orthodox except where it concerns:

- (i) The invasive potential of CIS.
- (ii) The value of cytology and the need for a population-based cervical screening programme.

7. b Should steps be taken to improve this training, or to inform previous trainees about the proper detection and treatment of cervical cancer and precancerous conditions of the genital tract?

Teaching on these topics needs improvement, particularly:

- (i) The significance of carcinoma in situ, its invasive potential, its incidence and its treatment.
- (ii) The significance of micro invasive disease and its treatment.
- (iii) Teaching students the importance of informing women patients about smear tests as a preventive health measure. Teaching should include the international evidence on the value of organised screening for 'at risk' women.
- (iv) Practical teaching involving patients requires far higher standards, and should comply with standards which will protect the woman's dignity and treat her with humanity. Formal teaching throughout the undergraduate and postgraduate courses should include ethical concepts and improved communication skills.

There should be dissemination of:

- (i) Information given to this Inquiry, including the views of patients on questions of consent, inclusion in teaching procedures or trials, their right to be involved in treatment or management decisions, and their right to be treated with dignity and humanity.
- (ii) Information, to general practitioners in particular, on generally accepted view of the significance of carcinoma in situ as a cancer precursor and the importance of offering smear tests to all at risk women and in particular Māori women. The Royal NZ College of Obstetricians and Gynaecologists has a responsibility in this area, as has the Royal NZ College of General Practitioners.
- (iii) The international and accurate New Zealand views of the value of population-based screening for cervical cancer and cancer precursors, so all medical practitioners have adequate information and will co-operate in a population-based programme.
- (iv) This report, and the material accumulated from expert medical, ethical, diagnostic and cultural authorities, should be accessible to all health professionals in training.

TERM OF REFERENCE EIGHT

The nature of the relationships between the academic and clinical units at the National Women's Hospital.

8.a Relationships have been poor in the past and from time to time have contributed to the failure to put patients' health and welfare first. The structure for formal communication exists, but has not always been effective. More effective monitoring should be developed by the University of Auckland and by the Auckland Hospital Board (or Area Health Board) to ensure that the primacy of the principle of patients' welfare is observed.

TERM OF REFERENCE NINE

Any other matter which in your opinion is relevant to the detection and treatment at the National Women's Hospital of cervical cancer and precancerous conditions of the genital tract, or to the foregoing terms of reference or to both.

9.a A nationally planned population-based screening programme should be implemented urgently. There should be full consultation with consumer groups, including women's health groups, the Ministry of Women's Affairs, the Health Department and all relevant health professionals to ensure that:

- (i) Administrative problems are kept to a minimum.
- (ii) Optimum numbers of women who are or have been sexually active are reached by the programme.
- (iii) Cultural, privacy and financial considerations are taken into account, so that screening is acceptable and available to all women. Given the difficulties in establishing an efficient programme and the likely marked increase in numbers of women suffering from disease of the genital tract, this is an urgent priority.

9.b A specialist oncology unit with gynaecological oncology, radiotherapy and appropriate support staff and equipment should be developed at National Women's Hospital for the treatment of invasive cancer of the genital tract. Alternatively, all radiation therapy, both external and intra-cavitary, should be conducted at Auckland Hospital where specialist services exist. A gynaecologist should be available to assist in that treatment. There is inadequate liaison over patients' care between the two hospitals and lack of some essential specialist services at National Women's Hospital. Additional resources must be provided to the relevant hospital to develop or extend its oncology unit.

9.c The histological and other material held at National Women's Hospital, particularly that which resulted from the 1966 trial and its supplementary trials, should be available for properly planned and approved research and teaching.

9.d Special duties are owed to:

- (i) All those women (123) whose names have been reported to the Minister of Health pursuant to Term of Reference 3.

- (ii) Māori women who have a three times greater risk of contracting invasive cancer than other women in New Zealand.
- (iii) All women in New Zealand who are or have been sexually active. Each year 200 women are diagnosed as having invasive cancer of the cervix and about 100 die of the disease. One in 80 women can expect to develop invasive disease before the age of 70. If present trends continue the incidence of this disease will rise and one in 28 women born around 1957 may contract the disease before the age of 70.

9.e These duties can be discharged by:

- (i) Providing optimal medical and support facilities for those 123 women who may need further treatment and advice. The facilities must be independent of National Women's Hospital, if that is what these women wish. Colposcopic examination should be provided where necessary as should culturally and emotionally appropriate contact and support services.
- (ii) Developing a programme in consultation with Māori women, which is sensitive to their needs, which will inform them of the nature of the disease and ensure that adequate screening, treatment and advice is readily accessible.
- (iii) Disseminating clear and accurate information to the public through the media, general practitioners, Family Planning Clinics, the Ministry of Women's Affairs and by any other appropriate means about
- the nature of CIS and the nature and symptoms of invasive cancer
 - the need for regular smear tests
 - the need to co-operate in a nationwide screening programme.
- (iv) Establishing a population-based screening programme.
- (v) As a parallel measure, attention must be paid to ensuring that cytology, pathology and colposcopy facilities are able to meet an increased workload and that
- a) Cytology
- a common nomenclature is developed *for* use by all New Zealand laboratories;
 - training for cytotechnologists is developed;
 - quality assurance programmes are developed;
 - continuing education is encouraged.
- b) Pathology
- more pathologists with expertise in both cytology and histopathology will be needed;
 - more training positions *for* pathologists should be established to meet this demand and replace those retiring.
- c) Colposcopy
- facilities *for* expert colposcopic examinations be expanded as a matter *of* urgency throughout New Zealand.

(vi) Appropriate training *for* those health professionals who treat disease *of* the genital tract to help them deal with seriously *or* terminally ill patients.