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'Not very Responsive for Kaumātua': A Wānanga-Based Qualitative Study (Single-Group Design) of Māori Kaumātua and Māori Health Provider Experiences of Type 2 Diabetes Care

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Abstract

Background Māori experience a disproportionate burden of Type 2 diabetes mellitus (T2DM), with ongoing inequities in access, continuity, and outcomes of care. While culturally responsive approaches are recognised as important, limited qualitative research centers kaumātua (Māori elders aged 50 years and over) voices in evaluating current diabetes care and informing service redesign.

Aim To explore kaumātua and Māori health providers' perspectives on the cultural responsiveness, strengths, and limitations of current T2DM management in New Zealand, and to examine perceived opportunities for community-embedded and mobile models of care.

Methods A qualitative study informed by Kaupapa Māori principles was conducted using a wānanga-based (collective forum for discussion and knowledge-sharing) approach. Kaumātua living with T2DM were purposively recruited through a Māori community organisation. Collective kōrero (conversation/discussion) were audio-recorded and analysed using reflexive thematic analysis, interpreted through a Kaupapa Māori analytic lens. Reporting followed the Consolidated Criteria for Strengthening Reporting of Health Research Involving Indigenous Peoples (CONSIDER).

Results Seven kaumātua and Māori health providers participated. Current diabetes care was described as fragmented and insufficiently responsive to cultural and contextual needs. Effective care was grounded in whanaungatanga (relationships and connectedness), manaakitanga (care, respect, and dignity), whānau engagement, culturally safe spaces, and accessibility. Structural barriers, including transport challenges, financial pressures, and fragmented information systems, constrained continuity of care. Participants strongly endorsed a mobile, community-embedded diabetes service as a culturally appropriate approach to improving access, continuity, and equity.

Conclusion Kaumātua perspectives highlight the need for relational, culturally grounded, and accessible diabetes care. Mobile, community-embedded models offer a promising pathway to address structural barriers while upholding mana, dignity, and whānau-centred care.

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Background

Type 2 diabetes mellitus (T2DM) remains a major contributor to morbidity and premature mortality globally and continues to present significant challenges for health systems. In Aotearoa New Zealand, Māori experience a disproportionate burden of T2DM, including higher prevalence, earlier onset, increased complication rates, and poorer health outcomes compared with non-Māori populations [1–4]. These inequities are well recognised and reflect not only individual-level risk factors, but also broader structural, historical, and cultural determinants of health that shape access to care, engagement with services, and long-term disease management [5].

Contemporary approaches to T2DM management in New Zealand have largely developed within Western biomedical paradigms, emphasising individual responsibility, pharmacological control, and clinic-based primary care. While these approaches are clinically important, they often prioritise measurable biomedical indicators over relational, cultural, and contextual dimensions of care [6]. For Māori, whose understandings of health are grounded in holistic concepts of hauora (holistic wellbeing) and collective wellbeing, such models may inadequately reflect lived realities, whānau structures, and cultural values. As a result, diabetes care can be experienced as fragmented, culturally misaligned, or insufficiently responsive to the needs of Māori, particularly older adults [4, 7].

A growing body of international and Indigenous health literature suggests that culturally grounded, community-based approaches characterised by Indigenous leadership, relationship-centred care, and co-design with communities have the potential to improve engagement and outcomes in diabetes management [8, 9]. Findings from a recent scoping review [10] demonstrate that although culturally tailored and community-based diabetes interventions for Indigenous populations show promise, the existing literature is dominated by outcome-focused evaluations, with limited qualitative exploration of how cultural responsiveness, accessibility, and models of service delivery are experienced by Indigenous elders within routine care contexts. Consequently, there is limited understanding of how existing health systems are perceived by kaumātua (Māori elders aged 50 years and over), and which aspects of care are seen as effective, inadequate, or misaligned with their needs and values [3].

Access to diabetes care presents additional challenges for kaumātua, particularly those living in rural or socioeconomically deprived settings. Reliance on clinic-based services may inadvertently disadvantage older adults who face mobility limitations, transport barriers, financial constraints, or competing whānau responsibilities. These barriers operate alongside historical and ongoing experiences of marginalisation within the health system, which can influence trust, help-seeking behaviour, and sustained engagement with care [1]. Addressing inequities in diabetes outcomes therefore requires not only clinical effectiveness, but also service models that proactively reduce access barriers and align with Māori ways of knowing, being, and doing.

Māori health organisations have increasingly advocated for approaches grounded in Kaupapa Māori principles, emphasising tino rangatiratanga (self-determination/chieftainship), whakawhanaungatanga, mana motuhake (autonomy/self-determination) and meaningful partnership with communities. Such approaches position kaumātua as knowledge holders and active contributors to health solutions, rather than passive recipients of care. From this perspective, understanding kaumātua experiences and priorities is a necessary foundation for designing or adapting diabetes care models, including community-led or mobile service delivery approaches intended to improve reach, continuity, and cultural safety [8, 9].

Despite policy-level recognition of equity and cultural responsiveness as priorities, there remains a paucity of qualitative research that centers kaumātua voices in examining current T2DM management. Little is known about how cultural responsiveness is enacted in everyday practice, what aspects of current care are perceived as working well, where gaps persist, and how alternative service delivery models may better support kaumātua living with diabetes. Accordingly, this qualitative study seeks to explore kaumātua perspectives on the current management of T2DM, with a focus on cultural responsiveness, enablers and barriers to effective care, and perceptions of community-based and mobile approaches to service delivery. By privileging kaumātua narratives and situating the research within Kaupapa Māori and Indigenous research principles, this study aims to generate contextually grounded insights to inform culturally safe, equitable, and sustainable models of diabetes care in Aotearoa New Zealand.

Methods

Study Design

This study adopted a qualitative design informed by Kaupapa Māori research principles [11] and was reported in accordance with the Consolidated Criteria for Strengthening Reporting of Health Research Involving Indigenous Peoples (CONSIDER) guideline [12]. A wānanga-based (collective forum for discussion and knowledge-sharing) approach was selected to enable collective dialogue, shared reflection, and culturally safe exploration of experiences related

to the management of T2DM among kaumātua [13, 14]. This approach aligns with Indigenous methodologies that emphasise co-construction, collective meaning-making, and respect for Indigenous worldviews [7]. A glossary of Māori terms used in this study is provided in Appendix 1.

Setting and Indigenous Partnership

The research was undertaken in partnership with (name redacted) Kaumātua Charitable Trust, a Māori-led community organisation based in the Waikato region that provides health and social services for kaumātua. The study was embedded within an established relationship between academic researchers, the community organisation and Māori health providers, reflecting the principles of tino rangatiratanga and accountability [7].

Participants and Recruitment

Participants were purposively recruited [15] through the Māori community organisation based on their identification as kaumātua living with T2DM and Māori health workers who work closely with and support kaumātua in the management of T2DM. Eligibility criteria included self-identification as Māori; recognition as a kaumātua within the community, lived experience of managing T2DM; and employment within the community organisation or related Māori health services with direct experience supporting kaumātua with T2DM care. Recruitment was facilitated through existing community relationships to ensure culturally safe engagement, with participation voluntary and consistent with Kaupapa Māori principles [14].

Ethical and Cultural Considerations

Ethical approval for the study was obtained from the Institutional Research Ethics Committee (WTLR). All participants received a written participant information sheet and provided written informed consent prior to participation. The study was guided by Te Ara Tika ethical principles, including whakapapa (relationships), manaakitanga, and mana (justice and equity) [14]. Cultural safety was actively upheld using mihimihi and karakia at the opening and closing of the wānanga, and by recognising participants as knowledge holders rather than research subjects [7, 13].

Data Collection

Data were collected through a facilitated wānanga led by a Māori researcher (MH) experienced in Indigenous health research. The wānanga followed a semi-structured format, guided by open-ended prompts exploring participants' perspectives on current T2DM management for kaumātua, the cultural responsiveness of existing services, barriers and enablers to effective care, and views on community-based and mobile models of service delivery. The decision to conduct a combined wānanga reflected kaupapa Māori principles privileging collective dialogue and shared sense-making [12, 13]. While this may introduce social desirability dynamics, facilitation emphasised respectful turn-taking and acknowledgement of differing positionalities. The collective format was considered culturally congruent and enabled relational insights unlikely to emerge in individual interviews [12]. The wānanga was held in a marae-based community venue, consistent with the kaupapa and the preference for a culturally grounded setting. The session lasted approximately 90 min and was facilitated by one researcher (MH). Field notes were taken during and after the wānanga to document contextual detail, group dynamics, and reflexive observations. There were no repeat engagement sessions. While formal member checking was not undertaken, participants were engaged in collective validation during the wānanga dialogue itself.

Data Analysis

Audio recordings were transcribed verbatim and analysed using reflexive thematic analysis, following the six-phase approach described by Braun and Clarke [16]. Analysis was primarily inductive and interpreted through a Kaupapa Māori analytic lens, attending to both explicit content and underlying cultural meanings [7]. Codes were iteratively developed and organised into candidate themes that reflected patterns related to cultural responsiveness, relational care, access, and service design. Coding was conducted inductively. Initial codes were developed through line-by-line reading of transcripts and refined iteratively. Themes were reviewed collaboratively within the research team to ensure conceptual coherence and alignment with Kaupapa Māori principles. Analytic discussions within the research team focused on ensuring cultural coherence.

Sample Adequacy

Sample adequacy was considered using the concept of information power. The study addressed a focused research aim, involved participants with direct experiential and professional relevance to the topic, generated rich collective dialogue in a culturally congruent setting, and was analysed using a theoretically informed interpretive approach. These factors supported the adequacy of the dataset for generating meaningful qualitative insights, while acknowledging limits to transferability beyond the study context.

Rigor, Reflexivity, and Trustworthiness

Methodological rigor was supported through transparent documentation of analytic decisions, reflexive engagement with researcher positionality, and engagement with the partner organisation. The primary analysis was undertaken by MH, a Māori researcher with established relationships in the community. Reflexive journaling was maintained throughout analysis to document interpretive decisions. Further, reflexivity was embedded throughout the research process, recognising the responsibilities and power dynamics inherent in Indigenous health research [6]. Co-authors reviewed themes for coherence and explanatory power. The research team included both Māori and non-Māori researchers, enabling critical dialogue and reflexive examination of assumptions. Trustworthiness was supported through credibility, field notes and documentation of analytic decisions to support dependability, and reflexive engagement throughout data collection and analysis to strengthen confirmability. Trustworthiness was further enhanced through alignment with Indigenous research principles and consistency between participant narratives and analytic interpretations.

Table 1 Participant characteristics

Participant characteristic	Numbers
Total participants	7
Female	4
Male	3
Kaumātua (50+)	4
Kaimahi / staff	3
Dual role (kaimahi and kaumātua with T2DM)	1

Note: Categories were not mutually exclusive

Reciprocity and Dissemination

Consistent with CONSIDER principles and the concept of utu (reciprocity), findings were shared with the partner organisation and participants prior to wider dissemination [12]. Knowledge translation activities are intended to inform future service development and culturally responsive models of T2DM care for kaumātua.

Results

A total of seven participants took part in the wānanga. Participants included kaumātua and kaimahi with experience of type 2 diabetes care, noting that these categories were not mutually exclusive. Overall, four participants were female and three were male. Four participants were kaumātua (aged 50 years and over) and three were kaimahi, with one female participant identifying as both a kaimahi and a kaumātua living with type 2 diabetes. Exact ages were not recorded (Table 1).

Thematic analysis identified four interrelated themes (Fig. 1) capturing perspectives on the cultural sensitivity,

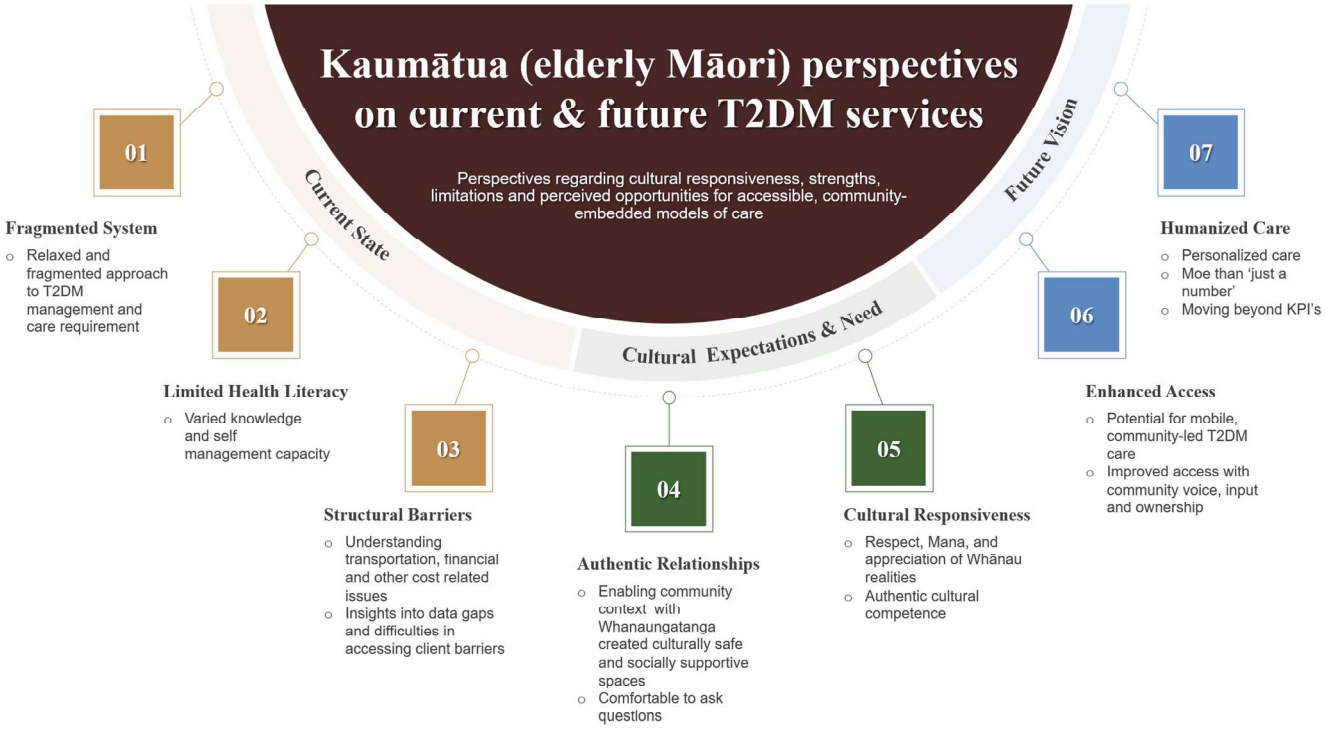

Fig. 1 Themes and subthemes showing perspective of kaumātua about T2DM care in New Zealand

effectiveness, and potential improvement of current T2DM management in Aotearoa New Zealand. Representative quotes are italicised and attributed to participant identifiers.

Theme 1: Fragmented and Structurally Constrained Barriers

Participants consistently portrayed current diabetes care for kaumātua as relaxed, inconsistent, and largely reactive. Routine monitoring and follow-up were frequently described as insufficient, with annual reviews often delayed or missed. Short GP consultations limited opportunities for education or relationship building. As one participant explained, "There is a very relaxed approach for kaumātua in terms of their management from GP practice… I wonder how long it has been since they last spoke to someone about their treatment" (IV1). Such fragmentation left kaumātua vulnerable to medication errors and preventable complications.

Systemic barriers constrained equitable care. Transportation difficulties, financial pressures, and the high cost of monitoring equipment limited participation in ongoing management. Furthermore, disconnected information systems prevented providers from sharing records or coordinating follow-up. "Access to information and client data… there's nothing more frustrating than being asked the same question over and over again" (IV3). Participants advocated for interoperable electronic systems and regular multidisciplinary hui (meeting/gathering) to promote continuity of care.

Theme 2: Limited Health Literacy

Kaumātua exhibited wide variation in understanding and self-management of diabetes. Some were highly motivated and engaged in community education programs, whereas others lacked awareness of basic dietary or medication principles. "They're all at different levels… some are still learning… some might not worry about it at all" (IV5). Participants emphasised the need for repetitive, hands-on, and individualised education that accommodates aging-related memory changes and differing health literacy levels.

Theme 3: Humanising Care Through Relational and Cultural Practice

Relationship-centred care was identified as a key facilitator of engagement. Community settings that foster whanaungatanga (relationships, connectedness, and a sense of belonging) created culturally safe and socially supportive spaces where kaumātua felt comfortable discussing their health. "Our organisation provides a point where they feel comfortable to ask questions" (IV4). Humour, shared kai, and peer interaction were seen as powerful motivators. As another participant noted, "You can create the best program, but if they're bored, it's a waste of time" (IV6).

Mainstream services were generally perceived as insufficiently culturally responsive. Participants noted limited acknowledgement of tikanga (customs, values, and correct cultural practice), mana, and the realities of multigenerational households where food decisions are collective. "If I put kaumātua as a culture, then my answer is that it's not very responsive for kaumātua" (IV1). Authentic cultural competence required recognising whānau structures, integrating Māori values, and ensuring care interactions-maintained dignity and respect. "Treat them with respect and respect their mana" (IV3).

Participants cautioned that mobile initiatives must avoid replicating the impersonal, target-driven approach of mainstream health systems. "I wouldn't like them to be treated as a number, or them being treated like KPIs" (IV5). Dignity, patience, and empathy were regarded as essential behavioural competencies for all staff. "Behaviours need to be right… not as a deaf, old person" (IV6). Upholding manaakitanga was viewed as central to quality and culturally safe diabetes care.

Theme 4: Enhanced Access

All participants endorsed a mobile, multidisciplinary diabetes service as an effective and culturally resonant solution. Such a model anchored in community spaces or delivered door-to-door could overcome transport barriers and provide on-the-spot education, annual reviews, and group sessions. "A purpose-built vehicle that has all the equipment and technology required… to pull up anywhere for checks, promotions, clinics and what not" (IV1). Integration with existing GP systems and appropriate resourcing were seen as prerequisites for sustainability.

Discussion

Summary of Findings

Collectively, the findings reveal that current T2DM management for kaumātua is often fragmented and inadequately tailored to cultural needs. Effective care is grounded in relationships, cultural respect, whānau engagement, and accessibility. Participants envisioned a mobile, community-embedded model as a practical and culturally appropriate means to enhance continuity, empowerment, and equity for kaumātua living with T2DM.

While previous Māori-led implementation research (e.g., He Pikinga Waiora) has emphasised community co-design

and culturally grounded interventions, this study contributes by foregrounding kaumātua-specific relational dynamics within existing T2DM service delivery. Unlike prior implementation-focused studies, our findings highlight how fragmentation within mainstream primary care is experienced at the interpersonal level by kaumātua, and how dignity, mana, and time for kōrero (conversation/discussion) function as practical determinants of engagement. The study also identifies operational features necessary for mobile, community-embedded diabetes services (e.g., integration with GP information systems, defined staffing mix, and relational continuity), extending beyond general endorsements of outreach models.

Racism, both interpersonal and institutional, contributes to Māori health losses and leads to inequalities in health between Māori and Europeans in New Zealand. Interventions and policies to improve Māori health and address these inequalities should consider the health effects of racism. Fragmentation of diabetes care must be understood within broader structural inequities and experiences of marginalisation that continue to shape Māori engagement with health services [1]. National data consistently show poorer continuity and access to effective diabetes care for Māori compared with non-Māori, reinforcing participant accounts of fragmented management [2]. Fragmentation in diabetes care reflects not only service gaps but a misalignment between mainstream chronic care models and Indigenous ways of organising health and wellbeing [9]. Evidence-based interventions with established efficacy may not be effective in indigenous communities without addressing specific implementation challenges [17].

Kaumātua in our study emphasized the importance of whanaungatanga (relationships, trust), manaakitanga and culturally safe spaces as essentials for their T2DM care. In this context, Indigenous health care services are best placed to meet the expectations of kaumātua as they can not only provide a culturally safe space but also culturally appropriate models of care [18]. In contrast, mainstream services are generally set up to cater for dominant cultures and may not have the resources required to respond to the needs of others [19]. This is in line with previous research that identified relational continuity, respect, culturally safe environments, and effective communication as key mechanisms underpinning engagement and quality of care [20]. Further, the expectation of more time for kōrero and relationship building are also in agreement with previous findings. These are not ancillary to Māori health care but foundational to trust, understanding, and engagement [21].

Kaumātua in our study emphasised the role of whanaungatanga and meeting whānau expectations as central for effective T2DM care. Recognition of whānau realities, including collective decision-making and everyday practices around kai, further shaped how care was understood and enacted. This integrated relational–cultural foundation aligns strongly with Kaupapa Māori and Indigenous health literature, which consistently identifies whanaungatanga, mana, and whānau-centred approaches as inseparable enablers of effective care [9, 20]. Kaumātua further highlighted structural barriers within mainstream services that were generally perceived as less culturally responsive. This is consistent with a study that showed that culture-centredness and community engagement provide better T2DM outcomes [9].

Kaumātua highlighted several barriers for accessing appropriate T2DM care including transport limitations, financial burden, and poor data integration. These barriers constrain continuity of care and place disproportionate responsibility on kaumātua to navigate complex systems, reinforcing inequities in T2DM management. These findings are in agreement with evidence and are markers of system-level failure rather than individual non-engagement [1, 2]. Given the access barriers, kaumātua strongly endorsed mobile, community-led models of diabetes care as a pragmatic solution to enable access and continuity challenges. Mobile services were viewed as mechanisms for embedding care within trusted community contexts, enabling timely reviews, education, and follow-up while reducing transport and cost burdens. Similar Indigenous-led models internationally demonstrate that community-embedded outreach services can improve engagement and continuity when they are adequately resourced and integrated with existing primary care systems [10, 20]. However, participants emphasised that access to shared records and coordinated multidisciplinary input are essential to prevent mobile services from becoming fragmented extensions of existing systems.

A crucial takeaway is that kaumātua cautioned that mobile service delivery alone is insufficient if it reproduces the impersonal, target-driven approach of mainstream medicine. Consistent with Indigenous health scholarship, they emphasised that quality care must remain humanised, relational, and grounded in manaakitanga, rather than dominated by throughput metrics or performance indicators [22]. Together, these findings suggest that equitable diabetes care for kaumātua requires not only structural redesign and service mobility, but also a deliberate shift away from transactional models of care toward approaches that privilege dignity, patience, empathy, and sustained relationships.

Participants' endorsement of a mobile, community-embedded diabetes service suggests the need for a clearly defined operational model. Such a service could be led by a Diabetes Nurse Specialist supported by a kaiāwhina (community support worker/helper), enabling both clinical oversight and culturally grounded engagement. The

model may operate on a regular itinerary (e.g., scheduled visits to marae, community hubs, and home-based outreach) to ensure continuity and accessibility [8, 9, 20, 23, 24]. A purpose-built mobile unit equipped for point-of-care testing (e.g., HbA1c, blood glucose monitoring, blood pressure assessment) and education would support comprehensive service delivery [25, 26]. Integration with existing general practice electronic health record systems is essential to ensure continuity of care, avoid duplication, and enable shared clinical decision-making. Privacy and informed consent procedures must be adapted to mobile settings, including secure data entry, confidential consultation spaces, and clear communication of data use [26]. The model should also include defined escalation pathways, enabling timely referral to general practitioners or specialist services where required. Collectively, these elements provide a practical framework for translating a mobile, culturally responsive model into routine diabetes care for Māori kaumātua [24].

Strengths and Limitations

The use of a Kaupapa Māori–informed, wānanga-based approach enabled culturally safe, relational, and collective exploration of kaumātua experiences of T2DM management. Another key strength was that Indigenous leadership was available throughout the research process that supported a culturally grounded interpretation and alignment with community priorities. This in turn not only enhanced the credibility of the findings but also its and relevance to clinical practice and community settings. The study also provides rich, practice-oriented insights into service design and implementation challenges that are directly informed by lived experience.

Several limitations should be considered. Participants were recruited from a single community organisation, and findings reflect the perspectives of kaumātua engaged within that context. While this limits statistical generalisability, the aim of the study was to generate in-depth, contextually grounded insights rather than representative prevalence estimates. Gender-specific distinctions (e.g., kuia and koroua) were not recorded to preserve anonymity, and therefore gendered experiences could not be explored. This is an area of future research. Nevertheless, the findings offer transferable principles relevant to Indigenous and marginalised populations in comparable settings.

Conclusion

The findings from our study demonstrated that current T2DM management for kaumātua is often fragmented and inadequately tailored to cultural needs. Our study showed that effective care of T2DM for kaumātua must be grounded in relationships, cultural respect, whānau engagement, and accessibility. Participants further endorsed a mobile, community-embedded model, which is culturally appropriate and supports equity for kaumātua living with diabetes. Future research should examine the feasibility, sustainability, and implementation of mobile diabetes services, including exploration of potential gender-based differences in experiences and perceptions of diabetes care.

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Declarations

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