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MAURI OHO, MAURI TU, MAURI ORA

ENHANCING MAORI HEALTH AND WELLBEING THROUGH A CRITICAL ENGAGEMENT WITH SOCIAL MARKETING

BY

RIRI TE WHARA ELLIS

A thesis submitted in partial fulfillment of the requirements of the degree of Doctor of Philosophy

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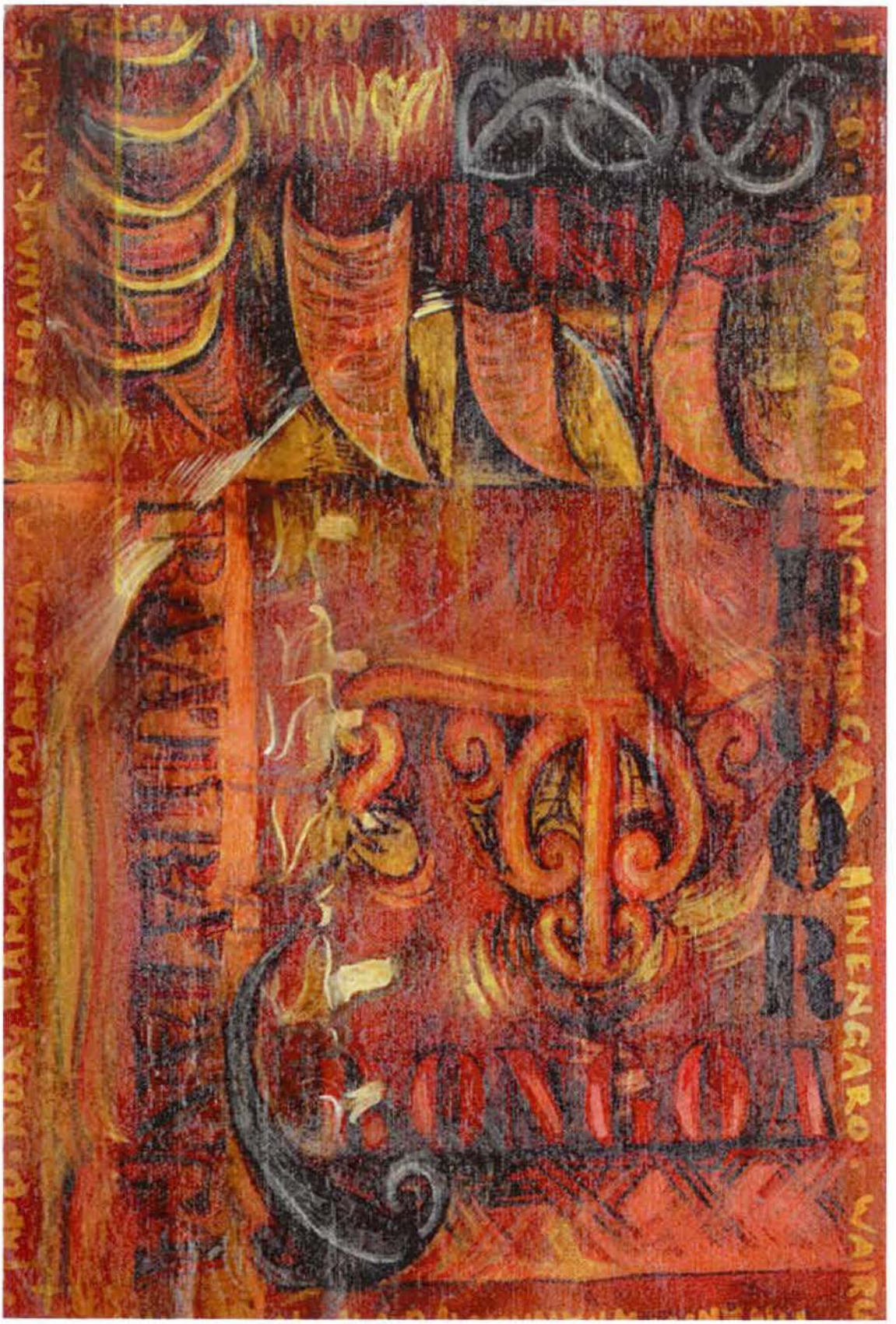

Naaku te tupuna i whakarau oratia

Te putanga mai ki runga ki a Mauao

Me takere te waka ki te awa ki Waipu

Ki te kawhakinga o te uru toa

Haere tonu ki Whareroa kia kite

I te paenga kakara

E tau ki nga pari tahataha

Ki Otamataha i rongo ai

I te riri a Koraurau

Mutu rawa i te pukenga

Ka kite i reira nga toka

Whakataratara o Tukairangi

I totohu ai toku waka

I raru ai au e

HE MIHIMIHI

Ko Mauao te maunga

Ko Tauranga te moana

Ko Ngaiterangi te iwi

Ko Mataatua te waka

Mauao is my mountain

Tauranga is my sea

Ngaiterangi is my tribe

Mataatua is my canoe

It is through the collective efforts of many that I have been able to complete this PhD thesis. The support I have been given during this work is as majestic as Mauao. I see in the gestures of others, the likeness of the magnanimity of our mountain. I have only aroha to give in return. I am indebted to you all.

HEI TOHU AROHA

Kei roto i te korowai aroha tenei mahi
mo toku whaea a Rahera Rangi
me toku koroua rangatira a Wiparera Te Kani hoki
Moe mai ra korua

I dedicate this thesis to
my mother Rahera Rangi
and my koroua
Wiparera Te Kani

PROLOGUE – HOKI KI NGA WHAKAARO NUI: LOCATING THE RESEARCHER

"Hokia ki to maunga, ko Mauao
kia purea koe
e nga hau a Tawhiri-matea

Return to your mountain Mauao
and there be cleansed
by the winds of Tawhiri-matea"

i. Introduction

In 1999, I returned home to Tauranga Moana, a coastal region in the western Bay of Plenty, Aotearoa New Zealand after living in Hamilton, a city in the centre of the North Island of Aotearoa New Zealand for eleven years.

Descendants of the original inhabitants of this region are Ngati Ranginui and Ngaiterangi. Colonial troops invaded tangata whenua at Pukehinahina in April 1864 and again at Te Ranga in June that same year. The tangata whenua were defeated. Shortly after, soldiers fighting in those battles were awarded land for their efforts, designating Tauranga as a military settlement (Stokes, 1990). Although most of the Maori lands in Tauranga were confiscated, some was returned as land grants through the Native Land Courts process. Land ownership (rather than stewardship) is a colonial concept. Ownership is vested in individuals. The returned land required individual names for the transaction to be legitimated. Compliance with this process embedded one of the most significant pillars of western organisation. Only ten names were recorded on the original certificates of title, despite whenua being a collective responsibility of all hapu members, who organised and managed it according to principles of kaitiakitanga (Walker, 1990).

The invasion of our whenua by British troops has always been understood by the people of our region as a violation of the Treaty of Waitangi, the Treaty which set in place the rights and responsibilities to be honoured by the people who share this geographic space of Aotearoa New Zealand, a Treaty that guaranteed Maori their sovereignty (Kawharu, 1989; Orange, 1987; Walker, 1990). Today, the area is a

modern coastal city, deriving wealth from the operations of the Port of Tauranga, horticulture, real estate, tourism and leisure activities. It is largely populated by European New Zealanders, but its resources are underpinned by much foreign ownership affecting all manner of economic outcomes.

Ngaiterangi and Ngati Ranginui still claim ancestral affiliation to all lands of Tauranga, although a significant portion of these lands have been alienated. Maori now constitute approximately fifteen percent of the regions population. Much of the Maori population suffer the consequences of this alienation from their land and identity. These consequences show themselves in the form of poverty, ill health and the characteristics of alienated populations .

ii. Reframing Myself

I left my home in 1989, to study management with a specialisation in marketing at a university located in the rohe of Tainui. While sport and socialising occupied much of my commitment in the early days at university, my concern for Maori wellbeing was a constant. However, opportunities to focus specifically on Maori organisations did not occur until my third year of study. That year, I took elective opportunities in my degree to investigate notions of Maori leadership, processes for developing new Maori health services and the impact of culture on marketing Maori products and services. In a self directed project in my fourth and final year of study for an undergraduate degree, I was concerned with Iwi development within Tauranga Moana, using a strategic planning framework in which I had been trained. In my post graduate courses, I examined the structures of Maori organisations involved in the fishing industry, maternity services for Maori women, the impact of tobacco consumption on Maori people and Maori economic development. To me at that time it appeared that I had found a way in the largely Pakeha institution to progress my interest in assisting my Whanau, Hapu and Iwi.

I began my post graduate research by responding to a desire to ensure that my work would be useful, beneficial, supported by and representative of the aspirations of Tauranga Moana Iwi; *Ngaiterangi, Ngati Ranginui and Ngati Pukenga*. Returning home provided me with an opportunity to apply the benefits of my education to assist my Whanau. Once settled back home, I could then

channel that passion through to this PhD. The exploratory work entailed my becoming involved in the daily concerns of the Whanau by forming new relationships – and new ways of working – that my education at the Management School had not prepared me for.

In the course of re-connecting to home and through my work in this PhD, it became clear to me that I was changing and with the changes within me, developed more changes in the way I worked and in the way I now think. The transformational claims of the research method chosen for this thesis were thus deeply personalised and professionally validated. For this reason I have crafted this *Prologue*. It is an insight into a process that is as integral to the research as the tasks I conducted as my 'field work'.

The original version of this reflection on research process served as an introduction to the methodology chapter of this thesis. It was written for two purposes. I was attempting to write into the text some of the issues I was experiencing as a Maori researcher. My conclusions could not have been justified without this explanation. It was also a means for me to make explicit the process of positioning myself as an insider researcher who is committed to working within the methodological paradigm of Kaupapa Maori – a critical, transformational oriented method of action research focussed on the liberation of Maori from the legacy of colonisation.

This expression of my reflection has since established its own place at the opening of this thesis. It provides a glimpse into the impact this work has had on me as: an academic, a researcher, a mokai and as a member of Whanau, Hapu and Iwi. It expresses the eyes and ears I have become and through which I have done this work.

iii. Framing Fractured Ideas of Belonging

Framed as I was within the disciplines of the western academy, I had taken on the mainstream (taken for granted) frameworks based on western instrumental and functionalist principles typical of the management disciplines at that time. I had come to concur with the modes of learning associated with the limited rationality

that have characterised Western thought since the Enlightenment to inform a series of contexts regarded as being Maori. The frameworks for analysis available to me were constructed from concepts that do not relate to the concepts of Te Ao Maori. No resources from that world appeared available to me. And the framework of my education did not suggest to me that this could be a problem. For instance, in one of my marketing courses, Maori was visible for consideration only as they might be reached to boost market share. Maori were positioned as a *forgotten market* (Grace, 1991) and perhaps 'the exotic other' (Said, 1991). On reflection, much of what I undertook as education served as a form of assimilation expressed through a western curriculum taught as if its values and processes are 'the norm', 'the only' or 'the best' way of cultural expression. In this case, they were associated with the processes of human organisation and the management of resources. It is what Humphries (1992) discerned as the hegemonic influence of the business school curriculum.

I was in my fifth year of study that I was stopped in my tracks. I was asked by Dr Kelvin Mataira: *"What is Maori marketing?"* With a group of Maori post graduate students in a number of disciplines, we sought to explore the depth of this question applied to our various fields. For me the question morphed into: *"What is marketing for Maori?"* and *"How does the discipline of marketing shape, inform and assist the enhancement of Maori health?"* It is through the deeper, philosophical explorations of these questions that I now review the notion of *Maori* marketing as a series of attempts by Maori to redress assimilation and to reposition *Maori* images and concepts as *Maori* ways of knowing validated with Maori forms of accountability. The PhD I present here is an application of this re-framing of the questions. It is an attempt to locate my scholarship and research work within an ontological position which is generated from *Te Ao Maori, Matauranga Maori and Kaupapa Maori* (Barlow, 1991; Marsden, 1992; Mead, 2003).

Through this doctoral research programme, I have learnt that research for, with and by Maori (rather than research *about* Maori) raises issues of legitimacy, accountability and even authenticity. Initially I believed that the issues I was experiencing as a researcher were unique to me. I have since come to learn that

my concerns about these matters were not unique; they are themes being explored by many Maori researchers (Bevan-Brown, 1998; Bishop, 1996; McNicholas & Barrett, 2002; Mutu, 1998; L. Smith, 1996). My reflections on these concerns have influenced the way I have conducted my relationships with the participants in this research and how those relationships have helped shape the research and the presentation of the outcomes. It has amplified the need for Maori to be competent in two worlds – a competency traditionally advocated so that the better of two worlds might come together for the flourishing of the people.

Sir Apirana Ngata, the Eastern Maori Member of Parliament in the late 19th century – mid 20th scholar and Ngati Porou leader championed the idea that the acquisition of knowledge both Maori and Pakeha should be acquired in the interests of Maori development (Durie, 2001; Sutherland, 1940). As a Maori leader, committed to fostering a society driven by the desire to enhance Maori development initiatives and passionate about that cause, he worked tirelessly to meet those ends. Few people who have followed in his path have matched his achievements. Today, Maori struggle to grasp the concept of dual-excellence or dual consciousness. Many are in pursuit of Pakeha forms of excellence at the expense of their experience in and for Te Ao Maori. Opportunities to use research as a way of influencing this issue are examined through *Kaupapa Maori* approaches to development (see *Chapter Three*).

E tipu e rea,
Mo nga ra o tou ao
To ringa ki nga rakau a te pakeha he
oranga mo to tinana
To ngakau ki nga taonga a o tipuna
Maori hei tikitiki mo tou mahunga
Ko to wairua ki to atua
Nana nei nga mea katoa

Grow, o tender youth
And fufill your destiny
Your hand mastering the pakeha tools
For your material well-being
Your heart cherishing your ancestral
treasures as a plume for your head
Finally your soul given to God
The creator of all things

(Sir Apirana Ngata)

The task of nurturing a sense of dual excellence is a huge one. It requires commitment to and competency in not just one world, but in two – *Te Ao Maori and Te Ao Pakeha.*

iv. Being Ngaiterangi, Being Tauranga

Throughout my research I have become more accustomed to the desire by many of our tipuna to unite the tribes of Tauranga under the auspices of kotahitanga. The historical injustices that have impacted our people have been re-lived through the recent Treaty of Waitangi Tribunal hearings held in Tauranga. For a number of Maori Whanau in this district, the experiences have been filled with anguish, anger and pain.[1] That journey is still in progress.

The reason I have chosen to reflect on my Iwi identity is a necessary one. I wish to ask the question, who is Ngaiterangi? Historical accounts present Ngaiterangi as fierce opponents in battle and a people strongly aligned with Mataatua waka: Ngati Awa, Tuhoe, Whakatohea and Whanau a Apanui (Stokes, 1990). What of Ngaiterangi today? What does being Ngaiterangi mean today? Ngaiterangi have suffered immensely. We have lost our lands, not only though the confiscation associated with the land wars, but also through public works takings (Cookson-Ua, 1996; Stokes, 1990; Willan, 1999). Our homes are situated on marginalised lands where we live at the edges of civilisation. We are viewed as the younger sibling to our older brothers and sisters from Mataatua. Timutimu (1995) tells the story of the loss of our language being at a crisis point amongst the middle aged and Gardiner (1997) warns us of the threat of genealogical colonisation described in her words as the theft of whakapapa.

I am struggling with the task of repositioning my sense of identity, as an Iwi member within a framework that reclaims Ngaiterangi's position as one of strength. I know that at one point in time Ngaiterangi was strong[2]. More

---

[1] In 1997-2001, Waitangi Tribunal hearings were held throughout the Tauranga region. In 2000, Ngaiterangi held its hearing in August at Whareroa Marae. The hearing provided for the voice of Hapu, whilst presenting the arguments supporting Treaty of Waitangi breaches by the Government as collective. Earlier that year, in May, Ngati Tapu held its hearing at Waikari Marae, and in December 2002, Ngai Tuwhiwhia, Ngati Tauaiti and Ngai Tukairangi presented their cases to the Waitangi Tribunal at Opureora Marae on Matakana Island. Ngati He, presented their case at the end of that week at Maungatapu Marae. I was not present at Hapu hearings that took place in earlier years. Pirirakau presented their claim in 1997. Ngai Tamarawaho, Ngai te Ahi, and Nga Potiki presented their cases in 2000.

[2] The Tauranga Moana Claims Case Book prepared by the Waitangi Tribunal provides a series of historical accounts that locates Ngaiterangi in a position of control and strength up until the wars in the 1860's. As a direct result of warfare, confiscation and the re-positioning of colonial rule, the platform of sovereignty held by Ngaiterangi was severely tested, and successfully eroded over the forthcoming decades.

importantly, my resolve is to assure ourselves that this was and still is so. A core task of this project then, is to reclaim that sense of Iwi strength within my sense of self.

v. Finding a Research Position

My pursuit of a doctorate began as an individual project. I was not exposed to any other way at that time. However, as I began to research and engage with other Maori academics and practitioners in my area of interest, I was prompted to reconsider my position. Whilst living away in Hamilton, I did not feel Iwi enough and I was not able to make sense of that inner feeling before moving back to Tauranga. I struggled with the urge and need to be connected, but connected to what? Timutimu (1995) helped me express these emotions and thoughts with the use of the phrase "invisible umbilical connection". I needed to feel that my work was supported and legitimated (Bishop, 1996; Irwin, 1994). It became inconceivable to me that I could pursue a doctoral project about Tauranga Moana, my turangawaewae without first re-establishing the necessary connections to those people who had kept the fires at home burning – *te ahi ka.* Validating these links and then walking along a pathway that ensured accountability to this living community, as well as the academic requirements was viewed as essential.

I spent much of the year in 2000 performing several tasks to establish a platform to work from. By committing myself to a raft of responsibilities, I was attempting to legitimate my right to pursue a research project of this magnitude in the interests of my people by reconnecting with my research communities. I attended marae hui, Hapu hui and kohanga reo hui. I played netball for the local community team, represented my Hapu interests at local council meetings, presented annual plan submissions on behalf of my Hapu and I accepted a position as the Tangata Whenua Representative for the *Smartgrowth Regional Research Study.*[3] I am a trustee on our local Whanau land block; a member of our Whanau reunion committee and I also acted as a volunteer administrator for my

[3] The Smartgrowth Regional Research Study was undertaken from 2001-2004 in Tauranga. It was a joint project between the Tauranga District Council, the Western Bay of Plenty District Council, Environment Bay of Plenty and Tangata Whenua. The purpose of the study was to plan for urban growth over the next fifty years and to ensure that the interests of a wide group of stakeholders were taken into consideration.

marae on my mother's side. It was exhausting trying to make meaningful reconnections.

In hindsight, I learnt two significant lessons. First, I was involved with the Treaty of Waitangi Tribunal claims for my Hapu and Iwi and I worked as best as I could to support those activities. I utilised the management skills I had acquired at university as a liaison with publicists and as a general organiser liaising with lawyers, ringing kaumatua and kuia and ensuring that panui and emails reached those people who needed to be informed. *I learned to observe and to listen.* Second, I observed the nature of human relations at those hui particularly between kaumatua and rangatira. I witnessed concepts of Hapu and Iwi leadership contextualised for Ngaiterangi, bearing little resemblance to the management theories taught at university. These leadership practices still exist, not as an outmoded system of leadership, but as a living system, that is heavily influenced and often stressed by years of colonial overlay. I do not always agree with the decisions made by some of our leaders and I am concerned that sometimes things don't seem to get done. However, in those hui, *I also learned not to be afraid to ask questions.*

I am also concerned our leaders are exposed to forms of verbal disrespect and abuse, sometimes by our own people. I reflect on those particular occasions and see how our people remain oppressed or subservient and how the importance of things Maori can be left unattended. Confronting issues pertaining to Hapu and Iwi, Treaty of Waitangi claims and land grievances in ways that are meaningful can feel too painful to resolve. I also see how, as a result of that form of anguish, one can assume other roles within Hapu and Iwi that demand a type of strength. Strength is not always something that evolves from specific tasks that one completes; strength can emerge from a process of transformation that comes from working to *tiaki* people in collective and assertive ways. My PhD work has since developed into a collective project, in terms of accountability, legitimisation and control (Bishop, 1996; Irwin, 1994). I believe that I have earned the right after three years to focus directly on my PhD programme as a full time project with the support of my Whanau, Hapu and Iwi. With its completion will come a new set of responsibilities.

vi. Reflexivity and Subjectivity – Multiple Subjective Roles

In terms of this research, I became what Smith (1999) called an inside/outside researcher. This realisation has become a common theme with Maori researchers (Kiro, 2001; Tiakiwai, 2001). Linda Smith however argues that it can be a problematic location.

> There are a number of ethical, cultural, political and personal issues that can present special difficulties for indigenous researchers who, in their own communities, work partially as insiders and are often employed for this purpose and partially as outsiders, because of their Western education or because they may work across the claim, tribe, linguistic, age and gender boundaries (Smith, 1999 p. 5).

I am a positioned researcher occupying a position inside, outside and in between the borders – I am occupying multiple subjectivities: researcher, university employee, student, Iwi and Hapu member, Whanau member, mother, daughter, partner and self. Hertz (1997) suggests that these subjective positions demonstrate the intent by the researcher to participate with people in communities as co-researchers, to research matters that are important to the communities as part of a team and to commit to action - before, within and beyond the research based as she says on the local knowledge articulated through the research. Hertz (1997) argues that to be reflexive is to accept that research is a political activity and to participate in the constructing of research writing is to also assist in the construction of knowledge. The researcher is not guided by principles of objectivity in the sense of western rationalism; instead the inquirer is mindful of his or her obligations.

A mindful inquirer presents other frames of reference built on the understanding that people are part of a socio-cultural landscape shaped by economic, cultural and political circumstances, but these structures are implicated in oppression and its impacts (Bentz & Shapiro, 1998). Counteracting oppressive activities is a central component to human inquiry and mindful inquirers may contribute to spiritual and social actions. A concern associated with adopting an insider research approach is that the researcher may occupy the role of the coloniser in his or her university cloak and the colonised as a member of the very community that is situated as the object of the research (Memmi, 1965). A re-examination of the researcher's role is therefore an essential part of reflexive research and forms part of the Kaupapa

Maori theory and methodology adopted. I draw on Villenas's account of potential contradictions with this position:

> I am both, as well as in between the two. I am the colonised in relation to the greater society, to the institution of higher learning, and to the dominant majority culture in the research setting. I am the coloniser because I am educated, marginalised, researcher, recruited and sanctioned by privileged dominant institutions to write for and about Latino communities. I am a walking contradiction with a foot in both worlds – in the dominant privileged institutions and in the marginalised communities. Yet, I possess my own agency and will to promote my own and the collective agendas of particular Latino communities. I did not even consider the multiplicity of self and identity and the nuances of what such consideration meant until I had to confront my own marginality as a Chicana researcher in relation to the dominant majority culture in the research setting (Villenas, 1996, p. 714).

vii. Connecting Myself to the Task

Without having a clear understanding of the intellectual process of completing the complex task of a doctorate, I consulted several examples of what a doctorate looked like and how they were organised. The poetry of language expressed by successful candidates was remarkable but at the same time it was also daunting. There were examples of authentic recollection of experience or reflexivity, which validated ways of seeing and interpreting social phenomenon. This authenticity struck a chord with me. I began at that point to take ownership of my doctoral experience. The first sense of responsibility came from tuning into my own voice, analogous to tuning into a radio station. I felt as though my voice was there on one of the frequencies, but I was not in tune with the right station and therefore my voice was not heard. The second analogy however is, as with all radio stations, a story had to be told and for that to happen I needed to tell the story, in co-authorship with the research communities I wished to work with. These narratives are more clearly elaborated in *Part II* of this thesis.

The task of how to do a doctoral research programme was difficult and at times I felt quite whakama about that realisation. But at the same time, I was becoming more certain that *our* story must be told and our future influenced for the better with the use of theoretical explanations. For some time, I had been searching as an emerging artist would for the creative ideas to 'mould this thesis'. I have benefited from the help of so many people. What I return now, in this PhD, is the result of all this thinking. The gift of the artist (my whanaunga) that opens this

document, the stories and insights shared by the participants and the challenges of the theorists I have read have brought me to this point – not a point of closure – but perhaps new departures – new questions. It seems that the more I engage with the world, the more questions come to me. I am encouraged by the words of Rainer Maria Rilke, mystic and poet (1875-1926).

"Live the questions and slowly without realising...
...you may live your way into the answers"

WHAKARAPOPOTO - ABSTRACT

This PhD research originally explored the efficacy of social marketing as potentially beneficial for Maori health providers involved with Maori health promotion activities. However, as I became conscientised to the potentially assimilist and neocolonial impacts of functional management disciplines, such as social marketing I turned my attention as a Kaupapa Maori researcher to the task of critique and transformative social action. I also became acutely aware that the future of Maori health advancement lies in the flourishing of Te Ao Maori - a flourishing deemed necessary for the wellbeing of the people and the natural environment in which Maori live is presented in this thesis. Te Ao Maori is therefore repositioned as a way in which to conceptualise Maori health and wellbeing, based upon holistic and cultural principles of living.

Based on the transformative aspirations of critical theorists and emerging theories of kaupapa Maori, I incorporate the holistic constructs of Te Ao Maori while minimising the impact of the externally imposed mechanistic and functional metaphors dominating the contemporary formulation of human wellbeing. Using a localised participative methodology called Kaupapa Maori, I have worked collaboratively with four Maori groups and various kaiarahi hauora in Tauranga Moana to examine and articulate a series of collective responses to research issues. As a result of this research, my findings indicate that Maori continue to articulate a desire to live by principles and practices espoused through holistic models of Maori health and wellbeing, nestled into Te Ao Maori. That vision however is affected by continual structural change, limited resources, lack of access to skilled people, the imposition of contractual regulations within the health system, the erosion of Maori cultural systems and the ongoing commodification of Maori health and wellbeing in concert with the principles of market driven economies driving much human activity globally. The experience of Maori in Aotearoa New Zealand is the localised manifestation of the experiences of indigenous people across the globe. We share with them a position of resistance to the values of others and the affirmation of our own values.

The potential of social marketing to contribute to enhancing Maori health and wellbeing was critiqued within these lived experiences, not those defined by social marketers themselves. In the control of uncritical social marketers, social marketing models are one of many conceptual frameworks that are being used to intensify economic rationality associated with the contemporary form of capitalism and the exacerbation of resource scarcity sanctioned by the existing health services system. Many of the co-participants in this research sought to provide health services and programmes that resembled and encouraged strong Maori cultural practices based upon tikanga Maori that emphasises a commitment to Whanau, Hapu and Iwi. However, the current health system does not help these goals to flourish. Instead, proponents of the system endorsed a regime of health services that operated within the specific constraints of contractual agreements – agreements which require responsibility for outcomes and accountability protocols that consume many resources better spent elsewhere. The opportunity then to engage in the enrichment of Maori health and wellbeing, through a holistic means was reported by participants in this research to be often undermined, minimised and sometimes made impossible.

This research demonstrates that Maori efforts to enhance Maori health development are negatively impacted upon by an ongoing commercialisation and commodification of health services. Ongoing efforts must be made to re-invigorate with and within Maori, an enduring commitment to a foundation of holistic health and wellbeing in the future, stemming from our own worldview – Te Ao Maori. The critical and Kaupapa Maori theories that inform this thesis have been used to bring into the open the contradictions and paradoxes Maori health providers in the Tauranga region are facing. The transformational aspirations of these theories would invite attention to be paid to values underpinning Maori communities and the ways in which they are useful to them. As reported upon in this research, those Maori health advocates adopting social marketing will find it difficult to achieve these aspirations. Instead, the assimilist modern colonising practices inherent in social marketing would turn Maori adopters into self colonisers.

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CHAPTER ONE: INTRODUCTION – LOCATING THE RESEARCH

"foreshore, seabed, mangroves, titiko, tikanga, kaumatua, kuia, reo, roadways and pathways, reserves, district councils, kura kaupapa, hikoi, rates reviews, tangata whenua collective, raupatu hearings, gorse, speeding cars, youth, swearing, stress, Hapu, Iwi, tangata whenua, waiata, kapa haka, kai, children, bills, electricity, marijuana, school uniforms, exercise, obesity, stress, vegetables, 5+ a day, alcohol, drugs, sex, lung cancer, gambling, strokes, trains, housing, caravans, marae, tangi, pokies, unveilings, birthdays, whanau, hui, P, headlice, sports, kiwifruit, railways, hauora"

1.1 INTRODUCTION

Audre Loude (1984), a Black feminist writer, is noted for the claim that "the master's tools will never dismantle the master's house" (p.99). In contrast, Ladson and Billings (2000) suggest that "the master's house will only be dismantled with the master's tools" (p.267). To reduce the articulation of theories for emancipatory action to a dualistic combat in this way, fails to do justice to the complicated thoughts and practices that have generated a history of resistance to colonisation. In this regard, researchers working with emancipatory intent face a paradox. In Aotearoa New Zealand, this is the work of Maori. We argue for Maori solutions to Maori problems founded upon the ontological foundation of Te Ao Maori. Yet, we look to the tools of a western critical discourse, which despite its critique of its own social context, is still a discourse of western thought that implicates generations of intellectual imperialism and colonisation. Western discourse carries with it for example concepts of individuality and freedoms that are not those of Maori. Techniques for organising human activities, drawn from western organisational thought, transport such concepts into practice and through their practice affect the context of their application when uncritically applied to Maori endeavours, whether imposed by funder or government requirements, or 'chosen' for lack of viable alternatives, their effects constitute the process of neo-colonisation. Thus, for Maori scholars concerned with processes and techniques for efficient or effective organisational processes, the paradox is expressed as an attempt to progress Maori emancipation from ongoing westernisation (sometimes

disguised as internationalisation or globalisation) without involving the use of western techniques of organisation that have colonising effects.

In this thesis, I seek to work with this paradox to explore the complexity of achieving a qualification by an Academy that is only just beginning to understand and recognise knowledge that is not limited to the western rationalism of organisational sciences in which I was trained. I also aim to contribute, through action (my research work, grounded as far as possible in a Maori ontology), to enhancing Te Ao Maori and through this, the wellbeing of Maori people. I do so through an adaptation of the emerging emancipatory action research developed by and for Maori - *Kaupapa Maori research.*

In this research, I focus on advancing Maori health development through a project based on principles of Kaupapa Maori research. The task has multiple dimensions. At a first level, *the principal purpose of this research is to investigate the appropriateness of social marketing in support of Maori health advancement.* Through this research, I seek to examine the risks and benefits associated with the uncritical adoption of social marketing principles and practices to address and advance Maori health and wellbeing. At a second level, this research is concerned with the challenges of locating the researcher and the research squarely within an ontological frame that generates and enhances Te Ao Maori - appreciating the fluidity, contradictions and paradoxes of our own world and at the same time meeting the criteria of success within an essentially western academy. At a third and more practical level, this research is about the way in which community organisations operate using the concepts of Whanau, Hapu and Iwi - concepts intrinsic to and expressive of Te Ao Maori, concepts very different from the individual that arise from a western ontology. Ensuring the research calls on and endorses Whanau, Hapu and Iwi helps transform the potential colonising impacts of contemporary health sector bureaucracy in Aotearoa New Zealand to enable a more receptive and enhancing way in which Maori communities might progress their own ways of health and wellbeing advancement. I am engaging with this complexity because working to enhance and improve the health and wellbeing of Maori is to strengthen Te Ao Maori – and to strengthen Te Ao Maori is to strengthen Maori wellbeing.

In this chapter, I provide a brief overview of the Maori health situation in Aotearoa New Zealand today. The institutional initiatives designed to redress the disparities that currently exist within the health industry are more fully outlined in *Chapter Six*. Despite the existence of a raft of Maori related health policies, I am concerned that the perpetuation of the current form of state interventions in Maori affairs, risks continued colonisation (neo-colonialism) and a new domestication to a form of global colonisation that may not service Maori well. Based on the questions generated from my earlier experience as a researcher concerned with Maori health improvement, I formulate, in this chapter, the themes and orientation of this inquiry.

1.2 LOCATING THE RESEARCH – MAORI HEALTH STATUS

1.2.1 Understanding the Problem - Maori Health Status

Conventional methods of measuring health status involve the presentation of morbidity (illness rates) with mortality (death rates) based on death registrations, the utilisation of hospital and clinical services, hospital admissions and departures, general practitioner visits and specific disease registers (Pomare et al., 1995). In Aotearoa New Zealand, alternative representations of Maori health have emerged. These contextualise Maori health within broader discussions about Maori socio-economic status and highlight disparities in health outcomes between Maori and other people within the population. An analysis of socio-economic status post-1840 focuses upon the significant impact of land alienation upon Maori people, the consequential effects of warfare and disease and the lack of economic opportunity attributed to the loss of land (Chapple, 2000; Howden-Chapman & Cram, 1998). Significantly important at that time was not just the tangible loss of land, but the impacts associated with the disconnection of a people who identified with the land from their source of energy and sustenance (Walker, 1990). Maori now hold only a small portion of the total land mass in the country. With this loss of land, has emerged a psychological disparity stemming from a deep disconnection with ancestral whenua (Robson, 2004). An analysis of health inequality from this perspective takes into account the various social, cultural, economic and historical circumstances that contribute to structural considerations

pertinent to Maori health advancement. Some of those circumstances have manifested from the impact of urbanisation upon Maori in the 1950's and the impact of significant government reforms in the 1980s (Kelsey, 1993).

Despite the evidence of some "absolute and relative socio-economic gains, it remains a well established fact that significant economic gaps still remain between Maori and non-Maori in New Zealand in education, health, income and labour market status" (Chapple, 2000, p.2). Maori health status is therefore, in this thesis, considered as part of a wider framework associated with Maori socio-economic status and/or social inequality. In the next section of the chapter, I outline Maori health conditions (or status) within a set of relevant broader socio-economic determinants of Maori health.

1.2.2 Maori Health Conditions

Maori people disproportionately suffer from a number of health conditions compared to the general population. These health conditions include cardiovascular disease, cancer, smoking, gambling, suicide and self harm hospitalisation, obesity and diabetes.

Cardiovascular Disease

Cardiovascular disease includes illnesses such as heart failure, stroke, heart disease and high blood pressure. Many Maori that die of a heart attack do so before the age of 65 and Maori who suffer from strokes do so at an average age of 55 compared to 75 years for non-Maori (Caccioppoli & Cullen, 2005; Heart Foundation of New Zealand, 2005). Mortality rates brought about by cardiovascular disease for both Maori and non-Maori continue to decrease. Despite these falls, the disparity between Maori and non-Maori cardiovascular rates persists. For instance, in the period 1996-1999, Maori males were three times more likely to die from cardiovascular disease than non-Maori men. The rates for Maori females were 4.2 times that of non-Maori rates (Robson, 2004). Although the incidence of cardiovascular disease was traditionally more established in wealthier communities, global trends signal a reverse of this development, with coronary heart disease mortality rates emerging at higher rates within lower socio-economic groups (Riddell & North, 2003). Maori feature most

amongst lower socio-economic communities in Aotearoa New Zealand and these socioeconomic inequalities directly relate to the higher levels of cardiovascular disease.

Cancer

Ajwani, Blakely, Robson, Tobias & Bonne (2003) outline a number of trends specific to Maori mortality and cancer. Maori males are 3.5 times more likely than non-Maori males to suffer from lung cancer Maori females are almost five times more likely to die from lung cancer than non-Maori females. Prostate cancer rates have increased for all, but Maori suffer at rates twice that of non-Maori. Breast cancer rates amongst Maori women continue to surpass non-Maori rates.

Smoking

Smoking is a cause of preventative death amongst many New Zealanders. Each year 4700 people are killed by smoking in Aotearoa New Zealand (Public Health Intelligence, 2002). By 2030, smoking is likely to be the greatest cause of death and disability in the world (World Health Organisation, 1999). Tobacco use contributes to over 600 Maori premature deaths (Reid, 1999). In the latest 2001 census, at least half of the Maori population smoked, in comparison to less than a quarter of the non-Maori population (Tobacco Control Research Strategy Steering Group, 2003). A third of Maori deaths each year is attributed to the use of tobacco. Smoking contributes to the incidence of heart disease, heart attacks, strokes, cancer, respiratory disease, flus, colds and chronic bronchitis (Te Puni Kokiri, 1999). Although the implementation of legislation to reduce the incidence of smoking by all New Zealanders is having a positive impact, Maori continue to be the highest users of tobacco. The patterns of tobacco use by Maori are burdensome upon Maori as individuals, families and communities. Smoking also takes away our culture and heritage by premature deaths of our kaumatua and kuia (Te Puni Kokiri, 1999).

Suicide and Self-Harm Hospitalisation

Suicide is a prominent cause of death amongst young people in Aotearoa New Zealand (Ministry of Social Development, 2003). Whilst the overall number of

people reported to have died by suicide remains steady, Maori continue to demonstrate a disproportionately higher rate of suicidal death. For Maori male youth the suicide rate was 25.7 per 100,000 compared with the non-Maori male youth, which was 16.2 per 100,000 (Ministry of Social Development, 2003). Females are much less likely to commit suicide (Ministry of Health, 2005). The suicide rate of youth (15-24 years), both Maori and non-Maori is higher than any other age group impacted by suicidal death. People in the 20-24 year age group had the highest hospitalisation rate for intentional self-harm (300 cases per 100,000). For non-Maori males, the highest rate of intentional self-harm was amongst 20-24 year olds and for non-Maori females, it was for 15-19 year olds. For Maori males, the highest rate of intentional self-harm was amongst 25-29 years of age and for Maori females the highest rate of intentional self harm was those of 20-24 years of age (Ministry of Health, 2005). Self-inflicted harm that resulted in hospitalisation is often reported as attempted suicide. Aotearoa New Zealand is the fourth highest rating country for suicidal death amongst all OECD countries (Ministry of Social Development, 2005).

Gambling

Gambling has emerged as a social problem for many people and families within Aotearoa New Zealand and Maori women in particular are adversely being affected by gambling habits (Dyall, 2004). In a National statistics report related to problem gambling, 6000 clients presented themselves for counselling assistance because the adverse impact of pokie machines upon Maori families (Hannifan & Gruys, 2002). Maori women are more likely to present themselves for help with problem gambling (Hannifan & Gruys, 2002). Dyall (1998) states that Maori women are likely to spend up to six times more per annum on gambling than non-Maori women (Dyall, 1998). People who experience gambling problems have more "stress-related illnesses than the general population...and studies show that between 10-30% of people who gamble have been involved in gambling related criminal activities ranging from embezzlement, to cheque forgery and stealing credit cards" (Orme, 2003).

Obesity and Diabetes

The World Health Organisation estimates that obesity related problems cost approximately $300 million in Aotearoa New Zealand (World Health Organisation, 2000). Obesity rates amongst Maori are higher than non-Maori (Russell, Parnell, & Wilson, 1999). Some of the reasons for increases in Maori obesity rates are attributed to socio-economic factors such as the inability to afford certain foods and the overall higher levels of deprivation. The inability of Maori to access traditionally inexpensive food sources e.g. fishing, and changing physical activity patterns occupationally and in leisure times have also contributed to onsets of higher levels of obesity (Ministry of Health, 2003).

Obesity is one of the leading indicators of the onset of diabetes (Diabetes New Zealand and Fight the Obesity Epidemic, 2004). Diabetes is the leading cause of blindness, kidney failure, nerve damage and diabetes related circulation problems. It can lead to limb amputation and heart disease (Birkbeck, 2003). Diabetes is three times more prevalent in Maori than non-Maori and by 2011, the number of Maori with diabetes will double (Ministry of Health, 2001). As Maori continue to become heavier at increasingly younger ages, the potentially negative impact of diabetes related illnesses will continue to affect increasing numbers of Maori people (Caccioppoli & Cullen, 2005).

Maori ill-health is not restricted to the diseases identified above. The incidence of alcohol and drug abuse, traffic related injury, disability, respiratory illnesses including asthma and mental health problems such as depression continue to be major concerns for many Maori people (Robson, 2004).

1.2.3 Social, Cultural and Economic Determinants of Health

The Ministry of Social Development *Social Report* (2003) provides nine social indicators as statistical clusters of information to measure the various aspects of social well-being. The nine social indicators include the following: health, knowledge and skills, paid work, economic standards of living, civil and political rights, cultural identity, physical environment, safety and social connectedness. In this report, social well-being is seen as more than the representations of health statistics based on rates of morbidity, mortality and life expectancy. The report

validates a more holistic view of health, which takes into consideration the person, the Whanau and their related environments – physical, social, cultural, economic and political. In this section, social, cultural and economic factors are increasingly identified as health determinants (Howden-Chapman & Tobias, 2000). The inequality of these factors between Maori and the general population demonstrate a link between these factors and the unequal health experiences that are the focus of this research. As part of this discussion, I outline how income and poverty, education, housing, and social connections and culture are forms of representation of Maori health and wellbeing.

Income and Poverty

According to the National Health Committee (1998), there is a constant correlation globally between poor health and the financially worst-off. By 1992, the proportion of total Maori households in the lowest income quintile had increased from 26 to 43 percent. The gap between average incomes of Maori and non-Maori households has also increased over the last decade (Ministry of Social Development, 2003). Poverty continues to be an important indicator of poor health (Calman, 1997). Poorer people have higher rates of disability, higher rates of death, disease and injury and these illnesses are more pronounced with families who have children (National Health Committee, 1998). In developed countries, such as Aotearoa New Zealand, poverty is depicted through the concept of *relative poverty.* Relative poverty compares individuals or groups with some norm – locally, nationally or internationally. In Aotearoa New Zealand, the increasing number of people requesting food parcels is an indication of the reduction in disposal income available for purchasing essential household items such as food (Waldegrave, 1996). The extent of relative poverty is reflected in income inequality statistics. In Aotearoa New Zealand, it is recognised that there is a continuing trend towards income inequality for Maori which is described as one of the fastest increases in any OECD country in the 1990s (Ministry of Social Development, 2003).

Employment and Unemployment

Employment directly relates to a person's ability to obtain income and as shown above – income (and the lack of it) directly affects the health of individuals and

their families (National Health Committee, 1998). Employment provides opportunities for people to enhance their social status, personal self-esteem, social contact and opportunities for community involvement. Employment and the income derived from employment have a direct impact upon the wellbeing of an individual, their community and society.

Unemployment is deemed detrimental to the physical and mental wellbeing of people (Department of Labour, 1994). From 1986, unemployment rates for Maori rose from 10.7 percent to a peak of twenty percent in 1992. In 2002, those rates declined to 11.3 percent (Ministry of Social Development, 2003). Unemployment has been demonstrated to lead to depression, self-doubt and a lack of motivation to succeed (Ministry of Social Development, 2003). While there has been a downturn in recent unemployment statistics, there are contrasting accounts for the decline. In some cases, the re-definition of employment to include part time positions (Statistics New Zealand, 1997), may account for the inadequate income in many Maori homes, even though these families are not dependent on the unemployment benefit. There are also geographic, age and ethnic differences for unemployment rates. For instance, recent unemployment statistics signal that unemployment rates in Northland are 6.7% and in the East Coast of the North Island 18%, although unemployment on the whole is decreasing nationally, these two areas are registered as some of the highest regions of unemployment in the country (Department of Labour, 2004; Te Puni Kokiri, 2001). These are regions of the country with high Maori populations. The extensive impact of economic de-regulation in the 1990s, has contributed to the type of work available particularly within labour intensive positions in which many Maori and Pacific Island people were employed (Kelsey, 2000).

Education

Low levels of education are associated with poor health status. Low levels of education impact upon opportunities for subsequent employment and income and the consequent social circumstances associated with existing opportunities for self and family development (National Health Committee, 1998). A comprehensive adult literacy study conducted in 1996 found that:

- Twenty percent of the adult population had very poor literacy skills

- Over sixty percent of Maori, Pacific people and other minority groups are functioning below effective daily levels of literacy
- Labour force status and income are related to levels of literacy
- Levels of retention at school are associated with improving literacy levels (Ministry of Education, 1997).

Disparities between education enrolment rates of non-Maori and Maori continue to be prevalent. Maori continue to have higher rates of school suspension. Approximately fifteen percent of Maori children aged fourteen years were suspended (Te Puni Kokiri, 2000). Access to health care, particularly in a more consumer oriented delivery model, relies on the ability of consumers to find and understand information. Literacy in this regard is a fundamental requirement.

Housing

House location, physical condition, levels of overcrowding, costs of renting or mortgage, warmth and hygiene are indices that all affect the physical, social and mental wellbeing of people (Housing New Zealand Corporation, 2005). Housing is the largest expenditure item for most families in New Zealand. Both Pacific Island families and Maori are prone to overcrowding (Ministry of Social Development, 2003). The incidence of overcrowding is directly attributed to lower socio-economic status and cultural attitudes. Where inadequate, sub-standard or overcrowded housing is provided, families are at risk of illness through dampness, lack of warmth and hazardous alcohol consumption (Howden-Chapman & Tobias, 2000; Johnson, 2005).

Social Connection/Culture

Social connection pertains to the interaction that people have with other people in groups, clubs, organisations and whanau and its persistence is an indication of health and wellbeing (Ministry of Social Development, 2003). The need for, or lack of social connection (with others) has arisen as a basis upon which to gauge health and wellbeing. Active participation and inclusion provides opportunities for social interaction and support. Maori patterns of social interaction are shaped by a belief system, founded upon Te Ao Maori. Maori people have certain

cultural protocols related to meetings and organisation and Maori are more likely than non-Maori to belong to a club or cultural organisation. Social connection is important to all cultures, but for Maori it is a way of maintaining whanau connections culturally, at marae, amongst whanau and friends and at other social occasions (Durie, 2001). A lack of social cohesion and connection can lead to decreased levels of health and wellbeing.

In this section, the presentation of socio-economic determinants of health are outlined as macro issues impacting the advancement of Maori health. However, this approach to analysing Maori health and wellbeing does not always adequately reveal the social and human aspects of interaction between people in their communities, or how these social relationships help shape and enhance community responses to health related concerns. In this research, a further set of themes is explored in an effort to help shape a different approach to exploring Maori health and wellbeing, based on a notion of what is different and what differences matter for Maori (Johnston, 1998). When Maori choose to present their engagement with health and wellbeing in this way, a different picture emerges.

1.3 NARRATIVES OF INQUIRY – GUIDING THEMES

Several themes guide the orientation of research in this thesis. The themes outlined below are presented as a series of sub-inquiries in this section, which all contribute to the overall interest in the potential contribution for social marketing to Maori health advancement. I link these themes to theoretical concepts that are explored in various chapters through a critical lens of inquiry (see *Chapter Three* and *Chapter Four*), and through which my work with research participants is considered. I explore these more fully as a series of sub-inquiries in *Chapter Eleven* and *Chapter Twelve.* My challenge is to give voice and substance to Te Ao Maori *(see Chapter Two),* not only as a set of theoretical concepts, but as embodied in a living community. The two preceding depictions of Maori health and wellbeing focus on the illnesses and stressful social circumstances of Maori. These are valid and troubling images. However, there is another picture emerging. Maori who are actively involved in the presentation of their work towards wellbeing, depict Maori as a determined people, who despite the

indicators of statisticians and social commentators, are actively involved in harnessing their values and energies to transform lives and claim responsibility for enhanced wellbeing. It is in this emerging focus of attention that I have placed my inquiry. The paradox outlined in the opening section of this thesis is amplified by the requirement to contribute to this endorsement of Te Ao Maori in the language of the coloniser. The various themes outlined below consider Maori ontology and epistemology, tribal and collective consciousness, Maori subjectivities and Kaupapa Maori.

1.3.1 Maori Ontology and Epistemology – Tribal and Collective Consciousness

Te Ao Maori remains resistant to the complete subjugation to western imperialism. This orientation is consistent with Apirana Ngata's observation of the persistent assertiveness by Maori to remain Maori throughout the various attempts at annihilation and assimilation that characterise the history of Aotearoa New Zealand. In 1940, he wrote:

> At the end of the century and a quarter of contact with the pakeha and his civilisation the influence of the tribe still affects every aspect of Maori social life and the vast majority of the Maori population. It would be easy to get the impression that because the material and outwardly observable aspects of Maori life such as food habits and housing arrangements have changed, other more spiritual things have altered correspondingly and in proportion. Actually, there is no correspondence, proportion does not apply and psychological factors characteristically Maori exert a persistent influence and supply a racial need (cited in Sutherland, 1940, p.155).

Each epoch has generated a Maori consciousness and commitment to survival appropriate to that time. Contemporary tribal consciousness however differs from that of the past, as New Zealand society has been shaped not only by colonialism, but also by modernisation and industrialisation, which have transformed the physical, environmental and technological society within which Maori people now exist (Ihimaera, 1998; Ritchie, 1992; Royal, 1998; L. Smith, 1999; Sullivan, 1995). Tribal estates continue to diminish and core principles of community living continue to erode (Walker, 1990). What does remain is a worldview for Maori based on the experiences and customs of old, articulated to suit the circumstances of today. This inquiry draws from this foundation of knowledge and presents a number of sub-questions focused upon an examination of Te Ao

Maori principles, customs and tikanga to help chart pathways for research that deepens the resistance to contemporary colonisation, and which enhances Maori consciousness and empowers Maori activism in the contemporary context. The knowledge my research approach draws on, represents the efforts of a courageous people from a culture that is alive. Like all living cultures, its knowledge is fluid – generated by its thinkers - so that it may be harnessed to serve the wellbeing of the people. It is a culture, however, that remains under duress (Jackson, 1998).
A critical aspect of this thesis is the amplification of Maori ontological and epistemological frameworks that serve as a guide to the theoretical discussions, the shaping of the research method and the intepretation of its findings. With a commitment to enhancing Te Ao Maori comes the challenge of accessing the knowledge base from which it comes. Our cultural symbols, our language and our stories are becoming less accessible (Bishop, 1997; L. Smith, 1999). Many of those that are most easily visible – are also the ones that have undergone the most reshaping – not always by the authors of our culture and thus, their uncritical use risk the unintentional diminishing of that identity that is being reclaimed, enhanced and empowered.

Many accounts of history are located in the oral traditions of our people. However, a significant amount is already lost, and recorded history in the literature is of varying quality and reliability. Some of it has been written through the demeaning eye of the coloniser (G. Smith, 1995). According to Mead (1996), Maori researchers searching for philosophical guidance, seem limited to re-incarnating Apirana Ngata, Peter Buck, Rua Kenana and Te Kooti. They sleep with their proverbs and sayings near their bedsides and recite them to re-enact the context that made their words so powerful. They display their photos near their computers to provide inspiration and guidance. Wayne Ngata (1998) explores this gap in living relations through the analogy of learning moteatea or traditional Maori chants not with human teachers but with audio tape recordings of the voices of koroua and kuia. This fabricated sense of guidance and protection that unfolds under contemporary conditions is the closest that many contemporaries will get to feeling the emotional, spiritual and political obligations associated with being Maori. Despite these challenges, Maori have no choice. Te Ao Maori is the

foundation of our collective Maori existence - it is who we are - we are not anyone else - we are *Maori* (Marsden & Henare, 1992).

1.3.2 Disconnecting and Reconnecting to Tribal and Collective Consciousness

Webster (1998) argues that some Maori people are learning to associate the concept of being tribal or being Maori as limiting and problematic. Others have simply lost touch by failing to retain an umbilical link to their people and their lands. For want of better words, *kua matao te ahi – their fires have been extinguished.* They have lost connection with their land and by doing so they have lost connection with that which they are (H. Mead, 2003). Being in a state of disconnection weakens the fibres that bind Maori together with their respective tribal confederations and related schools of thought. Today, an emphasis placed upon a person's tribal identity is being contested by dual or multiple orientations of identity (Moewaka-Barnes, 2000). Maori scholars propose that it is not so much that multiple facets of one's identity should not be recognised, but that in recognising these emerging identity configurations a process of antagonism and contestation to existing notions of Maori identity in Aotearoa New Zealand is being set into motion. These inquiries by Maori into aspects of their identity are then captured by unsympathetic and racist non-Maori people. The task of maintaining and enhancing connection to and with Maori epistemologies and narratives of meaning, within the growing contextual complexities of Maori health, education and cultural development is not only difficult, it is also politically, emotionally, spiritually and economically challenging and risky (Pihama, 1993). This difficulty is exacerbated if the focus of one's inquiry is the domesticating or emancipatory potential of techniques or systems of organising that appear as pragmatic solutions to immediate needs.

The retelling of historical narratives about Maori health in a way that transcends official political versions of history is an important means of redressing the fragmentation that has separated knowledge and power in the sphere of Maori wellbeing. Smith (1999) links the articulation of history, to writing. Her concern is with the construction of truth and meaning in educational texts, which do not always reinforce actions; customs, culture and Maori identity. These books tell stories about Maori that are untrue, negative and demeaning. Grace (1985) calls

for a *re-telling* - as a form of 'writing back' that has become pertinent to wider decolonising activities around the world. Mead (1996) presents 'writing back' as a compelling exposure of the assumptions guiding history in the past and challenges those ideas in her critique of writing and history. The context of Maori health within this historical narrative becomes an ongoing storyline of struggle, resistance, emancipation and quests for rangatiratanga (Jackson, 1996). The average New Zealander knows little of the historical endeavours of Maori and the ongoing struggle to retain sovereignty within a colonial regime over the last two centuries (Kelsey, 1990; Orange, 1987; Walker, 1990). The retelling of history in our own voices is a transformative exercise, which directly contests the ongoing legacy of bleak outcomes for Maori in education, welfare, health, land development and cultural development (G. Smith, 1997). One way of challenging these bleak depictions and the associated generation of despair and loss of self-esteem, is to focus on the active association of Te Ao Maori, in this case, through my commitment to the emancipative ideals and processes of Kaupapa Maori research methods.

Tribal consciousness, while still observable by Ngata in the 1940s is continually fragmenting. This fragmentation is described by Mead (1996) in a global sense as the breakdown of indigenous discourses that connect knowledge and praxis with power. The separation of indigenous peoples from their sources of knowledge (and thus power) is manifested in Aotearoa New Zealand for Maori through the challenge of being (and remaining) Maori. A task of this thesis, is then to question the state of this consciousness and then re-ignite, reinvigorate and maintain a sense of passion and unrelenting enthusiasm for its strengthening, which in turn strengthens our existence as Maori (Pere, 1994). Tribal consciousness coupled with an enthusiasm to nurture this knowledge is fundamental to the survival of Maori in the future. In this thesis, I contribute to this invigoration by focusing on Maori health and wellbeing through my investigation of Maori health development and the contribution social marketing may make to this agenda. Social marketing is thus a tool and a process of organising that may appear as a technical solution to immediate needs.

1.3.3 Maori Subjectivities/Identity Politics

A necessary aspect of this investigation into the potential contribution social marketing may make to the re-invigoration of Maori health and wellbeing is an examination of the articulation of Maori subjectivities. The literature is replete with essentialist or traditional subjectivities, bi-racial or multi-caste subjectivities and subjectivities as victims, heroes, criminals or scapegoats (Walker, 1996; Webster, 1998). These mostly negative configurations of identity reflect the growing complexities associated with being Maori within a post-modern, postcolonial society. These configurations shape and condition the responsibilities and parameters of participating in wider society and are often the types of subjectivities endorsed and entrenched by the predominant but limited depiction of Maori through the statistics of illness, injury and structural victim hood. Therefore, the unsettling of Maori identity expressed by the case groups in this research through our joint critical reflection of their organisational ethos, vision, policies and definitions contributes to greater insight into the current context of a services oriented Maori health sector in Aotearoa New Zealand. To that extent, our research process is also an outcome, an outcome of invigorated interest and commitment to Te Ao Maori.

1.3.4 Kaupapa Maori

As part of my commitment to the invigoration of Te Ao Maori and through this the advancement of Maori health and wellbeing, I have committed to a Kaupapa Maori research method. Kaupapa Maori (being/doing Maori) is not a set of prescribed rules and regulations that can be adopted without consciously understanding what, why and when its use is appropriate (G. Smith, 1997). Pewhairangi warned of the dangers of prescribing tikanga without first progressing through the appropriate levels of learning (King, 1992). The danger, in her view, is the inadvertent transgression of tikanga and of tapu – of that which is sacred. Kaupapa Maori theory, research, development and all the derivatives that come from the term are about a way of thinking, living and behaving (Bishop, 1996; McKenzie-Mohr & Smith, 1999; L. Mead, 1996; G. Smith, 1990). Kaupapa Maori research explores culturally appropriate terminologies to provide the context for this research. For instance, emancipation derived through research described by Mead (1996) includes decolonisation, identity formation and the

expression of kaupapa and rangatiratanga. In this thesis, I have drawn together the aspirations of Kaupapa Maori advocates and adapted critical theory into the concepts of *mauri oho* (conscientiousness), *mauri tu* (resistance) and *mauri ora* (transformative praxis) in order to create a Kaupapa Maori research process to investigate the potential contribution of social marketing to Maori health advancement. This three strand theoretical index helps shape the research insights and outcomes reported upon in *Chapter Twelve*.

1.4 KAUPAPA MAORI THEORY

Maori researchers generating what has become known in Aotearoa New Zealand as Kaupapa Maori research integrate concepts from Te Ao Maori with those drawn from Western Critical Theory (largely the Frankfurt School) and the ideas of social constructivists into a critical theory localised to the Maori situation called Kaupapa Maori theory. This thesis draws from the ontological position of Te Ao Maori and the transformational commitment of critical theorists through a social constructivist approach to knowledge construction. According to Burr (1995), social constructionists

- Advocate a critical stance towards taken-for-granted knowledge
- Focus on the historically and culturally specific
- Claim that knowledge is sustained by social processes and
- Suggest that knowledge and social action go together to create new knowledge.

The aim of social inquiry in a social constructivist regime moves from questions about the nature of people or society towards an examination of how certain phenomena are achieved by people in interaction. Knowledge is not something that a person has; it is not a possession. It is something that people do together through social relationships. Social constructivists understand that that which is experienced as knowledge, can be the outcome of the imposition or negotiation of meaning (Burr, 1995). Critical theorists place their focus on the imbalance of power, oppression and exploitation with a view to achieving liberation (Giroux, 2001). Social constructivists who employ a critical perspective are interested in

the way oppression and exploitation are historically constructed and how these conditions are transformed through emancipatory ideals and practices. Through these concerns, Kaupapa Maori theorists, social constructivists and critical theorists provide insight for my work and the foundation for the participatory action research process chosen to guide this research. In the tradition of participatory action research processes, process and outcomes are woven together in a complex process of committing to action. In this case, de-colonisation is sought as part of the process and outcome of the research.

Sometimes critical theories are broadly associated with all projects taking a critical viewpoint on contemporary society, coupled with an emphasis towards investigating repression, unfairness, distorted communication, exploitation and/or false consciousness. In other cases, researchers may only choose one thread of thinking associated with critical theories. Alvesson and Deetz (2000), prominent in organisational studies propose that instead of adopting a fully-fledged critical approach, it is more appropriate to adopt, "a relatively loose framework characterised by a set of comments, reflections and possible guidelines ...*with a critical edge*" (2000, p.2). Though critique is fundamental to both critical theory and Kaupapa Maori theory, so too is the commitment to transformative praxis and/or transformative social change (G. Smith, 1997). As such, the commitment to capacity building, development towards new ways of thinking, new models of practice or new skill building through the research process is all part of the expectations of a Kaupapa Maori theorist who draws from the auspices of critical theory. Critical and Kaupapa Maori theorists refute the possibility of a neutral observer who records objective facts. They argue that the identity of the researcher both shapes and is shaped by the process of research. My aspirations for meaningful research that contributes to transforming Maori health and my concern with the potential of technical processes that further diminish the foundation of Te Ao Maori have shaped the formation of the primary research purpose to examine the extent to which social marketing may contribute to Maori health advancement. My aspirations have therefore influenced my choice of research method.

1.4.1 Focus of Research – Enhancing Maori Health and Wellbeing through Maori Health Promotion

The extent to which social marketing may contribute to Maori health and wellbeing is interrelated with the ways in which Maori health promoters formulate processes of Maori health promotion. Maori health promotion is a culturally constructed concept informed by historical circumstances, political motives and aspirations for Maori ways of organising people and their activities. What Maori health promotion is and what Maori health promoters do, is part of a bigger set of concerns about Maori health development (Durie, 1999). One of the concerns in this thesis relates to the desire by Maori health researchers and Maori health practitioners to reclaim what is called '*mauriora*' – access to Te Ao Maori or the codes associated with Maori ontology and epistemology. Mauriora is one of six elements of a Maori health promotion model articulated by Durie called *Te Pae Mahutonga*. The five remaining elements include *waiora* (environmental protection), *toiora* (healthy lifestyles), *te oranga* (participation in society), *nga manukura* (leadership) and *te mana whakahaere* (autonomy). A critical component of this thesis is the articulation of Maori health promotion utilising Durie's ideas and approaches.

At the very heart of this research is a question about the potential contribution of social marketing in support of Maori health and wellbeing. According to Andreasen (1995), social marketing is the adoption and use of commercial marketing concepts and tools to encourage voluntary modifications in behaviour. Social marketing borrows extensively from the field of marketing and is accepted as a sub-field alongside strategic marketing, services marketing, direct marketing and contextual forms of marketing such as tourism marketing, places marketing and health marketing (Bloom & Novelli, 1981; Fine, 1990; Kotler & Zaltman, 1971; Lazer, 1969). It is therefore necessary to articulate the contrast between the ontological components of Maori health promotion (derived from a Te Ao Maori foundation) and social marketing (derived from a marketing knowledge base). As highlighted above, Maori health promotion is embedded within a Maori health development discourse, which acknowledges a distinctive cultural approach to health. Social marketing however, presents a worldview contrasting with that of Maori health promotion, its ontological foundation generates a western market

model in which seemingly independent and well informed customers purchase health from an already established market. The cultural configuration of human beings as consumers is well entrenched as part of the western individualisation of humanity.

In this research, I am concerned with this developing reconfiguration of Maori health and wellbeing and the potential risks and effects to Te Ao Maori associated with the uncritical uptake of yet another western technology. In this thesis, I argue that social marketing is a manifestation of a western way of organising human beings through social fabrications of products, consumers and markets. For instance, Maori health and well-being might increasingly be understood as an outcome of individual consumer purchasing decisions rather than as a process of relationships. The implications that may come from this set of assumptions may be extensive and sit at the heart of the concerns in this thesis.

1.5 LAYOUT OF THESIS

The first section of this thesis is the *Prologue*. Through *the Prologue*, I emphasise that my work cannot be separated from my location as a mokopuna of *Mauao*, returning home after a time away - a time that affected who I am and how I am today. This time away was in most part, for my professional education, an education that imbued me with technical solutions to a biased representation of social problems afflicting Maori whose potential colonising effects were not immediately obvious.

Following the Prologue, the thesis is presented in two parts. *Part I* considers the theoretical concepts, orientations and reviews are drawn upon to guide the development of the themes for the overall structure of the research. The first set of chapters serve as an explanation of the theories that form the lens through which the insights of my fieldwork are articulated and explained. *Part II* presents the research methodology, research methods and the voices of those who have participated in this inquiry through the case narratives or as kaiarahi hauora. Its conclusion draws together the process and insights of participants into the potential of social marketing to Maori health advancement and the way in which

Maori with an emancipatory intent might critically engage with social marketing in their aspirations to enliven Te Ao Maori.

1.5.1 Part I: Theoretical Foundations and Critical Reviews

This chapter, *Chapter One* introduces the thesis and provides an overview of the theoretical orientation and themes explored more deeply in various chapters of this thesis. *Chapter Two* explains the ontological and epistemological basis of 'being Maori'. This chapter helps articulate what it is to be Maori and why these concepts form the basis of Maori identity and knowledge today. This chapter suggests that Maori health and wellbeing is interwoven with values drawn from Te Ao Maori and provides an orientation for a critique of technologies that contrast with those values. *Chapter Three* presents Kaupapa Maori theory as the preferred theoretical framework for this research. In this chapter it is argued that Kaupapa Maori theory is part of a national Maori development movement focused upon 'doing things in Maori ways'. A number of international indigenous and ethnic movements seeking retribution, social justice, peace, equity and recognition of indigenous sovereignty support this commitment to an indigenous way of being. *Chapter Four* articulates the workings towards a critical theory of Maori health and well-being. This chapter emphasises the important contribution that critical thinkers such as Henry Giroux (1983), Edward Said (1991) and Paulo Freire (1970) have made by providing an analysis of their work with which critical Maori researchers have built on in their exposure of the ongoing domination of unequal power relations through discourse, neo-liberalism and neo-colonialism. Through the associated emancipatory aspirations of these theorists, Maori are encouraged to seek transformative solutions to these forms of oppression. *Chapters Two* through *Four,* thus provide the theoretical lenses through which this inquiry is progressed.

Chapters Five through *Ten* are a series of critical reviews of issues pertinent to the ability of Maori to improve their overall heath and wellbeing. For instance, *Chapter Five* is concerned with contesting the construction of colonial narratives through a process called 'writing back'. Through the unravelling of history, it is demonstrated that Maori have continually resisted the effects of hegemony and oppression. These stories however are not generally part of the national

consciousness of Aotearoa New Zealand. This chapter concludes that colonialism has been supplanted with neo-colonialism through the form of global capitalism. *Chapter Six* presents an overview of Maori health development goals within the context of the structural government reforms implemented from 1984 through to the 1990s. Outlined in the second part of this chapter are the ways in which Maori responded to these policies. *Chapter Seven* provides a discussion about various approaches to health. It presents the argument that the preferred way of viewing Maori health in this thesis ontologically emphasises a holistic approach to a relational ethic and a connection of the spiritual with the physical. Thus, Maori views are contrasted with western notions of health as commodities. The tensions between health discourses are founded upon different claims to truth and knowledge about Maori identity, power and change (Burr, 1995).

Chapter Eight describes the current tenets of Maori Health Promotion. The platform set for this model derives from Mason Durie and presents a structural approach to health promotion. Presented as a recent concept, it draws extensively from a Maori health development framework and Te Ao Maori. Though the tenets are accepted as a given, the components of the Maori health promotion framework serve as a guide for the case narratives. This chapter is also about validating the work currently undertaken by Maori health promoters. *Chapter Nine* presents and reviews the notion of Maori health providers. Maori health providers are seen as contradictory constructions that are characterised as Maori, though they are instituted through fabrications of legislative and bureaucratic processes. The interplay with power relations is an important consideration in this chapter. These chapters demonstrate a commitment to the aspirations of contemporary Maori within a post-colonial society.

Chapter Ten presents a critical review of social marketing. It posits that social marketing is a value-laden technology for health promotion that draws extensively from the commercial marketing field. This chapter re-aligns the benefits derived from adopting social marketing as acclaimed by international social marketing scholars against a discourse of Maori health promotion. In this chapter, some of the critical implications associated with adopting social marketing that have been identified in the available literature are presented.

1.5.2 Part II: Theoretical Reflections and Narrative Research Outcomes

Chapter Eleven positions Kaupapa Maori research methodology as the preferred set of assumptions through which the research in this chapter is based. Drawn from the methodology are four research methods: case narratives, in-depth conversations, workshop hui and literature/document reviews. As part of the process for constructing the case narratives, kaimahi hauora were invited to attend a workshop hui that provided an opportunity to discuss in-depth the potential and risks of social marketing. The chapter discusses the research ethics, protocols and processes adopted in this research project.

Chapter Twelve is a contextual narrative about Maori health development in Tauranga Moana. It draws together the practical application and insights derived from the research processes to address the primary question in this thesis, which is related to the potential appropriateness of social marketing to aid Maori health advancement. This chapter also demonstrates through the narration of participants, many of the theoretical issues highlighted from *Chapter Two* through *Chapter Ten.* This chapter demonstrates through the critical theoretical lens – conscientisation, resistance and transformative praxis – mauri oho, mauri tu and mauri ora that Maori are continuing to resist colonising techniques for conducting Maori health promotion where possible. Moreover, under circumstances where colonising techniques are accepted, the degree of acceptance is under a sense of duress, where the circumstances are viewed as inevitable. In this chapter, it is argued that through the Kaupapa Maori research method, conscientisation can be observed in action and that through action, social marketing is treated more critically and Te Ao Maori is more consciously endorsed and valued. It is a collaborative section, which demonstrates various insights from the case narratives and the kaiarahi hauora conversations. *Chapter Thirteen* draws together the analytical concerns expressed in *Part I* of this thesis with the experiences, hopes and concerns expressed by the research participants in Chapter Twelve.

PART ONE: THEORETICAL FOUNDATIONS AND CRITICAL REVIEWS

PART ONE: THEORETICAL FOUNDATIONS AND CRITICAL REVIEWS

Part I of this thesis outlines the core theoretical foundations and critical reviews presented in this thesis. The first three chapters, *Chapters Two* through *Four* provide a theoretical foundation from which to base this inquiry. The key theoretical tools include Kaupapa Maori theory and critical theory which have drawn from an in-depth understanding and commitment to Te Ao Maori. *Chapters Five* through *Nine* represent through literature the viewpoints of Maori relating to colonisation, health policies and reforms, concepts of Maori health development, Maori health, Maori health promotion and Maori health providers. These chapters locate the inquiry theoretically within the socio-political and cultural environment of Maori health. *Chapter Ten* presents a critical review of social marketing located within a rich contextual narrative concerning Maori health development.

CHAPTER TWO: THE FOUNDATIONS OF THE MAORI WORLDVIEW – TE AO MAORI

"Tenei au, tenei au, tenei au te hokai nei i taku tapuwae
Ko te hokai-nuku ko te hokai-rangi, ko te hokai
Ki te rangi-tu-haha, ki Tihi o Manono
I rokohina atu ra ko Io-te-matua-kore anake
I riro iho ai nga Kete o te Wananga:
Ko te Kete Tu-a-uri
Ko te Kete Tu-atea
Ko te Kete Aronui
Ka tiritiria ka poupoua ki a Papa-tu-a-nuku
Ka puta te ira tangata ki te whaiao
Ki te Ao marama!

Here am I, here am I, here am I
quickly moving by the power of my karakia for swift movement.
Swiftly moving over the earth,
swiftly moving through the heavens,
the swift movement of your ancestor Tanenuiarangi who climbed
up to the isolated heavens,
and there found Io-the parentless alone.
He brought back down the baskets of knowledge,
the basket named Tu-a-uri, the basket named Tu-atea,
the basket named Aronui.
Portioned out and planted in Mother Earth,
the life principle of human beings comes forth into the dawn,
into the world of light"

2.1 INTRODUCTION

> The worldview of the Maori is encapsulated in whakapapa, the description of the phenomenological world in the form of a genealogical recital. Implicit in the meaning of whakapapa are ideas of orderliness, sequence, evolution and progress (Walker, 1996, p. 13).

In this chapter, I seek to demonstrate that Te Ao Maori is a necessary philosophical foundation for being Maori. The first section explores various philosophical, metaphysical and ethical foundations of Te Ao Maori drawn from traditional Maori myths and legends. In the second section, a series of Maori concepts are provided to demonstrate the various principles of living that constitute Te Ao Maori and inform the contemporary organisation of Maori affairs. The final section provides an overview of the challenges related to living by the principles of Te Ao Maori in contemporary New Zealand society. This

section is presented against a historical backdrop which Belgrave describes as a time when Maori were "restricted by the loss of resources, by a lack of recognition by the courts and Parliament and by the persistent and prolonged promotion of individualism and assimilation" (cited in Law Commission, 2001, pp. 26-7). This chapter provides a glimpse into the Maori worldview and outlines some related thoughts and opinions expressed by Maori academics and leaders.

2.2 FOUNDATIONS OF TE AO MAORI – MAORI KNOWLEDGE

Te Ao Maori consists of a set of metaphysical, ethical, ontological and epistemological indices that give credence to being and thinking Maori - the Maori consciousness. To some, it is what constitutes the Maori mind, or the Maori psyche (Durie, 2001). To others it is what encapsulates Maori knowledge. The concepts and institutions interact with and merge with each other to form a whole institution or philosophy (Pere, 1984a). They are not a static set of principles and concepts; instead, they are subjected to further processes of enculturation particular to various Hapu and Iwi. Traditionally Maori people shared knowledge through oral traditions such as korero, waiata and whaikorero. Through these traditions Maori methods of knowledge formation and customs were intergenerationally transmitted, renegotiated and manifested in practice. The understanding of the inception of the Universe was one such example and is deeply connected to ideas about personal and collective well-being. Through these stories, Maori people exhibit a specific cultural way of conceptualising not only time and space but also other universal phenomenon.

2.2.1 Maori Cosmology

Shirres (1997) suggests that traditionally Maori believed that the whole of creation is a dynamic movement "i te kore, ki te po ki te ao Marama – out of the nothingness, into the night, into the world of light" (1997, p.16). The cosmological narrative involves teachings from two distinct schools of thought. The first version constitutes the practical application of knowledge and consists of applying proper names to the phenomena of nature and arranging those phenomena into an ordered sequence likened to "a genealogical table of human descent" (Buck, 1950, p.433). In this ontological framework, the first stage of the inception of the

Universe involved the nothingness or Te Kore. Barlow (1991) suggests that Te Kore is articulated as a space with nothingness, but instead it should be looked at as the initial conception point for all things Maori. The second phase was a period of darkness named Te Po. Various stages of Te Po prevailed such as Te Po nui and Te Po roa. Buck (1950) explained that various Iwi had different versions of the depictions of Te Kore and Te Po and each of them is meaningful in their own right. Each stage in his view outlines the cosmological ages preceding the birth of the gods.

The second school of thought called the esoteric version claims that Io metaphysically generated the world out of chaos, created life and caused the gods to appear (Buck, 1950). Shirres (1997) says the process was about understanding that the Universe was evolving. It is a model of the Universe made up of at least two worlds intimately linked, a world of spiritual powers and the material world we see around us. For Walker (1996), the periods Te Kore, Te Po and Te Ao Marama represent three different epochal periods in which the Universe developed. Te Kore and Te Po were periods that were succeeded by Te Ao Marama, the world of light in which humans exist.

In the creation stories, underpinning Te Ao Maori, the Sky father Ranginui manifested as the male element and partner to Mother Earth, also known as Papatuanuku and representing the female element developed spontaneously during the period of Te Po. During that period Ranginui covered the nakedness of Papatuanuku by covering her body with plants and vegetation. Insects and reptiles were put in the vegetation and shellfish in the waters. The completion of the various stages of po conclude with the union of Ranginui and Papatuanuku and the bringing forth of their progeny. It is said that Ranginui continued to cling to Papatuanuku and by this destined his children to eternal darkness (Walker, 1996). The brothers were unhappy being confined and after consulting each other, and with the exception of Tawhirimatea they decided to separate their parents to allow light into their world. Tanemahuta conjured up the idea of placing his hands on Papatuanuku and his feet thrust against Ranginui severing them from each other and pushing Ranginui towards the heavens. The number of their children accounted for in the stories varies from seventy to the more

commonly accepted number of seven (Buck, 1950) or sometimes six (Walker, 1996). These children were allocated specific responsibility for care of defined aspects of their world. The children became the personification of the natural elements with the spiritual powers. For example, each god or atua is identified with a particular area of creation and has responsibility for the following areas:

- Tane Mahuta is personified as the atua of the standing forest and produced trees, insects, forests and birds. He is also considered to be the progenitor of humans
- Tumatauenga has authority over warfare and human affairs
- Rongomatane is the atua of all cultivated foods and peace
- Haumietiketike is the personification of uncultivated food such as wild fruits, fern root and other indigenous plant life
- Tangaroa holds the domain of the ocean and all its creatures. He also controls the tides and looks after seafarers and fishermen
- Tawhirimatea controls the winds, storms and other meteorological aspects (Kamira, Mariu, Jones, Ellis, & Richards, 1998; Roberts, Norman, Minhinnick, Wihongi, & Kirkwood, 1995).

According to the Ranginui and Papatuanuku model of the Universe, humans identify themselves with different spiritual powers. In Shirres (1997) view, it is from the spiritual powers that humans receive their worth, their intrinsic tapu and it is from there that power or mana is received to carry out their respective roles as human beings. The personification of these atua is a distinctive aspect of the Maori worldview. The natural environment is seen as the embodiment of their atua in their domains, through which the relationship between them and Whanau resides. Walker (1996) says that some of the primary values of Maori culture are told within the creation myths. For instance, the food that grows from Papatuanuku sustains life and the practices acknowledged by those who recognise Papatuanuku attend to her care and embody this acknowledgement in rituals of gratitude through karakia kai. For those reasons, Papatuanuku is consistently acknowledged in waiata and stories for her caring and nurturing qualities.

The interconnection of Papatuanuku with the concept of whenua (a term applied to the earth as well as the placenta), demonstrates that people of the earth are born

out of the placenta. As the human mother nourishes her child in the womb and then upon her breast, so too does Papatuanuku nourish humanity (Marsden & Henare, 1992). Humanity is part of this network and the other forms of life such as the birds, trees, animals and plants are siblings. To highlight the symbolic connection, when a child is born it is traditional for the placenta of Maori children to be returned to the land, back with Papatuanuku. In performing that task, the child is forever bonded to the whenua and the people of that whenua (Palmer, 2002). When someone dies, death is conceptualised as a return to Papatuanuku (Walker, 1996).

Marsden and Henare (1992) suggest that the role of humanity in the greater scheme of things is as the kaitiaki or caretaker. In their views, humanity is the consciousness of Papatuanuku and plays a vital part in the regulation of her life support. Humanity's key role is to improve and sustain those systems. Because of the overlay of European ideas, imposed over the period of colonisation, those principles have been forsaken by those who now govern the regulation of the natural environment and human systems of organisation permitting in the process the perception of Papatuanuku as a commodity where her natural resources are seen as disposable property to be exploited.

Maori myths and legends (as with myths and legends in all societies) form an integral part of the body of fundamental knowledge held by Maori philosophers. Yet, western colonisers and current administrators dismiss these myths as superstitious imaginings of native subordinates. According to Marsden and Henare (1992), that depiction cannot be further from the truth. They state that these myths and legends are Maori cultural constructs employed by tohunga and rangatira to encapsulate and condense into easily digestible forms their views of the world. In addition, from these constructs come the cultural pattern perceptions that perceive what reality should be, they therefore encapsulate an ethical mandate. These conceptualisations constitute what is termed the worldview, which Marsden and Henare (1992) see as

> the central systemisation of conceptions of reality to which members of its culture assent and from which stems their value system. The worldview lies at the very heart of the culture, touching, interacting with and strongly influencing every aspect of the culture. In terms of Maori culture, the myths and legends

> form the central system on which their holistic view of the Universe is based (p.6).

An example of the transmission of ideas and value through myths and metaphor is the story regarding the three baskets of Maori knowledge. In Maori traditions, Tanemahuta climbed to the highest heavens and retrieved the three kete of knowledge (Shirres, 1997). The Kahungunu people have a different set of names for the three kete. There is te kete uruuru matua, the kit of knowledge, peace, goodness and love; te kete uruuru rangi, the kit of all the prayers, chants and rituals utilised by people; and te kete uruuru tau, the kit of all the knowledge of war, agriculture, earthwork and stonework (Percy Smith cited in Shirres, 1997).

Marsden and Henare (1992) provide an in-depth explanation of the three kete: Ko te kete Tuauri, ko te kete Tuatea and te kete Aronui[4]. Te kete tuauri literally means *beyond the world of darkness.* This is the world behind sense perception of the natural world. It is the world where a complex series of rhythmical patterns of energy to uphold, sustain and replenish the energies and life of the natural world. Four concepts are said to operate in balance within this realm – mauri, hihiri, mauriora and hauora (Marsden & Henare, 1992)[5]. Te kete aronui is translated as *that before us and that before our senses.* This is the world around us as apprehended by our senses. With respect to this kete it is the knowledge concerning traditions that are passed down to us through experience, through whakapapa and such lore is carefully minded and transmitted. For example, the types of techniques used for testing poisonous trees or foliage and berries were included. Te kete tuaatea is the knowledge that is beyond time and space. Traditionally, people saw space and time as bounded together and interdependent. For instance, space begat time and time begat space and both interconnected to form one realm (Marsden & Henare, 1992). This concept suggests that the Universe is infinite in extent and relative in time. It represents the infinite and eternal.

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[4] The basket named Tuauri, the basket named Tuatea and the basket named Aronui.

[5] Mauri – is a life force that interpenetrates all things to bind and knit them together. Hihiri is translated as pure energy or a refined form of mauri. Mauriora is the life principle or the bonding force which is further refined beyond pure energy to make life possible and hauora is the breath or wind of the spirit which was infused into the process to birth animate life (Marsden & Henare, 1992).

Within Maori traditions occasionally it appears that one is meant to acknowledge the teachings of the elders as authoritative, rather than to scrutinise that authority or negotiate with it for application to current issues. Marsden and Henare argue that the traditions themselves and the desire to acquire learning from those traditions are two different things. Patterson (1992) suggests that all the full range of human intellectual tools should be utilised by Maori to forge that greater understanding. For instance:

> Knowledge and wisdom are related but different in nature. Knowledge is a thing of the head; an accumulation of facts. Wisdom is a thing of the heart. It has its own thought processes. It is there that knowledge is integrated for this is the centre of one's being (Marsden & Henare, 1992, p.11).

Expressions of Maori knowledge relate to a complimentary world of symbol. According to Marsden and Henare (1992), the world of symbol is a deliberate human creation. They argue that humankind used symbols to depict perceived reality: words, formulae, forms, ritualistic ceremonies, interpreted stories, maps, models, paradigms. These forms were visualised within the mind as a way of understanding the world behind space and time. Marsden and Henare state that there are two types of symbol. One type is reserved for the revered attendant such as tohunga and the other type is more commonly made available.

2.2.2 Maori Narratives

The narrative or story that underpins Te Ao Maori is an essential component of knowledge building and manifestations of values into practices. Each Iwi and Hapu has their own stories about people, whakapapa and endeavours. In Tauranga Moana, the place of this research, there are stories that depict the specific regional, historical and cultural foundation of knowledge for Iwi in the area. One story for instance is about the nameless one and how he became named Mauao – meaning *caught by the light* - the majestic mountain now situated at the end of the Mount Maunganui peninsula (A. Ngatai, 1995). Intertwined within Iwi narratives is a series of teachings that provide people with a means of understanding not only about how Maori portrayed knowledge and how meaning could be derived from those stories, but also how the essence of culture is imparted through values, beliefs and customs that are included within the stories. The creation of humankind for instance is one such narrative in which

Tanemahuta created Hineahuone from earth, and later co-habited with Hinetitama his daughter. Once Hinetitama became aware of her husband being her father, she fled in shame to the underworld symbolically acting in the role as the kaitiaki of those who have passed away. This story is related now to form contemporary agreement that incest is a type of sexual behaviour between family members not deemed appropriate by the wider community.

In Maori philosophy, the atua are sources of knowledge and intermediary ancestors between atua and humankind acquire knowledge from their ancestors and transfer it to humankind - Maui fulfilled that intermediary type role. Walker (1996) states that Maui was the archetype cultural hero who in the face of adversity overcame many challenges. His endeavours prove to his younger siblings that they can succeed provided they hold certain attributes. Some of those attributes included: intelligence, cunning, initiative, boldness, fearlessness, determination, courage and bravery. In one of Maui's first endeavours, he deceived his mother by finding his father against her wishes. Maui's plight to find his father highlighted the importance of that relationship. Finding his father ensured that the performance of the purification tohi validated his standing in the world. With that ritual completed, Maui set about acquiring knowledge from his kuia Murirangiwhenua and Mahuika. In both cases, the knowledge he sought was gained by asserting certain leadership traits. By behaving this way, he challenged the relationship between the young and old and by doing so, he provided space for youth to assume roles of leadership (Walker, 1996). In Maori traditions, Maori elders are keepers of knowledge (Walker, 1993). Those bequeathed with that knowledge do not surrender it lightly. Some fear that knowledge directly influences one's status and mana and sharing it with others decreases that status. Others are concerned that the knowledge is significant to Whanau, Hapu and Iwi and that significance will be lost and/or abused if the information is shared (Marsden, 1992). Although Maui was acknowledged for his quests to fish up Te Ika a Maui – the North Island and the slowing of the sun for the benefit of all humankind there is one feat he failed to overcome. Maui sought immortality from Hinenuitepo, the goddess of the underworld. Before he could achieve those ends, the goddess crushed him and his failure explains human death. In the Tawhaki cycle of myths, there is a continued exploration of reinforcing and validating

Maori culture and customs. As Walker (1996) points out, the themes include amongst others: conflict with brother-in-laws, the pursuit for revenge, the naming of a song to commemorate conflict and the duty of underlings to recover the remains of their perished Whanau member from enemies.

The mythological guides for Maori customs and their manifestation in social practices and behaviours were based in pre-migration times. It is said that the endeavours of real men were not illuminated until the migration excursions from Hawaiki to New Zealand. An essential element of those templates was based on whakapapa and the genealogical connections between the atua and humankind. Walker says that only those ancestors that had pivotal roles in the transformation of the Maori world were recorded in the whakapapa. Tribal whakapapa was taught in schools of learning such as whare wananga. Whakapapa was maintained by tohunga, who were in turn taught to ensure that the tapu of that learning remained sacrosanct. That distinct and untouched relationship between what is tapu and knowledge contributed extensively to what is commonly regarded as the foundation for the Maori consciousness.

2.3 MAORI CONSCIOUSNESS – THE MAORI MIND

Marsden (1992) suggests that the retelling of Maori history by describing events that occurred and the heroes and villains associated with those pieces of history, is only one aspect of the Maori cultural set. He was deeply concerned with the lack of exploration of the inner consciousness of the Maori mind undertaken by Maori scholars. In his view, only an approach that describes the main features of the consciousness of the Maori offers a way of looking at what is regarded as the Maori worldview. Abstract rational thought and empirical methods cannot grapple with the actual act of existing, which is fragmentary and incomplete. The only way forward in his view is through a passionate, inward subjective approach. He further reiterates that for an individual to become fully immersed within society over a long period, formal schooling is inadequate, the living situation or immersion is recommended instead. Marsden and Henare (1992, p.12) support this idea:

> A truly educated person is not one who knows a bit about everything, or everything about something, but one who is truly in touch with his centre. He

> will be in no doubt about his convictions, about his view on the meaning and the purpose of life and his own life will show a sureness of touch that stems from inner clarity. This is true wisdom.

What Marsden and Henare attempted to demonstrate is that people must intimately understand more about themselves instead of taking for granted their Maoriness. People must therefore possess a sense of consciousness about what being Maori is about. Apirana Ngata presented the importance of maintaining a commitment to cultural enlightenment as a constant theme. In a tribute to Apirana Ngata by editors of the New Zealand Polynesian Society in 1951 it is noted that:

> The success of Ngata's efforts can be seen in the tremendous development of carving and other house crafts in the past twenty years, the revival of interest in traditions, in songs and dances and above all, in the growth of the Maori consciousness and self-confidence. This was Ngata's greatest achievement (Journal of the Polynesian Society, 1951, p.14).

Part and parcel of understanding Maori consciousness is the need to draw upon and look further into the cultural basis for Maori, which is reflected through Maori concepts as one way of delving further into the minds and hearts of people adhering to the principles of Te Ao Maori.

2.3.1 Maori Concepts

A pathway to understanding more about the philosophical commitments of Maori requires the examination of specific cultural concepts that cascade against a contextual history of anthropological and socio-cultural reflection of being Maori. Maori philosophy did not exist independent to or disconnected from the various events and context in which Maori existed. As such, what are often referred to as Maori concepts are viewed as Maori ideals; as with many cultures they form the epitome of Maori tikanga, customs, worldview and sense of being. However, equally important is the realisation that Maori ideals as with any type of ideals are not always achievable. Rather, they are explicitly stated aspirations. Mead (cited in the Law Commission, 2001) differentiates between the knowledge or ideal base (matauranga) and the practice of tikanga (te whakahaere) allowing for various interpretations of practice to be shared. Mead argues that tikanga varies from tribe to tribe because of the contextual environment in which they are practiced.

2.3.2 Te Reo Maori

The very essence of what is Maori and the activities that characterise being Maori are intimately connected to Maori language. It is the very vehicle through which the essence of the Maori worldview is expressed. Commentary on language significance often relays the incommensurability of Maori knowledge with Pakeha translations of Maori knowledge. Laden within words and terms is a mass of culturally specific meanings that go beyond the surface semantics of terminologies. According to Pere (1997) language is

> the lifeline and sustenance of a culture. Language is not only a form of communication but it helps transmit the values and beliefs of a people. Te Reo enshrines the ethos, the life principle of a people. It helps give sustenance to the heart, mind, spirit and psyche. It is paramount (p.9).

In the report of the Waitangi Tribunal on the *Te Reo Maori Claim* in 1986, Te Reo Maori is viewed as the very fabric of Maori existence. One statement outlined in the report said

> there is a great body of Maori history, poetry and song that depends upon the language. If the language dies all of that will die and the culture of hundreds and hundreds of years will ultimately fade into oblivion. It was argued before us that if it is worthwhile to save the Chatham Islands robin, the kakapo parrot or the notornis of Fiordland, is it not at least as worthwhile to save the Maori language (The Waitangi Tribunal, 1989, p.1).

Language is integrated with culture and the two dimensions together serve as a foundation from which one might experience Te Ao Maori. The importance then, of reiterating Maori concepts and explaining what spiritual, emotional and behavioural attitudes and behaviours result from the adoption of these concepts was not overlooked by those Maori academics who over the years have committed their works to writing (G. Smith, 1997; L. Smith, 1999a). The importance of these culture-language-settings was highlighted in a recent publication by the Ministry of Justice (2001). The Director of the research project, John Clarke and his colleagues, captured narratives about Maori tikanga to develop a greater understanding of Maori perspectives on justice. A key emphasis of their combined efforts was to present "a mixture of psychological, cultural and theological principles that help interpret the Maori mind" (Ministry of Justice, 2001, p.vii). It is constantly stated that if the language is not spoken it will die (Te Puni Kokiri and Te Taura Whiri i te Reo Maori, 2003). There is a threat then that its utility as a vehicle to express thoughts, customs, desires, hopes, frustrations,

history, poetry, metaphor, dreams, prayers, idioms and knowledge will also be lost and with its loss will come the loss of mana, well-being and life.

2.3.3 Whakapapa

The literal meaning of whakapapa is *to lay one thing upon another* (Barlow, 1991) or to lie one generation upon another. The concept of whakapapa or genealogy is not unique to Maori. What is unique however, is the way that whakapapa is used to organise Maori society and the way it is also used to facilitate both expression of identity, as well as the means for social change. Whakapapa is both the actual and symbolic representation of Whanau, Hapu and Iwi (Pere, 1984a). From a traditional perspective, whakapapa and mana were interrelated through chiefly lines of genealogy and the ability of descendants to connect with those chiefly lines. For instance, the following pepeha helps illustrate:

Ko Mauao te maunga	Mauao is the mountain
Ko Tauranga te moana	Tauranga is the sea
Ko Ngaiterangi te Iwi	Ngaiterangi are the people

This proverb serves as a means to identity by way of whakapapa the significant landmarks that present a connection to Papatuanuku (King, 1992). It is not uncommon for these proverbs to depict a binding relationship between people and the land. The connection between Maori and the land is therefore a spiritual, cultural, emotional and genealogical one (H. Mead, 2003). The recognition afforded to these significant landmarks and the representatives of those regions is also an indication of mana. What this means then is that mana does not reside solely within the person or the people; it is also an inanimate concept emanating from the land and those things in and around the land. When visiting people enter into the region of another people, it is respectful to not only acknowledge the people but also the significant landmarks that are associated with that people e.g. their mountains, rivers or other significant bodies of water (H. Mead, 2003).

2.3.4 Mana

The term mana is closely associated with several different meanings (Durie, 1994b). In a traditional context, mana means spiritual authority and power (Marsden, 1992) and relates to certain abstract conceptions of a spiritual phase of

mankind (Gudgeon, 1905). The contemporary interpretation of mana is collegial depicting a sense of respect, for a person in terms of his or her status in society (H. Mead, 2003). As a result of the dissipation of customary Maori lore and retribution using concepts of tapu and noa, the spiritual association that mana possessed in the past, may not always be as prevalent today. For instance, the awe and fear associated with traditional leaders and translated directly into a form of power observed in battle and warfare, in spiritual ceremonies and on specific excursions is not readily observed in these modern-day times. One of the reasons for this is that the context of battle and warfare of a physical nature has disappeared over time. The taken for granted assumption that mana maps automatically to a western influenced discourse of power is simply not correct. Mana then can be interpreted to mean respect, power, status, authority, awe and even fear and it can be emanated from both things animate e.g. people and nature, mountains or taonga (Barlow, 1991). Today, those people with mana continue to hold the esteem of their tribe as their most important consideration e.g. Te Ataairangikaahu – Maori Queen.

2.3.5 Wairua

Wairua is often literally interpreted as the spirit form of humankind (Shirres, 1997). The conceptualisation of wairua is not isolated to people as even the earth, animals, birds and fish are said to have a spirit as well. This understanding is consistent with the notion that when people die, their physical form returns to Papatuanuku but their spiritual self travels the pathway of Tanemahuta to the atua that created them (Barlow, 1991). It is not uncommon for people to refer those who have recently passed in their laments back to the Hawaiki, the ancestral place of Maori people. An excerpt by Karetu (cited in King, 1992, p.34) highlights the spiritual connection between people at metaphysical levels:

> Haere e hoki i runga i o koutou waka
> Ki Hawaiki nui, ki Hawaiki roa, ki Hawaiki pamamao
> Ki te hono i wairua
>
> Go, return to your canoes
> To Great Hawaiki, to Long Hawaiki, to Hawaiki of the Great Distance
> To the Gathering Place of the Spirits

More recently the acknowledgment of the wairua is contained in the term taha wairua or the spiritual side (McGowan, 2000; G. Smith, 1992). Maori in general feel that it is the most essential component of a person's being. Durie (1994b) states that without a spiritual awareness and a mauri (spirit or vitiality) an individual cannot be healthy and is likely to endure more illness and pain. Being spiritual ensures that one encompasses religious beliefs and practices that include but are not restrained to a belief in god. There is also a spiritual connection that one has with land, lakes, mountains, which is quite distinct from other considerations. Having an understanding of wairua is also connected to understanding concepts of tapu, noa and mana.

2.3.6 Mauri

Mauri is a special force, life principle, vitality or ethos of all things that is derived from the atua. Everything has a mauri including people, fish, animals, birds, land, forests, buildings and some forms of possessions. According to Pere (1984a) mauri involves the belief of a people and is therefore real and meaningful to those people. Pere argues that a person's mauri is reflective of the way in which he or she is respected and valued within a community. Should he or she not be able to make a positive contribution from their person their mauri may wane.

The physical symbols that are imbued within the mauri possess certain powers. The mauri of the kumara for instance is seen as a symbol that contains fertilising properties and is therefore crucial to the production of kumara plantations (Pere, 1992). Particular influences can either strengthen or weaken the mauri of a person or thing. Barlow (1991) also says that people cannot control mauri, but they can establish it. As an example he discusses how a building can have a mauri that is created once the building is established. Maori are reclaiming the notion of mauri as a central life-force of people, nature and even buildings. In this thesis, we look at mauri as a way of articulating the interconnected balance and pure energy between all elements – tinana, wairua, hinengaro, Whanau and te ao turoa. The flow of mauri, it's nurturing and protection amongst people, places and other creatures is essential for good health and vitality.

2.3.7 Tapu

The concept of tapu is closely associated with restriction or sacredness and it is viewed as the potentiality for power. Marsden (1992, p.121) defined tapu as:

> The sacred state or condition in which a person, place or thing is set aside by dedication to the gods and thereby removed from profane use. The tapu is secured by the sanction of the gods and reinforced by endowment with mana.

There is also the belief that if tapu is transgressed, ill fortune will fall upon the perpetrator. These meanings however are not the only interpretations of tapu. Shirres (1997) proposes that there are two elements to tapu; one based on reason and the other upon a religious or spiritual connotation. Both explanations however, link tapu closely with mana. According to Shirres (1997) tapu is intrinsic and all things possess an element of tapu based on their existence.

According to Mahuika (1992), both mana and tapu are said to come from the gods and therefore possess a spiritual relationship. Because of the tapu a chief possessed, they were regarded with a formidable respect. So great was this tapu, that some chiefs just by occupying a certain place for a short time, were said to make that place tapu. The violation of a chief's tapu usually ended in death. Marsden (1992) says that tapu also has a legal connotation. He notes that a person, place or thing is committed to the gods and by that act it is reserved for their sole use. It is untouchable and no longer available for common use. This relationship is a contractual one between the individuals and their deity, where they dedicate the place or thing to service of a deity in return for fortification against malicious forces teamed with the power to manipulate the environment to meet ones needs. The entering into this relationship was performed by tohi, or a series of karakia (Buck, 1950). In terms of bestowing mana, it is said that the spirits of gods guided and directed those who were said to possess mana such as rangatira or tohunga and in doing so, they are said to also be tapu. Tapu therefore can be seen as an institution of natural lore where the codes of restriction were adhered to for want of not offending others or bringing ill-fortune to ones person or family. Pere (1984a) outlines a number of interrelating factors that help explain the sanctity of the lore according to Maori custom. Knowledge was also seen as tapu and those who were fortunate enough to be taught specific

information were also tapu. An excerpt from Te Uira Manihere of Tainui explains:

> Tapu has to be held in the highest esteem. You see in people, it is not in the hands: it is in the head, in the crown. In the old days, you could never touch the head. We take it seriously, knowing that it survives. In particular it protects us from the temptations of the modern world. We may put on Pakeha clothes, we may eat Pakeha food. But deep inside we are Maori at heart and tapu will stay with us forever (cited in King, 1992, p.9).

And Ngoi Pewhairangi states:

> When you learn anything Maori, it has to be taken seriously. It involves the laws of tapu: genealogies, history, traditional knowledge, carving, preparing flax, in fact nature itself. Tapu is something that teaches you how to respect the whole of nature because Maori things involve the whole of nature....Some people Maori and Pakeha, say 'why don't those old people teach us how to do this?' But they don't realise it goes deeper. Only certain people can teach. It's like the Pakeha system. Only certain people can teach law, and certain people become statesmen. The same is with the Maori. Only certain people, certain families, inherit these different aspects of our Maoritanga and are entitled to pass it on (in King, 1992, pp.10-11).

2.3.8 Noa

The concept of noa is part of a dualism related to tapu. The two concepts feature as components of a type of equilibrium or synergy where one balances the other (Durie, 1994b). Pere (1984a) expresses a difficulty in explaining what the concept means as it is interconnected and merges with many other Maori concepts. She claims that it is applied to everyday living and ordinary situations whilst at the same time being an essential component of formal and complex rituals and ceremonies. The function performed by noa is that it releases people from a state of restriction and influence that is imposed by the concept of tapu.

The process of making or bringing about whakanoa is part of a particular process which traditionally related directly to some form of interaction with the metaphysical realm. For instance, Shirres (1997) says the karakia pertaining to the cutting of a child's hair is performed to state that the child now bound to the atua Tumatauenga is free from any restrictions and can go freely. Today, the process of whakanoa can be observed at the completion of powhiri when the process of welcoming people on to the marae has been completed. At the end of the formalities the people are greeted and then the process of eating kai after the powhiri or washing hands is seen as the process of whakanoa. In this regards,

water plays an important role in facilitating whakanoa. Durie (1994b) outlines the process when a person has taken ill, and the immersion of that person into running water as a means of removing tapu and as a cleansing ritual. It is common to see water readily available at the entranceway to urupa or near wharenui during tangihanga. Both noa and tapu also had a meaning in health: noa denoting safety and tapu denoting protection.

2.3.9 Whenua

There are two different interpretations of the concept of whenua in Maori philosophy. The whenua is the placenta of a newborn child, which nourishes the child while it is in the womb. It is also the term used for land, which is conceptually known as Papatuanuku the Earth Mother and nurturer of humankind. The wellbeing of Maori is intimately connected to the land that he or she is affiliated. The process of expressing an affinity to the land is also part and parcel of the nature of the affiliation. For example, Whanau and Hapu controlled, guarded, developed and cultivated the land with which they identified and tribal boundaries particular to the land are included within that psychology related to the land. The tribal zone in which people affiliate is not only an ancestral domain to which living generations associate their custodian roles it is also a place where people live according to their traditions and customs.

An individual demonstrated his or her worth in the community through the land and its natural resources. Labouring to procure the land for planting and harvesting crops was an important feat in its own right. Also characteristic to the concept of whenua is the sense of non-use. It was not uncommon for large tracts of Maori land to remain uncultivated or unused and that status was not seen as problematic or inconsistent with the notion of whenua. Indeed, the commodification of land is a contradiction of the concept of whenua, discussed in the Prologue - is a form of violation now extended to the commodification of biological material and intellectual property more generally. Pere (1984a) comments that the concept of property ownership in line with European philosophy is sometimes problematic for Maori as the association to that land is consistent with the concept of whenua which is not always observed.

Pere (1984a) says the urge to return to the whenua by those who live in different regions throughout the country is all part of the process of affiliating with the land. When children are born it is still common practice to return the placenta of the child to the land, and when a person passes on it is common for people to return home to be buried. In our community, one of our relations who had left the area when he was twenty years old, returned home in his eighties as an elderly man. He died later that same year and in accordance with tikanga Maori he was buried back in his tribal area. There are other spiritual characteristics of land that are reflected in waiata and also whakatauki. For example, Tuhoe are known as the people of the mist or sometimes people of the bush and Te Arawa people are regarded as people of the lakes. This way of identifying people has become a metaphorical expression of identity.

The concept of whenua is also related in ways to tapu and mana. A tribe as part of fulfilling their necessary spiritual role minded vast terrains. Their members were able to access and procure many delicacies during the process of hosting others, and by doing so they were deemed to possess mana. When the Government took land from tribes throughout Aotearoa New Zealand, their collective ability to preserve the concept of whenua in accordance with established Maori philosophy was diminished. Bennett (cited in Patterson, 1992) argues that land also represents a common place of standing for Maori and is therefore a source of identity:

> Attitudes to land are many and varied but in essence the concept of turangawaewae is that the land becomes an outward and visible sign of something that is deeply spiritual. It is a source of nourishment to the inner man rather than to his physical needs. His identity belongs there, his sense of self awareness begins there, his sense of mana and importance belong there (p.90).

Whenua is therefore important to Maori wellbeing for a number of reasons; it is a source of spiritual reconnection to Papaptuanuku, it is the manifestation of the living nurturing mother and people often see whenua as a living breathing entity, independent in her own right. The concept of whenua allows Maori to find purpose and self worth by recognising that they have a place to stand, to feel, to be and to express that validates who they are as a people.

2.4 MAORI SOCIAL STRUCTURES

This section provides insight into the prevalent social structures within Maori communities. Maori people utilised a well-established system of social organisation. The basic unit of the Maori society was the Whanau, which often included three or more generations. At the head of the Whanau were kaumatua and kuia, rangatira and also tohunga.

2.4.1 Rangatira

Rangatira is the Maori term for chief. Rangatiratanga is the extension of chief, to mean chieftainship. Rangatiratanga according to Walker (1993, p.1-2) was concerned with the mana and mandate of a leader and the basis upon which a chief was able to be a leader. Ariki was another form of chieftainship reserved for those who were born from senior lines of the tribal genealogy. The criterion of a chief in traditional times included many of the following; whakapapa - it was believed that a leader (rangatira) resulted from the union of two chiefly people described as a moenga rangatira. Thus the whakapapa, or birth credentials of the leader needed to be right. A person born from a moenga rangatira inherited certain pumanawa or talents passed on from previous chiefly family lineage (H. Mead, 1997, p.197). Another criterion was acceptance by the people, which was conditional on qualifications of lineage, talents and also some evidence of expertise. The knowledge of the identity of the leader by other Iwi was also important and it is not unknown for Iwi to recognize leadership with a person whose name has been associated over time with a specific group of people. The turangawaewae principle, states that a person must be firmly grounded on land that is associated with a descent group to which the leader affiliates in order that the leader may call on symbols of the people; the mountain, the river and/or the harbour. Gender, was not normally a hindrance in terms of leadership. Women occupied certain leadership roles and the expectation was that they would fulfil roles similar to those of men (Mahuika, 1992).

According to Walker (1993), a leader who possesses all of the qualifications above and satisfies the criteria is a person said to have mana tangata. Leaders in traditional Maori society had the power and authority to punish and reward

members of the various social groups. However, the support of rangatira was necessary for the well-being of the collective. A leader needs the support of the people and this need for support disciplined the behaviour of the leader (H. Mead, 1997). Mana is both a precondition to the acquisition of leadership, and an outcome of performing leadership duties. In most cases mana was bestowed upon a person through chiefly whakapapa links, or it was acquired through battle. There were also classes of leader: rangatira, ariki and tohunga. Gudgeon (1905) comments that there are certain classes of mana, which appear to be the result of heredity links rather than religious ones. For instance, mana is said to be transmitted through famous ancestors and strengthened in every instance by the belief "that a man of this type must be under the special care of the gods" (Gudgeon, 1905, p.4). Mana possessed by rangatira is not an unconditional quality or possession and could be easily lost by the tribe, or by individuals. Once bestowed, mana requires maintenance by retaining the respect of the people.

2.4.2 Tohunga

Tohunga are specialists or experts who acquire respect from Whanau and Hapu members for their expert knowledge. They are people that possess certain talents in various areas such as whakairo, fishing, navigation and also medical diagnosis. According to Durie (2001), the tohunga in his or her role as the traditional healer had varying degrees of experience with massage, incantation, water therapy, suffusions and heat applications. Tohunga also possessed the capacity to combine physical treatments with ritual, symbolic, metaphysical, spiritual and naturalistic practices. Their knowledge to heal went beyond the standard knowledge of herbal properties (McGowan, 2000). Sometimes those who were identified with this special characteristic of a tohunga were identified early and trained accordingly (Moon, 2003). The tohunga as a ritual leader catered to aspects of healing and illness that prevailed within Maoridom and often these people were seen as tapu and they were therefore isolated from the common areas of the community. Mead (1997) notes that often a tohunga could also be the head of a Whanau, the rangatira and the ariki and the roles overlapped from time to time.

2.4.3 Kaumatua

The use of the term kaumatua is denoted as an expression for elders within the Whanau and Hapu. Sometimes the term is used to signal that someone has reached a certain age and in other occasions the term is more reflective of a leadership type position of one who possesses wisdom and mandate to speak on behalf of the people. In this modern context kaumatua, koroua and kuia are terms sometimes expressed interchangeably. The status of the kaumatua depends on whakapapa, age, wisdom and experience (H. Mead, 1997). However, the term is being more readily adopted today to denote all elderly Maori people.

2.4.4 Whanau

The concept Whanau has two meanings, it refers to the extended family or it can also mean to give birth. As mentioned earlier, the Whanau was the basic unit of Maori society and consisted in most parts of several generations of Whanau members including great grandparents, grandparents, parents and children. Traditionally, the Whanau served as a collective unit within the broader village complex and that unit held in common certain household items; fishing nets, fowling gears and canoes. Many items of the Whanau were shared. The Whanau also served as a working unit for cultivation, gathering of food and cooking. From this unit emerged the Whanau leader and the common binding element of the Whanau was whakapapa or descent lines.

Whanau remains as a fundamental unit within the broader Maori social structure despite its increasing diversity brought about by changing circumstances including the impact of colonisation and the forced migration in pursuit of economic livelihoods. For instance:

> Urbanisation, alienation from physical resources, loss of language and other cultural skills, limited access to society's wealth and frank oppression have combined to render many Whanau vulnerable (Durie, 2001, p.95).

Durie (2001) provides a typology of Whanau which resembles their contemporary realities as: kin, shareholders in common, comrades and a model for interaction, neighbours, households and Whanau as virtual collectives. Examining the status of Whanau within these frameworks gives rise to not only the diversity of the

contemporary Whanau by alluding to the issues in which they respond, but also the recognition that whakapapa, though essential for defining Whanau only forms one way in which contemporary notions of Whanau are expressed.

2.4.5 Hapu

The concept of Hapu (sub-tribe) has two meanings. Firstly, it means pregnant or to give birth. Secondly, it describes the way in which Whanau collectives combine together through whakapapa to form a sub-tribe. The phrase Hapu emphasises the significance of being part of a group and also expresses the idea of expansion, demonstrating that a Hapu is capable of containing many Whanau. When Whanau expand to the point where it was no longer feasible to be called Whanau, it was not uncommon for a Hapu to develop. Sometimes, when Whanau members fought, a younger sibling would form his or her own Hapu through the acquisition of land by occupation or conquest. In such cases, these groups would be allocated new names after the new emergent leader or in some cases an event.

Hapu are significant because they assume a political identity. They were seen as the entity in which Whanau were politicised as a group. Walker (1990) explains that the establishment of a Hapu was dependent on a number of criteria. One such criterion is that the group was led by a rangatira. The principal role of the rangatira was to ensure that the group continued to exist and that its common resources remained intact (Ministry of Justice, 2001). As time passed, the identification of the rangatira with the Hapu was acknowledged through close affiliations of the people with the overall marae, especially the wharenui. Later, the wharenui became the enduring symbol of the Hapu. The naming of Hapu was often the chief's name, which was prefixed with terms such as Ngati, Ngai and Te Ati. Traditionally, the allocation of land and the requirements of the various Whanau within the Hapu were managed according to their needs. Some of those needs included: defence, ceremonial and religious activities, cultivation and fishing, food collection and storage, political activities, land utilisation, the development of waka, whare and communal settlements, and hosting guests. Association with a Hapu depended greatly upon whakapapa that united the

families to cooperate and work in unison. Defence and the maintenance of alliances both political and economic were seen as important functions of Hapu.

2.4.6 Iwi

Iwi is a term used to describe one aspect of social organisation in Maori society. Iwi denotes tribe, Hapu refers to sub-tribe and Whanau refers to family. Conceptually, the term Iwi also derives from koiwi or bones and signifies a special bonding with ancestors. Because people are identified through their whakapapa, the metaphorical attachment of people as bones to their people and their land is significant. Metaphorically, bones provide strength, they make the body strong and they give the body shape and form.

Iwi are larger independent groupings of people performing large politico-economic duties on the basis of the interconnections with Hapu (Walker, 1990, 1993). Traditionally, Iwi occupied regions, which they defended against threats and invasions. Disputes would normally be settled amicably unless battle was warranted to ensure that territorial integrity was maintained. As a collective, the Iwi formation was a tangible way in which to bind smaller political entities – such as Hapu, in times of warfare, political debates, economic opportunism and communal cultivation and harvesting. The performance of Iwi leaders was translated into the manifestation of mana and integrity of the collective (Ballara, 1998; Ritchie, 1992).

Although Iwi responsibilities are guided by traditional interpretations, there are numerous other formations of Maori groups that do not fall consistently within the traditional definitions. Some of those groups are Maori Councils, political parties, kohanga reo, incorporated societies and charitable trusts. All of these organisations have assumed some form of representative and organisational role with regards to Maori development although they emerge as non-traditional formations. Disruption of the bonds is deemed to impact health, or in the affirmative strong bonds bring good health.

2.4.7 Waka

The importance of waka relates to two main features of Maori social structure. Maori journeyed from Hawaiiki to Aotearoa by way of waka. Some of the names of waka include: Te Arawa, Aotea, Mataatua, Nukutere, Horouta, Mangarara, Ngatokimatawhaorua, Matahorua, Takitimu, Tainui and Tokomaru (Buck, 1950). These waka are referred to in waiata, stories and whaikorero explaining how Maori ancestors arrived in Aotearoa. The notion of waka serves as a political forum that unites Iwi. Although the links between Iwi from common ancestors is not as strong as with Hapu, when it is time to unite, the waka bond is used as a means of forming alliances. Walker (1990) says that the waka was only a very loose ideological bond. The Iwi of waka like the Hapu of the Iwi often fought each other. The waka alliances prevail today particularly with political and regional purposes such as with the political domain related to fisheries claims and also with respect to important matters that impact all Iwi nationally. The waka bond is also called on for contemporary use in sporting and culturally events (Ellis, Sperling, & Toma-Dryden, 1999).

2.5 NGA TIKANGA MAORI

Tikanga Maori literally means the correct Maori ways of doing things. It is therefore the practical manifestation of Maori knowledge and values. For instance, the practice of powhiri is performed for specific cultural reasons based on Maori values. As always, tikanga Maori and Maori values are closely interwoven and one does not occur without some reference to the other. Henare (1998 in the Law Commission, 2001) stated that tikanga Maori is the visual, symbolic or metaphoric representative of the ethics which underlie Te Ao Maori.

Linked to tikanga Maori is the knowledge inherent within Te Reo Maori. The two concepts of tikanga Maori and Te Reo Maori are interconnected. Understanding Maori language is therefore a window to the Maori heart. Karetu (in King, 1992) emphasises that the Maori language has much to offer those who care to examine its depth and beauty and the poetic figurative languages contained in karanga, poroporoaki, tauparapara, whaikorero, waiata, pepeha, whakatauki, haka and waiata-a-ringa.

The main features of the way in which tikanga Maori, Maori values and Te Reo Maori are intertwined and enacted pertain to the importance of collectivism or collective responsibility within Te Ao Maori. Maori society overall operated in accordance with an ethos of collectivism. If an individual undertook an activity individually, the impact of that activity would be borne by the Whanau and also the Hapu. For example, rangatira and kaumatua could not make unilateral decisions for the Whanau or Hapu without some form of consultation first taking place. Once that had occurred, the rangatira assumed the role as mouthpiece for the group. The Maori social structure system was thus an all embracing one where everyone had some form of place within the broader system of Te Ao Maori. Everyone therefore linked back to Whanau, Hapu, Iwi, Waka and all of those groups linked in some way back to the land as the common turangawaewae or place of standing for the person and the people in unison. The following concepts are examples of some of the ways in which Maori enact Maori values as practical activities.

2.5.1 Marae and Papakainga

The marae is a component of the papakainga. A marae includes a formal meeting house, with an open plan area called the marae atea in front of the wharenui. Included in the vicinity of the marae is an area for kai called the whare kai although it was not uncommon for people to eat out in the open (M. Ngatai, 2004). In traditional times, the entire pa or village would be centred on the marae and other whare would be closely erected near the wharenui and wharekai. The traditional whare were not the same as the ones today and most whare had dirt floors. In some cases temporary shelters were also constructed. There were also pataka or storage places, which were included in the marae complex. The marae served as a formal meeting area for the Whanau and Hapu and allowed rangatira to perform their duties as hosts with other visiting tribes from out of the region. There were also certain rules and regulations that determined the types of activities that were permitted on and around the marae complex that were closely associated with the lores of tapu. They also signified the realms of the different atua.

Traditionally, the papakainga was a broader concept that included hunting and fishing grounds, puna wai and streams as well as providing for areas that served as plantations and cultivation plots. Pere (1984a) for instance said that her papakainga included

> two underground springs, streams and a river as well as an expansive bushy area that provided birds and uncultivated foods; agricultural plots that provided good crops; and ceremonially restricted ground set aside for the burial of whenua and the dead....the papakainga also had several wharepuni and pataka for food. The cooking areas were normally sheltered and placed some distance away from the wharenui and the wharepuni (pp.28-9).

Another important aspect of papakainga is turangawaewae - a place of belonging. Pere argues that papakainga play an important role in ensuring that people have a physical place from which to manifest their identity as a member of a Whanau, Hapu and Iwi. The marae of today is where Maori hold together as much of the idea of papakainga as is feasible in their contemporary circumstances. For most, the surrounding lands and natural resources available to people such as fishing and hunting grounds have been severely restricted since colonial settlement. For others, new marae have been constructed in non-traditional circumstances to provide a place for the diaspora. The marae and papakainga are seen as the last places where it is possible to be fully and unapologetically Maori.

2.5.2 Hui

According to Pere (1984a), hui can mean put together, congregate, meet and assemble. It is about the gathering or meeting of people. The purpose of hui are varied. In some cases they are formalised processes relating to tangihanga, in other cases hui provide a forum for people to discuss greater issues of significance such as the political agenda related to land acquisition, or the course of action that might be taken as a result of a social issue that permeates through the Whanau of the marae and papakainga.

One of the purposes of hui is to enable senior members the chance to transmit whakapapa, mythology to their own descent lines and the Hapu as well. Pere (1984a) explains that the social interactions between Whanau members during hui is important because it strengthens whakapapa links and alliances and it also enables the host group to manaaki manuhiri. Walker (1990) explains that the

mana of the host is increased when the visitors are afforded the utmost hospitality. It is common practice for the Whanau of the marae to attend hui whenever they are in operation to give their support to the event, so that the mana of the Whanau and Hapu is upheld. According to Pere (1984a), the importance of hui to Maori well-being can not be underestimated. For many people there are limited opportunities to express ones taha Maori, except for hui. It is therefore a forum in which one can stand tall and display oratory skills and it is also a way of showing your respect when people have passed on. Hui serve as a way of expressing opinion about matters of the day. Hui are fundamental for organising Whanau members, and through hui people re-connect and form bonds that are required to enrich the identity of people, particularly when held at a marae.

2.5.3 Manaaki and Kai

Manaaki literally means to enhance or 'to aki' one's mana through the act of caring (Pere, 1984a). It is the responsibility of all Maori to ensure that manuhiri are afforded the utmost respect when they arrive within other tribal estates for hui or gatherings. One way of demonstrating manaaki is through the provision of kai, accommodation and entertainment. Pere (1984a) outlines that kai is associated with hospitality, industry, ceremonial rites, legends, endeavour, conflict, collective responsibility and courage. Every culture has its favourite foods and associated methods for acquiring those foods. For Maori seafood is a delicacy particularly for coastal tribes such as Tauranga Moana. For inland tribes the bush provides the delicacies. Maria Ngatai, a kuia from Tauranga Moana, provides an illustration:

> Just out here by Matapihi, there were also titiko and in some places around Tauranga you can get tio, pipi and tuangi. So, there were all sorts of fish, and other forms of seafood that were always plentiful (M. Ngatai, 2004, p.4).

Men fished and hunted for food and women cultivated vegetables and other forms of food. Much of the time was spent ensuring that there was enough food for Whanau and the wider community to eat. All of the people within the community combined their food contributions as part of a common meal that was eaten each evening (Buck, 1950). Despite the reduction in traditional food sources, the tikanga associated with the provision of food through manaakitanga is still a practice that is readily adhered to, particularly at marae. Manaakitanga can also

be expressed through the notion of aroha, which is the timeless and spiritual emotion that unites people, Whanau, Hapu and manuhiri. The provision and consumption of kai is also seen as a process of whakanoa. Access to plentiful, healthy food, where people were not dependent on a cash economy contributed to the overall health and wellbeing of pre-colonial Maori.

2.5.4 Whanaungatanga

Whanaungatanga is concerned with the practices that strengthen the kinship ties of a Whanau. Aroha is expressed through the practice of whanaungatanga and literally means to express affection for another person or people. Loyalty, obligation and commitment are common attributes that are expressed through the social system that nurtures the Whanau within Hapu and Iwi through the concept of aroha. The spiritual, psychological and physiological bond that people have to their Whanau members manifests into a strong supportive group in times of hardship. Pere (1984a) argues that the mental and physical wellbeing of the group depended upon the support systems that held Whanau together. As she points out, all Whanau members were required to come together as a strong functioning unit when necessary. It was also believed that there were certain Whanau members that were capable of giving spiritual protection to the members in times of hardship and uncertainty. The practice of whanaungatanga is facilitated through the manifestation of aroha, manaaki, tiaki and also of mana. A Whanau group was required to work together, to be seen together and to act in a certain way that strengthened the resolve and the mana of the group.

2.5.5 Kaitiakitanga

Kaitiakitanga is the manifestation or practice of the concept kaitiaki. Kaitiaki is traditionally seen as atua who perform the role of protection normally over sacred places and sometimes people. Kaitiaki can also be messengers and provide a means of communication between wairua and people. Kaitiaki can take on the form of fish, insects, birds, owls and even dogs. There is also evidence that kaitiaki are other forms of beings such as taniwha that look like logs or actual living whakairo. Barlow (1991) says that every Hapu and Iwi have their own kaitiaki and stories about kaitiaki. The active engagement of people with the

world of kaitiaki was seen by colonisers as psychotic and many people were institutionalised in western cultures for these types of behaviours. However, for Maori – the practice of kaitiaki through human interaction and spiritually is essential to good health.

Kaitiakitanga is the manifestation of the role of nurturer or protector over a particular area of sea, water, forest, land or cultural artefacts. It is closely associated with the natural elements and the term has become commonly taken up in a limited way by state entities such as the Department of Conversation and the Ministry of Environment. At its centre is a strong ethos that includes spirituality and eco-environmentalism. Kaitiakitanga therefore implies a sense of collective responsibility and wellbeing that relates to land and natural resources. There are practices related to restriction and protection, which serve as instruments of conservation (Kamira et al., 1998; Roberts et al., 1995).

2.6 CHALLENGES ACCESSING TE AO MAORI

It is important to acknowledge that Te Ao Maori has never been, nor exists now as a static system. Influential events in changing to a contemporary Te Ao Maori include the ongoing consequences of colonisation and contemporary assimilative pressures. Equally influential have been the series of reclaimed and reinvigorated practices such as rongoa Maori and mirimiri, challenging the restrictive measures placed upon the use of traditional Maori medicine in the early 1900's specifically with regards to the Tohunga Suppression Act 1907 (Dow, 2001; Lange, 1999; McGowan, 2000; Moon, 2003).

The educational movements of the kohanga reo, kura kaupapa Maori and more recently Whare Kura have forged the ground for the more recent expressions of being Maori (Jenkins, 2000; G. Smith, 1990, 1995). The launch of the Maori Television channel, in spite of the damning criticism from various quarters politically, economically and socially has been met by both Maori and non-Maori viewers with encouragement (Misa, 2004). The contributions made by Te Whare Wananga o Raukawa, Te Whare Wananga o Awanuiarangi and Te Wananga o

Aotearoa to uplifting the Maori spirit have not gone unnoticed (H. Mead, 1997; Walker, 2003).

The developments in the revitalisation of Te Ao Maori must in some way be situated within a broader philosophical discussion about Maori epistemology and ontology. To do so requires an exploration of Maori values, beliefs and customs. Patterson (1992) explores Maori terms and concepts, describes what he sees as the associated ethical practices and virtues associated with those terms then he provides a comparison of those Maori concepts where possible with European influenced philosophies. To provide an illustration:

> If we were to venture into the metaphysics that accompanies Maori values we would find that such pairs of equal and opposite forces are prominent: light and dark, life and death, male and female, tapu and noa. When things go wrong the trouble is often attributed to a lack of balance between one or more of those pairs of forces. Thus, the remedy is always a matter of restoring balance. Here we find a basic difference between Maori values and Pakeha values. The perfect Pakeha world contains only the good; the perfect Maori world contains light and dark, life and death, tapu and noa, always opposed but always balanced. When the Pakeha come to understand and appreciate such a worldview they have started to understand and appreciate a Maori point of view (Patterson, 1992, p.183).

Despite a re-energised appreciation of the value of Te Ao Maori, there are still unresolved issues particular to the impact of its vulnerability in the context of the overlay of dominant western ideals that has manifested in the growing number of estranged Maori throughout the country. Whilst there are Maori still living in rural areas who are closely affiliated to their ancestral lands through a process of 'ahi ka' -literally meaning that their 'home fires are still burning' (H. Mead, 2003). There are just as many Maori living in cities and towns who have lost contact with their Whanau both in the sense of connection of Whanau and in the sense of connection to land. Webster (1998) in *Patrons of Maori Culture* highlights that whilst many Maori participate in aspects of Maori culture within the traditional sense, there are those that do not actively engage the Maori way of life. For instance:

> Beneath this surface still are those who pass by the marae but will not stop, those who stay in their homes and go back to the hotel bar, those in the towns and cities or on the streets, who are too proud, frustrated or angry to come, or who have no car or money for petrol or bus fare or know no kin any more, who are too tired, whose parents no longer care or can't be found, all those in the gaols [jails], those already buried alone in ordinary cemeteries far from their kin, those who find out too late and those who will never know (Webster, 1998, p.47).

A strong and growing response to the wider range of wellbeing issues facing contemporary Maori is the re-invigoration of Maori identity, values and ways of being. Several recent publications by Mason Durie (1999; 2001; 2003a; 2003b) have highlighted a consistently important pre-requisite to Maori development as maintaining and increasing access to Te Ao Maori. Te Ao Maori however can not simplistically be acquired without some sense of deep inner conviction to be versed in Te Ao Maori. How that conviction can be transformed into a set of principles consistent with a contemporary sense of existence. The following section describes some of the obvious challenges associated with achieving those ends.

The challenge posed to many Maori people relates to how one can articulate Te Ao Maori today, as a consistent set of principles and beliefs about how one lives in this world and then, how that worldview can manifest into a set of principles and practice. In this thesis, I investigate the extent to which commitment to Te Ao Maori has transformed the way in which the delivery of health and wellbeing takes place. I argue that Maori wellbeing cannot be separated from its context in Te Ao Maori.

In my work, I have become aware that concepts about Maoritanga, about being Maori and about Te Ao Maori may become romantic notions that are not closely aligned to the person, the people nor their minds or hearts. Smith (1999a) highlights that concern in *Decolonising Methodologies.* She questions the practice of returning back to a form of traditional Maori essentialism as the panacea of Maori development. The other threat is that there is a fear of the unknown. Maori today feel pressured to fit the template of 'being Maori' and find that mould restrictive, oppressive and difficult to achieve and fulfil. The unnatural pressure to overtly express one's 'Maoriness' – often in a hostile environment is a phenomenon born from the impacts of colonialism which brings challenges and also opportunities.

I wish to digress for a moment to discuss the notion of being Maori in this contemporary time. During a tikanga wananga held at our local marae, I was exposed to a number of themes and concepts about being Maori that enabled me

to consolidate what I deemed as consistent contemporary approaches to being Maori. At the hui - being Maori was not about being normal, as the term might suggest semantically. It was about being different and cherishing that difference. This is a concept that Johnston (1999) uses often throughout her thesis on *He Ao Rereke: Education Policy and Maori Underachievement: Mechanisms of Power and Difference.* Being different in this sense has both positive and negative connotations. In my work, in and through this thesis, I cherish that which has provided me the opportunity to explore these issues at a much deeper level.

At an experiential level, Te Ao Maori is a spatial locator about being Maori. It is about the physical, mental and spiritual location in which one can be Maori. Unfortunately, there are fewer locations in which that can occur; there are kohanga reo, kura kaupapa, marae and hui; but even these places are being challenged in terms of their ability to maintain authentic difference and discussions about people of the hau kainga and their roles in maintaining ahi ka are important. The concept of ahi ka itself is traditional and reiterates the relationship that people have to the land (H. Mead, 1997). For example, I experienced over the three days of the wananga specific references to what being Maori within a framework of Te Ao Maori means within this contemporary time. It was about dealing with loss, about being thirsty for knowledge and not understanding exactly why you had not been taught Maori despite your parents being fluent speakers of the language. Contemporary Maori identity plays out a story of both loss and oppression that is complimented by youth who are buoyant ambassadors of language retention and prosperity.

There is a dearth of information and scope for being Maori at this time. In addition, the sacrifices for being Maori require personal commitment and perseverance that go beyond the realm of commitment. There is also a risk of over romanticising the place of Maori cultural identity today which is highlighted in the contrasting diversities of Maori reality. Webster (1998) for instance contrasts what he sees as the dangerously contradictory romantic notion of Maori culture based on traditions with a lucid expression of contemporary Maori existence:

> The other side of Maori culture is all around us and just as familiar as the lumpenproletariat of every city; far from uniqueness, harmony and wholeness it immediately and somewhat threateningly reflects New Zealand history and present society; the downcast uncomprehending eyes in response to spoken Maori; the insistent assertion of ignorance of Maori culture – 'I never learned any of that'; slaughterhouse gangs; two street maintenance workers leaning on shovels and watching a third dig around a water main; young unemployed eyes gazing expressionlessly from under a baggy stocking cap; battered women nevertheless staunch in standing up for their men; chain-smoking unto death; defiantly sprawling graffiti asserting that 'Maoridom is boredom;' street-kid 'homies' sleeping in derelict buildings; the shapeless threat of a motorcycle gang in the park; Black Power living in the midst of a 'traditional' Maori community; a Maori haka or war dance done not by a rugby team, but by the inmates of a [jail]; the laconic denial by an inmate tattooist that Maori motifs might be in need of the expert advice of Maori elders; every TV screen tuned into a Maori motif flown on the spinnaker of the Bank of New Zealand yacht in the America's Cup race; a jaggered scar where a piece is torn from the sacrosanct carving in the Maori meeting-house of a university most Maori can never hope to enter (pp.48-9).

Patterson (1992) argues that it is not enough to learn about some of the more visible and superficial aspects of Maori culture. That is tokenism, damaging and degrading. Although he was directing his thoughts to a predominantly Pakeha audience, his analysis drew upon an extensive scholarly and personal appreciation and understanding of philosophy that he possessed and a willingness to make a contribution to the scholarship in this area. Although this may be seen as problematic to some, his account is one of a limited number of scholarly contributions towards Maori philosophy. Therefore, his work must be seen as a contribution towards a greater understanding of the ontological foundation of Te Ao Maori – drawn from the works of a philosopher. There is a message in what he saw for many Maori who are unaware of the components of Maori philosophy. There are two reasons for this occurrence; one is that Maori take components of tikanga Maori or Maori philosophy for granted by not realising that the practices they tend to automatically perform as part of Maori cultural set are part of a broad system of beliefs, attitudes and values. The second reason is that many Maori have not been brought up within a Maori environment and as such, they neither understand their language nor their customs. This phenomenon is part of the impacts from the period relating to the enticement of Maori from rural areas into the city to work. Another point raised by Patterson (1992) related to the incommensurability of Maori words to Pakeha. In his view, Maori terms do not translate easily into English. This means that those interested in understanding more about the Maori worldview must master these concepts and to master these

concepts one must become fluent in the Maori language. Some efforts have been made in this chapter to express those concepts and their meanings but I acknowledge that I am working with a relatively simple translation of ideals as a starting point for my further investigation but with the intention of demonstrating the inextricable relationship between concepts, language, culture and health.

There are dangers of interpreting the Maori worldview espoused in Te Ao Maori as a universal remedy to all the ailments of Maoridom. The notion that the term Maori has not evolved substantially to encapsulate the diversities of Maori people is not only challenging, it is a very real concern. That concern should also be expanded to include Iwi and Hapu because there are just as many people who do not have a close affinity with the notion of Maori identity within that social framework. An obvious solution is to undertake further study to include the voices of the estranged, the lost or the different within the greater Maori domain though that strategy would only work for those who wish to be reconnected with their taha Maori. Those Whanau members who have been forced from maintaining a link to their taha Maori or who have chosen to disaffiliate themselves are often referred to as the assimiliated or perhaps even global citizens, often seen to cherish little of their cultural emblems and even less for their collective Whanau obligations and responsibilities. As Durie (1995) suggests, Maori people exist within, and portray different and diverse realities. The long term impacts of these diversities are yet unexplored within our current sources of literature and as such, we have not yet examined the possible implications as a result. The efforts of Maori researchers are constantly focused upon reclaiming and strengthening what has been lost through colonialism – leaving the analysis of the future impacts of the ongoing fragmentation of Maori consciousness incomplete. Through those emerging concerns, the ideals of Te Ao Maori must at some point to be explored within the scope of dealing with broader issues of assimilation and disenfranchisement stemming from the involvement of our Whanau in street gangs; youth gangs; competing worldviews drawn from Black America street language; the over-sexualisation of our children; urban Iwi and the theft of our DNA.

The idea that Te Ao Maori offers a platform to work from in terms of reclaiming identity, language and culture is only a partial solution to the problems and concerns outlined above. There is another issue related to including others who have become so estranged that their issues are not well articulated in the existing literature. Te Ao Maori and the ability of people to access being Maori must fundamentally be an inclusive process so that people identified as the estranged and/or disconnected might find support, encouragement and sanctity reconnecting back with their own.

2.7 SUMMARY

In this chapter, I have aimed to position Te Ao Maori as a solid foundation from which researchers such as I, may draw guidance in terms of the way in which to behave, live and exist as Maori. As a literal translation, pou tokomanawa is the supporting pole within the wharenui and in terms of this thesis; it refers to the foundation of learning, teachings and meanings that are espoused within Te Ao Maori as a result. Its importance in terms of the contribution for this thesis cannot be underestimated. Te Ao Maori is a physical, emotional, spiritual, intellectual, collective, individual, societal, mystical and ethical realm based upon traditional cultural practices. It is a way of seeing the world from a cultural perspective that reinforces being and flourishing as Maori. In this chapter, I sought to highlight that being Maori within Te Ao Maori is increasingly reclaimed and asserted by its proponents as valuable and cherished. Te Ao Maori and its teachings may therefore help guide people philosophically and practically. This chapter provides an ontological and epistemological foundation for this thesis as a whole.

CHAPTER THREE: KAUPAPA MAORI THEORY

"the language of each people and
each individual is a unique
imprint with a particular set of
hieroglyphs of a particular view of
the world"
(Sharfstein, Ben-Ami)

3.1 INTRODUCTION

In the last decade in Aotearoa New Zealand, Kaupapa Maori theory has emerged as a discipline to guide Maori educationalists in their efforts to resist the assimilist and domesticating effects of mainstream education. This chapter provides an overview of Kaupapa Maori theory and seeks to apply the main concepts of the theory to this inquiry into the enhancement of Maori health and wellbeing. I position Kaupapa Maori theory within a historical and socio-political context consistent with Maori aspirations for *tino rangatiratanga* - viewed in this thesis as the freedom to explore and reclaim ways of looking at the world through Maori cultural lens. Within academia, Kaupapa Maori theory is a relatively new contribution to critical social theory and de-colonisation theory. In this thesis, Kaupapa Maori theory is construed as a specific cultural framework that overlaps and connects to all three theoretical traditions: critical theory, postcolonialism and global indigenous/cultural studies.

3.2 KAUPAPA MAORI THEORY

The development of the Kaupapa Maori theory is attributed to contemporary Maori scholars such as Graham Smith, Linda Smith and Russell Bishop. Their works are drawn upon extensively in this chapter. However, recognition of some significant foundational work should be attributed to earlier Maori scholars, politicians and leaders such as Apirana Ngata and Te Rangi Hiroa (Peter Buck). Whilst the links between their works and Kaupapa Maori theory are not always visible, this may be due in part to the way in which scholarship was classified by disciplinary demarcations during their time. For instance, Ngata and Buck's

works were classified first as anthropology, then Maori studies (Sissons, 2000). Their work is now being linked to contemporary biculturalism and even post-assimilist theory.

Literature focusing upon the theoretical and methodological use of Kaupapa Maori theory has focused predominantly on establishing an alternative theory and praxis for the overall provision, development, strategising, delivery, organisation and analysis of Maori education. Progress in Maori education is fraught with complexities and far-reaching accounts have been well articulated by various Maori academics (Bishop, 1994, 1997b; Glynn & Bishop, 1995; Jenkins, 2000; Johnston, 1998; Pihama, 1993; G. Smith, 1990; L. Smith, 1991; Tiakiwai, 2001). Primary sites of struggle for Maori educationalists focus on the ongoing failure of pro-assimilist policies instigated by mainstream educational institutions and their key actors and agents. The education system - schools, institutions, teachers and government officials has not ensured that Maori children are engaged in learning processes that equip them to thrive in the economic, political and social environments of the future. Rather, schools have been 'sites' for the active Europeanisation of Maori children (Pihama, 1993; Simon, Smith, & Cram, 2001; Timutimu, 1995).

In the 1970s the ongoing subjugation of Maori people in the education system erupted into action when the loss of Maori language reached crisis point. At risk, was a future without Maori language which generated calls for drastic action. In the early 1980's, a series of resistance strategies served to hold back the negative processes, closely following on from those efforts were more proactive strategies such as the establishment and development of kohanga reo (pre-school language nests) and Kura Kaupapa Maori (total immersion Maori schools). Concurrent satellites of resistance were taking place within the area of Maori economic development and also Maori health development. In 1984 at the Hui Oranga a platform for launching new and positive initiatives for Maori health was established against a backdrop of questions about the status of health care for Maori at that time. Maori health efforts were focused in a number of key areas:

- The reinstatement of Maori health as a holistic concept that refers to the physical, spiritual, mental and Whanau dimensions of health (M. Durie, 1994; P. Ngata & Lyall, 1984; Pere, 1984) as articulated in *Chapter Two*
- Health services delivery such as clinical care, nursing, social services, administration, counselling, health professionals and their interaction with patients must be driven from Maori concepts of health
- The Maori health workforce and the interaction that takes place between people and the roles that Maori health professionals perform to provide care and service to others must be supported (M. Durie, 1994; Ramsden, 1990)
- 'Tino Rangatiratanga' – 'Maori autonomy' and the relationship between Maori health initiatives and the benefits Maori communities derive from those initiatives; who is responsible for those initiatives and how those initiatives are provided need clear articulation and resourcing
- Cultural norms and the interrelationships with Maori health, Maori culture and health services must be strengthened.

These themes will be expanded upon in greater detail in later chapters. For now it is important to state that in the 1980s, the lens for action were firmly fixed by Maori upon Maori health (as part of a greater drive for Maori development on the whole). These opportunities for achieving social change did not occur in a vacuum. A willingness by Maori to take a more active role in Maori health development coincided with government objectives to devolve responsibility for community development (including some health services) from the Government to the community, often without the necessary resources to make a significant difference. Neo-liberalism – the overarching, rapid and intense reorganisation of the macro economy of New Zealand since 1984 (as described more fully in *Chapter Six*) supported government policies that led to the sale of publicly owned assets in Aotearoa New Zealand, culminating in the loss of essential societal infrastructural resources to commercially driven multinational companies (Easton, 1997). For Maori, the sales meant the loss of resources they had thought were protected by the covenants of the Treaty of Waitangi. Kaupapa Maori theory therefore captured the dual tensions of those leaders and activists guarding Maori

against the full impacts of neo-liberalism (L. Smith, 1999), whilst also demanding that government officials removed barriers from Maori to determine their own pathways for development in the future (M. Durie, 1994).

3.2.1 Foundations of Kaupapa Maori Theory

In this section, I outline a number of concerns that Kaupapa Maori theory attempts to address and how those concerns manifest as contextual crisis encounters within Maori health, Maori business, Maori housing and social justice. Kaupapa Maori theory and praxis is

> primarily an educational strategy, which has evolved out of Maori communities as deliberate means to comprehend, resist and transform the crises related to the dual concerns of schooling underachievement of Maori students and the ongoing erosion of Maori language, knowledge and culture as a result of colonisation (G. Smith, 1997, p.27).

Kaupapa Maori strategies involve a

> complex arrangement of conscientisation, resistance and transformative praxis, which collectively seek to transform these twin crises, related to education and culture (G. Smith, 1997, p.27).

If these definitions are applied to Maori health we would be able to substitute education for health, housing or economic development to find that no further modification of the themes would be required. The structural impediments that Kaupapa Maori theory seeks to overcome remain present regardless of the contextual concerns given the continuous historic resistance to colonisation by Maori. It should not be a surprise that the traditional foundations of Kaupapa Maori theory can be found in the events, histories, stories, waiata, whaikorero and proverbs related to the impact of colonial settlement in Aotearoa. In Tauranga for instance, Rawiri Puhirake performed the gallant role as a chief fighting to uphold the mana of his tribal people in the battle of Gate Pa (Department of Internal Affairs, 1990). The Northern Tribes have a story concerning Hone Heke and the chopping down of the British Colonial flag (Moon, 2001). For Nga Puhi people, this story remains as an act of bravery and defiance to maintain tribal mana. For Tainui, the Kingitanga and its subsequent leaders forms a part of tribal consciousness for all descendants of the Tainui confederation of tribes (Mahuta, 1992). There are also the efforts of local Ngaiterangi figures such as Hori Tupaea,

Ruawahine, Hikareia and Koraurau who performed leadership roles. Their narratives have not been recorded extensively in the public literary form. Regardless, these people and these events contribute to local Hapu and tribal consciousness, a consciousness readily engaged by wananga, whaikorero and waiata. These events provide contemporaries with opportunities to maintain a connection to the 'beating heart' of the Maori world. These oral artefacts link history with stories, stories with epistemology and epistemology with knowledge. Ladson-Billings (2000), for instance argues that oral traditions (stories, folklore, narratives) contribute to epistemology. An epistemology is

> a system of knowing that has both an internal logic and external validity. This distinction between an epistemology and 'ways of knowing' is not a trivial one. For example, literary scholars have created distinctions between literary genres such that some works are called literature whereas other works are termed folklore. Not surprising, the literature of peoples of colour is more likely to fall into the folklore category. As a consequence, folklore is seen as less rigorous, less scholarly and perhaps less culturally valuable than literature....I argue that there are well-developed systems of knowledge or epistemologies, that stand in contrast to the dominant Euro-American epistemology (Ladson-Billings, pp.257-8).

As the quote suggests the literary efforts of Maori scholars of earlier times were not recognised by formal scholars for their contribution until decades later. Apirana Ngata and Peter Buck for instance were recognised for their roles in maintaining political and customary standing of Maori people. But, they were also engaged in Maori endeavours which later transformed into theoretical contributions explaining the plight of Maori in Aotearoa New Zealand (M. Durie, 1994). They also performed roles in retaining a practical commitment to enhancing the wellbeing of Maori people through the development and implementation of government policies. In later years their works emphasised the merits associated with tribal consciousness and tribal development (A. Ngata, 1944). Much of the work contributed to the retention of knowledge amongst the people and their efforts were known and trusted for their historical, social, political and cultural wisdom.

Sissons (2000) points out that the contemporary notion of biculturalism to which we have become accustomed stems from an earlier stance taken by Ngata. The biculturalism we know today developed as a reactionary measure to attempts to distract attention from the unique situation of Maori by reducing Maori to being

just one of the many other cultures in this land. Sissons claims that the efforts of Ngata should be recognised for its contribution to preserving a Maori sense of consciousness. The works of Ngata and Buck are aspirational and coincide with the current commitment by Maori people to enhance Maori wellbeing that is being articulated by Maori academics in a specifically cultural way.

Ngata was becoming more convinced that Maori should adapt modern technologies to fit with their own unique customs. One of the key differences between their efforts is highlighted in the socio-political environment in which these activities operated. For instance, the readiness of the Government to instigate policies focusing on social change was not always noticeable at that time. The lack of commitment by politicians to these matters has partially contributed to what Sissons describes as Ngata's change in thinking towards government policy in the mid 1920 to 1930's. Ngata was referring to a means of development that was consistent with 'old time paths', which in 1927 were not well articulated. By 1931 Ngata's inferences altered again to reflect the following means to Maori development:

> [As more] clearly defined as strong tribal leadership, a flourishing tribal spirit and the maintenance of persistent beliefs and customs (Sissons, 2000, p.50).

Ngata received a lukewarm reception by government officials to these alternative strategies for Maori development. But his sense of conviction solidified after being exposed to *the Clash of Culture and Contact of Races* by Pitts-Rivers (1927). Pitt-Rivers affirmed the fundamental worth of indigenous cultures as a foundation for racial development. He distinguished between *culture forms* (art forms, traditions, beliefs, customs and social organisation), *culture accessories* (weapons and solid implements) and *culture potential* (the ability to develop the capacity for new forms of artistic, scientific and technical skills). According to Pitt-Rivers, culture forms were premised on the potency of culture potential. For instance, culture is conditioned by the capacity of people to give expression to arts, traditions, beliefs and culture is far less adaptable to great changes in culture forms. Pitts-Rivers articulated the expectation that indigenous people would see value in their own culture rather than blindly following the lead of people whose preferred cultural gifts could never truly be made their own (1927, p.241).

In 1934, Ngata broke political tradition and made an irreversible break with assimilist-based approaches to Maori development. Ngata's post-assimilationist was based on two propositions:

- Rather than mimic Pakeha, Maori people needed to pursue their own path of development, drawing upon their unique racial inheritance and
- Tribal organisation and hereditary tribal leadership were the most important contemporary expressions of their unique racial inheritance and were the ideal foundation upon which to develop the race (Sissons, 2000, p.50).

Sissons highlights that Ngata's combination of racial uniqueness and strength with tribal persistence constituted a formidable theoretical defence against assimilation and laid the foundation for all post-assimilationist policy, including biculturalism and in my view Kaupapa Maori theory. Looking at his contribution in more detail, it may be argued that instead of applying the assimilist principles that were derived from western consciousness, he was asserting instead that Maori re-align their collective efforts to their own sense of knowledge and system of living. For instance, he asserted a commitment to Maori philosophy as a consistent approach to Maori development. The foundations for Maori development, which Ngata was attempting to re-assert, were based upon a clear and defined association to Maori philosophy, which were even more clearly articulated in later years. Ten years after his public announcement against assimilist policies for Maori development at the Porourangi Maori Cultural School, Apirana Ngata clarified his position:

> [I] was asked the question in 1944 – what is the use of knowledge of Maori culture, history and traditions? It is the realisation that such knowledge is necessary to the education of our youth, in that it is growingly being acknowledged as an asset by the people of New Zealand and of the world outside and that we Maori are expected to have and maintain the knowledge, which has caused me to welcome the respite from public duty. A Maori who knows neither his own language nor history and despises both should have his face bleached. A half-pie Maori, who pretends a knowledge he does not possess, is clearly dishonest and that class is increasing in number and pretentiousness. You will find it as you go around New Zealand. It is now seeking to make capital out of the exploits and fame of the Maori Battalion. What is needed to correct this ignorance and dishonesty is a movement to acquire the proficiency [of Maori traditions, language and knowledge] which all desire the youth of the Maori race to have (1944, p.4).

In Sissons account, Ngata consulted his colleague Te Rangi Hiroa (Peter Buck), stating that Maori would not suffer the same unfortunate 'rapid absorption' that had plagued the Hawaiians. Ngata knew that Maori were struggling to maintain their 'collective identity'.

> [Ngata] wholeheartedly agreed with Te Rangi Hiroa that the 'tribal spirit and canoe rivalry should blaze up and out of this will emerge a race consciousness. I can hear the chiefs of old crying across the marae, "*kia rongona to ingoa!*", "Let your name be heard"(AJHR, 1931, G-10 cited in Sissons, 2000, p.50).

The traditions that inform Kaupapa Maori theory are derived from similar tensions involving the perceived and actual loss of cultural and political recognition born primarily but not exclusively from the ongoing impact of colonial settlement and imperialism in New Zealand from the mid 1800's onwards (L. Smith, 1999). By the time biculturalism was suggested as an appropriate means of reconciling Maori social injustice, its prior origins in Ngata's post-assimilist efforts framed around the desire to resolve tribalism and individualism were lost from view (Sissons, 2000). He argued that this enduring contradiction has continued to manifest in the contemporary concerns of Maori people throughout Aotearoa New Zealand.

There is an existing tradition of resistance, which is demonstrated in Ngata's work that seems to be overlooked, or is hidden in the mass of academic scholarly traditions currently available for consideration. In attempting to identify a set of concepts or theories that adequately explain the endeavours of Maori phenomenon today, it is imperative that the roots of contemporary expressions of Maori consciousness are acknowledged.

3.2.2 Components of Kaupapa Maori Theory

Kaupapa Maori theory consists of contributory concepts, assumptions and ideas that develop and validate it as a useful tool for the articulation of Maori decolonisation. The components are drawn from the experiences of writers involved with Maori education initiatives, which can be applied to the advancement of Maori health and wellbeing as part of a greater commitment to bringing about transformative Maori development and social change. Kaupapa Maori works that can be drawn upon to aid this process are increasing in numbers.

For instance, some Maori academics have focused upon Kaupapa Maori methodology as a set of principles of engagement for researching various Maori concerns based on the validity of Kaupapa Maori theory (Bishop, 1996a, 1996b, 1997a, 1997b; Bishop & Glynn, 1992; A. Durie, 1998; Glynn & Bishop, 1995; Moewaka-Barnes, 2000; L. Smith, 1999).

Other initiatives have concentrated on the practical Kaupapa Maori praxis such as Te Kohanga Reo, Kura Kaupapa Maori, Whare Kura[6], Maori Midwifery and Nursing[7], Maori Resource Management[8] and Whare Wananga[9]. Kaupapa Maori theory is therefore a contemporary manifestation of an ongoing commitment for transformative proactive social change in Maori development. Smith (1997) reiterates that as a meaningful theory of change it has three significant components which align it to a critical theory framework: conscientisation, resistance and praxis with intent on transformation.

- *Conscientisation* is concerned with exposing the reality through the critical analysis and deconstruction of existing hegemonies and practices, which embed dominant social, economic, cultural and political advantages
- *Resistance* is concerned with stating a position and forming shared understandings and experiences as part of a process for developing 'collective politics'. Collective politics involves reactive activities (collecting and responding to dominant structures of suppression, exploitation and manipulation) and proactive activities (collectively resolving and acting to transform the current conditions)
- *Transformative Praxis* is concerned with reflective emancipatory change through transformative action. Praxis is both reflective and reflexive with respect to theory and practice.

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[6]Such as the Hoani Waititi Whare Kura in Auckland and the Rakaumanga in Huntly.

[7]An initiative of the Waikato Polytechnic.

[8]An initiative of the Waikato Management School at the University of Waikato from 1991-2000.

[9]Such as Te Whare Wananga o Raukawa, Te Wananga o Aotearoa and Te Wananga o Awanuiarangi.

These three components form one necessary whole. Freire's work pays ardent attention to the linkages between these three components and the need to be, and to be seen to be actively engaged in and through action:

> An unauthentic word, one which is unable to transform reality, results when dichotomy is imposed upon its constituent elements. When a word is deprived of its dimension of action, reflection automatically suffers as well; and the word is changed into idle chatter, into verbalism, into an alienated and alienating 'blah'. It becomes an empty word, one which cannot denounce the world, for denunciation is impossible without a commitment to transform and there is no transformation without action (Friere 1972, p. 60 cited in G. Smith, 1997, p.37)

The works of Freire, a visiting scholar to Aotearoa New Zealand in the 1970s, helped sharpen a Maori based and led approach to transformative praxis in Kaupapa Maori theory. Kaupapa Maori theory

- Validates and legitimates Maori knowledge, Te Reo Maori and Tikanga Maori as taken for granted
- Requires a critical analysis of existing power structures and societal inequalities that have been created through colonisation and free market reforms
- Requires a critical examination of the interface with economic, political and cultural structures of domination in the healthcare sector
- States that existing oppressive regimes are socially constructed and as such are humanly alterable
- Rejects dominant group constructions of Maori as 'other' and emphasises the status of Maori people as tangata whenua thereby encompassing the ongoing struggles of Iwi to reclaim land and tino rangatiratanga
- Re-centralises the importance of theory to inform the strategies adopted by Maori to bring about transformative social change
- Is premised on the dialectical relationship between theory and practice – praxis

The themes highlighted above will be discussed in further detail throughout this thesis.

3.3 KAUPAPA MAORI THEORY VARIANTS

Kaupapa Maori theory emerged from a series of concerns facing Maori educationalists. Now, emerging from the plethora of Maori development activities is an assortment of contributions to theorising, which have stemmed from different contextual sites and crises. These contributions may be seen as similar typologies or variants of Kaupapa Maori theory. I will present three variants for discussion: cultural safety, Maori resource management and indigenous psychology as a means to demonstrate that the aspects of the socio-political environment are similar and that a response through the lens of Kaupapa Maori theory in this thesis is consistent and the assertion of tino rangatiratanga unrelenting.

3.3.1 Cultural Safety - Kawa Whakaruruhau

Cultural safety was borne from an analysis of nursing theory and practice from a Maori perspective. Ramsden's (1990; 2002) *cultural safety* aims to address similar theoretical concerns as the constellation of theories umbrelled by Kaupapa Maori theory. Originally conceived in 1989 it was viewed as a methodology for ensuring that nursing education adopted and implemented clear practices of cultural recognition when interacting with patients. Cultural safety made considerable headway in the practical application of safe cultural practices, hence the implementation of concepts of care founded upon the recognition of differences between cultures. The key objectives of cultural safety aimed to ensure that student nurses and midwives do not blame victims for their predicaments; that they examined their own realities and attitudes; that they remained open minded and flexible in their attitudes and that a commitment to nursing practice that was "culturally safe from the perspective of the patient was paramount" (Ramsden, 2002, p.94). Cultural safety is described as actions which:

> Recognise, respect and nurture the unique cultural identity of tangata whenua and safely meet their needs, expectations and rights. Culturally unsafe [nursing] practices [are] any actions which diminish, demean or disempower the cultural identity and well-being of an individual (Ramsden, 1990, pp.7-8).

Ramsden (2002) suggests that the evolution of concepts such as cultural safety are marked by a very rapid and at times extremely political process for all concerned. She argues that people not involved in the development of cultural safety have

reinterpreted the concept and in doing that they appear to have diminished its potency. This observation is important because it challenges the very notion of intellectual respect that is afforded to academics and contributors to theoretical developments internationally. Whilst cultural safety was conceived as a very practical methodology, it has since evolved into a more theoretically influenced contribution, evident in Ramsden's PhD. More recently, the concept of cultural safety is being used for all cultures and not just Maori, highlighting the importance of cultural pluralism in all our activities. Maori insist that such pluralism must not just re-categorise Maori from the unique status of tangata whenua to be a number of 'other' non western groups in this country.

3.3.2 Maori Resource Management Programme (MRMP)

The concerns associated with managing natural and community Maori resources using conventional economic theories contributed to the development of the concepts, Maori resource management and Maori business management. Humphries (1992) helps articulate the concerns that these concepts attempt to address in the following statement:

> To learn the skills of managing resources in the changed circumstances of Maoridom, Maori youth have had to leave the group and pursue an education that returns to the group (if indeed they do return) individuals whose thinking is not recognisably Maori. We return to the Maori community, individuals who (in Clegg and Dunkerley's [1980] terms) have complex (non-Maori) rules built into them (1992, p.39).

Humphries (1992) challenged the involvement of tertiary institutions providing stewardship roles to Maori youth to consider the ramifications of ignoring the prevailing differences of Maori students in their potential future roles. Mataira (1994) explained the intricacies of Maori business using the notion of Maori accountability. Accountability to Maori he argued is culturally determined and the roles of individuals transferred into a collective accountability when tribal resources were involved. He encouraged emerging business professionals to recognise that the Maori concept of accountability could only be understood as part of a worldview unique to Maori culture. In 1993, at the University of Waikato, the Maori Resource Management Programme (MRMP) (led by Kelvin Mataira) provided an indigenous Maori approach to teaching and learning about

management studies[10]. The official aim of the programme was to provide students with an opportunity to pursue a combination of courses centred on their aspirations and needs to develop skills in economic development and Maori language (Richards & Ellis, 1998; Richards, Ellis, Mariu, & Awatere, 1998). Maori students enrolled in a Bachelor of Management Studies degree expected "a management education in a New Zealand context that recognised Whanau, Hapu, Iwi and Maori identities, languages, values and ontologies" (Parehau Richards cited in Muller, 1999, p.1). However, the integration of these expectations into the scholarly work of the students proved to be challenging, with many graduates of the MRMP only grasping fragments of the significant issues being presented for their greater consideration.

In 1998, graduate students offered the following comments about the MRMP as part of a report about the programme:

> The courses have given me a broad background of analytical skills when focussing on Maori organisations. I am well positioned to assume a greater role in the management and leadership of tribal resources and
>
> In the MRMP I have found numerous intellectual frameworks for analysing Maori issues enabling us, if we could get to grips with them, to present convincing arguments about why Maori should be viewed in a certain way. Some of those frameworks were: quantification of Maori resources in terms of Hapu and Iwi human and physical resources; conceptualising key tikanga variables in Maori development (e.g. mana, rangatiratanga, biculturalism, matauranga Maori etc); business planning for Maori development at individual entrepreneurial levels, Whanau, Hapu and Iwi levels for wider development proposals. The result was that throughout my university life I was able to articulate reasonably a Maori perspective on just about any other issue I came across in other courses (e.g. Maori tourism) (Ellis & Richards, 1998).

Maori management is now a topic within the National New Zealand Qualifications Authority framework for management education and the essence captured in the Maori resource management programme in the early 1990's has been transferred at least on paper into the accreditation process. Maori resource management and Maori business management form the foundation of a management discipline, which is offered at various tertiary institutions throughout

[10] The Maori Resource Management Programme was not established until 1993. However, in 1991 the lecturers involved with delivering the programme, Kelvin Mataira and Maria Humphries piloted two undergraduate courses to determine the level of student interest in the courses.

the country, including Whare Wananga[11]. In terms of this thesis, the programme serves as an example of the attempts by Maori students and lecturers to articulate Kaupapa Maori theory in its earliest formation in the context of professional organisational studies.

3.3.3 Indigenous Psychology

Indigenous [Maori] psychology has emerged from criticisms lodged against the assumptions that psychological theories and research based on only a few cultural groups is adequate to reflect universal patterns of human behaviour (Moeke-Pickering, Turangi-Joseph, Paewai, & Herbert, 1996). According to Thomas (1995), critics maintain that the dominant 'western psychology' contains an underlying bias towards self-contained individualism defined as "an individualistic social arrangement in which persons wish to be self-contained and self sufficient in order to be successful" (Sampson cited in Thomas, 1995, p.3). Nikora comments that psychology emerges from

> the western body of thought. It is premised upon and derives its theories from a western value base. Most of the textbooks used in psychology courses are American or of some other offshore origin all being driven by a western value base. There is no psychological body of knowledge within university psychology courses that derive from a Maori value base. A psychology for Maori would begin to spell out the parameters of a psychology emerging from a Maori value base. In addition, a psychology for Maori would also consider aspects of mainstream psychology that would assist in the self-determination of Maori but would first be subjected to a process of localising relevant theories, approaches and understandings to ensure their relevance and appropriateness (cited in Thomas, 1995, p.5).

Maori people are developing a psychology for being Maori that represents the localised issues pertinent to Aotearoa New Zealand. It includes both traditional knowledge relevant to psychology and the modification of psychological knowledge, processes and practice originating from other traditions and the development of an indigenous psychology model drawn from a conceptual Maori foundation based upon the notions of Taha Wairua and Whanau. In Thomas's view, there are three topics particularly useful to developing this methodology

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[11] The New Zealand Qualifications Authority is responsible for setting the course content of tertiary institutions throughout New Zealand. On the official website www.nzqa.govt.nz the framework for Maori management can be accessed. Similar types of courses are currently offered by other institutions throughout New Zealand as well.

- *Knowledge about cultural styles* – cultural differences between Maori and Pakeha involve contrasting conceptions of self and social identities and the way that behaviour is classed as a result. This point suggests that specific Maori cultural traits, beliefs and practices should be recognised as part of an indigenous psychology
- *Agenda-setting* – refers to the process of not only what is prioritised in psychology but who gets to decide what is prioritised. An indigenous psychology includes recognition that Maori should be involved in prioritising the agenda particularly when dealing with Maori issues in psychology
- *Socio-cultural contextualisation* – attempts to link psychological knowledge to local, social, political systems and cultural groups. A number of themes arise with respect to socio-cultural context such as identity, colonisation, oppression, racism, obligations to the Treaty of Waitangi, as well as the basic rights that people have to employment, schooling, housing, social justice and socialising. Maori people tend to emphasise identities which include self and social groups such as Whanau, Hapu and Iwi. There is also a clear commitment from Maori shown towards language and customs.

Thomas (1995) linked indigenous psychology to tertiary institutions and the expectation that institutions must ensure that students are given opportunities to engage with this paradigm to ensure that professionals acquire essential cultural skills to engage with Maori at another level. Moeke-Pickering et al (1996) locates indigenous psychology within a mental health context linked to principles of holistic Maori health and biculturalism. They also reiterate the fundamental importance of research and training in facilitating a model for indigenous psychology.

These three examples of where and how various initiatives in Kaupapa Maori theory have emerged suggests that a movement is in development centred on bringing about Maori emancipation, transformation and social change from a specific Maori consciousness base. The evidence of these variants (and others) suggests that the contextual and socio-political influences impacting upon the various sites of struggle or concern are consistent throughout and that the

particular phenomenon varies. What is also important is that these initiatives have provided space for Maori people to make contributions to disciplines of study to which they are intimately familiar e.g. education or social services. Another important feature of these initiatives is that they are no longer positioned in isolation from other fields of inquiry. Instead, they are being strengthened as other collective constructs and through this process they bring about transformative social change. It is highly conceivable that Kaupapa Maori theory can be seen as a collective term that allows for the encompassment of different typologies of theory or it can be a theory that relates to different contextual concerns such as Maori education and Maori health. Kaupapa Maori theory is also a method of analysis and a tool for resistance to the transformation of colonisation.

3.4 INTERNATIONAL TYPOLOGIES OF RESISTANCE – SPEAKING IN THE INDIGENOUS/ETHNIC VOICE

Kaupapa Maori theory is not only positioned as a useful framework for addressing concerns with Maori educational performance and Maori health development in Aotearoa New Zealand. It aligns to a global indigenous and cultural movement aimed at addressing the social inequities of marginalisation experienced by many indigenous peoples (Scharfstein, 2002). There are three aspects to this movement, which should be illuminated. The first aspect deals with the desire by marginalised people to address the social inequities that they have been exposed to in their respective countries. The second aspect deals with the impact that disenfranchisement has had upon indigenous communities throughout the world and how efforts to counter-act those impacts being addressed through specific cultural and ethnicity based paradigms and theories stemming from postcolonialism. The third aspect relates to the plight of indigenous people and concerns issues of sovereignty.

In this section I will outline some of the theoretical developments that have been generated worldwide relating to racialised discourses and ethnic epistemologies. Throughout the world, well-developed knowledge systems emanate from ontological foundations that differ from the dominant Eurocentric paradigm

(Scharfstein, 2002). Notions of double consciousness, mestiza consciousness and tribal consciousness are revealed by scholars of colour to illuminate the ways that discursive, social and institutional formations have fashioned a sense of 'otherness'. This sense of otherness excludes people from participating in the cultural space of the dominant paradigm.

3.4.1 Critical Race Theory

Critical race theory is presented as a method for exploring contrasting ethnic or indigenous worldviews. It sprung from a set of priorities within the United States of America for African-Americans. The theory aimed to rectify the slow pace of racial reform in the United States. Critical race theory is both an outgrowth of and a separate supposition from an earlier legal movement called critical legal studies. Critical legal studies is a legal movement that challenged the conventional legal research that focused on doctrinal and policy analysis in response to what was seen as a need to speak to the specificity of individuals and groups in social and cultural contexts (Crenshaw, 1988). Crenshaw challenged the supposition that the civil rights movement was a long and steady process of social transformation. He argued that the prevalent legal discourse in America was riddled with legal ideology that helped "create, support and legitimate America's present class structure" (Ladson-Billings, 2000, p.263). Scholars of critical legal studies are informed by Gramsci's notion of hegemony, which was a concept taken up to expose the legitimisation of the ongoing oppressive structures in American society. West (1993 cited in Ladson-Billings, 2000) argued that critical legal studies played an important role in identifying and exposing the inconsistencies of the legal profession, but the theory failed to offer strategies for change and more importantly it did not include an analysis of racism.

Critical race theory attempts to achieve four key goals. Firstly, it is premised on the notion that racism is an enmeshed fabric of American society and its social order. The goal of critical race theorists is to expose all variations of the social injustice that exist through racism. Secondly, it challenges legal tradition by adopting narration as a means of dialogue. As such, critical race theorists integrate experiential knowledge drawn from stories about struggle to overthrow

and address hegemonic processes and procedures. Thirdly, critical race theorists insist upon a critique of liberalism. Crenshaw (1988) claims that legal practices mandated the painstaking process of arguing through legal precedence to gain citizen rights for African Americans. Lastly, critical race theorists argue that affirmative action benefits all, not just African Americans. They base their argument on the assertion that American women are also beneficiaries of affirmative action. Calmore presents critical race theory as

> A form of opposition scholarship...that challenges the universality of white experience/judgement as the authoritative standard that binds people of colour and normatively measures, directs, controls and regulates the terms of proper thought, expression, presentation and behaviour. As represented by legal scholars, critical race theory challenges the dominant discourses on race and racism as they relate to law. The task is to identify values and norms that have been disguised and subordinated in the law...Critical race scholars seek to demonstrate that [their] experiences as people of colour are legitimate, appropriate and effective bases for analysing the legal system and racial subordination. This process is vital to...transformative vision. This theory-practice approach, a praxis, if you will finds a variety of emphases among those who follow it....From this vantage, consider for a moment how law, society, and culture are texts – not so much like a literary work, but rather like a traditional black minister's citation of a text as a verse or scripture that would lend authoritative support to the sermon he is about to deliver. Here, texts are not merely random stories; like scriptures, they are expressions of authority, pre-emption and sanction. People of colour increasingly claim that these large texts of law, society and culture must be subjected to fundamental criticisms and reinterpretation (cited in Ladson-Billings, 2000, p.263-266).

Though critical race theory provides an avenue for African Americans to view the world through their eyes, it is still subjected to criticism. It was found that there was no "canonical set of doctrines or methodologies" to which all critical race theorists subscribe (Crenshaw, 1988, p.xiii). Instead, theorists were unified on two fronts. They argued to gain a greater understanding of "how a regime of white supremacy and its subordination of people of colour had been created and maintained in America" (Ladson-Billings, 2000, p.264) and they sought to change the relationship that prevailed between law and racial power. Critical race theorists play an essential role in facilitating the opportunities for oppressed people to 'speak out' about the legal system. Although the theory is promising as a useful analytical tool for understanding law from African-American perspectives, its thesis is viewed by critics as a challenge to the American way (Ladson-Billings, 2000).

3.4.2 Double Consciousness

The works of William Du Bois *The Souls of Black Folk* (1953/1903) and Carter Woodson *The Miseducation of the Negro* (1953) are seen as remarkable contributions to African American scholarship, though their voices have remained invisible within the traditions of critical social theory. This is in spite of their works being published at a similar time that the theories developed by Max Horkheimer, Theodor Adorno and Hebert Marcuse were presented as part of the contribution from critical theorists. Du Bois and Woodson points of contention are that the dominant Euro-American scholarship has failed to assist them with explaining the Afro-American situation.

Du Bois presents the notion of double consciousness not as a failing, but as a transcendent position allowing one to see and understand concepts of inclusion and exclusion at the same time. Du Bois's notion of double consciousness can be applied to any people situated outside of the dominant paradigm. Ladson-Billings (2000) state that the notion of double consciousness dealt in part with the complexities of multiple consciousness and it did not seek to promote an essentialist model of 'blackness' or 'Native Americanness'. The notion of dual consciousness has a similar premise to the concept of biculturalism. It focuses upon the need for a person to possess not just the fragmented 'language bites', but to become intimately familiar and entrenched in the entire African American cultural framework.

Similarly, Native Americans have grappled with the notion of what it means to be 'Indian'. Double consciousness in this respect is centred on issues of tribal sovereignty. A loss of sovereignty is intensified by relocation strategies enforced by colonial authorities, systematic eradication of the native language, religious conversion and restructured economies towards cottage industries and dual employment roles (Lomawaima, 1995). The experiences of indigenous people, however was tinged with additional narratives of loss and pessimism which contrasted with other marginalised groups. Warrior (1995) describes this situation as the fourth world. Warrior is cautious of contemporary fourth world writers as their works tend to be essentialising in the call for understanding Native American culture as part of a global consciousness shared by all indigenous peoples

throughout all periods of time. He instead calls for intellectual sovereignty to enable writers to express themselves from a position free of tyranny and oppression. Another point raised is the notion that dual and multiple consciousnesses of the subordinated group are more inclined to possess these cultural traits. However, there is little that can be said about the role that Americans, or (in our locality), New Zealanders play in acquiring or possessing more than one consciousness.

3.4.3 Indigenous Movements – Aboriginal, First Nations People

Ladson-Billing's (2000, p.271) view helps position Kaupapa Maori theory within the growing foundation of indigenous academic scholarship. They can claim that

> the point of working in racialised discourses and ethnic epistemologies is not merely to 'colour' the scholarship. It is to challenge the hegemonic structures (and symbols) that keep injustice and inequity in place. The work also is not about dismissing the work of European and Euro-American scholars. Rather, it is about defining the limits of such scholarship. The push from scholars of colour is to raise the bar or up the ante of qualitative inquiry (Ladson-Billings, p.271).

Ladson-Billings suggests there is a place for these epistemologies to exist alongside the prevalent traditions of scholarship that exist throughout the world. She further reiterates that the current platform for this scholarship is unrepresented in the academy and that the prejudices associated with a presumed lack of quality should be actively challenged. As Delgado (1995) argues:

> Many members of minority groups speak two languages, grow up in two cultures...And so, who has the advantage in mastering and applying critical social thought? Who tends to think of everything in two or more ways at the same time? Who is a postmodernist virtually as a condition of his or her being? (p.8)

The focus of indigenous communities however is a somewhat different debate from ethnic diasporas or migrant populations. Worldwide, Indigenous people struggle to survive within their own countries. The issues of land loss, link directly to their existence as a people. Indigenous movements are also about challenging hegemony, but they are also about sovereignty. For example,: aboriginal sovereignty movements in Australia (Gilbert & Williams, 1996), the Mabo case – Eddie Mabo & Others vs the State of Queensland (Boyle, 1993), the Indigenous Rights Movement in Hawaii (Blaisdell, 2004), the Indigenous Peoples' Movement in Colombia (Ulloa, 2003) and the Tino Rangatiratanga

Movement in Aotearoa New Zealand (Walker, 1989, 1990), all form part of the overall global indigenous movement. Though this section of the thesis reiterates issues of epistemology and ontology clarification academically, it is important to highlight that these emerging theories are also about the fundamental rights of indigenous communities to survival, peace and harmony.

3.4.4 United Nations Forum for Support of Indigenous Development

The year 2004, corresponds with the end of the United Nations Decade of Indigenous Peoples 1995 – 2004. The decade was significant in that it highlighted the struggles of indigenous peoples globally by acknowledging the impact that colonisation, racial discrimination, marginalisation and implicit and explicit policies had upon the overall spiritual and physical resource base of indigenous nations. Indigenous people constitute more than 200 million people or approximately four percent of the global population (M. Durie, 2004). The decade marked the formulation of two major documents. The *Draft Declaration of the Rights of Indigenous People* (a working document for more than ten years) was presented to the United Nations for endorsement by a working group of indigenous populations internationally (Working Group on Indigenous Populations, 1993). Many governmental representatives of the United Nations were uncomfortable with the supposition that indigenous communities could maintain some form of ongoing sovereignty, despite colonisation. Arguably, the Declaration, even if endorsed would only achieve moral acceptance, as there were no requirements for enforcement of its tenets through international law. Indigenous peoples were far more optimistic about the possibility of ratifying the declaration. For many of them, it provided a charter for governments worldwide to recognise indigenous communities. It sought for instance to place a significant emphasis upon the protection of indigenous environments. In Article 13 of the Declaration, indigenous people were provided with a right 'to manifest, practise, develop and teach' spiritual and religious traditions (Working Group on Indigenous Populations, 1993). The document went further to actively encourage the reclamation and use of histories, languages, philosophies and practices of indigenous communities worldwide.

A second document was generated from more than a decade of work and was tabled in 1999 in Geneva as a result of the World Health Organisation International Consultation on the Health of Indigenous Peoples (M. Durie, 2004). A *Declaration on the Health and Survival of Indigenous Peoples* was prepared and forwarded to the United Nations Permanent Forum on Indigenous Issues in 2002 (Committee on Indigenous Health, 2002). The document included five sections that re-affirmed the basic rules of the Draft Declaration of the Rights of Indigenous Peoples and applied those ideals to health. The document pronounced links between indigenous culture, the natural environment, human rights and health. For instance:

> Indigenous Peoples' concept of health and survival is both a collective and individual inter-generational continuum encompassing a holistic perspective incorporating four distinct shared dimensions of life. These dimensions are the spiritual, the intellectual, physical and emotional. Linking these four fundamental dimensions, health and survival manifests itself on multiple levels where the past, present and future co-exist simultaneously (cited in M. Durie, 2004, p.5).

The two documents advocated for strategies for health improvement which focus on capacity building, research, cultural education for health professionals, increasing funding and resources for indigenous health, a reduction in the inequities accompanying globalisation, and constitutional and legislative changes by states. Broad determinants of health were identified: loss of identity, environmental degradation, community development, culturally appropriate care and war, conflicts and vigilantism (M. Durie, 2004).

In presenting these observations the necessity to acknowledge the sovereignty of indigenous communities is paramount. Every country purporting to claim some sense of colonial superiority is being called into question in regards to the protocols they have in place to improve the current circumstances. Also important is the significant value placed upon health being viewed from an indigenous worldview inclusive of cultural values and resources. In this research, the emphasis placed upon concepts of health integrating ecological and spiritual dimensions are emphasised. The concept of health articulated in the documents is holistic and refers to the interconnected dimensions of spirit, mind, body and the environment.

Indigenous populations worldwide are fighting for the right for health to reinforce worldwide principles of de-colonisation and social justice through the honouring of constitutional covenants with indigenous peoples and parliamentary officials. In New Zealand, these desires are manifested in different ways. For Maori, one strategy has sought acknowledgement and recognition of the Treaty of Waitangi as a constitutional document in government policy and legislation (Henare, 1998). For example, through the Treaty of Waitangi settlements process, economic retribution for Treaty breaches are being addressed through the formal process of an official apology teamed with financial and/or land compensation packages. Another government policy provides resources for Maori community initiatives such as the revival of Maori language (Te Puni Kokiri & Te Taura Whiri I Te Reo Maori, 2003). It is becoming more widely known that any Treaty of Waitangi settlements proposed will never compensate for the loss of land and sovereignty of Iwi and Hapu throughout the country, but it is one mechanism of at least attempting to right past wrongdoings by Crown officials and their historical predecessors.

Aotearoa New Zealand is not unique in this respect. Worldwide indigenous movements in education, health, sovereign rights, environmental protection and holistic living are gaining momentum. Internationally, indigenous communities are combining community, political and intellectual resources to address adversities such as resource depletion and economic uncertainty. Some of the most innovative indigenous thinkers are coming together to stimulate combined efforts for social change (L. Smith, 1999). The reclamation of Maori health models by Maori communities is therefore part of an international movement. The application of Kaupapa Maori theory seeks to strengthen that cause.

3.5 CRITICISMS OF KAUPAPA MAORI THEORY

The solidarity of Kaupapa Maori theory as a preferred theoretical position for Maori researchers (in health, education, social justice, social welfare etc) is open to criticism. Dr Elizabeth Rata for instance has challenged the theoretical assumptions of Kaupapa Maori approaches in Maori education and as a foundation for constitutional democracy in New Zealand (Rata, 2004). She

asserts that Kaupapa Maori is "the intellectual expression of a neotraditional ideology that serves the class interests of the neotribal capitalist elite" (Rata, 2004, p.3). How she arrives at that position is based on a commitment to the universal notion of one people, one nation – though in her case she fails to declare that intention. Her condemnation of Kaupapa Maori theory is seen as a direct attack to those people committed to the ongoing flourishing of Te Ao Maori. Her assertion undermines the work of Kaupapa Maori theorists and therefore the underpinning of Te Ao Maori. However, her challenge has been refuted for its lack of Maori participation and therefore voice. She has also been challenged for her failure to disclose her intentions (Pihama, 2004). It is my contention that through this research, the multiple perspectives and narratives of the research community are positioned to decide its relative worthiness as a basis for this research, through their comments and responses shall derive potential value. The outright dismissal of Kaupapa Maori theory without due recognition of the voices of the research community calls into question her critique. The intention in this study is to strengthen the field in an emancipatory way. In that way, it is potentially likely that a need for 'self-criticism' will emerge as a valued tenet of Kaupapa Maori theory in the future.

Kaupapa Maori theory may also be challenged as an essentialising project. Essentialism is typically defined as 'opposition to difference' (Said, 1993). Opposition reminds us that there is a complex system of cultural, social, psychical and historical differences that exist that are not based solely on some pure human essence. In the postcolonial context, essentialism is evoked to reduce indigenous people to some 'essential idea of existence' of what it means to be African, Samoan or Maori. The purpose of essentialism in this regard is linked to power relations through categorisation thus simplifying the task of colonisation. Said (1993) argues against this inversion on the basis that in postcolonial national states, the

> liabilities of such essences as the Celtic spirit, negritude or Islam are clear: they have much to do not only with the native manipulators, who also use them to cover up contemporary faults, corruptions, tyrannies, but also with the embattled imperial contexts out of which they came and in which they were felt to be necessary (Said, 1993, p.17).

In this regard, Kaupapa Maori theorists may need to further develop the theory. They do recognise the multiple positions within Maoridom, as there are multiple positions within Pakeha New Zealand diversity, which does not diminish the legitimacy of the category as a means of erasing the diversities that exist within the population of Maori people. The concept 'Maori' for instance is constructed on essentialist terms which exclude bi/cultural or multi/cultural specificities (Moeke-Maxwell, 2003). It is important to highlight that the issues are not about blood quantum or the derivatives of identities. They are about ontology and consciousness and the way in which people subscribe to these particular worldviews. Kaupapa Maori theory reiterates that people subscribe to a Maori prescribed sense of affiliation concerning positioning and standing within a specific paradigm that demands transformative change for Maori: Iwi, Hapu and/or Whanau and to do that demands a sense of knowing and commitment. Simply stating an affiliation to Kaupapa Maori theory without having or possessing an intimate knowledge of its elements and components is dishonest or naive. An equal concern is the possibility that people know of these concerns, but continue to manipulate power relations by claiming positions that demonstrate an authentic sense of being Maori, Iwi, Hapu and/or Whanau based on essentialism.

Secondly, there is a possibility that Kaupapa Maori theory may be criticised for similar reasons that postcolonialist scholarship and critical theory are criticised. Part of the reason for this is due to the qualitative and subjective nature of the theory which is challenged by advocates of positivism. It may also be challenged for its lack of tradition in that it has had to draw from established western academic traditions to source aspects of its current standing. Kaupapa Maori theory also relates to other racial and ethnic discourses prevalent within social theory which may expose its tenets to the shortcomings of other racial/ethnic theories. For instance, critical race theory was criticised for its pledge against the American way of democracy of 'one person, one vote, one law, and one people' (Ladson-Billings, 2000). As mentioned earlier, there is a possibility that Kaupapa Maori theory may be challenged as being 'undemocratic' and against the New Zealand way (Clifton, 2004).

I have argued in this chapter, that elements of Kaupapa Maori theory such as Maori knowledge, Maori language and Maori tikanga (customs) are validated and taken for granted. I stand by this assertion, knowing full well the challenges associated with this standpoint given the alignment of Kaupapa Maori theory to critical theory. In the following chapter, a greater appreciation of critical theory will be undertaken given the significance of its underlying tenets to Kaupapa Maori theory on the whole. From there, my efforts will focus upon the societal or socio-political environment or structural forces to which the endeavours and improvements for Maori health and wellbeing are subjected. In this regard, Kaupapa Maori theory provides a theory that aims to deal with structural issues as well as the need for human agency.

3.6 SUMMARY

I have introduced Kaupapa Maori theory, as the predominant theoretical tool that informs this inquiry into the enhancement of Maori health and wellbeing. Kaupapa Maori theory is a contemporary manifestation of an ongoing commitment for transformative proactive social change in Maori development. Smith (1997) reiterates that as a meaningful theory of change it has three significant components which align it to a critical theory framework to form one theoretical package: conscientisation, resistance and praxis. Kaupapa Maori theory validates and legitimates Maori knowledge, Te Reo Maori and Tikanga Maori as taken for granted. It requires a critical analysis of existing power structures and societal inequalities that have been created through the acts of colonisation and free market reforms. It requires a critical examination of the interface of the economic, political and cultural in forming structures of domination in the healthcare sector. It states that existing oppressive regimes are socially constructed and as such are humanly alterable. It also rejects dominant group constructions of Maori as 'other' and emphasises the status of Maori people as tangata whenua, thereby encompassing the ongoing struggles of Iwi to reclaim land and tino rangatiratanga. Kaupapa Maori theory re-centralises the importance of theory to inform the strategies adopted by Maori to bring about transformative social change. It is fundamentally based on the premise that a dialectical relationship exists between theory and practice – praxis.

CHAPTER FOUR: WORKING TOWARDS A CRITICAL THEORY OF MAORI HEALTH AND WELLBEING

"The revolution we openly rap about is one of total change...we see that many of our problems of oppression and racism are tools of this society's outlook based on capitalism; hence for total change one must change society altogether" (Polynesian Panther Party, 1975)

4.1 INTRODUCTION

In this chapter, I present key themes, ideas and concepts of critical theory that are employed in this thesis. These themes help theoretically explain many of the complexities associated with advancing Maori health and wellbeing. These concepts also serve to demonstrate where the commonalities between critical theory and Kaupapa Maori theory exist, as a means to posit a work in progress towards a critical theory for enhancing Maori health and wellbeing.

4.2 CRITICAL THEORIES

4.2.1 Foundations of Critical Theory in Maori Health

Critical theorists have as an aim the project of rethinking and radically reconstructing the meaning of human emancipation (Giroux, 2001). They seek to contribute to emancipation by exposing ways of thinking and being that are suppressive. Critical theorists advocate for alternative, more liberating ways of going about things, in the course of our normal daily lives. According to Kincheloe and McLaren (2000), critical social theorists are concerned with issues of

> power and control, justice and the ways of the economy, matters of race, class, gender, ideologies, discourses, education, religion and other social institutions and cultural dynamics interact to construct a social system (p.281).

Alvesson and Deetz (2000) propose that it is difficult to adequately define critical theory as one set of ideas. They suggest that researchers adopt a process of critique which involves the examination of social institutions, ideologies, discourses and forms of consciousness relating to representation and domination. According to Gibson (cited in Pihama, 1993) critical theory entails

- A preoccupation with theories focusing upon a belief that theory and practice are indivisible
- A method of engaging with 'real' problems, as both the subject and justification of its theorising
- An active analysis of and critique of positivism and the rejection of concepts such as naturalness and givenness in society
- A perception that all facts are socially constructed and therefore humanly changeable
- Proposing that people construct categories, concepts and facts that provide for the interests of specific groups of people
- A commitment to revealing inconsistent interests as a means to expose perceived power relations
- A set of 'emancipatory and liberatory objectives' that serve to not only explain problems, but to also provide solutions to those problems so that people are enabled to control and transform their own lives.

Critical theorists therefore question established social orders, dominating practices, ideologies, discourses and institutions as they seek to understand *micro-practices* of everyday life. They tend to use interpretative tools of inquiry with a view to contributing to a liberating transformation for areas of humanity within which they are concerned.

In this chapter, I seek to explore whether tenets of critical theory can be applied to Maori health and wellbeing. Annandale (1999) argues that the application of critical theory to the study of health and wellbeing is relatively new. She has observed the lack of comments related to the critical analysis provided within the

sociology of illness, medicine and more recently wellness and she sought in her account to find a relationship between the two. For instance, as early as the 1940s the interplay between the specific articulation of history and a limited ethnocentric anthropology were concepts linked to the analysis of Maori health and wellness. These limitations were counteracted in Peter Buck's (1950) *the Coming of the Maori.* Buck (1950) was passionate about sharing Maori stories that illuminated Maori perspectives of Maori social structures, Maori customs, Maori health, illness and wellbeing. In his work, he captured narratives from a deep appreciative and compassionate position empathetic to the Maori customary way. Although at the time, his work was classified as anthropological, his analysis in some ways could have aligned with critical theory tenets. In more recent accounts, contemporary examples of critique of Maori health and wellbeing is exemplified by Raeburn Lange (1999) in *May the People Live: A History of Maori Health Development 1900-1920*, Derek Dow's (1999) *Maori Health Policy* and Mason Durie's (1994) *Whaiora: Maori Health Development.* Their approaches review key Maori community concerns associated with progressing Maori health and wellbeing over the last century.

There are many forums for Maori health professionals (health promoters, doctors, nurses and community workers) to discuss issues of Maori health development. In all of these forums, consistent themes emerge. At the *Maori Health Promotion Gateway Hui* held in Auckland in April 2004, a summary of the key themes emphasised aspirations for Maori autonomy and

- The necessity to enhance Maori models of health
- The insurance that Maori are the paramount beneficiaries of Maori health services
- That contemporary tools are recognised as valuable
- That Maori health promotion models should be utilised
- That partnerships in Maori health should be mutually beneficial and
- That barriers to Maori health included societal, political, cultural and racism (Tunks, 2004)

The themes have endured. The uptake of critical theory as a foundation for Kaupapa Maori theory has provided an opportunity to make much more explicit in

the academy the workings of power under neocolonialism – and woven into Kaupapa Maori methodology, a transformational ethos and research process. In the next section I outline the concepts of critical theory in order to demonstrate their link to my research praxis in this project.

4.2.2 Concepts in Critical Theory – Seeing and Knowing Subjugation, Hegemony and Oppression

Critical theorists are concerned with exposing and transforming multiple layers of oppression and domination (Alvesson & Deetz, 2000). Exposing the process of colonisation reveals layers of domination and the many ways in which they manifest (Memmi, 1965). Jane Kelsey, a pre-eminent New Zealand academic writes that transformation of this domination requires action:

> You don't just become a postcolonial society by pretending colonisation did not happen. You make that transition by facing the demons of the past, you take responsibility for its enduring legacy, you recognise the mana and the rangatiratanga of those you dispossessed and you work out new ways forward that are constructive and just (Kelsey, 2004, p.1).

To transform the established social order requires an acknowledgement of the processes through which social order remains in place. Active resistance to that order goes hand in hand with positive action towards emancipation and liberation. In seeking to analytically expose oppression as advocated by critical theorists, I review oppression and hegemony as concepts that support existing patterns of social order argued to work against Maori aspirations to advance Maori health and wellbeing.

Oppression is a term used to describe the relationship between holders of power and those without power who are unable to wrestle their way out of situations of impoverishment and subjugation (Freire, 1970, 1994; Said, 1991, 1993). During the 19th and 20th century, oppression was viewed as an ethos that supported the debasement, dehumanisation and subordination of countries and their occupants (Said, 1993). In Aotearoa New Zealand, the processes of colonisation that were associated with breaches of the Treaty of Waitangi ensured that Maori people at that time were unable to influence the course of events that led to the loss of land and the loss of the cultural underpinnings of identity, authority and wellbeing

(Walker, 1990). Maori people were unable to bring themselves out of that predicament to reclaim 'a freedom' they had not given away - but was taken from them (G. Smith, 1997). Oppression to Maori meant loss of sovereignty, loss of tribal chieftainship, loss of culturally appropriate systems of organisation, loss of tribal estates and loss of land (Walker, 1984).

The concept of hegemony refers to the success of the dominant culture/classes to present their view of reality in such a way that it is seen as the only legitimate system even by those oppressed by it (Harawira, 1999a, 1999b; Pihama, 1993; G. Smith, 1997). Any contrary view is marginalised. For instance:

> The supremacy of a social group manifests itself in two ways, as 'domination' and as 'intellectual and moral leadership' and the 'normal' exercise of hegemony on the now classical terrain of the parliamentary regime is characterised by the combination of force and consent, which balance each other reciprocally, without force predominating excessively over consent (Story cited in Goldberg, 2004, p.2).

Smith (1997) says that hegemony functions in various ways to exercise control of dominant interests over groups such as women, Maori, labourers, students, homosexuals and immigrants. In his view, hegemony operates to sustain and reinforce the authority of institutions commensurate with the existing power relations. Hegemony then operates to both conceal and protect the existing status of domination and subordination. It is not a static concept. Its fluid processes influence the ability of dominant ideologies to remain intact through the constant struggle against the domination of multitude ideologies (Kelsey, 1993).

Paulo Freire's work is seminal in articulating a response to oppression and became influential among Maori activists, Maori intellectuals and non-Maori anti racism workers in the mid 1980s. Freire (1970), mindful of the hegemonic aspects of oppression argues that the oppressed must reject an image of themselves as oppressed and

> replace it with [one of] autonomy and responsibility. Freedom is acquired by conquest, not by gift. It must be pursued constantly and responsibly. Freedom is ... the indispensable condition for the quest for human completion. To surmount the situation of oppression, people must first critically recognise its causes, so that through transforming action they can create a new situation, one that makes possible the pursuit of a fuller humanity (p.29).

Freire argues that to be no longer subjected to the force of oppression requires the emergence from its force. This can only be done by the means of praxis: reflection and action upon the world in order to transform it. He asserts that challenging the system requires leaders of the oppressed to engage in dialogical conversations with people. The critical knowledge of leaders, mutually with the spirit and knowledge of the people provides a platform for countering the influence of oppression. Once oppressed people have been conscientised to their situation, transforming action can be enabled. The process and activity of conscientisation is therefore an essential component of critical theory.

Aotearoa New Zealand has witnessed various examples of cultural and ideological hegemony. One particular example is the perpetuation of land registry offices such as local government authorities and the Governor General of Land Valuation to view and actively value Maori land as if it were a commodity (Rikys, 2001). A growing number of Maori and most Pakeha have come to understand land as a commodity. All of these common discourses to do with land, manifest (normalise and naturalise) such a concept into practice. Many Maori and indigenous people around the world resist this re-conceptualisation of land as a commodity. They continue to treasure land as a symbol and as a tangible tribal taonga of significance (Pere, 1984; Rikys, 2001; Rolleston & Patuawa, 2004; Walker, 1990). Maori have also challenged the rating of Maori land through the Waitangi Tribunal claims process and also through an appeal against the Valuer General regarding Maori land valuations[12] (Rolleston & Patuawa, 2004). The Maori view in terms of how Maori land should be subjected to a rating system is continuously undermined (Rikys, 2001).

A recent example is the imposition of a new law, which seeks to extinguish Maori customary rights of the foreshore and seabed (Kelsey, 2004). Maori argue that this strip of land called the foreshore is a customary resource of respective Hapu and Iwi who reside on or near the land which is located by the foreshore (Jackson,

[12] The Mangatu Incorporation Case was lodged against the valuing of Maori land at market valuations rates. The judgement from the case provided remedial solutions based on the number of owners in any land block. See Valuer-General v Mangatu Incorporation [1997] 3 NZLR 641

2004). However, the Government presents a contrary argument and its representatives have pressed the issue forward with the proposal to pass a controversial law ceding the foreshore and seabed to the Crown (Sneddon, 2004a). The discomfort with the unallocated strip of land known as the 'foreshore' is a good example of the way in which Maori views and rights to customary land are undermined. Any balance of forces achieved is often unstable, always requiring ongoing attention and commitment. Fiske (cited in Goldberg, 2004) argues that hegemonic victories are never final (or total). Any

> society will evidence numerous points where subordinate groups have resisted the total domination that is hegemony's aim, and have withheld their consent to the system. The constant struggles referred to above, played out as resistance, as emancipation, as counter-hegemony and counter-narrating (p.2).

Critical theory can also involve an analysis of resistance theory and reproduction theory. Giroux (1983) argues that resistance theory in education as an approach to challenge the over-socialised, deterministic paradigm of reproduction theories that serve hegemonic control. Reproduction theories support, reinforce and legitimate the stratification of society through economic and ideological reproduction (Giroux, 2001; Giroux, Lankshear, McLaren, & Peters, 1996; hooks, 1990; Pihama, 1993).

To illustrate, these theories can be applied to the way in which schools are rated in terms of their socio-economic status, defined as a decile rating. For instance, if a school is located in a low socio-economic community, the decile rating is low and the funding received by the Ministry of Education is higher than if the decile rating was higher. Higher rates of funding in this instance is 'relative' and does little to contribute to addressing the many more complex issues related to long term poverty, unemployment and underachievement within the community. For schools, a higher decile rating does little to ensure that sustainable funding is available for the school and therefore the community in the long term. In terms of reproduction theory, a school may hold up a mirror and see itself as a reflection of the society in which it is located. In many cases the mirror image may be of an impoverished community (Norris, 2002). Could this theory be applied to health centres? I would argue that healthcare centres also hold mirror positions that reflect the stratification of society and community in which they are located. For

instance, poorer communities are more inclined to set up general practitioner services that have limited access (e.g. only open one day per week), but the services are provided at a much lower rate than can be substantially subsidised on the basis of social inequalities that might prevail in those communities. Although the services are quite irregular, they are often the only ones that poor community people can afford.

Resistance theory is seen as a response to the hegemonic imposition of the worldviews of the oppressor (Freire, 1994; Giroux, 2001; West, 1993). It is inherently critical and requires an explicit definition of what types of actions and behaviours are suited as resistance strategies. Pihama (1993) says resistance theory must incorporate a concept of power that is both exercised on and by people in a range of contexts that 'structure interacting relations of dominance and autonomy'. Prominent historical examples of resistance in action in Aotearoa New Zealand include the King movement (Mahuta, 1992), the various Maori religious movements (Kawharu, 1989), the Kohanga Reo movement (Hohepa, 1999) and Kura Kaupapa Maori (G. Smith, 1992) and recently the Hikoi against the seabed and foreshore legislation (Harris, 2004). Theories of resistance played out in the field of Maori health challenge the paradigms of biomedicine and more recently a particular orientation of 'new public health' (Petersen & Lupton, 1996), by actively aspiring to be guided by Maori concepts of health in their place (see *Chapter Seven*).

Resistance strategies can also be seen as very personal actions. For example, the contrasting metaphorical representation of a peaceful warrior or an aggressive warrior might be employed to achieve specific political interjections, to air ruptures between methodological assumptions in public forums, hui, formal complaint procedures, legal proceedings, hikoi, protests and acts of civil disobedience. The very visible and liberating experience of the Hikoi to Wellington in May 2004 is an example (Harris, 2004). This protest was organised as a form of resistance against Crown proposals for extinguishing Maori customary rights to the seabed and foreshore by way of a new Act of Parliament (Jackson, 2004; Kelsey, 2004). The ability of people to speak out against that proposal was undermined by government officials. Two specific examples were

highlighted during the period of the informal protest and the formal submissions process to the select committee concerning the first reading of the Bill. In the first instance, Maori public servants were forced to reconsider their professional careers as servants to the Crown. A memo was sent to all government agencies outlining that involvement in the hikoi would result in their immediate dismissal[13]. The second example involved a senior public servant who had submitted a formal response to protest against the Foreshore and Seabed Bill in another role he performs as a tribal leader. Haami Piripi, the Chief Executive Officer of the Maori Language Commission was publicly reprimanded for what was viewed by officials as an act of civil disobedience. He was put on notice for acting against his employer, the Crown. The public disciplining of Haami Piripi in his capacity as a Te Rarawa tribal representative served as a reminder to all employees of the State, particularly Maori, that this type of behaviour by senior officials would not be tolerated[14]. On this occasion the Eurocentric notion of good governance was the only worldview acknowledged. This is a good example of the ways in which hegemony operates. It mattered little that the submission was made on behalf of Te Rarawa, a prominent Iwi situated at the top of the North Island.

Aspirations and actions consistent with emancipation that are relevant to the Maori situation in Aotearoa New Zealand are concerned with asserting Maori autonomy in ways that are transformational, for instance an example may entail the active recognition and validation of Maori as a sovereign people, as manifested in the 1835 Declaration of Independence (see *Appendix One: 1835 Declaration of Independence*). It is recognition of the association that sovereign peoples have to exercise their rights to express themselves in specific cultural ways. It is also about recognising Maori rights as indigenous people affirmed in the Treaty of Waitangi 1840 (discussed in further detail in *Chapter Five*). The contextual expression and meaning of emancipation in light of this observation is about regaining the freedom to be Maori, to act Maori and to reclaim rights to resources that should never have been taken in the first place. The emancipation

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[13] New Zealand Herald, 2-3 August 2004.

[14] New Zealand Herald, 2-3 August 2004.

that Maori people seek is a dual notion of citizenship as New Zealanders and as sovereign people of this nation who possess different cultural signifiers and symbols, languages and rituals (Fleras & Spoonley, 1999). It is an emancipation that requires the New Zealand Government to recognise and honour the Treaty of Waitangi and to restore that, which has been lost through its many breaches (Walker, 1990). It is a sense of emancipation that requires that the New Zealand Government acknowledge the demoralising sense of loss that occurred as a result of warfare and battle.

The process of healing historical wounds is in progress at this time. Evidence of this is visible with the Treaty of Waitangi settlements reached with tribal groups such as Ngai Tahu, Waikato/Tainui, Ngati Whakaue, and Ngati Ruanui[15]. However, the platform and space for healing those wounds is being threatened by re-energised movements of counter attack by colonising voices. Prominent among these situations was the speech given on 27 January 2004 in Orewa by Dr Don Brash, leader of the National Party opposition. While he generated a surge of anti-Maori activity, the energy of this surge also fuelled support for the development of the Maori Party and pressed supportive Pakeha to become actively involved, declaring their own position regarding race relations in Aotearoa New Zealand. Workshops by and for Pakeha seeking to uphold the Treaty and to learn what it means to support these manifestations were held throughout the country (Sneddon, 2004b). The flurry of activity in support of these aspirations demonstrated the imperfect achievement of cultural hegemony in this country. It draws attention to the continued resistance of those working for Maori sovereignty since the 1880s.

The emancipation being spoken about by Maori is about achieving an unencumbered sense of freedom to exist as Maori or tribal beings, uninhibited by racism, hegemony, domination, ridicule and manipulation. Emancipation manifests as a vital concern of critical theorists according to Pihama (1993). It is

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[15] See the Office of Treaty Settlements for further information about the details of these claims. The Office of the Treaty Settlements is the government agency responsible for progressing Treaty of Waitangi Claims from the completion of their hearings to final settlement. See www.ots.govt.nz.

a transformative process through which oppressed people achieve freedom from the imposition of hegemonic ideologies. Freire (1970) regards the development of liberatory praxis as essential to the emancipation of oppressed groups. Just as vital is a process of conscentisation within which the oppressed identify social, political and economic contradictions, and in so doing revolt against the oppressive conditions that perpetuate positions of subordination. Conscientisation is therefore an act of understanding which allows the oppressed to identify unequal power relationships (Bishop & Glynn, 1999; Freire, 1970). It is the coming to terms with seeing the world as it is and reacting to that process of conscientisation with a strength and conviction to bring about transformative social change and emancipation. Theories of emancipation have been applied to inform the Maori renaissance movement in the 1970's and 1980's, which sought to contribute to a political and cultural consciousness amongst Maori communities (Walker, 1990). In the 1990's, the liberatory spirit which manifested from that agenda to seek freedom and social justice led to a concerted effort by Maori to prioritise and aspire to achieve Maori philosophical approaches to social change in education and health services (Durie, 1994). Significant developments in Maori health have since included the establishment of marae based health clinics and Maori health collectives (Te Puni Kokiri, 1994). Resistance strategies such as these are counter-hegemonic practices influenced by a Kaupapa Maori philosophy which emphasises conscientisation and liberatory praxis (Bishop, 1996a; G. Smith, 1992; L. Smith, 1999).

Emancipation is therefore closely aligned with the concept of empowerment. According to Bishop (1996b), empowerment translates into a form of praxis where Maori people have more control over the ways and means of decision-making, so that what is being done is manifested by Maori for Maori. According to Aronowitz and Giroux (1985), emancipation cannot be delivered from the outside; it must emanate from within marginalised communities. Freire (1970) contends that the oppressed themselves must resolve contradictions, which are part of their own world in order for them to understand their own experiences of the world. He writes that it is

> the great humanistic and historical task of the oppressed: to liberate themselves and their oppressors as well. The oppressors, who oppress, exploit and rape by virtue of their power, cannot find in this power the strength to liberate either the

> oppressed or themselves. Only power that springs from the weakness of the oppressed will be sufficiently strong to free both (Freire, 1970, p.21).

4.2.3 Transformative Praxis

Transformative praxis requires a profound commitment to praxis: reflection and action. Freire (1970) argues that for people to overcome oppression, they must first recognise its causes, so that through transformative action new situations can be created which make possible the pursuit of 'a fuller humanity'. The process of recognising its causes is part of the process of conscientisation: the recognition and acknowledgement of the 'domesticating forces of oppression' (Sawicki, 1991). Many people fear this freedom and autonomy and it is only when the oppressed or marginalised reveal the actions of the oppressor that they can become organised to struggle for liberation (Freire, 1994). Freire suggests that this discovery cannot be

> purely intellectual, but [it] must involve action; nor can it be limited to mere activism, but must include serious reflection: only then will it be praxis. Critical and liberating dialogue, which presupposes action, must be carried on with the oppressed at whatever the stage of their struggle for liberation....attempting to liberate the oppressed without their reflective participation in the act of liberation is to treat them as objects which must be saved from the burning building; it is to lead them into the populist pitfall and transform them into masses which can be manipulated (1970, p.47).

The role of the critical thinker is to provide opportunities for the transformative praxis to occur (Freire, 1970, 1994). In most cases, this type of commitment requires a passion for working alongside and with the people, to expose them to the tools and means to see oppressive instruments as they exist and to work in unison to overcome those subordinating instruments. Transforming the Maori situation requires a profound commitment to provide opportunities for conscientising not only our own minds against the desensitisation of colonisation, but also the minds of others. As Memmi (1965) warns, it is the oppressed who have assumed the mantle of the oppressor operating in the name of the oppressed that are the most dangerous. A transformative ethos has been and continues to be the way in which Maori education initiatives and Maori health initiatives aspire to operate (L. Smith, 1999). In many cases, these types of initiatives have emerged outside of the 'mainstream system' as renaissance and resistance movements

which are strongly committed to the transformation of a society in which *mana* is fully restored (Bishop, 1996b).

4.2.4 Organic Intellectuals

The ability to influence human emancipation and liberation as the theoretical discussions above suggest is influenced by a theory of leadership and a process of enacting that theory (Said, 1993). Traditional Maori leadership involved rangatira, ariki and tohunga (A. Mead, 1994; H. Mead, 2003; Walker, 1993). The roles they perform are already discussed in *Chapter Two* as an inherent part of traditional Maori social practices. These roles are enacted today but not with the level of influence that existed historically. Although the status of a *rangatira* is usually steeped with mana in the eyes of the people, this respect is often diminished by government officials who are required to engage with these leaders. This diminished respect is not only expressed by Non-Maori. John Tamihere, for example, previously a member of parliament and a Ngati Porou tribal member refutes the claim that traditional tribal leadership exists in contemporary society (Tamihere & Bain, 2004). He argues that tribal leadership is irrelevant for many Maori, particularly urban Maori. In reaction to these challenges, new and different types of leadership are emerging to cater with the various contemporary Maori spaces. One of these new spaces is associated with the role of the intellectual.

The role of the intellectual according to Smith (1997) forms part of Gramsci's ideas about hegemony, counter hegemony, intellectuals and war of position. Drawn together he suggests that these ideas are crucial components of bringing about transformative praxis. In this chapter, three constructs of the intellectual will be explored in this section: the traditional intellectual, the organic intellectual and the Maori intellectual. Edward Said (1994) explores the notion of intellectuals in *Representations of the Intellectual – The 1993 Reith Lectures*. He explores the contributions of Antonio Gramsci in detail. In the review, intellectuals are either traditional intellectuals or organic intellectuals. Traditional intellectuals are teachers, priests, professors, academics and administrators who have performed the same duties for generations. They function to legitimate the

existing hegemony of the dominant class by reproducing the ideas and aspirations of the people to whom they belong. Smith (1997) says traditional intellectuals are located within the official bureaucracy; schools, universities, media and so forth. Whilst these intellectuals argue that they are neutral, objective and autonomous thinkers, they seem to operate in a fashion that maintains the status quo.

In contrast, Said (1994) argues that organic intellectuals are directly linked to minorities or activities that require intellectuals to organise interests, increase power and solicit control. Gramsci (cited in Said, 1994) suggests that organic intellectuals are actively involved with people in society, to change minds and attitudes, and expand opportunities. Smith (1997) argues that organic intellectuals can be found throughout all classes, but characterises their work as continual attempts to create space for disenfranchised people or minority groups. Organic intellectuals operate from a position of solidarity with the oppressed, the colonised and the marginalised. These types of intellectuals have an interest in transformation, emancipation and the bringing about of better conditions. Their function is to instil aspirations for counter hegemony and to position transformative praxis as a legitimate and accepted outcome. Organic intellectuals working within academia are expected to perform a role in theorising and communicating new ideas/concepts to traditional intellectuals in the interest of giving voice to the marginalised. Smith (1997) suggests that the organic intellectual operates by a similar set of principles as the 'insider researcher', a term explained in the *Prologue* section. The concept of the organic intellectual, "best describes the reflexive and formative progression of Maori struggle, which is tracked out within the theoretical and practical dimensions of the author's praxis" (G. Smith, 1997).

In terms of the various Maori struggles, an organic intellectual requires the expansive skills set of the intellectual to prevail in a manner that does not alienate the people. There are many occasions and examples where those persons who possess these skills and who are provided with the mandate to progress issues on behalf of the people, enter and engage with multiple struggles in multiple contexts. For example, it has been my experience that whilst this thesis is focused upon the concerns related to Maori health, to gauge a true sense of the magnitude

of the Maori struggle requires a much deeper appreciation and affiliation with the 'Maori situation' at its most localised level. In most cases this involves an intimate knowledge and commitment to bringing about social change with people, through many of the methodologies that people are accustomed to, whilst also being able to expand upon those methodologies when appropriate.

The transformative praxis explored by a Maori organic intellectual requires that their work is located within relationships with and for the people. Maori organic intellectuals are people who know their place in terms of how and what to say as a method of contributing to the greater cause of the community. That person may be an expert in their field in terms of their qualifications or work experience outside of the Hapu or the Whanau, but within the confines of the people, that expertise must be filtered back through the appropriate channels of leadership, Hapu and Whanau decision making and the appropriate communication processes.

A Maori organic intellectual has a giving nature and works closely with their Whanau behind the scenes doing the work of the workers, but sensing and knowing when to move out of that space to perform duties for the Whanau on a different type of battlefield. These battlefields may include presentations to school board of trustees, local government authorities, annual submission forums, local working parties for tangata whenua interests and environmental hearings on behalf of the people. A Maori organic intellectual is also able to critically examine the position of the people in the greater context of Aotearoa New Zealand, balanced with a total commitment to the rights of Maori to tino rangatiratanga. They also work with ease within both Te Ao Maori and Te Ao Pakeha.

Julien Benda (cited in Said, 1994, pp.4-5) saw the role of intellectuals differently. She saw them as 'super-gifted and morally endowed philosopher-kings who constitute the conscience of mankind'. Real intellectuals, she argues, are very rare people who uphold eternal concepts of truth and justice not of this world. They seek the possession of intangible advantages. In this sense, the concept of the intellectual according to Julien is similar to the roles performed by tohunga. According to Best (cited in Moon, 2003, p.10) tohunga were "the holders of the

essence of what it meant to be Maori. Whilst all else was being pulled away, tohunga stood firm as repositories of this essence". Accordingly, it is not surprising that these people were the most persecuted in the process of colonisation as a result of the Tohunga Suppression Act 1907.

Said (1993) concurs with Gramsci that a less conservative perspective would see everyone working in some way to distribute knowledge in the role as an intellectual. He also suggests that an intellectual has a responsibility to represent, embody and articulate a view, message or philosophy to their people about certain matters of importance, which are guided by universal principles of freedom, justice and resistance to violations of these standards, which are constantly and critically being evaluated on an ongoing basis, with constant alertness. In a critical review of *Intellectuals*, Peters (1992) states that the traditional position of the intellectual is uncertain as new social movements and politics of difference emerge to contest the taken for granted role of traditional intellectuals. He argues that intellectuals must develop new ways of investigating conceptions of society that are not exclusively connected to dominant notions of rationality. He further reiterates that dualistic binary logic in terms of mutually exclusive opposites should be discarded, given the pluralistic and multi-dimensional influences upon our existence. The traditional role of the intellectual in 'speaking for others' is also being challenged in light of the emerging politics associated with representing 'who speaks' as an act of violation. Watt (2001) was concerned with the co-option of intellectuals as traditional institutions such as universities as they are influenced by market ideologies. He is concerned that intellectuals will become faculty within the research and development wing of particular companies and where students are refashioned as customers. Maori organic intellectuals and leaders (community, tribal) in their various configurations should actively resist this type of co-option. The role performed by these figures in supporting the liberation and emancipation of efforts by, for and with their people could be undermined as a result. The need then to match critical theory with conditions of the Maori situation provides a platform to support the convergence of critical theory with Kaupapa Maori theory.

4.3 CRITICAL THEORY AND KAUPAPA MAORI THEORY

An objective of this chapter is to develop links being made between critical theory and Kaupapa Maori theory. This section will attempt to highlight where similarities between the two theories exist. Kaupapa Maori theory employs a cultural approach to enhancing Maori wellbeing. In order for Maori to address their wellbeing in culturally appropriate ways necessary for their wellbeing as Maori, it is essential that forms of domination and hegemony are exposed, resisted and transformed. The resistance to subordination, domination, oppression and hegemony is well articulated within the traditions of critical theory and as such, it has served as a platform for Maori scholars to engage academia from a perspective with which many of them are familiar. For instance:

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

Bishop (1994) accentuates that concerns about researching into the lives of Maori people are addressable by critical theory, but at the same time he questions the hitherto silence of many critical theorists on the issues facing indigenous people the world over. Smith (1996) therefore positions Kaupapa Maori theory as a *localised critical theory* drawing on notions of critique, resistance, struggle and emancipation. Scholars of colour and Maori alike favour the critical tradition, although ironically it is in itself almost exclusively drawn from Western social history, or Western derived paradigms (see Stanfield in Scheurish & Young, 1997). For them, the critical tradition has until now, been the only readily available and epistemologically suitable approach for research. Its advantage is that it allows indigenous scholars to build on the already legitimated work of critical scholars to extend this scholarship in their own ways. For instance, it is opposed to racism and actively resists the production of negative social outcomes (Scheurish & Young, 1997).

Kaupapa Maori theory, therefore, can be seen as a racialised or ethnically focussed strand of critical theory (Stanfield cited in Scheurich and Young (1997). Both critical theory and Kaupapa Maori theory support the adoption of indigenous

based epistemologies, which reconnect ways of knowing to positions of power, based on alternative forms of identity. Kaupapa Maori theory however sets this reconnection to Te Ao Maori at the forefront of its potential contribution to enhancing social change (G. Smith, 1997; L. Smith, 1999).

However, it is one matter to disclose an affiliation with a tradition of scholarship and inquiry, but it is another task to draw specific links from those traditions to the field of inquiry concerned. In this respect, Smith (1997) highlights what he sees as a close affiliation with the works of specific critical, emancipatory, resistance theorists such as Freire, Gramsci, Apple and Fanon with associated transformational aspirations.

> There is something in all of their work, which connects closely with indigenous experience and struggle – all of these writers speak from a position 'alongside' or 'within' the 'ranks' of oppressed/exploited people. All of these writers' works address the 'struggle' in a positive and optimistic way. All of these writers put emphasis on transformative outcomes. All of these writers openly declare their particularation in various forms of struggle. What distinguishes these writers and their respective works (and other writers in this vein) is the empathy, which they are able to achieve with other peoples reality across the other side of the world who are involved in similar struggles. In a sense, this is also a validation of their work (G. Smith, 1997, p.35).

Critical theory is appealing to Maori and indigenous communities alike because it seems to find a common foundation through which the tenets of each of the theories (Kaupapa Maori and critical theory) can be seen almost as one in the same. However, there are aspects of critical theory that are quite distinct from Kaupapa Maori theory. For example, critical theory does not prioritise the epistemological or ontological position of the community of concern or the people undertaking the critique. In contrast, Kaupapa Maori theory fundamentally emphasises the importance of 'being Maori'. Kaupapa Maori theory supports cultural institutions that contribute to its uniqueness, however advocates of this theory may be criticised for failing to review the contradictions that arise as a result of taking this knowledge base for granted.

Positioning myself squarely within Te Ao Maori is an act of commitment to a consciousness or a way of living – as outlined in *Chapter Two: The Foundations of Te Ao Maori.* Here a possible contradiction rests. Critical theorists advocate a commitment to 'critique' underpinning ideologies by not taking any ontological

characteristics for granted. Kaupapa Maori theorists advocate for the right to 'take for granted' the validity of Te Ao Maori as the ontological foundation for being Maori. My resolve is to see the ironies, contradictions and paradoxes that establish and maintain a world view unique to Maori as legitimate (as do other cultures). To do so is a form of open and critical inquiry in itself and its relationship with other cultures (as must other cultures) as ongoing concerns that will generate the energy required for scholarly attention in the future by Kaupapa Maori theorists. 'Being Maori' continues to provide tangible opportunities for reconnection to the community in a world that is currently being threatened by threats of terrorism through the 'peaceful mechanisms of globalised economies' that shift resources from the poor to the rich (Mander & Goldsmith, 1996; Roddick, 2001), cosmetic surgery designed to westernise and perfect faces and bodies in the images of unnatural western ideals of beauty (Clifton, 2004), and inconceivable notions of identity formation through the internet. Being Maori provides a bastion for 'grounded-ness', by attachment to the physical notions of the world.

Through persistent attempts by Maori to hold on to notions of spirituality and human dignity, our courageous acts of resistance, through our solidarity with indigenous people across the world are being achieved. These western cultural impositions are increasingly disruptive to human dignity (Mander & Goldsmith, 1996). This analysis exposes a contradiction to the espoused principles of democratic ideals and in this paradox lies the seed of transformation. In keeping with New Zealand's adherence to the principles of democracy and associated ideals of human rights, Maori rights to be treated respectfully and to have their treaties honoured and their identities and aspirations acknowledged, manifest into their own worldviews. The examination of these ideas (inclusive of the apparent contradictions) forms the theoretical foundations of Kaupapa Maori theory which serve as the analytical basis for the subsequent sections of my thesis.

4.4 TOWARDS A CRITICAL THEORY OF MAORI HEALTH AND WELLBEING

In this section, I will draw from the critical theory discussions presented in this chapter and Kaupapa Maori theory (from *Chapter Three*) to construct a series of

tenets aligned more closely to critically theorising the enhancement of Maori health and well-being (by Maori for Maori). This model is a work in progress and serves as a potential set of parameters for the future to guide protocols for engagement by Kaupapa Maori theorists working in this area. However, I also draw upon the three strands of thought, which are aligned with Freire's notion of critical theory (Freire, 1970, 1994). For instance, where Freire theoretically framed practice around the three concepts: conscientisation, resistance and transformative praxis, I align these concepts with Kaupapa Maori theory concepts: *mauri oho*, *mauri tu* and *mauri ora*. These alignments are performed to enable the themes to more readily progress towards the workings of a *potential* critical theory of Maori health and wellbeing.

4.4.1 Mauri Oho: Conscientisation

Mauri oho is a concept that is likened to 'coming to know', or being awakened to circumstances or situations that are oppressive physically, socially and mentally. There are three potential tenets *of a critical theory of Maori health and wellbeing* which align with this concept of conscientisation or awakening.

A critical theory of Maori health and wellbeing must be conscientised to the benefits associated with working from a Maori health development framework

The acknowledgement of a Maori health development framework as an existing and robust system of analysis and delivery of Maori health (Durie, 1994), is essential to appreciating the way in which the concept of critique is applied in this thesis. My premise is that the contemporary Maori health situation cannot be separated from the historical and contemporary political, social and economic experiences of Maori people within New Zealand (Durie, 1998b). Levels of educational achievement, employment, crime and social justice all impact in some way upon the ideology and practice, application and understanding of Maori health development (Durie, 2001; Ministry of Health, 2002; Ministry of Social Development, 2003; Robson, 2004). The statistical recording and public presentation of Maori pathology and morbidity are a necessary but limited depiction of Maori health and wellbeing. The necessary but equally limited exposure of the systemic issues of poverty, exclusion, racism and neocolonialism

do not give a full or fair picture of Maori health. Much of the courageous and creative efforts of Maori, to gain and retain health under these circumstances are made invisible in these representations. Ensuring these efforts are made visible and celebrated is a necessary part of the conscientisation of Maori and non-Maori alike that I bring through this thesis. I therefore endorse the overall goal of Maori to engage in the provision of core services for improving Maori health and the planning, implementation, control, management and ownership of Maori health initiatives throughout the nation. By endorsing these types of developments, Maori assume control and leadership of activities that directly relate to the health and wellbeing of their own communities in their own way.

A critical theory of Maori health and wellbeing draws attention to the role performed by health experts, as agents of the Maori health development framework. These experts and their patients engage in these encounters which can forge advances in Maori health and wellbeing (Scrambler, 2001; Scrambler & Britten, 2001). The relationship between health professionals (nurses, doctors, health promoters) and patients and people has become a site of contestation in New Zealand and may be more clearly articulated as one of the sites of wider conscientisation.

Waitzkin's (1991) analysis of the relationship between doctors and patients as a 'micro-practice' suggests that discourse (medical, health) reproduces the ideology of individual responsibility for these problems. These micro relationships help construct the broader macro picture, which in turn forms a comprehensive background of broader social contexts at a 'macro-level' (Prilleltensky & Prilleltensky, 2002). The ongoing analysis of the context of micro relationships (through patient and health professionals) and macro relationships (through structural considerations) potentially impacts the ways in which Maori health is advanced. Raising awareness of these dynamics as part of a necessary but limited depiction of Maori is a step towards a broadened awareness of Maori as creative and resilient people under unacceptable personal and societal pressures.

The encounters between Maori people and health professionals are being more readily explored and exposed. Ramsden (2002) for instance highlighted that a

number of concerns can be attributed to the interpersonal relationships of health professionals with their patients, which in her view, if not well managed, directly and negatively impacts upon the wellbeing of Maori patients and their families. Highlighted in her analysis was an ongoing disregard for the importance of cultural safety in these relationships (Ramsden, 1990). Ramsden (2002) was instrumental in recognising the importance of cultural understanding between professionals and patients. Ramsden's critical concern and wake up call to Maori and Non-Maori health professionals (doctors, nurses, therapists, health promoters, social workers, administrators) concerns their roles as people with *expert power* which is exerted to administer medication, medical advice and hope (Waitzkin, 1991). She argued that health professionals have a duty to offer services in ways that neither undermine nor subject people to undue stress and tension. Critical theory and its antecedents ensure that the social relationships between professional and patient are not taken for granted and anomalies are exposed between the conflicts in power relations between these parties (Petersen & Lupton, 1996; Prilleltensky & Prilleltensky, 2002; Scrambler, 2001; Scrambler & Britten, 2001; Waitzkin, 1991).

A critical theory of Maori health and wellbeing must awaken and conscientise to the impacts of the 'new public health' discourse

The 'new public health discourse' espoused by Petersen and Lupton (1996) focuses on lifestyles and a new consciousness about risks, which operate at an individual level and are incorrectly deemed as uncontrollable by a population trained to treat health as 'provided' through medical remedy to illness. Their ideas contrast slightly with some established public health models. For instance, Petersen and Lupton's view of *new public health discourse* is that it is seen as "regimes of power and knowledge that are oriented to the regulation and surveillance of individual bodies and the social body as a whole" (Petersen & Lupton, 1996, p.3). Further characteristics include: an elaboration of the biomedical model to ensure and embed a recognition that solutions to public health are multidimensional, a broader conceptualisation of public health environments, an increased focus on new environmental threats and risks, and an increased affirmation by traditionally marginalised groups to assert alternative frameworks for health (Petersen & Lupton, 1996). Robust advancements of these

aspirations require a conscientisation of the general public. Within these considerations, cultural attributes must be considered for all ethnicities. In this respect, the specific status of Maori as tangata whenua provides a unique position for Maori in health policy development in Aotearoa New Zealand (Durie, 1989; Glover, 2001; Kiro, 2001). This position acknowledges the dramatic circumstances under which Maori are addressing their health and wellbeing *not only* as a group suffering disproportionately from the conditions of social exclusion that manifest in specific health related outcomes, but as tangata whenua, partners in the Treaty of Waitangi which forms the basis of the relationship between Maori and Non-Maori in this country. Constant attention to this unique postion must be part of the conscientisation of Maori and non-maori alike.

A critical theory of Maori health and wellbeing must recognise the crucial roles performed by Maori people to lead and manage the social and economic endeavours of Iwi, Hapu and Whanau

In *Chapter Two*, Maori communities continue to demonstrate and adhere to principles of social organisation founded upon whakapapa (Marsden & Henare, 1992; Rangihau, 1992). Iwi, Hapu and Whanau structures are prevalent and kaumatua and kuia (recognised in their roles as whanau leaders) are still held in the highest regards (Diamond, 2003). Strategies for positive social change can be enacted within Iwi, Hapu and Whanau structures and continue to this day. Those Whanau who have chosen, or have been forced to disassociate themselves from the traditional tribal structure find solace in contemporary adaptations of Whanau structures such as kohanga reo, sports clubs, kapa haka groups and urban Maori authorities (Durie, 1995, 2001). Regardless of the organisational formation available to them, these affiliations are clear statements that being Maori is important. A critical theory of Maori health and wellbeing would actively recognise and endorse those Maori organic intellectuals and traditional Maori leaders who come from within Whanau, Hapu and Iwi.

4.4.2 Mauri Tu: Resistance

Mauri tu is a concept that invites resistance to the activities of people, social systems, social practices and social structures that impede upon Maori systems of organisation and existence. The process of conscientisation described above is a

necessary first step towards this tenet. There are four potential tenets *of a critical theory of Maori health and wellbeing* which align with this concept of resistance.

A critical theory of Maori health and wellbeing resists the existing social order by acknowledging and revealing the practices and colonising effects of governmentality and health surveillance associated with neocolonial models of development

Maori health advancement is particularly vulnerable to shifts in government policies and the impact of government officials to oversee the implementation of policies into action (National Health Committee, 2002). The environment in which primary health care in Aotearoa New Zealand is deemed to be provided by communities for communities, but must be done through a controlled and prescribed system creates a paradox. Armstrong (cited in Jones, 2001, p.176) describes this process as maintenance of control through the continued [and perhaps politically coloured] medical gaze into communities through the extension of public health surveillance. Governmentality is proposed as a form of power practiced in the space between self-regulation and overt regulation/domination (Sawicki, 1991; Turner, 1997). Jones (2001) suggests that *the State* no longer overtly coerces or dominates to encourage 'direct free will' or 'individual responsibility'. A focus on the contextualisation of the responsibility for self directed development, within the context of contractual constraints and requirements to comply with culturally biased forms of accountability and risk management brings this suggestion into question.

Acts of resistance that lead to outcomes that are inconsistent with the requirements of the government contract may be interpreted by government funding bodies as evidence of incompetency or of an unwillingness to act responsibly. A robust critique of this response will entail the examination of the techniques of administration for their arms length domesticating effects (Humphries & Paine, 2004). Thus acts of resistance to have transformational potential must include conscious attention to the disciplinary effects of contemporary techniques of control, discipline, punishment and the re-establishment of domination.

A critical theory of Maori health and wellbeing must resist against the encroachment upon Maori ways of interpreting Maori health knowledge transmitted by Iwi and Hapu experts.

The emerging space of lay knowledge is becoming more prominent within the traditional clinical and medical oriented provisions of health services and advice (Petersen & Lupton, 1996). This particular tenet is consistent with social constructivism (Burr, 1995). The ideas have also existed as part of the traditions of countries operating within the parameters of holism and health such as the eastern countries e.g. China and India (Capra, 1982). In Maori health terms, the re-invigorated importance of rongoa Maori, tohunga and other spiritual healers has become more prominent (Durie, 2001; McGowan, 2000; Moon, 2003) as has the conceptualisation of Maori health models that are based on tribal knowledge bases (Pere, 1984). Often, these models have come from Hapu and Iwi experts, not trained in the traditions of western academia. Therefore, their acceptance as skilled holders of knowledge is challenged by western academics. A critical theory of Maori health and wellbeing would assert the right of Maori to endorse and accept these community leaders as those with knowledge.

A critical theory of Maori health and wellbeing must examine, challenge and resist the influences of consumerism and market ideologies

Consumerism and market ideologies have surfaced as contrasting ways in which health is both conceptualised and operationalised (Henderson & Petersen, 2002). Consumerism encourages the commodification of health as a product and as an object that is subject to the economic influences of buying and selling on the open market (Petersen & Bunton, 1997). Market ideology if applied in practice over time encourages the redefinition of people as 'markets' (Radlin, 1996). If market ideology is applied to the value of health and wellbeing, it is highly probable that it would be repackaged into profits and entire health systems may be re-conceptualised on the basis of a cost benefit analysis exercise. The potential impact of this way of conceptualising the provision of health is that it may emerge as a dominant ideology of health care provision within the New Zealand health system (Ashton, 1999). Maori health initiatives are not excluded from this influence; they are potentially subjected to further assimilation with support by Maori functionaries. Critical theory would require that the impacts of

consumerism and market ideologies are examined and resisted as part of an inquiry into the advancement of Maori health and wellbeing (Petersen & Bunton, 1997; Scrambler, 2001).

A critical theory of Maori health and wellbeing seeks to resist the impact of different approaches of rationality upon the enhancement of Maori health

According to Giroux (2001, p.171), rationality is "a specific set of assumptions and social practices that mediate how an individual or group relates to the wider society". In Aotearoa New Zealand, different forms of rationality such as the biomedical approach; public health approach; holism and more recently consumerist approaches have influenced the way in which Maori health is thought about within the greater context of health development (Capra, 1982; Petersen & Bunton, 1997; Petersen & Lupton, 1996). These approaches are influenced by distinctive assumptions and practices that transpose directly to the way in which health is assessed (Prilleltensky & Prilleltensky, 2002). More will be highlighted about the ways, in which rationality impacts Maori health and wellbeing in *Chapter Seven* on Maori health conceptions (Petersen & Bunton, 1997; Petersen & Lupton, 1996).

4.4.3 Mauri Ora: Transformative Praxis

Mauri Ora is a concept derived from Te Ao Maori and means complete health and wellbeing. Within the context of critical theory, this concept refers to 'transformative praxis or transformative social change'. It is the way in which one conceptualises the flourishing of human potential (Radlin, 1996). There are three potential tenets *of a critical theory of Maori health and wellbeing* which align with this concept of transformative praxis.

A critical theory of Maori health and wellbeing draws from a consciousness about Maori health that is derived from Te Ao Maori and resists externally imposed disciplines and transforms this resistance into creative energies and self determination.

Chapter Two indicated that Maori derive their notion of ontology from a different consciousness and worldview. This consciousness is known by different names such as Te Ao Maori, Maoritanga, Maori worldview, taha Maori, taha wairua and

the Maori mind (Barlow, 1991; Marsden, 1992; H. Mead, 2003; Patterson, 1992; Rangihau, 1992). Maori thought as to how the world should be comes from this source. These ontological, epistemological and teleological views frame the earth as a living being in which humans are interconnected (Pere, 1984; Shirres, 1997). To illustrate, human beings do not dominate nature and its inhabitants; instead principles of co-existence and co-habitation are deemed paramount and consistent with Maori worldviews (Roberts, Norman, Minhinnick, Wihongi, & Kirkwood, 1995). In this thesis, Maori concepts of Maori health and wellbeing posited in this inquiry, are derived from a deep understanding and appreciation of Te Ao Maori (Barlow, 1991; Marsden, 1992; H. Mead, 2003; Patterson, 1992; Rangihau, 1992).

A critical theory of Maori health and wellbeing endorses and nurtures credible and effective forms of Maori leadership and management.

Durie (1998b; 1999) emphasises the need for effective Maori leadership and management. He advocates what is seen as an ongoing critique, evaluation, review, modification and analysis of the way in which the provision of health is managed and the enacted through leadership and management. The transparency required to ensure that these types of goals are met is not always forthcoming and the commitment to a platform for Maori health that can provide these types of assurances is fundamental. One of the requirements related to management and leadership is that those purporting to lead Maori health advances are suitably enabled through the process of Iwi and Hapu processes to bring about change (Durie, 1994, 1998a). Also important, is a critique of current health management systems and their consistency with regards to supporting Maori methodologies of Maori health advancement. A very real risk in this area is the uncritical adoption of western management models that may come as a condition of the contract. These health contracts may endorse techniques of efficiency and effectiveness which are all the icons of western discourse of good governance (Humphries & Paine, 2004), and like a modern day Trojan horse, hide the colonising ethos contained within them.

A critical theory of Maori health and wellbeing subscribes to an ethos of Maori health advancement that is liberating and emancipatory for Maori people

In this chapter, I have outlined the conditions of oppressions and sought to explore concepts of emancipation (Freire, 1994) and counter hegemony (Giroux et al., 1996). These theoretical tools provide a platform for developing solutions to Maori health and wellbeing that are based on notions of transformative praxis - the continual process of reflexive practice and action (G. Smith, 1997). These tenets of critical theory ensure the pursuit of transformative social change and not just *critique*. In this thesis, and within this research inquiry the works of Paulo Freire (1970; 1994), Henry Giroux (2001; Giroux et al., 1996), Graham Smith (1990; 1992; 1995; 1997), Linda Smith (1993; 1996; 1998; 1999), Russell Bishop (1994; 1996a; 1996b; 1997a; 1997b; 1992) and Leonie Pihama (1993) become particularly important as a means to posit a *work in progress* towards a critical theory of Maori health and wellbeing.

4.5 SUMMARY

The lessons drawn from critical theorists that have been highlighted in this chapter provide a number of inferences about the issues that should be considered when intending to advance Maori health and wellbeing. As an example, there is a growing body of literature that is critical of positivist rationalism and more accommodating of an ontological position that supports 'cultural difference' (Bishop, 1997b; Johnston, 1998; L. Smith, 1999). These examples, when drawn together as a theoretical lens helps support assertions of liberatory and emancipatory expressions and solutions to problems specific to Maori. If we, as Maori are to accept the working model towards a critical theory of Maori health and wellbeing, we are required to question theorists who continue to address Maori health and wellbeing based on positivist rationality with assimilist outcomes, which have not served Maori well. Equally significant in this chapter is the recognition that tenets of critical theory if applied to Maori situations, allows for more localised and culturally specific solutions that are owned, controlled and operationalised by those respective Maori communities.

In this chapter, theoretical components of a critical theory of Maori health have been presented and aligned with components of Kaupapa Maori theory. What has emerged is a sense of consistency between the two critical theory derivatives. A number of issues related to Maori aspirations for autonomy, ownership and

control, Maori models of Maori health, as well as the implementation of solutions to managing and organising Maori health and wellbeing activities that are derived from Te Ao Maori. The commitment expressed in this chapter establishes a platform for recognising 'exploitation' and 'repressive social order' wherever it continues to occur. The theoretical tools also provide the platform to circumvent and disrupt the continuation of those processes and to provide the opening and energy for a new way of transformative social change to arise. All of these issues intertwined within this chapter contribute *towards a critical theory in Maori health and wellbeing*.

CHAPTER FIVE: DECOLONISING COLONIAL NARRATIVES WITH 'COUNTER NARRATIVES'

"colonial leopards do not change their spots, they just stalk in different ways"
(Moana Jackson)

5.1 INTRODUCTION

In the previous three chapters, the theoretical lens of Kaupapa Maori theory were presented and explored drawing from both Te Ao Maori and critical theory. In this chapter, I explore the impact of colonialism upon Maori displacement, physically and psychologically. However, the transformation of this situation is made possible through processes of counter-narrative construction and decolonisation. Through the methods of critical theorists, the act of writing history is exposed as a process of constructing a colonial truth. I examine the Treaty narratives and how resistance strategies and commitment to emancipation transformed a people on the brink of extinction to exhibit what Paul Diamond (2003) describes as *a fire in your belly* to act for change. I conclude that colonialism has challenged the spirit of Maori people. The process of decolonisation is a starting point to reclaim and reinvigorate Maori pathways to enhancing Maori health.

5.2 COLONIAL AND COUNTER NARRATIVES

5.2.1 Whose Writing, Whose Narratives

In this section, I use the traditions of critical theorists to expose the oppositional debates about history and how history creates meaning through writing. I deconstruct the colonial views of history about Maori people with a method called "writing back" (Mead, 1996) – a method that finds expression through the work of Trinh Minh-Ha . Smith also uses "writing back" to renounce the potency of colonial interpretations of history by highlighting the limited assumptions

associated with colonial interpretations of history as 'truth' and then re-directing the reader away from the colonialists' view to that of the native. Smith (1999) says to achieve this task, it is necessary to unpeel the layers of meaning already attributed to colonial interpretations of history. The act of writing back is not simply "an inversion of how we have learned to write...the different audiences to whom we speak makes the task somewhat difficult" (Mead, 1996, p.50).

5.2.2 Contested Views of History

For Maori, contesting constructed historical narratives about 'ourselves', who we are, and where we are positioned in the landscape of stories about Aotearoa New Zealand is an essential process towards social transformation. Our narratives are intertwined within symbols of our identity; whenua, waiata, whaikorero and whakapapa. Contesting history, whose history counts and who is writing and recording (orally and in text) history is influenced by power, who has power, who doesn't, and how power affects placement or forces displacement. *Contesting history* is a process of resistance to (incorrect) placement or displacement (within the margins) of a sequence of events, as if they are truth.

Jackson (1993) argues that 'truths of the past', both Maori and colonialist, fabricated a picture of Maori as savage natives and the colonialists as superior beings (Howe cited in Ballara, 1982). In 1846 for instance, the myth of the dying race was perpetuated by Dr Isaac Featherston, a member of the House of Representatives and superintendent of the Wellington Province. He declared that Maori were

> a barbarous and coloured race [which] must inevitably die out by mere contact with the civilised white; our business therefore and all we can do is to smooth [a] pillow for the dying Maori race (cited in Durie, 1994, p.31)

In less than fifty years the Maori population of New Zealand went from being a race that lived a self-sufficient life, to what Buller in 1884 describes as an inevitable period of displacement and extinction (Durie, 1998).

It is tempting to see such 'historical depictions' as sequential events unfolding over time (Fleras & Spoonley, 1999). Belich contends that history is also constructed as a contested narrative about the past, where particular interpretations

aim to support one particular view over another. Sharp emphasises this point with the following explanation:

> Doing history consists in writing or speaking only about those parts of the past of which the historian also chooses. These choices occur in the historian's own time, not in the past; so history is generated in the historian's present, and appears to us to be as much a record of the historian's times as they are of the pasts of which they write (1997, pp.159-160).

The assumptions informing colonial narratives are imbedded in a colonialist psychology that subjugates Maori as 'other, marginalised, native and inferior'. The notion that Maori occupied roles and positions that represented power do not fit with colonial assumptions, for instance the role of land occupier and/owner as highlighted in *the Prologue* contradicts the view of Maori and consequently was dismissed. Many colonialists held strong beliefs that their superiority transferred to a right to exclude, subordinate, exploit and dominate other people (Jackson, 1993). Historical accounts demonstrate that those beliefs and actions have led to physical, emotional, cultural and political upheaval and the displacement of tribes from their lands (Belich, 1998; Hugh Kawharu, 2003; Kelsey, 1990). Colonial assumptions also influence the way legislation and judicial processes are framed. In the past they excluded Maori from making decisions about land alienation; democratic decision-making and even the way in which their own children were taught in native school programmes (Kelsey, 1990; Walker, 1990).

From a Maori perspective, the impact of colonial settlement was extensive. For example, between 1840 and 1990 more than one hundred pieces of legislation and regulations focused upon acquiring land from Maori (Jackson, 1993). For example, the 1863 New Zealand Settlements Act sanctioned illegal land confiscation and the 1967 Maori Affairs Act permitted Maori land sales without the consent of the multiple owners. The 1894 Validation of Invalid Land Sales Act highlighted the extent to which reigning parliamentarians were prepared to go to usurp Maori authority (Jackson, 1993). Over time, the imposition of British systems of living (transferred to Aotearoa New Zealand) culminated into the loss of dignity, human spirit and life of Maori. It was not just the core tangible features of Maori sovereignty at stake, but intangible symbols and signifiers that represented the spiritual, cultural and social indices of a people (such as mana) that were also threatened during the 19th century (Mutu, 1998; Walker, 1996). It

was not until political debates revealed the various colonial assumptions that the underlying contradictions were exposed and challenged (Dow, 1999; Lange, 1999). However, as individuals some Maori did benefit from aspects of colonialism technologically and economically; but on the whole the impacts were devastating.

Giroux, Lankshear, McLaren and Peters (1996) argue that official narratives contribute in part to the ongoing maintenance of a national consciousness based on a different set of beliefs to indigenous people. One hundred and sixty years later Maori continue to actively unravel historical fabrications about colonial enterprise and honour by re-asserting stories about Maori resistance and quests for Maori sovereignty. However, a risk of rewriting Maori history in the position of victim is that the neocolonialists cannot see the leadership that was there then and which remains here now.

5.2.3 'Speaking Out' with Counter Narratives

Counter narratives are presented as a theoretical tool to reclaim not just stories, but also their authenticity (Giroux et al., 1996). They are the 'little stories' of those individuals, groups and populations whose knowledge and history have been subjugated, devalued, forgotten and marginalised. They serve as a means to critique grand narratives and they also provide a tool to argue against the construction of official narratives by those in power, seeking political or economic ends. Giroux et al (1996) claim that official narratives purport to enhance activities relating to social justice derived from capitalist beginnings. Burger (1985) says capitalism remains "the private appropriation of collectively produced surplus value" (p.117). Burger reiterates (as a critique of the sociological concept of postmodernism) that "the maximisation of profit remains the driving force of social reproduction" (p.117) and that the celebration of the role postmodernism plays in bringing about transformative change is premature. In his view the narrow focus upon new right policies as part of the neo-liberal agenda is only one component of emerging societal concerns. As a warning, Peters and Lankshear draw our attention to a "blind commitment to a free market economy" as well as

the fragmented and pluralist conditions that exist within society (1996, p.7). They reiterate that assumptions guiding the development of counter narratives draw upon postcolonial and decolonial influences. I take their conclusion to infer that different stories concerning Maori people occurred, but they were not included as part of the official historical narrative of Aotearoa New Zealand. As a result the task of reconnecting to Maori narratives concerning social justice, equity and human rights is a necessity. There are also warning signs directed at social transformation that is based on an uncritical or apolitical support for the underpinnings of neo-liberalism.

As a result of the impact of colonialism, Maori are less concerned with articulating a clear link with existing theories such as postmodernism to theorise about these circumstances. The task of engaging in transformative social change demarcating colonialism from cultural/indigenous/decolonial or postcolonial influences are more important (Bishop, 1996; Pihama, 1993; G. Smith, 1997; L. Smith, 1999). Nevertheless, Peters and Lankshear suggest that counter narratives have an association with particular variants of postmodernism and also postcolonialism. Maori academics such as Smith (1999) and Bishop (1996) dispute that Aotearoa New Zealand is experiencing postcolonialism. To them, the conditions of colonisation appear to be persistent. They draw our attention, instead, to decolonisation theory, critical theory and more recently Kaupapa Maori theory. The examination of new social and political conflicts involving the, 'marginalised, excluded, ethnic minorities and also indigenous communities can be explored through these lens. The questioning of history 'as progress' is also considered in further depth, guided by the tenets of these theoretical underpinnings, which seek to expose ideologies of ongoing imperialism, colonialism and domination.

5.2.4 Imperialism, Colonisation and Decolonisation

Critical theorists seek to expose oppression, discrimination, exploitation and injustice as a means to contribute to social transformation and to bring about equality and liberation. Kaupapa Maori theorists draw from this tradition as they seek to apply these ideas to Maori situations. As Maori seek to regain autonomy, it has become equally important to interrogate the lineages of these ideologies

through a series of discussions about how, what and why these themes continue to be perpetuated within the very communities they impact. Edward Said, a leading decolonisation theorist in *Culture and Imperialism* and *Orientialism,* outlines the deep contradictions of imperialism that go beyond the process of establishing or maintaining an empire (Said, 1991, 1993), to an ongoing process of exploitation not only of the land and resources of the colonised country, but also its people.

The principles, nuances and etiquette espoused within the imperialist discourse are at the very heart of the conflicting relationship that prevails within Aotearoa New Zealand. For instance, narratives of Maori endeavours were hidden, made invisible and dismissed. The conquest of Aotearoa New Zealand was simply part of a global strategy embarked upon by global imperialist players. When land acquisition did not occur at the levels expected by British officials, wars were inevitable. The driving force behind the decision to colonise Aotearoa New Zealand according to Kelsey (1990) was an economic decision perpetuated by the premise that Aotearoa New Zealand would be the next "little England" (p.4). Hill and O'Malley (2000) support this claim:

> British cultural assumptions as to the supposed inferiority of native peoples, combined with the economic expansionist motives that underpinned imperialism, made it inevitable that, once in a position to impose their will, the colonisers would seek to undermine and eventually destroy the socio-cultural identity and collective organisation of Maori (p.1).

This section has emphasised the physical impacts of dislocation through colonisation and imperialism, based on traditional notions of colonial settlement. However, the impacts of colonialism are not restricted to land and people, the tenets of domination and exploitation have expanded to include all things that can be commodified for profit within the global economy. This form of exploitation is harnessed by multinational companies worldwide to exploit people, resources, space, air and water (Mander & Goldsmith, 1996). All of these items are no longer sacred under the new premises of globalisation. The old imperialism and colonisation have become neocolonialism, neoimperialism and globalisation .

To counteract the colonial project, decolonisation and its related theoretical variants continue to be useful. Decolonisation is a tool to reclaim our histories as sovereign indigenous people of this country. In Hutchings (2000) view,

decolonisation provides a different analysis from postmodernist accounts of deconstruction, which require an analysis of parts of the situation which are segmented and studied independently to make some sense of the whole. Decolonisation examines how parts interrelate and affect the whole. The concept of decolonisation sees as a task - liberation from internalised colonial ideologies. It unashamedly endorses a critique of grand narratives - grand narratives which have been used to decimate the lives of many.

The application of decolonisation theories to indigenous concerns in Aotearoa New Zealand has been made by a number of Maori researchers and academics (Bishop, 1996; Cunningham, 1998; Glover, 2001; McNicholas & Barrett, 2002; Tiakiwai, 2001). Smith (1999) sees history as an important part of appreciating the present by understanding the past. In her view, the reconstruction (or decolonisation) of history should be more closely aligned with a Maori worldview of that history, harnessed to conscientisation and in support of aspirations for transformation. The ways in which Maori acquire knowledge have also been dismissed as contrary to accepted methodologies. The role of tohunga in Maori health is a case in point (Dow, 1999; Durie, 1998, 2001; Lange, 1999; McGowan, 2000; Moon, 2003).

Smith (1999) proposes that historical accounts are narratives of the powerful, how they became powerful and how they use their power to keep them in positions in which they can continue to dominate others. This relationship with power she claims, is why indigenous people have been excluded, marginalised and othered. Harawira (1999) says that in the early days of colonisation western academics and anthropologists were guilty of perpetuating the subjugated position as they rewrote indigenous peoples' histories and reinscribed their practices. The resulting distortion of history has contributed to diminished levels of Maori health and wellbeing. The contribution to the transformation of this situation is a major aspiration in this research.

In sum, historical narratives are intimately related to concepts of representation and identity and the insistence that these narratives accurately represent those people upon who they purport to portray is fundamental to 'counter narrating'.

Without narratives of history that reflect everyday experiences of the cultural parameters articulated by Iwi, Hapu and Whanau; threats to identity and power are prevalent (Harawira, 1999; Kelsey, 1990; Ramsden, 1994; L. Smith, 1999; Walker, 1994). The loss of dignity and identity directly relates to the overall health and wellbeing of people, exposing the divisiveness of the coloniser in perpetuating this process.

5.2.5 Treaty of Waitangi

Although the Maori counter narrative presented in this chapter argues that Maori never ceded their sovereignty, it is through an analysis of the Treaty of Waitangi ('the Treaty') that this position can be confirmed. The Treaty contains three articles and it is viewed as an agreement between two sovereign powers, Maori and representatives of the British sovereignty. The articles of the Treaty witness the rights of Maori to unencumbered opportunities to improve their health and wellbeing.

Both Kelsey (1990) and Walker (1990) exclaim that the first article of the English version [underlines added] of the Treaty claims to cede sovereignty from the rangatira of Aotearoa New Zealand to the British Crown. The Maori version of the Treaty does not convey that meaning. According to Walker (1994), the chiefs of Aotearoa New Zealand ceded kawanatanga to the British Crown. Kawanatanga is derived from the transliteration of governor to kawana, which with the suffix 'tanga', becomes governance. This clause, together with the preamble, legitimised English settlement in Aotearoa New Zealand and eventually the constitutional government in the form of parliament or government. The problem that arose from this clause relates to the use of 'sovereignty' in the English version of the Treaty and 'kawanatanga' in the Maori version. Walker (1994) argues that tangata whenua did not cede sovereignty to the Crown, instead the right to govern was provided.

Article Two of the Maori version of the Treaty guaranteed to the chiefs [tino rangatiratanga], absolute chieftainship, over their lands, villages and treasured possessions. The second article also allowed for the sale of land by the chiefs to the Queen or one of her agents at an agreed price (Orange, 1987). Walker (1990)

says for the chiefs, this clause meant that the British Crown guaranteed tangata whenua sovereignty in exchange for the Crown's right to govern. This view is clearly evident in the statement by Nopera Panekareao's interpretation of the Treaty as the 'shadow of the land' going to the Queen, but the 'substance remains with us' (Walker, 1994, p.2). However, William Hobson, James Busby and the missionaries interpreted the first article as the straight cession of sovereignty (Walker, 1994). Kawanatanga in the Maori version had been translated as sovereignty in the English version. The disparity of the terminologies is at the heart of the contemporary Treaty discourse between Maori and Pakeha (Henare, 1998; Jackson, 1993; Kelsey, 1990; Walker, 1994). The site of disagreement centres on kawanatanga verses tino rangatiratanga (Fleras & Spoonley, 1999).

Article Two of the English version of the Treaty is similar in nature, principle and interpretation to the Maori version of the Treaty, for instance, 'the full exclusive and undisturbed possession of their lands and estates, forests, fisheries and other properties which they may collectively or individually possess....'. And also, 'the individual chiefs yield to Her Majesty the exclusive right of pre-emption...' (Fleras & Spoonley, 1999; Walker, 1994). Article Three was translated accurately as to guarantee to the chiefs and their people, 'all the rights and privileges of British Subjects'. Walker (1994) states that this clause incorporates the democratic values of freedom, equality and justice and can be seen as Aotearoa New Zealand's first Bill of Rights.

While it is useful to look at the semantics of the Treaty or analyse it in further depth, the alternative interpretations that exist as a result of presenting two versions of the Treaty, the fundamental premise of the agreement cannot be downplayed. According to Walker (1989), tangata whenua did not give up rangatiratanga or sovereignty; it was governorship or kawanatanga that was ceded. Biggs (1989, p.303) sums up the predicament:

> How can one hope to translate, in a word or a phase, a concept which lawyers require whole books to define?

The debate surrounding the role of the Treaty in contemporary New Zealand society is an enduring one, beyond the task of this thesis to explain. However, a brief overview of the Treaty serves to indicate that to this day Maori continue to

claim that they have not ceded rangatiratanga – sovereignty in this nation. The Treaty serves as a reminder of the ongoing and unfulfilled obligations of the Crown and the enduring pain and anger felt by many Maori regarding the Treaty as a result.

5.3 NARRATIVES OF COLONIAL DEVELOPMENT: AN INTERPLAY WITH MAORI HEALTH DEVELOPMENT TO 1975

Jane Kelsey in *a Question of Honour (1990)* retells compelling accounts of colonial infiltration into the very core of Maori existence in the past. Kelsey claims that Maori presented substantial resistance to Pakeha incursions on their rangatiratanga (Kelsey, 1990). In order to account for the process of colonisation in Aotearoa New Zealand, it is useful to revisit her account of the acts of resistance in various timeframes and how they correspond with the colonial activities that took place from 1840 onwards. Consideration will therefore be given to community initiatives, which appeared to contradict the 'official colonial agenda.' These initiatives appeared at times to operate independently of regulations set by, or being set by parliamentarians. For instance, medical officials and missionaries often practiced medicine or dispensed medical provisions for humanitarian purposes, although they were sometimes not qualified as medical practitioners (Dow, 1999). In a review of *Maori Health and Government Policy from 1840-1940* by Derek Dow (1999), a historian and archival expert, no reference was made to the impact of land alienation on Maori health, the incidence of disturbed mental health amongst Maori, consideration of the Treaty or any analysis of the outcomes of government policy on Maori health. Dow comments that it was not until 1955 that such an analysis took place. Contemporary accounts of colonialism by Kelsey (1990), Walker (1984) and Kawharu (1989) critically reflect upon previous historical accounts of Maori sovereignty, Maori development and also Maori health. This discussion is no different; on the one hand it identifies imperialism as a theory of subjugation that discounts the struggles of Maori parliamentarians, native health officials and chiefs regarding the provision of health services to Maori communities. But, on the other hand, it celebrates the meagre achievements made by the same Maori

parliamentarians, native health officials and chiefs as part of the existing Maori psyche for social change. However, Kelsey (1990) argues that a historical association between colonialism and Maori health disparities can be made and some insight into the contextual factors that impacted upon Maori health development from 1840 onwards is highlighted. The works of Jane Kelsey (1990), Derek Dow (1999), Raeburn Lange (1999) and Ranginui Walker (1990; 1993) are drawn from extensively within this section. Whilst Kelsey and Walker are renowned for their expertise in critical analysis, Dow and Lange are both historians who do not address some of the concerns raised by Kaupapa Maori theorists.

5.3.1 1840 –1870 Era of Acquisition

Kelsey stated that the first thirty years of formal colonisation was a period of extensive capital land acquisition, which led to extensive tribal fortification against threats of colonial militia with a series of tribal battles against the Crown in the 1860s. Non-resident land speculators in Australia and England were able to secure large land holdings, through constructed laws that worked in favour of the growing number of emerging urban professionals, merchants and settlers. There was little evidence of disruption to Pakeha settlement as opportunities for property ownership through outright sale, dispossession or military service were rife (Kelsey, 1990). During that same period tribal economic development activities flourished. Opportunities for trade in Australia allowed Maori to develop their land and fisheries resources using traditional labour and production practices:

> By the 1840's, the tribes had thousands of acres in crops and were rapidly extending their trade. By the 1850's there were numerous Maori owned-flour mills through the northern half of the North Island...[T]he initiatives came largely from the Maori who were keen to capitalise on the new settler markets, and take advantage of new technology (Waitangi Tribunal cited in Kelsey, 1990, p.13).

The Maori economy was based on "equivalents, relative worth and reciprocity", not "possessions, absolute ownership, contracts without continuing obligations and the equation of personal wealth with status and power" (Waitangi Tribunal cited in Kelsey, 1990, p.13). For example, Hori Ross (2000) of Ngai Tukairangi Hapu recounts examples of trade between Tuhoe and Ngaiterangi told to him by

his grandfather. He recalls how pipi were dried and then taken to the bush people and exchanged for kereru and other forms of birds. Hori Ngatai, chief of Ngaiterangi Iwi also owned and operated a flourmill (Stokes, 1993).

Once Pakeha capitalism was established and colonial legislation entrenched, the natural resource base was threatened and opportunities for Maori to continue trade were exhausted as efforts to counteract colonial pressures increased. Maori were being forced to assert their rights to survival through ongoing strategies of resistance. The history of Maori resistance, from the early stand of Hone Heke to the armed resistance in Waikato, Taranaki and Tauranga is well documented (Belich cited in Kelsey, 1990, p.13). In Tauranga the battle of Gate Pa and Pukehinahina in 1864 occurred and more than 250 000 acres were subsequently confiscated as a result (Belich, 1998). According to Kelsey (Belich cited in Kelsey, 1990) and Orange (1987) these wars were fought as a concerted effort by Maori to assert tribal rangatiratanga.

In terms of Maori health development, Dow (1999) describes this same period as "a tolerably efficient system" where there was more extensive health care provision for Maori than has been generally realised (p.15). Under the New Zealand Constitution Act 1852, a fixed amount of £7000 pounds per annum was earmarked for Maori purposes in the civil list budget, controlled by the Governor (Dow, 1999, p.16). This period was also characterised by a missionary zeal for "alleviating the physical and moral condition of Maori" with a combination of spiritual guidance through Christian teachings and medical provision or herbal care (Dow, 1999, p.21). Although missionary care lasted for almost forty years, it was superseded by the introduction of subsidised medical attendants for Maori from the late 1850's onwards. Dow does not address the transfer of responsibility from Maori based in Te Ao Maori to Maori as 'subjects of the system'.

In 1847, the first hospital was established in Wellington. It was based on a 'European model' and it was seen as a means to "civilise" Maori (Dow, 1999, p.27). Further hospitals were established in Auckland, New Plymouth, Wanganui, Otago and Canterbury. The costs of these hospitals were the responsibility of the Government. Admission to hospital care was initially free of charge until the mid

1850s when a growing tendency to admit paying patients prevailed. While there is limited accurate data on the number of Maori patients admitted to hospital during the 1850s, the maintenance of the hospitals was viewed by Governor Grey as a "matter of paramount importance to the native race" (Dow, 1999, p.35). A swell of settler criticism saw the hospitals, sometimes referred to as Maori hospitals as a "waste of money" (Dow, 1999, p.35). Critics were more concerned with amenities such as roadways and bridges.

At the same time, the subsidised Native Medical Officer programme was in operation around the country. The programme was often described as ad hoc and from a policy perspective, 'inconsistent'. Records were poorly kept and medical officers in one district were reimbursed at a rate divisively different to a medical officer in another district. In the 1840's when the scheme was first introduced in Aotearoa New Zealand, there was no expectation that Maori would contribute directly to the costs of the service by paying fees. By the mid 1860's, parliamentarians and others were questioning that position. In 1866, Native Minister Colonel Andrew Russell sought to clarify the matter:

> It has been intended from the outset, that Maori should contribute to the income of their medical men, and he personally objected to the system of pauperising the natives by giving them so much graciously (Dow, 1999, p.44).

Some critics thought that medical care for Maori should be paid for from land sales. There appeared to be no solution to the issue and the question of eligibility for free healthcare occupied the thoughts of parliamentarians for over three quarters of a century.

The programme of vaccination for smallpox was also initiated during this period. Prior to large-scale colonial settlement, there had only been sporadic infectious breakdowns amongst Maori. Other diseases were beginning to impact on Maori health; smallpox, yellow fever, cholera and typhus were some. A commitment to a programme of vaccination saw the passing of the Vaccination Act 1863. The Act empowered provincial superintendents to appoint medical officers to administer the vaccines (Dow, 1999). Dow comments that the three schemes: medical officers, hospital care and vaccination were examples of how the

Government (although in an adhoc manner) attempted to alleviate the native race of the illnesses during that period.

5.3.2 1870 – 1935 Era of Consolidation

This period signalled a time of change. Society moved from the depression in the 1880's to major economic and political transformation, consequently Pakeha had no reason to heed the Treaty (Kelsey, 1990). Parcels of Maori land were quickly being converted into settler townships, with lots for homes and pasturelands for farming. The colonial legal system swept through the country supporting all means of resettlement by European settlers. Maori on the other hand were excluded from

> fisheries, land title was individualised, Maori land continued to be alienated for public works, financial assistance provided for Pakeha was not afforded to Maori, Maori spirituality was legislated against and the role of the Maori in the courts and as paid officials was terminated (Kelsey, 1990, p.15).

Despite the overwhelming evidence verifying the ongoing imperial subjugation of tangata whenua by colonial officials in the 1860s, little recognition was paid to their resistance strategies. The ethos behind this lack of recognition according to Kelsey was that the British officials did not take tangata whenua seriously. British officials interpreted the ceding of sovereignty as the basis upon which British power and control was legitimised. Maori voices seemed to be recognised only when their acts of rebellion hindered access to the remaining parcels of desirable Maori land. For Maori, the Treaty remained the fundamental key to tino rangatiratanga, but as Kelsey says, it was becoming increasingly difficult to assert. Whilst members of the Young Maori Party attempted to effect positive change within the parliamentary forum, many of their proposals were not implemented and the proposals that were implemented often suffered from under-resourcing and/or 'personnel inadequacies'. The emergence of the Ratana Movement in 1918 provided a new impetus for demands to honour the Treaty. A further petition on the Treaty to England achieved no response.

Though Maori were unrelenting in lodging repeated appeals to Crown officials, their ongoing subjugation continued. It is of little consequence that the most significant impact upon Maori society during this period was the influx of

European settlers and the gradual demise of the Maori population. In just over half a century, the indigenous population reportedly dropped from 770,000 to 45,000 falling as low as 42,000 in 1896 (cited in Dow, 1999, p.57). During that period, the European population increased by over one million. Durie (1977; 1998) saw the introduction of diseases and effects of warfare as the primary causes of the decreases in the Maori population.

However, in terms of government policy and Maori health, the era saw policy changes with the transferral of the Native policy for Maori health to the Justice Department, the Native Department and then the Health Department. The payment of the relevant Native health programmes became a contentious issue with an array of departments transferring the responsibility of payment from one sector to the other. No clear policy consideration seemed to guide the application of the £7000-pound civil list allocation for Native purposes or the Native reserve trust funds to Maori health (Dow, 1999, p.58). The continual call for 'Maori hospitals staffed by Maori nurses and doctors' was also proposed on a number of occasions, but never implemented. Hospitals were seen as places where people went to die, or in other cases where a chief did die, rendering the hospital as tapu (Dow, 1999). The interaction between Maori and hospitals in the latter decades of the nineteenth century presents a complex picture. At the same time, many Maori became disillusioned with Western medicine, or were discouraged by opposition from Europeans to proposals such as establishing Maori hospitals.

The place of tohunga within western medical practice was also stringently challenged. In 1875, Hopkins Clarke, Native Officer for Tauranga, complained that "Maori often delayed bringing patients to hospital until the 'Maori doctor' had exhausted his range of remedies by which time the patient was 'past all hope'" (Dow, 1999, p.64). The Tohunga Suppression Act 1907 was an attempt to curtail what Ngata described as 'bastard tohunga' as opposed to healers of the old days (Dow, 1999). The Act made no reference to traditional healing per se, but focused on those who misled any Maori by professing to possess what Crown officials described as supernatural powers. However, for some critics of the Act, it merely continued to devalue Maori methods of healthcare and debase the emerging movements espoused by Maori prophets such as Te Whiti and Ratana

(Durie, 1998). The intention of the Act was contentious, particularly as it was supported by Maori members of Parliament. Regardless, its affects were devastating.

Two further programmes that sought to curtail Maori ill-health were the training and establishment of more Maori health nurses and the placement of native health inspectors within the new Maori councils. Their roles were to assist with healthcare provision in hospitals and also through native schools. For the health inspectors, their primary responsibility was to improve Maori hygiene and sanitation at villages and pa. At the turn of the century opinion was divided on the position of Maori. At one end of the spectrum were the 'dying pillowers' such as Newman and Walsh who regarded the demise of the Maori race as inevitable. The members of the Young Maori Party and a health reformer, James Pope sat at the other of the spectrum and thought the situation was not irreversible (Dow, 1999). Commitment to Maori health improvements continued despite the sporadic and sometimes uncoordinated implementation of government policy. The outbreak of typhoid, tuberculosis and other contagious diseases helped matters none. The involvement of key Maori medical men such as Maui Pomare and Peter Buck considerably aided and supported Maori health issues. James Pope (cited in Dow, 1999) also advocated a preventative approach to Maori health. His publication *Health for the Maori: A Manual for Use in Native Schools (1884)* was utilised as an educational tool that was viewed by some as a blueprint 'of hope' for Maori health. A fourteen-plan blueprint for Maori health prepared by Pomare in 1904 included a range of strategies to combat Maori health decline (Dow, 1999).

The creation of the Department of Public Health in 1900 and the creation of the Maori Councils Bill 1900 also provided opportunities for Maori throughout the country "to organise themselves for a measure of self-government and redress the lack of statistical information on Maori health" (Dow, 1999, p.99). The proposal for Maori councils however was severely under funded and the Maori councils vote fund decreased in 1909 from £840 pounds to £659 pounds the following year, despite an increase in responsibilities by delegated authority through the Public Health Department. Buck argued that unless the Government:

> [was] willing to spend a reasonable amount in attending to the health of Maoris, they might as well let them die out (cited in Dow, 1999, p.101)

Dow notes that Maori already felt that Western medicine discriminated against them, in the services offered and in the rejection of traditional health practices. Some were already disillusioned by the lack of commitment shown by officials to improve Maori health status. A new Maori hygiene division of the Department of Public Health led by Buck was one further attempt to deal with the issues of Maori health status, but once again the section was seriously under-funded. As well, Maori met the impact of hospital medical care with mixed responses. For some, the hospital was an alien threat, for others it was seen as a vital component of health provision and for others, geographical restrictions meant it was an unattainable goal (Dow, 1999). Institutional racism was endemic in the healthcare sector. Tutere Wi Repa, a Maori doctor was offered a position of house surgeon at the Gisborne Hospital in 1908, only to be dismissed when administrators discovered he was Maori (Dow, 1999). At that same time, Buck had highlighted the lack of Maori medical practitioners, and consequently stressed the need for medical men to have an awareness of Maori language and customs.

5.3.3 1935-1975 Era of the Welfare State

The welfare state emerged as a response to the 1930's depression. As Kelsey (1990) states:

> It was an era imbued with the ideology of meritocracy, equal opportunity and national interest, which obscured the continued class, race and gender bias of economic and political structures. The mass media and the state education system reinforced the universality of the conformist white, middle-class, two-parent, consumption-oriented family unit (p.17).

In the early 1930's, the Department of Public Health was attempting to establish a preventative approach to healthcare delivery. For Maori in particular, several incidents were occurring which contributed positively to Maori health advancement in one instance and curtailed development in other instances. Hospital boards around the country were complaining about the lack of fees being paid by Maori and some hospitals were going as far as refusing admission to some Maori altogether. Certain Iwi around the country challenged the Government on this matter saying that land gifted to the Government was on the basis that a 'Maori hospital' would be established. Those proposals were never implemented.

The collection of Maori health statistics through death and birth registrars was also a new development, which led to the realisation of the extremely high mortality rates of Maori children. The re-focusing of health care provision on public health initiatives focused on improving housing, drinking water and sanitation was also clearly placed within the portfolios of government policy during this time.

Aotearoa New Zealand, now seen as a fully westernised society pursued a mixed economy with limited nationalisation, social welfare and employment protection. Maori however at the time were experiencing a subtle crisis. Welfarism according to Kelsey was built on the myth of one people working together to distribute fairly the fruits of the nation. The problem was that most of those fruits were acquired as a direct violation of the Treaty. As well, the focus of the future seemed to separate both Maori and non-Maori from the colonial past. Urban migrations became the trend forcing a dislocation of Whanau and Hapu from their turangawaewae. Assimilist practices became the norm and discrimination against Maori a common occurrence. Monoculturalism and hegemony actively sought to erase Maori history by suppressing the language and rationalising Maori failure (Kelsey, 1990). The 1957 Labour Government suggested that no action should be taken with the Treaty, lest it "may arouse the Maori elements to a level unacceptable to the public..." (Rata cited in Kelsey, 1990, p.19). However, the Treaty was commemorated with the reinstatement of the Waitangi Day in 1976. For some at least, the Treaty was back on the top of the agenda. The following chapter continues this discussion, paying attention to the influence of Government structural reform upon Maori health development from the 1970s onwards.

5.4 NEOCOLONIAL INFLUENCES IN CONTEMPORARY SOCIETY

This section outlines a number of ways in which colonialism continues to influence the ability of Iwi, Hapu and Whanau to enhance Maori health. Ramsden (1994) says that Aotearoa New Zealand is still experiencing neocolonialism and will continue to do so until Maori can make a range of choices and decisions which consistently result in successful improvements in social indicators of well-

being and quality of life. The focus of Maori to achieve real outcomes in equality, social justice and economic development continues to be subjected to neocolonialism. The old colonialism which focused upon land acquisition and colonial settlement, contrasts with contemporary neocolonialism, which is informed by global capitalism. Global capitalism seeks to undermine the civil, moral and indigenous rights of Maori to maintain a sense of indigenousness.

The impact of neocolonialism upon Maori health takes place in both direct and indirect ways, through the institutionalised exertion of domination through politically and economically motivated power relations. For example, for many Maori, citizenship and personal identity are constructed from the interconnected relationships between Whanau, Hapu and Iwi. John Rangihau for instance, reiterated that his identity was drawn from his being Tuhoe and not Maori (King, 1992). Tipene O'Regan and Robert Mahuta, both leaders of their people associated who they were with their tribes (Diamond, 2003). For Maori people, this relationship to Iwi and Hapu is positive and enriching. Sullivan (1995) argues that the strength of the people still lies in the concept of tribal affiliation. But, colonisation gives the impression that tribalism will disappear or at the least be rendered ineffective. However, the desire by Maori people to reiterate their tribal identities is on the rise. Racial overtones expressed by Pakeha who do not understand the importance of tribal identity to Maori and who are not willing to learn, contribute to the further subjugation of Maori. Racism expressed in this way impact upon these Maori who see no other choice and who consider the merits of assimilation as a viable option for constructing a national identity. Their inability to resist these forms of subjugation contributes to the ongoing fragmentation of Maori. Consequently, the complexities of identity, racism and nationhood emerge as a highly contentious issue within Aotearoa New Zealand as a result. Some commentators, even Maori (e.g. John Tamihere) view the tribal structure (traditional and contemporary) as an outdated vehicle from which to seek Maori autonomy.

The need for Maori to continuously assert the legitimacy of the Treaty in Aotearoa New Zealand (and the energy, resources and political will to do this work) reflects the unequal power relations between Maori and the Crown

particularly with regards to the rights of Maori people in this country. In the recent past, the Treaty has been referred to in legislation, surrounding physical resources such as the environment, land and the sea (Durie, 1998). A concerted effort by concerned leaders of public sector organisations has seen the Treaty referred to in social policy documents of government agencies and some private organisations, particularly community organisations.

Henare (1998) says that the strength of the Treaty is not in its detail, but in its force as an acknowledgment of the inherent rights of Maori. She says the Treaty did not create the rights, but it did 'evidence them'. Where reference has been made to the Treaty within social policy, it has arisen out of a concern for the disparities between Maori status or cultural values rather than from a sense of Treaty-based obligations or rights (Durie, 1998). Durie (1989) links the provision of health, education and other social services to the Crown's obligations to citizenship rights, as outlined in Article Three of the Treaty. The Royal Commission on Social Policy review supported this approach to social policy:

> The Commission is not convinced that 'areas of silence' can be so clearly identified. Within the Treaty, economic, social, constitutional, cultural and spiritual dimensions are intended. Article II obviously refers to ownership and management of such resources as land, forests, fisheries and villages. Given the relationship of people to that environment the article must also be concerned with economic and social issues and with the many factors that contribute to well-being. The relationship is even more evident when due weight is given to the notion of 'chieftainship' and the responsibility that entails for the care and welfare of all sections of the community (cited in Durie, 1989, p.283).

Several recent publications and reports commissioned by central government agencies have incorporated an official perspective on the relationship of the Treaty to the provision of public sector services. Innovative partnerships have developed as a result of both the health reforms and the recognition of the Treaty. Yet, in many cases the partnerships on paper have been based on the notion of Treaty principles, which is a 'watered down' agreement between Maori and the Crown, undermining the sovereign position of Maori in Aotearoa New Zealand.

Smith (1999) argues that the ill health of Maori can be linked to the dishonouring of the Treaty of Waitangi. She states:

> The symptoms of oppression for Maori women are manifested in appalling rates of cancer and heart disease, in worsening rates of mental ill-health and in a host

> of other diseases. Maori males and Maori children are trapped in a similar web of suffocating ill-health. We are also locked into a time bomb, for we could lose a third of our population to smoking-related diseases in the next decade (pp.49-50).

Although five women signed the Treaty, it is possible that others may have been prevented from doing so because the status of Maori women was negatively impacted upon by the patriarchal attitudes of Victorian England, rather than by the attitudes of Maori. The subjugation of the role of Maori is contested given the primary role of Maori women in Maori mythology. For instance, Hine nui te Po – Goddess of Death was a woman. The role of media is implicated through its actors and agents in contributing to the construction of Maori as the subjugated - even still today. Moana Jackson, a lawyer and Maori champion draws an association between colonisation and representation through visual imagery. He claims:

> Colonisation is about creating suspension of disbelief, which requires that those from whom power is to be taken have to suspend their own faith, their own worth, their own goodness, their own sense of value and their own sense of knowledge. Today, colonisation is a process of image making, where we're bombarded by Hollywood about what should be worthy in our lives and today's scriptwriters, today's controllers of knowledge [and therefore research] are the descendents of the old scriptwriters of colonisation (Jackson, 1998, p.71).

The impact of colonisation and imperialism continues to manifest and in response new calls by Maori for due consideration to issues such as: genetic modification, intellectual property rights, inappropriate use and commodification of kupu Maori by multinational organisations, capitalisation of 'genetic indigenous make ups' for scientific exploitation and the multitude of virtual non-Maori proprietors selling 'authentic' Maori taonga (Gardiner, 1997). Many commentators on the issues surrounding the constitutional debates of Aotearoa New Zealand are ill equipped to deal with these neocolonial forms of indigenous exploitation. The plight of tangata whenua for sovereign rights which were never and are still not within the corporate battlefields, has put 'Pakeha' and 'tangata whenua' on the same side of the playing field, vying for community rights to sovereignty based on a contemporary ethos by many New Zealanders to retain a national sense of collective ownership in national and Maori icons, including natural waterways and treasures.

The most recent example of 'political engineering' related directly to indigenous sovereignty involves the contestation over control of the foreshore and seabed of Aotearoa New Zealand. The issue of extinguishing Maori rights to the foreshore and seabed through government legislation is viewed by many commentators as a modern day confiscation (Jackson, 2004; Kelsey, 2004; Sneddon, 2004). The way in which the media portrayed the events demonstrates a disregard for balanced accounts of the story, in place of 'sensationalism'. The psyche of New Zealand people varied so considerably that the media was not able to draw clear conclusions from the debate that would be unanimously accepted by all New Zealanders. The diverse views have polarised all New Zealanders, to the extent that informal discussions have transposed into heated debates about nationhood. A hikoi of protest was undertaken in May 2004. Tens of thousands of people marched to Parliament in Wellington from a number of different towns and cities throughout the country (Harris, 2004). Many more people, who could not make the journey to Wellington, remain engaged in community action on the ground.

5.5 SUMMARY

History is viewed as a constructed narrative of views and interpretations of those who construct it (L. Smith, 1999). The assumptions and beliefs underpinning the views of a writer shape and frame the way they construct history and the subsequent social policy. It is therefore a role of Kaupapa Maori theorists to deconstruct these views by presenting counter narratives of indigenous viewpoints. In this chapter, I argue that colonialism, remains as an entrenched ethos within the current parliamentary and common systems of thinking and for many New Zealanders, colonialism informs an ethos of engagement with Maori people. Consequently, it is my view that it is not valid to refer to contemporary society in Aotearoa New Zealand as a postcolonial society. Not only are Maori still being subjected to defending their sovereignty, the populace in general is enthralled in an ongoing colonisation process called corporate imperialism, noted by some as leading to a form of global neo-feudalism (Handcock, 1997). The power relations between Maori and the Crown in these instances, whilst somewhat improved from the 1860s still position Maori as subjugated through imposed legislation and government policies. Maori are rarely the architects and

key beneficiaries of the system. Maori are no longer controllers of vast terrains of land; instead the tribal estates of the 1800s have been reduced to miniscule amounts.

To overcome the process of colonialism, Maori are encouraged to employ counter narratives to re-story history in ways that reflect upon the lived realities of Maori people. For that process to occur, *decolonisation* is essential. In decolonising colonial narratives however, the existence of, and influence of neocolonialism is not eliminated, it reappears in different ways through policy, legislation, power relations and regimes of governance, reconfigured as neocolonialism and globalism. Neocolonialism is intimately informed by concepts of power and power relations and how they work through the complexities of nationhood, sovereign rights, citizen rights and social policy. Recognising neocolonialism is fundamental to enabling a process of social transformation to occur. Social transformation can not take place if people are not able to see and recognise, resist, overcome and transform the negative impacts of neocolonialism.

CHAPTER SIX: MAORI HEALTH DEVELOPMENT AND HEALTH REFORMS

"Maori aspirations will not find expression by rhetoric alone. If they are to be converted to practice, sound conceptual foundations, clarity of purpose, and a capacity for measuring both progress and impact must underpin them"

(Mason Durie, 2003)

6.1 INTRODUCTION

In this chapter, I present an overview of Maori health development aspirations against a backdrop of the ongoing Maori struggle for Maori autonomy. I have attempted to weave within the chapter, the interconnecting ways in which the neoliberal economic, labour and later health reforms have impacted upon Maori development visions from the mid 1980s onwards. I explore a range of critical responses to these reforms, before presenting an overview of ongoing concerns that impact upon Maori health development on the whole. Most important in this chapter an acceptance that Maori health development is based upon a recognition of Maori sovereignty and autonomy as well as the implementation and support of Maori frameworks for Maori health. The neoliberalist underpinnings of the health reforms directly threatened those aspirations.

6.2 MAORI DEVELOPMENT: STRUGGLE WITHOUT END

The desire to advance Maori health development is an ongoing struggle etched in events of the past. According to Harris (2004), the modern Maori struggle began in the late 1960s, and centred on "land, the Treaty of Waitangi, Te Reo, Mana Maori Motuhake and Tino Rangatiratanga" (p.13). During the 1970s, slow but steady progress was being made to address some of these concerns. For instance, in 1975 the profile of the Treaty was on a high and the enactment of the Treaty of Waitangi Act 1975 allowed Treaty breaches to be heard by the newly established Waitangi Tribunal. A Maori land march against Maori land grievances started from Whangarei and ended at Parliament buildings in Wellington and the Bastion

point and the Raglan occupations both took place during this period as well (Walker, 1984).

During that period, positive developments were occurring in a small but growing number of areas for Maori. For instance, the establishment of the Kohanga Reo movement (Maori driven revitalisation of language through pre-school education) (Smith, 1993) and the role of the Maori Women's Welfare League (an organisation devoted to caring for Maori families) were becoming more prevalent (Walker, 1990). The *Rapuora* project, organised by the Maori Women's Welfare League was a significant step towards Maori asserting control of a project about their own health and wellbeing (Murchie, 1984). At the same time Maori health initiatives were being established such as Tipu Ora in Rotorua (Durie, 1998b). Maori development narratives continued, enriching Maori consciousness and contributing to the overall notion that Maori could and were controlling their own destinies, based upon principles of rangatiratanga and drawing from a philosophy that was inherently Maori.

Aotearoa New Zealand (and therefore Maoridom) did not escape the impact of increased world oil prices and economic distress emanating from the mid 1970s. Aotearoa New Zealand (led ironically by Labour parliamentarians of the day) was poised to embark upon a programme of neoliberal economic infrastructural upheaval that would rip into the very fabric of society; socially, politically and culturally (Kelsey, 1990). In 1972, the Labour Government released the *White Paper: A Health Service for New Zealanders* outlining problems with the then current health system (McGuigan, 1975 cited in Gauld, 2001). However, many of the recommendations were not acted upon until the succeeding National Government came into power. As a start, National piloted the concept of the Area Health Board (AHB), later cementing the concept in health policy by passing the Area Health Boards Act 1983. But, it was not until the end of the 1980s that the boards were fully implemented. As the AHBs formed throughout the country, Iwi began establishing Treaty relationships with hospital representatives. These relationships were seen as one way in which the Government could be seen to meet its Treaty obligations.

Most New Zealanders by this time had become accustomed to the notion that public health was largely meant to be available for all. Aotearoa New Zealand initiated this type of health system as a response to the Great Depression under the 1938 Social Security Act. Plans to adopt new economic and social reforms were a contradiction to these espoused egalitarian ideals. In 1984, the first wave of the neoliberal structural reforms involved an extensive overhaul of the economic system and labour regulations. The premise for the reforms was founded upon the Treasury recommendations to "improve the unstable fiscal position through radical change" (Gauld, 2001, p.39). Treasury officials therefore proposed less

> government, the privatisation of state assets and businesses, increased economic efficiency, reduced public expenditure and rolling back the welfare state. Excess productive capacity would have to be liquidated, the existing labour force retrenched and new, efficient technology introduced. Those sectors of the economy that could not survive should be allowed to fall victim to market pressures (Kelsey, 1993, p.16).

The reconciliation of the Governments acknowledgement of the Treaty was nestled uncomfortably alongside a new shift towards free market policies. A paradoxical position for Maori was imminent, culminated from a misunderstanding by Maori of the Government's intentions with the reforms (Durie, 2004). The stated goals of the reforms were "reduced state dependency, devolution and deregulation." Maori comprehended devolution as a means to promote partnership relationships between Maori and the State, and as a way for Maori to assume greater responsibility for themselves (self-management). Those of a critical inclination interpreted the opportunities as a form of cost cutting, and parting of specific responsibilities by the Government to Maori.

At the same time of the economic reforms, Maori economic development was tabled as a key focus of the Labour Government sponsored *Hui Taumata*, seen as the embryo of a decade of Maori development. Sullivan (1995) claims that those in attendance at that hui were clear about their aspirations:

> If equality and equity were to be achieved between the indigenous people and those of the dominant culture, then Maori operating from their traditional base of tribalism could, at the very least, do no worse than government (p.53).

Aspirations for Maori health advancement were prioritised at the *Hui Whakaoranga* held that same year. The hui called for greater Maori control of

their own health development by defining their own concepts of health, in ways that were drawn from a Maori worldview (Ratima, 2001). During the 1980s, the Department of Health began to include Maori perspectives in its policies and practices (Rolleston, 1989). The Department also set Maori health goals as a priority in 1984-85, which filtered through to the AHBs in local district communities.

But, the 1984 neoliberal reform agenda and its stated intention of labour force retrenchment and withdrawal of services by the State, led to other casualties such as the disestablishment of the Department of Maori Affairs, which was the only government agency that focused consistently on advancing Maori interests. The Department had been responsible for Maori and Pacific Island matters for decades, and established in its place was Manatu Maori (a policy monitoring unit) and the Iwi Transition Agency (responsible for devolving social programmes to Iwi). The impact of the structural reforms upon poor and labourers, many of which were Maori was direct.

Over that decade, Maori had become significant participants in the provision of social welfare, health, labour and education services that had previously been provided by the State (Durie, 2004). However, the gains made occurred within the context of confined government policies for Maori health services development and the architects of those policies were parliamentarians. In Gauld's (2001) view, whilst government officials claimed to be keen to form partnership arrangements with Maori, there was limited evidence that those intentions were reflected in service agreements. The initial role of Maori in health development was confined to service delivery and not the design of effective Maori health policy. Maori health advocates were beginning to see that the programme of devolution initiated by the Labour Government did not equate to aspirations for autonomous Maori health development as was hoped (Durie, 1994). Whilst the responsibilities for health development were being shifted to Maori, the resources commensurate did not transfer along with those responsibilities.

6.2.1 Maori Health Development Decade

In *Whaiora,* Durie (1994) reviewed key themes of the Maori health decade (1984-1994). He presented six central themes pertinent to Maori health development advancement: the Treaty of Waitangi, Tino Rangatiratanga, Iwi development, economic self-reliance, social equity and cultural advancement. A Maori health development framework was developed, based on these themes. Maori health development assumes that there is

> an expectation that Maori control and leadership will be critical factors in the determination of strategies appropriate to the wider economic and social arenas as well as the health sector itself. Secondly, there is confidence in Maori delivery systems, Maori management, and an integrated approach to cultural, social, and economic development. Thirdly, wherever possible positive approaches and preventative measures are favoured over those, which represent later stages of intervention. A fourth feature of Maori development is the notion of partnership between Maori and the State (Durie, 1994, p.3).

The framework enabled Maori to both consolidate a view of Maori health and instil within Maori a collective vision for improved Maori health gains in the future. The framework was based upon a broad recognition of and commitment to integrative development inclusive of social, cultural, economic and political indicators. However, Iwi who had recently formed agreements with AHBs said that the commitment by Maori and the Government to the health reforms at that time was seen as a negation of their concerted efforts (Durie, 1994). Maori Whanau who were lumped into the catchment population pool felt threatened by the commercial overtones of the reforms. For instance, part charges for hospital care and outpatient care and prescriptions added to their anxiety and contributed to the creation of barriers for accessing quality health care. Durie (1994) however suggests that the reforms provided Maori with some opportunities, but it equally had too many limitations. One of the limitations is the absence of Maori policy designed by Maori for Maori. The most significant finding from the review is that Maori were articulating aspirations for Maori health development that integrated the importance of service provision within a broader set of parameters concerning Maori development as a whole. Maori reiterated the importance of their expression for a consensual view of Maori health that was both holistic and cultural.

6.2.2 Health Reforms 1990s

In 1991, the Government announced further radical health reforms which were hastily implemented. They abolished the only recently established AHB system, and put in its place a contracts-based purchaser provider system managed by four Regional Health Authorities, as the purchasers. Hospitals were reincarnated as Crown Health enterprises and the Department of Health became the Ministry of Health. A proposal for health care plans was also tabled, although never implemented (Gauld, 2001).

Maori however questioned whether Maori development was primarily a Maori kaupapa or whether it was part of the Governments plan for further privatisation, continued reduced state responsibility and user-pays (Durie, 1994). Maori policies continued to be decided upon by parliamentary representatives and Crown officials. The Treaty of Waitangi Fisheries Commission, the Maori Land Court and the Maori Language Commission all have their policies created by Crown officials. The development of health policies was no different (Durie, 1998a). Even though there was a Ministry of Maori Development that could rightly assist with Maori people to devise policies that did not occur. Instead, the policies were designed in draft before being distributed to Maori communities for further submissions.

Many Hapu and Iwi benefited from the 1990s health reforms through contractual arrangements for the delivery of health services. But, the contracts included prescribed service delivery parameters, limiting the opportunities to extend upon their current range of service offerings (Kiro, 2001). Durie (2004) notes that the indicators within the contracts frequently failed to reflect Maori worldviews and seldom focused upon the integrated nature of Maori health aspirations, taking into consideration spiritual, mental, social and physical considerations. Arguably, health contracting constraints impacted upon the way in which Maori health was conceptualised, practiced and measured.

Not everyone benefited from the reforms. In 1991, the unemployment rate for Maori reached an all time high of 24.2% with only nine percent for non-Maori at the same time. These impacts encroached upon the overall wellbeing of Maori families. The repealed Runanga Iwi Act 1990 was part of that ensemble of

structural events. In 1991, the Manatu Maori and the Iwi Transition Agency merged into Te Puni Kokiri - the Ministry of Maori Development, creating a government agency that merged the policy and operational arms of Maori Affairs.

6.2.3 Early Critics of the Government Reforms and Restructuring

After a decade of structural reforms, several critics began to challenge the basis for the reforms (Boston, Dalziel, & John, 1999; Collins, 1987; Easton, 1997, 1999; Kelsey, 1990, 1993, 2000). The public health system was reaching a crucial point of strain (Ashton, 1992). Initially, economists and politicians argued that changes from the 1990s health reforms would be limited, but by the latter half of the decade, an extensive reorganisation of the New Zealand public health system seemed inevitable. Kelsey (1990) contends that for Maori the results have been devastating:

> It has been Maori workers and communities who have suffered most – Maori families on marginal land with high debt levels; young Maori school leavers without educational qualifications and concentrated in high-unemployment rural and urban areas; Maori adults and in many cases, entire communities made redundant by wholesale closures of workplaces; unskilled and part-time Maori women workers forced out of light industry and coping at the same time with heightened economic and emotional stress within the home (p.2).

Kelsey argued that Maori should not have been surprised by the insidious intention of the reforms and the way in which they were played out through government policy. She claims:

> During the nineteenth century both economics and law became separated into sciences allegedly devoid of political and ideological content, divorced from each other and from the overt agencies of government. The economic system of capitalism, the political structures of parliament and the rules and procedures of English law became unquestioned goods – the universal symbols of civilisation to which all must aspire. Any other economic, political system or law was inferior, primitive, uncivilised or ideologically biased. Such were the economic, political, legal and ideological structures, which the English state imposed on Aotearoa New Zealand (1990, p.3-4).

The scenario intensifies the fundamental contradiction which has existed in Aotearoa New Zealand since 1840 – between the interests of a society born of colonial capitalism and the rights of the tangata whenua to their own political and economic sovereignty.

The neo-liberal infrastructure reforms were based on an individualist notion of freedom. The foundations of the reforms re-configured the meaning of freedom to fit market liberalist ideals. Kelsey (1993) articulates:

> *Freedom* no longer meant liberation from enforced economic, racial or social inequality. Instead, it had the meaning of freedom for the individual to achieve objectives free of constraining conditions. *Devolution* meant the Government retaining power over essential resource and policy decisions, while delegating delivery to the voluntary or private sector. This dominant/subordinate relationship was termed a *partnership....accountability* would be achieved through market efficiency measures of profit or contractual performance criteria. All this would *empower* individuals to take control of their lives as free and equal actors on the level playing field of life. *Liberation* was defined by Treasury to mean 'the promotion of the dignity of people through direction of their own lives'. There was no room for putting altruism ahead of self-interest, compassion ahead of efficiency, or mutual obligations and collective identity ahead of individual benefit. Nor was there any doubt about the intrinsic superiority of the marketplace (p.79).

The idea of freedom championed by neoliberalists leads to inequality. Inequality can be measured in different ways, it can refer to differences in income, health, education, housing and economic development. The recent economic reforms contributed to increased income inequality and the health reforms contributed to a reduced level of access by poorer families to health care services at primary and secondary levels. This stark contrast in inequality is a growing national and international concern that increases the gap between the rich and the poor. Neubauer (1997) illustrates that

> the richest 358 people in the world possess assets which exceed the combined income of countries accounting for forty-five percent of the world's population...The richest twenty percent of the world's population experienced a rise from seventy percent to eighty-five percent share of global income. The share of the poorest twenty percent dropped from 2.3 percent to 1.4 percent (Weisman cited in Neubauer, p.4).

It is also a doctrine premised on the notion of market superiority and justified by claims

> that state intervention does not work, that all alternatives to markets are seriously flawed, that government failure is more common than market failure and that anything beyond the minimal state violates individual freedom (Gamble cited in Kelsey, 1993, p.17).

The structural goals of the Government's policy shifted resources and control from the Crown to the private sector, based on the assumption that the reduced responsibilities would be beneficial for all New Zealanders. The private sector

benefited immensely from the acquisition of essential infrastructural resources required for all modern countries reliant upon technology, electricity, rail, communications, roading and so forth. Once the sales were completed, the private sector – local or international – was completely free from any reciprocal duties to the rest of the New Zealand population. When the state transferred its resources through privatisation, or its power through devolution, it would also divest its ability to perform and to be held accountable for this lack of performance.

Maori were incensed by the plans for privatisation of state resources. They saw the proposed sales as breaches to the Treaty of Waitangi. As clearer links between economic development and Maori development began to emerge, the sale of state and natural resources that could be utilised for the settlement of Treaty of Waitangi claims or which the Crown had no mandate to sell was challenged, but with limited success. With no other avenues for official redress, Maori sought to utilise the Waitangi Tribunal process to halt the corporatisation and subsequent privatisation of natural resources which many claimants contend are intrinsically linked to the wellbeing of Maori. Claims lodged with the Waitangi Tribunal must demonstrate a clear breach of the Treaty of Waitangi. Dr Paparangi Reid stated:

> To her knowledge the Waitangi Tribunal is the only official forum where the health reforms have come under official scrutiny. She says this happened recently when a group of brave, elderly Maori challenged the decision to close Napier Hospital (cited in St John, 1999, p.1).

Opposition against the reforms came from other quarters as well. Easton (1997) claims that the Government chose to ignore the advances of the medical profession based on the premise that their insistence that the 1990s health reforms were detrimental was fuelled by vested interests. Other forms of dissension came in sporadic bursts of public displays, pickets and petitions rather than real threats to the Government's agenda. The Coalition for Public Health, in which a number of unions and community organisations bandied together to defend what they saw as 'the attack on the public health system' (Easton, 1997). The Coalition provided informed commentary to the public on the reforms by supporting media efforts to access key spokespeople. Its members had a deeper knowledge of the health system than even the Government at the time, yet the Government ignored their

input. The sentiment of unwillingness to converse created a pool of resentment amongst critics who were impacted by the reforms. Political boycotting remained ineffective as successive governments continued to re-design the health system. In terms of improving Maori health status, the limitations of the reforms were all too apparent (Durie, 1994). The health reforms did appear to improve access to health care, but they fell short in terms of significantly improving housing, employment, educational achievement and adequate incomes (Durie, 1994). The health reforms were also about their implications upon the poor, elderly, mentally ill, disabled and minority groups. For example, Ashton claims that

> the changes impacted disproportionately on women, Maori, Pacific Islanders and the elderly. Overall, the evidence suggests that Aotearoa New Zealand will become a less egalitarian society with growing disparities between the rich and poor. Such developments are likely to prove socially and politically divisive and exacerbate racial tensions (1992, p.155).

6.2.4 Maori Health Development from 1994 Onwards

In 1994, it was seen appropriate to reflect upon the first decade of Maori development to determine whether the aspirations for Maori development had and had not been met. What was clear was that the underpinning assumptions of Maori development and therefore Maori health development remained the same. A second national health hui - *Te Ara Ahu Whakamua* continued to call for self determination in the developments of Maori health. This commitment to Maori health development transpired into small, but significant achievements in Maori development as a whole. For instance, an emphasis was placed on Maori deciding what was needed to improve Maori health status. The recording of ethnicity in official census documentation was one way to contribute to tracking and monitoring Maori health status progress.

Other significant activities and changes were occurring in the socio-political arena for Maori as well. In 1996 for instance, the introduction of a new parliamentary system called 'mixed member proportional representation' (MMP) allowed for the addition of an extra Maori seat into Parliament. It also provided the opportunity for more Maori politicians to enter Parliament through the list candidacy system (New Zealand Electoral Office, 2003). For the first time in decades, Maori seemed to be able to achieve more political mileage from the political system. In

spite of this new process, the new voting system received numerous criticisms from various other quarters particularly from those in positions of power who felt threatened by the potentialities of the MMP system. The MMP process led to the securing of another Maori seat into the electoral system.

Moreover, visible signs of Maori health development were recorded in the increased number of Maori providers and the publication and importance placed upon government endorsed Maori health policy during that time. To illustrate, in many regional locations, umbrella organisations such as Te Whanau Poutirirangiora a Papa, a consortium of Iwi throughout the Bay of Plenty and a Treaty partner with the Bay of Plenty AHB were established (Durie, 1994). In the Northern Regional Health Authority (RHA) region, Iwi based Maori purchasing organisations (MAPOs) were established to manage the development and delivery of health services to Maori in respective regions (Kiro, 2001). Also, aspirations for improving Maori health policy received Public Health Commission (PHC) support with the commissioning of reports to clarify who was responsible for improving Maori health advancement and implementing culturally appropriate models for Maori health development at national, regional and community levels.

However, the health reforms impacted upon Maori health development aspirations in a number of different ways; one of which was the inconsistent way in which government created Maori health policy. Durie (1994) highlights two particular strategic policy documents. *Te Urupare Rangapu* prescribed the relationship between the Crown and Maori and provided a framework relevant to Maori social policy which was designed for Maori people. *Ka Awatea* outlined the Governments intention to prioritise Maori development; one of those areas was Maori health. The Maori health policy document *Whaia te ora mo te Iwi* (Department of Health, 1992), sought to overcome "perceived fears of Iwi/Maori in relation to the enactment of the Health and Disability Services Bill, which was the key piece of legislation for the health reforms process" (Cunningham & Durie, 2005, p.217). A second document called by the same name, called for

- Greater participation of Maori at all levels within the health sector
- Resource allocations that took into account Maori health needs and

- Culturally appropriate practices as integral to the purchase and provision of health services for Maori (Cunningham & Durie, 2005, pp.217-8).

Moreover, the way in which health services were provided (including health promotion) was about to be subjected to more dramatic changes, particularly with respect to the purchasing and contracting systems for primary health which up until then had been provided by the Health Funding Authority (previously called Regional Health Authorities) (Davis & Ashton, 2001).

The 1990s health reforms were underscored by a critique of the previous health system that described it as inefficient, lacking in information, poorly accountable and unable to adequately integrate services between primary and secondary care (Ashton, 1999). By the end of the 1990s, Ashton suggests that, "market liberals generally argue that health care is no different from other commodities in terms of the expected responses to market mechanisms" (1992, p.147). Even when ill, individuals are the best judges of their own welfare and should therefore accept responsibility for their own health care. It was also apparent that the current public health system in New Zealand continued to be influenced by actors driven by market theory and managerialism, despite the growing concerns related to the lack of validation for these models in Maori health development (Gauld, 2001).

In 2001, a vocalised commitment to depart from market liberalist policies was tabled by the incumbent Labour Government. A reversal in thinking by senior government officials working on health policies also reverted hospitals (called Crown Health Enterprises) back to the control of district health boards and the disestablishment of the Health Funding Authority (previously the Regional Health Authorities). As a result of these changes, the overall mandate for governance, decision making and budgetary control was also passed on to District Health Boards (DHBs).

For Maori, relationships with government representatives of health agencies formed over the previous six years were threatened by the new changes. Maori health providers throughout the country had entered into contractual arrangements with the Health Funding Authority, only to have those contracts subjected to

further reforms. Having spent all that time forming high level relationships, the process needed to be initiated all over again with different groups and different representatives. Maori leaders were understandably anxious that the momentum achieved over the last ten to fifteen years was not lost as a result.

6.3 KEY ISSUES PERTAINING TO MAORI HEALTH DEVELOPMENT

In this section, I will briefly outline a number of ongoing issues for Maori related to Maori health development and the Government's structural and institutional reforms.

6.3.1 General Response to the Reforms by Maori

Responses by Maori to the 1990s market type health reforms have been mixed (Durie, 1994). On the one hand the health reforms demarcated where the Government instigated neo-liberalist policies for economic and social development and where Iwi and community groups were able to actively engage in the provision of health services. On the other hand, the health reforms enabled government representatives to experiment with the nations future estate by dismantling the welfare system and replacing it with what they claimed would be a leaner, more efficient political machine (Easton, 1997; Kelsey, 1993, 2000).

The Ministry of Maori Development (1993), an organisation responsible for reviewing specific Maori issues at a national level failed to provide critical dialogue on the health reforms. Maori argued that they prioritised commitment to the Government's direction as opposed to providing key policy advice to Maori people. Their officials focused on the business of health care provision by Maori rather then providing an analysis of the ideological foundations for the reforms. This fuelled a perception that Maori supported the moves of the Government towards privatisation (Durie, 1994). But, Maori supported a strategic approach to Maori development, which embodied principles based on Maori health development. Cunningham and Durie (1999) clarified that position by explaining that Maori were dissatisfied with the situation:

> A rise in 'negative spending' for poor Maori outcomes, the emphasis was on reduced reliance on the state and growing confidence in the Iwi delivery model for some public services for Maori. Central importance was given to the Treaty of Waitangi as the basis of interaction with the Government. The major thrust was on economic initiatives, but several papers on Maori health and unemployment left no doubt of the need for improved social policies to be integral to Maori advancement, with Maori themselves ready to be the major agents of change (p.238).

Undoubtedly, the structural reforms and consequential health policies and strategies that emerged from those reforms since the early 1980s have benefited Maori by enabling active participation within the health sector. Maori health providers are key participants in the provision of Maori primary health care. Maori health providers such as Ngati Porou Hauora are also involved in the provision of secondary care e.g. Te Puia Hospital. However, participation within the health sector has not ensured that Maori have a stronghold upon the wellbeing of their people or that the resources to remain involved in the sector are adequate. Cunningham and Durie (1999) highlight that Maori have improved self-management of their destiny within health, but it is unclear whether moves towards tino rangatiratanga – Maori autonomy can also be claimed.

6.3.2 The Third Way and Maori Aspirations

As with all reform periods, recommendations for structural change to the health system were premised on a set of ideologies. Ongoing criticism of neo-liberalist ideals underpinning the structural reforms in Aotearoa New Zealand during the 1980s and 1990s led to the adoption of what is called the 'Third Way' by the current Labour Government. The Prime Minister, Helen Clark espoused

> [Our government] is a third way government striving to achieve a better balance between a dynamic market economy and a fair society, which offers opportunity and security for all (cited in Kelsey, 2002, p.50).

Steven Maharey, Minister of Social Welfare articulates that it is a new approach that will balance:

> The demands of the individual to do his/her own thing with the need for social cohesion or 'community'. Where the First Way (Old Left) over-stressed the commitment to the collective, and the Second Way (New Right) over-stressed self-interest, the Third Way seeks a balance (Independent cited in Kelsey, 2002, p.61).

From an official government perspective, the 'Third Way' offers another approach to pursue economic stability in Aotearoa New Zealand within a political landscape consisting of more than a decade and a half of reform. But, what did it all mean for Maori? Kelsey (2002) argues that the Third Way is merely a political management strategy aimed at neutralising the tensions generated by globalisation. In her view, the Government's disregard to address the deeper tensions is politically unsustainable in the long term. Government officials were convinced that the new approach offered something new and exciting. However, Kelsey said the new approach is indicative of "recycled old neo-liberal wine in a new social democracy bottle'. The Third Way was literally 'globalisation with a social face'" (2002, p.85). She urges Maori to identify neo-colonialist ways of organising human potential and to work to transform the structural and practical ways in which they take place. One way this is happening is through the construction of meaning. For instance, with Maori, partnership with the Government had been reinterpreted from meaning 'equals' to meaning one of the constituent groups among many, deflecting energy and resources away from the specific issues of Maori as the Treaty partner (Durie, 2004).

6.3.3 Maori Representation at Governance Levels

The 1990s health reforms highlighted the absence of a clear strategy for Maori representation at national and local levels. As early as 1988, calls by Maori made to key ministers such as the Minister of Maori Affairs, Koro Wetere were acknowledged with the establishment of a Ministerial Advisory Committee on Maori Health chaired by Professor Mason Durie (1994, p.172). However, strong Maori leadership at national and local DHB levels involves multiple approaches to social transformation to enable Maori to provide adequate and effective responsiveness to key Maori issues.

In 2001, a review undertaken by the Health Reforms Research Team (2003) highlighted concerns by Maori within the lack of Maori leadership and governance capacity within DHBs. Many Maori respondents argued that although Maori put forward candidates for consideration, the electoral process of selecting

successful candidates meant low numbers of Maori were elected into governance roles.

Without Maori representation in these key governance roles, it is difficult to progress specific issues pertinent to Maori health development. For instance, the review found that Maori continued to be concerned with the watering down of the Treaty partnership which was transferred from central government to local government representatives of the DHBs. Some elected board members did not support the premise of the DHB partnerships being based upon the Treaty; they argued that it was a national responsibility for the Ministry of Health to consider. However, DHBs were given delegated authority on behalf of the Ministry to address these types of issues within local regions. Maori were agitated by being continually forced to articulate the need for Maori health improvement within the Treaty of Waitangi framework.

Maori respondents also highlighted concerns about the ability of the DHB to achieve health outcomes for Maori given the historical track record. The ongoing political commitment to improving Maori health was essential. Concerns were also raised about the dilution of the relationship between the DHB, Iwi and Hapu as a result of the adoption of pan-tribal approaches to Maori health development. Although in practice the DHB worked with Iwi and Hapu, there were concerns that this would not always be the case. The related documentation did not always adequately reflect a need to fulfil that responsibility.

6.3.4 Maori Health Policies

The 1990s health reforms and the aspirations by Maori to improve Maori health development highlighted a gap within the way in which Maori health policies were designed, implemented and monitored (National Health Committee, 2002). The development of the *He Korowai Oranga* – the Maori Health Strategy (Ministry of Health, 2001) and *Whakatataka* – the Maori Health Action Plan 2002 – 2005 (Ministry of Health, 2002) were viewed as positive ways in which to overcome these problems. At a strategic level, the documents reflected aspirations by Maori and government officials for

> Whanau Ora – Maori families that are supported to achieve the fullness of health and wellbeing within Te Ao Maori and New Zealand society as a whole. This aim builds directly from the New Zealand health strategy and the seven fundamental principles that should be reflected across the health sector including: acknowledging the special relationships between Maori and the Crown under the Treaty of Waitangi (Ministry of Health, 2002, p.2).

A commitment to Whanau focused health development is a clear shift from previous policies for Maori health (Cunningham & Durie, 2005). The strategy requires that health workers consider the wellbeing of the individual within the context of a Whanau. The acknowledgement of Whanau as the wellspring of achieving Maori health is a positive strategic change. Cunningham and Durie (2005) see the Whanau foundation as an essential way in which to better manage asthma, diabetes and also cancer. However, two issues must be considered with regards to the Whanau ora strategy. First, the *Whanau Ora* concept is couched within a strategic government document that relies on the complex institutional arrangement of health care delivery with its interconnections between mainstream and Maori providers. The translation of these strategic expectations is largely dependent an in-depth understanding by the health workforce of these issues as they are responsible for delivering these health services. Second, the framework of analysing and measuring the outcomes of this holistic approach to Maori health advancement depends upon the type of evaluation model adopted. A model designed to cater to the assessment is called *Te Ngahuru: A Maori Outcome Framework* (Durie, Fitzgerald, Kingi, McKinley, & Stevenson, 2003). However, its current discussion is beyond the scope of this thesis.

6.3.5 Maori Health Workforce – Public Sector and Iwi/Hapu/Whanau, Health Experts

There are multiple facets in which the resourcing of the Maori health workforce becomes essential. One of those roles is directly related to the public service. Within the public health sector, the duties and roles performed by Maori public servants (those who have strong connections to their Whanau, Hapu and Iwi) can be most important. However, it is often shown that Maori public servants have two masters, their employers and their Whanau, Hapu and Iwi. This tension is demonstrated with the following illustration presented by a senior Maori health public servant:

> The Treaty is about preserving a place for Maori in their own country; good health is critical to that....indeed motivation for the Treaty stemmed in part from health concerns as long ago as 1837....The Waitangi Tribunal has agreed that taonga katoa includes cultural as well as material properties...Maori have contended repeatedly that health can be described as a taonga and therefore entitled to protection under Article 2 of the Treaty (Workman, 1996, p.17).

Whilst this Maori public servant advocated the place of the Treaty of Waitangi in Aotearoa New Zealand, as a senior public servant he also argued that "the health reforms have largely advantaged Maori and provided opportunities for Maori to emerge as purchasers, providers, planners and developers of positive Maori health policies" (Workman, 1996, p.17). The role of the Maori public sector adviser is therefore a paradoxical one; drawing into conflict their roles as government advisers and their commitment to their Whanau, Hapu and Iwi. The challenge of balancing these responsibilities is difficult for many who are located in such a compromising position. Sometimes, these employees become domesticated and mimic the coloniser (Memmi, 1965), bringing into disrepute their role in the relationship with the Crown, themselves and their people.

6.4 SUMMARY

In this chapter I have sought to outline Maori aspirations for Maori health development against a backdrop of changing social and economic reforms. The 1990s health reforms were an orchestrated attempt by neo-liberalist parliamentarians to re-construct the health system. At risk was not just the overall health and wellbeing of New Zealand people, but the fiscal constraints of the Government and the responsibilities associated with managing those constraints (Reid, 1999). Parliamentarians guided by those ideals justified in principle and actuality the dismantling of the welfare state and the re-distribution of charges for hospitalisation from the State to the patient (Easton, 1997). Maori – a population suffering more ill health and lower incomes than most New Zealanders were delivered a double blow. For Maori, the health reforms and the landscape for health development in New Zealand brought (in the context of wider primary health care services) opportunities for engagement in the delivery of primary health services. But, in doing so Maori were being re-classified as Maori health providers and their provider status was based on their effectiveness as community vehicles to enhance Maori health. The Maori health provider framework was not

always equipped to deal with improvements in Maori health that are dependent on attitudinal commitments to Te Ao Maori, as well as financial resources – a catch twenty-two situation.

Kelsey (2002) argues that the neo-liberal reform period demonstrated that economic theories of market liberalism can and do infiltrate the moral foundation upon which the provision of health services are based. For example, where traditional spaces within social movements (voluntary sector, Maori, community) were previously off limits to these types of terminologies, now it has become increasingly prevalent to not only use these terms, but it is now more common to see the ethos applied as if it was a philosophy of practice. Kelsey (2002) warns against this type of behaviour. She claims that neo-liberalism has contributed to the deep acceptance of market culture; by groups that were traditionally opposed to these ideologies e.g. social service agencies. Easton (1997) argues that incremental changes may have been a better approach to health sector restructuring instead of attempting to overturn the current systems with the haste in which it was performed. However, it could also be argued, that Maori were permitted (as a direct result of the health reforms) entry into the primary health care sector that may otherwise not have been opened, had the reforms not occurred. The positive outcomes of the reforms have seen the establishment of marae clinics and clusters of Iwi focused on improving Maori health as a vehicle for Iwi autonomy. Nonetheless, Durie (2003) states that over the last three decades Maori have been forced to construct new frameworks to accommodate a shortcoming of the Government.

Historically, Maori health gains emphasised improvements in disposable income, housing, education, socio-economic status and Iwi development. Reid (1999) insists that Maori must develop a collective vision for Maori health based on a clear set of workable objectives. Durie (1994) claims that misgivings felt towards the reforms were focused on the contradiction that Maori could be health providers (through the reforms) but that the Government failed to acknowledge that Maori health frameworks should be based on a Maori development model. This issue is an enduring one, and to this day there continues to be a mismatch between the parliamentary health reforms and aspirations by Maori for Maori

health. The basis of He Korowai Oranga upon Whanau ora signals steady progress, however resourcing and monitoring the implementation of the strategy will be imperative.

A key issue in this chapter and throughout this thesis has been a deep-seated disregard by the Government to acknowledge any notion of dual sovereignty between Maori and the Crown. Maori attempts to have their unmet desires for sovereignty as an indigenous people recognised are continually overlooked. Where agreements have been reached they have been minimised. Deeply threatening to parliamentarians and their neo-liberal supporters is the possibility of Maori having their claims to resources (natural, seabed, land) substantiated within parliamentary and judicially approved processes. The contestation of sovereignty is not only about the tangible elements at risk, debates about sovereignty involve a recognition of different ontological and epistemological perspectives as well. In this regard, the health reforms and the place of Maori within those reforms has been as a people committed to a different worldview of health that does not stem from neo-liberalist ideals being generated by government officials.

For Maori, the bottom line of the market-driven 1990s health reforms is measured by improvements in the overall health of Maori people and their progress towards tino rangatiratanga. Prior experience has shown that competing ideologies of health influence the actual delivery systems of health services. Maori health advocates therefore argue that health achievements must be consistent not only with the holistic definitions of Maori health, but with wider parameters of Maori health development as well.

CHAPTER SEVEN: MAORI HEALTH

"E wha nga kokonga o taku whare
ko te taha wairua, te taha
hinengaro, te taha tinana me te
taha whanau, ka hinga tetahi ka
ngaro taku whare

My house has four cornerstones,
spiritual, psychological and
emotional, physical and whanau –
extended family, should one corner
stone be weaker, than the others my
house is at risk" (Sir Peter Buck) [16]

7.1 INTRODUCTION

In this chapter, I will explore the theoretical underpinnings of contrasting historical and contemporary constructs of health as a means to validate a 'taken for granted' way in which Maori health is located within Kaupapa Maori theory. I argue for greater recognition and appreciation of the holistic and cultural approaches to Maori health which is drawn from Te Ao Maori and viewed in this thesis as an ontological commitment to being Maori. I also discuss some of the challenges associated with recognising and practising holistic approaches to Maori health.

7.2 TRADITIONAL MAORI CONCEPTIONS OF HEALTH AND ILLNESS

7.2.1 Traditional Maori Public Health System

Prior to European contact, the geographical isolation of Maori in Aotearoa New Zealand helped prevent the onslaught of infectious illnesses such as influenza, typhoid and measles. Traditionally, Maori recognised the importance of healthy communities through a public health system based on values that represented a close relationship between people and the surrounding natural environment (Durie, 1994b). The traditional sanitary practices of Maori were exemplary (Dow,

[16] This proverbial saying has been attributed to Sir Peter Buck (Te Rangihiroa). However, many Maori health providers and Maori health promoters have used it extensively. It was sourced in a publication prepared by John Ohia for Whaioranga Trust in 1995.

1999; Lange, 1999). Whilst the prevalence of different forms of diseases of the skin, eye and teeth were common, in general it was deduced that the Maori population was *healthy* (Durie, 1977). Maori health and wellbeing was not an isolated phenomenon, rather it was a total system of living interrelated within and to the concept of traditional Maori public health. The effectiveness of these systems relied on a communal regulation system and the way in which it was enforced through collective notions of responsibility and stewardship.

Maori activities involved the gathering of food, cultivating gardens, constructing homes and shelter, composing waiata, constructing waka and fishing nets, maintaining local versions of arts and crafts, collegiality of Whanau groups and the ability of the rangatira to lead and care for members of Whanau and Hapu (Buck, 1950). Designated areas of land, sea, bush or water often became wahi tapu as a form of respect and responsibility to the greater elements; Papatuanuku in the land and Tangaroa in the sea. The concept of rahui was applied as a prohibitive means of protection. Rahui was enacted as a means of conservation, protection or danger (H. Mead, 2003). Traditional Maori health and wellbeing therefore formed part of an interconnected living ecological system.

7.2.2 Tapu and Noa

Traditional Maori notions of health and illness are also intrinsically connected to cultural concepts of tapu and noa (Durie, 1977) (discussed in greater detail in *Chapter Two*). Tapu and noa formed the basis of communal law and order. In terms of health, tapu could be seen as a preventative measure as well as a causation of sickness; for instance where breaching tapu led to illness. For Maori, the concept of tapu offered a set of practical guidelines to protect communities from known dangers. Parts of the body were tapu such as the head, genitalia and heart and people at different times were also tapu, such as during childbirth and mourning (Shirres, 1997).

In contrast to tapu, the term noa was viewed as a state of relaxed access and no prohibitions were set in place. Food ready for eating was noa and partaking of a meal with strangers helped render their potential threats as noa. Tapu and noa are

two sides of a binary relationship that enact at a complementary level, creating a dynamic relationship that aims to generate balance and harmony. Durie (1998b) says:

> The balance between tapu and noa was a dynamic one, moving to accommodate seasonal, human and physical needs within a value system that was sufficiently holistic to accommodate health interests. Both noa and tapu had meaning for health, noa denoting safety, tapu denoting protection and [prohibition] (p.9).

For the lore of tapu and noa to be effective (as with any system of ideas) they require faith and commitment. In contemporary settings, traditional Maori lore have been challenged as superstitious or undervalued as communities overlook the importance of culture. But, there are still numerous examples where events continue to validate the power of tapu; elders can still be seen today talking with people who others cannot see. Barlow (1991) warns that:

> We will never become tapu under a particular power or influence if we lack the commitment and dedication to follow what we believe in relation to the power of that tapu (p.128).

Pre-European Maori concepts of health based on tapu and noa, influenced the traditional Maori public health systems and helped establish clear links to holistic philosophies in which physical and spiritual wellbeing were inseparable.

7.3 CARTESIAN PHILOSOPHY: BODY AS A MACHINE

I draw extensively from the work of *Fitjof Capra* (1982) to provide an overview of Cartesian philosophy. Cartesian philosophy is premised on a belief in the certainty of scientific knowledge, where "knowledge is rejected when it is merely probable. Only those things that are perfectly known should be believed" (Capra, 1982, p.55). The world is therefore a material one founded upon mechanical laws and principles of reductionism, a complex phenomena where understanding is reached only by reducing things to their constituent parts (Capra, 1982). Reductionism endorses a regime of power relations that are exercised by the medical elite, who doubt everything that cannot be managed such as traditional knowledge or healing.

Cartesian philosophy informs the biomedical health model, which conceptualises the human body as a machine and disease is seen as the malfunctioning of

biological parts of the body. Although the biomedical model of health is a prominent approach to health within many Western societies, considerable pressure has built up over time for doctors to go beyond the mechanistic view of the body. This has led to a growing interest by medical professionals of indigenous approaches to healthcare and wellbeing - an interest which has disguised contemporary Western healthcare scientific medicine models predatory patenting practices for commercial gain. The acquisition of indigenous DNA samples by commercial enterprises is an example (Gardiner, 1997; Harawira, 1999b).

Historically, the gradual acceptance of western medical care by Maori communities, following European settlement was influenced by a number of concurrent events. First, the availability of Maori medical officers throughout the country became more prevalent, as did the establishment of hospitals in growing settlements around the country, making medical care more readily accessible. Second, the inability of traditional Maori healers to deal with the spread of pathological illnesses, previously unknown, in their communities led to a growing sense of concern. Diseases such as tuberculosis, typhoid and flu were illnesses that were introduced to New Zealand by early settlers, traders and missionaries (Dow, 1999). They were illnesses to which Maori people had not been previously exposed. The acceptance of medical care founded upon the biomedical model was often a last resort against introduced diseases which were incurable by traditional Maori means. Those who were unable to seek medical attention often became critically ill and many died in the process. Third, the work undertaken by Maori members of parliament: Maui Pomare, Peter Buck, James Carroll and Apirana Ngata provided assurances for adopting alternative forms of practice for health and wellbeing in Maori communities. However their efforts appeared to endorse a commitment to the superiority of Western medical practices, which for Pomare was derived from his training as a medical practitioner. Fourth, the passing of the Tohunga Suppression Act 1907 curtailed the use of traditional Maori healers and diminished the viability of community health processes associated with that traditional life style.

During the late 1800s, it could be argued that health related policies were engineered by the medical profession to ensure that any form of medical practice adhered to the philosophies of biomedicine (Dow, 2001), which coincidentally were incompatible with Maori ways of treating the ill. The tensions raised as a result received limited attention. When attention was given, it generally took the form of increasing annihilation of Maori processes or assimilation to the medical model. However, a section of traditional healers continued to practice their work, unabated by the legal ramifications associated with providing relief to people under the auspices of tohungaism. By 1964, when the Tohunga Suppression Act 1907 was repealed, traditional practices associated with tohungaism and healing were in the process of being lost (McGowan, 2000).

In the early 1980s, Maori medical professionals sought to re-align medical healthcare alongside other alternative health practices. Many Maori doctors and nurses were convinced that medicine failed to adequately meet the emerging health needs of Maori. They emphasised a growing responsibility to promote medical practices that went beyond physical diagnoses, to include spiritual, psychological and mental remedies. In contemporary times, Maori health professionals are demonstrating a growing commitment to culturally appropriate approaches to enhancing Maori health development (Durie, 1994).

7.4 HOLISM, WELLNESS AND HEALING

Holistic health is concerned with the balance of the physical, spiritual and psychological aspects of people. The World Health Organisation (WHO) definition of health as, "a complete physical, mental and social wellbeing and not merely the absence of disease and infirmity" is consistent with that view (World Health Organisation, 1947, p.12).

Any system of health care, including modern western medicine is a product of its history and exists within a certain environmental and cultural context. Throughout history, approaches to health by different peoples appears to oscillate somewhere between reductionism and holism. With many indigenous cultures, the origin of illness and the process of healing are seen to be associated with

forces belonging to the spirit world. Consequently a variety of healing rituals and practices have been developed to deal with these illnesses (Capra, 1982). Holistic therapies represent and emphasise the restoration of harmony or balance within nature, in human relationships and in relationships with the interrelated realms.

Traditionally, Maori healers depended on first drawing a distinction between tapu and noa and then reconstituting a sense of balance between the two. A skilful practitioner's process of diagnosis was concerned with uncovering any breach of tapu and the outward manifestations of health related problems. Durie (1994b) describes the process as scientific teamed with further scrutiny related to the outcome of the treatment. However, traditional healers saw themselves as custodians of knowledge (Durie, 1994b). Uppermost to them was the wellbeing of the tribe, which was connected to protecting knowledge. Tohunga then and today are revered experts who perform healing tasks such as: ritenga and karakia, rongoa, mirimiri, wai and surgical interventions (Durie, 1994b). Arguably, Maori traditions of health and wellbeing have been ahead of western medical practices. Maori traditional healing is similar to pre-industrial practices in western society, which accentuate religious, spiritual and moral explanations of illness and health. Maori healers and tohunga employ all of the disciplines of herbalism, clinicians and matekite, though all within a holistic cultural context (McGowan, 2000).

The practice of holistic health by other cultures is prevalent. The Chinese medical system is holistic in that its practitioners believe that their remedies will not just remove the core symptoms of the patient's illness, they will affect the entire person, which they treat as a dynamic whole (Capra, 1982). Capra contends that a truly holistic approach will recognise that the environment created by our social and economic system is based on the fragmented and reductionist Cartesian worldview. In contrast, an ecological approach to health supports holism and can only make sense if it leads to insightful changes in our technological, social and economic structures.

An interest in traditional healing has increased as the removal of stigma related with the practice, has aligned with Maori aspirations for reclaiming Maori methods of health. Ironically, this move has also coincided with an acceleration

of the commodification of health care. Robert McGowan (2000), a rongoa Maori practitioner, is concerned that the loss of tikanga associated with the use of medicinal plants is negatively influencing the practice. However, he is heartened by the enthusiasm of many young people to learn rongoa Maori, as this will help retain the traditional practice. This view is also supported by Hohepa Kereopa, a traditional Maori healer of Tuhoe in *Tohunga* (Moon, 2003). However, learning rongoa Maori in these contemporary times is not the same as possessing traits of a tohunga.

Traditional Maori healing practices have changed over time and the extent to which they are practiced in Aotearoa New Zealand is currently unknown. In the past, expertise and credibility has been based on natural skills, which in time were ratified by the community. In contemporary times, those who have healing gifts share their skills, but shy away from professionalising and commercialisation of what they see as gifts passed down by their ancestors. Western health practices are also endorsing alternative-holistic approaches to advancing health in this contemporary time, though there has and continues to be resistance to its acceptance within the medical profession.

7.5 PUBLIC HEALTH PERSPECTIVES

Traditional western public health perspectives are concerned with controlling filth, odour and contagious diseases and illnesses (Durie, 1994b). Traditional public health is thus based on a body of knowledge, a discipline and also a practice which encapsulates an array of professions, institutions and actors who are responsible for promoting, implementing, measuring, monitoring, regulating and improving the public's health. Public health activities focused upon infectious diseases that caused mortality (Pomare et al., 1995). Public health efforts on the whole were concerned with the wellbeing of populations as opposed to individuals (Katz, Peberdy, & Douglas, 1997).

In contrast, the *new public health discourse* emerging from the 1980s and 1990s is characterised by a preoccupation with lifestyles and risks and the way in which the social, cultural, political, economic and environmental dimensions of society

impact upon individual aspirations to advance their own public health goals. Western public health has a genealogy that is traditional and contemporary. It is seen as a series of scientific knowledges' such as sanitary reform, hygiene and disease containment, and a narrative of succession from "causal episodes in which the advance of science plays an independent and key role in improvements in life expectancy of individuals and also the populations well-being" (Martin and McQueen cited in Petersen & Lupton, 1996, p.2). Petersen and Lupton's (1996) articulation of the new public health is as a series of regimes of power and knowledge that are oriented to the regulation and surveillance of individual bodies and all social bodies as a whole. A comprehensive new public health concept has developed that specifically targets populations and brings together

> environmental change and personal preventative measures with appropriate therapeutic interventions, especially for the elderly and disabled. However, [it] goes beyond an understanding of human biology and recognises the importance of those social aspects of health problems which are caused by lifestyles. In this way, it seeks to avoid the trap of blaming the victim. Many contemporary health problems are therefore seen as being social rather than solely individual problems; underlying them are concrete issues of local and national public policy and what are needed to address these problems are 'health public policies' – policies in many fields which support the promotion of health. In the new public health the environment is social and psychological as well as physical (cited in Petersen & Lupton, 1996, p.21).

Martin and McQueen (cited in Petersen & Lupton, 1996) caution whether the emerging perspectives of public health can be ratified as liberating. New public health themes include

- A shifting away from a biomedical emphasis on the individual towards social and lifestyle factors
- Recognition of multidimensional aspects to developing solutions to public health
- A broad conceptualisation of environments, which include social, physical and psychological dimensions
- An acknowledgement of an increase in expert knowledges and activities, which focus on new environmental threats and risks.

Concerted efforts have been made by marginalised groups to assert alternative frameworks of health advancement to overcome public health problems in their respective communities (Petersen & Lupton, 1996). Public health also umbrellas

a growing range of strategies and concepts such as health education, social marketing, health promotion, epidemiology, immunisation, community participation, health public policy, health advocacy and health economics. Efforts have been focused upon voluntary approaches to public health, although legislative means are employed particularly in the prosecutable offences of knowingly passing on communicable diseases e.g. AIDS (Patton, 1990). Within the new public health discourse, the WHO health definition is increasingly seen as an archetypal prescription of health, rather than an existing robust and living definition in any existing society at this time. Links to medical science are being severed from public health approaches, which are prioritising inoculation and immunisation regimes. Public health has a far greater and broader reach that looks at the notion of health of society as a whole.

As outlined earlier, traditional Maori public health systems operated effectively in pre-European times, where health indicators were related to the provision of food, shelter, water, warmth, protection, cleanliness, hygiene, sanitation and personal contact (Durie, 1994). Contemporary debates concerning Maori public health have since focused upon defining Maori health, designing Maori health policies and reshaping Maori public health within a mould that is culturally, socially and politically astute (Durie, 1994a). Nationwide, collaborative energies are being applied by community people and health professionals to build robust infrastructures of people - Iwi, Hapu and Whanau communities who seek to reassert communal autonomy and responsibility for Maori health gains. But what is actually taking place in reality? Are these esoteric aspirations for Maori public health gains significantly different to non-Maori public health gains? Are there resources available to improve Maori health and wellbeing? Are Maori in control of this process? Are Maori guilty of producing a panacea for Maori health, which is simply not achievable? If Maori are conceptualising an alternative framework for Maori health, how is it being done?

In these contemporary times, public health concerns are largely unchanged, although specific behavioural and environmental contexts have changed significantly. For instance, there are limited sources of fresh fish and stocks of cultivated food available for Maori communities to access. There is a decreasing

number of sustainable communities, where people cultivate the land and care for the surrounding waterways. Human lives in a contemporary context, are subjected to environmental pollutants despoiling the health giving characteristics of the soil, water and air combined with the habitual nature of convenience shopping which is based on a consumerist lifestyle and consumer products imbued with chemicals and toxins (Roddick, 2001). In the past, families relied on a limited range of food supplies and they planted vegetable gardens out of necessity. Husband (2004) questions what has happened to the

> good old days of vege-loaded meals? When nobody needed to be told to eat vegetables, they just did because it was healthy and cheap [or grown in the backyard] – brackets added (p.1).

Few Maori live in sustainable communities with access to seafood and gardens with fresh vegetables and fruit. Concerns about poverty, malnutrition, hunger and increasingly unsafe levels of unhealthy consumption of convenience food are infiltrating our once sustainable communities. Added to those concerns are the influx of crime, unemployment, violence and loss of education which were not key features of deprivation in the past (Durie, 2001). Today there are signs of a global society on the brink of an ecological catastrophe, with few solutions for improvement (Roddick, 2001). Efforts are being made by countries worldwide to curb these problems and the Kyoto Protocol and the Declaration of Rights of Indigenous Peoples is a step in the right direction (Working Group on Indigenous Populations, 1993). But, these proposals are being hampered by the unwillingness of dominant countries such as America and Europe to endorse more sustainable practices worldwide.

In response to these global challenges, the new public health discourse seeks to transform the awareness of individuals in order that they might become more self aware, self-regulating and productive at meeting their own needs, as well as those of society at large. By endorsing this type of approach to public health, a set of guiding principles and norms might be developed to help individually organise and monitor the implementers of the new public health. In this way, an emphasis is placed upon *voluntary conformity* to address health needs according to prescribed governmental health goals. Petersen and Lupton (1996) suggest that these steps represent a crucial feature of the concept of neo-liberalism - a

philosophy based on the freedom of individual development and limited state intervention.

7.6 HEALTH CONSUMERISM

The emergence of health as a consumer-based phenomenon in New Zealand is reflective of, and influenced by a global consumer movement. The notion of health as a commodity is based on market-liberal philosophy fuelled by economic exchanges between consumers and manufacturers (Radlin, 1996). Society is seen as a consumer based one where people are clustered into markets consisting of potential and existing unmet consumer needs. Annandale (1999) implicates the political economy perspective for its contribution to health consumerism. Engels (cited in Annandale, 1999) says the political economy perspective is critical of the social production of illness under capitalism, founded on the central contradiction between the pursuit of profit and the stewardship of health in this analysis (Doyal cited in Annandale, 1999). Medical practice is therefore implicated for contributing to the capitalist agenda. The re-defining of surgery for survival verses surgery for self-indulgence is an example.

Annandale (1999) argues that through the people, capitalism influences all areas of life creating health-related problems such as unemployment and stress. Competition forces capitalists to expand their output and sales to generate profit. Profits made from new ventures are reinvested again and the cycle continues to form patterns which underpin the operation of formal and informal healthcare and services. Ways and means of maximising profit have shifted from the production of commodities to the production of knowledge and information. Capitalists have merely reconfigured their focus, to find new areas of exploitation. Annandale (1999) suggests that it is possible to isolate the implications of consumers in a number of key health areas such as health inequalities, restructuring of healthcare provision and the reflective accounts of ill health. The far-reaching ramifications of developing designer babies for instance outweigh any preconceived notions of the boundaries of medicine and health (Begley, 1998). Ethical borders are being crossed in the new un-chartered territory of tissue sampling, organ procurement

and plastic surgery disguised as science, but also seeking profit (Darnovsky, 2001).

Using this premise, the market is seen in everything and nothing is beyond being commodified (Landry and Maclean cited in 1999). Henderson (2002) argues that human identities are characterised and shaped by the items we consume and the symbolic meanings attached to those goods and services. A new sense of reflexivity mirrors the breakdown in traditional structures of social class and family with consumer defined categories such as consumer sovereignty (Annandale, 1999). Consumer sovereignty requires a consumer society to operate around consumption and the individual person (redefined as a consumer), in an autonomous manner to exude a sense of individual independence, representing consumer power. The power of the individual to contemplate and exercise their consumer rights has reached new heights and transcended new boundaries. Herzlinger (1997) argues that

> the market and only the market can provide the health care that the American people want at a price they are willing to pay (p.ix).

Ashton (1999) argues that Aotearoa New Zealand has experienced a series of radical health reforms that have altered healthcare provision particularly for hospitals (see *Chapter Six*). Critics of the use of a market model contend that its application to health services is problematic given that there are numerous opportunities for market failure (Easton, 1997). They include the imbalance in knowledge held by patients and professionals, the influence of decisions by patients, difficulties in measuring output, high transaction costs with maintaining markets and inevitable conflicts of interest between those funding the services; those using the services; those managing the services and those providing the services (Ashton, 1999; Easton, 1997). The market liberal perspective supports the principle of individual responsibility and accepts that scarce resources for health care provision may be better utilised under a targeted regime of funding. The regime also supports the idea that if consumers are well informed, they will make the best decisions about the services they wish to utilise and why. The commercialisation of public providers is commonplace, competition is encouraged, patients are encouraged to choose between providers and the role of private providers is increased. These arrangements are designed to strengthen the

incentives for efficiency, whilst maintaining access to essential health services. The debate concerning the appropriateness of the market model in health systems involves not only questions about service delivery and technical expertise; it also involves more fundamental questions about social justice, identity and whether people subscribe to being labelled as consumers and the implications associated with those questions.

Annandale (1999) criticises the consumerist approach to health on the basis that it is described as a runaway character, subject to an assault of information and products. Crawford (1984) argues that a capitalist ideology is refracted through health beliefs, be this through promotion and consumption of new medical technologies (diets and exercise programmes). Beck, Giddens and Lash (cited in Annandale, 1999) highlight that

> when macro-conditions that affect health appear out of control, self-control over the considerable range of personal behaviours that also affect health is the only remaining option (p.20).

This statement implies that the responsibility to act 'healthy' shifts to the individual thus eroding the connection between good health and the demand for public services in the process. With this manifestation derives a series of conceptual reconfigurations regarding health and health responsibility. If Maori accept that people can be viewed as a market and segmented into demographic, behavioural or psychographic representations of society, people can be exploited into accepting that public health is subject to market ideologies and frameworks encouraging the idea of health as a commodity. Commodification is a particular way of socially constructing things people value (Radlin, 1996). It refers to the social process by which an object, thing, idea or concept comes to be apprehended or viewed for its value within the marketplace.

7.7 CONTEMPORARY MAORI HEALTH

Contemporary notions of Maori health have emerged in response to ailing health statistics, global epidemic trends and also as a means to respond to Maori health concerns using Maori health ideas, models, strategies and protocols implemented by and on behalf of Maori people (Durie, 1994b; M. Durie, 1998a).

At the national Hui Whakaoranga conference in 1984[17] two Maori health models, Te Whare Tapawha (Durie, 1994) and Rose Pere's (1984) Te Wheke were accepted as appropriate Maori health models. The Tapawha model, metaphorically compared health to the four walls of a house (all being necessary to ensure balance and strength). Four dimensions were represented; taha wairua (spirituality), taha hinengaro (thoughts and feelings), taha tinana (physical side) and taha whanau (family).[18] Pere's (1984a) Te Wheke model focused upon health from a whanau perspective and health was conceptualised as an octopus (Durie, 1994b). Each tentacle symbolises a dimension of health and the octopus body represented the family unit. The components of this model were wairuatanga (spirituality), taha tinana (physical), hinengaro (the mind), whanaungatanga (whanau), mana ake (uniqueness of family and the individual), mauri (life essence), ha a Koro ma a Kuia ma (breathe of life from our forebearers), whatumanawa (the expression of emotion) and waiora (total well-being) is represented in the eyes of the octopus.

Another model *Nga Pou Mana,* developed by the Royal Commission of Social Policy in 1988, described a set of four values as prerequisites for health and wellbeing (Durie, 1994b). The four interconnecting variables in this model focused on *mana*, cultural integrity, a sound economic base and a sense of confidence and continuity. This model focused on the external environmental factors and oral traditions. The four dimensions of this model were whanaungatanga (family), taonga tuku iho (cultural heritage), te ao turoa (the physical environment), and turangawaewae (land base). Reference to te ao turoa was influenced by the impact of Waitangi Tribunal decisions in respect to claims made by tribes to the Crown.

The conceptualisation of Maori health from a Maori perspective is a means to realign the power to define and name things Maori to Maori. With this power has emerged a willingness by Maori health professionals and researchers to resist

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[17] Many of the attendants were Maori medical practitioners and Maori community leaders from throughout the country.

[18] The components of health were first tabled at a hui of health professionals in 1982. Dr Mason Durie presented the framework at a health hui later that year in Palmerston North.

discourses of health. The *Te Whare Tapawha* model for instance has also been adopted as a Maori health framework by the Ministry of Health. *Te Whare Tapawha* is also regarded as a Maori health paradigm unto itself (Glover, 2001). Mason Durie's recent publication *Mauri Ora* (2001) clearly details how these frameworks can be operationalised as guiding health principles. The conceptualisation of Maori health in this way clearly challenges the notion of health as merely the 'absence of physical ailment'. Maori health, constructed in this way is viewed as a holistic model encapsulating principles of wellbeing and holism. For instance, te ao turoa in *Nga Pou Mana* does not only describe physical environmental issues that impact upon Maori health, it also refers to other environmental concerns such as social, cultural, political and economic. With regards to the *Te Wheke* model, there are limited references which reinforce its use as part of Maori health practice. What can we make of this? Maori health models appear to be appropriate theoretical propositions about Maori health, but there is limited evidence that these models are adopted in practice either as overriding principles or overriding philosophies of practice. If Maori health models such as *Te Wheke* and *Te Whare Tapawha* are being utilised, there is limited research available to explore how their use is being undertaken.

Therefore, any system of health is reflective of the historical, cultural and environmental context in which it exists (Capra, 1982). As the environmental context changes, the health system is subjected to those changes, consequently adapting to, and being modified by variable economic, social and political influences (Fougere, 1990). As a social phenomenon, Maori health is built on a platform not too dissimilar to the foundations underpinning the health for most New Zealanders. However, Durie (2001) argues that Maori health is a complex ideology and praxis constructed from an understanding of cultural, historical, spiritual and philosophical influences. Emerging from observations by Maori health practitioners, community leaders, Iwi and Hapu leaders is a platform for Maori health that seeks

- Control of the epistemology, resources, aspirations and outcomes of Maori health and;

- Recognition of Maori health models that were regarded as being culturally authentic and appropriate.

The interrelated threads of theoretical concepts being interwoven together have largely become part of a Maori health discourse. This discourse is supported and nurtured by Maori health practitioners and leaders. Within this process they are aligning their aspirations for better health with indigenous communities throughout the world, who are also articulating cultural and holistic health perspectives.

7.8 ONGOING CONVERSATIONS ABOUT MAORI HEALTH

Theories of health reflect an increasingly diverse and complex humanity. Gorin and Arnold (1998) portray that complexity in the diverse views of health as "an antithesis of disease; a balanced state; a growth phenomenon; a functional capacity; goodness of fit; wholeness; well-being; transcendence and empowerment" (p.3).

In this chapter, I argue that Maori people aspire to advance holistic and cultural models of Maori health. However, the notion that Maori health is holistic without due consideration of the way in which this holism is practiced emerges as an issue of contention in this thesis. To illustrate, although the *Te Whare Tapawha* model surfaced within the last twenty years, it can be argued that its tenets draw from traditional Maori knowledge and can be applied to a contemporary context. But how does holism translate into transformative praxis as a total system of living? For example, the Healthy Lifestyles Programme was developed by the Maori Women's Welfare League as an initiative for, "preventative measures for health based on positive values inherent within Maoridom; such as caring and sharing which provide a vehicle for promoting healthy lifestyle changes among a critical target group – young Maori women" (Te Puni Kokiri, 1993a:10). The vehicle for the programme was netball and its philosophy drew from the *Oranga* model. *Oranga* coveys the wellbeing of families through oranga tinana – physical health, oranga hinengaro – mental health, oranga ngakau – emotional health, oranga wairua – inner self health and oranga whanau – family wellbeing. Another

component was added to the philosophy of the programme, which was concerned with physical and sporting excellence – hiranga. The aim of the programme is to

> promote wellness and improve health among young Maori women. The objectives are to reduce smoking by having smokefree players in all grades at national tournaments and to have all healthy lifestyle activities, field days and national tournaments in smokefree environments (Te Puni Kokiri, 1993a, p.11).

The philosophy of the programme was conveyed as a model of Maori health based upon Maori concepts of health. The Maori Women's Welfare President reiterates that philosophy:

> Maoritanga and whanaungatanga are in this programme. Participants don't question this aspect. It's in action at every stage of the programme. A sense of belonging is here and so is wairua Maori. From the players to the squads, through to live-ins, (these) are whanau based. Here at national tournament you have a bigger whanau. For those who are not familiar with their Whanau, Hapu or Iwi links, it is an education process. They are helped to find their roots (Te Puni Kokiri, 1993a, p.17).

To many Maori elders, concepts such as Maoritanga and whanaungatanga are essential aspects of Te Ao Maori. But, in the evaluation report conducted by Te Puni Kokiri in 1993, whilst the philosophy reflected six components, the review focused only on oranga tinana – physical health and the overall organisation of the sporting event. However, it may have been that Maori health concepts do not necessarily transfer unimpeded into conventional forms of health promotion and the uncritical assumption that they do is the cause for reflective consideration. Alternatively, the evaluation report may not have utilised an evaluation model that adequately catered to exploring all six components of the *Oranga* model. In any case, the reporting of the programme does not provide a robust analysis of all aspects of the model, which questions issues related to holistic health in practice and how the implementation of these types of models occur.

The need to state this observation is based on the reality that many Maori do not have an in-depth understanding of the Maori concepts of health. As a result their views of health oscillate between various health perspectives and meanings dependent on their exposure and understanding at certain points in time. To some Maori, health can mean 'survival' by any means possible. To expect people to adhere to public health messages about refraining from consuming alcohol or smoking cigarettes do not feature as important considerations in their daily lives

(Coney, 1996). Consequently, there is a real danger that holistic notions of Maori health are prone to *rhetoric*.

Moreover, the ability of Maori to enjoy the benefits of holistic Maori health is also severely impacted upon by the interplay of power relations with dominant health discourses and cultural rights. In both cases, Maori people are subjugated by social actors to the imposed dominant conceptions of health highlighted earlier in this chapter. The medical approach to health has permitted further insights into the intimate mechanisms of the human body, which have led to the development of sophisticated techniques and technologies. Yet in spite of these great medical advances, society is now experiencing a profound crisis in health care across the globe (Capra, 1982; Roddick, 2001). Reasons for this crisis include: widespread dissatisfaction with medical institutions, inaccessibility of services, lack of sympathy, care and also malpractice.

The importance placed upon cultural constructs of Maori health is also influenced by a fundamental debate about identity, sovereignty and cultural rights. Minister of Treaty Negotiations, Margaret Wilson views the debate as an unnecessarily competitive one, fuelled by unsuccessful and unsettled Treaty grievances. Karetu (2000) argues that a definition of cultural right must highlight "my right to practice my culture in my own way without hindrance or interference from the majority culture" (p.87). His definition is therefore defensive, but out of necessity. Karetu (2000) reiterates that Maori culture and language have no place to go except Aotearoa New Zealand. He reiterates that cultural rights are therefore viewed as part of a larger sovereignty agenda based on survival and existence.

7.9 SUMMARY

This chapter explored various constructs of health that have influenced the way in which Maori health has been viewed in the past, now and in the future. This chapter presents a construct of contemporary Maori health, which is currently derived from Te Ao Maori philosophy, and which is also consistent with a Maori health development approach. A Maori notion of health includes at least the

dimensions of wairua, hinengaro, tinana and whanau (Durie, 1994). Many Eurocentric definitions of health reinforce traditional medical approaches to health. For instance, only illness and sickness are focused upon as opposed to a wider view of health. Maori health professionals and leaders have also asserted that Maori health is influenced by traditional Maori definitions of illness and sickness, which differ from traditional western notions of health (Buck, 1950). Maori health professionals are therefore convinced that good health could not be obtained by measuring physical health gains alone, spirituality and emotional factors are equally as important (Durie, 1994b). This holistic approach to health advancement is also being welcomed by non-Maori health experts.

Whilst Te Ao Maori forms the primary foundation for working with Maori people, at times it is necessary for health professionals to be aware of the prevalent and contrasting perspectives within the New Zealand health sector at this time. People familiar with these approaches will be more inclined to recognise the inherent differences as a result. In this thesis, I have argued for a holistic notion of Maori health. However, the acceptance of this view is not universal. Ensuring that the philosophy of Maori health aspired to transforms into, and through the various structural formations that impact upon Maori health services and programmes within the health sector of New Zealand continues to be a struggle. This chapter sees that goal as a fundamental aspect of achieving collective goals for Maori health and wellbeing.

CHAPTER EIGHT: MAORI HEALTH PROMOTION

"In former times, a wealth of meaning
was clothed within a word or two
as delectable as a proverb
in its poetical form
and in its musical sound"
(Sir Apirana Ngata)

8.1 INTRODUCTION

One of the aspirations for this research is to critically articulate and build upon a commitment by Maori to enhance Maori health and wellbeing drawing from Te Ao Maori. In previous chapters, the conceptual foundation of Maori health and Maori health development were reviewed. In this chapter, I continue to support that process by presenting a Maori health promotion framework as the basis upon which Maori health advancement can be actioned. As a starting point, the tenets of health promotion are reviewed in brief, before reviewing Maori health promotion in general and the *Te Pae Mahutonga* model more specifically.

8.2 HEALTH PROMOTION

In *Chapter Seven,* it was reiterated that health is more than the absence of disease and infirmity "it is a state of complete physical, mental and social wellbeing" (World Health Organisation, 1947, p.12). This definition corresponds with Maori and non-Maori views of health being espoused by health promoters worldwide. Both of the contrasting conceptualisations demonstrate a deep appreciation for health advancement as more than the notion of physical wellbeing.

The advancement of health can occur through health promotion and by health promoters. Health promotion is a discipline that includes several activities that aim to prevent disease, improve health and enhance well-being (Naido & Wills, 1998; Perkins, Simmett, & Wright, 1999). Its activities are constructed out of sets of values and principles from which social agents seek to enhance and promote

opportunities for healthy living for individuals and communities (Gorin & Arnold, 1998). The core intention of these efforts is to bring about positive social and healthy opportunities for people to advance their own health and the health and wellbeing of others.

When considering pathways for improving health, the Ottawa Charter is a significant strategic reference. In November 1986, the *Ottawa Charter for Action in Health Promotion* was presented and adopted at the first international conference for health promotion by the World Health Organisation, Health and Welfare Canada and the Canadian Public Health Association (World Health Organisation, 1986). The Charter was part of a worldwide public health movement affirmed by the experiences of international health experts and community health workers present at that the conference. The Charter outlined essential conditions for health such as peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity. It also referred to three general principles of health action, to advocate, to enable and to mediate. These three principles provide mechanisms through which to ensure that the prerequisites of health are being met.

Health promotion is defined within the Charter as "the process of enabling people to increase control over and to improve their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs and to change or cope with the environment. Health is therefore seen as a resource for everyday life and not the objective of living" (World Health Organisation, 1986, p.1). For many health promoters, the Charter is considered as the first comprehensive approach to health advancement.

The Ottawa Charter presents five principles of health promotion action which include

- Building healthy public policy – by putting health on the agenda of policy makers in all sectors of society and at all levels ensuring that representatives are aware of the consequences of their decisions upon the general health and wellbeing of all in society

- Strengthening community action – by providing necessities for the empowerment of communities to enhance and strengthen their social networks and support for advancing social change through information sharing, education and the provision of resources
- Creating supportive environments – by surrounding people with supportive advocates and forms of social, economic, cultural and political environments as a means to advance the improvement of health and wellbeing for all
- Developing personal skills – by focusing on supporting personal and social advancement through the provision of education, information, social support and lifeskills enhancement. By doing this, the options available for people to exercise control over their lives is enhanced
- Reorienting health services - by sharing the responsibility for health promotion amongst the community, its people and the professionals who constitute those communities (World Health Organisation, 1986).

These principles are seen as ways in which to guide the advancement of health promotion worldwide. The Charter recognises the basic requirements for healthy living and existence such as clean air and clean water. At this fundamental level, health promoters are responsible for bringing about positive advancement and improvement in health by ensuring that communities can access these basic requirements. In Aotearoa New Zealand, the Charter is recognised as a prominent health promotion model for all New Zealanders.

Ten years on from the first international health promotion conference, health promoters reviewed the Charter. They emphasised that individual countries should focus upon "their own current climates" (Health Promotion Forum, 2000). These directions spurred a re-emphasis upon a series of priorities for health promoters in Aotearoa New Zealand which included

- Affirming and sharing the vision and values of health promotion
- Emphasising the creation of alliances across and between sectors
- Honing our knowledge, skills and capacity to improve health; emphasising political commitment and the development of health public policies; strengthening our communities and

- Ensuring that health systems reforms promote health both inside and outside the health care system (Health Promotion Forum, 2000).

In Aotearoa New Zealand, efforts were being made by health professionals to acknowledge the unique circumstances of this country. This coincided with an acknowledgement by reviewers of the Charter that "health promotion strategies and programmes should be adapted to the local needs and possibilities of individual countries and regions to take into account differing social, cultural and economic systems" (World Health Organisation, 1986, p.2). This direction stimulated the development of *TUHA-NZ: A Treaty Understanding of Hauora in Aotearoa-New Zealand* (Health Promotion Forum, 2002). This model recognised the importance of the Treaty of Waitangi in relation to health promotion, despite unease in Aotearoa New Zealand with this relationship. *TUHA-NZ* is therefore significant because it provides a way in which to operationalise the Treaty relationship in health promotion. Signal (2002) argues that the impetus for *TUHA-NZ* is part of a wider movement to articulate Maori approaches to health promotion instigated by people such as Mason Durie, Paparangi Reid and Mihi Ratima. But, the process of developing the strategic document helped build a solid foundation for progressing health promotion that was built upon the acknowledgement of the Treaty as the founding document of this country and the recognition of Maori as the first people of this nation.

8.3 MAORI HEALTH PROMOTION

From a historical perspective, Maori health promotion derives its conceptual influences from traditional Maori customs associated with health and well-being (Durie, 1994b; Glover, 2001; Ratima, 2001). The instrumental efforts of Maori doctors such as Dr Maui Pomare in the early 20th century are a case in point (Durie, 1999, 2003a). Pomare was the first Maori medical practitioner and his efforts helped strategise an approach to Maori health development. Pomare adopted a five-point plan for Maori health promotion which served as a podium for 'contemporary Maori health approaches'. The first point involved health leadership of which Pomare stipulated that: medical experts should work

alongside community leaders; Maori councils, Maori medical officers and Maori chiefs to improve the incidence of health deprivation throughout the various villages. Second, Pomare linked social and economic adversity with health. With the use of health statistics he was able to report on issues such as housing, village sanitation, unemployment and land development initiatives. He argued that the improvement of Maori health does not depend on the improvement of the human body alone. Third, Pomare drew links between culture and health sometimes detrimentally but mostly in the interests of ensuring that Maori health advancement was conditional upon Maori maintaining close links to their cultural identity. Fourth, Pomare worked within political forums to bring about social change in Maori health. He worked closely with parliamentarians to establish healthy policies for improving Maori health in villages, communities and hospitals. He argued that political commitment was just as vital as community and professional levels of commitment.

The fifth point related to human capacity through skilled health workforces. Through Pomare's own work patterns he established dual competencies that recognised both cultural and medical qualifications as pertinent prerequisites to effective health leadership. The combination of medical skills with existing community skills helped ensure that community health promoters working within the community possessed appropriate skills. Once these systems were put in place, he strongly advocated for the community health workers to be Maori. As a result, the strategy to develop Maori public nurses was set in motion. Durie (2004) argues that these principles are suitable guidelines for future Maori health promotion efforts.

Durie (2004) also highlights an intimate association between Maori health promotion models and Maori knowledge. The significant difference between conventional health promotion models and indigenous or cultural models, he observes is that Maori explicitly conceptualise Maori forms of health promotion derived from Te Ao Maori. The Maori health promotion model *Te Pae Mahutonga* is a model that is consistent with that assertion.

8.4 TE PAE MAHUTONGA

The *Te Pae Mahutonga – Maori health promotion* model was created by Mason Durie (1999; 2003a). The model attempts to associate principles of Maori health promotion with visual imagery related specifically to Maori people. Durie (2004) contends that "it uses a constellation of stars popularly referred to as *the Southern Cross* that is visible high in the southern skies in Autumn and acts as a marker of the magnetic south pole" (p.10). Its intention is to provide visual and metaphoric stimuli for a navigational tool for Maori to chart their way through the terrain of Maori health promotion. It is a "symbolic chart for mapping the dimensions of health promotion, including mental health promotion and the promotion of health for indigenous children and young people" (Durie, 2004, p.10).

There are six components with the Te Pae Mahutonga model. The first four central stars signify key elements of health: cultural identity *Mauri ora,* environmental protection *Waiora,* well-being and healthy lifestyles *Toiora* and full participation in society *Whaiora.* The two remaining elements are required to stimulate change: effective leadership *Nga manukura* and autonomy *Mana Whakahaere.*

8.4.1 Mauri Ora: Access to Te Ao Maori

Mauri Ora is concerned with cultural identity and the pathways to ensure that access to and maintenance of cultural identity remains unhindered. Durie (1999) argues that "identity means little if it depends only on a sense of belonging without actually sharing the group's cultural, social and economic resources"(p.3). This model articulates that it is important for people to have access to their language, knowledge, culture and its related institutions such as the marae. It is important for people to have affinity with Iwi and Hapu landscapes such as fisheries, forests and whenua. Maori must therefore have access to social relationships through Whanau and Hapu. The commitment to social cohesion by being Maori is therefore encouraged. A Maori health promotion aspiration stemming from a commitment to mauri ora would seek to promote security in ones cultural identity. An example might be facilitating Wananga reo as part of a health promotion program. In these contemporary times, it is concerning to see

the number of people who have become disassociated from their source of identity, their inheritance, customs and traditions.

8.4.2 Waiora: Environmental Protection

Durie (1999) distinguishes mauri ora from waiora by discussing the environment in which the concepts are more prevalent. In his view mauri ora refers to the inner qualities possessed by people such as inner strength, conviction, vitality and identity. In contrast, waiora is linked to the external characteristics that link human wellbeing to cosmic, natural and metaphysical elements of the environment. In this respect, health is determined not only by the inner most interpretations of physical health, but also by the external interpretations of health that are presented in the environment. For example, the pollution of waterways directly violates the opportunities for people to expand their horizons in terms of health and wellbeing. The spiritual connection that people have with the whenua, through the wellbeing of the whenua is articulated in the notion of waiora.

Literally, waiora means 'healthy water' and it is interpreted to mean health of the natural environment in its most far-reaching interpretation. Cultural phrases such as 'tiaki te whenua' are derived from a traditional Maori obligation to look after people and the environment. Health promotion must therefore take into consideration the balance needed between environmental protection and the wellbeing of populations. A Maori health promotion goal related to waiora may be about harmonising people with the environment; keeping water clean, ensuring the air people breathe is clean, ensuring that land is rich with vegetation and that people take the opportunities available to interact with nature.

8.4.3 Toiora: Healthy Lifestyles

The wellbeing of human beings is directly impacted upon by social behaviours. The incidence of smoking, drugs and alcohol, obesity, diabetes, unprotected sex and driving whilst under the influence of alcohol are all part of a spectrum of activities related to the lifestyles that people live. A Maori health promotion aspiration related to toiora may be to reduce health risks by preventing harm and improving our behaviour through positive forms of social development and

change based on advancing Te Ao Maori. This is not an easy task and people are easily swayed by the ability to disrespect the self. Also, people are not as active as they were decades ago and amounts of food consumed by children in particular are not being counteracted through physical exercise. The theme espoused through a healthy lifestyle is to create positive daily behaviours that make exercising a normal part of life. An example might be the growing of your own fruits and vegetables. The activity uses physical energy and provides nutrition through the actual fruits and vegetables. Maori values of living can be utilised through the practice of providing food through koha to kuia and kaumatua in the community and harvesting may only be done after karakia has been performed.

8.4.4 Te Oranga: Participation in Society

Although health is dependent upon providing access to Te Ao Maori, through healthy lifestyles and environmental protection it is also important for people to actively participate in society – economically, educationally, culturally, socially and spiritually. Wellbeing is partial to the way in which humans interact with those facets of society. For example, whether people have access to a good education is as important as whether a person gets enough exercise each day. The interaction that people have with their Whanau during the holidays and the social relationships that are maintained during those festive occasions are often more important that the material gifts. The time taken out by family members to attend religious meetings, to take morning walks, gardening, learning waiata, yoga classes or listening to music is vital to a person's sense of wellbeing. The point is that people are part of an interconnected system, which must be kept in balance for human and ecological sustenance. A Maori health promotion goal related to oranga seeks to enhance Maori wellbeing by increasing positive Maori participation in society: the economy, education, employment and through decision-making.

8.4.5 Nga Manukura: Leadership

Durie (1999) presents leadership as an essential prerequisite to providing effective health promotion. Having good leadership requires a combination of skills, influences and networks of relationships that can be called upon if necessary and

where required. Health leadership requires a diverse set of skills from people within the community, health professions and from within Whanau and Hapu. Each form of leadership plays a vital role in promoting coordination by those actioning health promotion and those engaging in health promotion activities. Health promoters must manage relationships and alliances between community leaders, representatives of other health organisations and health professionals. Health promoters must connect with communities at their levels; they must therefore be effective communicators with diverse audiences. Durie (1999) discusses the role of the Health Promotion Forum and the Public Health Association in contributing to the development of a health promotion workforce in New Zealand. He qualifies that comment by suggesting that there is still a long way to go to increase the Maori health promotion workforce capacity so that every Maori community can have access to skilled health promoters.

Leadership in health promotion is also about providing a vision for better health that translates into the very essence of the projects being initiated to improve health. Effective leadership must take place at all levels: community, tribal and through alliances with other groups. The instilling of leadership at these levels is seen as an essential prerequisite to bringing about positive change in Maori health.

8.4.6 Te Mana Whakahaere: Autonomy

Good health is not a product; it cannot be sold to people like coke or soap. Good health is about instilling in people the vision, hope and faith to create living notions of health for families and communities. For Maori, health is also about the control and autonomy to bring about better opportunities for improving health. Autonomy is the exercising of personal and collective power to decide what health means and how health can be collectively achieved. Durie (1999) for instance warns that there is no point in running a health promotion campaign that does not connect with the hearts and spirits of the people within the community. The capacity to decide and then take responsibility for owning and governing specific health promotional programs is central to the notion of Maori health promotion which can be seen at various levels – Whanau, Hapu, Iwi, rohe and nationally.

Maori health promotion aspirations require that community autonomy and the autonomy of leaders are protected and promoted. Concepts such as control, aspirational acceptance and recognition, relevant processes, self-reliance, indicators of success, governance and sensible achievable measures of effectiveness are important in this regard. In this discussion, Durie (1999) presents the *Te Pae Mahutonga* model as a thirty six point checklist within six overriding themes. Whilst these thirty six points are useful for quantifying what may be included in the model, they do not necessarily provide any extra means for exploring whether all of the points are necessary and under what conditions it is important for all of these points to be utilised. This observation may be seen as a weakness of the model. This model is also an example of the broad potential that Maori health promotion has for enriching human potential to engage with the challenges life has to offer at a values based level. This potentially positive attribute requires further exploration which is beyond the scope of this chapter at this time.

8.5 DISCUSSION

The *Te Pae Mahutonga* model for Maori health promotion was first presented at a Health Promotion Forum conference in 1999 (Durie, 1999). The model highlighted that Maori health professionals and health promoters throughout the country had conversed about the importance of health promotion models derived from an ontological perspective such as Te Ao Maori. The acknowledgement of Te Ao Maori as an integral aspect of the model provides space for Maori values to be endorsed as the guiding principles of Maori health promotion. Secondly, the historical context for the model derives from the works performed by pioneering Maori doctors such as Maui Pomare. Third, the vision for Maori health promotion espoused within the model is articulated throughout Durie's contemporary works concerning Maori health. Ratima (2001) also presents a potential Maori health promotion framework called *Kia Uruuru Mai a Hauora.* Her model acknowledges Maori worldviews and identifies six health promotional strategies to improve Maori health: reorienting health services towards cultural and health promotional criteria; increasing Maori participation in society; Maori capacity building; public policies that affirm health and culture; cross-sectoral

action for health and adequate resources. In her analysis of Maori health promotion she claimed that Durie's *Te Pae Mahutonga* model was

> the first step towards the development of a macro-theory for Maori health promotion...the model is groundbreaking in the sense that it is the first attempt to conceptualise Maori health promotion in a comprehensive way (Ratima, 2001, p.237)

Ratima (2001) noted that although the model lacked explicit reference to a theoretical or empirical grounding, its author drew from his extensive experience in the field which was seen as consistent with "Maori aspirations for health development" (p.237). The model was also supported by similar research undertaken by Druis Barrett and Daphne Ropiha. The conceptual principles of Maori health promotion espoused by Ratima and Durie are similar in many respects. At the heart of both of these frameworks is a deep concern for advancing Maori health as holistic, cultural and emancipatory. However, Ratima contends that Maori health promotion draws heavily from both Maori health development knowledge and health promotion knowledge concurrently. In her view, ideas are loaned liberally from both fields. This demarcation contrasts her ideas somewhat with that of Durie. He attempts to align the tenets of Maori health promotion with Te Ao Maori, Maori terminologies and Maori imagery which are then supported by general health promotion traits.

In 2003, the *Te Pae Mahutonga* model received further recognition and acknowledgement when it was presented as the conceptual tool for the Public Health Association conference held at Turangawaewae Marae in Ngaruawahia. Conference participants were asked to provide abstracts for conference presentations directly aligned with the six different components of the model. Equally significant that year was the Maori Health Promotion Conference called *'Mana Hauora, Mana Tangata – Healthy Wellbeing, Health Community'* which was a Gateway Conference in association with the *'18th World Conference on Health Promotion and Health Education'* held in Melbourne. One of the themes of the conference was to reach consensus about the key Maori health promotion themes by Maori health administrators and practitioners before attending the international conference. In Melbourne, a delegation of Maori health representatives reported key recommendations which focused on improving Maori

health in accordance with emerging ideas about Maori health promotion for the gateway hui (Tunks, 2004). The recommendations included an expectation

- That health promotion for indigenous peoples will be led and controlled by indigenous peoples
- That this approach should be reflected in the structures and processes of the World International Union of Health Promotion and Health Education (IUPHE)
- That the IUHPE recognises (and therefore advocates for) the recognition of the validity of indigenous health promotion frameworks, models and concepts
- That the IUHPE gives priority to indigenous people's health promotion
- That the IUHPE pays particular attention to supporting capacity building for indigenous health promoters and that these initiatives are led by indigenous people (Tunks, 2004, p.2).

Whilst the recommendations reiterated that Maori people are talking about Maori health promotion, there still remained limited scholarship written about Maori health promotion from a conceptual level to help guide practitioners. Some of the reasons for the lack of scholarship related directly to the existing capacity of researchers and practitioners in general. It was clear that aspirations for Maori models of health promotion continued to be articulated. The opportunity for Maori to implement and be driven by models of practice that are not only based upon Te Ao Maori, but which emphasise and support the very basis of being Maori is imperative for our collective future development as culturally enriched people. Clear associations between the loss of identity, ill-health and economical, spiritual, social and political deprivation make this task imperative. Ratima's (2001) research on *Kia Ururu Mai a Hauora* is a substantial contribution to filling this current research and health framework void. The ongoing argument that Maori are different and that this difference matters aligns directly with arguments presented by Maori educationalists and Maori health researchers (Bishop & Glynn, 1999; Johnston, 1998).

Maori endeavours to establish Maori conceptual and practical models for Maori health advancement are being genuinely and collaboratively endorsed by many health promotion advocates nationwide. Arguments about the Ottawa Charter not being a model derived from New Zealand are being addressed by the implementation and utilisation of models such as *Te Pae Mahutonga* and *Kia Uruuru Mai a Hauora.* There is also evidence that aspiring Maori health promoters within the community, local district health boards and Maori health clinics are ensuring that the philosophy embedded within *Te Pae Mahutonga* are part of the requirements for new recruits into the health promotion workforce[19]. However, the degree to which people fully understand the model and its principles is a work in progress at this point.

8.6 SUMMARY

This chapter has sought to first review health promotion generally and Maori health promotion more specifically. Health promotion is presented as a broad discipline encapsulating universal concerns for health. Those concerns are articulated through values focused upon social justice, peace, equity, equality and capacity building. They are addressed through the practical application of processes and frameworks designed under the auspices of health promotion, health protection, health education and healthy public policies. The concepts of Maori health promotion are relatively new constructs and therefore little academic analysis of Maori health promotion has been recorded. However, the contributions of Mason Durie (1999; 2004) and Mihi Ratima (2001) have been instrumental. The tenets of Maori health promotion are viewed as guiding principles for the engagement of resources and people to enhance Maori health and wellbeing.

In this chapter, observable alignments between the health promotion and Maori health promotion have been illuminated. However, key differences have stemmed from the desire by Maori to not only control the Maori health development

[19] My colleague attended an interview at Health Waikato in 2003 and the documentation she had for the interview outlined a requirement to be familiar with the Te Pae o te Mahutonga model.

process for Maori health advancement, but also to ensure that the conceptual basis upon which Maori health promotion is founded is consistent with Te Ao Maori. I agree in principle that Maori health promotion combines both the concepts of traditional Te Ao Maori and new tools of health promotion being utilised in contemporary times (Ratima, 2001). However, I see Te Ao Maori as not only a tenet of the framework; I believe it is the fundamental basis upon which Maori health promotion should be based.

CHAPTER NINE: MAORI HEALTH PROVIDERS

"He kai na tangata he kai titongitongi he kai
na tona ringa, tino kai, tino ma kona noa

You can only nibble at another's food, but
with food you have cultivated yourself, you
can satisfy your appetite"

9.1 INTRODUCTION

In this chapter, I critically review the construction of Maori health providers as a collection of people mandated to advance Maori health. I focus upon the location and activities undertaken by Maori health providers, their expressions, aspirations and constraints. I also compare and contrast the traditional organic notion of Maori social organisation with the contemporary constructed version of the Maori health provider.

9.2 CONSTRUCTS OF THE MAORI SOCIAL ORGANISATION

The 'Maori health provider' is a relatively new construct designed to draw together traditional aspects of Te Ao Maori and contemporary Maori aspirations through health service organisations mandated to enhance Maori health and wellbeing. Until pre-European contact, Maori organised themselves through kinship-based constructs of Whanau, Hapu and Iwi (Kawharu, 1984). These institutions have endured; however, the meanings invested in these constructs have been altered. Like the reconfiguration of meanings associated with whenua – the subtle replacement of collective responsibility for care of whenua to ownership vested in individuals, as discussed in *the Prologue.* So too have the constructs of Iwi and Hapu been adjusted and re-defined over time to facilitate compatibility or compliance with the ideals of the coloniser state and its modern manifestations. Traditional Maori organisations have been re-constructed through legislative and institutional encroachment of dominant Pakeha institutionalisation upon Maori social systems. Henry (1994) groups the contemporary organisational

configurations through which Maori are required to enact their social and economic activities into three broad areas: legislatively constructed organisations, institutionally constructed organisations and independent initiatives. Typical examples of legislative entities, based on British legal constructs include Maori Trust Boards constituted under various Acts of Parliament e.g. Te Arawa Trust Board; Maori Councils developed through the Maori Welfare Act 1962 (Henry, 1994), various charitable trusts and incorporated societies such as the Te Kohanga Reo Trust. A number of Maori organisations are also constituted as companies through the Companies Act 1993. While named as *Maori institutions*, this adjective obfuscates that the construction is actually a western one.

However, to look only at the institutional frameworks of these constructs, misses what I would describe as the mauri or essence motivating the people who conduct their work through these institutional forms. A closer look at the historical circumstances surrounding the development of these organisations highlights this point. For instance, although the institutionalisation of these groups by European legislation can be criticised as neocolonialist, it would be incorrect to assume that the hegemonic control implied by this term is complete or that many Maori did not understand some of the potential contradictions and paradoxes they confront daily. The recognition of these contradictions and paradoxes generates ways and means of working within (or in spite of) the colonising system where systemic connection is inevitable. An example is the New Zealand Maori Council. Although the New Zealand Maori Council was formed under the Maori Social and Economic Advancement Act 1945, its agenda was driven by Maori spiritual, political and tribal leaders such as Ratana, Ngata and Te Kooti. Their task was to enhance wellbeing for their people against colonial hegemony. For example, it was through the Council's discussion that Nga Tamatoa emerged, a movement instigated and nurtured with far reaching consequences for the politicisation of Maori youth and future leaders (Walker, 1990).

Despite their formalisation as entities based on British legal custom, these organisations are technically called Maori organisations. I continue with this adjective but I wish to make the distinction between these organisations and those

organisations shaped and governed according to the constructs of Te Ao Maori e.g. Iwi, Hapu and Whanau. To illustrate:

> Organisations with a specific kaupapa Maori focus found that Maori frameworks do not sit well within non-Maori designed regulatory and compliance systems. They found the differences caused barriers to Maori organisations achieving their core purposes (Ministry of Maori Development and Federation of Maori Authorities Inc, 2003, p.10).

In this regard, the late Sir Robert Mahuta stressed the predicament faced by Tainui in transposing a western centric standard model of representation into the Kauhanganui and Tekaumarua governance structure of the tribal confederation. The structural problems aligning a constitutional framework with Maori ethics manifested into a constitutional crisis (cited in Dodd, 2002, p.5). These complexities take into account that 'Maori organisations' are in common use and generally means those organisations, in principle are mandated to conduct activities with, by or for Maori people.

A study undertaken by the Ministry of Maori Development and the Federation of Maori Authorities (2003) reviewed ten Maori organisations. Four pertinent issues were identified in the research. They were

- That there was a wide range of technical competences held by people in the organisations. Their skills varied in the processes of governance, management, health, culture, finance and communication. As a consequence of this variation, organisational outcomes also varied

- That the legal, political, organisational and economic environments that impact on the organisations are complex and subject to ongoing change

- That there was an expressed need for reliable information and competent analysis to enhance governance decision making

- That compliance and risk management reporting and ever changing regulations impose a 'paradoxical burden' upon Maori organisations and were consequentially viewed as cumbersome but tolerated as necessary.

The authors observed that all the organisations were Maori owned and kaupapa driven. The generation of profits was articulated as a means to an end rather than an end in itself. Dodd (2002) is wary of neo-liberalist ideals associated with conventional economic enterprise and highlights the way in which these contaminate Maori governance structures (and their elected or nominated representatives). This process of contamination is not unique to Maori – but a localised expression of a global process. For instance, Fukuyama (cited in Dodd, 2002) argues that "globalisation involves a process of increasing homogenisation of all human societies, regardless of all their historical origins of cultural heritages" (p.3). The promise of postcolonial or bicultural organisations now highly visible in the State's re-configuration of service deliverers provides yet another site to explore the real parameters of tino rangatiratanga. The task of resolving the tensions and differences between Western and Maori worldviews of social organisation is complex and demanding. The Maori health provider construct does not escape this anomaly.

9.3 MAORI HEALTH PROVIDERS

Although literature relating to the striving by Maori to improve their health can be traced back to the mid 1800's (Dow, 1999; Lange, 1999), the contemporary 'Maori health provider' is a recent social fabrication - a collection of people (experts/professionals and volunteers) working through a formalised entity, bound by regulation and policy and resourced largely by contracts. It is not assumed that these organisations are to be guided by the same tikanga based principles that guided precolonial Iwi and Hapu. Their contemporary manifestations are expected. Whether these manifestations are adaptations driven by Maori aspirations or made to meet the conditions of the contract is therefore worthy of inquiry.

By the time of the post 1984 health reforms as outlined in *Chapter Six*, many Maori were ready to engage in the provision of social and health services for their communities (Durie, 1998; Kiro, 2001). Through these reforms and often with support from Iwi and Hapu, Maori have been mandated to develop and deliver primary health services to Maori by Maori in local communities. Nationwide,

there are now over 240 such Maori health providers. More than ten Maori health providers operate within the Bay of Plenty region[20]. Whilst an increase in Maori health providers has improved access to primary health care, it is unclear to what extent better access translates into improved health and wellbeing (Health Reforms 2001 Research Team, 2003).

Kiro (2001) examined strategic Maori health policy, the phenomenon of Maori health providers located in the Northland Districts and the way in which these two elements influenced Maori health development. In reference to Maori health providers, Kiro presented a number of key ideas. She drew inferences between the proliferation of Maori health providers and new Maori health policy. She outlined in greater detail their distinguishing traits. Kiro documented the processes related to Maori health providers entering, existing and flourishing within the health industry in Aotearoa New Zealand. Finally, she provided empirical evidence that was validated by her theoretical inquisition. Of particular importance in this chapter are the characteristics of Maori health providers which I discuss in the next section.

9.3.1 Characteristics of the Maori Health Provider

The Maori health provider as an entity is a contemporary response to the opportunities provided by the 1984-1990 health reforms. These reforms enabled Maori to enter into the provision of primary health care services and programmes. There may be a need to reflect on the changes to the social constructs of Te Ao Maori, made by Maori to serve Maori, and those that have been superimposed or ushered in under the guise of 'technical necessity', 'good governance' requirements and 'professional competencies'. Kaupapa Maori theorists are concerned with the variety of assumptions upon which the work of the Maori health providers is based. Cram and Lenihan (2000) highlight that Maori health providers are influenced by Kaupapa Maori theory. She argues that Kaupapa Maori philosophy, principles and practices for practitioners attempt to

[20] See http://www.maorihealth.govt.nz/providers

> improve our effectiveness for Maori by using inherently Maori processes, values and beliefs to frame and guide our behaviour. The thing is that it can mean different things to different people (p.ix).

This acknowledgement of the unique and often diverse cultural characteristics of Maori and the organisations that are created to serve their needs invites a closer inspection of their characteristics. Regardless of the origin of these characteristics, there is now a raft of Maori service providers with a range of common characteristics. Crengle (1999, p.8) articulates these as

- being governed and owned by a Maori organisation
- being based on kaupapa Maori and utilising tikanga Maori in the development and delivery of their programmes and services
- being accountable to the Maori community
- being a construct that is utilised by Maori staff wherever possible
- attempting to provide Maori communities with services that are affordable, of high quality, accessible and appropriate
- providing a range of general practitioner, nursing and community programmes e.g. health promotion and education.

Kiro (2001) has fleshed out these characteristics more fully. In her experience, Maori health providers

- operate from an ethos of holistic health and wellbeing
- operate within a Maori health development framework which is founded upon principles of tino rangatiratanga
- operate from a position of inclusion rather than exclusion
- are opportunistic and entrepreneurial, yet there were many groups that found it difficult to secure initial contracts for service

- were in their infancy period in the early 1990's, but many developed substantially to be leaders in their fields from that point onwards
- are accountable to their communities – Whanau, Hapu, Iwi and rohe
- are under-resourced for the services that are provided
- provide services and programmes to their communities in culturally appropriate locations and using culturally appropriate methods
- have much in common with other third-sector health providers
- operate within the confines of tikanga Maori
- are subjected to ongoing political scrutiny by external parties and internal Whanau dynamics
- are subjected to an intensely competitive environment of governmental health contracting.

Kiro (2001) notes McLean's concern with clarifying the identification of providers as *Maori.* McLean writes:

> I think we have to be quite careful [when we use the term 'by Maori for Maori']. I think we can define 'for Maori by Maori' under three categories. The first term I would use is tuturu Maori, traditional healers for example. The second term is for Maori by Maori services where the patient is mainstream for a non-Maori organisation – and we have many of those, they've sprung up all around the country side...and the third one, [is] by Maori for Maori - Raukura Hauora is a good example of that. Now what's so unique about the Te Puea marae service [is that] (a) it is owned and managed by Maori, (b) because it brings all of those added dimensions that makes that service culturally safe (cited in Kiro, 2001, p.321).

Ellis (2004) provides a typology that characterises Maori health providers as being *Marae based* (physically located within the marae complex and accountable to the Whanau of the marae) *Hapu/Iwi Based* (serving the needs of Hapu/Iwi and is accountable to Hapu/Iwi), *Pan-tribal* (serving the broader needs of all Maori); *Collective Maori Organisations* (a network group that serves needs of many Hapu/Iwi and Maori), *Independent* (serves the needs of Maori but has no accountability requirements in place) and *Mainstream* (offers health services to all

potential users of which Maori are one group). The ability of these groups to be described as one of the labels above is also dependent on

- the location of the health provider physically (e.g. within the marae complex) and structurally (e.g. marae, Hapu or Iwi based)
- the conflicting accountability systems between the health provider, the community, their aspirations to adhere to tikanga Maori and the requirements of health funders
- the capacity of people involved within the organisation directly impacts upon the ability of the organisation to achieve health development objectives.

9.3.2 Maori health professionals

Key responsibilities within the field of Maori health provision include the work typically associated with community workers, nurses, general practitioners, administrators, kuia, kaumatua and rangatahi. In smaller organisations, however, there is likely to be only one person providing all these services and completing administrative duties. In other organisations, teams of administrative staff work closely with community workers and clinical experts. These people and their efforts, expertise and commitment constitute the Maori health provider organisation. Without their skills, and physical and mental capacity there would be no such construct as a Maori health provider.

9.4 DISCUSSION

In this chapter, the description and analysis of the political, economic, competitive, social and cultural environment within which Maori health providers operate must be recognised as a series of pathways through which the coloniser maintains control. The ongoing conceptualisation of those environments within a market lexicon requires attention. Kiro (2001) for instance, positions Maori health providers within the 'primary healthcare market'. In a pure market economy, the success of a supplier to the market is governed by supply and demand mechanisms. Using this analogy, the longevity of a Maori health

provider is premised on the ability of its representatives to source government funding, closely followed by compliance with efficiency and effectiveness, not as a representative of the people, but as a service provider to Hapu consumers. The ability to decide where health resources are provided however remains the sole responsibility of the local district health boards and Ministry of Health representatives - and not the people. Consequently, the market model forecasts the demise of the inefficient and unproductive Maori health provider, and its appropriateness of use within Maori health development should be revised.

The construction of the Maori health provider as a legislated entity rarely allows for consideration of tikanga Maori as often aspired, though in practice this tension is overcome using common sense and adherence to marae protocols. There are often no formal rules or regulations guiding these practices, they are often spontaneous and fluid. The ability however to maintain spontaneity and fluidity is premised on Maori health provider access to kuia and koroua, seen in this light as the human repositories of Maori knowledge. Those Maori health providers caught without those people are therefore exposed to vulnerabilities and conflicts prevalent with legislative, policy, cultural and autonomous expectations which contrast with the responsibilities of tikanga Maori.

Maori development aspirations are therefore couched within the traditional metaphoric expression of 'working for the people'. This expression implies that a set of moral and ethical assumptions guides the work performed by Whanau members. How that ethic of responsibility translates into the organisational structure of modern bureaucracies or contemporary Maori organisational entities is fraught with complexities. For example, some Hapu workers may only be employed for ten hours per week as part of a health contract provided by a government agency, but that person works another ten hours unpaid to perform other Hapu duties such as ensuring that the Hapu register is up to date or mowing the lawns at the grounds of the urupa. These findings were highlighted in Kiro's (2001) thesis. The complexities contrast to the institutionalised expectations of employees operating within the confines of alternatives organisational models. Where further complexities are added, it is when the funding agency expects that

the organisational framework should provide services for a contract that mimic structures and pre-determined guidelines as to what and how a Maori health provider resembles those characteristics. But, they also manifest into a doctrine of social order. Representatives of Te Whare Wananga o Raukawa highlighted this concern in a publication about successful Maori organisations (Ministry of Maori Development and Federation of Maori Authorities Inc, 2003).

Maori health providers are therefore social fabrications, created by people to facilitate the work of people, through legally constructed entities. Their construction however is not without severe impacts, shifting the authority from the Iwi to the legal construct (and its representatives), the power base and along with that, future potential. An example is the Ahu Whenua Trusts constructed from the Maori Land Court process. Excised from Te Ao Maori, is the principle that land provides sustenance for all of the Hapu through the crafting of the Ture Whenua Act 1993. This Act takes away the potential of the Hapu for economic progress and development as a collective. Instead, the power resides within trustees, shareholders and beneficiary owners, who often reside outside of the papakainga.

What are we to make of this form of constitutional re-branding of Iwi and Hapu? To illustrate further, Ngaiterangi is now called 'Ngaiterangi Iwi Incorporated Society.' Ngati Ranginui Iwi is also complying with the same identity anomaly. Although these organisational constructs are created in the name of the Iwi, they have unintended impacts through their re-branding. Those organisations that form as Iwi collectives or regional collectives are even more concerning. For these organisations, they are constructed as charitable trusts or other forms of legal entities. However, through their construction they impact upon the organic Hapu and Iwi, taking from the people the potential through resources, energy, social agency for enrichment and growth as a collective. It is not that Maori health providers do not perform their duties. To assume that they don't would be incorrect, but the way in which these prescribed duties are perceived is not always through a collectivist ideal. It is often an individualist one where tangata are

redefined as patients, consumers and clients who are not engaged with as Whanau or Hapu – and all that this would imply.

The construction of the contemporary Maori health provider therefore contradicts in important ways the organic constructs of Iwi, Hapu and Whanau. For example, whilst we perceive a Marae based health clinic to resemble a traditional Maori social organisation derived from the ethos of Te Ao Maori, closer examination of this institution may expose an entity governed not by the Marae Whanau; but by the accountability mechanisms outlined in an incorporated society deed or the specific clauses of a service contract. The emerging contradiction reveals a series of misguided assumptions that the Maori health provider operates from a Te Ao Maori basis, when often it is the legislative and regulatory rules that take precedence for accountability, over the precedence of accountability to the principles of Te Ao Maori or Kaupapa Maori. It should therefore not be taken for granted that the label Maori health provider automatically ensures that its representatives subscribe to a kaupapa that is founded within Te Ao Maori. This chapter has highlighted that legal, instrumental, compliance, regulatory and contractual obligations are contaminating that process.

Kaupapa Maori theorists argue that it is the duty of all social actors to overcome the oppressive ways of the coloniser, to recognise the dominant power relations that exist and to work to disavow those processes (L. Smith, 1999). Kaupapa Maori theory also subscribes to the conscientisation, resistance and social transformation of dominant discourses, frameworks and processes in the interests of achieving and developing human potential (G. Smith, 1997). All those people working to advance Maori health have a fundamental responsibility to ensure that these issues are continually addressed. The whakatauki at the beginning of this chapter helps reiterate the level of responsibility expected of those working in the field of Maori health development, by drawing upon the links between contemporary society (present) and the past. The responsibility of Maori health is therefore intergenerational.

9.5 SUMMARY

In this chapter, I have critically reviewed the construction of Maori health providers as people mandated to advance Maori health. I have also focused upon the location and focus of their work, the expression of their aspirations and the constraints they perceive in manifesting these aspirations. I have derived through that process a number of key concerns. First, the traditional organic pre-colonial construct of Iwi, Hapu and Whanau still exists, though the institutions have been weakened and often reconfigured to conform with constitutional, good governance, technical and legislative rules and regulations perpetuated by Crown instruments of social control. Although these processes are founded upon neo-colonial assumptions, the complete assimilation of Maori though severe, is still incomplete. However, the process of enforcing conformity continues to disenable Iwi, Hapu and Whanau of their capacity and potential to advance, grow and proper as Te Ao Maori would subscribe. That debilitation is liked to the weakening of the mauri or essence of people.

The construction of the Maori health provider and all neo-colonial formations are done so in the name of Whanau, Hapu and Iwi, but the bureaucratic and legislative processes of accountability within these formations re-configure the organic constructs to such an extent that it is difficult to see the resemblance of the old within the new. Although, Maori health providers claim that they are mandated and supported by Whanau, Hapu and Iwi they are equally if not more accountable to the rules of compliance set by the Crown.

The process of conscientisation of Maori to the effects of the coloniser is an ongoing process of recognition and response to power shifting, rule changes and ongoing subjugation to new forms of regulations and social control. The ability of people involved as Maori health providers, to overcome and conquer these shifting rules and regulations is often insurmountable. The potential to enrich the ethos of 'by Maori, for Maori' is therefore constrained by this process. In sum, the contemporary Maori health provider emerges as a contradiction resembling dual accountabilities to the coloniser and the colonised. On the one hand the Maori health provider is viewed as a potential conduit of the people striving for health and wellbeing, but it is constrained by the implements of social control and

domination. Those Maori health providers who transpose these conditions are guided by Whanau members who possess the skills as technicians and who adhere to the teaching of old to overcome the ongoing hegemony of the State. In this thesis attempts to examine some of the concerns raised in this chapter help inform the findings of the research reported upon in *Part II* of this thesis.

CHAPTER TEN: CRITIQUE OF SOCIAL MARKETING

"Health promoters are not in the business of trying to get the public to buy anything. The purpose of health promotion is to give the public control over the conditions that affect their lives and health"
(Epp, 1986)

10.1 INTRODUCTION

The normalisation of social marketing in a growing number of social and public sector institutions is examined in this chapter. Building on the works of Kaupapa Maori theorists and critical scholars, as discussed in *Chapters Three and Four*, I now assume the role of critic. I am consciously and strategically

> adopting the position of a dissenter (disbeliever) who looks behind to see the very humanness, fragility and uncertainty with which constructions of such [social] artefacts take place (S. Lawrence, Alam, & Lowe, 1994, p. 71).

Despite their vulnerable origins in human thought, once established as embedded discourse, these artefacts appear to attain a life of their own. They become 'normalised' through uncritical application. They become so taken for granted that their origin in human thought is lost . They become apparently solid entities on the landscape of positivistic disciplines. My concern is with the effects of the uncritical application of the artefacts of social marketing to aspirations of Maori health enhancement.

10.2. HISTORICAL OVERVIEW, EMERGENCE AND CONTROVERSIES

10.2.1 Early Definitions and Origins

Social marketing originated in the broadening of the concept of marketing developed for commercial consumer attraction into non-commercial terrains

(Kotler & Levy, 1969). A growing number of marketers considered the potential of using marketing concepts and processes to influence community affairs, the quality of life, the reduction of poverty, the enhancement of health and the development of community related affairs (Lazer & Kelley, 1973a). Those who sought to extend the concept in this way did so on the premise that the more a social cause resembles (or could be made to resemble) the characteristics of a product, the more likely it was that a social change campaign would succeed (Kotler & Zaltman, 1971). By 1971, social marketing was defined as

> the design, implementation and control of programmes calculated to influence the acceptability of social ideas involving considerations of product planning, pricing, communication, distribution and marketing research (cited in Kotler & Zaltman, 1996, p. 10).

By the mid 1990s, the potential use of social marketing to influence the behaviour of population groups was made explicit. Social marketing was now described as

> the application of commercial marketing technologies to the analysis, planning, execution and evaluation of programmes designed to influence the voluntary behaviour of target audiences in order to improve their personal welfare and that of their society (Andreasen, 1995, p. 7).

Not all marketers accepted the extension and application of the concept of marketing. From the outset, social marketing was criticised by marketing academics for going beyond the confines of established marketing practices into social domains (Luck, 1969); for not emanating from a coherent body of social thought, such as sociology (Lazer, 1973); for lacking resilient definitions and related terminologies (Luck, 1974) and for unfounded claims to business success based on consumer satisfaction (Takas, 1974). Luck (1969) concerned himself with the apparent trend that "if a task is performed anywhere by anybody, that has some resemblance to a task performed in marketing, that task would be considered as a form of marketing" (p.53). He claimed that the branching off of social marketing was an act of "confusion compounded" (Luck, 1974, p.70).

In 1979, the first critical review of social marketing focused on ethical concerns (Laczniak, Lusch, & Murphy, 1979). During the 1980s, problems with transferring conventional marketing approaches to non-conventional issues such

as safe driving continued (Bloom & Novelli, 1981). The concerns related to adapting marketing concepts such as market segmentation, organisational design and channels strategies. For instance, in some cases the conventional use of distribution channels was difficult to secure as no tangible products were in place. Instead, what people were being offered were 'health messages' (Maibach & Parrott, 1995). Through these health messages people were targeted to modify their behaviour. However, social marketers found they were required to sell a set of complex behaviours that had to be repeated over a considerable time period with irregular funding cycles. They also found that once decided, the implementation of preferred positioning strategies (associated with these messages) was problematic. As a result, social marketers were often forced to ignore positioning and focus their efforts on developing advertising or promotional strategies instead.

Different theoretical concepts and foundations for social marketing have been explored and social change theory emerged as appropriate towards the middle of the 1980s. Terminologies such as persuasion, voluntary change and enforcement became more prevalent as a result. Although conventional health promotion and health education practices focused on changing behaviours, progress to advance large scale behavioural change during this period was being hampered by what seemed to be the shortcomings of these classical approaches (C. Lefebvre & Flora, 1988). Elliot (1991) suggested that social marketing's focus on individuals reflected western values of individual freedom of responsibility and control over one's own destiny. In his view, the convergence of social marketing, public health and health promotion occurred because of the emphasis placed on communication and information. Too often people were using isolated social marketing tools and concepts instead of the complete social marketing system as first anticipated (Hastings & Leathar, 1985). Towards the end of the 1980s, health promoters were being more realistic about the role of social marketing. The ultimate goal of social marketing in almost all instances

> is to affect behaviour. Social marketing like most communication tools assumes a link between attitudes and behaviour. The secret to successful social marketing lies in focusing on strengthening the links or connections between attitudes and behaviour. If this is to occur social marketing must once again return to behavioural science where process models of how attitudes guide behaviour are emerging. The outcome for social marketing is that by understanding the

> processes it will be possible to improve its salience and efficacy (Elliot, 1991, p.159).

In 1991, Elliot (1991) undertook a critical re-examination of the social marketing. His findings supported earlier criticisms that social marketing as a complete package was rarely utilised in programmes and that social marketing did not appeal to consumer needs (as claimed) because it utilised a persuasive ethos to promote behavioural modification to target audiences. The persuasive ethos of social marketing (refuted by some social marketers) is a crucial consideration in this critique that appears noticeably absent from the literature except for Elliot. Failing to disclose and discuss concepts such as persuasion, renders the prevailing literature as inadequate for any crucial discussions about power relations, the role of social marketing experts in exerting that power within social marketing programmes and within the intimate relationships between professionals (social marketers) and patients or people (customers). The general lack of critique emanates through the mass of literature outlining the merits of social marketing (Andreasen, 1994, 1995; Fine, 1990; Kotler & Roberto, 1989; Kotler & Zaltman, 1971; Lazer & Kelley, 1973b; R. Lefebvre, 1994; R. Lefebvre, Lurie, Goodman, Weinberg, & Loughrey, 1995; R. Lefebvre & Rochlin, 1997; McDermott, 2000; W. Smith, 2000; Weinreich, 1995, 1999; Young, 1989).

By the mid 1990s, social marketers focused their efforts on a growing recognition of the importance of transferring marketing knowledge to non-commercial domains. By the year 2000, social marketing is in a state of maturity with a dedicated academic journal called *Social Marketing Quarterly* supporting scholarship in the field[21] (Andreasen, 2003). In spite of this claim for maturity, academics and practitioners internationally are still re-visiting social marketing fundamentals to consider whether a universal understanding exists (W. Smith, 2000). The debate is an enduring one that continues to illustrate confusion over the nature and purpose of social marketing, even amongst practitioners (W. Smith, 2000).

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[21] Other journals such as the Journal of Health Communication and the American Journal of Health Behaviour contributed special issues to social marketing. In late 2003, Marketing Theory dedicated two issues specifically to social marketing.

Despite debates about its efficacy, social marketing is now unproblematically applied in the spheres of education and training, employment, civil rights, urban development, reducing pollution, culture and arts, conservation, recreation, healthcare and government relationships (Kotler & Roberto, 1989; McKenzie-Mohr, 1999; Mokwa & Permut, 1981). It is now commonly promoted as a management technique of its own right that embraces the challenges of enhancing the health and well-being of communities (Kotler & Roberto, 1989; C. Lefebvre, 1992). In Aotearoa New Zealand, social marketing is being applied to a number of projects including host responsibility (Kaye, 1994), the prevention of child abuse and violence (Stannard, Hall, & Young, 1998) and smokefree initiatives e.g. Quitline (Health Sponsorship Council, 1998). It has been considered for road safety (McDonald, 2002), fire safety (McDermott Miller Ltd, 2001) and it is also being promoted to Maori as a viable model for changing health related attitudes and behaviours (Lambert, 2003; K. Lawrence, 1999).

10.3 SOCIAL MARKETING: BASIC FABRICATIONS COMBINED INTO A FIELD OF KNOWLEDGE

Andreasen (1995) argues that an appreciation of social marketing is drawn from gaining an understanding of marketing concepts, structural frameworks, strategic principles and research principles which constitute the "marketing mindset" (p.37). Marketers therefore see themselves no differently from many other organisational scientists in this regard. Like any other science, their 'knowledge' consists of mental constructs and orchestrated relationships between them that originate in the imagination of its practitioners. The mental fabrications that are combined with the field of social marketing include, for example, market segmentation, consumer research, product concept development and testing, directed communication, facilitation, consumer orientation, audience analysis, segmentation, market research, exchange theory, channel analysis, social marketing mix, process tracking, marketing management incentives and exchange theory to maximise the target adopters responses (Albrecht, 1996; Andreasen, 1995; Kotler & Roberto, 1989; C. Lefebvre, 1996; W. Novelli, 1990; Weinreich, 1999)

Social marketing advocates claim it is a model derived from different disciplines (e.g. behavioural sciences, communication and marketing), though the influence of the limited range of social theories drawn from for social marketing is commonly eclipsed by favouritism towards marketing knowledge as the preferred source of scholarship (W. Novelli, 1990). The interdisciplinary characteristic of social marketing is not unique in itself, though it presents challenges for those responsible for identifying sound theoretical frameworks to guide the implementation of social marketing programmes. These challenges also lend some weight to the growing concern that social marketing is not only being broadened too far, but that the supposed supremacy of marketing has been overly asserted (Luck, 1969). On this basis, "everyone is a marketer because virtually everyone engages in some social exchanges" (Graham, 1998, p.8). Implicit in this discussion is the underlying intention of the social marketer to construct the social marketing problem as if it were a conventional marketing problem. The context for its application is based on the assumption that 'the whole social world' is transformed into a marketplace and the necessary tools for solving the problems are derived from the marketing kitset (Radlin, 1996).

Novelli (1989) asserts that social marketing projects are hybrid public health oriented social action programmes grafted onto commercial distribution and marketing systems. Hybridity occurs because social marketing is still being learned and applied by planners trained in other disciplines such as health education or health communication. The Academy for Educational Development clarified the way in which the cross-disciplinary fertilisation of social marketing occurs, particularly within public health:

> Public health communications incorporate theories and methods from several disciplines. Social marketing provides a framework for selecting and segmenting audiences and for promoting products and services. Behaviour analysis supplies tools for investigating current practices, defining and teaching new practices and motivating change. Anthropology reveals perceptions and values which underlie existing practices and which can help sanction new ones (Rasmuson, Seidel, Smith, & Booth, 1998, p.9).

Faith in the potential of social marketing to address social concerns, through the acquisition of social marketing knowledge that is later transferred into practice is not unlike the assimilation of processes associated with colonisation. For instance, external experts and/or recently trained converts to the social marketing

way encourage the assimilation of social marketing knowledge through a series of directives. Most difficult to isolate and attend to in this assertive manifestation of its gospel are the effects of instrumental logic and the modification of a sense of the spiritual, not easily contained in a behaviourist paradigm. Absent therefore from a discussion about social marketing's efficacy are the voices of people most at risk or in need (now redefined as 'customers' – or even more objectified and depersonalised as 'a market segment'). Those who are engaged in the delivery of these programmes at a grass root level within the communities. Although it may be argued that their voices are incorporated as part of the consumer research process, they are still the voices of those positioned outside the core decision-making process.

Absent in a social marketing discussion (by social marketers) is an analysis of the power relations between those advocating social marketing's benefits and those (workers, people) required to deliver these programmes, or who are preferred recipients re-defined as targets of the programmes. It is the architects in governance roles that decide how health campaigns are framed; often their views are based upon the advice of external consultants, many of who are trained in the profession of marketing.

The pressing of a counter narrative to social marketing's focus upon assimilist inclinations is lacking in the literature. Instead, social marketing converts are being trained in the diction and lexicon of social marketing, inclusive of its embedded instrumental and functionalist meanings. The context within which social marketing potentially impacts the conception of Maori health and well-being is through that lexicon, therefore challenging the basis upon which holistic ideals of health and well-being aspired to by communities such as Maori can find expression. A critical review of social marketing's diction and its hidden meanings forms part of this chapter's purpose.

10.4 SOCIAL MARKETING AND PUBLIC HEALTH

Public health is concerned with improving the health of all people or a community of people (Petersen & Lupton, 1996). Public health strategies incorporate health

promotion, health protection and disease prevention as a series of ways in which to improve health. One of the earliest accounts of public health advocates embracing social marketing occurred in 1988 (C. Lefebvre & Flora, 1988). They focused on population-based changes to health behaviour emphasising that insight could be gained from the commercial sector in regards to programme design and project planning (Neiger, Thackeray, Barnes, & McKenzie, 2003; Walsh, Rudd, Moeykens, & Moloney, 1993). Social marketers assert that their work can be differentiated from other health campaigns because of their overriding interest in 'consumers' and that they place an emphasis on monitoring and tracking programme performance. They also draw on a range of theories such as mass communication theory.

The growing support of social marketing can be argued on two fronts. First, social marketing advocates see the model as a superior behaviour change tool which draws from a marketing knowledge base and which has proven to be a successful approach to impacting consumer behaviour with commercial goods and products (Andreasen, 1995; B. Smith, 2000). Second, social marketing is presented as an effective planning and organisational tool in comparison to other social change approaches in health education, health promotion and public health (R. Lefebvre & Rochlin, 1997; W. Novelli, 1990). Social marketing therefore appeals to health administrators as it offers a systematic research based process for solving health problems founded upon proven commercial practice (C. Lefebvre, 2001).

However, there are still prevalent concerns related to the adoption and potential utility of social marketing in health domains in general. For instance, social marketers have limited influence upon the societal influences and context of the social problems within which their campaigns operate. Social marketers largely ignore these macro issues except for a few isolated studies (Buchanan, Reddy, & Hossain, 1994; Elliot, 1991; Erben, Franzkowiak, & Wenzel, 1999). A growing number of social marketing opponents are concerned with the uncritical application of social marketing in public health and health promotion (Buchanan et al., 1994; Elliot, 1991; Erben et al., 1999; Jones, 1982; Vanden-Heede &

Pelican, 1995). Their criticisms are based on political and/or functional reasoning applied to the process of doing health promotion as if it was a marketing activity and the impact of that conceptualisation of health (as a consumer good) upon health and well-being (Buchanan et al., 1994).

10.4.1 The Constructed Efficacy of Social Marketing

Social marketing critics are wary of claims made by social marketers to efficacy (Heede & Pelican, 1995). Wenzel (1998) challenges the efficacy of social marketing on the basis that it is the change agents who are in control of the social marketing process and hence they are viewed as the powerful elite. He suggests that defining social problems is complex in that - objectives, goals and solutions defined by social change agents are fraught with problems. Bloom and Novelli (1981) support this position:

> Evaluating the effectiveness of a marketing programme is difficult for all marketers. One must determine measures of effectiveness and then develop a research design capable of isolating the role that the [social] marketing programme has had in shifting those effectiveness measures (p.87).

Social marketing's efficacy is directly related to the resources made available. For instance, when a new health promotion project is launched it must be supported financially and also politically. For example, the 'Like Minds, Like Mine' mental health campaign focuses on changing attitudes to stigma associated with mental illness in New Zealand[22]. The Health Sponsorship Council of New Zealand, a publicly funded national health organisation was established in 1990 to promote health and encourage New Zealanders to enjoy healthy lifestyles. With both of these projects, they are well resourced financially and politically making it easier for them to achieve their organisational goals.

Lefebvre and Flora (1988) argue that the adoption of social marketing presents a number of challenges for public health practitioners. They believe that social marketing's effectiveness is impaired by socio-economic constraints. Social marketing is also described as a form of 'victim blaming' because social

[22] See the official website for further information www.likeminds.govt.nz

marketers construct their audience as consumers who make obvious choices and carry responsibility for these bad choices regardless of the broader issues affecting choice outside the control of poverty by the individual (Erben et al., 1999). Social marketers are continually faced with ethical questions about selling public health and implementing the framework without adequate training (Laczniak et al., 1979). Novelli (1990) was concerned with social marketing's claims for efficacy:

> Evidence based on numerous programmes in various settings indicate that the systematic application of marketing principles and practices to social and health issues can contribute to measurable behaviour change. Unfortunately, this is as far as one can go in making a claim for social marketing's efficacy (p.365).

Laczniak, Lusch and Murphy (1979) criticised social marketing as potentially unethical on the grounds that groups are empowered to influence public opinion on contentious issues such as abortion. This has contributed to the notion that social marketing is manipulative and anti-intellectual. Tensions have also arisen with health educators debating issues about academic identity and territory, credibility and also certification processes (Andreasen, 1995). Some health practitioners saw social marketing as a legitimate threat to established disciplines. Health practitioners have thus been concerned that poor social marketing efforts might impact on the reputation of marketing in general (Fox & Kotler, 1980).

10.4.2 Ethics of Social Marketing

Buchanan, Reddy and Hossain (1994) maintain that using a marketing framework impacts the way health promoters think about their relationships with people. They highlight a growing concern for the "encroachment of technical and economic modes of reasoning into social and political human experiences" (Buchanan et al., 1994, p.53). The importation of social marketing principles into health promotion is premised on the notion that as long as the ends are achieved, the means are irrelevant. This type of reasoning they claim, is typical of "technical, economic logic, it may be contrasted with socio-political reasoning where means and ends are seen to be inextricably intertwined" (Buchanan et al., 1994, p.54). Buchanan, Reddy and Hossain (1994) are also concerned with the range of methods that can be adopted in social marketing campaigns. In their view, marketing experts are prone to exercising their creativity with the types of

motives and messages conveyed in their communications. For instance, conventional advertisers convey "materialism, cynicism, irrationality, selfishness, anxiety, social competitiveness, sexual preoccupation, powerlessness and/or loss of self-respect" (Pollay cited in Buchanan et al., 1994, p.54). If health promoters conceive of their work in line with these types of approaches, then the way in which social marketers think about their relationship with people will exhibit those conceptual foundations and possibly collapse into a 'manipulative relationship'. In response to these types of concerns, Heede and Pelican (1995) argue that aspects of social marketing may be useful e.g. some tools, but on the whole the model is viewed as inappropriate for adoption in the area of health education.

10.4.3 Health is Political

Health is political and health promotion is political (Signal, 1998). It is political because a community's welfare (in terms of health) is dependent upon resources that are subjected to a political process. The health system of Aotearoa New Zealand is built upon a structure of government officials and senior managerial staff within hospitals, government agencies and community organisations (Coney, 1996). However, the community has limited input into the decision-making processes regarding public resource allocation for health. Those types of funding decisions are largely presented as part of the parliamentary budget, tabled by Treasury (Ashton, 1999, 2001).

The interface between politics and health is especially visible within the person-health professional relationship. Many people throughout the country rely heavily upon the advice and expertise of those health experts in whom they trust (Petersen & Lupton, 1996). Health promoters, administrators, policy analysts and community workers are all implicated in this process. Coney (1996) argues that professional people who establish health policies for public health have different values from those who are viewed as the recipients of public health programmes. Therefore, whilst health officials view health as paramount, people may see health as only one value amongst a number of values to consider. Often the pursuit of

health is not the highest priority. The socio-economic differences between makers of policy and those who are targeted for their implementation are also relevant. Coney (1996) contends that paternalism can thrive in this relationship, given that

> the privileged work earnestly to keep a man away from his baccy, or to make his pint hard to find. While the middle class hop in their cars and drive to the wine shop for a bottle of Morton Estate while the poor are deprived of their right to put a cask of wine in their trolley at the local supermarket (pp.23-4).

Coney argues that unless you assert that poor health status is largely political rather than personal, there is the risk of moralising about the victims and reducing their ill health to an individual failure to heed health messages. Jones (1982) claims that social marketers in general, refuse to acknowledge the relationship between health, power and politics. Essentially, concerns are based on the unequal power relations between social marketing experts and people. In her view, social marketers fail to recognise the 'expert role' they often perform. The location of social marketers in these types of roles supports the idea that social marketing is premised upon notions of persuasion and influence (Elliot, 1991).

10.4.4 Social Marketing Misunderstood or Unappreciated

Heede and Pelican (1995) contend that marketing is an inappropriate model for education in general and nutrition education specifically. In their view, marketing is only able to convey messages while educators encourage learners to become autonomous decision makers. Heede and Pelican maintain that educators can adopt some of marketing's valuable tools without assuming marketing's consumer orientation or marketing's philosophy as the ultimate goal of education. For instance, Novelli (1989) proposes that programme managers looking for universal solutions run the risk of rushing to embrace social marketing and its inflated expectations. Lefebvre and Flora (1988) argue that public health officials need to be more attentive to the resource exchanges that are occurring with the promotion of ideas and programmes. They suggest that attention should focus on enhancing the benefits derived from health programmes for actors in roles *as buyers and the sellers.*

In response to criticisms, Lefebvre, Lurie, Goodman, Weinberg and Loughrey (1995) contend that a misunderstanding of social marketing has contributed to a misconstrued notion of the social marketing approach. Lefebvre et al (1995) support this analogy and challenge the idea that social marketing is manipulative. They claim that social marketing critics are afraid of the accountability that comes with a results-focused approach to health promotion. Social marketing in their view could easily be misapplied to certain public health activities, as suggested in the case of nutritional education and cardiac patients. Social marketing is therefore seen as more comprehensive than public service announcements or just advertising and it had much to offer public health professionals, academics and practitioners (Andreasen, 1994; Bryant & Bowen, 1998; R. Lefebvre, 1994; Sutton, 1994).

Andreasen (1995) argues that social marketing is being confused with social advertising or social communication; it was misunderstood and also unappreciated. As an integrated approach that starts with identifying the needs, wants and perceptions of target customers, he claims it is more grounded than alternative approaches to influencing behavioural change. McDermott (2000) cautions that social marketing is not the answer to all health-related problems in society. There are still a number of difficulties associated with measuring the success of social marketing campaigns (Young, 1995). There are still questions surrounding the use of social marketing ahead of alternative forms of intervention or behaviour change. Given that government funding is available to support social marketing, these issues are important considerations that are yet to be clearly resolved.

10.5 MAORI HEALTH AND WELL-BEING CONTEXT

In this section, the critique of social marketing is contextualised to the overall task of enhancing Maori health and well-being. In the previous nine chapters several interrelated narratives sought to articulate the philosophical foundation of being Maori, a way of being in the world that is increasingly vulnerable to dominant and contrasting worldviews espoused through neo-liberalism. Neo-liberalist ideals are implemented through government policies and reiterated through micro

relationships in communities, schools, hospitals, playgrounds and churches (refer to *Chapters One* through *Nine*).

In this review, the conceptual and practical engagement between social marketing and Maori health and well-being is a micro-site where many socio-political issues are performed. As such the very subtle way in which words and symbols construct language and meanings is essential to drawing some conclusions about the potential implications of adopting social marketing (Heede & Pelican, 1995; Jones, 1982). As a warning, Jones reiterates that the frequent use of marketing terms

> dehumanises and therefore devalues, the individuals who are to be cared for or helped, the values and services that are being offered, at the cost (or price) of immense caring, hard work, not to say frequent disappointments, on the part of the people involved (1982, p.47).

Jones claims that people should not be subjected to this type of characterisation. In her view people should be encouraged to find their own pathways to independence as critical decision makers of their own lives in their own ways (Heede & Pelican, 1995).

In this thesis, I have sought to promote Maori concepts of health, Maori health models and Maori processes as necessary pathways towards Maori health and well-being. In recognition of the complexities associated with progressing Maori health, Durie states:

> Maori health is more complicated than illness, injury or lifestyle. People belong to families, communities and a nation and are reflective of the values and policies therein. Individuals, or at least Maori individuals, do not have a great deal of personal control over their social and physical environments; their lifestyles will inevitably be as much a comment on the whole of society as on them as individuals. That does not remove individual responsibility for health, but it does balance it with collective accountability. Rather than punishing those who have unhealthy lifestyles, we need to agree on public policies, which can convey a sense of order in a changing environment and yet at the same time encourage Whanau and communities to nurture each other (1994, p. 216).

Moreover, the commitment by Maori to transformative Maori health development is subjected to the interplay of power relations at various levels, both macro and micro. Those who have the control of meanings, words, symbols and language

also have a role in influencing the way that health development is conceptualised and organised. But, who decides which meanings are valid? The role of those in power to define and name is therefore crucial. The potential implications become visible when exploring the promotional and marketing tools offered to Maori communities: Marae and Hapu health clinics, Iwi health groups and Iwi collective groups. With the commitment to the Maori worldview espoused throughout this thesis, it is essential to re-examine the types of models that are more conducive to advancing the type of health outcomes Maori desire to achieve, in contrast with the proposed benefits articulated for social marketing.

Much of the literature has highlighted that the adoption of social marketing potentially threatens those aspirations. Yet a growing number of Maori and non-Maori health advocates are articulating a role for social marketing in achieving Maori health goals (see *Social Marketing Conference*, 2004)[23]. The earlier sections of this critique have presented implications associated with the continual application of social marketing to advance Maori health. In my view, Andreasen's (1995) proposition to transfer marketing knowledge to social issues (of which Maori social problems could be one) must take into consideration the desires by Maori to adopt Maori approaches to Maori health development. Failing to do so renders the social marketing project an endorsement of assimilist approaches to Maori health development.

The transferral of marketing knowledge to ethnic communities has been examined (Sabogal & Cordingley-Klein, 1999). Sabogal & Cordingley-Klein recommend that congruence with the goals, values and culture of the consumer group can be achieved if health messages are consistent and relevant to the groups based on their norms and beliefs. On this basis, Sabogal and Cordingley-Klein (1999) considered the importance of trust, community involvement, economic barriers and cultural context are important issues for consideration with regards to planning and executing health promotion programmes. Issues related to

[23] Government funded campaigns such as Quitline, which has a Maori focus to it through Au Kati and the Careers Services Mana programme, are examples. See www.socialmarketing.co.nz for more information about the social marketing in New Zealand and Australia. The presentations from the 2004 Social Marketing Conference held in New Zealand are also available at that website.

sensitivity to language and culture, understanding perceptions about the causes of health problems and community support were considered as possible constraints to its implementation. A concern raised with these ideas is that the philosophical mindset of social marketing remains intact; concepts such as trust and social justice are seen as peripheral issues to address. These concerns should not imply that Maori have not and do not use marketing techniques. The adoption of marketing philosophies, concepts and practices has become prevalent particularly within the area of Maori business (Light, 1999). However, the context of profit maximisation, for which businesses are responsible for achieving, is quite distinct from the advancement of health.

Social marketing literature perpetuates an argument that the social marketing model is useful for communities most at risk of disease or illness (Andreasen, 1995). In the context of this review, it is possible to hypothesise that social marketers are placed in positions of power (design policy and health promotion contracts) and who decide whether social marketing is a useful model or not (Jones, 1982). In these circumstances, it is important to ask what Maori think. Should social marketing be utilised or not? Are Maori in control of the development of the frameworks for Maori health development? Are Maori in control of the types of services being provided to their communities and their people? Are Maori in control of the public resources for Maori health? It is my contention that Maori people have every right to ensure that Maori policies regarding the types of health models adopted in national health campaigns are consistent with Te Ao Maori. Doing so helps challenge the uncritical indoctrination of ideas generated through public sector publications, many underpinned by the social marketing process.

Advancing Maori health and well-being is the core kaupapa for Maori health development. But, who decides whether this kaupapa is achieved? Who takes responsibility for providing pre-defined target markets with instantaneous gratification (e.g. thirty minutes of exercise) or is our responsibility more extensive than that? In supporting this pathway, Maori health advocates must be critically mindful of the implications that new tools (such as social marketing) have upon Maori aspirations to be Maori.

Social marketing advocates have discussed the possibility of modifying social marketing to be more relevant to the particular cultural differences prevalent in New Zealand (K. Lawrence, 1999). What would that mean for Maori and how would it or could it be done? One of the uncritical assumptions profiled by social marketers is the idea that those using the model are familiar with its mindset and concepts. But, such prior understanding is not possible without some form of prior training or education. Can there be any certainty that social marketing trainers will expose health advocates to vast critical concerns involved with adopting social marketing? Where that familiarity does not exist, it is taught. Once taught, there is an underpinning assumption that health advocates will fully appreciate the implications associated with using social marketing concepts, tools and processes.

For example, the conceptual implications related to transferring marketing knowledge to other cultures such as Maori is lacking in the literature. Gleaned from the literature is a series of potential hypotheses that have been borrowed from social marketing advocates and critics. Dr Ed Maibach, Senior Vice President of Porter Novelli on visiting New Zealand suggested that existing textbooks could be modified with local references to the cultural differences in this country (K. Lawrence, 1999). What that would actually mean in the context of Maori health is unclear without exposure to the critical tools required to evaluate that training. Of more concern is that Maori health advocates will be influenced by business-related concepts and practices that may create conceptual tensions between marketing knowledge and Maori health knowledge.

The idea that social marketing can address cultural concerns has led to the notion of ethnic social marketing (Sabogal & Cordingley-Klein, 1999) and culturally adapted social marketing (Epstein, 1999). However, there is limited evidence to conclude that these frameworks are suitable for Maori health development. In a social marketing conference held in Wellington, New Zealand, Maori were at least seen to use aspects of the model, but within the confines of a broad organisational commitment to social marketing (Sailer, 2004). One way of inquiring whether marketing is an appropriate model for dealing with the health concerns of indigenous groups is to transfer findings from previous studies to Maori health

situations. However, that is a problematic proposition because the literature lacked specific commentary about the behavioural change technologies used with different cultural groups. If marketing is transferred to Maori health issues, what tensions (if any) would be created as a result? Would the terminologies adopted by health promoters need to be altered or modified? In sum, this critique of social marketing has provided insight into the potential implications associated with the uncritical application of social marketing within the context of Maori health and well-being.

10.6 SUMMARY

In this review, I argue that social marketing is derived from the disciplines of marketing which draws from the theoretical influences of neo-liberalism. Neo-liberal principles reinterpret the enhancement of Maori health and well-being within a compartmentalised mechanistic system of buyers and sellers in a marketplace. Social marketing is not a neutral force in engaging Maori health ideals. It is based on technical and economic rationality that commodifies Maori health as a product and people as consumers. Its uncritical adoption potentially undermines Te Ao Maori values with assimilist and overwhelming implications.

The review highlighted that there is a rich source of literature that outlines the many merits associated with adopting social marketing (Andreasen, 1994, 1995; Fine, 1990; Kotler & Roberto, 1989; Kotler & Zaltman, 1971; Lazer & Kelley, 1973b; R. Lefebvre, 1994; R. Lefebvre & Rochlin, 1997; McDermott, 2000; W. Smith, 2000; Weinreich, 1995, 1999; Young, 1989). However, there were unexplored hypotheses related to the potential use of social marketing by Maori health practitioners which were not so clearly articulated. One of these ideas included the adoption of some social marketing tools, in place of adopting the complete social marketing model (K. Lawrence, 1999). As a result of the many varied views provided in this review, it was highlighted that it was difficult not to see social marketing as a value-laden technology where ethical boundaries can be crossed. Buchanan, Reddy and Hossain state:

> By pushing certain issues (product, price, place and promotion) into the foreground, other issues – the justice of certain kinds of social arrangements, the quality of shared public life, the tolerance of poverty, the regard for the rights of minorities in democratic institutions – receded into the background. We think this is unacceptable (1994, p. 56).

Social marketers continue to assert that indigenous communities worldwide could benefit from social marketing because of the proposed benefits that can be derived from its use (Andreasen, 1995; Epstein, 1999; Sabogal & Cordingley-Klein, 1999). However, that assumption is difficult to substantiate with the literature in this review. The literature appears to suggest that the adoption of social marketing by Maori health advocates at best becomes an architectural framework that helps health promoters more effectively design, plan and manage their health promotion efforts to target Maori as 'consumers' or to more effectively communicate messages to people (Neiger et al., 2003). However, at worst it could undermine Maori health development approaches to Maori health that have become more pronounced over the last two decades. Social marketing has the potential to fundamentally contradict the philosophical work being performed by Maori health practitioners, professionals and advocates to strengthen the foundation for Maori health based on Te Ao Maori.

PART TWO: THEORETICAL REFLECTIONS AND NARRATIVE RESEARCH OUTCOMES

PART TWO: THEORETICAL REFLECTIONS AND NARRATIVE RESEARCH OUTCOMES

i. INTRODUCTION

There are three chapters in this section of the thesis called *Theoretical Reflections and Narrative Research Outcomes*. *Chapter Eleven* outlines the Kaupapa Maori research methodology and methods adopted to conduct the research in this study. *Chapter Twelve* provides an in-depth analysis of the kaimahi hauora and kaiarahi hauora responses gathered in the research process and the workshop which are subsequently reported on as part of this inquiry into the appropriateness of social marketing in support of Maori health development. *Chapter Thirteen* draws the research in this thesis to a close.

ii. OVERVIEW OF NARRATIVES OF INQUIRY

In 2002-2003, I worked with a number of dedicated Maori health groups to research the potential contribution of social marketing to support Maori health wellbeing, with funding support from the Health Research Council of New Zealand. The findings from this research have been presented as four case narratives, in a separate report in February 2004 *(see Appendix Ten: Case Narratives)*[24]. They were generated by work with the following organisations: *Whaioranga Trust, Mana Manaaki, Pirirakau Hauora and Waipu Hauora,* which were all based in Tauranga Moana, Bay of Plenty, Aotearoa New Zealand. The case narratives constitute the rich source of information for this thesis. Each case narrative is summarised below.

Case Narrative One: Whaioranga Trust

Whaioranga Trust was the first marae-based health promotion, social services and education services provider operating within the Western Bay of Plenty region. It provides mental health services, general practitioner services, youth holiday programmes and kaumatua and kuia health checks. Whaioranga is located at

[24] This research was funded by the Health Research Council of New Zealand.

Whetuoterangi Marae in Welcome Bay, Tauranga. It has been operating since 1981 and during the last twenty years it has experienced many changes. The facilities of Whaioranga are adjacent to the Ngati Pukenga Iwi Runanga office, kaumatua and kuia flats, the Whetuoterangi Marae and the Nga Peke Kohanga Reo. Whaioranga has sought to operate a holistic approach to Maori health.

Case Narrative Two: Mana Manaaki

Mana Manaaki was originally a programme created by Tauranga Moana Maori to reduce the consumption of alcohol and health related impacts of drink driving by Maori in the region. It was managed on a daily basis through the Western Bay Health Promotional Unit, before being transferred to Toi te Ora Public Health, now located within the Bay of Plenty District Health Board, Tauranga Moana. Mana Manaaki is a way to promote Maori health by Maori health promoters within the Tauranga office of Toi te Ora Public Health. It is now seen as a model to advance Maori health development.

Case Narrative Three: Pirirakau Hauora

Pirirakau Hauora was established under the umbrella of Pirirakau Hapu Incorporated Society in 1994, before being established as a Charitable Trust in 1999. Pirirakau Hauora is situated at Te Puna, Tauranga. Its primary purpose is to improve the overall health and wellbeing of the Pirirakau community and its four marae communities - Poututerangi, Tawhitinui, Tutereinga and Paparoa. Pirirakau is also the name of the Hapu in the area. In this case narrative, one of Pirirakau Hauora's health initiatives called Tu Pou Tahi – Rangatahi Health and Wellbeing Suicide Prevention and Rangatahi Sexual Health is reviewed. The type of health activities performed by Tu Pou Tahi kaimahi includes a range of promotional and educational events and programmes and one-on-one counselling advice sessions. Tu Pou Tahi works and operates within the Western Bay of Plenty region.

Case Narrative Four: Waipu Hauora

Waipu Hauora was established in 1994 to help progress the improvement of health and wellbeing of people within the Matapihi Whareroa community. It is operated through the Hungahungatoroa Marae and services the Whanau from the three marae: Hungahungatoroa, Waikari and Whareroa. The two Hapu in this area are Ngati Tapu and Ngai Tukairangi. Waipu Hauora is associated with the Poutiri Trust, which serves as an umbrella organisation for several Maori health providers in the greater Bay of Plenty region.

CHAPTER ELEVEN: KAUPAPA MAORI RESEARCH METHODOLOGY AND METHODS

"Kaupapa Maori approaches to research are based on the assumption that research that involves Maori people, as individuals or as communities should set out to make a positive difference for the researched. This does not need to be an immediate or direct benefit. The point is that research has to be defined and designed with some ideas about likely short-term or longer-term benefits. Obvious as this may be, it must be remembered that historically, indigenous peoples have not seen the positive benefits of research."

(L. Smith, 1999a)

11.1 INTRODUCTION

Methodology is the study of research methods and the focus of this chapter. Building on my commitment to depict Maori health advancement as an active resistance to contemporary colonisation, I sought methods of research that would not only provide *insights* into the appropriateness of social marketing for Maori health promotion, but also contribute to the vitality of Te Ao Maori, posited in this thesis as the source of Maori health and wellbeing. Research methods for this work were adapted from emerging research approaches collectively known as *Kaupapa Maori research.* These methods draw on the transformational aspirations expressed by both Kaupapa Maori researchers and critical theorists. They invite the researcher to work as closely as possible with the community of interest with a clear intent, not merely to record information, but to change the world in some way for the better.

Kaupapa Maori research "seeks to make a positive difference" for those involved in the research (1999a, p.191). In the context of academic research, such work must be consistent with international principles of good research. Thus, the research must be situated 'in context' and presented in ways compatible with research norms of the Academy. In keeping with these conventions, research methods adopted for this research include literature and document reviews, in-depth conversations and workshops, from which we generated case narratives.

The conversations with research participants were guided to remain on task – however they were purposefully left as open as possible to allow the expression of original and creative thought to emerge. The workshop was designed to engage participants in both describing and developing their understanding of an appropriate use of social marketing in Maori health advancement and the development of case narratives. These activities were designed using principles of Kaupapa Maori research.

The principles of Kaupapa Maori research and their associated ethical commitments are discussed in this chapter. In this research these commitments are shaped in a way that prioritises a decolonising standpoint. I employ these methods to create a series of critical narratives generated from Te Ao Maori and thus providing both an insight into the appropriateness of social marketing for Maori health advancement whilst reinvigorating a Maori world view.

11.1.1 Te Ao Maori – Maori Knowledge

In *Chapter Two,* the foundations of Te Ao Maori were presented as an interwoven collection of Maori concepts and systems that constitute Maori knowledge and Maori practices (Barlow, 1991; Marsden, 1992; Marsden & Henare, 1992; McGowan, 2000; Mead, 2003; Patterson, 1992; Pere, 1984). However, the impact of colonialism unsettled this knowledge base. Many Maori leaders realise that this Maori knowledge base is fragile. They realise more effort and commitment is required to reinvigorate Te Ao Maori so that Maori researchers are able to contribute to enriching new research practices which seek to enhance Maori knowledge (L. Smith, 1991). There is a growing expectation by Maori researchers, scholars and an increasing number of Maori communities who embark upon research projects in the name of Maori research that they must contribute to this cause. Maori researchers are therefore expected to delve into the depths of the ontological foundations of Te Ao Maori and by doing so, reap the rewards of enhancing Maori knowledge and positively advancing Maori wellbeing – wellbeing as Maori – more properly expressed as wellbeing as Whanau, Hapu and Iwi.

Conventional academic research traditions involving Maori have emphasised a predominantly western worldview - characterised by principles of reductionism, objectivity and positivism (Guba & Lincoln, 1994; Pihama, 1993; G. Smith, 1990; L. Smith, 1991). A Lakota scholar, Cheryl Crazy Bull notes that the scientific method [borne from a positivist research paradigm] "requires the researcher to remain outside the research experience, to investigate through observation and discovery and to draw conclusions based on those observations...but, seen from an indigenous viewpoint, such a method does not guarantee objectivity" (cited in Porsanger, 2004, p.110). Researchers adopting research techniques drawn from this worldview are being challenged for their roles in constructing knowledge about Maori that can be inaccurate or misleading.

The limitations of the positivist approach to understanding human experience is now well articulated in post positivist research paradigms (Guba & Lincoln, 1994). These perspectives eschew the very notion of an objective observer (L. Smith, 1999b). The damaging effects of the objectification of Maori people in such research, and the use of the resulting skewed interpretations of the 'observers' has generated aspirations for other ways of researching ourselves. It has also invited a reformulation of nature and a validation of the research relationship between the researcher and those whom they seek to understand (Villenas, 1996). Kaupapa Maori researchers are particularly concerned with the power relations inherent in positivist assumptions about research, and they developed ways to change these (Bishop, 1996a; G. Smith, 1997; L. Smith, 1999a).

Indigenous peoples throughout the world have made some headway in contesting the presumption that western positivist thought holds a superior set of guiding principles for research (McNicholas & Barrett, 2002). Whether that headway has significantly impacted the interrelated power relations or whether researchers continue to support oppressive, neo-colonial and fatalistic trajectories is a challenge for new generations of researchers. Jackson (1996) is not optimistic. He argues that the predominant research paradigm

> will force us to take our tikanga, take our views and twist and shape it into a set of protocols which are not our own and the end result is research that is damaging to our people. If we are a people worthy of being who we are, why can't we just

> study ourselves in comparison to nobody but ourselves and not as an isolated unit divorced from the world around us, but as people worthy of a study in ourselves (p.9).

Kaupapa Maori researchers are therefore obliged to commit to the promotion of principles for conducting research by, with and for Maori that are derived from a Maori worldview. Kaupapa Maori research methods are being developed and adopted by a growing number of Maori researchers (Bishop, 1996b, 1997a, 1997b; Cunningham, 1998; Glover, 2001; Irwin, 1994; Jahnke & Taiapa, 1999; G. Smith, 1992; L. Smith, 1996). The outcome according to Maori researchers is a greater likelihood that research will not only contribute to the construction of, and retention of Maori knowledge, but that Maori will also have greater ownership and control of the research processes and protocols that inform and enhance their world.

11.2 METHODOLOGY

Methodology is the study of assumptions and principles that influence specific research methods and processes of inquiry. Methodology is concerned with the philosophical basis from which a researcher is guided in their research (Cram, 1995). It is the work of matching a research question(s) to a set of appropriate research strategies (L. Smith, 1991). In the context of indigenous research – it is the development and justification of the "rules employed by indigenous researchers in the study of indigenous people" (Porsanger, 2004, p.107). Smith (1991) argues that personal assumptions about research are not enough to articulate a conviction about methodology. A much deeper appreciation of theoretical approaches to research is required. It is for this reason, that so much discussion has been devoted in this thesis to the connection of research methods and its contribution to the enhancement of Te Ao Maori (outlined in *Chapter Two*) – and through this analysis to the enhancement of Maori health and wellbeing.

11.2.1 Kaupapa Maori Research Methodology

Research principles and convictions are derived from an ontological and epistemological understanding about what counts for knowledge and how knowledge comes to be accepted as valid, reliable or true. Assessing the validity of knowledge about Maori may depend on the way in which such knowledge is generated. Such validity may depend on who is involved, how the research is conducted and by what means the information is gathered and translated into knowledge.

Cunningham (1998) describes four levels of involvement and control by Maori in research. The first approach assumes *no specific Maori involvement* in research. An example of this may be the traditional approach to a western positivist project involving the identification of chemicals within matter. At this level a limited scientific paradigm assumes the scientist is culturally and ontologically neutral, and that he or she is able to observe phenomena and record their observations 'objectively'. In this framework, whether a scientist is Maori or Chinese is deemed irrelevant – Maori would therefore have no control over the process or outcome of the research.

In the second approach *Maori might be identified as a discrete group of people*, subject to observation as a unique population. In this case, the researcher identifies the population according to preconceived notions of who is to count as Maori and how they might best be observed. This is a common approach in medical research based on pathologies attributed to specific populations. An example may be a national study about tobacco consumption. The findings of such research "will produce mainstream de-contextualised and seemingly apolitical knowledge of Maori pathological behaviour"(Cunningham, 1998, p.4).

The third approach may be a *Maori centred approach* or pan tribal approach to a research project. An example of this is a longitudinal research project focusing upon Maori aspirations, which is operating within a specific location drawing from broad Maori concepts of knowledge. In this approach, Maori may be involved as participants, researchers and analysts and to that degree Maori do have some control of the research process and outcome. In this modality, the

possibility of producing Maori knowledge is greater, though this knowledge may be subjected to a re-articulation in order to conform to preconceived mainstream expectations of research funders.

The fourth approach is described by Cunningham as *Kaupapa Maori research.* An example of this could involve the researching of Hapu waiata by an identified Hapu kaumatua undertaken during wananga by Hapu members focusing their efforts upon the enhancement of their Hapu knowledge, drawing from and to Te Ao Maori. The research involves researchers and participants whose lived experiences and aspirations as Maori, Iwi, Hapu and Whanau contribute to the transformative experience of the participants.

The conceptualisation of Kaupapa Maori research methodologies can vary. Smith (1999a) for instance, presents an overarching set of assumptions about Maori research that distinguishes between indigenous and non-indigenous research which contrasts with research approaches that form part of a continuum of research typologies. Iwi specific research methods have also been presented for consideration as Kaupapa Maori research (Bevan-Brown, 1998; Broughton, Hauora, Rimene, & Sporle, 1998; Durie, 1998; Harmsworth, 2001; Royal, 1998; Walsh-Tapiata, 1998).

Variations of Maori research methods deal with the contextual concerns of Maori research in different ways. In doing so, the ability to decide what differences matter and who decides what differences matter is illuminated (Johnston, 1998). Each of the taxonomies provided by Cunningham (1998) outline variations in power relations which influence important research decisions through to the manifestation of research methods involving Maori and/or non-Maori, and the impact these positions have upon their full political participation as Maori, Iwi, Hapu, Whanau and tangata. Kaupapa Maori research methodologies are therefore an articulation of principles and assumptions from a distinctively cultural, political, ontological and epistemological position.

Kaupapa Maori is an umbrella term to describe research derived from an ontological foundation generated from Te Ao Maori. Although Kaupapa Maori

methodological developments are increasingly seen as culturally specific and often collaborative, its tenets were generated from the theoretical traditions of European (predominantly the Frankfurt School) critical theory and research (L. Smith, 1999b). This alignment with European critical theorists who critique western thought (as outlined in *Chapter Four*) has been used to help explain the impacts of the colonising and domesticating effects of western rationalism on colonised peoples in the way the knowledge generated through these methods has been used to empower oppressive regimes.

Kaupapa Maori research methods were established as a tradition in the Academy from the 1980s. The transformative aspirations associated with these methods have been harnessed by Maori to redress colonisation. Maori researchers with decolonising aspirations have adapted the work of critical theorists such as Paulo Freire, Henry Giroux and Matt Alvesson to serve their emancipatory ideal. These authors have provided Maori researchers with a way of theorising the negative impacts of domination and a means by which to work towards their emancipatory aspirations through the research process itself.

11.2.2 Links to Qualitative Methods

The first three taxonomies provided by Cunningham (1998) do not consciously produce a research paradigm generated from the ontological foundation of Te Ao Maori. They do not in my view constitute Kaupapa Maori research. Although findings from such research may well be of interest to Kaupapa Maori researchers, the distinction between quantitative and qualitative research does not make one or the other approach more or less appropriate for Kaupapa Maori researchers. However, there are some considerations of this distinction I wish to highlight. Quantitative research can be of value, when statistics are deemed important. Knowing for example, the numbers of Maori children with 'glue ear' will be useful when the resources for remedies are being allocated. But just 'what' is to be counted and where the boundaries between discreet entities are drawn are ontologically defined.

Kaupapa Maori researchers tend to favour qualitative research traditions (Mataira, 2001). Their interest permeates from a commitment to engage in research with the philosophical, psychological, transformative and political indices pertinent to the research, researcher and research community at heart. For instance:

> Maori researchers tend to use qualitative lines of inquiry more because 'subjective' experience is valued, than the clinical tendencies of quantitative research...Qualitative methodology accepts both the phenomenological and subjective nature of social science and embraces the interpretation of experience as a gauge to how people think and relate to their world. Maori research draws on this approach, as it is sensitive to acknowledging 'meaning' as defined by Maori people (Mataira, 2001, p.5).

Lather (1991 cited in Bishop, 1996b) argues that qualitative approaches are more readily able to address concerns about the overemphasis of researcher control. For instance, qualitative research involves both the researcher and research participants in discussions about advocacy, subjectivity, participation, positioning and authenticity. Qualitative researchers are concerned with finding substance and clarity in a mass of complexity, convolution and pluralism (Davidson & Tolich, 1999). The result therefore is the emergence of thematic patterns in a story or narrative.

The ideals of the critical Maori researcher who works with an emancipatory intent and a commitment to the invigoration of Te Ao Maori are drawn together in qualitative and participative methods of research. The intent of this synthesis of ideals is to honour and empower the understanding and aspirations of specific communities. Qualitative research in this respect provides indigenous communities with the power to decide the destiny of research and how it might directly advance community wellbeing and development. The assumptions that guide qualitative research methods include an emphasis on process, meaning, people, fieldwork, description and inductive reasoning (Marshall & Rossman, 1980). Those concerned with quantitative research are more inclined to have predefined notions of what objects are to be counted and how these objects can be arranged in descriptive, predictive or normative equations. Contrasting assumptions are at work guiding the way in which research comes to be understood, validated and used. Qualitative researchers recognise that all

phenomena are social constructions, fabricated from ontological assumptions that might at any time be renegotiated. Because of this perspective they pay particular attention to the identity of researchers as people who bring to any discussion a set of values and beliefs that will affect what they see and understand, what they bring to a community and what they may take away. Kaupapa Maori researchers are thus integrally concerned with researcher position(ing) and they have generated some general guidelines for good research practice.

Kaupapa Maori research principles guide researchers and participants to aspire and commit jointly to enhancing outcomes for Maori (L. Smith, 1999a; Tiakiwai, 2001). Bishop (1996b) states that in this mode of research, the researchers position is founded upon an epistemology of whanaungatanga for which, "whanaungatanga consists literally of kin relationships between ourselves and others and is constituted in ways determined by the Maori context" (p.215). Kaupapa Maori research therefore articulates a "reciprocal relationship between the researcher and the research [participants] who must become 'a family' to be interconnected in a reciprocal way in the frames of the particular research project with which they are involved" (Porsanger, 2004, p.111). To illustrate this, in the *Prologue*, I have emphasised that as a researcher I occupied an insider/outsider position derived through whakapapa links and my commitment to Maori health development in Tauranga. For example, one case group was my own Hapu. This meant that I had to position myself as both a researcher and as a Hapu member. In the other three cases, although I was from the same Iwi, it took time to establish a research relationship before I was able to move from being an outsider researcher to an insider researcher.

The movement in the researcher position is facilitated through relationships being built on trust, respect, reliability and common purpose with kaimahi hauora representatives. This required much work from all participants before I was able to journey with them to explore deeper research issues. The insider/outsider positioning highlights the complexity brought about when one works in partnership with a community (L. Smith, 1999a). While the positivistic separation of researchers from the research community allows for a clearer drawing of

boundaries between issues and people – the very drawing of those boundaries (to serve 'clarity') may well over simplify the significant potential contribution that comes from both the process of the research experience and the outcome from qualitative expressions of research outcomes such as narratives, stories and information.

Holstein and Gubrium (2000) argue that the process and context of research experience is just as significant as the research outcomes:

> If we are to study lives, including selves in social interaction, we must study them from within the social contexts they unfold, not separate from them...Human beings don't settle their affairs with meaning once and for all. Rather, they continually engage the interpretative process, including the interpretation of what they mean to themselves...The methodological interpretation of what they mean to themselves...the methodological direction here is to document the articulation and emergence of meaning in rich detail as it unfolds, not in lifeless analytic categories and statistical tables (p.33).

Holstein and Gubrium therefore argue that research context; research process and research outcomes are interconnected aspects of a research journey. The analogy that they draw is consistent with prevailing principles and assumptions of Kaupapa Maori research.

11.2.3 Kaupapa Maori Research Principles and Assumptions

Kaupapa Maori research is founded upon principles and assumptions permeating from a cultural paradigm that values the subjectivities associated with research relationships. These approaches are embedded in inherent relationships associated with abiding to a research process that is consistently respectful, trustworthy, accountable and credible. Bishop (1996b) provides a series of questions to guide Kaupapa Maori approaches to research. He asks:

- Who has helped define the research question?
- Who has input in deciding whether the research is worthy and relevant?
- How does this research contribute to new knowledge and which cultural group will benefit?
- Who is the researcher accountable to?

- Who will benefit most from this study?
- What processes are important to the research community?

These questions help ensure that issues related to power and control before, during and after the research relationship is addressed, and then aligned with Maori aspirations for knowledge development and transformation. As such, some themes that relate to Kaupapa Maori research principles include the examination of research initiation, legitimacy, accountability, research benefits and representation (Bishop, 1994, 1996a, 1996b, 1997a, 1997b; Bishop & Glynn, 1992). Qualitative assumptions such as credibility, transferability, dependability and confirmability are also important (Joniak, 2000). Smith (1997) reiterates these ideas in a discussion about Maori research ethics in which seven key considerations are highlighted:

- Aroha ki te tangata (respect for people)
- Kanohi kitea (the seen face is a requirement – to present yourself face to face)
- Titiro, whakarongo…korero (look, listen…then speak)
- Manaaki ki te tangata (share and host people, be generous)
- Kia tupato (be cautious)
- Kaua e tahakia te mana o te tangata (do not trample on the mana of people)
- Kaua e mahaki (do not flaunt your knowledge) (p.120).

The cultural, ethical, epistemological and ontological principles embedded within Kaupapa Maori research methodologies greatly influence the types of applicable research methods for this project. Taking into consideration the complex and multiple realities associated with advancing Maori health development (outlined in *Chapters Two* through *Ten*), it is appropriate to support and endorse cultural-qualitative orientations towards research methods. These methods include case studies/narratives, in-depth interviews/conversations, workshop/hui and literature/document reviews.

11.3 RESEARCH QUESTIONS

In *the Prologue,* I explained that this research project was originally narrowly focused on the potential to implement social marketing as a functional tool to advance Maori health. This articulation was, at the time I began my research fairly consistent with the positivistic traditions of my professional training. However, I had also been developing a serious interest in ensuring that being Maori was an important part of my life, in Whanau and in employment. This quest brought me to the work of Maori scholars. As I became more conversant with Kaupapa Maori research, I wanted a radically different approach to my research to the one I first envisaged. This aspiration also led to my own radical re-education as a researcher throughout the project.

The re-education as a (Kaupapa) Maori researcher, led to a more complex consideration of the contrasting characteristics of social marketing and Maori health promotion. I became much more sensitive towards the subtle distinction between Maori views about Maori health advancement and the values that are embedded in the seemingly neutral tools of western organisational procedures or 'techniques'. What remained through my re-education was my initial intention – to contribute through my work, to the enhancement of Maori health and wellbeing. However, now the questions and the processes of the research were subtly changed. What is different is the way I went about exploring this question with the participants in this research, who were Maori and who were concerned with Maori flourishing in a Maori way. The research primary question therefore aims to critically examine [through the lens of Kaupapa Maori theory] *the appropriateness of social marketing in support of Maori health advancement.*

The primary research focus is positioned in this research as an 'overlay of interconnected and interrelated themes' related to the advancement of Maori health. These themes form a layering effect which weave together and build upon each other eventually contributing to a rich textual expression of meaning that stems from the theoretical and literary inquiry. Many themes such as *power and control, colonialism, Maori health concepts, Maori health development, Maori health promotion, Maori health reforms and social marketing concepts* have

already been alluded to in earlier chapters. Therefore, a deeper appreciation and understanding of these issues is provided through the exploration of interrelated sub-questions.

11.3.1 Research Sub-questions

The sub-questions that emerged as I moved toward a more participatory research model are outlined below. The key themes within each question have been underlined to provide an indication of the key focus of the questions.

- What is the nature of the relationship between the process of colonisation in Aotearoa New Zealand and the past and current status of Maori health?
- What are the narratives concerning Maori sovereignty and the emergence of a Maori health development approach to Maori health for each of the Hauora within that claim to sovereignty?
- What is Maori health and how is it articulated?
- How do health reforms and policies impact Maori aspirations for Maori health development?
- What is Maori health promotion and how has it emerged as a theme within the broader framework of Maori health development?
- What are the fundamentals of social marketing?
- What are social marketing advocates and critics saying about social marketing?
- What is being said about social marketing's possible contribution to health promotion in general and Maori health development in particular?
- What critical factors should be examined within a discussion concerning the similarities and differences within and between social marketing, Maori health promotion and Maori health development
- What are the potential contradictions and paradoxes that emerge in a discussion about Maori health development and social marketing?

- What are kaimahi hauora saying about social marketing?
- What could we learn about the research to enact tino rangatiratanga?

11.4 RESEARCH METHODS

The research methods generated from the assumptions and principles stemming from a Kaupapa Maori orientation are addressed in this section of the chapter. According to Alvesson and Deetz (2000), research methods attend to how one develops

> research questions, how one attends to social reality, what vocabularies are used in clarifying and reinterpreting what emerges in the voices of the members of the community. Method is also how one achieves a level of systematicity and logic in the way empirical material is treated, for example the principles for how to cope with the ambiguities and contradictions in interview statements, observations and other forms of qualitative information. Method connects theoretical frameworks with the production and productive use of empirical material (pp.4-5).

For this project, the research methods include – literature and document reviews, in-depth interviews/conversations, a workshop/hui and four case studies/narratives. The rationales for using these methods are outlined below and the processes associated with the adoption of the methods are explored.

11.4.1 Literature and Document Reviews

According to Davidson and Tolich (1999, p.88), research results "are always placed in the context of existing theory and existing theory provides a framework for new ideas about what to research." This study included literature reviews pertaining to the decolonising aspirations of Maori, the historical context of post-Treaty period, the configuration and re-configuration of health delivery entities, Kaupapa Maori, Maori health promotion, social marketing and Maori health development. The first phase of this research prompted my interest in Kaupapa Maori research methods and the underlying commitment to enhancing Te Ao Maori.

Literature reviews serve to unravel the extent to which a research interest and a related research topic have been attended to by academies and researchers. In the

area of Kaupapa Maori research, the connection to the European critical theorists and their influence on contemporary critical organisational theory reinforced my interest in connecting Kaupapa Maori methodologies and contemporary organisational theories – in this case – the theories of social marketing. Questions that inform a literature review include:

- What is the historical context of the topic?
- What have been some of the chronological developments in the topic?
- What have others said about the topic?
- What theories address the topic?
- What research has already been conducted in this area?
- Is there a consensus in the field?
- What are the gaps in the research? (Davidson & Tolich, 1999, p.88).

Literature reviews also inform readers that the researcher is conversant in the various fields and aware of the current scholarly debates. Often a literature review can highlight the current state of knowledge in the chosen topic by assessing the supporting literature in terms of its strengths and weaknesses. In some cases, responses to these sub-questions were illuminated within the literary reviews and subsequently reported upon in earlier theoretical chapters. In other cases, the case narratives developed from the in-depth conversations provided an additional set of insights that were not otherwise available in the literature.

The document review related specifically to the case groups. The purpose of searching through documentation is to obtain an array of rich information (letters, contracts, reports, surveys and minutes) that will contribute to the development of the case narratives. In some cases, the documentation was limited. However, because multiple case narratives were developed, the lack of documentation by one group was overcome by increasing the number of conversations held with their representatives, and/or by drawing upon documents provided by other case groups for comparisons. The literature and the documentation collected and analysed provided further information about the themes emerging throughout the

research process and the socio-political context within which the advancement of Maori health occurs.

11.4.2 In-depth Interviews and Conversations

The development of conversational type interviews is a derivative of a research practice that responds to the growing recognition of the importance of mutual research relationships. Lather (1991) claims that interviews constructed in this way offer a means for constructing meaning for people in their own voice. Burgess (1988) highlights the benefits of adopting a conversational approach in interviews. Haigh (2002) suggests that conversations can have a significant influence on a person's thinking about learning. His conceptualisation of a conversation reflects serendipity. Conversations are not prescribed, all participants can influence the dialogue and there is a particular type of openness in the discussions. The conversation is viewed as a means to "focus on depth, detail and probe beneath the surface, soliciting detail and providing a holistic understanding of the interviewees point of view" (p.32). The ability to enable people to share their stories often depends on trust. Reinharz (1992) presents trust as a notion of reciprocity, respect and care.

The concept of reciprocity is not new to Maori people. It is about manaakitanga or caring for the individual, the collective and the knowledge (Bishop, 1996b). Time constraints (mine and that of the participants) generated a hybrid process of semi-guided conversations that allowed me, with a series of questions in mind, to merge those questions with the interests and processes acceptable to the participants. This approach acknowledges and accepts that although the primary interviewing technique adopted in this research project is based on traditional in-depth open-ended and unstructured interviewing – it was grounded in a conversational type process to encourage a naturalistic and free flowing process. In order to ensure that many facets of the case studies were considered, between two and three conversations were held with each of the case group representatives. This process is often described as multiple interviews (Reinharz, 1992).

11.4.3 Workshops as Conversations

In this research project, the workshop is viewed as an extension of the conversations that were held with many people working in collaboration. The workshop was based upon a transformative and reflexive learning process and context where individuals were able to learn from the collective group of individuals gathered for the specific research purpose. All case group representatives (particularly the health promoters) were invited to participate in a one day training workshop as part of the research project. The workshop was likened to a focus group or hui whereby all case group representatives met as a collective group to reflect and comment on the issues presented, in the context of their work.

Whilst there is ample commentary concerning focus groups in qualitative research literature (Denzin & Lincoln, 1994), and hui as a cultural construct specific to Maori (Mead, 2003), the development of workshop/hui/conversation concept - drawn from contemporary aspirations of Te Ao Maori - has yet to be merged with current thinking by being acknowledged as a viable and meaningful research method. The theoretical depiction of a workshop/hui is an underdeveloped conversational research method that is not present in research methods literature. The *hui* is a Maori cultural construct that is, however, extensively used as a method of consultation by public service organisations in New Zealand and many research organisations actively involved in co-partnership relationships with Maori (Harmsworth, 2001, 2004; Ministry of Health, 2004). The focus on hui as a conversation is highly valued by Maori. Positioning the workshop/hui *as* a research conversation with its related processes of engagement with people enabled researchers

- To provide opportunities for transformative means of engagement and learning
- To ensure that Kaupapa Maori processes such as 'kanohi ki te kanohi' are achieved
- To ensure that co-researchers have input into the workshop experience in a way that has meaning for them

- To provide the opportunity for the co-researchers to re-direct and refocus the researcher on their research aspirations
- To ensure that 'collaborative opportunities' to discuss, reflect and analyse the issues and the implications of the research are provided.

11.4.4 Case Narratives

The collaborative aspirations of the research project provided the impetus to validate the case narrative as an appropriate contribution to the overall research methods undertaken in this project. A case narrative draws from the literature about case studies and often the terms are interchangeable. A case narrative is both a process of inquiry about the case and an outcome from the inquiry (Stake, 1995). The purpose of the case method is to "describe as accurately as possible the fullest, most complete description of the case" (Zucker, 2001, p.1). A number of reasons validate case method approaches as appropriate. Firstly, the researcher is interested in reaching a greater sense of understanding and meaning about a particular issue and an emphasis upon intrinsic benefits is encouraged. Secondly, the case may be examined to provide insight into an issue as a secondary interest to a primary research purpose. This type of approach is described as an instrumental case study. Thirdly, the researcher may wish to investigate a number of cases in order to arrive at a greater understanding of a phenomenon or population. The cases are chosen with a collective view of reaching a better understanding of their experiences and insights about broader issues. This approach is called a collective case study. There are other types of case methods such as exploratory, descriptive and explanatory (Yin, 1994). The case method approach has been too little honoured for its intrinsic contribution and its potential to involve community in the co-creation of research and research outcomes (Stake, 1995). As a qualitative research tool, not everything in a case needs to be understood and the complex nature of case studies or narratives sometimes makes that task difficult.

The case study approach adopted in this research project draws from traditions in story telling, narrative inquiry or interpretative inquiry (Denzin & Lincoln, 1994). It is an approach that acknowledges the oral traditions of Maori people and the

social organisation of Maori people into Iwi, Hapu and Whanau. Bishop (1996b) describes these methods as collaborative stories. Collaborative storying is a sequential series of semi-structured in-depth interviews as conversations, conducted in a dialogic, reflexive manner to facilitate ongoing collaborative analysis and construction of meaning and explanations about the lived experiences of research participants. The result is a collaborative story with researcher and research participants as co-researchers and co-authors. The development of appropriate conversational opportunities is often context and resource dependent. Our workshop was a synergetic merging of people, time, energy and thought, drawing upon the research resources and the inner commitment of participants to advance Maori health in a conversational environment, within the working context of the co-researchers.

The process of research analysis involves sifting and sorting through information provided and obtained from the conversations to identify and interpret thematic categorisation, focusing particularly on similarities and contradictions in the information – searching always for the ability to generalise conclusions (Thorne, 2000). In that respect, "case method and analysis occur simultaneously as an iterative process, wherein the researcher moves between the literature and field data and back to the literature again" (Zucker, 2001, p.3). Participants, to the extent of their interest and resources are invited into the process in various capacities as contributors of the stories as co-readers, as gatekeepers of sensitive information, as presenters of case narratives, as participants in hui and as active supporters. Narrative analysis recognises that stories provide insights about the experiences of people's lives in the context of their aspirations and their work. Consequently, the analytic method and process relating to the emergence of narrative themes help researchers and participants discover, interpret, understand and draw meaning from those experiences (Thorne, 2000).

Case narratives and case studies are methods that are not without limitations. A key consideration of case representatives using this approach is that the results reflect an organisation's own story. Stake (1995) suggests that such reports are subjected to the researcher's dressing of the case story. This can be overcome when the decisions pertaining to representation are discussed in co-partnership

with researchers and participants. The success of this method is dependent upon the acceptability of the process by the case group organisation, thereby facilitating the development of strong research relationships between the researcher and the research participants. It is also a method that values research experiences and processes as fundamental aspects of the overall research outcome (Zucker, 2001). Researchers and research participants are therefore positioned as co-constructers of knowledge when adopting the case study research (Denzin & Lincoln, 1994). In the case of the hui/workshop, not only are research conversations being constructed, but through a commitment to do so in a Maori way, Te Ao Maori is strengthened as an outcome of the process.

11.5 RESEARCH PARTICIPANTS

This section of the chapter outlines who the research participants were how they became involved and the procedures adopted during the research process to involve the research participants. There were two primary groups of participants namely – case groups and their participants – kaimahi hauora, kaitautoko and kaikorero, and individual health leaders – kaiarahi hauora.

11.5.1 Case Groups - Hauora Maori

The original number of case groups for this study was four. In July 2000, exploratory conversations were held with seven representatives of Maori health organisations in Tauranga to determine what types of criteria would be required for inclusion in the study and what types of issues were prevalent in their field of work. The criterion for including the groups that emerged from that process was based on the following characteristics

- That the groups included represented all three Iwi groups and that one group was a mainstream health provider.
- That the groups were involved in health promotion by way of providing a distinct health promotion service or a range of health related activities.
- That the groups were willing to participate and that there was a willingness to provide the necessary resources in people time and documentation for the study.

At that early time, only some of the Maori health organisations were eligible for inclusion. Out of the potential seven groups originally approached, only four groups were formally invited to participate in the project.

Each of the Tauranga Moana Iwi - *Ngaiterangi, Ngati Ranginui and Ngati Pukenga* were represented through the different case groups. The criterion of Iwi representation reflects a commitment by the researcher to Kaupapa Maori research methodologies by acknowledging the important representative role that is performed by the Iwi in Tauranga Moana. As such, no group represented more than one Iwi. One further mainstream case group was selected to provide a different perspective from which to work within this research project. The four groups involved in this project included: *Waipu Hauora, Pirirakau Hauora, Toi te Ora Public Health and Whaioranga Trust.*

11.5.2 Research Participants - Kaimahi Hauora, Kaitautoko, Kaikorero and Kaiarahi Hauora

Once the groups for participation had been decided, individuals were included either as a recommendation through their manager or through the snowballing process. The snowballing technique is a sampling method used where research participants give the researcher the name of another person, who in turn gives the name of another person (Vogt, 1999). It is a useful qualitative technique which provides an ability to uncover aspects of "social experience hidden from both the researcher's and lay person's view of social life" (Atkinson & Flint, 2001, p.4).

A limited number of health leaders or *kaiarahi hauora* associated with other Hauora or health organisations were invited to participate. The purpose of the inclusion of the representatives was to obtain a diverse range of information about other important issues that may not be highlighted through discussions with case group representatives. For instance, a Maori health organisation may promote healthy messages to Kohanga reo whilst another Maori health promoter may be affiliated to a national health organisation. Another example is the involvement of the Maori representatives of the District Health Board. The involvement of these people was by way of the roles they held within their organisations as health

leaders. The involvement of these people in this project helped consolidate and compliment the information obtained from case group participants.

Once the involvement of research participants was formalised and the relationships with the case group representatives developed, it became obvious that conventional terminologies used to describe these people were inadequate. For instance, the case groups now became *Hauora,* literally meaning health. Also, the naming of positions for people involved in this research is itself a note-worthy aspect of the participatory process. Words were carefully chosen to reflect their position within the research relationship e.g. *kaikorero - kaitautoko - kaimahi and kaiarahi hauora.*

The importance of names and labels cannot be underestimated. They give expression and meaning to the context of the research that might not otherwise be adequately explained. For instance, Maori words such as hui and wananga help explain the importance of discussions, the way discussions occur and how those systems influence Maori research. The terms research participants and key informants were replaced with the terms *kaitautoko* (supporter) and *kaikorero* (the person that speaks[25]). The selection of these named positions helped address concerns with power relations emphasising the participative intent, power sharing and social constructivist intention of this research by using Maori concepts and ideas. For example, a kaitautoko or supporter does not occupy a superior position to the kaimahi. Their joint roles support the 'Whanau' in the widest sense of the word. For instance, in one Hauora a person was asked to participate who had not been involved directly with that Hauora for over fifteen years. However, this person had extensive historical and background knowledge of the group. Their role in the research was seen as an obligation associated with values generated from a collective understanding of Te Ao Maori, demonstrating the reciprocity expected in Kaupapa Maori research in support of all of the wider Whanau or Hapu. Kaitautoko may not be directly associated with each of the Hauora, but their assistance is called on from time to time. In respect to the *kaiarahi hauora*

[25] This term 'kaikorero' was adopted to highlight the equal power relations between the researcher and the research participant. The term was utilised to denote a conversational type exchange between two or sometimes three people at any one time.

(health leaders), this term was adopted to acknowledge the role of these people in the health sector, though their input did not directly influence the four main case narratives. Their involvement was crucial to ensure that the qualitative expectations of credibility as a Tauranga Moana wide research project were met.

11.6 RESEARCH PROCESSES

One essential principle of the Maori research processes involves kanohi ki te kanohi or face to face communication (Bishop & Glynn, 1992). Although, the contemporary understanding of the term suggests that meeting once may be enough - that is simply not the case in many projects involving Maori. In conducting Maori research especially with Whanau, Hapu and Iwi it is important to meet several times to build trust and familiarity. In this project, the principle of kanohi ki te kanohi was essential. Personal contact with the kaimahi hauora enabled the research to be conducted in a collaborative manner. These relationships were maintained through emails, phone calls, letters and numerous meetings.

11.6.1 Ethical Approval to Initiate Research

The Bay of Plenty Ethics Committee provided ethical approval for the research reported upon in this thesis (*see Appendix Two: Ethics Approval*). The Waikato Management School Ethics Committee also endorsed the ethical considerations guiding this work.

11.6.2 Affirming Connections

In preparation for this research, I talked informally with many people about becoming involved in this project. Once the research project was formally initiated, I contacted people officially with an initial phone call, followed shortly after with a letter inviting them to participate. For the case groups, an initial meeting was held to provide the potential groups with background information about the research project. During these conversations, many preliminary questions were asked about the purpose of the research, what the involvement entailed and a detailed information sheet was distributed (see *Appendix Three:*

Information Sheet). To illustrate, I met three times with one manager and once with the trustees of one group before verbal agreement to be involved was provided. With another group, I met once with the health promoter and then again with the Marae Chairperson. An official meeting and a conversation was scheduled once agreement to participate was provided. During these meetings, informed consent forms were distributed and completed before the conversations were initiated (see *Appendix Four: Informed Consent Forms*).

The process to invite individuals to participate in the research project as kaitautoko or kaikorero needed to be very flexible. This was to allow people to participate at their convenience. Most of these people were very busy and I needed to ensure that I was not imposing on their valuable time. Once agreement was reached to be involved, I liaised with people to provide background information about the project and to arrange to meet. In some cases, an appointment time was arranged and an interview conducted and completed in one meeting as it was the most convenient way for the kaikorero or the kaitautoko to be involved. In other cases, up to three meetings were held before a formal conversation was recorded.

11.6.3 Meetings, Conversations and Procedures

Meetings were arranged at times and places convenient to the participants. In some cases this meant visiting people at home or at work. On occasion, they came to the University of Waikato in Tauranga. The first stage of the process involved a review of the project and the revisiting of any concerns that could arise prior to the conversations beginning. A copy of the research documentation and a series of orientation questions for the subsequent conversations were forwarded earlier to participants if requested. There were two different sets of questions for case participants and kaiarahi hauora (*see Appendix Five for Schedule of Questions*). They served as a guide only and a degree of flexibility and spontaneity was invited in regards to questions and discussions. The meetings we had resembled what might best be described as conversations (Bishop, 1997a).

As I knew many of the participants personally and/or professionally, a foundation of trust already existed. Tauranga Moana is a relatively small city, which enabled the likelihood of getting to know most Maori people involved in Iwi, Hapu or regional development issues. The work I had performed in other areas such as business training and Hapu development also contributed positively to the research relationships. I had no research budget for koha for the interviewees, except when kaumatua and kuia were involved. However, I provided lunch on many occasions as a demonstration of my commitment to tikanga or the Kaupapa Maori research ethic of manaakitanga or hosting appropriately.

All case group representatives were asked to provide documentation to outline prior activities performed by the organisations, such as the mission statement of the organisation and the key terms of the reference for the organisation. In some cases, organisations also provided information about funding and contract details. Organisational representatives were free to give whatever information they felt would be useful for the research project. The documentation also provided accurate information about dates, names of people involved with the organisation and the types of activities that were undertaken in their roles as health promoters, key information about programme design and the types of models utilised for the health promotion activities. The various reports, letters, minutes from meetings and other forms of documentation were private records held by the groups that were not otherwise available if it were not for the research project. Where the documents were required for the day to day running of the organisation, a copy of the material was made with the consent of the respective managers and returned as quickly as possible. On some occasions, where information was historical, the researcher was able to keep the information for the duration of the research project. Formal requests for information were submitted to Te Puni Kokiri (Tauranga office) and representatives of the Smartgrowth[26] research project in Tauranga to obtain up to date information on Iwi statistics.

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[26] The Smartgrowth Study is a programme aimed at developing and implementing a plan for managing growth in the Western Bay of Plenty. This programme's social, economic and environmental goals are to be achieved in a sustainable way leading up to 2050 and are being led by Environment BOP, Tauranga District Council, Western Bay of Plenty District Council and Tangata Whenua, on behalf of the community. Smartgrowth is a brand developed in the United States during the 1990's. It arose after concern about loss of quality of life and prosperity, as a

While some groups varied with the type of information they provided, further questions were asked of those where information was lacking. In other cases, the documents provided in total (by all case groups) were sufficient sources of information to cover the main concerns of all case groups. For instance, two Hauora provided copies of their service contracts and the type of programme outcomes expected. These contracts were deemed to be standard approaches across all four case groups although the specific content of each contract may vary; there was a consistency in their basic presentation and formatting.

11.6.4 Workshop Rationale and Procedures

Representatives of the four case groups were invited to participate in a full day workshop about social marketing and Maori health promotion. The workshop ran for six hours from 9am to 3pm. The workshop was recorded on audiotape and a note taker recorded other observable details during the day, which were later collated into notes and workshop transcripts. The range of people included health managers and health promoters involved with the Hauora. The workshop provided a forum for the kaimahi hauora to discuss their ideas and views about the focus of the workshop session and the research as a whole. Seven people attended the workshop which was held at Pirirakau Hauora. The workshop involved the participation of at least one representative of each of the case groups, though some groups encouraged more people to participate on their behalf.

The workshops provided an opportunity for those involved to experience a process of transformative learning and critical reflection associated with any research design. During preliminary conversations with representatives of each of the Hauora, it became clear that many of the health promoters were not familiar with social marketing, although some of the organisations were involved in the delivery of health promotion activities on behalf of national and/or regional organisations who sometimes subscribed to an uncritical use of social marketing in their work. Consistent with transformative aspirations of Kaupapa Maori

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result of rapid urban growth and urban sprawl. In particular there were concerns about; traffic congestion, loss of open space, farmland and habitat, infrastructure costs and inner city decline. (source: http://www.smartgrowthbop.org.nz/what.php) .

theory, I provided an interactive workshop in which my growing understanding of the organisational critique of Western instrumental practices (as applied to social marketing) became part of the conversation about social marketing and Maori health promotion. A detailed manual was prepared for the workshop called *Maori Health Providers Workshop – Is Social Marketing an Appropriate Model for Maori Health Promotion?* (Ellis, 2003) This manual is included in *Appendix Six: Workshop Manual.* The first part of the workshop involved a whakawhanaungatanga or mihimihi session[27] to ensure that participants were familiar with each other and to build the trust so needed for critical, co-constructed work (Bishop, 1996b). A series of four sessions were conducted involving interactive exercises and designated reading from the workshop manual. They are outlined below.

Session One: Maori Health in Tauranga Moana

In this session, participants expressed their knowledge and concern about the serious condition of Maori health and wellbeing. Emphasis in this workshop, as in this thesis, was on the organisational responses/responsibility to this situation. A chronological overview of the historical and current activities, events and players involved in Maori health development in Tauranga was discussed. The session provided participants with the opportunities to review some of the earlier research findings obtained from pre-workshop interviews. All endorsed a desire to address their responsibility in a Maori way:

> *It's really about Maori ways of doing things. We do our best, but it has to be brought back. It has to be brought back to <u>our</u> world view of things (Workshop Two, 2003).*

Here is another example:

> *There has never been any doubt that these types of [Maori] models that are holistic and involved with a sense of wairua appropriate to our people so it is just natural to encompass it (Workshop Two, 2003).*

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[27] This means to establish relationships and usually aims to do that through whakapapa links. In this session, the whakawhanautanga session was also about reducing barriers to discussion and to allow the participants to share their thoughts openly.

These proffered concerns and expressions provided the basis for some reflective work together. The following dialogue about the words 'holistic' and 'wairua' helps illustrates how our conversations unfolded:

> ***Kaikorero Tuatahi:*** *[it means] holistic*
>
> ***Kaikorero Tuarua:*** *Beliefs and values*
>
> ***Kaiwhakarite:*** *Does everyone understand when we write holistic what that actually means? We are not just putting it up there as a term.*
>
> ***Kaikorero Tuarua:*** *I can put it up as a term, but it is more. Wairua, it is the* ***whole concept.***
>
> ***Kaikorero Tuawha:*** *Whereas some cultures see there is a difference, being that you are a vegetarian that you use herbal medicines, but you have no wairua attachment, there is a variety of different perceptions there, that are attached to that word and quite often it is assumed that Maori have the same view as Pakeha and [often] they do not.*
>
> ***Kaikorero Tuarima:*** *[holistic] is something that is organic, is that an outcome for us to use? As different community groups, we are different organisations and there may be not one term for or one description or one definition of that although we are able to describe holistic, as we need to in our services. I think the trick there is that other people describing our services.*
>
> ***Kaikorero Tuarua:*** *You know, that might have answered your question (Workshop Two, 2003).*

Open discussion was encouraged between kaikorero to help derive where possible the deeper meanings behind the phrases. Once this occurred, the words and meanings were drawn together and put within stars that were drawn on the whiteboard. This process continued until a collection of phrases, terms and words were placed on the whiteboard in the likeness of a 'constellation of whetu'. The use of this visual representation was deliberate. At the same time that the whetu were being developed a process of conscientisation was occurring. Through that process the importance of Te Reo Maori was emphasised. The meanings of words as carriers of values were demonstrated in our conversation. The choice to continue to use these words and a greater consciousness of their meanings endorsed the work of each participant and at the same time strengthened Te Ao Maori from which these words derive their meaning.

Kaikorero Tuawha: *Pakeha language for instance is the means to communicate whereas with Te Reo it's more a way to express your values, your value system. It is not just a mechanism to communicate its more of a mechanism to assure and express your values (Workshop Two, 2003).*

Kaikorero Tuarima: *Given that the language is that important, we all use two languages to actually try and use ahuatanga and kaupapa. We should actually use our language in a more productive way (Workshop Two, 2003).*

Kaikorero Tuarua: *Actually the more [we] talk about that the more I would rather go back to our Reo and use all those ways because mana connects from the past to now and we want to go forward. I would rather do that (Workshop Two, 2003).*

Session Two: Maori Health Promotion

In this session, participants engaged in a reading activity, taking turns to work through the manual. Once that exercise was completed, an open conversation drew upon various experiences of those in the room. Some people had been to the Public Health Association Conference in 1999, where the *Te Pae Mahutonga* model was first presented by Mason Durie and these people shared their experiences, which were greatly appreciated by the participants. The overall purpose of this session was to demonstrate that Maori health promotion exists as a discrete collection of principles and practices that sit alongside existing models such as the Ottawa Charter. The session provided the participants with an opportunity to learn more about Maori health promotion.

The six components of *Te Pae Mahutonga* were discussed in depth. Six card stars were placed on a large whiteboard to depict these components. These six components were overlayed with the concepts that were developed in session one from the preliminary research results. This process of linking participant ideas about Maori health concepts to an established Maori health promotion process helped participates arrive at a collaboratively achieved set of ideas, concepts and terms about Maori health promotion within the context of Tauranga Moana. With these concepts and ideas agreed upon, an understanding of Maori health promotion by the participants was constructed and then validated. The

constructed constellation of stars from the previous session helped illuminate the commonalities between the research-derived aspects of Maori health promotion developed by the participants and the *Te Pae Mahutonga* model. The constellation of stars created as a result of that workshop is included in *Chapter Twelve* as a research outcome.

Session Three: Fundamentals of Social Marketing

In this session, an explanation of the historical and conceptual development of social marketing was shared with the participants (see pp. 12-31 of the workshop manual). The session focused on transferring knowledge and concepts about social marketing to the participants within the context of the prior two sessions about Maori health development, Maori health promotion and their own health promotion experience. The topics discussed within this session included

- Social marketing origins
- Social marketing concepts e.g. marketing concept and consumer orientation
- Social marketing mix e.g. product and price
- Social marketing approach
- Social marketing appeals
- Social marketing critiques.

A detailed explanation of the definition of social marketing was provided in this session. Participants were given the opportunity to deconstruct, compare, discuss and contrast the terms and intentions of social marketing. Many other social marketing related concepts were discussed throughout the workshop; specific reference was made to the use of terms which contrasted both philosophically and practically with Maori approaches to health promotion.

Session Four: A Critical Reflection - Conceptualising Maori Health Promotion and Social Marketing

In this session, the participants were provided with the opportunity to discuss the issues discussed in the workshop as a contrasting set of ideas between Maori health promotion and social marketing. Some of the discussions centred on the differences between concepts, beliefs and assumptions about health advancement

with the two models. Comments were sought about the different procedures and ways in which human relations are organised within the contrasting models. Further discussions focused on the different use of labels, terms, practices and the values embedded in the procedures. This session determined, at least in principle whether the participants saw any benefit in the concept of social marketing, in light of their aspirations for Maori health advancement. This was a reflective exercise which required a critical analysis of the various types of models presented in the earlier sessions. The workshop concluded with a collaborative type resolution about the overall purpose and context of issues discussed during the day. The workshop in its totality provided a series of opportunities to

- Share preliminary research findings
- Construct collective responses to core issues
- Outline a chronological overview of health development in Tauranga Moana
- Develop collective concepts about Maori health promotion
- Learn about Mason Durie's Maori health promotion model – *Te Pae Mahutonga*
- Learn more about social marketing and
- Provide a forum for constructive discussions about the proposed merits of social marketing.

A series of post-workshop interviews were conducted with participants within a two-week period following the workshop. These interviews were crucial as they provided an opportunity for participants to reflect on the learning, conversations and readings that were provided during the workshop. Secondly, the workshop was an open forum and some of the younger participants were not accustomed to speaking out so openly. In the post-workshop conversations concerns associated with speaking out in forums such as the workshop were overcome. The collection of notes and workshop transcripts were collated and utilised to help construct the research findings in the following chapter.

11.6.5 Transcripts and Returning Transcripts

External transcribers prepared the transcripts. This approach was essential as I was not able to complete the task myself within the allocated timeframe of the research plan. In order to get an understanding of the comments in the interview, a check was made by listening to the tapes again to confirm the discussions transcribed and to check for any errors or omissions in the transcription. Copies of the transcripts were sent back to the participants and comments were sought in terms of any changes that were required. Approval by e-mail, verbally or in writing was required before the transcript was included in its raw data form for the research project.

11.6.6 Koha for Kaikorero, Kaitautoko and Kaiarahi Hauora

Koha is an acknowledgement of the contribution that one person makes to another person. While koha was not included in the original budget, funds remaining from the research project were distributed to the case groups and kaimahi as koha for their involvement. Each case group was given a koha as a gesture of appreciation for the collective input from their kaimahi and trustees. Individual kaimahi and kaiarahi hauora were also provided with a koha for their involvement in the research project shortly after the dissemination hui.

11.7 RESEARCH DISSEMINATION PROCESS WITH NARRATIVES

Before the case narratives were printed, a formal process of endorsement took place with each of the Hauora. All case groups formally endorsed the case narratives before they were included in the research report completed in 2004. Case group representatives and kaimahi hauora were given the opportunity to comment on the draft cases and request revisions or alterations before the final report was printed. When the final drafts were completed, they were given to trustees; senior managers and specific kaimahi hauora for proof reading before signing the endorsements for their inclusion in the report (see *Appendix Seven: Group Consent Forms*).

11.7.1 Ethical Considerations for Endorsing Case Narratives

Especially important in this research process was the ethical and cultural requirement to take the research back to the Whanau of the Hauora. By Whanau, I am referring to the kaumatua, kuia and kaiarahi hauora who helped steer the kaimahi of the Hauora along certain pathways in their official organisational roles as trustees. For instance, with Whaioranga and Pirirakau Hauora, I attended respective trustee meetings. On one occasion the hui was at night and I had dinner with them prior to the meeting. Two kuia at the hui were original trustees. This experience demonstrated to me how the western term 'trustee' fails to convey the importance of these women in terms of Hapu and Whanau matters. These two women were highly regarded amongst Whanau, Hapu and Iwi. Their responsibilities extend well beyond the formalised concept of the term *trustee* understood in western governance discourse. On another occasion, the Chairperson of the Hauora was positioned in Te Ao Maori as a mokai for the old people. The term mokai conveys a sense of service to elders. The term Chairperson, is a western position of power and leadership through delegated authority. This interpretation was contrasted with the way in which the role was enacted in this particular situation. In this respect, it was the kuia and kaumatua who held the power to approve or disapprove whether the stories of the Whanau or Hapu that were depicted in the case narratives were supported. The achievement of this approval is consistent with tikanga Maori. It is also a necessary precaution when exposing Maori processes to public scrutiny. The potential co-option of this information, for the further disciplining of Maori communities under neocolonisation remains a risk.

These types of interactions were not recorded in any formal way, but their importance in the process of this research as a whole cannot be underestimated. In these two situations, it was not so much the content or the words used in the case narratives that were of concern, as the Chairpersons and managers held the responsibility to ensure that those things were tended to.

In these hui, it was my conduct, the way that the research was positioned and whether the integrity of people was upheld that was of the utmost importance. Upon reflection that process was about reciprocity and accountability back to the

people (Bishop, 1994). On that basis it is only the people who are able to decide whether the research is valued and therefore valid, and with that decision making power, mana is often derived. According to Te Ao Maori, the place to decide future pathways for Whanau, Hapu and Iwi rests with particular kaumatua and kuia, and by performing these duties; the mana of the people remains intact. This phrase helps explain:

> *Part of being entrusted with knowledge is that you also accept responsibility of carrying that knowledge and using that knowledge for the benefit of the community* (T18: Kaiarahi Hauora - Tane, 2003).

11.7.2 Recommendations from the Research as Transformative Commitment

I have built on the work of Bishop (1996b) and Smith (1997) to emphasise a commitment to the importance of research activities benefiting those people whose lives are affected by the research. One method of achieving that responsibility involved the active reflection of findings through the presentation of recommendations to those involved in the research. This process provides an avenue for developing consensus about agreed pathways for transformative change. A number of recommendations were presented in writing and reviewed in collaboration with each of the Hauora. Some of the recommendations focused upon long-term career planning for their kaimahi to create a sense of long term planning for people development. This recommendation focused upon improving people skills in the field of Maori health in Tauranga and overcoming the need to continually recruit and retrain new people. It also highlights that whilst there is a pool of Maori health providers in the Tauranga Moana region, the skills base could continually be improved. For instance, there was a limited research skills base amongst people promoting Maori health. There are avenues available to improve those skills[28]. This research demonstrates that enhancing research capacity through Kaupapa Maori methodologies can help not only to improve research capacity within the community, but to create research processes that have

[28] As an example, the Health Research Council of New Zealand has provided career opportunities for emerging Maori researchers. The programme has been provided the opportunity for many aspiring Maori scholars and academics to research their potential as researchers. The programme has, and continues to ensure that Maori people are completing doctoral research programmes to help ensure that the research capacity of Maori health researchers continues to be strengthened. See www.hrc.govt.nz for further information.

immediate benefits for the participants and organisations concerned. This research can be done in such a way that the very process of research contributes to the vibrancy of Te Ao Maori.

In keeping with the transformative outcomes aimed for in this research, the findings from this process of interactive research do not only provide insight into organisational processes with which we concerned ourselves, it also provided ideas about how to address them. The research method provides useful pragmatic research information that was of immediate use. Some of the ways in which the information was beneficial included the gaining of a better understanding of the conceptual differences between health promotion and health development, a deep reflection on the values of the participants and their translation into organisational practices and importantly, experience in co-operative inquiry as a form of research that can be personally and institutionally empowering in a way that enhances Te Ao Maori.

In this mode of inquiry, the establishment of recommendations (in and of themselves) is not viewed as transformative unless there is some way that those recommendations can be enacted. As a result, most (not all) of the recommendations provided were supported with ways in which they could be achieved. Inadequate funding for health promotion was emphasised as a crucial issue.

The research demonstrated that Maori health providers are being under-funded and the perpetual cycle of under-funding is leading to a number of internal questions about their ability to perform with integrity in the context of an under-resourced institution. This is an issue that must be addressed as it puts all of their endeavours and aspirations for change at risk. It is an example where the uncritical institutional compliance with externally imposed risk/quality accountability measurement may satisfy funders. However this compliance puts at risk those employees who seek to meet the real and often urgent needs of their community regardless of whether these needs are recognised in the contract. The risk of under-resourcing the real needs of communities has implications for the

organisation and its staff, the sustainability of Te Ao Maori – and ultimately the wellbeing of the country as a whole.

In the case narratives, I sought to ensure that umbrella Maori organisations and funding bodies take on more of a responsibility to address these issues. Maori health providers in turn are being encouraged to provide a true indication of their actual costs to provide their services instead of relying upon a resource base that is fundamentally inadequate.

11.7.3 Research Dissemination Hui

In February 2004, a hui was held at Hungahungatoroa Marae in Matapihi, Tauranga to disseminate the research findings. All those active participants in the research and Hauora representatives who were not involved but who were located in the broader Western Bay of Plenty region were invited to attend. The hui was part of the responsibilities of a Kaupapa Maori researcher to report back to the community. This hui also contributed to ongoing transformative praxis. For instance, Maria Ngatai, a kuia from Ngaiterangi and Ngati Ranginui presented a korero about Maori health (Ngatai, 2004). Her contribution established a platform for discussion about health in a way that ensured accountability to the intangible notions of enhancing Maori health and wellbeing. It was also the first research paper she had presented. The second aspect of the hui provided the opportunity for the Hauora representatives involved in the project to summarise from their own perspectives how they saw the research and whether it benefited them in any way. This process was new to some of them and their input required nurturing. I worked with two of the Hauora to discuss the ways in which the information might be presented and the issues they might wish to discuss. The presentations also provided the opportunity for kaimahi to share what their groups were doing, which was important for many reasons. One reason was seen as obtaining useful information about future developments and networking opportunities. In my presentation, I provided a summary of the research project and I also highlighted the research concerns that emerged during the research. A series of maps are included within the case narratives (see *Appendix Eight: Map Disclaimers*).

In the final session of the hui, representatives from the University of Waikato and the Foundation of Research Science and Technology provided information about future research opportunities that were available for community groups, such as the Hauora. The presenters opened a doorway to new research opportunities for Maori in Tauranga. The hui concluded with a presentation by my whanaunga, Chanz Mikaere who created the artwork that is the cover of the earlier research report (see *Appendix Nine: Te Karanga Hokinga Mai - Explanation of Artwork*).

11.8 LEARNING NEW WAYS TO VALUE RESEARCH

At the beginning of this research, there was limited appreciation by kaimahi hauora of the way in which research could benefit their work. Research skills are perceived to be a specialist skill (in the way health promotion, accounting or management are also viewed as specialist tasks). As the research process unfolded, it became more evident that it is important for each of the Hauora to develop these skills within their own people. In part, through this research (activity, processes and outcomes), it was hoped that a greater insight into the benefits of engaging in research would be encouraged. One area in which this research experience enhanced the existing research base was to suggest that existing evaluation skills include other types of research outcomes, for instance to turn evaluation surveys into specific project reports with transformational intentions and outcomes. Some of the research tasks undertaken in this project provided capacity building opportunities particularly with respect to forging a greater understanding of research processes. Basic skills associated with interviews, transcripts, collective decision-making, research presentations and also proof reading draft case narratives became part of the research experience. Deliberate engagement with participative and transformational methodologies can enhance research skills and research knowledge, whilst simultaneously achieving some of the changes that are needed. More work in the development of both the interest in and the many possibilities of research as transformational activities were presented as viable projects for development in the future by all those attending the dissemination hui.

The reporting of research through the academic process helps position reclaimed knowledge and new knowledge about Whanau, Hapu and Iwi within established academic institutions. This research has helped ensure that stories about Maori which are written and endorsed by Maori, are available to Maori. Providing these types of narratives is a powerful way of sharing stories. Sharing is a way of learning and teaching. However, ensuring that these stories are approved with reflection on the potential outcome of their exposure remains a tension to be resolved by Kaupapa Maori theorists and researchers in the future.

11.9 SUMMARY

In this chapter I have outlined how and why Kaupapa Maori research methodology provides an appropriate set of research assumptions for this research. I outlined the links made between the critical theoretical associations of the early creators of this approach to research by and for Maori. I also outlined the relevant traits of qualitative research for this research and I considered the way these qualitative research techniques contribute to and align with Kaupapa Maori research methodology. The principles and protocols of research emerging from these discussions have influenced the research methods adopted in this study and the way that they have been adapted to suit the ethical and cultural issues emanating from the complexities of conducting Maori research.

The research methods adopted in this research include literature/document reviews, case studies/narratives, workshop/hui and in-depth interviews/conversations. From these methods derived the insights that were used to form the four case narratives about: Whaioranga Trust, Mana Manaaki, Pirirakau Hauora and Waipu Hauora. Alongside these organisational stories are the voices of kaiarahi hauora, seen in this research as health leaders in their own rights. The case narratives and the conversations of the kaiarahi hauora combined as one, form the basis for which narratives of experience are drawn together as a means of contribution to this inquiry. This research process demonstrated the validity of the claim that research generated from a commitment to the values of Te Ao Maori will provide both insights and outcomes that are deemed legitimate in the Maori communities I worked with. My simultaneous researcher position as

both insider and outsider and my respect for the principles of Kaupapa Maori methods help to address the concerns of the research community associated with unequal power relations within this research experience.

CHAPTER TWELVE: MAURI OHO, MAURI TU, MAURI ORA - THEORETICAL REFLECTIONS AND NARRATIVE RESEARCH OUTCOMES

"Any changes we achieve will only be truly transformational if political, economic and cultural decolonisation are seen as inseparable"
(Jane Kelsey, 2003)

12.1 INTRODUCTION

Research outcomes associated with investigating the appropriateness of social marketing for advancing Maori health are discussed in this chapter. This chapter also presents responses to the sub-questions which focus on the future aspirations and ways in which Maori health can be enhanced within Tauranga Moana. These sub-questions elaborate upon the main research question in ways that would support the emancipatory intent of the research process discussed in *Chapters One* and *Eleven*. The responses provided in this chapter are drawn from the four case narratives (see *Appendix Ten*) and the kaiarahi hauora conversations. The recognition of the case narratives as *research outcomes* (as well as a research method) is central to the decolonising effects Kaupapa Maori research methods seek to advance. This chapter, thus, reports on the responses of participants and also demonstrates the validity of the process of Kaupapa Maori research as a process of conscientisation and as a process of invigorating Te Ao Maori.

This chapter is presented in four sections. The first section responds to the primary research purpose - the investigation into the appropriateness of social marketing for advancing Maori health. The remaining three sections are presented as reflexive strands of Kaupapa Maori theory; reflecting on the creation, conduct and conscientisation achieved through the workshops that generated the four case narratives. These sections also address the sub-questions that have not already been reflected on in earlier chapters. In keeping with my commitment to shape an approach to research that invigorates Te Ao Maori, these reflections are represented

through the use of the concept *mauri*. Mauri pertains to the life-force and ethos of things and is important to those that uphold it (Pere 1984). In the lexicon of social scientists, mauri is an essential aspect of the ontological foundations of Te Ao Maori. One of the kaiarahi hauora spoke of mauri as something that was alive:

> *I think that there's a whole world within – a whole natural world that we don't take sufficient account of, that whole place of – you know what is a mauri? People have a lot of thoughts about mauri and a whole lot of definitions, but you know to me, we look at mauri and you hear it talked about by the old people – it actually is an entity in itself, and a mauri can actually be alive and functioning but it hasn't found a person to reside in and if you can sort of somehow tap into that, well that in itself is a tremendous source of knowledge* (T18: Kaiarahi Hauora - Tane, 2003).

I wanted to generate a sense of mauri in this research by exploring its potential to awaken or endorse the inner consciousness about being Maori among participants. Firstly, I refer to the concept *mauri oho* as *conscientisation* – seeking to reflect the notion of awakening and coming to know and acknowledge the impact of social domination and domestication. This approach echoes the work of Paulo Freire decribed in Chapter *Four*. The second cluster is *mauri tu* – referring to *resistance*. This concept helps articulate the organisation of Maori health development in ways that reflect being Maori and resists being assimilated uncritically into westernised notions of social organisation. This approach echoes the decolonising activities advocated for by Smith (1999) and Bishop (1996), and articulates Kaupapa Maori research methods as described in *Chapter Eleven*. The third cluster of thematic responses aligns with *mauri ora* - representing enduring wellbeing of the inner essence and *transformative praxis*. This theme is the culmination of my adaptation of the insights of social constructivism and Kaupapa Maori research methodology in the participatory action research method devised for this research. These three themes: *mauri oho, mauri tu* and *mauri ora* must be read as *one,* as fluid and as cascading across all three phases at different times, sometimes all at once. Quotes and excerpts selected from the case narratives demonstrate the insights and contributions from participants, their changing perceptions of social marketing, the centrality of Te Ao Maori to their identity and their determination to be more reflective about the potential emancipatory or domesticating effects of the tools used in their organisational actions. However, the limited space available and the constraints of the

lineal process of written documentation prevent a more complete representation. Therefore, this report can only be a limited reflection of the rich integration of insights drawn from the case narratives.

12.2 SOCIAL MARKETING

In this section, conversational excerpts are selected to represent participant responses to a collaborative investigation into the appropriateness of social marketing to enhance Maori health and wellbeing. In this section, responses to sub-questions about social marketing fundamentals, the potential contribution of social marketing to Maori health promotion and the similarities and differences between social marketing and health promotion are presented. The research participants and I began our inquiry with an examination of the concept of social marketing and its potential relationship with existing Maori health promotion people and their activities. Each participant brought varying levels of experience and insight into this inquiry.

12.2.1 Social Marketing Fundamentals

In *Chapter Ten*, a detailed review of the literature and works of social marketing critics and advocates was presented. Themes drawn form this review were shared with the participants. In this section of the thesis, I discuss their responses to those themes along with their responses to the earlier themes discussed in *Chapters Two* through to *Chapter Nine*. In the workshop participants were asked about their existing knowledge and understanding of social marketing. Many of the participants had heard of marketing, but not social marketing. One kaikorero commented:

> *I [have] never looked at health promotion and marketing together before, I have never considered it at all really, but when you look at it I can see how it could fit* (Pirirakau Hauora Case Narrative, 2004).

This question was not asked with the intent to merely capture and report a gap in knowledge about social marketing among health workers. In keeping with the intentional educative aspect of this research, the question was asked within the context of an intensive workshop that provided material about social marketing, its precepts and promises. With an elaborated understanding of social marketing, kaikorero were invited to consider whether they believed that it would be possible to

replace or elaborate their existing models of health promotion with social marketing. One kaikorero said:

> *I think I can see social marketing fitting into what we are doing* (Pirirakau Hauora Case Narrative, 2004).

However, an apprehensive kaikorero suggested:

> *It's hard to take that model [Maori health promotion] away from our people, it would be such a mission, because that's basically who they are. We are different* (Pirirakau Hauora Case Narrative, 2004).

Highlighted in the workshop was the concept of voluntary behaviour change to which social marketing subscribes, a concept consistent with the respondents understanding of Maori health promotion to which participants were already familiar with:

> *All we could ever hope for is voluntary behavioural changes. We could sit somebody down in a chair and brain wash them but at the end of the day when they leave it is still up to them whether they take on that brain washing. So, everything revolves around that comment [voluntary behaviour change] really* (Pirirakau Hauora Case Narrative, 2004).

The workshop demonstrated to the participants that the social marketing model includes a number of concepts such as 'market' and 'marketing mix'. The marketing mix includes four elements; price, promotion, place and product. When adopting a social marketing framework, not only is the lexicon associated with the marketing mix implied but the concepts conveyed through this lexicon are already assumed to be taken for granted. 'People' are already conceived and categorised as 'markets'; 'purchasers', 'providers', 'customers' and 'suppliers'. The extent that this lexicon and its values are already embedded within the participants consciousness was demonstrated by one kaikorero who asserted that, *'people are a market for us as a provider'* (Whaioranga Trust Case Narrative 2004). And from others:

> *I suppose they are a market because without the needs of the people we wouldn't even be here and its funny you ask me that because one of the tangata whaiora said to me, "If I wasn't so sick you wouldn't be here"* (Whaioranga Trust Case Narrative, 2004).

> *Well they are [a market] in a way, well this place wouldn't hold a contract if it wasn't for our Whanau or Hapu they are our clientele* (Waipu Hauora Case Narrative, 2004).

Participants were provided with an opportunity to articulate and reflect on the articulation of 'ill people' as 'markets', in fact, markets of illnesses through which the services (and jobs of the participants) depend. Within this scope of analysis, a critical reflection emerged. One kaikorero went on to say that while it is possible to see whanau as a market *"it doesn't sound good"* (Whaioranga Trust Case Narrative 2004).

The example above demonstrates that through conversation we demonstrated not only that the use of marketing terminologies is becoming more naturalised in the area of Maori health but that it is possible to question this. The conversations went on to contemplate the limited opportunity for this type of reflection and the proposal of other possibilities under the current funding regime:

> *There is no big expectation that we would outline the type of approach we would adopt in terms of practices or that we actually align with communities* (Mana Manaaki Case Narrative, 2004).

One kaikorero expressed her long held concern that the name of organisational positions should accurately reflect the roles and responsibilities being performed within the organisation. To her, these labels conceal the most important aspects of the mahi, making them invisible – and perhaps un-resourced. She

> *never liked 'health promoter' and that coordinator was better than promoter or facilitator. But, social marketer sounds flash and it doesn't really sound like 'health'* (Waipu Hauora Trust Case Narrative, 2004).

In response to an invitation to reflect on the differences and similarities between the use of the word 'social marketer' and 'health coordinator/promoter', participants expressed a degree of apprehension:

> *You couldn't really think the two people are the same thing or that the two names were the same, 'social marketer' and 'health coordinator', [social marketing] sounds like they are out there advertising and promoting, advertising kind of like what the health promoter wants*....(Waipu Hauora Case Narrative, 2004).

The responses above are chosen for this chapter because they are typical of the responses more fully presented in the Case Narratives (in *Appendix Ten*). These responses demonstrate that participants in this research who are employed by these organisations are clear about their identity as Maori but who, in the interest of pragmatism have, to a large extent, already accepted and integrated a market orientation as the organisational metaphor into their work to advance the wellbeing of their Whanau. With an opportunity to reflect on this phenomenon, they were able to articulate inconsistencies and risks, and restate their aspirations for the manifestation of Maori concepts as essential to Maori wellbeing. In doing so, they too were participants in invigorating Te Ao Maori and thus demonstrating the effectiveness of the participatory process as both providing simultaneously descriptive insight and transformational commitment and information demonstrative of the emancipatory process.

12.2.2 Negative Potential Implications of the Uncritical Uptake of Social Marketing

The assessment by participants of the appropriateness of social marketing as a tool for Maori health development was tempered by a range of potentially negative implications. One kaikorero was concerned with retaining Maori ways of thinking about health and thought that there was a likelihood that social marketing could, *"take over the focus – our reason for being here"* (Whaioranga Trust Case Narrative 2004). Another participant emphasised the merits of the tool, but highlighted the need to retain a Maori way of thinking:

> *I think that management should at least have a look at social marketing, [along with] all the relevant stuff, but not to forget that we are Maori and that we have our own way of thinking* (Pirirakau Hauora Case Narrative, 2004).

And also:

> *I don't know, I would have to have a really good look at it and make it a bit more kaupapa Maori and a bit more acceptable to the situation that we are working with* (Pirirakau Hauora Case Narrative, 2004).

The adoption of social marketing as a tool created apprehension about the actual beneficiary of implementing social marketing. In one of the conversations a thought

provoking question was articulated: Is it the social marketer or the community who benefits? A social marketer might be an individual person or an organisation. For example:

> *Social marketing to me is like taking all those fundamental things and trying to capitalise on them you know what I mean. You take all those values that people have and you try and portray them in a way that looks really positive to people but they [the people] don't get the benefit from it, it is the marketer that does* (T34: Kaiarahi Hauora - Tane, 2003).

> *Social marketing - there is too much fragmentation coming into it, if you are looking at social marketing from a Health Sponsorship Council point of view, their brands are all that count; from an ALAC point of view, their brands are all that count; from a SPARC (Sports and Recreation New Zealand) point of view their brands are all that count* (T34: Kaiarahi Hauora - Tane, 2003).

Markets are, about selling products and services. In the market orientation to the illnesses of Maori, expressed in *Chapter One*, Maori emerge as a lucrative market, and the social marketer is just one of many professionals finding a market niche to *exploit*. This is the way of markets. It is for this reason that I have taken up a different way to depict a commitment to Maori health advancement – a way that acknowledges the seriousness of the illness and morbidity experienced by Maori and the social influences that diminish wellbeing, into a method that illuminates and endorses the active assertion of Maori-ness and a growing resistance to the imposition of techniques that diminish Te Ao Maori – the source of Maori wellbeing. The intentional expression of Te Ao Maori is demonstrated by kaikorero hauora who spoke about the erosion of tikanga and the diminishing of the fundamental principle of reciprocity displayed by Whanau involved with some of the health programmes and the very serious implications this has had upon the Hauora and their ethos. The following korero demonstrates:

> *I felt that our people had taken advantage of us, there were things that we have to pay for, other than the kaumatua and kuia, you would very seldom get koha* (Whaioranga Trust Case Narrative, 2004).

The emerging failure by people to acknowledge the importance of goodwill and reciprocity in this way is contributing to the erosion of *aroha*, which is a binding ethic between extended Whanau collectives (not just individuals). In the context of this study, the erosion of reciprocity (as a core Maori value) was symptomatic of a changing socio-cultural environment which explained why people thought negatively about the proposed benefits of social marketing. But ironically, while there was recognition of the diminishing effect of a market mentality, pragmatism generated compliance as the following excerpt implies:

> *While I would think twice about social marketing... I think it is just the climate of the day and we've got to move with it (*Whaioranga Trust Case Narrative, 2004).

As the reflection on the principle of an increasing market orientation progressed, the connection between the role of the Government as the funder, empowered through various health reforms, came under scrutiny. One kaikorero discussed concerns related to government interference and increased surveillance under the proposed social marketing regime. For instance:

> *It looks a lot like how I approach my job anyway, but if we were to take it on as a model we would risk having the Government tell us who the target is, and how to do it, like 'we want you to work with this age group of kids and for this we would really like you to look at kids that were expelled from school or drug addicts instead of just saying like our contract at the moment is targeted to those aged between 15 and 24 for the whole Western Bay of Plenty. If you took on this structured [approach], then it opens up the Government to really have input, because we report back to the Ministry* (Pirirakau Hauora Case Narrative, 2004).

But government intervention was not the only concern that was generated from this reflection. A series of concerns arose about the business-oriented discourse of social marketing. Claims of social marketing's efficacy were balanced by more unfavourable impacts:

> *"Marketing"! I don't like that word marketing, because it implies the use of profit and that sort of thing and you won't do it unless you've going to make a profit, which means the service can actually be cut down and that is the wrong approach* (Whaioranga Trust Case Narrative, 2004).

The process of learning and consciousness raising through the process of conversation and questioning was successfully demonstrated by an increasingly deeper delving into the lexicon of markets. Whether these terms could be applied to Maori health promotion demonstrated ambivalence. For instance, while for some, 'Hapu' could be seen as 'a market', one kaikorero reflected:

> *But I don't know whether I would use [market]* (Mana Manaaki Case Narrative, 2004).

It was agreed that that market lexicon was well established in their work as health promoters. These terms

> *are certainly in the contracts. You've got targets. They don't use that word officially, but they say that's your market* (Mana Manaaki Case Narrative, 2004).

Whilst social marketing terms were being used by participants prior to this research, the opportunity to reflect on this situation allowed the articulation of a concern about the ability of Maori health workers to work with people through the vehicle of Whanau and Hapu, which one kaimahi hauora acknowledged was being severely compromised. For instance:

> *What happens is that in breaking it down that way and servicing it that way, it further disempowers or disables our opportunities as Maori workers to work with the people at the kainga so you know when we in the past have been able to work with a lot more flexibility, that whole target group is Maori and we would only take delivery of our programmes to Maori, not just to the tamariki and not just the rangatahi and all that. The whole motivation is quite deliberately identified as targets that clearly we need to market to* (Mana Manaaki Case Narrative 2004).

A further question referred to the way in which an established market discourse will facilitate the further segmentation and prioritisation within markets according to the needs of various stakeholders. Where the Government is positioned as a key stakeholder, funder or customer – orientation to the concerns of the Government of the day – rather than the needs of the people can be more easily prioritised. For instance, if a programme entails funding by a certain drug manufacturer, market segmentation becomes an even more direct subjugation of Whanau needs to manufacturer opportunity. Therefore, the opportunity to explore these possibilities

was based on the proposition that Maori are the most health deprived and on that basis they should receive more resources to combat ailments. For example:

> *You know that your argument in this organisation is to capture that market* (Mana Manaaki Case Narrative, 2004)?

The excerpts of conversations provided above demonstrate recognition by participants that a passive compliance with a market metaphor reduces the health dynamic to one of consumers, products and services targeted to meet the interests of various stakeholders – in which Maori, as individuals or collectives are often positioned as a vulnerable stakeholder group. One response to this analysis is to accept the market metaphor and to invigorate Maori in a more rigorous harnessing of this process. In this event, based on the statistical evidence provided in *Chapter One*, Maori should be receiving more resources to focus upon Maori health needs in terms of service delivery and access to the market products deemed to alleviate the conditions that afflict Maori. If the market model is not to be seen as a cynical opportunity for profiteering, but a vehicle to deliver Maori health, then the social contributors to Maori 'illhealth', in terms of housing, health, and employment, as discussed in *Chapter One*, should also be perused with some vigour.

12.2.3 Positive Responses to the Potential Use of Social Marketing

A number of participant responses demonstrated a positive disposition to the use of social marketing. This excerpt highlights that for one participant, the model had some credibility because it had similar features to the ISO 9000 model, with which this kaikorero was familiar.

> *It reminded me a lot of ISO, the planning and satisfying your clients and customers and how do you do that. It had to be measured to analyse your improvements. I think it is a good thing* (Waipu Hauora Case Narrative 2004).

The same kaikorero hauora indicated that she had prior knowledge of marketing principles and as a result the use of marketing was viewed as appropriate. For instance:

> *I think it is good to market. I feel like I am marketing when I put out my flyers. I feel I am marketing in some way, when I try to get people involved in whatever I am*

doing, I feel it is right. My thinking about marketing is you go out there and market your organisation and promote and tell them what it is about (Waipu Hauora Case Narrative, 2004).

Two kaikorero thought the model had some appealing features. One comment related to its clear set of processes:

It's clear and its processes have a goal, you know right there what you're trying to achieve and how you're going to do it and what you need (Pirirakau Hauora Case Narrative, 2004).

One kaikorero saw financial benefits associated with implementing social marketing. The kaikorero reiterates:

You know when you talk about going out and making money – business wise, being business minded. I could see the sense in [social marketing] (Whaioranga Trust Case Narrative, 2004).

One kaikorero discussed the adoption of social marketing and explained that these types of tools are already being adopted and that it

would be an improvement, especially the promotion side of things. We are using it in a way, the venue, the budget, who we were targeting and our target age group (Waipu Hauora Case Narrative, 2004).

One kaikorero thought the social marketing model was an honest tool. For example:

I can accept when people say I got the latest profit out of this, I can accept that, I find it very difficult for people to say things like the alternative "this is going to help our people, we are going to improve". I hate to be negative but I like the social marketing approaches and it can be useful. Let it be another option where our people have to choose the tools (T12: Kaiarahi Hauora - Wahine, 2003).

While some participants expressed significant concerns about the intensification of a market orientation to Maori health development and that these concerns were amplified as the conversations progressed, for others, the market model holds great potential. For them, the elaboration of the market model with a social dimension

provides the opportunity for adaptation that will provide consistencies with Maori concepts and aspirations and thus could be a useful contributor to Maori health development.

12.2.4 External Influences Upon the Conduciveness to Use Social Marketing

Conversations about social marketing and its possible benefits that were generated by participants in this research were tempered by insights into the influences of the external environment. These influences were seen as significant impediments to bringing about significant social change. The changes that have occurred in the environment: socially, politically, culturally and economically have had enormous impacts upon the types of health related activities that can be put into place by Maori health providers. Given this situation is a reality within which the research participants apply themselves, social marketing appears as a pragmatic addition to the tools already in use.

> *The environment is conducive to looking for that sort of thing* (Mana Manaaki Case Narrative 2004).

This pragmatism is driven by the reality of the predominance of market strategies successfully undertaken by corporations whose products are potentially detrimental to the overall wellbeing of Maori. The strategy following from this analysis is to play the game better.

> *I think its just me fighting against Pakeha, we're fighting against these marketing strategies, we are fighting against Tobacco companies and then Lion Red, so to me the only way to market it is to 'out-market' them...*(Mana Manaaki Case Narrative 2004).

Kaikorero suggested that social marketing encouraged them to address marketing campaigns presented by large companies by becoming more familiar with marketing tools and to use these tools as a combative approach within the arena of health promotion.

The participants in this research demonstrated diverse responses to the potential of social marketing to serve as a tool for Maori health development. For all, the

embedded concepts in the tool warranted some critical reflection. For some, this generated a determination to ensure that any social marketing model should be consistent with Maori concepts and aspirations. For others, the reflections provided an opportunity to express concerns and challenges that drive to the heart of the reconfiguration of health as a market product rather than a process of life generated from the values associated with Te Ao Maori – a world in which a human person is considered as a spiritual being connected to others, in the present, the past and the future. A concept deeply undermined by the reconfiguration of the human being as a market consumer or provider, with accountabilities determined by stakeholders as diverse as the Government, local bodies, other funders, the manufactures of drugs and remedies, service providers, consultants and marketers.

These more radical challenges were expressed as concerns about the differences in worldviews expressed by the young and the old in terms of health, and in terms of what each of the Hauora can offer their people. For the old people, reciprocity is a key facilitator of community. Koha is its expression and its material manifestation. Young people do not seem to hold these same views. A market model may provide choice, diversity and even freedom from the obligation of reciprocity. The difficulties that come with the impressions and expectations of youth are problematic for Hauora kaimahi. To illustrate:

> *A lot of them have been brought up in cities and they've lost that and then they come home and they expect [a hand out]. You know what I mean and the need is there definitely, but we do not have to go so far as an organisation that we make them dependent on us* (Whaioranga Trust Case Narrative, 2004).

In this example, the returning urbanised Maori accept the generosity that comes from Te Ao Maori, but do not understand the obligations that are associated with it. Such a clash within a culture is unsustainable. The tension generated from this clash may well provide the energy to invite a deeper understanding of Te Ao Maori for those coming from the cities in which the market is the vehicle for exchange. The tension is palpable in the expression of the participants.

> *I am still with the old people and I'm torn between young and old so in a way you try and compromise but is that any good for the organisation* (Whaioranga Trust Case Narrative, 2004)?

These responses indicate that the tikanga base that was once there is not as strong as it used to be and this gap is contributing to a break down in the reciprocity between kaimahi and tangata whaiora. The erosion of these practices is negatively affecting the Hauora and requires a response to ensure sustainability of service to whanau. For some kaimahi, social marketing may provide a means to address this tension. For others, the reflection on the potential of social marketing to assist them in their mission to enhance Maori health has also been an opportunity to reflect on the erosion of Te Ao Maori, an erosion of the source of Maori wellbeing that is deeply implicated in the health status of Whanau.

Despite the complexity of the situation, pragmatics appear to rule the day. Changes in the health sector and to health reforms (as outlined in *Chapter Six*) have contributed to a sense of inevitability to adopting social marketing. For example:

> *I know we have to go there. I feel that we have to go there. We're doing it now. It's just finding the process that suits our values, finding the process that fits in with the people you see, your Hapu, your Iwi, finding the process. I know we have to use it, you can't get away from it, we're doing it now and I think this is where our young people like yourself – it's your responsibility* (Whaioranga Trust Case Narrative, 2004).

> *It's the reality, but then again you know how everything is changing there might come a time when that's all you can be because our young people it's the language they speak* (Whaioranga Trust Case Narrative, 2004).

12.2.5 Social Marketing Labels and Terms

Several conversations among participants demonstrated what could be deemed a particular understanding of the meaning of words, terms and labels – which has led to an increased consciousness in their use as part of the construction of the reality within which Maori health development takes place. These conversations demonstrated a variety of opinions and concerns, tensions and paradoxes. One outcome of this research is the activation of critical thinking. While some participants would be happy to leave this philosophical work to kaumatua, others recognise that this work must be part and parcel of their responsibilities. The variety of responses to the reflective aspects of the research process generated a focus on words and their

meanings. For instance, one kaikorero felt *"most uncomfortable"* with some of the social marketing terms (Whaioranga Trust Case Narrative 2004). Kaikorero thought that the terms could be changed to fit more comfortably within the Maori context. For instance:

> *I think the terms could be changed, I was fine with the concept [that] people are a market but if you found a word to match that then the rest of us might be quite happy with* it (Whaioranga Trust Case Narrative, 2004).

> Instead of saying 'product' you'd say it's 'the goods'. It's just switching the words to something that they can adapt to. Anything can happen from just doing that...*(Pirirakau Hauora Case Narrative, 2004).*

One kaikorero was concerned with the predominate use of commercial words:

> *The words you used for that whole part of the workshop were business type words, they were commercial words and commercialism and business means profit and I don't know what it is like working for the University, but the rest of us aren't there for profit....It would be freaky alright if you turned around and said Pirirakau market* (Pirirakau Hauora Case Narrative, 2004).

Other Maori health promoters were interested in terms that reflected Maori words, for example:

> *Tangata whaiora is a lovely way of putting it and I can live with that as a Maori you know, but if you say the 'customer' or a 'product'....I think "Oh please!!!"* (Whaioranga Trust Case Narrative, 2004).

A kaikorero was grateful for the input made by kuia regarding matters with the appropriateness of words and tikanga. For instance:

> *The role [kuia and koroua] play is to focus you back on where you are and what you are doing* (Whaioranga Trust Case Narrative, 2004).

The potential for the uncritical inter-changing of terms was an issue that arose during the conversations. The kaikorero related the use of marketing terms such as client and customer to be, *"just terminology in the Pakeha sense"* and that some explanation needed to take place for others to understand that (Waipu Hauora Case Narrative 2004). It was clarified that:

Client or customer means whanau and the same [applies] for the whole meaning to social marketing and we were already changing words aye? ...Taking words out and that was just so it was easier for us to understand (Waipu Hauora Case Narrative, 2004).

Another excerpt suggests that there was limited time in the working role of health promoters to explore the in-depth meanings associated with the concepts and models that were used. For instance:

When we are out there doing health promotion, we don't think 'what does health promotion mean'? I mean it is good to know the definition of health promotion or social marketing. But when you are doing your work, we don't get time to think about that (Pirirakau Hauora Case Narrative, 2004).

The issue of changing terms extended into a deeper discussion about the concept *profit* in the social marketing model. Further responses were presented:

A lot of people were jumping up about the money side of things, but you can easily do away with the profit thing, you can say rather than getting paid you are getting knowledge or whatever. There are [also] other ways of getting around that...The word profit is related to money. They think because it is all that they want to make is some bucks. People will ask what you want to make bucks for? You're just trying on some of those other technical words, they'll get mixed up. I knew we were talking about people so it wasn't a problem whereas the others sounded like they were talking about money (Pirirakau Hauora Case Narrative, 2004).

The notion that profit is about money or a substitute for money or some other value then yeah.... I mean you could change profit to social profit (Mana Manaaki Case Narrative, 2004).

Although some participants demonstrated concerns with the way in which social marketing adopted the use of the term 'profit', there were also some respondents who resolved that the concerns with this association could be alleviated by changing the word profit to *social profit*.

Some participants demonstrated further concerns with the uncritical use of social marketing concepts, highlighting in the process a deep concern for the international origin of the model. For example:

> *Say someone from America came in and tried to give us that model it could quite possibly be social marketing, it may become a really money oriented thing just like any other business. I think if this was to come into Maori health, it would have to be run by Maori, but even then you would have to find the right person so that they are not money grabbing politicians like they have had in the past that were pro-Maori apparently* (Pirirakau Hauora Case Narrative, 2004).

This sense of concern was further articulated within the context of a discussion about the appropriateness of aspects of the social marketing model for the purposes of 'promotion'. However, social marketing was not necessarily seen as an appropriate model overall for Maori health development. The following expression illustrates:

> *I don't see any problem marketing services, marketing what you are doing and developing other services, that is the idea that is becoming a lot more flexible with marketing things that you would like to see happen but, "Marketing, I don't like the word marketing, because it implies the use of profit and that sort of thing and you won't do it unless you've going to make a profit, which means the service can actually be cut down and that is the wrong approach"* (Whaioranga Trust Case Narrative, 2004).

One kaimahi hauora was highly concerned with the social marketing tool. The following excerpt demonstrates that although the goals of Hapu were extensive in their collective aspirations, those aspirations were not viewed as being the basis upon which to necessitate the adoption of the marketing model. In his view, *'marketing'* was a concept many of the Hapu would be suspicious of – and unlikely to generate the information that is being sought:

> *If you go to them – talking about marketing and this is in some way marketing because you're marketing the concept of the claim. And it never worked and since then my experience too – I mean I have a resource consent application that comes in and it's for Omokoroa, so I go to the koroua and he spent a lot of time there and so on and so I put him in the car and we go for a ride. And so, there was an opportunity to take these old fullas out for some fish and chips and go down to Plummers Point*

and you know – we'd spend most of the day there, but in the process we'd go and do the job. And the korero that came – would come out from them was amazing. When you put things before them they can't answer you – or won't answer you, so I'm a little bit suspicious of something called marketing. I think you can achieve what it is that you want – I'm not sure about the other Hapu - but you can achieve, but you need to think about how you encourage them to pass on information (Pirirakau Hauora Case Narrative, 2004).

Other concerns about an uncritical uptake of social marketing were located in the context of decision making processes within the Hauora, processes which were guided and protected by kaumatua and kuia within the community. They, in turn, were often expected to act as guardians of the Hauora kaupapa. For instance, when participants were asked whether there would be any trade offs associated with the use of social marketing, one kaimahi responded:

No. Not at the moment and why I say that is the people won't let you (Whaioranga Trust Case Narrative, 2004).

The same kaimahi hauora commented that the ethos of Hauora kaupapa would be protected because the ethos and expectation of inclusiveness inherent in the way in which Maori health services were provided continued to prevail. For instance:

[Everyone has] got to be included in the planning, the decision-making – the young and the old. The idea is to all come together and we're great for hui and we have to come to a consensus – not everyone will agree (Whaioranga Trust Case Narrative, 2004).

These two comments demonstrate that there is an automatic process of accountability that appears to exist within the way in which Maori people interact with each other in their work to ensure that decisions made in the interests of the Hauora and the wider community will be conferred and endorsed by the people, in the interests of the people. When participants were asked about the potential implications of social marketing terms such as 'place' and 'product' and how they might affect the kaupapa, the responses indicated that there would be implications.

The location of the Hauora within the marae complex contributed significantly towards an expectation placed upon the kaimahi hauora to work from within the premise of living concepts such as *taha wairua* and *taha hinengaro*. Although, these concepts derived from a living and thriving sense of Maori community, the specific terms included within health promotion contracts, supported the ongoing use and adoption of social marketing terms. Nonetheless, the fusing of two different sets of concepts, taha wairua and social marketing demonstrated some difficulties as the following excerpt suggests:

> *I think that is hard, because we are based on the marae and whenever we hold a hui, we use our tikanga Maori...that is where we are at and we are on a marae and a lot of hauora are not on a marae* (Waipu Hauora Case Narrative, 2004).

Emergent ideas consistent with Te Ao Maori, such as *tino rangatiratanga* or community ownership, provided a particularly strong principle of practice for Hauora and helped provide a context from which contrasting views were acknowledged. A response by one of the participants highlighted that

> *the principles behind [social marketing] were different* (Whaioranga Trust Case Narrative, 2004).

12.2.6 Organisational Implementation Issues

Participants were asked whether they would adopt social marketing and/or whether the potential adoption of social marketing was subject to some form of alteration or modification. One kaimahi hauora demonstrated, as a result of being given the opportunity to explore social marketing that in her view there was a possibility that social marketing could be useful.

> *Now that I have looked at social marketing, I am pretty much social marketing the programme. I have picked the target group, I have worked on how to try and help that target group, I haven't really gone through costs and pricing and that part of it, but I am sure if I sat down I would probably have to (Pirirakau Hauora Case Narrative, 2004).*

Another kaikorero considered the potential appropriateness of social marketing for supporting Maori health advancement within the context of being one tool of many that was available. But, whilst there appeared to be receptiveness towards the use of

the model, its receptiveness appeared unlikely unless a convincing argument about its use was presented to entice management of its benefits. To illustrate:

> *I think it is another extra tool to come on board, I would be quite happy to undertake the whole exercise. In terms of developing the social marketing approach further and applying it, to see how it would go. Whether we could actually implement it internally? I can't guarantee...[that we would] (Mana Manaaki Case Narrative, 2004).*

Some of the excerpts emphasised that the implementation of new models, such as social marketing, was a management responsibility to consider:

> *It's more professional for management, you know to be able to do all of those things and for us to organise the programme (Pirirakau Hauora Case Narrative, 2004).*

And also:

> *I think you would have to spend a lot of time convincing them [the management] to believe it* (Mana Manaaki Case Narrative, 2004).

The enthusiasm of participants to explore the use of social marketing within the organisation was also influenced by events taking place within the health environment. The following comment explains:

> *If the marketing approach is going to be useful to take to the PHO and say look, this is an approach that would really suit you and the things you have got. I am not saying this is where our work will go, I am saying that is an approach that PHO will be able to look at and they understand what our business is. It is another mechanism in the game for an organisation like this to fully appreciate and understand the dynamics of the environment...*(Mana Manaaki Case Narrative, 2004).

The insights derived from the queries posed within this section about the potentiality of social marketing tools and terms are varied. In some circumstances, a degree of resistance by Maori health promoters existed. Kaikorero highlighted that it would be difficult to use terms like the 'marketing mix' in their work because it compromised their current ethos of Hauora derived from Te Ao Maori. Although there was a degree of acceptance of some of the terminologies such as marketing and market, the possible implications associated with the use of these terms would warrant changing or modifying them. The appropriateness of social marketing in support of Maori

health advancement and in this thesis practically expressed through Maori health promotion must therefore take these issues into consideration. Although these excerpts above demonstrate that there is a sense of inevitability about adopting social marketing, the context of that inevitability weighs heavily upon commitments by kaimahi hauora to adapt and/or modify the social marketing process so that it aligns with the cultural beliefs of our people, Iwi, Hapu and Whanau.

The responsibility to ensure that a process is in place to protect kaupapa was seen by some kaikorero hauora as a task for others coming up in the field to monitor. The abdication of responsibility to address the compromising aspects of values embedded in ostensibly neutral tools arises as a serious concern in this thesis. This, together with the mere pressure to achieve tasks at preset outcomes and an understandable deflection from the work of abstract thinking, could be argued to contribute to a contemporary disciplining of Maori, of providing the preconditions for hegemonic control in the contemporary situation of Maori.

12.3 MAURI OHO – RECOGNISING OPPRESSION AND HEGEMONY

The concepts of hegemony and oppression are integral to both the critical theories and the Kaupapa Maori methods adopted in this thesis. Oppression and hegemony are experienced at micro levels through social relationships and at a macro level through the socio-political and economic influences of society. An analysis of existing social order and the uncovering of "those effects that exist beneath the level of everyday consciousness" (Morgan, 1992, p.136) is an essential consideration in this research.

In this section, insights into the way in which kaimahi hauora recognised oppression and hegemony within the context of their commitment to advance Maori health through Maori health promotion activities are presented. The concept used to portray those responses is described as *Mauri Oho*. Mauri Oho as a concept encourages the recognition of oppression and hegemony. According to Freire (1994), it is through the process of recognition and conscientisation about the processes of power and control that one learns to be free. In this section of the research inquiry, I present participant responses to sub-questions concerned with the recognition of the impact of colonisation, oppression, hegemony and the effects of governmentality associated with the health reforms upon the enhancement of Maori health and wellbeing.

12.3.1 Manifestations of Prevailing Social Order

Social order is established through prevailing laws, regulations, policies and institutions and the work of those who maintain them. Existing social order can be a debilitating system consisting of socio-political and economic conditions that penalise the poor through the normalisation or even naturalisation of dominant ideologies that support and/or condone inequality and social stratification. Borne from these macro-level processes are the day to day conditions and regulations that influence employment, housing, welfare, social services and social justice and are thus the immediate experiences of those with marginal or limited access to these necessities of life. In this research, kaimahi hauora were invited to respond to a number of queries concerning what is deemed 'prevailing social order'. One kaimahi demonstrated that the cost of living, influenced extensively by environmental circumstances emerged as a societal woe.

> *People can't afford to live these days, so they worry about feeding their kids and the nurturing and all the rest of it becomes irrelevant and then they have got nothing. Society is complaining that kids are off the rails and all the rest of it, because we can't afford to do any other things, you have to be very good to know where your kids are every minute of the day when you are working your ass off to feed them and to send them to school, to pay for their school uniforms, nothing is cheap and in New Zealand wages aren't going up to match inflation* (Pirirakau Hauora Case Narrative, 2004).

Many of the conversations highlighted ways in which the existing social order contributes to societal manifestations of social and health related problems as outlined in *Chapter One*; suicide, diabetes, cancer, heart disease, kaumatua and kuia welfare, tamariki care and mental health needs are all at crisis levels in the lives of many Maori. The health issues outlined in that chapter, reflect wider Western Bay of Plenty health concerns expressed through a high incidence of youth suicide, violence, motor vehicle accidents, sexually transmitted diseases, unplanned pregnancies and drug and alcohol related abuse and illness (Bay of Plenty District Health Board, 2002). Tu Pou Tahi kaimahi for instance highlighted that 'societal pressures' are contributing to youth health ailments.

My understanding of suicide is pressures, its all about pressures and that is why I know with pregnancy, relationships, drugs and alcohol all of these are all added pressures to a teenager (Pirirakau Hauora Case Narrative, 2004).

Efforts by kaimahi hauora to enhance health and wellbeing were also being hampered by an institutional focus upon illness, contrasting with a desired focus upon the holistic advancement of health and wellbeing from a Te Ao Maori basis. For instance:

[Public health officials] constantly look at illness and Maori are under attack all of the time, yes they are unwell, and there are alcoholics and smokers. I want a big mind-shift to wellness, which is what I think, is important. And contracts in public health emphasise illness (Mana Manaaki Case Narrative, 2004).

For many Maori, the psychological pain and anguish that stems from the colonial enterprise of others can negatively impact upon the way in which young people deal with these complex societal issues. The following excerpt presented by one of the kaimahi hauora provides greater insight into those issues.

What I have been seeing is young people are being, or getting more and more involved in issues surrounding the land issues, the resource issues, the constant pressure that is being placed from the Resource Management Act on Whanau and Hapu lands and the constant pressure that comes from local government on the need for resourcing the wider community and the only free areas that are around seem to be held in Maori hands. And so there is constant pressure on those Hapu and on those family groups to provide for the wider good of Tauranga. And what you are seeing is young people getting involved in all of those issues and they see all of the negative stuff behind resource management and public works, behind growth and what is happening is that we have got a very young, very negative group of people who are becoming an influential voice within their Hapu. They are becoming very vocal and a lot of it, I see it almost at a crisis point where in terms of depression around what is happening in our rohe. And what is happening is that the young people are taking the brunt of that and they are becoming really negatively focused on a lot of things and they can't pull themselves away from those negative things that are coming out of it (T34: Kaiarahi Hauora - Tane, 2003).

12.3.2 Power Relations and Governmentality

In *Chapter Four,* I used critical theory as a means to expose the interplay of power relations contextualised within the lived experiences of human beings. In Aotearoa New Zealand, funding for publicly provided health services is derived through public tax funding which legitimates the involvement of governments, in designing the infrastructure and related policy for health services (also see *Chapter Six*). Publicly funded health institutions and the people employed to maintain these systems are bound by the rules and regulations of organisational systems, Maori included. Although high-level government policy documents help shape aspirations for Maori health advancement, the aspirations are implemented and delivered by many community groups and Maori health providers (Ministry of Health, 2001a). Insights into obtaining a greater understanding of the impact that power relations and their manifestation in the rules of 'good governance' have upon processes relevant to advancing Maori health and wellbeing demonstrated in the research conversations, has found that those aspirations are sometimes reshaped into something that is not directly related to health. Instead, the legally policy driven social order demonstrated within each of the Hauora complies with technical and specialist accreditation (S. Lawrence et al., 1994). Through these power relationships - administrators, policy advisers and funding representatives become the actors or implementers of the system and invariably these representatives perform active roles in domesticating the Maori health workforce. Their progress is monitored through assessments of measurable outcomes determined in the contract. One kaikorero hauora illustrates:

> *Improving measurability is something that should be looked at and that is what is going to come into the reporting. There is actually going to be more paperwork and more expectations and more in-depth one on one approaches to targeting people* (Waipu Hauora Case Narrative, 2004).

Within the case narratives, a consistent trend within health policy practices demonstrated an increasing expectation by funders of Hauora to provide more service deliverables within existing contracts. This intensification of expectations is raised as a consistent concern across all of the case narratives that Maori health providers felt they were not always able to overcome. This excerpt demonstrates:

> *I hope you find it in other providers because even though we've got the same contract, the mahi has got more intense and the workers are covering a whole lot*

more in the same hours. And they are fantastic workers. So you know we've got to get out there and we've got to both fight for that contract and prove that it's done well or we drop it (Whaioranga Trust Case Narrative, 2004).

Participants working to advance Maori health demonstrated that they were exposed to a series of constraints associated with increased bureaucratic duties and skills of contract negotiations, which threatened to undermine not only their work, but also their existence. What emerged from the research was an anomaly. Who is the most vulnerable if this situation is allowed to persist? Is it the Ministry of Health, the umbrella Maori health organisation or the Marae based health provider? What about the people who are in dire need of the services, while institutions spend badly needed resources deciding upon the basis of Maori health development through a series of contractual agreements? One kaikorero hauora was concerned with these types of inconsistencies as the following excerpt illustrates:

I still question sometimes whether the whole thing is being promoted as a cost saving exercise, rather than a means of ensuring that Maori get the appropriate care, you know that the level of funding that the Hauora actually receive doesn't match the level of funding we'd require to provide some of the services, but I mean that's the reality thing – there isn't as much funding. There's not enough to do everything and so there's a bit of a balance [needed] there (T18: Kaiarahi Hauora - Tane, 2003).

Kaimahi haoura were invited to respond to a question about adequate resourcing for health advancement efforts relative to the capacity of Maori health providers to meet their health aspirations. Highlighted in these inquiries is the reality that adequate resources must be allocated to Maori health providers so they are enabled to meet their policy and contractual responsibilities. However, sometimes that responsibility was not necessarily articulated within the contractual agreement of health, which transpires into a monitoring and compliance type relationship. To illustrate:

Part of our role is to monitor providers to ensure that they are meeting their contractual obligations through monitoring reports. Each portfolio manager in my team has designated providers that they are responsible for. They will meet with them on a regular basis to ensure things are tracking well, any issues that have come up, they deal to those issues...prior to a contract expiring, a portfolio manager will go out and do a review of that contract, undertake a site visit and see how things are going. If any issues emerge, we do an assessment of their monitoring report, then we

do an assessment of their contract to ensure that they are meeting their contractual obligations (T19: Kaiarahi Hauora - Wahine, 2003).

The risks associated with attributing blame for accepting unrealistic expectations in contracts to Maori health providers appeared to contribute to the proliferation of under resourced groups who try to meet many more needs, over and above the contract specifications – because there are real needs for their communities. The over-producing in one area of Maori health development may seem to lead to under-performing on the actual contract on the whole. This under resourcing and over producing scenario is a prevalent observation of existing power struggles within the Maori health sector as the following excerpt implies.

It's amazing what you can do with money and that's why I talked about the funding side of it. If Maori only had a portion of what goes into mainstream, or even under the Treaty, even if we had a bit of that, especially the amount of money that is put into smoking – Maori, we must be able to have a bit of that putea (T35: Kaiarahi Hauora - Wahine, 2003).

The under funding scenario highlighted above, is symptomatic of some of the inconsistencies derived from an over competitiveness within the health sector. Unfortunately, in many instances the competitiveness of health directly impacts upon the potentiality for meaningful health outcomes. The following excerpts help illustrate that point:

Evaluations are good in terms of making sure that your programme has longevity because if your evaluation comes out positively then great, but the thing about evaluations is that it is putting things in their places and it is limiting and people will see it and say, this is what works so don't do this or that and straight away you are alienating things that some people want to do...(T34: Kaiarahi Hauora - Tane, 2003).

What they do ask for is numbers. I hate the numbers thing. I have a certain number of people that I have to have involved in what I have done or encouraged people to do and that number is in the tens of thousands...(T34: Kaiarahi Hauora - Tane, 2003).

The roles performed by health promoters are important to the way that health services are perceived and the way in which the concept of health is constructed. In many

cases, the views of a health promoter become the driving impetus for enhancing health. Some of the health promoters reacted to this issue by stating their affinity to the concept of health that enabled people to make more informed choices in the future.

> *I didn't want anybody to actually facilitate or present at the expo it was more about letting the youth make their own choice and actually go towards the information provided for them in their own way* (Pirirakau Hauora Case Narrative, 2004).

The expert-patient relationship and the interplay of power discussed within this relationship (see *Chapter Four*) influences the way in which Maori health is constructed and people are treated (Waitzkin, 1991). Coney (1996) highlights the role of power exerted by health promoters in *the Politics of Public Health and Health Promotion.* In this research, all of the kaimahi were passionate about their roles, but at the end of the day their work and its eventual value is something that is judged by others through the monitoring of health contracts – often through statistics that obfuscate the real needs of the people and the real achievements of Maori health workers.

12.3.3 Impact of Neo-liberialism

Chapter Six outlined some of the explicit ways in which neo-liberalism impacts upon the way in which contemporary health and wellbeing is constructed by politicians, policy makers, the medical professionals and even by community health workers. The State (government ideologies and policies) through the actions and willingness of people to comply with them has embarked upon an increased commitment to devolution. The devolution strategy was couched in "rhetoric of community empowerment, accountability and responsiveness" (Kelsey, 1993, p.80). In this research, although kaiarahi hauora did not 'name' the term devolution, they were accustomed to the way in which government health policies and processes transfer to community groups, the responsibility of achieving national goals for health, but not necessarily the resources. This response demonstrates the impact of this scenario, for instance:

> *Invariably, we only get 20-30% of the funding that the State gets to do the same thing across the board; justice, education, health, welfare. We operate on 20-30% of what*

they get to do it. They do a great job compared to us, well of course you [would]. You get a lot more money to do it and a lot more resources to do it well. So, they are not adequately resourcing the people to do the jobs properly, so when they fall over they are saying that we are not doing our job properly (T33: Kaiarahi Hauora - Tane, 2003).

Our biggest challenge now is having the same putea for long periods of time, not having it reviewed and not having time to be able to develop our organisation (T28: Kairahi Hauora - Wahine, 2003).

It was not until 1989, that funding was provided for one of the groups in this research (Ropiha, 1993), and it was not until the mid 1990s that changes in health policy at a national level began to resemble aspirations for Maori health (Cunningham & Kiro, 2001). But, even then there were concerns with the way policies were implemented and who took responsibility for ensuring that policies translated into Maori health gains (National Health Committee, 2002). As reiterated in *Chapter Six*, changes to the health reforms conjured up sceptical responses by Maori as the excerpt demonstrates:

I don't think this government is treating 'Maori health'; they treat it as an oddity, as opposed to both a priority and normality, so they throw money at it. And the auditors have a tick in a box in terms of dealing with Maori health (T33: Kaiarahi Hauora - Tane, 2003).

Neo-liberalism is a political ideology that is implemented by people on behalf of the Government. By association, social actors (politicians, administrators, health promoters and medical professionals) subscribe, sometimes unwittingly to the development of systems that condone the compartmentalisation of health care. Invariably, the way in which some service contracts were arranged contrasts to the aspirations that Maori health providers are articulating in all of the case narratives. Yet, the provision of Maori health promotional activities as part of a series of efforts to advance Maori health within this current socio-cultural context is consistent with an increasingly competitive environment of health where those with the greatest ability to survive will prosper (Kelsey, 1993). For instance:

Even though we've got the same contract, the mahi has got more intense and the workers are covering a whole lot more in the same hours [of pay](Whaioranga Trust Case Narrative, 2004).

The competitive environment of health has also stifled opportunities for collaborative ventures and contributed to growing tensions among various Maori health providers.

Competitiveness you know, that's designed to divide and rule us, in every new health funding formula that is introduced, it immediately has an impact that sets Maori against Maori (Mana Manaaki Case Narrative, 2004).

This competitiveness is further exacerbated by the perception that Maori health issues and processes are being subjugated by technologies emanating from business models that are continually exposed as being inappropriate for the context of holistic health care. This comment by one of the kaimahi illustrates:

A manager is rewarded because he can return a positive balance sheet at the end of the year, not because he's actually successfully done the job that he's done, and if you make the successful delivery [of whatever it is], the priority and they come out in the red, you may have done a magnificent job, of really responding to the needs [of the community], but you will be punished by the system because you returned a negative balance sheet (T18: Kaiarahi Hauora - Tane, 2003).

As part of a process for advancing Maori health and wellbeing, further negative consequences of the imposed market system emerged, some of which were the consequential reconfiguration of Maori health as a product or a commodity and the reclassification of people as customers and Hapu as markets or a prescribed set of tasks and activities. The following example demonstrates that the way in which 'Maori health advancement' is presented within health contracts, directly impacts the way in which services are provided.

A contract is provided on the basis of one aspect of care, such as diabetes testing and the Trust is providing a type of service that involves a series of other things so there are tensions (Whaioranga Trust Case Narrative, 2004).

This process is a more consumerist approach to health care provision (Henderson & Petersen, 2002). The holistic kaupapa for Maori health such as that espoused by the *Whare Tapawha* model (Durie, 1994b), and which is constantly referred to in the case

narratives is incompatible with this type of compartmentalised approach to health highlighted above.

In the case narratives, it was demonstrated that Maori health providers are burdened by the increased number of administrative duties required to be performed. However, these expected and often extra duties are not always catered for in terms of the health agreements and service contracts. One of the bigger organisations had just grown enough to cope with those costs as the excerpt below illustrates:

> *We have always been short on administration finance...its only after having grown over these last few years that we have been able to have the administration ability to look at our future growth and the finances to be able to go ahead and do that* (T1: Kaiarahi Hauora - Koroua, 2003).

The concerns raised by Maori health providers in the conversations and case narratives are that these extra bureaucratic tasks are performed at the expense of the actual delivery of health promotional activities to people within the community. As a group of Maori health providers within this research project, it was acknowledged by many that there is a danger in accepting these systems as the only way in which health gains can be made in the future.

12.3.4 Organisational Constraints

During this research and through the conversations held with participants, other constraints that impact upon the ability of kaimahi hauora to perform their roles as advocates for Maori health were illuminated. For instance, it was claimed that most mainstream organisations would not have to deal with the multiple duties that Iwi and Hapu groups deal with each day as the quotes below reveals:

> *I don't know any Pakeha organisation that has to confront such a diversity of issues and the background of having to link tikanga with Pakehatanga and that is the reality of it, we have to link in there....*(T1: Kaiarahi Hauora - Koroua, 2003).

> *It is a very challenging role because we are already serving two communities...it's the volume of work, the variety of work, the difficulty of the lack of finances. It's not easy; it's a very difficult role that we are trying to fulfil* (T1: Kaiarahi Hauora - Koroua, 2003).

Kaimahi hauora were further exasperated by a number of organisational concerns regarding staff recruitment and retention, which arose as a consequence of the not for profit health sector to which Maori collectives affiliate. But, the fact that Hauora are prone to staff being transitional is a symptom of a greater problem brought about by under-funding and limited contractual leeway to resource certain skills set. Invariably, Hauora are forced to employ more part-time employees instead of very skilled experts. This problem was ongoing as this response demonstrates:

> *Sometimes circumstances change for staff, they have to look for a full time job. We cannot always fulfil that. Many people who have started in Whaioranga have gone on into other full time positions* (Whaioranga Trust Case Narrative, 2004).

One of the kaiarahi hauora highlighted that staff turnover is symptomatic of some of the problems associated with limited resources within the health sector in general. In this particular response, a direct link was drawn between staff turnover and macro-structural influences.

> *If all staff leave, then there is a problem at the macro-structural level. If you hold on to your staff, it is a clear sign that things are going well. In the health field, there are lots of people moving in an out of health work all of the time. And that is a clear signal that there is something going on* (T33: Kaiarahi Hauora - Tane, 2003).

However, the excerpts demonstrate that skilled people form the backbone of an organisation and the loss of people impacts upon the ability of Hauora to perform current and future duties. While some staff turnover may be useful to an organisation in terms of new ideas, the constant recruiting, re-training and up-skilling of people replacing those who have left impacts upon the ability of the Hauora to connect to the prevailing core health issues at hand as illustrated:

> *If we are really serious about Maori health provision, we don't just have to focus on the delivery of health services, we have to focus considerable resources on the development of Maori health resource people, and that needs to be done in a way that in actual fact enables them to take on the depth of Matauranga Maori* (T18: Kaiarahi Hauora - Tane, 2003).

Within the socio-cultural context of advancing Maori health and wellbeing, the commitment required to 'be Maori' sometimes generates misunderstandings and disagreement about control and power.

People who understand the political climate are trying to unite Maori so that they can meet the criteria that have been set for them nationally. Some who do not quite understand that at home and in clinics and with the different Hapu structures are thinking "who are they?" They are actually coming over the top and trying to take over these things and that causes friction (Mana Manaaki Case Narrative, 2004).

Sometimes the realisation of the way in which development (health, education, welfare and culture) is influenced by externalities can be seen as a detrimental constraint to future progress, such as that which occurs when the construction of health is viewed politically. To illustrate

Health has become far too political and it still is. It is far too political and it is getting away from what it is there for in the first place. It is there for uplifting the wellbeing of the people that use the services (Whaioranga Trust Case Narrative, 2004).

12.3.5 Maori Accountability

Maori accountability is about exhibiting and working towards an ethical and cultural code of conduct and responsibility to Whanau, Hapu and Iwi. In the context of *mauri oho,* it is a call to awaken and endorse traditional, cultural and ethical practices for Hauora. The desire by kaimahi to serve the community through the giving of their time, efforts and aspirations for health is linked to Maori concepts of accountability. Maori traits of accountability are different from those expressed in policy documents (K. Mataira, 1994). These excerpts illustrate the importance of Maori accountability within the context of delivering Maori health promotion activities.

You're not answerable to the organisation; you're answerable to your own people around you – your Hapu and Iwi (Whaioranga Trust Case Narrative, 2004).

I sit on a lot of health organisations so at the end of the day your Hapu is the one that is always going to be there to hold your heart and I owe my heart to Pirirakau. I owe my Hapu, so they get the benefits of any knowledge that I gain (Pirirakau Hauora Case Narrative, 2004).

Accountability is also about ensuring that people are responsible for upholding the mana of their Whanau, Hapu and Iwi in regards to reciprocity. The ethic of Maori accountability and the way in which it links with the concept of mana, helps instil

through roles models of that time what Whaioranga subscribed to in terms of pan-tribalism. This excerpt illustrates:

> *At that time, all people intermingled between Iwi, so the idea that Iwi were separate entities was not so apparent then. The leaders of that time; Wiremu Ohia and Turirangi Te Kani, they moved inter-Iwi. In addition, they could do that then, so with the Whaioranga Trust it was not an Iwi based venture. At the moment, because it is based at Whetu and with the [Treaty of Waitangi] claims and other events shaping the identities of people in Tauranga, there is a perception that it is an Iwi venture but that was not the case* (Whaioranga Trust Case Narrative, 2004).

Maori accountability is also about adhering to protocols of conduct with the way in which hui are held and people are treated. This ethos of caring – *manaakitanga*, is an example, in this case translated into the organisational kaupapa. For instance:

> *Maori are bound to those cultural values and those values help us to keep within the boundaries of our kaupapa* (Whaioranga Trust Case Narrative, 2004).

In this analysis, Te Ao Maori serves to instil, awaken and endorse within Maori the desire to move Maori ways of health and wellbeing from the margins of society (as the strange and odd) to the centre, to occupy more constructive and holistic ways of engaging in the development and advancement of Maori health. In this section, the excerpts shared from conversations held with participants in this research reflect a commitment to *mauri oho* – awakening of the essence of life.

12.4 MAURI TU – NARRATIONS OF RESISTANCE

In this section, I illuminate excerpts from the research conversations to demonstrate a strong commitment by participants to *mauri tu* – narratives of resistance. The word 'tu' denotes, 'standing tall' or 'to stand'. Using this concept I position Maori health and wellbeing activities and events as active ways of resisting the impact of ongoing dominant discourses and practices that serve to subjugate Maori within the prevailing non-Maori paradigms of health development. The concept of resistance is therefore not always negative. It can be seen as enriching and positive. It may be an essential aspect of transformation. In this section of the research inquiry, participant responses to sub-questions concerned with the process of resisting neocolonialism, oppression, hegemony, and the impact of health reforms and policies through the recognition of

Maori kaupapa of hauora, Maori health development pathways in Tauranga Moana and Maori concepts of health and wellbeing are provided.

12.4.1 Kaupapa of Hauora – Organisational Vision and Mission

Hauora representatives were invited to share what they believed to be the fundamental ethos of their kaupapa for health advancement for their communities. Each of the Hauora portrayed different and unique characteristics to express their Maoriness, which in turn links to the Hauora kaupapa. Whaioranga emphasised pan-tribalism, Pirirakau was concerned with Hapu development, Waipu Hauora endeavours to ensure that the health needs of the three marae communities are addressed and Toi te Ora Public Health (the government health agency) focused upon the health needs of the broader Western Bay of Plenty region (Ellis, 2004). The kaiarahi hauora endorsed the kaupapa of the Hauora, by highlighting kaupapa for their respective communities that aligned with kaupapa of the Hauora. To illustrate, the mission of Whaioranga is to "enhance the health and wellbeing of the diverse Whanau, Hapu and Iwi of Tauranga moana" (Ropiha, 1993). Whaioranga translates to mean 'seek wellness or wellbeing.' In a similar way, each organisation in this study was able to demonstrate a commitment to wellness, wellbeing and health development in this type of way.

12.4.2 Maori Concepts of Health and Wellbeing

Kaikorero expressed a deep commitment to advancing Maori health from a holistic and cultural perspective, expressed in *Chapter Two* and in *Chapter Seven.* Examples from the narratives include the adoption of *Whare Tapawha* and *Mana Manaaki* as foundations for approaching Maori health. To illustrate, the purpose of Mana Manaaki is to:

> *Build on positive cultural concepts such as manaakitanga, kotahitanga and participation to raise awareness about the amount of harm that was being caused by excessive alcohol consumption* (Mana Manaaki Case Narrative, 2004).

Further prompting with the kaimahi hauora, enabled a response to clarifying what Mana Manaaki meant at a deeper level for the community.

> *I could tell you two things about Mana Manaaki. Firstly, it was a philosophy to motivate our people instead of going with the usual approach. We are talking in*

terms of looking after each other and caring for each other and that was the philosophy that I think was useful. I think in terms of the Mana Manaaki programme, the work they had done and the practices it was a good vehicle I think. It was a good vehicle to take programmes to our people or to develop "for Maori by Maori" type programmes (Mana Manaaki Case Narrative, 2004).

The conceptualisation of Maori health by respondents is seen in a holistically cultural way, which draws together the mind, spirit, body and Whanau of a person. This conceptualisation is an act of resistance to the ongoing medicalisation and/or the ongoing commodification of Maori health. One kaiarahi hauora helped explain that concern with the following excerpt:

Whare Tapawha comes out in education, in social work, everywhere. I think it is nice. I just think that it is a bit limiting. There are more than four sides to this house. And just as important is the foundation of which the house sits on (T33: Kaiarahi Hauora - Tane, 2003).

Maori health is also interrelated with other environmental influences such as culture and politics. A contrasting political view of health that emerged in the research, takes into consideration the impact of land alienation and the ability to conduct the processes of living and dying in the appropriate geographical and spiritual spaces. For instance, one kaikorero illustrated that 'good health' is far reaching in that many issues impact upon her notion of what is healthy and what is not:

Stopping the exploitation of the little bit of land that you have left, good health is about my urupa, it's [filling up] and where are we going to go? That worries me. That is health for me. It's about our kukuroa, they are disappearing and it's also about the pollution, we can't swim in our waters at the moment, because they are so polluted...we can't swim and we can't control these things and that is actually a huge thing for me – exploitation and the development that is coming and to me it is always about us having a lack of control over ourselves...that is about good health to me (Pirirakau Hauora Case Narrative, 2004).

The opportunity to express a greater understanding of Maori health conceptually was part of the workshop focus. In the workshop, kaimahi hauora came to endorse their own convictions and conceptualisations of Maori health during the course of the

research, in ways that were consistent with their re-kindled understanding of Te Ao Maori. For instance:

> *I am even more inclined to think it is really necessary to keep the original focus of Mana Manaaki intact and to pursue those types of [activities], to ensure that we continue to work using those Maori values to guide our practice in Tauranga* (Mana Manaaki Case Narrative, 2004) .

12.4.3 Maori Health Development in Tauranga Moana

In *Chapter* One, I committed to building my thesis on the depiction of Maori health advancement not only as a statistical representation of ill-health, nor on the depiction of Maori health pathologies based on structural deficits. Rather, I chose to depict Maori health advancement as a dynamic process of people under duress, though continually committed with courage and limited resources to resist assimilation where this is not healthy for them. In *Chapter Four,* it was argued that Maori health and wellbeing must be drawn from a Maori health development framework. My research, not only demonstrates how this is achieved – but there is also a relationship between the respondent's conversations and through these conversations a reinvigoration to that commitment. The narratives present consistent stories about instrumental and innovative approaches to Maori health development and Maori health promotion. The following response illustrates and acknowledges Tauranga Moana achievements in Maori health advancement, which are often not commonly known:

> *I do think Tauranga has practically been a forerunner of things. However, modern writing [doesn't reflect that] so it's actually not known. Whaioranga was one of the first Hauora around Aotearoa and Te Puna Hauora here. This was the first model of kaupapa Maori health for a secondary service [in the country]. In addition, I think there are many very intelligent people here who have been like the forerunners of events. They are very good thinkers, so even though there is a lot of welfare here. I think people here still have a lot more than other people do. The marae are very strong and people are really working them and if we looked at health, that's where health bases are either on the marae or near the marae and those are really strong* (Whaioranga Trust Case Narrative, 2004).

Some of the Hauora projects were significant and the acknowledgement of these events serves as a way of instilling pride into the hearts of those working at the flax

roots of Maori health development in Tauranga Moana. Their collective works need to be acknowledged and this research was one way to contribute to the celebration of those achievements to those, who have gone before and those who are doing the work today. The research undertaken by Whanau at Mangatawa Marae for instance, led to a world first discovery of a degenerative gene, which could be demonstrated to lead to the onset of a particular form of cancer. For instance:

> *We were the first one to find that gene; we are the only ones to find that gene in the world. This is not just in Tauranga or with the Tauranga hospital. This is worldwide. People are coming over now and asking us for help, to see what we are doing* (T14: Kairahi Hauora - Wahine, 2003).

Such depictions of the active and sophisticated pursuit of good health and wellbeing are not generated from the medicalised or even social deficit depictions typical of approaches to health advancement.

12.4.4 Maori Health Providers

The Maori health provider (see *Chapter Nine*) emerged as an anomaly within this research project. In many cases, all of the providers were named after some cultural feature of Te Ao Maori specific to their respective communities, which in itself is a form of resistance. This naming declares a deep commitment to a Maori way of being. However, at the same time they are legally instituted entities governed by external regulations, legislation and rules. Some Hauora are either incorporated societies or charitable trusts. When health services are established within the confines of different institutional entities, the way in which their duties and roles are defined can also change. The following excerpt illustrates these anomalies:

> *What is happening is that we create all of these little organisations to assist their Hapu, their Iwi structure and then they become really internally focused. They are working really hard for the greater good of their people and for a certain extent that is good, but when you are talking of the greater health for the region it becomes really difficult for them to go from here to here to create a greater relationship* (T34: Kaiarahi Hauora - Tane, 2003).

And also:

All of these people, they are hiring in all of these people, our people in an entirety who are all from that marae, are not learning to do the health themselves. They don't learn to design and control their own programs and participate in it. All they learn to do is to listen to the Maori health promoter who says, blah, blah, blah. Here is a koha, but we don't learn to do it ourselves. We don't learn to design it (T33: Kaiarahi Hauora - Tane, 2003).

These quotes illustrate that some kaimahi hauora are complying with funder expectations, through a misunderstanding of the differences between a health activity and bureaucratic contractual responsibilities that seem to endorse accountability measures stretching far beyond the expected requirements of specific 'health promotion' activities. Additional forms of compliance in the types of additional duties they are required to perform (e.g. paying wages, filing taxes, business planning and occupational safety requirements) create a mechanism through which power and control can be exerted upon the kaimahi hauora. These tasks have little resemblance to health promotion. As a result, it is difficult to see how the implementation of 'social marketing' within the Hauora would change that.

In *Chapter Six*, it was also made clear that the way in which health services are provided and the resources made available are framed within the context of existing government health policies and thus government derived health service contracts. Whilst there is room for exploration with some of the aspirations of the policy, it is unclear whether these aspirations can be translated into the service agreements between Maori health providers and those groups providing the resources for those services. If there is confusion about the way in which the agreements are prescribed and who has the final say on whether flexibility exists, then there is a risk that the Maori health provider may be exposed to the paradox. The paradox exists when Maori health providers comply to agree with new aspects of a health contract, not necessarily aware of the full implications. The following excerpt highlights this scenario:

We don't actually run our health budget, the government runs the whole lot. If you belong to the Trust you may think that you are running and controlling your lot, but you are not. That whole notion about tino rangatiratanga does not exist. And [each Hauora] thinks that they have tino rangatiratanga, but they don't because they have

to report on everything they do, and they have to do things as determined by the state (T33: Kaiarahi Hauora - Tane, 2003).

Enhancing Maori health and wellbeing from a Te Ao Maori perspective is a form of resistance to the imposition of standardised governmental notions of health care provision. Within any community, it is important to know who and what to resist and why. Kaupapa based approaches to health development are also about people and the way they interact through the social relationships they form. These people shape the way health promotion activities are delivered. Some people have certain skills that are difficult to replicate and if these strong people are not present within the mix of skills of people working in Maori health, the strength to resist what may be a pathway contrary to Te Ao Maori aspirations is therefore at risk. The following excerpt illustrates the risks associated with an insufficient people skill set within an organisation:

> *The people who could take on that responsibility for drink driving aren't the same. They don't have the same sort of thinking behind them – those philosophies. With Mana Manaaki initially, the intent with Orewa and them was around the drink driving and host responsibility. People like Ani and Lorraine they added in the other factors, the Manaaki factors that weren't written down as part of contracts, it was just an understanding that this is what we actually needed to happen* (Mana Manaaki Case Narrative, 2004).

12.5 MAURI ORA – NARRATIVES OF TRANSFORMATIVE THINKING FROM TE AO MAORI

In this section, responses focusing upon the transformative aspirations of Maori health advancement are discussed. Interrelated to these inquiries is a question about the transformative potential of the social marketing tool to benefit existing Maori health promotion efforts. Remaining questions in this section focus upon broader themes related to *mauri ora* or social transformation within Maori health advancement per se, and how participants respond to those inquiries. Responses from participants focus primarily upon sub-questions concerned with exploring issues about Maori health promotion and the commitment by Maori to strengthening Te Ao Maori. These themes are highlighted within the context of the concept of mauri ora – transformative praxis.

12.5.1 Is Social Marketing Transformative?

In section 12.2, participants responded to the workshop process which sought to impart learning and critical understanding about social marketing. The day long workshop generated a number of insights pertinent to this thesis. In this research, a key consideration in revisiting these conversations is to ascertain whether through our active engagement with the promises of social marketing, the process of research that we undertook could be aligned with the aspirations of *transformative praxis* or *mauri ora.* A fundamental expectation related to this query is whether participation in the research enhanced the emancipatory aspirations sometimes explicit – but always implicit – in any claim by Maori to remain and live as Maori. In our example, we attempted this by devising a research process through which participants could learn more about social marketing and its potential contribution to the aspirations of health development of Maori, by Maori, for Maori.

In their analysis, social marketing certainly did not come out as a vehicle through which the current state of Maori health could be transformed. For instance, the groups were not overly anxious to go away and immediately implement the model. However, several people came to the realisation that some of the terms were already being utilised and as a result, there appeared to be some benefits in adopting the social marketing model e.g. use of marketing terms. For instance:

> *Well they are [a market] in a way, well this place wouldn't hold a contract if it wasn't for our Whanau or Hapu, they are our clientele* (Waipu Hauora Case Narrative, 2004) .

One kaiarahi hauora claimed not to use social marketing, but thought that she might incorporate it, now that she understood a bit more about it:

> *I probably do not use social marketing but I use other models of health and I try and incorporate it into the things that I do* (T28: Kairahi Hauora - Wahine, 2003).

However, many of the participants learned to understand some of the implications associated with the uncritical adoption of social marketing and its constituent concepts. This deeper understanding which emerged as part of the process of research could be construed as an emancipation of 'thought and consciousness,' in that people came to know that their aspirations for Maori health development rested with a

greater desire to strengthen Te Ao Maori. At the same time that this clarity surfaced from the research conversations, the contradictions in the various disciplines also emerged in that social marketing was not a transformative tool consistent with aspirations of critical theorists; instead it was seen by the participants as one of many possible models that could be adopted by Maori health promoters.

12.5.2 Te Ao Maori

In searching for *mauri ora*, it became clearer from the case narratives and the conversations that the pathway towards transformative praxis rested with developing a greater understanding and appreciation of the importance of Te Ao Maori, expressed in very subtle but powerful ways throughout the research. One kaiarahi hauora described Te Ao Maori as *taha wairua*:

> *It goes back to Taha Wairua...Maoritanga, it is a system of knowledge, a whole lot of things that you have in your head – it isn't the things that you get pass marks for, it's a way of living and a way of belonging to the world* (T18: Kaiarahi Hauora - Tane, 2003).

Another kaikorero described access to taha wairua as fundamental to underpinning who we are as Maori and how we operate:

> *We've got to grab some of the stuff back and somehow – and get it [taha wairua] to underpin the way we operate, we need our community to do that* (Waipu Hauora Case Narrative, 2004).

Throughout the case narratives, two contrasting perspectives emerged in regards to Te Ao Maori. The first series of korero articulated Te Ao Maori as something that was being lost and that the gradual loss of tikanga and kaupapa within Hauora emerged as a consistent concern throughout the case narratives. The loss has been gradually occurring at the same pace that we are losing our kaumatua and kuia who are the human repositories of the Maori worldview. Future generations are not being provided with the opportunities, resources or encouragement to fill the gaps that are emerging. The sense of gradual loss is something that has emerged as a stark reminder of the dangers Maori face in the future through a naive sense of security regarding these issues. The following excerpt positions that discussion through the notion of being different and that difference matters:

I mean we are different and you know, we can even talk about being colonised and integrated and all that stuff, but fundamentally we're different – we're absolutely different and I think that if we stop acknowledging that we're different and if we lose sight of why it is that we are different and the things that underpin those differences, then you know, we'd be lost – a lost people. So the connections are really strong with me and yeah they do start with the Whanau and then whakapapa and Whanau in the wider sense but it starts with the initial immediate Whanau but you know, your Whanau in terms of your marae and Hapu and those links are really strong (Waipu Hauora Case Narrative, 2004).

Some participants expressed an optimistic outlook. For them, Te Ao Maori is a reclaimed foundation upon which to base new developments for Whanau, Hapu and Iwi in Tauranga Moana. Te Ao Maori is not a singular concept; it is a complete worldview that is founded upon cultural and philosophical ways of seeing the world from a Maori perspective. One kaikorero hauora articulated a view of Maori health as follows:

The picture that I strive towards is like: What makes Tukairangi good at being Tukairangi? It's important [to know] what [that] is. Because if Tukairangi is going ok, then everyone is happy and they are essentially capable of practicing being Tukairangi. That's the picture of health for them. What more could they want? And so, I mean, its about looking at what those Hapu are striving for and the freedom to express and be who they are (Mana Manaaki Case Narrative, 2004).

In the conversations with participants, it was evident that Te Ao Maori was a cultural bastion of existence for Maori that was valued and needed to be nurtured and protected as part of the efforts towards advancing Maori health within Tauranga Moana.

12.5.3 Maori Health Promotion

All of the kaimahi hauora involved in this research were asked to articulate their views about Maori health promotion and what it meant to them and how it should be conducted (see *Chapter Eight*). In all cases, the kaikorero reiterated the importance of cultural values, kaupapa and boundaries. One response highlighted how it was important to understand wairua and broader concepts of Maori health promotion:

The workshop was good for us as it supported a lot of our natural practices but it was also a bit difficult. You know like Pakeha who don't understand wairua they just deal with health, because they still view a lot of public health not of the broader concepts of what we are in. For example, what does the water level in the river mean to health? How can that make you unhealthy (Mana Manaaki Case Narrative, 2004)?

Another person reiterated how ironic it was that Maori were utilising the Ottawa Charter when Maori could be using their own models. The whole picture of health was reiterated as important and this is a consistent theme restated in approaches to Maori health promotion. Two kaiarahi hauora spoke about the importance of advocacy not just for performing health promotion, but for performing health promotion that was Maori. For instance:

There is a lot of advocacy stuff that goes on in the background as well about promoting the benefits of being involved in these types of activities that Maori subscribe to. If Maori want to do kapa haka, let's help them do kapa haka. Because it is about getting out regularly and being active. It is not just about getting them to practice because you have to practice at home. Because the thing about mau rakau, poi etc, is that you have to practice all those things at home if you want to be better. How do we get past that, well I say that is an area that we encourage our people to get into (T34: Kaiarahi Hauora - Tane, 2003).

And also:

I am conscience of the model of health, when I do health promotion programmes and I am conscience of the Ottawa Charter and the different things, and when I set something up like an event, I try and bring those things into it, like what is my kaupapa? What things do I want to do? Like we had a day at Pilot Bay one year where all the Whanau came out and I was thinking what do I need this morning? Let's look at the kaupapa of the day okay. It is not oral health day, it is about wairua today, having Mauao there, whanaungatanga, Tauranga Moana (T28: Kairahi Hauora - Wahine, 2003).

During the conversations held with participants, it was demonstrated that the promotion of health should be looked upon through the lens of 'wellness' and not 'illness'. Events such as the *Mataatua Kapa Haka* competitions were viewed as positive examples of ways in which to be involved, that were consistent with Maori health promotion ideals of hauora, for instance:

We are getting the opportunity to stand by Mataatua in rejoicing who they are, what they are – what makes them well. So we are supporting them to promote their wellness in their Hapu, that's right we are health promoters – not ill health promoters (Mana Manaaki Case Narrative, 2004) .

The workshop also provided a forum for kaikorero hauora to converse and share ideas about social marketing and Maori health promotion. As a result of that workshop, participants developed a visual representation of their own constructed representation of Maori health promotion in what is called *Te Kahui Whetu: Maori Health Constellation (see overleaf).*

Once the constellation was completed; participants were given the opportunity to draw links between aspects of the *Te Pae Mahutonga* model and their own constructed meanings of Maori health promotion as a result of the workshop process. Some of the responses shared in the post workshop conversations help illustrate the collaborative understanding that was derived through the workshop. To illustrate:

For me what was interesting was that every one of those cards could have gone into every one of those stars (T12: Kaiarahi Hauora - Wahine, 2003).

I think everyone in that room would have agreed that if we could have all sat back and looked at it again, we would think: 'True! Everything belonged in everything'. And that's a common ground for all of us; it displays the general part of us as Maori (Mana Manaaki Case Narrative, 2004) .

What was also important was that their work was validated as different and specifically Maori from the conventional approaches to health promotion. That realisation was a very powerful moment within the workshop (T12: Kaiarahi Hauora - Tane, 2003).

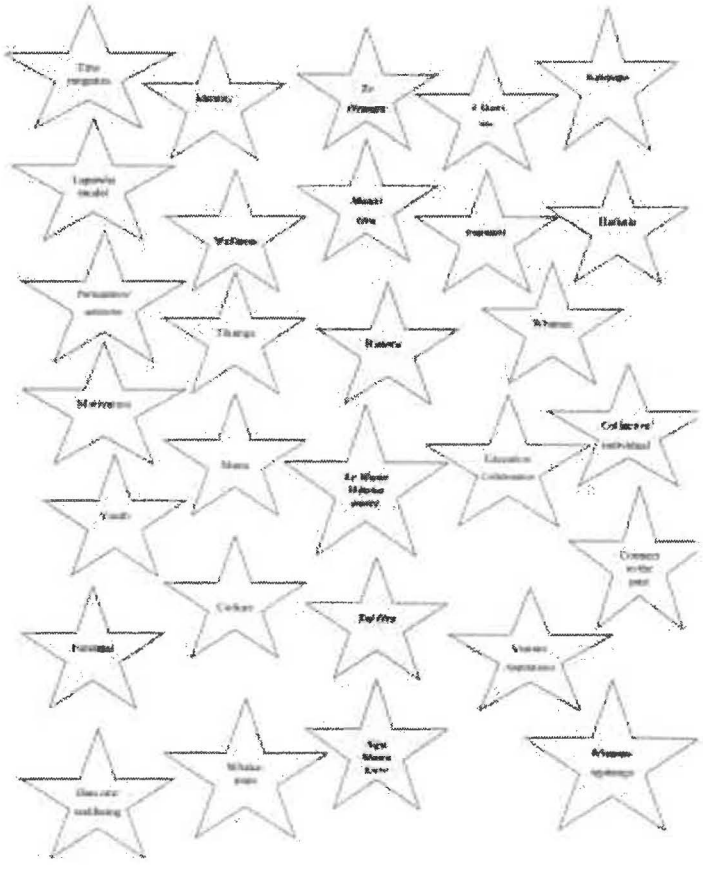

Figure 1: Te Kahui Whetu - Maori Health Constellation

Although not immediately evident at the time of the workshop, it is clear through the research that a commitment to Te Ao Maori flowed through the discussions by kaikorero hauora in attendance. Respect demonstrated by the importance of values that were passed through kupu Maori, was a powerful finding that requires specific illumination in this chapter. This excerpt demonstrates the value of collaborative research processes such as hui, wananga and in this case a workshop:

> *I think everyone of the [participants] has been inspired by that workshop session to look at how collectively we have come to this place and how we can see Mana Manaaki as a good value to take through* (Mana Manaaki Case Narrative, 2004) .

While it was not always clear whether transformative praxis occurred throughout the research experience, there were examples were it was quite obvious. For example, the compilation and completion of Te Kahui Whetu was a realisation and conscious process of emancipation related to ones knowing being consistent with established Maori health promotion models.

One kaiarahi hauora highlighted the complexity of language and the way in which meaning is derived from the combination and placement of words. For instance:

> *I am interested that you used the word 'Maori health promotion' last week, because to me what does that mean? I made an assumption of what that meant is to health promotion and for me there are quite significant differences, one being Maori health promotion where there is a level of education required whereas Pakeha, there is nothing other than you as the health promoter or facilitator to enable education and training whereas in Maori we would undertake that training ourselves. That is one of the obvious differences...it immediately signals a different approach to just health promotion, it is something else* (T12: Kaiarahi Hauora - Wahine, 2003).

12.5.4 Ongoing Challenges

Endeavouring to address Maori health needs is not merely associated with identifying the critical factors related to the organisation of Maori health development. In some cases it is important that as Maori, the recognition of enduring contradictions are seen and overcome. This raises numerous challenges, some of which were raised through the research conversations. One kaimahi thought for instance that as Maori, sometimes tokenistic efforts are being made to improve our own situations:

> *In some ways, I feel sometimes we are tokenistic too many times – saying we're doing things for our people and we're not. We can't even sort out issues within our own Hapu sometimes and we're expected to go out there and support the wider community. Until we really start becoming happy within ourselves we're always going to struggle* (Pirirakau Hauora Case Narrative, 2004).

Concerns were expressed about the contradictory way in which our communities continue to be ravaged by the use and abuse of alcohol and drugs.

> *I say that we are a contradiction because our Whanau here is really strong, they're a really strong close Whanau, but when it comes to some of those things like that, you know that they enjoy [such as the use of marijuana], that's the part I think you would think that we could achieve enormous things here [such as eliminating the use of drugs]* (Waipu Hauora Case Narrative, 2004).

One of the kaiarahi hauora expressed concern about the erosion of commitment by people to whanaungatanga, bought about by increased individualism.

We talk about values whanaungatanga, that used to be one of the strongest binding things behind how Maori went about doing things, whanaungatanga around our marae, our Hapu, our families and that was a binding thing that kept Maori families together. Well now, you know, the reason we have a lot of illnesses is because whanaungatanga is not as strong a value within our people anymore. We have become very individualistically minded, I want, I want, as opposed to we need. Let's get together and do things (T34: Kaiarahi Hauora - Tane, 2003).

The contradictory relationship between health models such as *Whare Tapawha* and the contractual obligations of health service delivery were clearly understood as this korero demonstrates:

That fluid approach to health is something that the Trust has maintained. It has not worked within a compartmentalised approach to health and this is where some issues arise for our people. In addition, health for Maori means so many things involving socialisation and so forth. A contract is provided on the basis of one aspect of care, such as the infections for diabetes and the Trust is providing a type of service that involves a series of other things so there are tensions. There are tensions in respect that the Trust is doing mahi that is not recognised in the contract. There are tensions when the contract is the definition associated with health, particularly when pursuing a more holistic approach to health (Whaioranga Trust Case Narrative, 2004).

The inability of Maori to actively pursue ways and means that resemble tino rangatiratanga is frustrating to many of the kaikorero and kaiarahi hauora. In particular, concerns focused upon issues of control and decision-making.

It is certainly about control. It's all about how to wield that in real terms, because the rest of the stuff will trickle out to the various arms of it but unless we have control at the higher echelons we will lose it. We will never get the right outcomes no matter how much fancy numerical power we get (T33: Kaiarahi Hauora - Tane, 2003).

One kaiarahi hauora reiterated the importance of control through the articulation of the need for Maori to have a greater voice in decision making related to health advancement for their own communities:

It is important for Maori voices to be heard and heard strongly on those boards [DHB] and for us to have people sitting on the seats around the table where the decisions are actually made (T1: Kaiarahi Hauora - Koroua, 2003).

Kaiarahi hauora throughout the research articulated a desire to re-vitalise Maori ways of dealing with health in the broadest sense of the word. In some cases, they referred to the importance of maintaining identity and that through a strong identity as Maori, Iwi, Hapu - health development would be enhanced.

> *You know the focus here is Hapu. That's not to ignore the whole Iwi but its about the wellbeing of the Hapu first and by association Iwi and Maori, that is the focus of everything, it is really Hapu driven* (Pirirakau Hauora Case Narrative, 2004).

In other cases, it was more about the way in which Maori make a commitment to enrich who they are as Maori people:

> *In terms of actually understanding the taha wairua side...it's a question of not what you do, but how you do it. If you were to sit down and talk straight about those sorts of things, a lot of people would sort of back off...with my way of teaching, if you want to call it that, is to teach with parables. You tell lots of stories, lots of memories, lots of jokes and all those sorts of things, and those sorts of things actually ease away people's resistance and make them much more willing to look at the really hard questions* (T18: Kaiarahi Hauora - Tane, 2003).

However, kaiarahi hauora aspirations for social change were tempered by a growing concern with the motives of individual Maori people and the way in which they conduct themselves as community leaders. In some cases, the basis from which these types of Maori leaders work does not support the collective people nor Te Ao Maori aspirations – referred to as *Tuturu Maori* in this except:

> *I notice those old people and those koroua, they say, "Oh, its neat, you know these people can do all the mahi", but those young people are not all looking to Tuturu Maori. In fact, some of them are not looking Maori at all – they just want to get on and do the mahi and do things that they feel that are good for them and then...And a lot of it is not good for them because they don't look at doing it for the whole of the community* (T23: Kaiarahi Hauora - Kuia, 2003).

Some expressed a concern that in other cases, the learning of some people based on the University educational system of learning does not always expose Maori people to the foundations of Te Ao Maori:

> *These people who have come through the university system, who have battled and done well and now heading down to Wellington [the capital city and the locus of*

government], making decisions for the whole country, who are very proud to be Maori, who have a beautiful gift of the reo, but they in actual fact have a very Pakeha mind. I have a feeling that maybe this is the final death knell of the whole of the Ao Maori you know [added] (T18: Kaiarahi Hauora - Tane, 2003).

12.6 SUMMARY

Research outcomes gauged through the case narratives and research conversations held with kaimahi hauora and kaiarahi hauora were presented in this chapter as a means to illuminate the primary purpose of this research inquiry into the appropriateness of social marketing to support Maori health advancement. The responses are presented as narrative excerpts which are divided into four different sections, seeking wherever possible to address several research sub-questions presented in *Chapter Eleven.* The first section of the chapter reports on the conversational excerpts that focus upon the potential positive and negative implications associated with utilising social marketing as a tool for advancing Maori health and wellbeing, through the practical expression of Maori health promotion. In this series of inquiries, it was illustrated that many of the kaimahi and kaiarahi hauora are receptive to using social marketing. Reasons for its use included that social marketing terms (drawn from marketing) are already being used by Maori health advocates, that the model could improve planning and organisation and that there is a certain type of trendiness associated with using 'marketing'. However, many of the participants were not aware of the potential implications of the uncritical uptake of apparently neutral organisational techniques – of which social marketing is one, until the workshop was conducted. A greater sense of understanding the associated risks to the viability of Te Ao Maori would not prevent them from implementing social marketing if the opportunity arose. What did impact their willingness to implement social marketing was the availability of resources and a willingness by management to progress the implementation. As such, the warnings implicit in our explorations did not seem risky enough to kaimahi hauora, to warrant discarding the potential that the model appeared to promise. It was also reiterated that if social marketing was to be useful, its conceptual foundations would need to be modified to align with Maori health desires as a result.

In the second section, a series of participant responses were presented regarding oppressive and domesticating effects associated with progressing Maori health advancement. Many illustrations were presented throughout the research conversations. Some of the concerns included: disquiet with the impact of neoliberalist policies upon Maori health and the interplay of power between government health officials, health promoters and the community. The way in which ideologies of neoliberalism have filtered through to influence the enhancement of Maori health and wellbeing being articulated within health agreements with Maori health providers is an example. The cyclical and short term nature in which health contracts are provided is also deemed problematic. The ongoing devolution of services through to community groups continues to transfer accountability and responsibility for health advancement from the Government to the community-based groups and organisations of which Maori resemble.

The growing complexities of social ailments in society and the impact they have upon Maori families is undermining the resolve of Maori community people to find solutions to their own health concerns and needs. Maori health providers are therefore attempting to address these concerns with the resources made available to them through government health contracts. However, their efforts are constrained by under-resourcing and often extended work performed by kaimahi that is not translated nor recognised in future funding opportunities. The transitional nature of staff is also problematic. The lack of specific skills sets within the community-based committees is impacting upon the ability of these groups to grow and prosper. These clearly articulated impediments inevitably affect the services, activities and opportunities that were made available for their communities.

Notwithstanding, Maori health providers within Tauranga Moana consistently articulate a desire to provide holistic opportunities for Maori to achieve health and wellbeing founded upon Te Ao Maori. However, these aspirations are destabilised by: the prevailing social order, prevailing health rules and regulations and the subtle ways in which Maori health is compartmentalised into specific contractual tasks and activities. Whilst the passion for encouraging and working towards Maori health goals instils resolve in many of our people to work in this area, sometimes the work is difficult to fulfil, given the practical and conceptual expectations of this type of work.

To conclude, the narratives demonstrate that benefits could be derived from implementing the social marketing approach through improved planning, or that modifying aspects of the model would overcome many of the concerns highlighted in the analysis. The narratives also generated a growing clarity among some participants that in the long term, social marketing concepts and the potential threats posed with reconfiguring health as 'a commodity', 'Hapu' as 'a market' and 'people' as 'things' pose significant risks to the platform for holistic Maori health and wellbeing being espoused consistently throughout this research.

CHAPTER THIRTEEN: HOKI ANO KI NGA WHAKAARO NUI – CONCLUSION

"Mauri Oho
Mauri Tu
Mauri Ora

Awaken essence of life
Vibrant, Invigorated
Eternal Wellbeing"

13.1 TE TIMATANGA – INTRODUCTION

Research efforts claiming 'Kaupapa Maori research' status, *must* fundamentally demonstrate an explicit commitment to the re-invigoration of Te Ao Maori – the source of Maori health and wellbeing. This research investigation into the appropriateness of social marketing to support Maori health advancement is therefore compelled to meet that requirement, or at the very least demonstrate where connections to strengthening 'Te Ao Maori' can be achieved and where vulnerabilities persist. This task is not merely an academic exercise. It is a form of transformative praxis focused on the express wishes of those engaged as participants in this research. The task is to uplift the 'spirits of people' to endorse transformative social change, not just as something likened to a 'lofty dream', but as a *social obligation.* In the words of a kaimahi hauora:

> *My hope is that we can organise ourselves and we can strengthen our identity. I think we need to do that. I was going to say, it's not selfish, we have to be selfish! Absolutely selfish about protecting our identity of who we are. This whole thing is around your opportunities. This is the value thing around your obligation to protect things for the next generation* (Waipu Hauora Case Narrative, 2004).

In the context of this research, the strengthening of Te Ao Maori is channeled through the active advancement of Maori health and wellbeing, drawing from and towards strengthening ontological and epistemological forms of Maori knowledge.

In Aotearoa New Zealand, there are at least three ways in which Maori health is being portrayed. The first, a medical depiction provides disturbing statistics of Maori

morbidity and mortality (Ajwani et al., 2003). The second depiction extends beyond the medical model by providing an insight into the socio-political conditions that contribute to Maori ill-health and a lack of well-being (Howden-Chapman & Cram, 1998; Howden-Chapman & Tobias, 2000; Robson, 2004). These were discussed in *Chapter One.* In this thesis however, a third and different approach to the depiction of Maori health is presented. In collaboration with the research participants, guided by the principles of Kaupapa Maori researchers and building upon the principles of Te Ao Maori, we have depicted Maori health as an aspiration for wellbeing actively, courageously and passionately pursued under less than ideal social, economic and political circumstances. It is through this third approach that our inquiry into the potential contribution of social marketing to Maori health development was conducted.

In this final chapter, I accentuate the concern that has arisen for me as a result of our working closely with the research participants in this research. My concern is with the *uncritical* uptake of social marketing as an attempt to meet immediate contractual or pragmatic needs of organisations. I contend that any tool (technique or mechanism) taken from Western organisational practice carries with it obfuscated concepts and values that may undermine the transformational aspirations all participants were passionate about through the [unwitting] transfer (or infiltration) of cultural concepts common to western marketing paradigms. Many of these cultural concepts, epitomised in the reframing of 'the human being' as a 'customer' or 'target market', undermine the holistic understanding of nga tangata Maori.

I demonstrate through the research narratives that Maori involved in this research are expressing a willingness to explore the adoption and adaptation of these foreign technologies or tools as a possible means of enhancing Maori health and wellbeing, sometimes through the need for perceived contractual compliance, other times by choice. This thesis has demonstrated how through our collaborative critique of social marketing that my participants and I have been able to unravel aspects of social marketing that would serve as a subtle undermining of Te Ao Maori. We have demonstrated a process of work that meets the principles advocated by Kaupapa Maori theorists nationwide. Through our work we attended not only to the task of understanding social marketing and its potential risks and benefits, we also actively

engage in the invigoration of Te Ao Maori. There are three remaining sections in this thesis. The first section reviews the research pathways adopted to complete this research. The second section presents a summary of the concluding research insights. The third section draws the thesis to a close.

13.2 NGA HUA O TE RANGAHAU – RESEARCH PATHWAYS

In the *Prologue,* I identified how my academic training in the functionalist traditions typical of management disciplines influenced the way in which I initially framed my aspiration to contribute through my research to the work of enhancing Maori health and wellbeing. The functionalist approach was a predominant and generally unquestioned paradigm of my education at that point. This approach had allowed me to identify some conceptual tensions between the discourses of social marketing and those of Maori health development. The paradigm that provided these insights, however, did not provide a way forward to resolve those tensions. At best, it required only a superficial engagement with the people I wanted to work with and it would not, as a methodological or ethical commitment, require any in-depth understanding by the participants of the overall research project and process. However, as the initial phases of the research transformed my learning, I became apprehensive about exploring and asserting what it means to be Maori within contemporary management research disciplines. I needed to address this discomfort.

As I came to address the misfit between my original training and the transformational aspirations I had for my research, the theoretical tenets being explored by Kaupapa Maori advocates enabled me to reassess my direction. Kaupapa Maori theory provided me with an opportunity for a new way of thinking. Coming to familiarise myself with this way of thinking compelled me to explore the work of contemporary critical theorists working in the organisational disciplines. Their emancipatory aspirations urge researchers to challenge the domination bought about by unequal power relations manifest in many research processes (Alvesson & Deetz, 2000; S. Lawrence et al., 1994). Kaupapa Maori research perspectives generate a localised critical theory that can and has been applied to Maori social phenomena (L. Smith, 1991). The application of Kaupapa Maori tenets to explore the contextual tensions

between Maori health and social marketing was now a path open to me. Through the extensive works of Graham Smith, Linda Smith, Russell Bishop, Leonie Pihama and similar theoretical orientations associated with Maori development and indigenous development internationally by other authors, I found a common theoretical foundation for emancipating indigenous and marginalised people that justified embedding this work within Kaupapa Maori theory. The outcomes of this research provide insight into the processes and appropriateness of social marketing for Maori health development.

Through this research it has been possible to elaborate upon and amplify the insights of Kaupapa Maori theory towards a critical theory of Maori health and wellbeing. Whilst it is acknowledged in the literature that strands of this theory have been previously applied to Maori education, in this research those theoretical strands were applied in an exploratory way to the efforts of advancing Maori health and wellbeing (see *Chapter Four*). A commitment to those theoretical tenets facilitated a consciousness raising effect among all participants, myself included.

By association, Kaupapa Maori theory influenced the examination of Kaupapa Maori research methodological concerns and the adaptation of compatible methods in this research. Kaupapa Maori research methods appealed to me because they include and value the contribution of the community as equals and not passive objects of study. The voices of the kaikorero and their reviewing of the research process and research documentation ensured that the research rests with the community in partnership with the researcher. As such, the story reporter or researcher, through their obligations as a Kaupapa Maori researcher ensures that the criteria of accountability, authenticity, responsibility and legitimacy are adequately met (Bishop, 1994, 1996b, 1997a). This is an obligation I undertook and have demonstrated throughout the various activities that combined to make up this project and in the writing up and handing over of the cases to the organisations involved. The validity of the process is established by the support of the participants for the written work that has emerged and the ongoing good relationships that have been established.

Aspirations in the research process for collaboration - an important ethic - influenced the development of research methods adopted in this research - case narratives, conversations, workshop hui and document and literature reviews. These drew out significant and important ways of recognising and endorsing Maori concepts of research engagement borne from Te Ao Maori, such as the emergent terms adopted to describe Maori researcher position such as kaiarahi hauora, kaitautoko, kaumatua and kaikorero. These terms were an outcome from this inquiry that emerged organically from a commitment to the ethos of Kaupapa Maori research. The symbolism and meaning of these descriptive words facilitated the positioning of researchers and participants in ways that endorsed Te Ao Maori. The research narratives that were developed from the conversations and hui provided another opportunity for the research community to come together, share, reflect, review and endorse the process of research and the research outcomes.

Kaupapa Maori research aspirations, methodology, methods and their application facilitated insights well beyond the original project I had envisioned from my positivistic beginnings. To illustrate, it was found that Maori women in particular performed multiple tasks as a chairperson, trustee, health worker, grandmother, parent, kuia, mentor, not within the one organisation but across several organisations simultaneously. This type of multi-tasking was not reflected in the organisational management literature or the research methodology literature. Nor was the term hui – an appropriate cultural construct for group meetings reflected as a viable Maori research method in the literature. The development of culturally appropriate research terminologies was another positive outcome of this research project that was not originally intended at the outset. However, despite the evidence that this type of research provides rich insight as well as engagement in social change, Kaupapa Maori theory and methodology are still difficult to locate in the organisational literature. Kaupapa Maori theory and methods of research are much dependent upon the researcher who wishes to be guided by Te Ao Maori. Their application is still relatively underdeveloped in mainstream management schools of learning in Aotearoa New Zealand. Consequently, the strengthening of Te Ao Maori is inherently interlinked with an expectation by Maori researchers to also strengthen Kaupapa Maori theory, methodologies and research methods. It is a generative circle.

13.3 NGA KORERO WHAKAHIRAHIRA – RESEARCH INSIGHTS

In the preceding chapter, conversational excerpts were presented to demonstrate participant views about their commitment to Maori health and their insights into the potential of social marketing. In this section, concluding research insights (see *Chapter Twelve*) are collated to focus on the primary research purpose of *investigating the appropriateness of social marketing in support of Maori health advancement*, the sub-questions pertaining to wider environmental issues impacting upon Maori health advancement and deeper ontological and epistemological issues about Maori values, beliefs and norms. The emphasis drawn from these research insights have been developed into five themes: social marketing review, Maori health promotion, a commitment to Te Ao Maori, health sector issues and organisational issues.

13.3.1 Social Marketing Review

The most prominent outcome of this inquiry into the potential appropriateness of social marketing for Maori health development is the reporting of a willingness by participants to consider its adoption or adaptation. The grounds upon which support was given include

- The pre-existing use and familiarity of some social marketing terms
- The existence of an organisational environment conducive to the use of social marketing (making more explicit that 'health' has already been embedded and accepted as a 'market product' among us)
- The perception that the technique is something new and improved that could be harnessed to a desirable effect.

Those kaikorero who were keen to adopt social marketing recommended that particular terms be modified or altered to address their perceived incommensurability with the aspirations of Maori health providers to promote Maori health in a cultural appropriate way. How that modification might occur was not a debate readily discussed in the literature. Simple word modifications in the literature were associated with the potential impact of social marketing terms upon an established and alternative lexicon for health promotion (Buchanan et al., 1994; S. Jones, 1982), but

there was no commentary associated with modifying social marketing terms, to best suit different cultural settings, of which Maori were potentially one.

A number of negative implications emerged within the discussions of potential adoption or adaptation. Of particular concern to me however, is the basis upon which kaikorero viewed the modifications to social marketing as appropriate. The conversations demonstrated that Maori health providers were resigned to adopting the social marketing model because it was seen as a necessary requirement within the current socio-political arena of health care provision. Some kaimahi hauora seemed to conclude that there were limited alternatives available to them and that whilst they would not necessarily implement social marketing within the foreseeable future, they would do so if required and they would not see this compliance as overly problematic.

Some participants expressed discomfort with using terminologies such as 'target market' to define Maori populations and 'clients' or 'customers' to define their Whanau members, kuia and kaumatua. As these discussions unfolded, other participants, particularly the kaiarahi hauora, were quite verbal about the potential contradictions that would ensue should social marketing be uncritically implemented as a typical model for Maori health promotion. Many of the kaiarahi hauora were mature, highly experienced and possessed a vast knowledge base in Maori health development issues on the whole, making their views, as critics in this research inquiry worthy of the utmost consideration. Whilst the research indicated that short term benefits may be derived from adopting social marketing as a model for health promotion, when the model was situated within a Maori health development framework its shortcomings were exposed as a stark contradiction to the holistic aspirations of Maori.

But, the most prominent insight to emerge from this research related to the uncritical application of the social marketing lexicon by Maori health promoters in their work. It was shown through the narratives that Maori health promoters are at risk of further reconfiguration of 'health' into 'products' or 'commodities'. For instance, the use of the term 'market' for 'hapu' and 'client' for 'Whanau' conjured up a sense of uneasiness amongst participants. One kaimahi respondent stated that, *"it [simply] doesn't sound good"* (Whaioranga Trust Case Narrative 2004). Although all of the

kaimahi hauora involved in the development of the case narratives understood the implications associated with the use of social marketing as a result, they remained receptive to its use.

The undermining effects of this 'meaning-creep' I describe above, has cost te Ao Maori significantly in the past. As an historical example, I am thinking now of our complicity in the re-configuration of the concept of whaea. This concept, in the context of Te Ao Maori refers to the broader notion of a mother, who cares for extended Whanau members as well as her own. Today, in policy and in practice, it is a word that denotes the biological mother of a child. The imputation of new meaning onto this word serves to reconstitute Maori Whanau in the image of the coloniser. The process of consolidation of the preferred family structures of the coloniser is not that far removed from the reconfiguration of humanity as mere 'market producers' and 'consumers', a form of neocolonialism affecting the world at large. It is to the critique of this global colonisation of humanity, that Kaupapa Maori researchers have a significant contribution to make.

Without a more invigorated critique amongst Maori practioners in all social organisations, from law to agriculture, from preschool education to mental health care, the uncritical acceptance of this type of conceptualisation of Maori 'service delivery' will undoubtedly see the ongoing superimposing of a globalising worldview over Maori worldviews. As a result, a subtle but powerful form of re-colonisation of Te Ao Maori through instrumental and technical means will continue. To transform this outcome, Maori researchers are encouraged to consider a critical orientation towards the theorisation of Maori health and well-being based on Te Ao Maori – and in all the professions that claim to serve Maori.

13.3.2 Maori Health Promotion

The *Te Pae Mahutonga* model outlined in *Chapter Eight* (Durie, 1999) was used as a basis for Maori health promotion. The model provided a set of principles and concepts to guide aspects of the workshop concerning Maori health promotion. *Te Pae Mahutonga* and other models such as *Kia Uruuru Mai a Hauora* (Ratima, 2001) help retain and locate the importance of Te Ao Maori as central to the way in which

Maori health promotion activities can and should be conceptualised and operationalised. Through the collaborative work undertaken by the kaimahi hauora and I during the workshop, *Te Pae Mahutonga* was not only endorsed by the participants, but they went as far as to posit another Maori health which was called *Te Kahui Whetu* – an assembly of supporting concepts representing stars. The kaimahi hauora found that the conceptual principles for their approaches to Maori health promotion contributed to strengthening those concepts already presented in existing Maori health promotion models. What this finding implies is that Maori think about and practice Maori health promotion according to prescribed tenets in similar Maori health promotion models, though they do not necessarily verbalise the tenets as a prescribed model of practice.

The research also achieved the alignment of the concepts - *mauri oho* (conscientisation), *mauri tu* (resistance) and *mauri ora* (transformative social praxis) with Te Ao Maori and critical theory concurrently to demonstrate a commitment to addressing Maori health advancement through Maori health promotion. For instance, in *Chapter Twelve* the notion of resistance through *mauri tu* is a positive way in which to reinforce the values inherent in Te Ao Maori. The notion of *mauri ora* is one of the themes in this research, which draws our attention to the overall wellbeing of our inner essence, our life-force. In sum, the research insights gleaned from this research have helped shape a collaborative research narrative of inquiry related to the enhancement of Maori health and wellbeing through a critical engagement of social marketing by kamahi hauora in Tauranga Moana. In particular, the four case narratives, created as a direct result of this research process, are a testament to the commitment and perseverance of Tauranga people to continually advance the health and wellbeing of their Whanau, Hapu and Iwi. Through these processes, the ongoing commitment of Maori to Te Ao Maori will balance with the practical reality of managing the contemporary phenomenon of Maori health development through Maori health promotion.

13.3.3 Commitment to Te Ao Maori

In *Chapter Two*, I articulated an obligation by Maori health advocates to Te Ao Maori. Through the research, a coherent commitment by kaimahi hauora to an

ongoing influence of Te Ao Maori emerged. In the case narratives for instance, Te Ao Maori provided a foundation for kaimahi to explore the health benefits derived from forging closer connections between enhancing Maori identity and health. For instance, the prominent and continued use of Te Reo Maori sprang from a deep commitment to the cultural meaning derived from our own language, which was not to be taken for granted. Te Reo Maori provided Maori health advocates with a doorway to Te Ao Maori. The term *tangata whaiora* is an example of the way in which Te Reo Maori conveys meaning simply and eloquently. This term translates into 'person in pursuit of wellbeing,' a term quite different from consumer or client - which literally means recipient of services. The use of Maori language ensures that Maori philosophical teachings are transmitted through language and it serves as a means of resisting the subtle and also outright embedding of neocolonial and neoliberal terminologies within our practices. For instance:

> *tangata whaiora is a lovely way of putting it and I can live with that as a Maori you know, but if you say 'the customer or a product'...I think oh please!* (Whaioranga Trust Case Narrative, 2004).

Tikanga Maori is seen in the research as a way in which Te Ao Maori was practiced (A. Durie, 1998). The flourishing of these cultural practices through the inclusion of whenua, marae, wharenui, papakainga and those people who helped maintain connections to Maori ways such as kuia and kaumatua were acknowledged for their ongoing meaningful contribution to the enhancement of Maori health and wellbeing. Also, the emergence of a deeply expressed desire by kaimahi hauora to provide health promotion and health education development opportunities for the community that are holistically and culturally consistent with being Maori emanated from this commitment to Te Ao Maori.

The thriving of Te Ao Maori was deemed by participants to offer much to enrich Maori health and wellbeing. It was also considered to be constantly under threat of dissipation by externalities such as urban sprawl, the loss of tikanga in contemporary organisational practice, the passing away of the kuia and koroua who were seen as human repositories of matauranga Maori and the ongoing fragmentation of the Maori populace. In the research, kaiarahi hauora and kaimahi hauora had the task not only to ensure that Te Ao Maori is the basis upon which Maori health and wellbeing

emanates, but also to ensure that the knowledge base is protected and nurtured. In the context of the trustworthy nature of the research conversations, it was also brought to light that Maori conceptual frameworks of health were sometimes limiting. For example, one kaiarahi hauora explained that Whare Tapawha had only four walls. But where is the roof? Ongoing work is therefore needed to extend upon the work already built by previous Maori health advocates. I suggest that one way to invigorate these constructive reflections is through processes of research demonstrated in this thesis.

13.3.4 Health Sector Issues

Chapters Five through Nine theorised the socio-political context of Maori health development and the externalities that impact upon the ability of Maori to enhance Maori health and wellbeing. These chapters also serve as a means to respond to secondary questions raised in this research. These chapters highlighted that all of the Maori health providers were exposed to gradual forms of neocolonialism that threaten to co-opt our people into thinking that health can be constructed as a commodity to be purchased on the market, undermining holistic and spiritual approaches to health in the process. This compartmentalisation of health - often required in health service contracts is contrary to the aspirations that Maori health providers are articulating in the research narratives. This increasingly competitive environment of health impacts all of the Hauora – adding more stress and tension to the achievement of the goals as they are set - and at the same time deflecting energy and resources away from creating something more compatible with Te Ao Maori. This trend is further exacerbated by the perception that Maori health issues and processes are being subjugated by technologies emanating from business models that are inappropriate to the context of holistic health care. A negative consequence of the imposed business system upon Maori health providers in particular is the reconfiguration of 'Maori health' as a 'product' and 'Hapu' as a 'market'. The holistic kaupapa for Maori health as espoused by the *Whare Tapawha* model and constantly referred to in this research emerges as an incompatible contradiction. The extent to which Maori practioners will attend to this contradiction will affect the very possibility of our people becoming the tangata whaiora of the future.

The creation of a competitive health environment has stifled some collaborative ventures and contributed to the establishment of new institutions, which are now responsible for addressing many of the political concerns associated with Maori health advancement. This competitive and political environment of health has exposed Maori health providers to the volatility associated with ensuring that people possess adequate skills sets and that these people are retained within the health sector. It has also contributed to a construction of health as political (Coney, 1996). These types of traits are becoming characteristic of the current New Zealand health sector in which Maori health providers operate. One Hauora rationalised these impediments by calling themselves 'kohanga reo' for health workers, as they progress through their careers (Whaioranga Trust Case Narrative, 2004).

The narrative of Maori health development in Tauranga Moana outlines many accomplishments amongst the challenges. For instance, the Whaioranga Trust narrative is indicative of the ongoing strength prevalent within Maori health provider centres. Whaioranga emerged as a strong but steady contender for serving the needs of tangata whaiora in their search for ways to improve their wellbeing (or in the case of mental health), searching for ways to ensure that their people retain their rightful place as valued members of the community. For example, the innovative spirit of Whaioranga's inception has been rewarded with recognition of their efforts as one of the first marae based Maori health providers in the country (Te Puni Kokiri, 1994). Similar Tauranga Moana narratives of development and perseverance emerged through this research. These narratives helped to cement the value and importance of sharing stories. This research, although conceived as a concern for the health status of our people, reports a spirit of innovation in Tauranga Moana. This spirit has translated into some of the most remarkable achievements in Maori health development seen nationwide within the last two decades.

> *People in Tauranga have really deserved to be acknowledged for all their support, involvement and participation that they have put into Maori health. Some have done it locally, some have done it in their Whanau and a significant number have done the kinds of things that have been modelled for a time for other people in the rest of the country* (T24: Kaiarahi Hauora - Wahine, 2003).

13.3.5 Organisational Issues

A number of organisational issues emerged across the Hauora during the research. Most prominent was the lack of adequate resources within the health sector in which Hauora are situated. Adequate resources must be allocated to Maori health providers so that they are able to meet their policy and contractual responsibilities. For instance, the risk of attributing blame for accepting unrealistic expectations in contracts upon the Maori health provider leads to the proliferation of under resourced groups who try to meet many more needs, over and above the contract specifications. It is reported by some Hauora that they are required to accept increased service deliverables within existing contracts, although they are provided with few reasons and no extra resources for these changes.

An analysis of Maori health policy illuminates the effects of the devolution of responsibility from government agencies to private providers. Maori health providers are a part of this global trend in western economies. The process of devolution has contributed to increased bureaucratic duties required to help track and record performance of contractual obligations. In this regard, participants report that health is achieved through a system of measuring health as a series of checklists and evaluation reports that dehumanise the achievements of community people in health into legalised contractual arrangements. Passionate community workers unfamiliar with these political and legislative components of contracting in the current health environment accept the conditions as mandatory. Kaiarahi hauora articulated that they saw this added responsibility as the ongoing unequal redistribution of health resources dressed up as community opportunities in primary health care.

While concerned with the sometimes unrealistic requirements of the contractual cultures, the people who have remained and grown with these organisations for some time claim that they are ready to lift the standard of performance. Their call, however, is that they need to be properly resourced to do this. Their skills and knowledge of Te Ao Maori, of working with limited resources and of making a little go a long way must also be acknowledged.

High turnover of people within the sector is a concern for each of the kamahi hauora. Skilled people form the backbone of any organisation and the loss of people impacts upon the ability of Hauora to perform current duties and to plan for the future. While staff turnover may be useful to an organisation in terms of new ideas, ongoing recruiting, re-training and up-skilling of people replacing those who have left impacts upon the ability of Hauora to connect to the prevailing core health issues at hand.

As well, emancipatory tenets of Kaupapa Maori theory require some form of commitment to social transformation. In this research a series of recommendations were presented to help transform some of the concerns raised by kaimahi hauora. The recommendations sought to highlight the benefits of ongoing research within the Hauora through enhanced capacity building of kaimahi. The recommendations provided suggestions for transformation. For instance, one recommendation to emerge from the conversations is that evaluation surveys be converted into reports that help decision makers with organisational improvement and growth. The use of research, as modelled in this thesis, is another avenue through which to enable each of the Hauora to devise future opportunities for development. The discussion about the dearth of skilled people and ways to retain them led to recommendations for long-term career planning and ongoing training to improve people skills. It was also recommended that all of the Hauora should organise annual community hui to gauge what types of services are needed within the community and to ensure that meaningful connections between people and the Hauora remain constant and strong.

13.4 NGA KUPU WHAKAMUTUNGA – FINAL WORDS

At the heart of this inquiry has been a deep concern for the way in which Te Ao Maori may be undermined by the imposition of functional management disciplines such as social marketing. Social marketing may be seen as a discipline, a process or a tool. It is comprised of techniques that appear value neutral. Further analysis has exposed its foundational roots nestled squarely within the bastion of neo-liberal capitalism and it rationalities and techniques of which social marketing associates is but one. This broad ideology, recently expressed as a 'Third Way' (see Giddens, 1998) is a compilation of profound values that are not always compatible with those that comprise Te Ao Maori. That insight in and of itself is not inherently problematic

except when those tenets are broadened to claim jurisdiction over all non-commercial and social terrains, discounting in the process the ethos and principles of existing and other approaches to social change. Social marketing is therefore argued in this thesis to be a value-laden technology founded upon an agenda which commodifies health and wellbeing. For Maori, those implications translate into the reconfiguration of 'Hapu' as 'markets', 'Whanau' as 'clients' and 'hauora' as products. The use of commercial terminologies has also exposed Hauora to the influences of technical rationality and instrumental reasoning, revealing the vulnerability of these organisations to economic rationalism, drawn from the ever increasing influence of 'business' upon 'health'.

Through this research I sought to contribute to the strengthening of Te Ao Maori by providing Maori health advocates with critical tools (such as Kaupapa Maori theory and workshop training) to analyse the implications of adopting social marketing. In the process, I have also demonstrated the importance that Maori place upon cultural identity. Ongoing commitments by kaimahi hauora to develop holistic approaches to Maori health and wellbeing that are based on cultural foundations have consistently emerged in this research. But, these talks become problematic if Maori health advocates argue for space to implement Maori health models whilst simultaneously being receptive to an uncritical application of technical tools such as social marketing. I have argued that the risks associated with uncritically implementing social marketing contributes to the further embedding of the commodification of Maori health and the colonisation of thinking attuned to that technical worldview.

As a result of the deep and generous conversations that constitute this research, it is now my view that in the long term the potential threats associated with using social marketing far outweigh the short-term benefits. The long-term risk is the diminishing and devaluing of the constructs that underpin Te Ao Maori and the very emotional, spiritual, cultural and holistic ways in which people are viewed within broader communities, Whanau, Hapu and Iwi. If Maori health advocates, do not see that potential realisation as problematic, and do not heed these cautions, they risk contaminating the very *mauri* of Te Ao Maori to which they are trying to protect and invigorate.

The obligation to protect these things that are sacred is the responsibility of us all; it is not an insurmountable task. It requires strength, commitment, conviction and dedication. That strength can be drawn from the pursuit of dreams based upon a deep sense of passion for *mauri ora* - transformative social praxis. The sense of hope and optimism is what fuels the notion of *mauri ora* reiterated within this thesis.

Glossary of Maori Words

ahi	fire
ahuatanga	likeness
ao	world, cloud
Aotearoa	land of the long white cloud
ariki	first born male or female of a chiefly line
aroha	love, compassion, affection
atua	god, supernatural being
haere	come, go, depart
haka	war dance
Hapu	sub-tribe
hauora	health, Maori health organisation (contemporary)
hihiri	eagerly desire, long for, spring up, rise up
hikoi	walk, march
hiranga	greatness
hono	join
hui	meeting, gathering
ika	fish
Iwi	tribe
kai	food
kaiarahi	leader
kaiarahi hauora	Maori health leader
kaikorero hauora	health spokesperson
kaimahi	worker
kaimahi hauroa	Maori health advocate, Maori health worker
kaitautoko	supportive advocate
kaitiaki	carer, or guardian
kaitiakitanga	responsibility of care
kanohi	face

kapa haka	group of performers
karakia	prayer
karanga	call
katoa	all, the whole
kaumatua	male elder
kaupapa	topic, theme, plan, scheme, proposal
kawana	govern
kawanatanga	government
kete	kit
koha	gift/ contribution
kohanga	nest
kohanga reo	Maori pre school language nest
koiwi	bones
koroua	male elder/ female elder
kotahitanga	unity
koutou	all, three or more people excluding the speaker
kowhaiwhai	painted scroll ornamentation
kuia	female elder
kukuroa	horse mussels
kupu	word
kura	school
kura kaupapa	total immersion school
mahi	work
mana	influence, prestige, power, respect
mana wahine	influence, prestige, power, respect of female
manaaki	foster and care
manaakitanga	responsibility to foster and care
manuhiri	visitors
manukura	chief, leader in council
maoritanga	Maoriness
marae	immediate buildings, meeting house and dining

	hall
marama	clear
maramatanga	understanding
matao	cold
Matariki	Pleiades, the first appearance of which before sunrise indicated the beginning of the Maori year; this was about the middle of June, constellation of stars
matauranga	knowledge
mau rakau	traditional Maori combat training with a long stick
Mauao	caught by the dawn. Name of the mountain that pertains to the people of Tauranga Moana
Maunganui	large mountain. The name that Mauao is known by today
mauri	life principle, thymos of man
mauri oho	conscientisation
mauri ora	transformative praxis
mauri tu	resistance
mirimiri	massage
moana	sea
moenga	bed
moenga rangatira	union of two chiefly people
mokai	responsible assistant
mokopuna	grandchild
moteatea	lament
nga	more than one, plural
ngakau	heart
noa	free from restriction (tapu)
nui	big, great
oranga	participation in society, well-being

Pakeha	European settlers, New Zealanders
Pakehatanga	expression of Pakeha culture and beliefs
papakainga	sub tribal settlement or village
pataka	storehouse
pepeha	A series of statements linking one to cultural symbols such as specific mountains, bodies of water, and well known tribal leaders
pipi	cockle, *chione stutchburyi/ amphidesma australe*
po	night
poi	traditional Maori pass time with a ball on a string
poroporoaki	farewell ceremony
powhiri	welcoming ceremony
pumanawa	natural talents, intuitive cleverness
puna	spring *(of water)*
puna wai	spring of water
putea	collection of money
rahui	a mark to warn people against trespassing or for temporary protection of fruit , birds or fish
rangatahi	youth
rangatira	chief
raupatu	confiscation
reo	language
rima	five
ringaringa	hand
ritenga	likeness
roa	long
rohe	geographic area
rongoa	medicine, healing
rua	two
runga	up
taha	side

taha hinengaro	psychological well being
taha tinana	physical well being
taha wairua	spiritual well being
taha whanau	familial relationships and well being
tahi	one
tamariki	child (singular), children (plural)
tangata	person
tangata whenua	people of the land
tangi	cry
tangihanga	funeral
taonga	treasure
taonga tuku iho	cultural heritage
tapu	sacred, restricted
tauparapara	incantation
tauranga	resting place, anchorage for canoes, fishing ground
Tauranga Moana	coastal region in the Bay of Plenty, New Zealand
Te Ao Maori	the Maori world
te ao turoa	external environments: social, cultural, political environments
Te Pae Mahutonga	the southern cross constellation of stars, Maori health promotion framework
tiaki	look after
tikanga	custom, rules
tinana	body
tino rangatiratanga	absolute sovereignty
tio	rock oyster
titiko	mud snail found in Matapihi
tohi	ceremony
tohunga	skilled priest, expert, knowledgeable one
toiora	healthy lifestyles

toru	three
tuangi	cockle, bivalve mollusks, *Protothaca crassicosta*
tuarima	fifth
tuarua	second
tuatahi	first
tuatoru	third
tuawha	fourth
turangawaewae	place of standing, land base
tuturu	fixed, permanent
urupa	cemetery
wahine	female
waiata	song
waiata-a-ringa	action song
waiora	environmental protection, total well being
wairua	spirit
wairuatanga	spirituality
waka	canoe
wananga	meeting
wha	four
whaia	pursue
whaikorero	speech
whaiora	pursuit of health
whakahaere	motivate
whakahihi	boastful
whakairo	carvings
whakanoa	make free from restriction (tapu)
whakapapa	genealogical connections
whakatauki	utter a proverb
whakawhanaungatanga	familial ties, making connection
Whanau	family
whare	house

whare puni	A closely built house with three layers of raupo in the walls, such as those generally used for sleeping in. Sometimes the term is used for the principal house.
whare wananga	school of higher learning, university (contemporary)
wharekai	dining house
wharenui	meeting house
whatumanawa	the expression of emotion
whenua	land
whetu	star

Appendix One: Declaration of Independence

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Declaration of Independence

This is an international declaration signed on 28 October 1835 which recognises the sovereignty of the Independent Tribes of New Zealand. It was the forerunner of the Treaty of Waitangi and has a flag to symbolise tribal rights to trade as independent nations.[1]

The Declaration of Independence

English Version

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 the 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 acknowledgment 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 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

HE WAKAPUTANGA O
TE RANGATIRATANGA
O NU TIRENI

1. Ko matou, ko nga Tino Ranatira o nga iwi o Nu Tireni i raro mai o Hauraki kua oti nei te huihui i Waitangi i Tokerau i te ra 28 o Oketopa 1835, ka wakaputa i te Rangatiratanga o to matu wenua a ka meatia ka wakaputaia e matou he wenua Rangatira, kia huaina, ko te Wakaminenga o nga Hapu o Nu Tireni.

2. Ko te Kingitanga ko te mana i te wenua o te wakaminenga o Nu Tireni 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 Kawantanga hoki kia meatia i te wenua o te wakaminenga o Nu Tireni, ko nga tangata anake e meatia nei e matou e wakarite ana ki te

ritenga o o matou ture e meatia nei matou i to matou huihuinga.

3. Ko matou ko nga tino Rangitira ka mea nei kia huihui ki te runanga ki Waitangi a te Ngahuru i tenei tau i tenei tau ki te wakarite ture kia tika ai te wakawakanga, kia mau pu te rongo kia mutu te he kia tika te hokohoko, a ka mea hoki ki nga tauiwi 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 Tireni.

4. Ka mea matou kia tuhituhia he pukapuka ki te ritenga o tenei o to matou wakaputanga nei ki te Kingi o Ingarani hei kawe atu i to matou aroha nana hoki i wakaae ki te Kaara 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 kia matou i to matou Tamarikitanga kei wakakahoretia to matou Rangatiratanga.

   Kua wakaaetia katoatia e matou i tenei ra i te 28 Oketopa, 1835, ki te aroaro o te Reireneti o te Kingi o Ingarani.

Appendix Two: Ethical Approval

Bay of Plenty
Ethics Committee
144-146 The Strand
P.O. Box 13
Whakatane
Phone/Fax (07) 308 503
Email: Adcam@clear.net.



5 September, 2001

Riri TW Ellis
Tauranga University College
Private Bag 12027
TAURANGA

RE: Assessing Social Marketing Tool to improve Maori Public Health gains
(Our Ref 01/06/21)
Local Investigator: Riri TW Ellis
BOP

Thank you for your responses to the committee's recommendations, which have now been reviewed by the Chairperson, Christine Bowering.

We advise that the amendments as submitted have satisfied the requirements of the committee and ethical approval is granted for the above study to 5th September 2002

A copy of the annual report form is attached. Ethical approval is conditional upon the committee receiving these annual progress reports for reapproval of the study, and a final report on completion of the study together with a copy of any publication. Please notify us if the study is abandoned, or the protocol changed in any way.

Please note that the committee grants ethical approval only. If management approval from the institution/organisation is required, it is your responsibility to obtain this.

The Committee wishes you well with your research. *Please include the reference number and study title in all correspondence & telephone queries.*

Yours faithfully,

Christine Bowering
CHAIRPERSON

COPY

Ethics Committee
144-146 The Strand
P.O. Box 134
Whakatane
Phone (07) 308 5030
Fax (07) 308 5033
Email: adcam@inug.co.nz

7 September, 2002

Riri TW Ellis
Tauranga University College
Private Bag 12027
TAURANGA

RE:	Assessing Social Marketing Tool to improve Maori Public Health gains **(BOP/01/06/21)**
Local Investigator:	Riri TW Ellis BOP Site Specific

Thank you for your annual report in respect of the above study, which was considered by the Bay of Plenty Ethics Committee at its meeting of the 13th August 2002.

The Committee advises that the study has been granted an extension to December 2003. If management approval from the institution/organisation is required, it is your responsibility to obtain this.

A copy of the annual report form is attached. Please notify us if the study is abandoned, or the protocol changed in any way.

Please include the reference number and study title in all correspondence & telephone queries.

Yours faithfully,

Christine Bowering
CHAIRPERSON

Appendix Three: Information Sheet

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Phone +64 7 577 0620
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THE UNIVERSITY OF WAIKATO
Te Whare Wānanga o Waikato
TAURANGA CAMPUS

INFORMATION SHEET

Research Project

"Social Marketing and Maori Health Promotion"

PURPOSE OF STUDY:

This research project aims to critically examine the implications associated with adopting a social marketing model as the framework for Maori Health promotion activities.

ABOUT THE STUDY:

The processes of the research project are as follows;

(a) Collection of Information

- The researcher will collect information on the processes (or methods or frameworks) adopted by Maori health organisations that provide Maori health promotion programs. This will be performed with the use of case study analysis with three to four case study groups. A Maori, Iwi, or Hapu provider is a case study group.
- The researcher will collect information on the processes (or methods or frameworks) and policies used by 'health funders' who contract organisations to provide Maori health promotion programmes. This will be performed by obtaining organisational planning documents and also interviewing key people in, and associated to the organisation.

(b) ..... Interviews and Observations

- The researcher will interview Maori health promoters and Maori health providers to obtain their expert opinions on how Maori health promotion activities are presently being offered and performed.
- The researcher may observe health promoters in the field. This will be performed as part of the case study analysis.

(c) ..... Analysis of the Information

- The researcher will collect all of the information obtained through documentation, personal interviews and case studies at various phases of the research project. Analysis of the information will take place to develop a series of themes, which provide insight into the issues related to improving Maori health promotion activities.

- As part of this project, the researcher aims to conduct a collective social marketing workshop/hui to provide Maori health promoters with the opportunity to evaluate the model.

As the project is based on qualitative research methods, it makes no attempt to find conclusive or statistical results for any of its findings. The fundamental goal of this project is to allow Maori health promoters the opportunity to understand, critique, and evaluate the social marketing model as a framework for improving Maori public health. The reason for this is that it has been extensively tested and researched overseas for over twenty-five years as a viable tool to improve public health. If that research can be validated, every health promotion campaign or programme in New Zealand should be based on a social marketing framework. There is limited evidence to date based on New Zealand examples to support or refute those claims.

PATICIPATION:

In you role as a key informant, key stakeholder group representative, or a case study group, you are invited to participate in this research project. Your participation in this project is voluntary, and at any time you may;

- Refuse to answer any questions;
- Stop the interview;
- Ask any questions you want about the study;
- Ask another person to be present at the interview;
- Decline to participate in the interview;

Each personal interview will take between one to two hours to complete. Each case study group will involve twenty to thirty hours of time through the interviews, meetings and observations with a variety of personnel within the organisation. With you permission, the interview/s will be recorded. Participants in the research projects will be referred, recommended or selected through word of mouth. Case study groups will be selected prior to the initiation of the data collection process. Up to ten personal interviews per case group, and a total of forty to fifty personal interviews for

the entire study will be conducted. Between three and five case study groups will be involved in the research project as well. The research project will take place primarily within Tauranga. The duration of the study is eighteen months with the completion of the interviews scheduled as 31 December 2003.

BENEFITS RISKS AND SAFETY

There are no associated foreseen risks associated with being involved in this research project, although you may be inconvenienced because to the time involved to complete the interview.

GENERAL

Research participants will be forwarded a summary of the research findings at the end of the research project. Further information about the project can be forwarded to research participants at any time, and an interpreter in Te Reo Maori can be made available if necessary. If you have any queries about your rights as a participant in this study, you, may wish to contact the local Health and Disability Advocate on 0800 42 36 38 (Bay of Plenty). A copy of the *Code of Rights* highlighted in the Health and Disability Act is also available on request.

CONIDENTIALITY

The primary data collected during this research project will be stored in files at the Tauranga University College in a locked office. Audiotapes will be kept until the interview is transcribed. Following the transcription, the tapes will be forwarded back to the interviewee on request, or alternatively erased at the conclusion of the research project. Under no circumstances will material, which could personally identify you, be used in any reports on this study.

RESULTS

At any time research participants are welcome to contact the researcher to obtain an update on the progress of the research programme, and published findings will be made available e to all research participants. However, there is likely to be a significant delay as a result of the time required to publish the completed report of

findings. Summary reports will be made available prior to the completion of the final published report.

STATEMENT OF APPROVAL

This study has received ethical approval from the Bay of Plenty Ethics Committee.

PRINCIPLE RESEARCHER:

This research project is being undertaken by:

Riri Ellis
Researcher
Waikato Management School
Tauranga University College
University of Waikato
Private Bag 12027
Tauranga
DDI: 64-07-577-5323
Fax: 64-97-577-5327
Email: riri@waikato.ac.nz

Physical Address
144 Durham Street
Tauranga
64-07-577-0620

Please feel free to contact the researcher if you have any questions about this study.

Naku noa

Riri Ellis
Researcher

Appendix Four: Informed Consent

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THE UNIVERSITY OF WAIKATO
Te Whare Wānanga o Waikato
TAURANGA CAMPUS

INFORMED CONSENT FORM

Research Project

"Social Marketing and Maori Health Promotion"

REQUEST FOR INTERPRETER

English	I wish to have an interpreter.	Yes	No
Maori	E hiahia ana ahau ki tetahi kaiwhakamaori kaiwhaka pakeha korero.	Ae	Kao
Samoan	Oute mana'o ia iai se fa'amatala upu.	Ioe	Leai
Tongan	Oku ou fiema'u ha fakatonulea.	Io	Ikai
Cook Island	Ka inangaro au i tetai tangata uri reo.	Ae	Kare
Niuean	Fia manako au ke fakaaoga e taha tagata fakahokohoko kupu.	E	Nakai
	Other languages to be added following consultation with relevant communities		

Please read the following clauses to ensure that you are fully informed of research project, its aims and who is responsible for undertaking the research. If you have any questions, please do not hesitate to ask the researcher.

1. I have read and I understand the information sheet dated September 2002 for volunteers taking part in the study designed to examine the implications associated with adopting a social marketing framework for Maori health promotion activities. I have had the opportunity to discuss this study. I am satisfied with the answers I have been given.

2. I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time and this will in no way affect my employment.

3. I understand that my participation in this study is confidential and that no material, which could identify me, will be used in any reports on this study.

4. I have had time to consider whether to take part.

5. I know whom to contact if I have any concerns about the research project.

6. I know whom to contact if I have any questions about the research project.

7. I consent to my interview being audio-taped. YES / NO

8. I wish to receive a copy of the summary results. YES / NO

Please Note: There may be a significant delay in the publication of the results.

My mailing address for the summary results is as follows;

Name	
Postal Address	
City	

DECLARATION: I _____(insert full name) hereby consent to take part in this study.

Date:

Signature:

This research project was explained by:

Riri Ellis

Researcher

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E-mail: riri@waikato.ac.nz

Physical Address

144 Durham Street

Tauranga

64-07-577-0620

Signature:

Date:

Appendix Five: Schedule of Questions

CASE STUDY GROUPS RESEARCH GUIDELINES

(subject to development throughout project)

One on One Case Work

- Describe the organisation, goals, aims and what is involved in the particular health programme.
- Describe the health programme and the existing parameters, protocols and systems in place.
- Observe the casework presently undertaken through literature review, document analysis and observations at worksites.
- Undertake an evaluation of the existing methodologies in partnership with the Case Group.
- Develop a preliminary scoping report for analysis by the researcher and the case group.

Learning Process

- Inform all case groups of the basis of social marketing through a series of meetings and hui.
- Re-design the health programme based on the social marketing framework.
- Develop an appreciation by case groups of the pros and cons associated with promoting a social marketing process in public health campaigns.

Sharing the Results

- Meet with case groups individually to obtain feedback on the process and the applicability of the model in the public health sector.
- Meet with all case groups to share results through the presentation of reports.
- Researcher to prepare case study reports in partnership with the case groups as a report of findings.

Publication of Results/Dissemination of Results

- Collate the case group reports with other research undertaken during this study as a draft report of findings to be presented at a hui.
- Obtain support by kaumatua and kuia, case group organisations to prepare the findings into a publication for further dissemination.
- Utilise HRC established guidelines to disseminate the results after approval is obtained by the necessary parties and as per the research project proposal.

INDIVIDUAL PERSONAL INTERVIEWS

(subject to alterations throughout the project)

The questions below serve as a guide for the interview:

1. What is your health profession?

2. What role do you play in the provision of health services or health policy for Maori health development?

3. In facilitating this role, what tasks do you perform?

4. What particular programme/campaign/strategies have you been involved in with progressing Maori health development?

5. In your opinion, what are the differences between public health, health promotion and Maori health promotion?

6. In your opinion, what key public health issues for Maori are prevalent in society at the moment?

7. In your involvement with health, do you have an influence on the provision of public health campaigns aimed at improving Maori health?

8. In your opinion, what are the key components of effective public health campaigns targeted at Maori groups?

9. In your opinion, what key challenges are there to promoting health messages to Maori groups?

10. Are you aware of any particular policies, strategies or models that have been particularly useful for the promotion of public health messages to Maori? Can you elaborate? Do you have any documentation or contact people who I could contact for further information about Maori health promotion campaigns?

11. From these factors below, how do they feature as important components of developing, implementing and evaluating Maori health promotion campaigns?

    - Prior research e.g. target groups, attitudes, behaviour and previous studies.
    - Societal influences e.g. socio-cultural influences, income, and employment.
    - Control and ownership e.g. land ownership, housing and tino rangatiratanga.
    - Resources e.g. community, government, Iwi, Hapu and Marae.

- Public health approaches e.g. health promotion, health education and health communication.
- Utilisation of models e.g. community development or health promotion.
- Financial constraints e.g. volunteers, salaries and health resources.
- Campaign effectiveness e.g. promotion, behaviour change and displays.
- Maori methodologies e.g. Whare Tapawha or Kaupapa Maori.

12. In your role, how do you assist with the development of Maori health?

13. From your observations, have you noticed any changes in the approaches adopted with health promotion for Maori groups in particular?

14. From your observations, can the campaigns be improved?

15. Have you heard of social marketing?

16. Do you know of any organisations in New Zealand that have utilised social marketing?

17. I have some information about social marketing with me, I will leave it with you to look through or you can get back to me if you have any questions if not aware?

18. If you are aware, what is it and do you think it would be a useful model to use by Maori health organisations? Please explain.

19. What are your thoughts about the utilisation of such a model within Maori health on the whole?

20. What are your aspirations and goals for Maori health development in Tauranga?

21. What are some of the key factors within Maori health that impede that development?

22. Do you have any further comments?

POST WORKSHOP SCHEDULE OF QUESTIONS

(subject to alterations)

1. Do you think it is important to be guided by kaupapa with regards to Maori health?

2. Do you think it is important to reflect on the health development that took place in Tauranga Moana?

3. What are you thoughts about linking your work to Maori health development?

4. Are those concepts developed important to the work that you do? Would you like to comment?

5. Was that exercise to decipher Maori health concepts useful? If so, please explain? Was it useful to look at those comments and share your comments with others?

6. What are your thoughts about the session about Maori health and Maori health promotion?

7. In your view how important was it to see health in that way and to reflect upon those comments in that workshop? Do you think that was useful not useful or should I go back? Is it important to see health from those broader concepts of wellbeing?

8. What did you think about the Maori health promotion model? Do those six components have relevance for you in the work that you do?
    - Mauri ora - access to Te Ao Maui
    - Waiora - environmental synergy
    - Toi Ora - healthy lifestyles – toi ora
    - Te Oranga – participation in society
    - Nga Manukura – leadership
    - Te Mana Whakahaere - Autonomy

9. When you discussed social marketing in the latter stage of the workshop what were your initial thoughts?

10. What about some of the concepts like profit, marketing, target markets, the marketing mix, what was your initial reaction with those terms? How would you feel using those concepts in Maori health? What about the procedures and the way that things are organised in social marketing and the examples that I gave were those 4 "P's Price, Promotion, Place and Product"?

11. Is there anything about the social marketing model that particularly appeals to you?

12. Do you have any other comments?

Appendix Six: Workshop Manual

Maori Health Providers Workshop

Is Social Marketing an Appropriate model for Maori Health Promotion?

Facilitated by Riri Ellis

In conjunction with Case Group Participants in Tauranga Moana

March 2003

Disclaimer

This workshop will be recorded onto audio-tape, and the discussions will be transcribed to form part of the data for the research project. A recorder of notes will be present during the workshop as well.

The notes from the transcripts will be made available upon request to those who wish to have a copy for their records. The transcripts and notes obtained during this session are subject to the same procedures outlined as part of the informed consent process. The identity of all workshop participants will not be identifiable in the transcript notes.

Workshop Outline

9.OOam Mihimihi

9.15am Session One - Maori Health in Tauranga Moana

- Maori Health Models
- Components of Maori Health
- Models of Practice
- Maori Health Development

10.15am Kapu Ti

10.30am Session Two - Maori Health Promotion

- Maori Health Promotion in Tauranga
- Mason Durie's Te Pae Mahutonga

11.30am Session Three - Fundamentals of Social Marketing

- Introduction to Social Marketing

12.OOpm Tina

12.30pm Fundamentals of Social Marketing

- Analysis of Concepts, Assumptions, Tools
- Analysis of Labels

1.30pm Kapu Ti

1.45pm Session Four - Conceptualising Maori Health Promotion and Social Marketing

- Comparing Beliefs & Values & Kaupapa
- Comparing Processes and Procedures
- Comparing Practices and Labels

2.45pm Workshop Conclusion

- Resolution from Workshop

3.OOpm Karakia Whakamutunga

Kia ora koutou!

Mihimihi &

Programme

Let's talk a bit about what we all do in our lives.....sharing with our neighbour .... psst - three points about your neighbour....what he or she does in the area of Maori health.....

GET OUT THE QUESTIONNAIRE!

He aha te kaupapa - What draws us here today?

Besides the most obvious reason for being here today - hence, the research project, there are broader more collective goals which operate at levels that we are often unaware of until we take the time to have a look, and to examine those guiding principles and beliefs about why you or I are involved in Maori health initiatives, and why you remain loyal to Maori health development in Tauranga.

Is there also something about being Maori that makes our work important to us, or does being Maori have nothing whatsoever to do with your mahi each day?

What about Iwi? What about hapu? What about whanau? What about marae? What about kaupapa?



Collect up those thoughts, and those queries.....

Session One: Maori Health in Tauranga Moana

There are a number of ways in which Maori health might be looked at in Tauranga Moana. It could be looked at in terms of the timeline related to the development of providers and the services currently offered. We could look at Maori health in terms of the broader Maori health development initiatives around New Zealand and how there have been similar initiatives in Tauranga. We could look at the Maori health in Tauranga, as a direct response to the Treaty of Waitangi, or we could look at the impact of the health reforms upon Maori health. To recap upon some of those issues, we have;

- Timeline of events
- Maori health development in New Zealand
- In response to the Treaty of Waitangi
- Health Reforms and Maori Health

TASK: Let's draw a chronological table of events in Tauranga related to Maori health

Year	Particulars	National	Tauranga	Organisation

One further way is to look at health is from a Kaupapa perspective, in terms of the driving reasons behind Maori health initiatives. For each of our organisations, the kaupapa may be different, or in other cases in might be very much the same. Over the last three months I have been collecting information from research participants to assist with the process of recollecting the kaupapa for Maori health. I'm going to utilise some of

the comments obtained from the research, to help us shape our thoughts about Maori health as a collective group in Tauranga Moana.

TASK: Distribute comments from historical research

I know the aspirations for (A) at that time was strengthening whanau, strengthening young families - #A03:2

You know so it teaches me as a provider to look down that road and just look further than who we are, not forgetting who we are but look further as far as health and social service delivery and services have got to we should be looking at the wider picture, we keep our tino rangatiratanga and our mana when we're on our whenua - #A03:29

The kaupapa that led the Trust was based on a community approach to health that suited, and was led by the women at that time, and according to the existing needs - #A01:1

There has never been any doubt that these types of models that are holistic, and involve a sense of wairua are appropriate to our people. So, it is just natural to encompass it - #A01:2

I think the actual concept was that Manaaki concept ...so we're actually wanting to promote a philosophy, hopefully our people will move towards to them and take it up.... -#B02:4&7

I think Maori for health, for me as a Maori anyway, is about wellness, which has got nothing to do with sickness. ...-#B02:20

I like the ideal of wellbeing is the four cornerstones. I like the idea that we discuss health as wellbeing. It is about yourself, your place of belonging. - #B01:4

You know the focus here is hapu. That's not to ignore the whole Iwi but is about the wellbeing of the hapu first and by associating with Iwi and the Moana, that is the focus for everything is really hapu, hapu driven. - #C02:16

It's really about Maori ways of doing things. We do our best, but it has to be brought back. It has to be brought back to our world view of things. - #C03:22

TASK: Brainstorm together some core principles about Maori health development in Tauranga

- Concepts for Change
- Concepts for Liberation and Tino Rangatiratanga
- Core Principles

Session Two: Maori Health Promotion

It is difficult to pinpoint exactly what Maori health promotion is and what it isn't. Is it a tool utilised in health that draws extensively from the Ottawa Charter (see Appendix One)? Is it a tool that comes purely from a foundation for health based on Maori principles and beliefs? Is it about practice, or systems of health? Does Maori health promotion exist? Let's take a bit of time to explore some of the current issues prevalent in the field of health promotion at the moment.

What is health promotion?

The origins lie in the World Health Organisation definition for health that 'health is not merely the absence of disease, but a state of complete physical, mental and social well-being." Health promotion as such as emerged as a complex and controversial activity that was primarily focused on changing people's health behaviour to a broader all encompassing movement which aims to work at the levels of individuals, communities, organisations, governments and through international agencies. According to the Ottawa Charter, which serves as a type of guide to health promotion, health promotion means

- Building healthy public policy
- Creating supportive environments
- Strengthening community action
- Developing personal skills and
- Reorienting health services.

Health promotion in this context involves the process of enabling people to increase control over, and to improve, their health. How do these concepts relate to Maori health promotion?

Current Themes in Health Promotion for Maori

Health Promotion for Maori is a practice and theme that appears to have developed from both the general field of health promotion, and the broader Maori health development field as well. As with many models, tools, and frameworks, it is not until someone articulates its components in writing, that it begins to take shape and form. In 1999, Mason Durie developed a model of Maori health promotion called Te Pae Mahutonga, which includes the following components (adapted from PHA Conference Flyer Appendix Two). This year it is the current theme for the Public Health Association Hui. What is different about this model, compared to the Ottawa Charter?

Te Pae Mahutonga - Southern Cross

Mauri Ora - Access to Te Ao Maori: values, whanau, customary land, language and knowledge, Marae and culture.

Waiora - Environmental Synergy: natural environment, clean water, air, protection from ecological risks, turangawaewae and adaptation to modern environments.

Toiora - Healthy lifestyles, safety, exercise and healthy eating.

Te Oranga - Participation in Society: This includes some of the big picture aspects to health such as macro-policies of the state, socio-economic determinants of health etc.

Nga Manukura - Leadership: community cohesion, workforce development, community leadership - determining the `who' and the `what'.

Te Mana Whakahaere - Autonomy: Self-determination, power sharing, community priorities, aspirations and control.

Clarifying the Assumptions that Guide Maori Health Promotion

With the use of the components for Maori health promotion highlighted in the Te Pae Mahutonga Model, we can clarify its underlying assumptions (Appendix Three).

Mauri Ora - Access to Te Ao Maori: values, whanau, customary land, language and knowledge, Marae and culture.

Assumption; Promotion of security of identity through access to Te Ao Maori is fundamental for the promotion of wellbeing.

- *Access to language and knowledge*
- *Access to culture and cultural institutions such as marae*
- *Access to Maori economic resources such as land, forests and fisheries*
- *Access to social resources such as whanau, Maori services, networks*
- *Access to societal domains where Maori is facilitated not hindered.*

Waiora - Environmental Synergy: natural environment, clean water, air, protection from ecological risks, turangawaewae and adaptation to modern environments.

Assumption; That the harmonising of people within their external natural environments is fundamental for the promotion of wellbeing.

- *Water free from pollutants*
- *Clear air*
- *Earth abundant with vegetation*
- *Healthy noise levels*
- *Opportunities to experience the natural environment*

Toiora - Healthy lifestyles, safety, exercise and healthy eating.

Assumption: To actively achieve healthy lifestyles, action is required at several levels

- *Harm minimisation*
- *Targeted interventions*
- *Risk management*
- *Cultural relevance*
- *Positive development*

Te Oranga - Participation in Society: This includes some of the big picture aspects to health such as macro-policies of the state, socio-economic determinants of health etc.

Assumption; That the participation of people in society, as contributing citizens with voice is a fundamental component to achieving wellbeing.

- *Participation in the economy*
- *Participation in education*
- *Participation in employment*
- *Participation in the knowledge society*
- *Participation in decision making*

Nga Manukura - Leadership: community cohesion, workforce development, community leadership - determining the `who' and the `what'.

An Assumption: That the basis for leadership within Maori community is different, *and needs to be developed and nurtured.*

- *Community leadership*
- *Health leadership*
- *Tribal leadership*
- *Communication*
- *Alliances between leaders and groups*

Te Mana Whakahaere - Autonomy: Self-determination, power sharing, community priorities, aspirations and control.

Assumption; That the quest and demonstration of autonomy in *health promotion activities is a fundamental component for achieving well-being.*

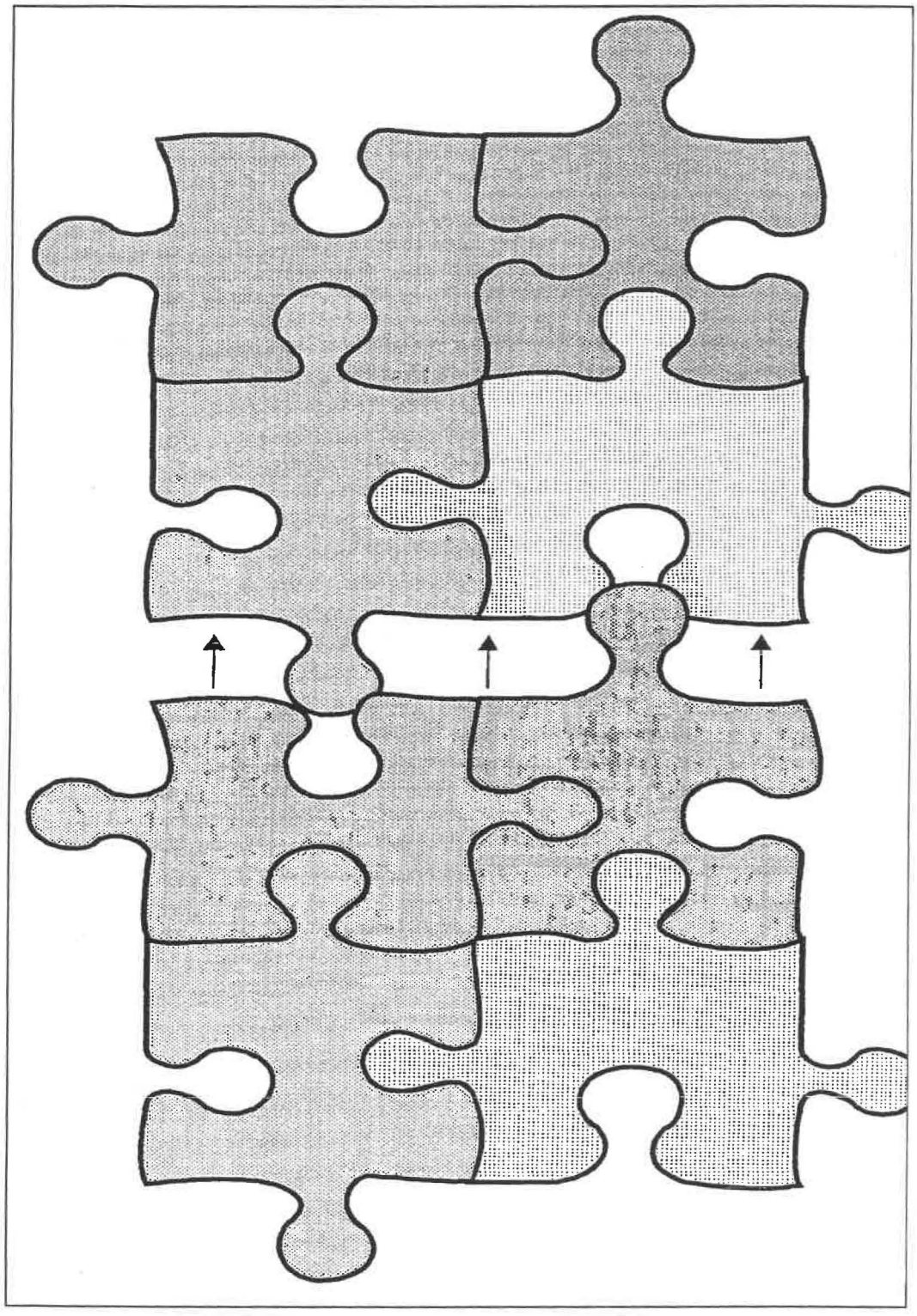
- *Control*
- *Recognition of group aspirations*
- *Relevant processes*
- *Sensible measures and indicators*
- *The capacity for self-governance*

TASK: Discuss Te Pae Mahutonga in the context of Maori Health Development in Tauranga?

Some questions:

- Do these concepts relate to the work that is currently being undertaken in hauora?
- Are they concepts that adequately and appropriately reflect our aspirations for health in Tauranga?
- Kei hea matou? Where are we as a community of Maori health promoters in Tauranga Moana situated in respect to Maori health promotion?
- Do we have a strong position to work from in terms of Maori defined processes for Maori health promotion?

Is the jigsaw pattern starting to form? Are our assumptions about Maori health promotion clear? Fill in the pieces with the assumptions and beliefs forming....



Session Three: Introduction To Social Marketing?



Now that we appear to be coming to a resolution about the assumptions of Maori health promotion, its overall purpose, goals and objectives. Let's look at social marketing.....

Let's start with this assumption...

'marketing has a great deal to offer public health..... the methodology works; it is not new. The only thing new is our awareness of its value in the field of health'(Novelli, 1989).

Where did social marketing come from?

1969	*Broadening of Marketing Concept*
1971	*Social Marketing Concept coined by Zaltman and Kotler*
1980	*First Review of Social Marketing - decade of adoption*
1990	*Further use of model in many fields - use in NZ limited*
1994	*Development of Journal - ALAC use of model - host responsibility campaign*
1998	*Use of Social Marketing by CYPS*
2000	*Ongoing use of model by health promoters in New Zealand - Health Sponsorship Council, Market Research companies, consideration by ACC*
2002	*Ongoing adoption and use by some DHBS in New Zealand*



Social Marketing Origins

Kotler & Levy (1969) saw the opportunity to examine whether marketing principles were transferable to the marketing of services, persons and ideas and found that marketing like activities were already being performed by organisations who were not viewed as traditional businesses such as museums and schools. In their view

> all organisations must develop appropriate products to serve their sundry consuming groups and must use modern tools of communication to reach their consuming publics. The business heritage of marketing provides a useful set of concepts for guiding all organisations (Lazer & Kelley, 1973:42).

Lazer & Kelley (1973:7) suggested five reasons for the evolution of social marketing

- Given a society of affluence and abundance, people can afford to pay increasing attention to social goals and social needs. Hence, as countries become more developed, they also become more concerned with social aspects of marketing instead of pure economic aspects of marketing.
- Members of the younger generation were more idealistic and humanistic on the surface at least and expressed a greater concern for society as a whole.
- A number of people had accepted the responsibility of being an interface with social marketing.
- The communications focus, particularly through television and newspapers has inevitably increased the educational awareness of society.
- That fact that consumers have more time for leisure and travel has made them more socially aware.

Social marketing advocates claim that the process is already making a difference and its ideas seemed attractive in the present political climate (Novelli, 1989). It appears to be a new set of tools that are attractive to public health people because it seems to work. McDermott concludes;

> It appears that there is substantial literature available to comfortably support the idea that social marketing's time has come(1994:5).

Andreasen(1995:7) states that social marketing is;

> the application of commercial marketing technologies to the analysis planning, execution and evaluation of programs designed to influence the voluntary behaviour of target audiences in order to improve their personal welfare and that of their society.

As with any tool, social marketing should not be expected to solve ever social or health related problem. At best, social marketing can increase programme use and build customer satisfaction with existing services. Perhaps our expectations of social marketing are too high? Social marketing's aim is to change behaviour ..... **what do we mean when we say change behaviour?** Andreasen (1995) says social marketing's bottom line is to change behaviour.

What assumptions are made in these discussions?

Is health a public good or a product? Are people people, or markets? What are the implications?

Let's take a closer look?

SOCIAL MARKETING CONCEPTS

Social Marketing is a Framework and not a Theory?

Social marketing is a framework, or structure (perhaps a paradigm) in which to approach social and health problems (Lefebvre, 1992:61) or social change campaigns (Kotler & Roberto, 1989). Lefebvre reiterates that social marketing is a tool that can be used for health promotion, as well as a series of other social issues (1992:61). Where social marketing had previously occupied a space of contributing to health promotion, or health education, it now serves in its own right as a discipline (Heede & Pelican, 1995:142).

Here are some of its components

Consumer Orientation - Social Marketing Mindset

Conventional business practice was characterised by a series of evolutionary *stages, production orientation, sales orientation, consumer orientation and* more recently *societal marketing orientation. A* production orientation approach is concerned with increasing output and decreasing costs. According to Lefebvre & Flora, the "we know *whats good for them"* attitude characterises this approach. The second stage, sales orientation has been characterised by selling and promoting existing products to generate high sales and high profits. Social advertising methods that sell products such as a *"quit smoking"* programme is an example. Both of these strategies are agency centred. These types of orientation have also been described by Fine (1981) as 'Push' strategies - where the agency pushes its ideas onto the consumer. Little attention is paid to the needs of consumers with push strategies. Consumer orientation addresses the needs of consumers in the development of their goods and services or what Fine calls "pull" strategies - where the agency pulls ideas from consumers. A fundamental element of the social marketing is that it is consumer driven (Smith, 2000; Andreasen, 1995; Kotler & Roberto, 1989 & Lefebvre & Rochlin, 1997; Weinreich, 1999). With this focus on clients, social marketing has tended to target its audiences with more precision through audience analysis and segmentation.

The **marketing concept** is the foundation upon which consumer orientation is based. There are three components to the marketing concept; *Integrated marketing efforts, consumer satisfaction and satisfaction of organisational* goals (Lefebvre & Flora). Social marketing has led to a re-evaluation of the marketing concept. The new marketing concept according to Lazer(1969) is a customer-focused orientation guiding all functions within an organisation towards the achievement of profits which have both economic and social benefits for the consumer. The literature

suggests that a marketing approach to health is necessary if health agencies wish to be responsive to consumer needs before, during and after the programme is completed.

What are some of the assumptions?

_____

_____

_____

_____

Audience Analysis and Segmentation

Audience analysis and segmentation of a population or market into target markets or segments is a feature of marketing. The intent of audience analysis is to identify the needs of target groups, and the related costs and benefits associated with meeting those needs. According to Lefebvre & Flora, audience analysis serves two roles; to *define subgroups with similar distinguishing characteristics* for message *and programme design purposes* and to *identify target segments* for *distribution and channel strategies* Segmentation is based on *geography* (location, region, country), *demography* (age, race, occupation, gender), social structure (families, churches, workplace), *and psychography* (lifestyle, personality, identified needs). Specification of the characteristics of segmented groups relevant to the behaviour change process may require different "marketing strategies". Whilst this may bring about additional complexity into the intervention effort, it also increases the potential reach and effectiveness of the message, product, service or programme and its receptivity by the target audience.

What are some of the assumptions?

Continual Market Research

Another important and crucial element of social marketing practice is the notion of continual market research. A basic assumption with marketing is that human behaviour, whether it is purchasing a bottle of milk or adopting a regular exercise routine, is a moving target (Smith, z000:14). Market research recognises the need to continually integrate action with research. The research process begins by listening to and observing the consumer, trying to identify the keys to effect exchange. Andreasen (1995) calls this process to listening and Weinreich (1999) breaks the process into three stages of evaluation, formative, process *and outcome.* Lefebvre & Rochlin (1997) call this process market analysis. What is most important about the market research element of social marketing irrespective of the terminologies used, is that it is a continual and cyclical process. Hence, adjustments and refinements are made continually during the delivery of a health programme based on information received before, during and after the marketing research process.

What are some of the assumptions?

Exchange Theory

Although the underlying philosophy of marketing is described as consumer orientation, the operational mechanism is based on exchange theory (Lefebvre & Flora). Exchange theory posits that individuals, groups or organisations have goods or services they are willing to exchange for perceived benefits (Kotler & Levy). The buyer pays the price - money, effort, time or other resources and the seller provides the good (physical offering eg, contraceptives); service (stroke advice); or idea (quit smoking). According to Novelli(1989), the key to extracting voluntary exchanges with target groups is to provide benefits that are perceived as being greater than the cost.

Exchanges can occur at a number of levels. People can be *threatened* to exchange, *coerced* to exchange, *commanded* to exchange (although these are considered unethical approaches), *encouraged* to exchange or they can be involved in an exchange on a voluntary basis. In public health, resources typically available to promote exchanges include money, technical expertise and a range of ideas, products or services. The health benefits derived from these items include, better quality of life and a general feeling of well-being for instance. Health agencies of course, achieve organisational objectives by providing these programmes. Health agencies however seldom acknowledge these costs and benefits, and interventions are rarely viewed in terms of an exchange process (Lefebvre & Flora).

What are some of the assumptions?

_____

_____

_____

_____

Channel Analysis

A channel in social marketing refers to the medium that delivers a product, service or a health programmes messages, and involves the marketing mix components place and promotion (Weinreich, 1999). Public health interventions utilise a variety of channels to target audiences such as print media, physical outlets, radio, newspapers, internet websites, promotional brochures, posters etc. The specification of which channel singly or in combination will best service a health agency to reach its audiences is an essential task of channel analysis. Thorough analysis and selection of channels and the respective groups, which are connected to the channels, requires careful consideration of product, service and message design dissemination. Lefebvre & Flora suggest that behaviour change is more readily influenced at an individual level as a result of effective, deliberate and tactical channel analysis. Channels can have different features such as ability to transmit complex messages, medium, costs, reach, frequency & continuity, intermediaries, overuse and saturation and perceived authenticity or credibility, The planning and implementation of distribution strategies involving channels is a vital component of social marketing campaigns.

What are some of the assumptions?

_____

_____

_____

_____

Process Tracking

Lefebvre & Flora suggest that an integrative and control system for social marketing is necessary to monitor ongoing activities of the change agency. The system in their view should be able to meet a number of evaluation purposes concurrently, but particularly it should provide longitudinal

information for the assessment *of* program delivery and utilisation rates. Over the course *of* a programme, process-tracking data can assist a change agency with assessing the 'bigger picture' of the agencies activities. Without this type *of* approach to analysing information, an agency's management will fail to recognise the strengths and weaknesses of a marketing plan at key intervals. The consequence according to Lefebvre & Flora is the inability of the agency to respond to consumer needs and wants.

What are some of the assumptions?

_____

_____

_____

_____

Marketing Management

Lefebvre & Flora take the opportunity to remind change agencies such as public health organisations that marketing activities are often poorly understood and insufficiently appreciated by administrators, and inappropriately located in organisational structures. They offer seven reasons;

1. Marketing connotates manipulation and thus has no place in the health field.
2. Marketing requires more resources than available, which then constrains programming.
3. Audiences should not be segmented because it will lead to more underserved groups.
4. Marketing terminologies might be appropriate for businesses, but not the health field.
5. The overemphasis on research will negatively impact on service delivery.
6. Health agencies rarely have marketing expertise to guide and implement marketing plans and

7. Marketing requires an undue level of planning and action that may be disruptive to the agency and its staff members.

They also believe that a perception exists that if health programmes are market oriented, the remaining organisation will soon become `market driven' and all programmes managers will be at the beckon call of consumers. However, they offer two solutions, *that care is exercised to blend staff talents and beliefs with the social marketing process;* and strong *reliance on sound health education and behaviour change methods is maintained (Novelli 1989:40).*

What are some of the assumptions?

_____

_____

_____

_____

Other Components

Some other elements of importance include the idea of *competition.* Competition to social marketers refers to other behaviours, other agency programmes or promotional activities (eg; alcohol advertisements), or simply the non-adoption of the target behaviour. For instance, if the behaviour promoted was to 'exercise' daily, competition might be watching television, economic and non-economic costs to attend fitness gyms, sleeping or just by not exercising at all. Competition according to Weinreich can have a huge negative impact on a health programme, and the key can be to reduce the perceived costs to changing behaviour, or increasing the perceived benefits by modifying behaviour. Being *cost-effective is* also an important feature of social marketing. As Andreasen notes:

> social marketers .... are constantly aware that they are entrusted with limited resources and that they must use them wisely. This makes them willing to make trade-offs, ignore certain markets, seek cooperative alliances, and otherwise leverage meagre resources to achieve what are often very dramatic objectives (1995:14).

What are some of the assumptions?

Social Marketing Mix - Use of Labels

You may have begun to notice that there is a different language associated with the use of social marketing. For instance, a group of people are called a market. What does it mean when we use these labels, and more importantly what are the assumptions behind the use of these labels? Let's have a closer look at some more labels, a particularly famous one called ***the marketing mix,***

Social marketers do not rely on just one programme element to bring about change, they recognise that at least four different sets of factors called the ***marketing*** mix are used; product, price, *place and promotion* (Andreasen, 1995; McDermott, 2000; Lefebvre & Flora, 1988). There are pros and cons associated with the use of these terms, which are not readily articulated. Let's see what our instincts tell us about these terms.

Product

A product is typically viewed as something tangible such a5 a physical ;tem that can be exchanged with a member of a target market. Social marketing however, extends this concept to include ideas, social causes, services and behavioural change. Weinreich describes the social marketing product as the behaviour or offering for the target audience to adopt, where a continuum of offerings ranging from physical products (eg: condoms), to services (eg: general practitioner examinations), to practices (eg; exercising daily), to intangible ideas (eg; conservation). Lefebvre & Flora express the difficulty with marketing 'intangibility' in a way that appeals to target audiences, for instance, how do one buy a 'healthier lifestyle?' The creation of a consumer market for products and services such as 'healthy eating kits' is also important. They also state that thought needs to be given to viewing messages as products instead of simply repeating health promotion

messages. Andreasen(1995) claims that the product also needs to be made as desirable as possible to target groups. Weinreich views this as the identification of attributes and benefits to position the product in the target audiences mind. An attribute is an objective fact describing the product and benefits related to the value derived from the product by the consumer (p.10). The features, quality, brand name and packaging of products can also make an extensive impression on how the change agency is perceived by the target audience, and whether that impact will sufficiently motivate people to utilise the product. Lefebvre & Flora expands the notion of social products by describing the *width, depth,* and range of product offerings and suggests that regular reviews of these elements of the product are conducted to ensure an ongoing demand for the product. In their view, a problem associated with programme planners is the employment of programmes as the only product line, which can lead to relatively low participation rates and possible programme discontinuation.

What are some of the assumptions?

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Price

Price can be viewed in a number of ways; economically, socially, behaviourally, psychologically, temporally, structurally, geographically *and* physically (Lefebvre & Flora). Often described as costs, or barriers to behaviour change, the price can also be viewed as an incentive as well. The challenge for social marketers is to reduce the barriers associated with behavioural change. Research plays an important role in identifying the cost of behavioural change with the target audience. For instance, the price that young men might pay for using condoms could be the

possibility of rejection by their partner, or giving up the pleasure of unprotected sex (Weinreich). Roberto & Kotler (1989) provide an in-depth analysis of the objectives associated with pricing behavioural change. For example, the concept of demarketing was used to discourage as many people as possible from adopting a particular social product. For instance, the price for being caught drinking alcohol and driving in New Zealand now can be an automatic twenty eight day impounding of your motor vehicle if found over the legal limit.

What are some of the assumptions?

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Place

Social marketers realise that behaviours must be convenient and easy to perform. Place or distribution channels decisions need to consider the level and quality of programme/service coverage an agency wishes to achieve, the location of distribution centres that can be reasonably managed, the number of intermediaries required as part of the distribution strategy and the availability of response channels that are attuned to the distribution system through which the target market can access product offerings. Social marketers appreciate that programmes can fail if products and services are not readily available to target audiences. A successful family planning campaign in rural communities requires education, motivation, social pressure and the availability of resources such as birth control pills and condoms (Andreasen, 1995). The decisions about place and distribution are made through in-depth channel analysis prior to a campaign's implementation to guarantee that where people are more likely to encounter messages in their

everyday routines, for maximum exposure and reach. Attendance of key events is also a consideration for the maximisation of exposure and reach eg; health screening with a citywide events that have non health themes (Andreasen, 1995).

What are some of the assumptions?

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Promotion

Promotion is what many people conceive when they hear about social marketing. Although only one element of an integrated strategy, it is nonetheless an important one. Promotion relates to how an agency gets its message about the product out to the target audience. There are several different mediums available to social marketers as part of the promotion; *advertising, media advocacy, direct marketing, personal selling, special events, sponsorship, public relations, promotions and entertainment* (Weinreich, 1999). According to Lefebvre & Flora, too often programmes involve very little thought about the other elements of promotion. Promotion is more than "awareness development" or advertising. The effective management of promotions can greatly increase the accessibility of products by the target audience.

What are some of the assumptions?

_____

_____

_____

_____

Not all of the labels are derived from consumer based marketing, and there are many that have developed as a direct -result of the transferal of marketing knowledge into the area of social development. Some of the terms are; publicity, publics, partnerships etc.

QUESTION: Can commercial marketing practices be transferred to health without taking on board the beliefs and assumptions of marketing? Do Maori health promoters wish to be Maori health marketers?

Behavioural Change! Is that our Business?

The position taken by social marketers is that the prevailing techniques utilised to achieve health promotion goals have their limitations. Some of those limitations are listed below and are still prevalent today. Remember to keep your minds clear about the purpose of health promotion for Maori, and always to be mindful of those ends.

Educational Approach

This approach *assumes that individuals will do the right thing if only they understand why they need to do what is being advocated and know how to carry it out (p.9).* The educator presents the health related facts to the target audience in a compelling manner. It is the foundation for the Health Belief Model used extensively in the health field. Four key sets of beliefs were seen as the fundamental drivers for behavioural change:

- *Perceived vulnerability to a certain health condition;*
- *Perceived austerity of the condition;*
- *Perceived benefits from taking action;*
- *Perceived impediments to taking action.*

Andreasen identified three components lacking in the educational approach. First, it assumes that if beliefs are changed, behaviour will follow, therefore behaviour was not focused upon. Second, it does not take social pressure into consideration and third, the delivering of facts to change beliefs can have the opposite effect.

Persuasion Approach

This approach goes one step further than the educational approach and *assumes that educated consumers will do the right thing if sufficiently*

motivated. This approach encourages the consumer to adopt the persuasion its view of the world. Andreasen describes this method in marketing terminology as the *selling approach,*

Behavioural Modification Approach

This approach *assumes that people do what they do because they learn the techniques necessary for the action and find the outcomes rewarding.* A problem with this approach is that behavioural modification has to almost always be at an individual level; as such the costs are high.

Social Influence Approach

This **approach *assumes that the most*** *cost effective way to reach and change individuals and families is to directly influence community norms and collective behaviour.* The approach is limited to situations where;

- *Social issues are well understood;*
- *Pressure to conform is extremely strong;*
- *The behaviour to be changed is social important.*

Andreasen sees a place for this approach in communal societies where community ties are still strong. However, the more educated or emancipated an individual, the less likely they are to be influenced by group or collective norms (p.13).

Social Marketing Approach

The social marketing approach incorporates all of these technologies. But social marketing is both dissimilar and more comprehensive then the previous approaches. Social marketers contend that learning facts is only important if it leads to a desired behavioural change. Trained social marketers will not implement interventions unless there is research to

ensure that the intervention will led to increased readiness to change. Good social marketers are also aware of the length of time required to bring about long-term lifestyle changes. Social marketers are concerned with being cost-effective and zealously customer centred in their approaches to behaviour change modification. Social marketers do not rely on one or two programme elements to bring about change. Andreasen (1995:13-18) also discusses seven key features of social marketing that differentiate its approach from the alternative approaches mentioned above:

1. *Consumer behaviour is the bottom line.*
2. *Programmes must be cost-effective.*
3. *All strategies begin with the customer.*
4. *Interventions Involve the Four Ps: Product, Price, Place and Promotion.*
5. *Market research is essential to designing, pre-testing and evaluating intervention programmes.*
6. *Markets are carefully segmented.*
7. *Competition is always recognised.*

Appeal of Social Marketing

Public health administrators identified a range of reasons for social marketing's appeal:

> We in public health have often been like preachers, says Fred Kroger, a communications specialist at the Centers of Disease Control. "We pass out the truth and expect everyone to recognise it". But the old-fashioned ways don't work on everyone. Massive publicity efforts surrounding the Surgeon General's 1964 report on smoking persuaded millions of Americans to give up cigarettes, for example, but one in four adults still smoke. Modern marketing techniques can go further"(Braus, 1995:2).

Social marketing offered a **systematic research based process** for solving health problems. Fox & Kotler identified three areas where social marketing is particularly useful; *when new information and practices need to be disseminated, when counter marketing is needed, and when activation is needed.*

Sutton (1994) says social marketing uses **solid consumer research** as a solid basis for planning and implementing health care services and communications. She also claims that social marketing has moved the public health community over the abyss between theory and implementation as it has given these professionals the tools to carry out the public health mission.

The focus of social marketing campaigns on **behaviour change** instead of information campaigns as has been in the past has also appealed to health professionals in the field. She further reiterates that social marketing has assisted health professionals to see that health alone is inadequate to motivate people to live a lifestyle that is synonymous with well-being.



Critics of Social Marketing

Social marketing is not without its critics. For instance,

> If social marketing was that easy, we would have changed our processes already without needing any knowledge of social marketing (Wenzel).

Some of the issues raised in criticism of social marketing include

- Change Agents are in control of process, not consumers.
- Definition of social problems is problematic, and concludes that target audiences are viewed as subjects to processes they have no control over.
- Health is only one amongst many factors to be considered by health consumers.
- Public health officials can be seen as paternalistic, and part of the privileged few.
- Poor health status is political rather than personal - social marketing does not take responsibility for these considerations.
- Far more difficult to market goods as opposed to marketing health.

Relevant to this discussion about Maori Health promotion and social marketing is whether it supports the aspirations of Maori to maintain access to Te Ao Maori, and to the other components of health promotion identified in the Te Pae Mahutonga model.

Session Four: A Critical Reflection - Conceptualising Maori Health Promotion and Social Marketing

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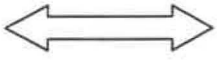
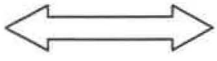
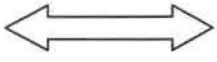
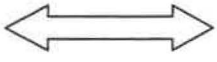
Maori Health Promotion	**Social Marketing**
Concepts, Kaupapa, Beliefs and Assumptions 	
Procedures and Ways of Organising 	
Practices and Labels 	
Are the outcomes and expectations different? Health/Hauora/Wellbeing/Product 	

Does Social Marketing Appeal to Maori?

The arguments to support the alleged benefits of adopting social marketing as a model for improving health in place of a health promotion model, or now a Maori health promotion model as far as I am appear remains un-chartered territory, particularly at a conceptual level. The responses derived from our workshop today, and from our post-workshop interviews will forge a new understanding about the implications associated with adopting social marketing ..... we may not be sure at this point, and if that is the case, as Maori people; our instincts and hunches will show us the way

`the greatest theories about life, are based on hunches'

It is time now to reflect.....

Summary

In our quest for the reclamation of Maori ways of doing things, such as is taking place in the field of health promotion, can we be sure that the claims made about social marketing can stand up to scrutiny? And despite the growing interest and application of social marketing processes in private and public organisations, there are still many unresolved issues. For instance,

- Social marketing makes claims for self-efficacy - can this be proved?
- Social marketing campaigns and related success are difficult to measure.

  Andreasen says that identifying behavioural change, as the bottom line is crucial, otherwise the score will be kept by output and the number of brochures distributed will monitor success
- Social marketing is accused of being manipulative and anti-intellectual
- Social marketing must deal with conflicts between disciplines.
- Social marketing expertise is limited.
- Social marketing requires a change in approach - behaviour change is the bottom-line!
- Social marketing as of yet lacks comparative analysis
- Social marketing is founded on principles of marketing and consumerism.
- Social marketing is not founded on principles that are derived from Te Ao Maori.

And the Benefits?

- Substantial international evidence to support its use
- Well defined process that involves range of strategies
- Relatively new tool!
- Consumer research based approach to health interventions
- Pool of strategies to adopt to influence voluntary behavioural change
- Influenced by existing theories of change eg; Prochaska
- Better, faster.....

Conclusion

The claims to success purported by social marketing advocates, practitioners and academics seem to speak for themselves. **But can we be that sure? Can we be sure that adopting a model with a different set of assumptions and principles will, not undermine the work undertaken by Maori health practitioners in the field? Can the two approaches be resolved? Does social marketing work with kaupapa-based approaches to Maori health? What do we all think?**

Or are we jumping ahead of ourselves, should we support its implementation and if so, why?

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Appendix Seven: Group Consent Form

CASE GROUP CONSENT FORM

INSERT TRUST NAME

The trustees of the (Trust Name) acknowledge that the case narrative has been perused.

There are no issues that the trustees wish to bring to the attention of the researcher.

OR (please delete the appropriate clause)

There are some issues that the trustees wish to bring to the attention of the researcher that must be addressed.

1.

2.

3.

We, the trustees of the (Trust Name) give our consent to include the case narrative of Trust in the final published research case report.

Name of Trustee: _____

Signed: _____

Date: _____

Name of Trustee: _____

Signed: _____

Date: _____

I would also like the following number of reports to be provided for our organisation No: _____

Please fax/hand/send this form back to:

Riri Ellis

University of Waikato at Tauranga

Private Bag 12027

Tauranga *Fax: 07-577-5327*

Appendix Eight: Map Disclaimers

17/03/2004 11:06 +6475779020 WBOP DC PAGE 01/01

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Bastos Corner
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Private Bag 12033
Tauranga 3030
Telephone 07 571 9003
Facsimile 07 577 9920
customercare@wbopdc.govt.nz
www.wbopdc.govt.nz

16 March 2004 Marion Dowd

Riri Ellis
University Of Waikato at Tauranga
Private Bag 12027
Tauranga

BY FAX: 577 5327

Dear Mr Ellis

Map Enquiry - Riri Ellis

Thank you for your enquiry about use of the maps supplied by Council. As indicated, the following is the statement of copyright that we would like appended to the maps: -

"CROWN COPYRIGHT RESERVED. LINZ DIGITAL LICENCE NO. HN/352200/03 & TD093522. COUNCIL ACCEPTS NO LIABILITY FOR ANY EFFOR. MAPS COURTESY OF WESTERN BAY OF PLENTY DISTRICT COUNCIL."

We trust your project has gone well and that the publication of the report will receive the attention it deserves.

Yours faithfully

Michael Lethbridge
GIS Technician Inputs

Date: 16/03/04

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Tauranga City Council
Map Disclaimer
==========

This letter is to confirm that Riri Ellis of the University of Waikato (Tauranga) can make copies of the following maps referenced below. The information is the exclusive property of the Tauranga City Council and any respective copyright owners, and shall be used only for the purposes of the project requested.

The final report is a combination of four different case studies about Maori health.

Map references;
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- P:\TDC_Project\External\riri@waikato_ac_nz002_a4l.mxd
- P:\TDC_Project\External\riri@waikato_ac_nz003_a4l.mxd
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Appendix Nine: Artwork - Te Karanga Hokinga Mai

'Te Karanga Hokinga Mai'

By

Chanz Pautehau Aroha Mikaere

There is a karanga, which bounces from the cliffs of Mauao to reach numerous mokopuna, nga uri whakatupu. The karanga dives into the chest cavity, coiling about the ribs, embracing the heart, its rhythm resonating about the lungs. There is a quickening as the karanga reaches the whare tangata and turns to traverse the spinal column, affirming the fortitude and strength of whakapapa. Exploding forth it is heard by all whose blood flows with the tides of Tauranga Moana.

Despite colonisation this karanga continues to remind us of what distinguishes us as tangata whenua. Rongoa is our holistic lifestyle. Reo is the spoken embodiment of this ethos. In our quest for indigenous inspiration and affirmation, this sacred knowledge is what nurtures us. In the days ahead, Mauao's karanga will reach into the hearts of its mokopuna, urging them to maintain their courage in the face of adversity and instil this mettle as kakano in the hearts of those to come. This is the beginning of my journey home, having heard the karanga of my tupuna. Mauao, I have arrived home.

The artwork at start of thesis was commissioned for:

"Enhancing Maori Health and Wellbeing Through a Critical Engagement With Social Marketing: Tauranga Moana Speaks Out" by Riri Ellis, February 2004

Appendix Ten: Case Narratives[29]

"Sharing is a good thing to do; it is a very human quality. To be able to share and to have something worth sharing gives dignity to the giver. To accept a gift and to reciprocate gives dignity to the receiver. To create something new through that process of sharing is to recreate the old, to reconnect relationships and to recreate our humanness" (L. Smith, 1999a:105).

Three Maori health providers and one mainstream health provider located in Tauranga Moana agreed to participate in this research project. The individual case groups as per the order that they are presented in this report include; *Whaioranga Trust, Toi te Ora Public Health, Pirirakau Hauora and Waipu Hauora.* The stories about these case groups are presented as four separate case narratives. Each case narrative is presented in six different sections. Section one introduces the case. Section two provides an historical overview of the organisation and highlights concerns that they are currently experiencing. Sections three and four separately analyse social marketing from the viewpoint of the kaikorero and kaitautoko respectively. The sections also include discussions about the wider issues affecting the organisations. The remaining two sections provide a summary of conclusions and recommendations.

The case narratives emphasise the importance of recapturing some of the earlier stories about Maori health within the broader context Iwi, Hapu and Whanau goals and aspirations for health development in Tauranga Moana[30]. Another important point in the case narratives has been the use of Maori terminologies to describe participants in the research project. In regards to Kaupapa Maori methodologies, the

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[29] These case narratives were part of a report of findings called '*Enhancing Maori Health and Wellbeing Through a Critical Engagement with Social Marketing*', written by the author of this thesis in February 2004.

[30] The interviews in this research project were completed from November 2002 to May 2003. As a result, the stories captured in the case narratives are reflective of historical discussions and documents collected from each Hauora during that time. The case narratives highlight the issues and concerns that arose in the research conversations during that respective timeframe.

principles that guide the way that research is conducted have been established and followed, but I found there was still room to strengthen the methodology with other suggestions that arose during the research. For instance, I chose not to use the term key informant or research interviewee in the case narratives. I instead used the term kaikorero to reflect the equal conversational relationship between the researcher and the research participant. By using the term kaikorero for both the researcher and the research participants, the power relations more closely resembled the notion of equality that I was trying to portray. With the term key informant, I used kaitautoko in its place because that term adequately reflected the role that these people played in this project. For instance, kaitautoko were supportive advocates of Maori development in Tauranga Moana and their input in the project was part of an ongoing commitment they all seemed to have related to Hapu, Iwi and or Maori development overall.

Finally, each case narrative included in this section is the outcome of the joint efforts of those kaikorero, kaimahi and kaitautoko who made the time to be included in this research project. Interwoven together like the strands of the whariki, the case narratives form a collective story about the struggles, challenges and triumphs of Maori health development in Tauranga Moana. Most importantly, they collectively provide an insight into the extent to which social marketing might be useful for enhancing Maori health.

Case Narrative One: Whaioranga Trust

1.1 Introduction

The aim of this research project is to ascertain whether social marketing models may be beneficial for enhancing Maori health. The aim of this case narrative is to explore the implications of adopting social marketing as a model for practice within the Whaioranga Trust (Whaioranga). Whaioranga is one of the case narratives included in this research report. Whaioranga was originally located at Whetu Marae but later moved to the central business region of the Tauranga city. It is now based at Whetu Marae in Welcome Bay, Tauranga. It has been operating since March 1981 and during the last twenty years it has experienced many changes. The facilities of Whaioranga are adjacent to the Ngati Pukenga Iwi Runanga office, kaumatua and kuia flats, the Whetu Marae and the Nga Peke Kohanga Reo. The Whaioranga case narrative is presented in six different sections. Section 1.1 is the introduction and Section 1.2 presents an historical overview of the organisation. Section 1.3 provides an analysis of the research as a reflective conversation and Section 1.4 presents a thematic analysis of korero with other kaitautoko involved in the study. Sections 1.5 and 1.6 present a number of conclusions and recommendations that emerged during the research.

1.2 Historical Overview

Whaioranga was the first Marae-based health promotion, social services and education services provider operating in the Tauranga Moana district (Te Puni Kokiri, 1994). Its past and present services consist of mental health services, general practitioner services, youth holiday programmes and kaumatua and kuia health checks. Although the Hauora does not provide any educational or promotional programmes as standalone contracts, it does provide a series of promotional activities as a component of its other service delivery contracts. Whaioranga has sought to operate a holistic approach to Maori health which has proved challenging. This case narrative outlines some of the historical characteristics that contributed to shaping Whaioranga's operations.

The initial driving energy of the Hauora came from a group of determined Maori mothers who called themselves Tautoko Wahine[31]. Those women were interested in a number of activities such as education, welfare, te reo and also health and well-being. Some of them assisted the Hauora by occupying various voluntary positions such as trustees and volunteer health workers, whilst others took up paid positions in administration, health education and health promotion. However, according to one of the respondents, the *Nga Tamatoa Movement* also contributed significantly to strengthening and re-energising the resolve of Maori community leaders throughout the country to reclaim Maori approaches to education, health and community development. Whaioranga members were also influenced by the ideas articulated in that movement.

1.2.1 Whaioranga Trust Kaupapa

The kaupapa of the Hauora has remained constant since its inception in 1981. It aims to encompass and affirm the links and interactions between te taha wairua, te taha hinengaro, te taha tinana and te taha Whanau (Te Puni Kokiri, 1994). The word Whaioranga means *to 'seek wellness or well-being'*. Whaioranga personnel utilise the following whakatauki to emphasise the kaupapa (Ohia, 1995).

E wha nga kokonga o taku whare
ko te taha wairua, te taha hinengaro
te taha tinana me te taha Whanau
ka hinga tetahi ka ngaro taku whare

My house has four cornerstones, spiritual
psychological and emotional
physical and Whanau – extended family,
should one corner stone be weaker
than the others my house is at risk

[31] Supportive women.

1.2.2 Vision and Mission

In 1995, the mission of the Trust was to maintain and improve the health status and well-being of the Maori people (Ohia, 1995). Specific goals that are derived from those statements include:

- To maintain and improve the quality of life for kaumatua (elderly).
- To maintain and improve the quality of life for pakeke (adults).
- To maintain and improve the quality of life for rangatahi (adolescents).
- To maintain and improve the quality of life for children including babies.
- To maintain and improve the quality of life for Maori women (Ohia, 1995).

In 2001, a series of training and planning hui were facilitated for the Hauora to consider whether the goals had changed. The most recent version of goals looks at both the health objectives stated above and the overall organisational activities that are required to achieve those goals. The goals are:

- To establish and maintain a marae and community based health and social service Whanau centre for people of the Tauranga Moana district, in particular the Welcome Bay area.
- To provide marae and community based health and social services for whanau, nga pepi, nga tamariki, nga rangatira me nga pakeke.
- To promote te reo me ona tikanga (Winiata, 2001).

The current mission of Whaioranga is '*to enhance the health and well-being of the diverse Whanau, Hapu and Iwi in Tauranga Moana'*.

1.2.3 Services Region – Pan Tribal Approach

The ethos of pan-tribalism and inclusiveness emerged as part of the Hauora's inception and remains as a guiding organisational principle. Maintaining a pan-tribal ethos in the earlier days was a relatively simple task as the Hauora was the only Maori health provider in Tauranga for some time. However, with the establishment of Iwi Runanga and Hapu based health providers throughout the country in the mid 1990's, that pan-tribal approach was challenged, *'...at that time, all people intermingled between Iwi, so the idea that Iwi were separate entities was not so*

apparent then. The leaders of that time: Wiremu Ohia and Turi Te Kani, they moved inter-iwi. In addition, they could do that then, so with the Whaioranga Trust it was not an Iwi based venture. At the moment, because it is based at Whetu and with the [Treaty of Waitangi] claims and other events shaping the identities of people in Tauranga, there is a perception that it is an Iwi venture but that was not the case'.

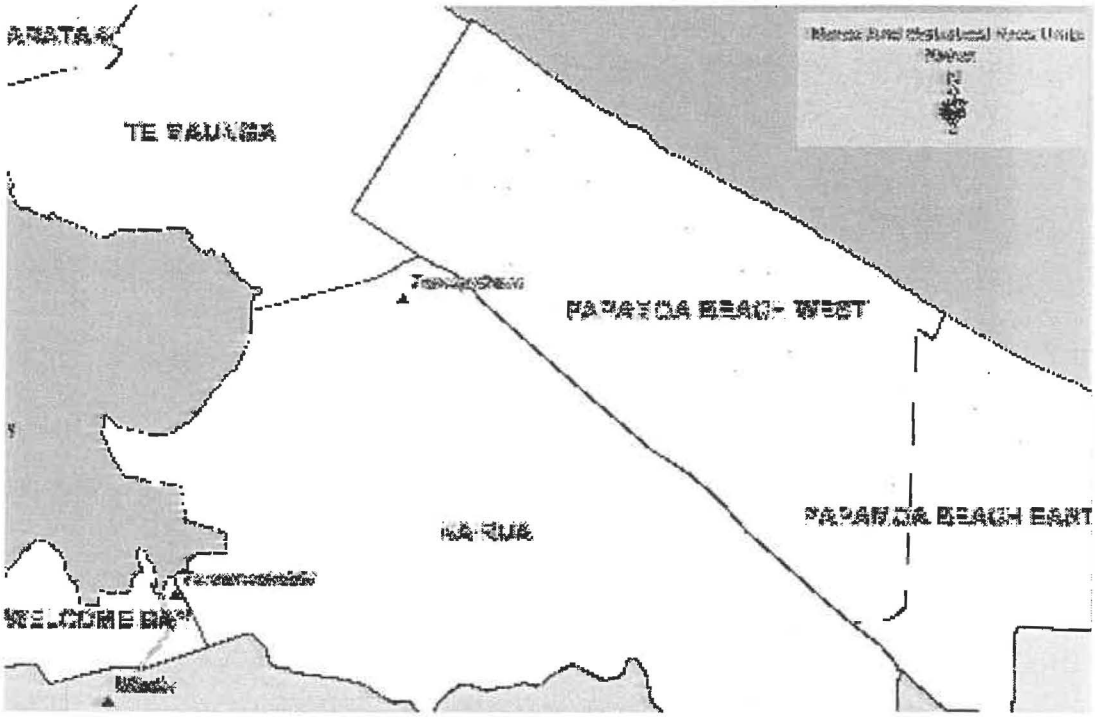
Whaioranga continues to operate under the auspices of pan-tribalism by providing services to all who wish to utilise them. However, Whaioranga's location within the Whetu Marae complex has an influence on the people who are more likely to utilise its services. For instance, Whaioranga primarily services the rural district of Kairua in *Figure 1* and Welcome Bay in *Figure 2*. The statistics from the 2001 Census and Populations and Dwelling provide an indication of the number of recorded Maori located in that area as 1500. It is not clear how many of those people are from local Iwi or from other Iwi outside the district. *Table 1* highlights statistics recorded for Ngati Pukenga living within the Western Bay of Plenty Region as 411, and throughout New Zealand as 1137. Although the Whetu Marae affiliates to the Ngati Pukenga Iwi the relationship between Ngati Pukenga Iwi and Whaioranga is currently viewed as complimentary.

Table 1: Maori in Kairua and Welcome Bay Region

	All	Maori	Non-Maori	Other
Kairua	381	216	162	24
Welcome Bay	6504	1284	5349	279
Total	6885	1500	5511	303

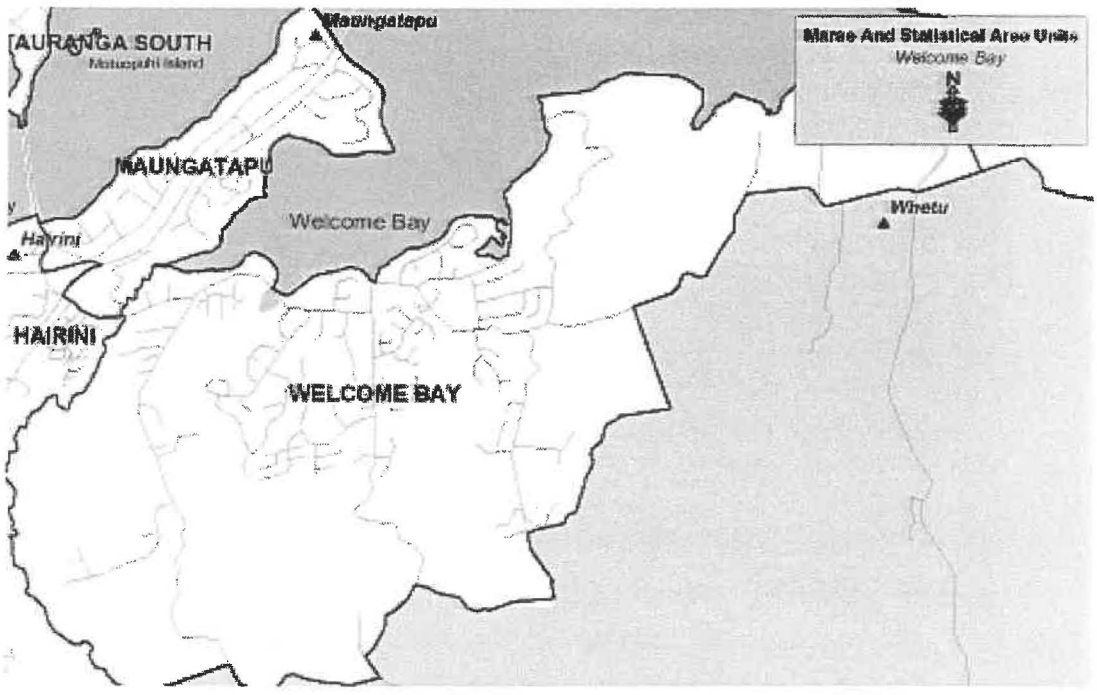
Source: NZ Statistics 2001

Figure 2: Kairua Services Region



Courtesy of Tauranga District Council

Figure 3: Welcome Bay Services Region



Courtesy of Tauranga District Council

1.2.4 Nature of Services and Programme

There appears to be a variety of approaches utilised to describe the nature of services and programmes offered by the Hauora. What is clear from the documentation available is that the Hauora, or more correctly the key initiators of the Hauora (including trustees) possessed a collective innovative and opportunistic spirit, which served as a catalyst for the provision of services that were not at that time being provided by any other Maori health provider in the region.

Whaioranga has had an active history that included the provision of a range of activities and services:

- Whanau support.
- Oranga tinana programme.
- Mana manaaki programme.
- Part time general practitioner practice.
- Cervical screening programme.
- Immunisation education.
- Kaumatua care programme.
- Community health work training.
- Cot death education.
- Alcohol and drug abuse education.
- Family violence education.
- Baby care.
- Aromatherapy.
- The inter-marae sports federation.
- Women's support group.
- Healthy eating promotion.
- Blood pressure and diabetes testing and;
- Sauna therapy (Te Puni Kokiri, 1994).

It currently provides mental health services, health education services, a kaumatua and kuia care programme, holiday programmes, family violence education, mirimiri, alcohol and drug education services, home care services, Whanau counselling, Whanau support, rangatahi education, tamariki ora, diabetes and asthma education (Winiata, 2001).

1.2.5 Evaluation of Services and Programmes

Whaioranga has undergone several evaluations of services and programmes during its years of operation (Ropiha, 1993, 1994; Ropiha & Wilkinson, 1994; Te Puni Kokiri, 1994; Whariki Research Group, 1995). The evaluations have served as a means of inquiry into the concepts of health and the processes adopted by trustees and kaimahi to deliver those health services. The majority of earlier reports indicated that the trustees aspired to provide holistic health services and programmes that were consistent with the overall kaupapa of the Trust. Ropiha (1994) argued that a holistic approach whilst admirable was not only difficult to operate, it was also difficult to evaluate for effectiveness. The issue of effectiveness in services delivery was not easily deciphered from preliminary evaluations and reviews. The evaluations aimed to determine whether Whaioranga met the health needs of the people it served. More importantly today, some of those earlier reviews are no longer relevant to the Hauora's present operations (Te Puni Kokiri, 1994; Whariki Research Group, 1995).

More recently, Whaioranga has adopted similar evaluation techniques used by other health providers. For instance, staff meetings are used as a forum for programme evaluations, evaluation forms are distributed where possible during events, visual assessments of events, services and programmes are undertaken and reviewed, the numbers of people already using the services are tallied and people are regularly asked to provide verbal feedback. However, respondents felt that more could be done to improve the evaluation methods that are currently in place.

1.2.6 Organisational Structure, People Resources and Responsibilities

Whaioranga operates as a charitable Trust that is governed by a group of trustees.[32] A full time manager is responsible for managing employees and their job responsibilities. The number of employees and the nature of roles, responsibilities, skills and experiences are largely dependent upon the types of contracts held by Whaioranga. In an evaluation report conducted by the Whariki Research Group, staff

[32] The Whaioranga Trust was certified under the Charitable Trusts Act 1957 as Ngapeke Whai Oranga Trust in 1983, and changed its name to Whaioranga Trust on 23 November 1993.

recruitment and retention was seen as a critical concern (Whariki Research Group, 1995). This concern was still an issue for one respondent, '*...sometimes circumstances change for staff, they have to look for a full time job. We cannot always fulfil that. Many people who have started in Whaioranga have now gone on into other full time positions. [Whaioranga] is like a kohanga reo even for health. Heaps of people have come through [Whaioranga] and moved on through to other health positions. Whaioranga has been like a kohanga reo for many people'.*

Although Whaioranga is located physically within the perimeters of the Marae complex, it is not legally responsible to the Marae Committee, the Iwi Runanga or the Kohanga Reo. The relationships that exist between these groups operate on the basis of kinship or tikanga Maori.

1.2.7 Partnerships

Whaioranga has provided some of the services listed in Section 5.2.4 in partnership with other organisations within Tauranga. Some of the ventures were initiated by the Hauora but later assumed their own autonomy, whilst in other instances the Hauora worked in joint venture arrangements with other groups. For instance, the Hauora established the Whaioranga ki Whetu Te Kohanga Reo[33] and it formed a relationship with the Te Awanui Maori Women's Welfare League to establish the Te Tuinga Whanau Trust (Ohia, 1994). In the late 1990's, the Hauora became involved with the Coastline Rugby League Association, the Inter-Marae Sports Federation and the Ngati Pukenga Incorporated Society. The Hauora currently affiliates to Te Manu Toroa, a regional Maori health organisation that is funded for regional health initiatives through the Ministry of Health. It is also affiliated to Te Whanau Poutirirangi Ora a Papa; a health related governance body for all Iwi in the Bay of Plenty Region and it was involved briefly with the Poutiri Trust, a Bay of Plenty wide umbrella organisation for Maori health providers.

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[33] The Kohanga Reo was changed to Nga Peke Kohanga Reo at a later date as highlighted in the first section of this case narrative.

1.2.8 Issues of Control and Ownership

Whaioranga was the first Maori health provider to operate within the Tauranga region, and one of the first Marae based health centres to operate in New Zealand (Durie, 1994b; Te Puni Kokiri, 1994). Whaioranga instead spent a lot of its initial inception time struggling to access resources through traditional health funding agencies for Hauora resources (Ropiha, 1993). One of the difficulties they faced was policy related. At that time, Maori health was not earmarked as a priority and as a result funding was not made available. A second challenge was that Whaioranga was not well known by funding agencies and representatives of those agencies were reluctant to fund them because of the perceived obscurity. The ability of Whaioranga to have some sense of ownership and control of their destiny as a Maori health provider was consequently minimised. It was not until 1989, that major funding was made available through the Ministry of Health (Ropiha, 1993).

1.2.9 Current Organisational Issues

Whaioranga has been operating for more than twenty years now and its longevity is an indication of its commitment to improving the long-term health status of its community. However, there were still recurring concerns that affect the ability of kaimahi to reach new levels of performance. Those issues include a lack of transport, the inability to retain trained staff members and a lack of resources. For instance, *'...resources are lacking so we will most probably have to get staff to really network. There has been a problem in the past with the politics of it all. Consequently, I believe we have not fully recognised what is out there'.* Another issue raised was concerned with transport and staff retention, *'...my biggest issue is transport for our people and actually retaining staff and talking about full time verses part time staff. Its alright working part time but sometimes circumstances change for staff and part time isn't enough.'*

Whaioranga has also been adversely affected by the establishment of Maori health providers in the district, particularly in regards to its restricted ability to provide district wide health programmes, *'...at the start, with Whaioranga being the first Maori centre for health in Tauranga, some of the programmes were more extensive.*

However, as more groups became involved, it did have an impact on the provision of services provided by the Trust. And this is not a bad thing, it is great that these clinics are up and running, but it did have an impact on the provision of services provided by the Trust.'

1.2.10 Current Health Issues

Although the provision of health services is influenced by service contracts between Whaioranga and the respective funding organisations, there was other health concerns raised that went beyond the scope of those contracts. The health needs that emerged during the conversations with respondents demonstrated an increase in the incidence of prostate cancer, the need for mental health services, the need for drug and alcohol services and the need for asthma and diabetes education. One person said, *'...one of our biggies in the whole Western area is drugs and alcohol'.*

It was also highlighted that expectations to increase contract deliverables had not been matched with any further financial compensation for those increased expectations. Those added burdens impacted upon the ability of Whaioranga to meet the health needs of its tangata whaiora, *'...even though we've got the same contract, the mahi has got more intense and the workers are covering a whole lot more in the same hours. And they're fantastic workers, so you know we've got to get out there and we've got to either fight for that contract and prove that it's done well or we drop it.'*

1.2.11 Aspirations Articulated by Kaikorero and Kaitautoko

Feedback was sought from kaikorero and kaitautoko about their aspirations for Whaioranga. One kaikorero commented that it is about strengthening Whanau. Another said the aspirations of Whaioranga included a total commitment to tino rangatiratanga, to build up the workforce into a team of professionals and for Whaioranga to give services that they can with integrity. A kaikorero said, *'...I have been through a whole lot of stages with Whaioranga and I can honestly tell you now that the aspirations that were back then have still not been realised. And for me,*

when I look back, I actually feel frustrated about it. But I know there has most probably been a whole lot of stuff that has happened [to impede our development]....'

1.2.12 Research Focus of Case Narrative

The research issues that will be considered in this case narrative relate to the health promotion and educational activities of the Hauora. Whaioranga possesses different characteristics from the other case groups participating in this research project, as there is no one single health promotion contract in operation. Instead, there are health promotion components within each of their health contracts. The areas of inquiry with this case focus upon the principles and concepts of health promotion that are practiced by kaimahi, why those practices are performed the way that they are and the way in which health promotion is articulated within the broader range of Hauora activities. Related to those areas of investigation is the need to understand the broader principles of Maori health, Maori health promotion and Maori health development, which underpin the ongoing work performed by Whaioranga. The second area of inquiry involves the examination of social marketing and the extent to which representatives of Whaioranga might consider utilising it as a framework for its health promotion activities.

1.3 Reflective Conversations

This section presents a series of reflective conversations about Maori health promotion and social marketing within the Whaioranga context. The comments are derived principally from post-workshop conversations with kaikorero and kaitautoko. There was one person involved in the post-workshop interview and three kaitautoko in total involved in the development of this case narrative. The conversations have been ordered into topics, which surfaced during those discussions. Each conversation is contextualised into themes that were then critically examined. The quotes in italics are a sample chosen to represent the overall concerns. Space constraints did not allow all comments to be included.

1.3.1 Kaupapa Based Health Promotion

An important aspect of this research is to identify whether Maori health organisations are guided by concepts of health that are different to other health organisations in New Zealand. The first conversation excerpt is concerned with kaupapa and what that might mean for Whaioranga. For instance, *'Maori are bound to those cultural values and those values help us to keep within the boundaries of our kaupapa'.* This response suggests that kaupapa is a set of cultural values that guide kaimahi in their activities. Two words in particular, *manaaki* and *pono* provide a glimpse of what constitutes kaupapa to the kaikorero.

1.3.2 Maori Health Development in Tauranga

An important component of the workshop and the post-workshop interviews involved reflecting upon the state of Maori health development within Tauranga, regionally and nationally. This exercise provided a collective opportunity for the Maori health providers to reflect upon their goals and visions and to analyse the achievements of predecessors. The exercise also provided an opportunity for participants to contextualise their achievements and concerns within the broader scope of Maori health development. For instance, the first issue was concerned with the nature of their relationship with national bodies such as the Government, one kaikorero said, *'I suppose when we contract or say we're going to do something for government, we are bound so you're accountable'.* The second issue appeared to suggest that the events occurring nationally did not have a significant bearing upon the work of Whaioranga if an identified need existed within the community, for instance, '[*Maori health providers in Tauranga] have led a lot of things in that way because of the need of the people.'* The participants acknowledged Whaioranga's pioneering role in health development during the workshop.

Kaitautoko Responses

One of the kaitautoko was supportive of the role that Tauranga Moana has played in health development. It was emphasised that there were innovative initiatives performed in Tauranga that were spearheaded by a pool of intelligent people committed to health development for Iwi and Hapu. For instance, *'...I do think*

Tauranga has practically been a forerunner of things. However modern writing [doesn't reflect that] so its actually not known. Whaioranga was one of the first Hauora around Aotearoa and Te Puna Hauora here, this was the first model of kaupapa Maori health for a secondary service [in the country]. In addition, I think there are many very intelligent people here who have been like the forerunners of events. They are very good thinkers, so even though there is a lot of welfare here. I think people here still have a lot more than other people do. The marae's are very strong and people are really working them and if we looked at health, that's where the health bases are either on the marae or near the marae and those are really strong.' These responses suggest that stories about Tauranga led health initiatives are not being told within the bigger context of Maori health development.

1.3.3 People Development

The development of people within Whaioranga and the inability of the Hauora to retain experienced and qualified staff members long term was identified as a significant concern in preliminary reports and interviews (Whariki Research Group, 1995). This particular concern is re-visited as part of a complex conversation. Two themes are highlighted in this discussion. The first theme refers to the development that has occurred by people involved with Whaioranga and that many of the previous employees now occupy different types of roles within the field of Maori health. There were two reasons provided for this, one is that Whaioranga has been in operation for some time and people have come and gone within that period. The second reason is that Whaioranga has been perceived as a training kohanga hauora or nest of learning for health, *'like it's been the Kohanga for health in Tauranga Moana, so a lot of people have come through and moved on, and you're right – into higher positions, more responsible positions and they just need that – there are no qualms'.*

The second issue relates to the limited people base within Whaioranga itself and the impact this can have on other areas of Whaioranga such as communication. For instance, whilst individual people are assuming different roles, there have been implications for the operational activities of the Hauora particularly with the flowing down of information from trustees. For instance, *'there were some times when*

[previous kaimahi] get to those [governance] levels but that is where the core things are stuck, because that is where they have to look after their tasks and sometimes – especially for me – communication gets overlooked....'.

However, it was acknowledged that in order to assume those types of roles, people required a different set of skills and the responsibilities placed upon them in those roles are more intensive. The accountability mechanisms in place are also more extensive. For instance, *'One thing I feel about our people – I mean you can make so many botch ups, but if it is one big one – well look out! In addition, you're not answerable to the organisation; you're also answerable to your own people around you – your Hapu and Iwi'.* This example was concerned with the unique nature of accountability with Maori organisations in comparison to non-Maori organisations that are different and positive.

Kaitautoko Responses

Two further comments were raised in respect to people development. One issue emphasised the need for Maori health employees to have a tikanga base, 'we need more people with a tikanga base, we have had good staff who have a good clinical background but they are lacking in the reo. I think that's quite common in lots of places, but – to me the ultimate would be when we have got to where the vision was in the first place.' A further comment emphasised the need for ongoing staff training and development to ensure that tasks or expectations for health development can be achieved. For instance, 'I think it is because of the skill knowledge of staff. I'm not going to say they, we all need to keep on upskilling and having the confidence to go and promote all those things out to our tangata whaiora, our community and our marae. They are the community, Iwi, Whanau, Hapu.'

1.3.4 Maori Health Promotion

The opportunity to review concepts related to Maori health promotion as opposed to health promotion for Maori was provided during the preliminary interviews and in the workshop. Participants were asked to provide a list of concepts about Maori health from earlier comments in the interviews. Those concepts were then compared to

Mason Durie's Maori health promotion model called *Te Pae Mahutonga*. Three points were raised about those related concepts during the conversation. Firstly, it was the view of the kaikorero that *'the model or framework, it still encompassed culture'*. As such, it was derived from and formed part of a cultural framework. Secondly, the ideas proposed in the model were not new, *'I believe that Mason had a way of actually writing it down and everything so that everyone could understand but I believe his ideas were there anyway...it could have been my koro down the road'*. Thirdly, the model was developed not just as a means of validation for Maori involved in Maori health promotion, but also, *'so tauiwi could understand it'*.

The second passage raises a number of issues about the effectiveness of existing Maori health promotion practices for Whaioranga. For instance, Whaioranga has in place existing procedures and practices that include planning, promotional activities and programme execution. Secondly, the activities must be performed on a marae wherever possible. Finally, a current set of criteria for evaluating a successful promotional activity already exists. To illustrate, *'....95% of the time we always say it was successful, one - because the people have chosen to come. Two - because we have ensured that everything was there for tangata whaiora and the workers are there to explain what they do. Three - we actually open up our doors to other people to come in e.g. for the asthma society to come in and share. Four - it is a place of whanaungatanga, a huge part of [health promotion] is about whanaungatanga for us, catching up with old friends, making new links, networking with other organisations and of course you have to have a kai. That is all part of our culture'*.

The points raised above could be used as criteria for health promotion for Whaioranga. The points again are:

- Those people expected to participate do participate.
- The promotional activity is well prepared and organised.
- The promotional activity is collaborative e.g. work in with other groups and;
- The promotional activity is based upon and reiterates Maori values e.g. whakawhanaungatanga and kai hakari.

1.3.5 Accountability and Measurability

The issue of accountability emerged as an important point of discussion. The concern however, was not related to a sense of accountability to the people as reiterated in an earlier section. The interpretation of accountability referred to in this discussion is about tangible evidence and or proof. According to a kaikorero, culturally influenced accountability mechanisms such as *kanohi ki te kanohi* or face to face are founded on oral historical traditions and they are sometimes taken for granted as an accepted practice. But the kaikorero was concerned that the practice was not always accepted by funders, *'I feel that I've got to have some evaluations for tangata whaiora, because then we can reflect back and say 'look at their comments.' And was it really successful?* The response suggests that Maori forms of evaluation through face to face communication were not seen as adequate evidence for evaluation.

1.3.6 Social Marketing Concepts, Assumptions and Themes

The assessment of the value of social marketing as a tool or framework by kaikorero in the area of Maori health promotion is a core concern in this case narrative. As such, an important part of the interviews and the workshop was the active critical review of the model. The following excerpts provide an indication of the issues raised about the model from the perspective of the kaikorero. In the first excerpt, it is difficult not to see the impact of financial concerns within the conversation and the possible benefits that social marketing might bring because of its implementation. The kaikorero reiterates, *'you know when you talk about going out and making money – business wise, being business minded so I could see the sense in [social marketing]'*. However, there was a concern with the likelihood that social marketing could, *'take over the focus – our reason for being here'*. Two compelling points were raised as to why it might be an appropriate model. The first concern relates to the burden carried by kaumatua and kuia in terms of contributing to the Hauora. For example, *'I felt that our people had taken advantage of us, there are things that we have to pay for, other than the kaumatua and kuia, you would very seldom get koha'*. This is a very serious issue because it demonstrates an erosion of tikanga amongst the people. The lack of reciprocity from people using the services in accordance with tikanga Maori is encouraging people involved in Maori health to, *'think twice about social marketing... because I think it is just the climate of the day and we've got to*

move with it.' The responses suggest that practices that would ensure reciprocal relationships between parties are being eroded. The erosion of these practices is negatively affecting the Hauora, so much so that kaimahi may be prepared to utilise social marketing as a result.

1.3.7 Environmental Changes

The changes in the environment; socially, politically, culturally and economically have had an enormous impact upon the types of health policies that are put in place by Maori health providers to perform their roles. With Whaioranga, the climate for change is viewed as a possible reason for adopting the social marketing model. A number of contributing comments were raised by kaikorero regarding environmental changes particularly with changes in people's attitudes. Firstly, there are concerns about the differences in worldviews from the old people and the young people in terms of assisting Whaioranga. For the old people, a koha is a contribution that is given as a gesture of reciprocity, but for young people they do not seem to hold those same views, *'a lot of them have been brought up in cities and they've lost that and then they come home and they expect [a hand out]. You know what I mean and the need is there definitely, but we do not have to go so far as an organisation that we make them dependent on us'.* The difficulties that come with that type of mentality are problematic for Hauora kaimahi. One kaikorero saw that issue as a conflict between the young and the old, *'I am still with the old people and I'm torn between young and old so in a way you try and compromise but is that any good for the organisation?'* The response suggests that Whaioranga is dealing with a different environment, where people are starting to think and behalf differently. The tikanga base that was once there is not as strong as it used to be and this gap is contributing to a break down in the reciprocity between kaimahi and tangata whaiora.

1.3.8 Market and Marketing Mix

The social marketing model includes a number of concepts such as market and marketing mix that contributes to the reconfiguration of health as a product or a commodity. The query in this section was concerned with obtaining insight into what kaikorero thought about the use of those concepts. One kaikorero demonstrated an unwillingness to admit that; *'people are a market for us as a provider'.* The

description was qualified with the following comment, *'I suppose they are a market because without the needs of the people we wouldn't even be here and its funny you ask me that because one of the tangata whaiora said to me, 'If I wasn't so sick you wouldn't be here'.* The comments appear to suggest that the use of marketing terminologies is becoming more frequent in the area of health including Maori health. However, despite its increased use, the kaikorero demonstrated an initial resistance to the concepts.

1.3.9 Social Marketing Labels

The further exploration of the use of social marketing labels and terminologies was also discussed. The use of labels might include social marketing concepts, assumptions and terminologies. The kaikorero felt uneasy with some of the social marketing terms, for instance, *'I'd feel most uncomfortable'.* However, if the terms were different and reflected Maori words, it would be different. For example, *'tangata whaiora is a lovely way of putting it and I can live with that as a Maori you know, but if you say 'the customer or a product....I think oh please!'* The kaikorero was particularly grateful for the input made by kuia with regards to matters such as these at Whaioranga; *'...the role they play is to focus you back on where you are and what you are doing'.* The findings from this section suggest that the use of all of the social marketing tools and terms by Maori health providers may be subject to some resistance. The kaikorero also highlighted that it would be difficult to use terms like the marketing mix in their work although there was an acceptance of the term market.

1.3.10 The Appeal of Social Marketing

Kaikorero were provided with the opportunity to discuss what was particularly appealing about the social marketing model or if it appealed at all, *'I know we have to go there. I feel that we have to go there. We're doing it now. It's just finding the process that suits our values, finding the process that fits in with the people you see, your Hapu, your Iwi, finding the process. I know we have to use it, you can't get away from it, we're doing it now and I think this is where our young people like yourself – it's your responsibility.'* The excerpt above provides an indication that there was a sense of inevitability about adopting the model yet at the same time there were concerns about finding a process that fits in with the people, the Hapu and the

Iwi. The responsibility to ensure that a process is in place to protect kaupapa was a task for others coming up in the field to perform.

1.3.11 Implications Associated with Social Marketing

The ability to identify whether the kaikorero had any reservations about the social marketing model was imperative. The excerpts related to identifying what the kaikorero saw as implications are provided below. These excerpts are revealing because they indicate that there are criterion for decision making in place that serves as a mechanism for protecting the kaupapa. For instance, when asked if there were any trade offs associated with the use of social marketing, the response below was, *'No. Not at the moment and why I say that is the people won't let you'*. This comment suggests that there is an automatic accountability mechanism in place to ensure that decisions made will be conferred by the people. When asked whether the terms such as place and product would affect the kaupapa, the response was affirmative. However, it was also noted that, *'it's the reality, but then again you know how everything is changing there might come a time when that's all you can be because our young people it's the language they speak'*. Another principle of practice that seemed to ensure that the kaupapa would be protected was the expectation of inclusiveness. For instance, *'[everyone has] got to be included in the planning, the decision-making – the young and the old. The idea is to all come together and we're great for hui and we have to come to a consensus – not everyone will agree'*. Last, the idea of ensuring the ownership resided with the people was a particularly strong principle. As such, it was acknowledged by the kaikorero that, *'the principles behind [social marketing] were different.'*

Kaitautoko Reponses

One of the kaitautoko provided a response to the question of whether social marketing was an appropriate model for Maori health promotion. The responses indicate that whilst it was appropriate to use marketing as a means of promotion, it was not necessarily an appropriate model overall. The following comments illustrate, *'I don't see any problem marketing services, marketing what you are doing and developing other services, that is the idea that is becoming a lot more flexible*

with marketing things that you would like to see happen' but, *'Marketing, I don't like the word marketing, because it implies the use of profit and that sort of thing and you won't do it unless you've going to make a profit, which means the service can actually be cut down and that is the wrong approach.'*

1.4 Other Kaitautoko Responses

This section explores a number of issues raised in conversations with kaitautoko that did not emerge during the post-workshop interviews. They relate primarily to two core issues about health services in general and the wider context of Whanau, Hapu and Iwi development.

1.4.1 Maori Health Models

A number of comments emphasised the challenges associated with delivering what the organisation sees as kaupapa through its health services. The first comment focused upon the broader components of health and how Whaioranga tends to those issues, *'I suppose what we look out for is not illness. It is about how we can help them and I would say we would more or less focus on their finances, housing, their own well-being and you can't help but look at the environment they are living in.'*

The following comment reflects upon the contradictory relationship between health models such as Whare Tapawha and the contractual obligations of health service delivery. The responses highlight that there are emerging tensions between Maori concepts of health and contractual definitions of health. For instance, *'that fluid approach to health is something that the Trust has maintained, it has not worked within a compartmentalised approach to health and this is where some issues arise for our people. In addition, health for Maori means so many things involving socialisation and so forth. A contract in contrast is provided on the basis of one aspect of care, such as the injections for diabetes and the Trust is providing a type of service that involves a series of other things so there are tensions. There are tensions in respect that the Trust is doing mahi that is not recognised in the contract. There are tensions when the contract is the definition associated with health, particularly when pursuing a more holistic approach to health.'*

The next comment highlights that current Maori health models are appropriate, but in the future the focus upon Maori by Maori will change and the reality of Maori diversity will be more prominent, *'I* really *believe that Maori for Maori need something right now, but I believe down the line, maybe ten years time, that focus is going to change.'*

1.4.2 Contracting Nature of Hauora

An issue that arose related to the service contracts and the ongoing expectation that existing contracts should achieve more results. This point was particularly concerning for the kaitautoko, *'I hope you find it in the other providers because even though we've got the same contract, the mahi has got more intense and the workers are covering a whole lot more in the same hours. And they are fantastic workers. So you know we've got to get out there and we've got to both fight for that contract and prove that it's done well or we drop it.'*

1.4.3 Competitive Environment of Maori Health

The increasingly competitive environment of Maori health was also proving to be challenging for Whaioranga. The issues raised are concerned with competitiveness and the increasing emphasis put upon Maori health organisations to be well organised, *'Primary Health Organisations, like the District Health Boards they are just another system, that's coming into play and honestly if you're a Maori provider in this kind of environment you need to be up with it to survive. I feel sorry for those who aren't.'*

The second issue was concerned with the continuously changing health policies and the influence that these policies have upon Hauora such as Whaioranga. For instance, Whaioranga has been forced to collaborate in the development of new health entities without necessarily being in a position of control within that entity, or sometimes without a clear indication of how that alliance might contribute to health gains within the community. For instance, '*It is at the grassroots that the work is actually going to be done. The last thing that we want is to have is an external organisation imposing directives upon groups like the Whaioranga Trust. The innovation, the initiative, the self-determination of a particular health organisation such as Whaioranga can be*

minimised as a result.' This comment highlights that Maori health is becoming increasingly competitive and that sometimes groups like Whaioranga become involved in entities that maintain the politicisation of Maori health. One of the kaitautoko commented, *'Health has become too political and it still is. It is far too political and it is getting away from what it is there for in the first place. It is there for uplifting the well-being of the people that use the services. This is really Whaioranga's primary objective.'*

1.4.4 Whanaungatanga – Iwi Relationships

There were also comments raised about the impact of Iwi and Hapu involvement in the provision of health services to Maori. One comment in particular highlighted how Iwi could work together particularly with respect to sharing resources, *'I think that we do not share enough information between us Maori providers; I do not know what it is or what is the failure. Well, I kind of know and it is a cultural thing in Maori culture, it's about the boundaries for instance, this is Pukenga, this is Ngati Ranginui, there's Ngai Te Rangi. We all deliver to our own people, hey that's alright, but why not share resources and skills, you know?'*

The second comment highlighted how Iwi could work together and that the expectation that Iwi work together all of the time on all matters is not universally accepted. Instead, the relationship building between Iwi should occur when it was needed, *'If you put Ngaiterangi there, Ngati Ranginui there and Ngati Pukenga over there. They could come together for some things where there is the intersection there right. Ngati Pukenga and Ngati Ranginui might come together for certain other things and all these other ones and then there will be a lot of other times, which they will be operating by themselves.'* The responses seem to suggest that the maintenance of Iwi relationships is an essential pre-requisite to surviving within the Maori health environment.

1.4.5 Te Whakaoho Mauri – Growth Opportunities

Whaioranga is presented with a few opportunities for development in the future. The two comments below outline the increasingly diverse Maori population that will emerge in the future and that Whaioranga should prepare now for re-organising its services to meet the needs of those particular types of tangata whaiora. The first comment noted that, *'you see our people our elderly people, we're losing them and a new generation is coming through, we're going to be the new elderly and yet we're the baby boomers, the population of elderly are going to just boom. So, we need to look to the future for Whaioranga. We need to look at how to handle that and how to prepare ourselves for that. And for me, culture will not come into it as it is about my needs. Then you get our clever young rangatahi coming through with te reo as well. So, how can Whaioranga deliver health services in the future with the increasing diversity that will emerge amongst Maori? All this diversity that's going to be here, we've got to be prepared for it.'*

The second comment noted that the ethos of pan-tribalism should remain as the main thrust for Whaioranga in the future and that the Te Wananga o Aotearoa model was something that should be considered for future growth opportunities by the trustees. For example, *'Whaioranga has become restricted with where it could operate. It has become an organisation that works together with Ngati Pukenga; it is not under Ngati Pukenga, simply because Ngati Pukenga alone is too small. If Whaioranga went back to its pan-tribal influence and I think that will come, if we look at the model of Te Wananga o Aotearoa and maybe it might come in things like training, working in partnership with places like Te Wananga o Aotearoa.'*

Despite the increasingly competitive and political environment of Maori health, one kaitautoko remained optimistic about the future for Whaioranga, *'I'm really proud that Whaioranga is still going and my aspiration for Whaioranga is about unity and as Maori providers we retain our tino rangatiratanga and our own autonomy. Then we build up our workforce, so they become a professional workforce and a health community workforce. So we strive to build up our work force capacity'*

1.5 Conclusion

Whaioranga is a Marae based health promotion, social services and education services provider. There are various types of approaches utilised by the Hauora that can be described as interventions, eclectic, Whanau based, kaupapa Maori based and community based. In Section 1.2 of the case narrative, I provided background information about the historical development of the Hauora. The intention of this section was to provide a backdrop for a critical investigation into the extent to which social marketing might be adopted to improve Maori health. Sections 1.3 and 1.4 were concerned with presenting aspects of the reflective conversations that developed during the research process. The key findings that have been drawn from those conversations are outlined below.

The research conversations indicate that trustees and kaimahi of Whaioranga have continued to provide a range of health activities founded on the holistic principles of Whare Tapawha. The vision for providing holistic health has remained unfettered throughout its twenty-two years of operation. Holistic health was also articulated as an overriding theme within everything that Whanau want to do and how they actually do it. Whaioranga was a leader of Maori health services in its earlier days and the services it offered covered the entire Western Bay of Plenty region. However, the ability to maintain that services reach was reduced when other Maori health providers established the services.

A number of emerging trends within the health services environment have exposed Whaioranga to a series of organisational weaknesses. One of those trends is the increasing expectation by health funders that Whaioranga kaimahi should provide more service deliverables from the existing contract fund. One kaikorero said, *'I hope you find it in the other providers because even though we've got the same contract, the mahi has got more intense and the workers are covering a whole lot more in the same hours. And they are fantastic workers. So you know we've got to get out there and we've got to both fight for that contract and prove that it's done well or we drop it'.* There are tensions that exist in respect of what the Hauora is doing and what is recognised in health service contracts. Another trend is the

increasingly competitive environment of Maori health and the impact the increased numbers of health providers has had on long-term health providers such as Whaioranga.

Another emerging concern was the partial loss of tikanga and the effect this trend has on the foundation for the Hauora. Although there are kaumatua and kuia that closely affiliate to and advise the Hauora, their input cannot be taken for granted as translating into organisational knowledge. As a result, the potential future loss of tikanga is an issue that can best be addressed by establishing a structured pathway for new employees to acquire reo and tikanga. As well, the expectation that employees come to Whaioranga with tikanga and reo and also health expertise is tempered by the realisation that these types of skills are difficult to source and then retain. It is also challenging when the resources available are insufficient to compensate that particular type of expertise. Whilst Whaioranga was the first Hauora to articulate an aspiration for holistic health services under the guise of Maori tikanga, maintaining a commitment to that kaupapa long term requires constant ongoing attention and resourcing which is proving difficult to source.

Concerns about the increasing subjugation of health services to business related practices were confirmed by the kaitautoko's awareness of business related terminologies, yet that trend was tempered by a measured resistance to the conversion of human need in the community to a market model. The reconfiguration of Hapu into a market is one such example. There are also concerns that the holistic care for others no longer correlates with Maori health improvement by reducing health to a commodity is at the centre of the unease. These concerns mirror the emerging tensions that exist with holistic approaches to health verses the compartmentalised approach to health that is characteristic of the contracting nature of health. As one of the kaitautoko said, *'a contract is provided on the basis of one aspect of care, such as diabetes testing, and the Trust is providing a type of service that involves a series of other things so there are tensions'.* The provision of holistic health does not end there, kaimahi look at the person's tinana, nutrition and mental aspects of health as well.

The research conversations suggested that Whaioranga found it challenging to retain kaimahi long term. Further prompting on this issue highlighted that long-term kaimahi retention related to a number of factors. One key factor was to the lack of long-term financial resources to provide full time employment opportunities; many of the positions were part-time positions. This issue also impacted upon the ability of Whaioranga to retain well-qualified staff members as well. Whaioranga saw knowledge of Te Reo and Tikanga Maori as an important skill in kaimahi that complemented health skills. Whaioranga made it clear that an ideal kaimahi possessed both health skills and cultural skills in Te Reo and tikanga Maori. Yet, there were limited resources available within the Maori health services sector to retain these types of skilled kaimahi within Maori health centres such as Whaioranga.

The initial purpose of this study was to inquire into the extent to which social marketing might be usefully adopted to facilitate the achievement of Maori health enhancement. The exploration of prominent social marketing models and concepts with kaikorero provided a platform for discussions. On the one hand, kaikorero suggested that there was a sense of inevitability about the future use of social marketing. It was thought that some social marketing terms were already being used and as a result, ongoing use was expected. However, on the other hand it was also thought that some terms were inappropriate and a request for the terms and processes to reflect Maori words such as Whanau, Hapu and Iwi was not seen as unreasonable. It was also suggested that the future likelihood of the terms being adopted would be tempered by support from the people, particularly from kaumatua and kuia. Kaikorero suggested that marketing might be useful for the promotion of health services by acknowledging that there was a growing acceptance of that practice. However, the full implementation of marketing philosophies meant that when things were not going well, services would also be axed in line with that philosophy and for Maori health, that realisation was seen as a stark implication.

The prosperous future for Maori health development in Tauranga relied on many things. One issue was the need to nurture and manage Iwi relationships and utilise them when required. The expectations that Iwi should work together all of the time

on all matters was not part of that proposition. A second issue related to the politicisation of Maori health and the disenabling impact this had upon the provision of Maori health services. The effective management of Maori health as a political kaupapa was therefore imperative.

Whaioranga pursued four aspirations that have been articulated within this case narrative in spite of the challenges highlighted. Firstly, Whaioranga should be concerned with identifying opportunities to meet the needs of the growing diverse group of Maori people in the future. Secondly, Whaioranga should explore training opportunities that may arise from following the Te Wananga o Aotearoa model. Thirdly, Whaioranga aspired to achieve unity and autonomy and to develop a professional workforce in the future. And finally, Whaioranga should become less reliant on traditional forms of funding for Maori health.

To conclude, the case narrative has sought to critically examine the extent to which social marketing may be useful to Maori health development. As an isolated research inquiry it would have been possible to conclude that social marketing would facilitate an improvement to the methodologies currently adopted by Whaioranga, despite a degree of apprehension associated with the adoption of some of its terms. However, when broader health issues within the environment for Maori health were considered, it was noted that social marketing would provide momentary improvements to the way that health promotion is delivered by Whaioranga kaimahi. However in the long term risks associated with its use would be seen as a stark contradiction to the Whare Tapawha model, which has been used to guide the enhancement of Maori health in the future.

1.6 Recommendations

There are four key recommendations that have been identified as part of this case narrative. They are provided for the benefit of Whaioranga trustees and the Manager. The recommendations are also directed towards funding agencies in the hope that serious critical thought is made to address some of the concerns raised.

That Whaioranga promotes itself as a Hauora that envelopes training as part of its services delivery. To do that Whaioranga trustees should re-examine the way that career opportunities are provided for its kaimahi in the interests of retaining kaimahi long term. As part of that role, it is important that Whaioranga encourages kaimahi to prepare five-year career plans, as part of its employment planning process. Funding should be made available to achieve career goals that emerge from those plans.

That Whaioranga in collaboration with the Kairua Welcome Bay community re-invigorates its commitment to a holistic approach to Maori health development founded upon Te Whare Tapawha. In acknowledging that commitment, new pathways may be discovered that emphasise and addresses the concerns raised about tikanga and reo development in this case narrative. It is also recommended that regular kaupapa hui are held to identify what the community identifies as kaupapa and that those suggested activities become the foundation of the way in which Whaioranga provides health services to the community.

That Whaioranga develop a five-year plan that focuses upon the long-term health needs of the emerging diversity of Maori in the future. It is important that the five-year plan forms the basis of Whaioranga's future direction.

That Whaioranga work in conjunction with contracting organisations to ensure that activities performed in health contracts, are at least equivalent to the financial resources provided as part of those contractual agreements. In cases where the financial resources are insufficient, Whaioranga and the funding organisation should endeavour to reach an agreement that reduces its contractual expectations or increases the funding made available to meet existing contractual agreements.

Case Narrative Two: Toi te Ora Public Health – Mana Manaaki

2.1 Introduction

The aim of this research project is to critically scrutinise the extent to which social marketing may be adopted to enhance Maori health development. The aim of this case narrative is to explore the implications associated with adopting social marketing as a model for health promotion within the Mana Manaaki programme (Mana Manaaki). Mana Manaaki is one of the case studies included in this research report. It is administered by Toi te Ora Public Health (Toi te Ora), the Health Promotion and Health Protection arm of the Community and Disability Services of Pacific Health. Pacific Health is owned and operated by the Bay of Plenty District Health Board. Although Mana Manaaki is now seen as a historical programme, the concept for health that is derived from Mana Manaaki still remains. Mana Manaaki now, is a conceptual framework for Maori health that guides the health promotion activities of some Maori health promoters within the Tauranga office of Toi te Ora. The Mana Manaaki case narrative is arranged into six sections. Section 2.1 is the introduction and Section 2.2 provides an historical overview of Mana Manaaki. Section 2.3 provides an analysis of reflective conversations with kaikorero and Section 2.4 presents a thematic analysis of kaitautoko responses. Sections 2.5 and 2.6 present the conclusions and recommendations.

2.2 Historical Overview

Maori health promoters and Maori community groups within Tauranga contributed significantly to the establishment of Mana Manaaki (Barrett-Ohia, 1994). The aim of the programme was to reduce the consumption of alcohol and the health related impacts of drink driving. It was managed on a daily basis through the Western Bay Health Promotional Unit, which later transferred its services through to Toi te Ora. Although Mana Manaaki was conceived in 1991, it was not until 1992 that the first series of promotional activities were launched. Mana Manaaki has almost become

synonymously associated with the work performed by the first Coordinator, Orewa Barrett-Ohia. However, according to Ohia, a large group of people participated in planning, strategising and operationalising Mana Manaaki[34]. Bob Rawiri provided the name Mana Manaaki which was interpreted as follows, *'Mana is value in taking care in each other with manaaki and there is a whole value thing in being a host, in Mana Manaaki. Therefore, there is mana in being able to take care of people. And just jumping back to that, the Pakeha ideas is that, that person was driving drunk, but with Mana Manaaki it was with seeing it all as our responsibility'* (Barrett-Ohia, 1994).

The New Zealand Police who were sanctioned to impose harsher penalties for drink driving offences supported Mana Manaaki. Although the programme was noted as the first of its kind for Maori, it was later modelled by the Alcohol and Advisory Council of New Zealand (ALAC) as a framework for the establishment of the national Manaaki Tangata programme. Although the original Mana Manaaki programme has since ceased to operate, the Mana Manaaki concept is active within Toi te Ora. There are steps currently being undertaken to re-consider how the concept might be utilised as a kaupapa driven approach to Maori health promotional activities throughout the region. Some ideas being explored include seeing how it might inform smokefree initiatives, problem gambling and even the re-initiation of inter-marae sports.

2.2.1 Mana Manaaki Kaupapa and Vision

The core kaupapa of the Mana Manaaki programme during the mid 1990's was, *'to build on positive cultural concepts such as manaakitanga, kotahitanga and participation to raise awareness about the amount of harm that was being caused by excessive alcohol consumption'* (Barrett-Ohia, 1999).

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[34] Some of the committee were Bob Rawiri, Clinton Lovett, Uta Rolleston, John Ohia and Lorraine Rawiri.

The Mana Manaaki concept serves as a guiding principle behind the health promotion activities conducted by some of the Maori health promoters at Toi te Ora, particularly those located within the Tauranga Moana region. For instance, *'I have just made it so that all my work is under the banner [of Mana Manaaki] and that is the philosophy for everything I do. It is not smokefree, not sun smart, not anything – it is about manaaki and how we as a community support each other and it is families and how we build each other up, how we strengthen each other. And that is the sort of motivation for the work that I do.'* One of the kaikorero said the Mana Manaaki concept is about manaakitanga and kotahitanga, *'for me it is so easy to talk about Mana Manaaki. Those are our protocols for taking care of people on the marae and taking them to the clubrooms. You do not let people go home drunk and kill themselves. You would not let that happen on the marae, so people come in, are they made to feel welcome? On a marae they are, so you do the same thing at the clubrooms.'*

Mana Manaaki was established throughout the wider Western Bay of Plenty district. Its primary aim was to promote host responsibility by patrons and employees of Maori sports clubs throughout the region. One of its secondary objectives was to acknowledge the efforts and achievements made by contributors to the Mana Manaaki campaign. Further objectives included the promotion of moderation as opposed to abstinence, the promotion of messages of choice which was facilitated by offering sensible alternatives and the promotion of manaakitanga (Barrett-Ohia, 1994). Another objective of the programme was to ensure that there was positive role modelling, which in turn led to positive Maori development.

2.2.2 Services Region

Toi te Ora is part of the Community Health and Disability Services (CHADS) division of Pacific Health, a provider of health and disability services (Curtis, 2002). Pacific Health is governed by the Bay of Plenty District Health Board and is responsible for delivering regional public health services to the Western Bay of Plenty, Eastern Bay of Plenty and Lakes District. It has three offices located in Whakatane, Rotorua and Tauranga. As an organisation, it is a significant provider of

health promotional activities, messages and ideas within those three regions and regularly works in partnership with other providers.

Figure 4: Western Bay of Plenty Services Region

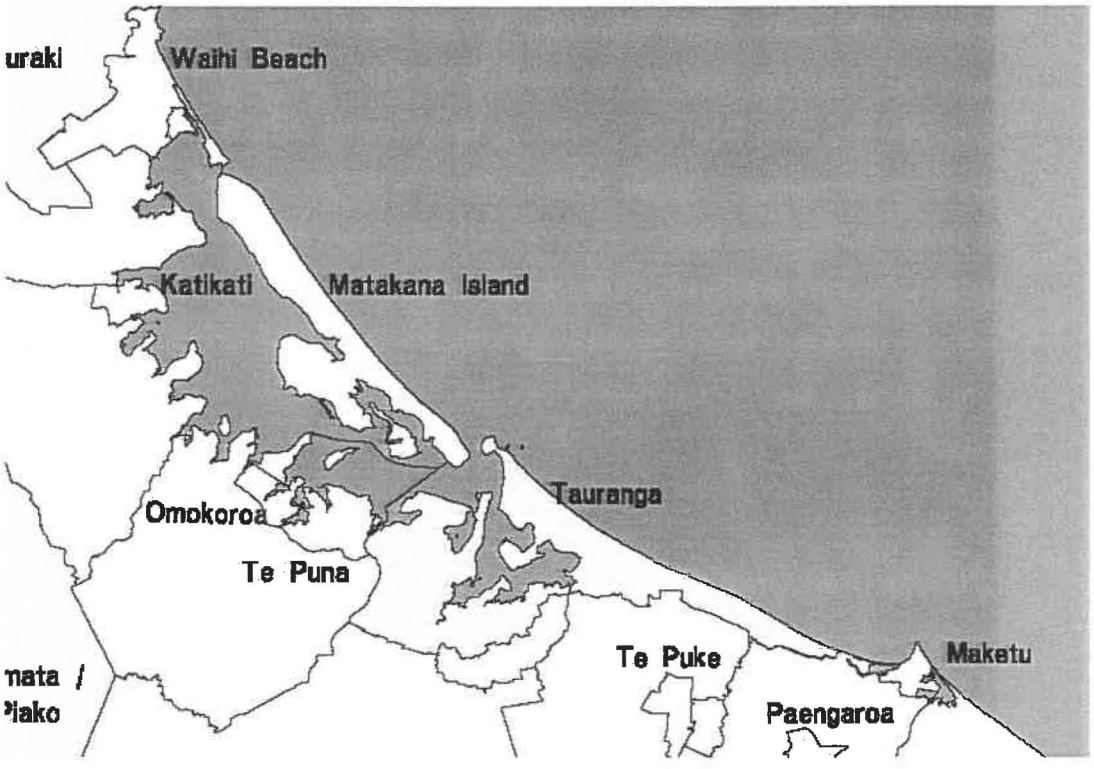

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Figure 3 highlights the Western Bay of Plenty District where Mana Manaaki was operating. In this area, there is approximately 24,000 Maori (Statistics New Zealand, 2002). There are two larger Iwi groups in the district, Ngaiterangi and Ngati Ranginui and one smaller Iwi Ngati Pukenga.

2.2.3 Nature of Mana Manaaki Programme

Toi te Ora provides a range of health promotional activities and programmes of which the Mana Manaaki programme was one. In the mid 1990's, Mana Manaaki consisted of joint venture type health promotion initiatives facilitated through sponsorship arrangements with sports organisations. For instance, organisations were provided with funding for resources and banners to display at the sports venue. As well, an

extensive Maori host responsibility training programme was provided for several Maori sports club affiliates. The efforts made during training were acknowledged by way of annual awards for the respective sports clubs in question. A further initiative was the Inter-Marae Sports Competition, which worked closely in with Mana Manaaki and its coordinators, although run by the Inter-marae Sports Association.

Another important issue was the competitive impact that ALAC funded Manaaki Tangata programme had upon Mana Manaaki. The comparative inability of Toi te Ora to continue resourcing the local programme, when a similar programme was being provided at a national level was very challenging.

2.2.4 Past Activities and Services

The types of activities undertaken during the course that Mana Manaaki operated included:

- Mana Manaaki sports club resources.
- Banners for promotion by sponsored groups.
- Inter-marae sports competition.
- Annual Mana Manaaki sports club awards.
- Mana Manaaki training in manaakitanga and;
- Different forms of media advertising: cinema, radio, road signs, newsletter and magazine.

The most important feature of Mana Manaaki was the way in which the promotion of responsibility with alcohol consumption by Maori was conducted. It was a philosophy of practice based on Maori principles of manaakitanga. In 2001, the activities utilised to promote safer driving throughout the community consisted of traditional mainstream forms of promotion such as road signs and cinema advertisements. Efforts were also made to support existing initiatives such as driver licensing training.

2.2.5 Evaluation of Services and Programmes

Two evaluation reports examined Mana Manaaki in detail. The first report looked at the actual activities performed by the hosts of sports club to provide for their guests (Ahomiro, 1996). The evaluation included an assessment of the range of activities, non-alcoholic drinks, food and options for drive safe initiatives. The evaluation also assessed the way the programme was perceived and implemented by affiliated sports clubs throughout the region.

The second evaluation report examined the future aspirations and comments collected by representatives of sports clubs for Mana Manaaki (Barrett-Ohia, 1999). The report unanimously supported not only the re-establishment of the programme, but also the expansion of the programme into other unexplored areas of health promotion. Several reasons for Mana Manaaki's popularity were highlighted in the report. One compelling reason for re-establishing Mana Manaaki was that it provided Maori in the region with a sense of ownership, '*Mana Manaaki is ours*'.

2.2.6 Organisational Structure and People Resources

The Mana Manaaki project committee consisted of a small group of people who worked in collaboration with several representatives of Marae based sports clubs. They worked with two to three Toi Te Ora employees to coordinate the programme. Several volunteers were involved with the organisation of the events that emerged as part of the programme.

2.2.7 Partnerships

During the time that Mana Manaaki was in full operation, the Coordinators worked closely with the Inter-marae Sports Association, other sports club managers, health promoters and also ALAC. The relationships that existed between managers at sports clubs and Toi te Ora staff members were a core component of the programme. Without a strong foundation of relationships, Mana Manaaki would not have been disseminated so extensively throughout the region.

However, as original members of the project team moved on from Toi te Ora, so too did some of the vitality to maintain the ongoing activities of the programme. During the latter years of the programmes operations, Maori health promoters at Toi te Ora in Tauranga assumed responsibility for running activities that emerged out of a concern to promote the Mana Manaaki concept. As more Maori health providers established in the region, the relationships that existed between Toi te Ora and the sports clubs transformed, necessitating new types of relationships between Toi te Ora and Hauora Maori.

2.2.8 Issues of Control and Ownership

The issues related to control and ownership with Mana Manaaki was not about resources, or even funding. For example, Mana Manaaki looked at ownership in concepts, knowledge and processes. As such, Mana Manaaki was viewed as a health promotion package that belonged to Maori within the Western Bay of Plenty area (Barrett-Ohia, 1999). The sense of ownership is a strong foundation for any future coordinators of Mana Manaaki. For instance, the usual impediments associated with delivering health messages to Maori in the future will not be as prevalent, as Mana Manaaki offers an existing model of practice for Maori health promotion. There may however be some impediments related to control and ownership issues that arise within the new environment for Maori health services in the region. For example, when Mana Manaaki was operational the Whaioranga Trust was the only other Maori based health provider operating in the region. Now, there are several Maori health providers operating in the Western Bay of Plenty region.

2.2.9 Current Organisational Issues

There are organisational issues identified that had the potential to negatively affect the extent to which Maori health gains could be obtained by Toi te Ora. These issues were highlighted in a report on the state of relations between Toi te Ora and Ngati

Pikiao.[35] The concerns can also be related to the Western Bay of Plenty region as well. The core issues raised were:

- Monocultural focus of Toi te Ora.
- Lack of Maori community focus.
- Inappropriate message delivery to Maori.
- Maori services structure and;
- Lack of a Maori public health strategy (Curtis, 2002)

On a more positive note there was an identified willingness by all Toi te Ora staff members (of whom a large number were Maori) to progress Maori health development. Whilst all of these issues have an impact upon the likelihood of Mana Manaaki being re-established in some form in the future, other issues were also important. Those issues included; the lack of clarity associated with what Mana Manaaki consisted of and where it might best be focused in the future. Secondly, the impact of constant health system re-structuring contributed to the perceived lack of collaborative working relations between Maori health providers in the region. Another important issue is the perceived move by Toi te Ora away from the actual delivery of health promotion services within the community, to the increased emphasis placed upon a politicised focus for health promotion. The energy that moved Mana Manaaki in the past appears to have dissipated. Therefore, there is a need to re-focus some of those efforts to re-investigating the role of the Mana Manaaki concept in the future.

2.2.10 Current Health Issues

Toi te Ora was heavily involved in the provision of several health education, health protection and health promotion activities within the community. Some of those issues concerned; communicable disease control, physical environmental protection, food safety and quality, prevention of drug and alcohol related harm, tobacco control, nutrition and physical activity, well child promotion, sexual health, mental health

[35] Ngati Pikiao is an Iwi located within the Te Arawa confederation of tribes. The report prepared for Toi te Ora Public Health focused specifically upon Ngati Pikiao. The concerns raised in the report have been used as a foundation for the concerns in Tauranga.

promotion, injury prevention, health information and health advocacy (Bay of Plenty District Health Board). However, the specific health concerns raised by two of the kaitautoko in this case narrative identified two key issues; the need for health promotion to emphasise well-being and the loss of Maori identity. For instance, *'.... they constantly look at illness, and Maori are under attack all of the time, yes they are unwell, and there are alcoholics and smokers. I want a big mind shift to wellness, which is what I think, is important. And contracts in public health emphasise illness.'* Also, *'...for me, the biggest thing is identity that is our crisis. Everything that we do goes back to our identity. I hate some of our programmes because of the approach, such as safe sex. I hate them, because we have gone so far away from what is normal in our own culture. If people knew who they were, some of these things would not happen....that is why I want to go down that Mana Manaaki track, because it deals with these issues here. I think that is more important then things like sun smart. Because it teaches us all about values....'*

2.2.11 Aspirations Articulated by Kaikorero and Kaitautoko

The interviews undertaken as part of the historical section of this case narrative suggest that Mana Manaaki was exposed to organisational vulnerabilities that contributed to its constrained visibility. Respondents interviewed in the 1999 Mana Manaaki survey however challenged that presumption (Barrett-Ohia, 1999). They recommended that Mana Manaaki must continue (Barrett-Ohia, 1999). For instance, *it should not only continue but the words 'Mana Manaaki' should be promoted around everywhere. It has so much potential to mean a lot to a lot of people.'*

The success of Mana Manaaki is said to speak for itself. It is also argued that Mana Manaaki has the potential to form the guiding principle of any future Maori health promotion programme. For example, *'I could tell you two things about Mana Manaaki. Firstly, it was a philosophy to motivate our people instead of going with the usual approach. We are talking in terms of looking after each other and caring for each other and that was the philosophy that I think was useful. I think in terms of the Mana Manaaki programme the work they had done and the practices it was a*

good vehicle I think. It was a good vehicle to take programmes to our people or to develop "for Maori by Maori" type programmes.'

2.2.12 Research Focus of Case Narrative

The research issues within this case narrative focus upon the principles and concepts of health promotion that are practiced by those Maori staff members involved with Mana Manaaki. The research will also look at why those practices are performed the way that they are and the way in which health promotion for Maori is articulated within the broader range of activities of the Toi te Ora activities. Related to those areas of investigation is the need to articulate the broader principles of Maori health, Maori health promotion and Maori health development that underpin the ongoing work of some Maori staff within Toi te Ora at Tauranga. The assessment of social marketing and whether it can be utilised within the Mana Manaaki framework is also a crucial consideration in this study.

2.3 Reflective Conversations

This section presents a series of reflective conversations about Maori health promotion and social marketing within the context of this case narrative. The content is obtained principally from a post-workshop conversation with kaikorero and other conversations held with kaitautoko. There were two kaikorero involved in the post-workshop conversation and four kaitautoko involved in the development of the entire case narrative. The conversations are contextualised into themes and then critically analysed. The quotes in italics are a sample chosen to represent the overall concerns. Space constraints did not allow for all comments to be included.

2.3.1 Kaupapa Based Health Promotion

During the research, kaikorero were questioned whether sports clubs and Maori staff members within Toi te Ora were guided by kaupapa that was different to other staff members and or health providers. The following excerpt highlights that kaupapa was interpreted as Maori values and that kaikorero were guided by kaupapa in their work. For instance, *'I am even more inclined to think it is really necessary to keep the*

original focus of Mana Manaaki intact and to pursue those types of [activities], to ensure that we continue to work using those Maori values to guide our practice in Tauranga'. What was also highlighted was the value of collectively examining kaupapa and how being guided by concepts such as manaaki was important, *'I think everyone of the [participants] has been inspired by that workshop session to look at how collectively we have come to this place and how we can see Mana Manaaki as a good value to take through'*. Kaupapa, in this excerpt appears to conjure up ideas about conceptual foundation or philosophy of practice.

2.3.2 Maori Health Development

The broader theme of Maori health development was also considered in this case narrative. There were several layers of responses provided in respect to this area of questioning which highlights the complex nature of Maori health development. According to the kaikorero, discussing Maori health development in the workshop provided an opportunity for health promoters to contextualise local and regional development within the national framework of health development. For instance, *'...it was important in terms of seeing local and regional development verses national development'*. Secondly, the initiatives undertaken by Hapu are sometimes portrayed as contrary to the national agenda for health. Unfortunately, they are described as fragmentary when they are not. To illustrate, *'sometimes the leads for Hapu to develop independently can sometimes be used by national strategists and portrayed as fragmentation amongst Maori people'*. Thirdly, the context of Maori health development is influenced by the ability of Maori health promoters to participate in the industry. Access to funding has an important role to play as a result, *'...whenever there is any funding or [a new] funding regime is introduced into health it has always been detrimental to Maori...because it comes as an expense in this particular instance to Hapu or Iwi providers'*.

The next excerpt extends the concerns raised above into the political environment. Two key issues are highlighted in this area. Firstly, those Maori in the health sector who are familiar with the climate have attempted to bring about collective responses to these changes, although their advances are not always welcome, *'... people who*

understand the political climate are trying to unite Maori so that they can meet the criteria that has been set for them nationally. Some who do not quite understand that at home and in clinics and with the different Hapu structures are thinking 'who are they?' They are actually coming over the top and trying to take over these things and that causes friction'. Secondly, the competitive environment of health is detrimental to the extent that Maori are being forced to tender against each other for health promotion resources. For instance, *'and that competitiveness you know that's designed to divide and rule us, in every new health funding formula that is introduced, it immediately has an impact that sets Maori against Maori'.* The excerpt above suggests that the Maori health industry is becoming increasingly competitive and that publicly funded health regime is similar to a business as it involves competitive bidding and tendering for contracts.

2.3.3 Maori Health Development in Tauranga

An important component of the workshop and the post-workshop interviews was the opportunity to provide feedback about the condition of Maori health development in Tauranga. The following excerpt suggests that Maori health providers in Tauranga forged a positive pathway in health development that is still exhibited today. As well, it was thought that Tauranga is also doing well because young staff members are able to maintain a positive outlook towards health despite the politics. For instance, *'I think Tauranga is doing well because to me I think the young staff aren't caught up in the politics, they were still able to just do their work. They were able to facilitate and work within the environment quite well because a lot of the grass roots staff are protected from [the politics].'* Tauranga has also found a way to move forward in spite of all the changes and constant re-structuring occurring within the health industry.

Kaitautoko Responses

One of the kaitautoko complimented the health related developments that had taken place in Tauranga. She highlighted three main points; that Tauranga had made extensive headway in the provision of Maori health services; that Tauranga health initiatives were used as models throughout the country and that Tauranga should be

acknowledged for those achievements. She went on to highlight Te Whanau Poutiri Rangi ora a Papa as an example. For instance, *'I think there have been huge strives by Maori in Tauranga in developing services in health. I think Tauranga has done really well, more than they are given credit for sometimes. Maori people in the communities throughout Tauranga, as far as I can see have played some part in developing or supporting some health service.'*

Also, '... people in Tauranga really deserve to be acknowledged for all their support, all their involvement and all of their participation they have put into Maori health. Some have done it locally, some have done it in their Whanau and a significant number have done the kinds of things that have been modelled for a time, for other people in the rest of the country.' Lastly, 'Te Whanau Poutiri Rangi Ora a Papa was a leader in its own right by setting up an umbrella organisation. That was in a huge demographic region and they set up the memorandum of agreement [with the Area Health Board]. They led in that respect for that time.'

2.3.4 People Development

Another important issue that arose concerned the skills base of people and their responsibilities and expectations to engage in matters at higher political levels in the future. The following excerpt relates to the importance of protecting new Maori employees from the broader political tasks required in the area of health promotion. For instance, *'there is a level of responsibility that you give to new workers coming into the scene whereby you protect them until such time that they are experienced enough to conduct their own functions within their own responsibilities'.* However, once those initial induction stages have passed, there is an implicit expectation that Maori health promoters engage in some of the harder tasks affecting Maori health promotion, *'I think it's a responsibility that Maori workers have to the rohe'.* This excerpt illustrates the increasingly political nature of health promotion and that people entering the field of health promotion need to have a sense of resilience to its challenges. They also need to empathise with those directly impacted at the same time. One kaikorero said that the opportunity to at least be exposed to those broader issues in health was seen as essential. Those people working at the marae in the kitchen were encouraged to come out and listen to issues at a hui. The reason being

that those people, *'ultimately they don't just look after the kitchen they usually are the ones that look after the whole marae'*, including looking after the people as well.

2.3.5 Prescribed Health Promotion Verses Needs Approach

Another issue that arose in the research conversations was concerned with the contradictory prescribed approach adopted in the delivery of health promotion services. To one of the kaikorero, it was felt that an emphasis should be placed on designing health services based on community needs, as opposed to government strategising alone. For instance, *'sometimes we are given a direction so some of our workers directive is quite descriptive and for me on the ground sometimes I think it should come from the need identified within the community and this should be able to influence what they end up purchasing. I suppose it's a two-way thing but I think who better to know what the communities needs then those who are working in amongst our people. It's about what takes priority the needs of our people or the needs of the Government'.*

Equally important, was the way in which health promotion was contextualised as a political issue. The excerpt provides an insight, *'..to me its simple, to me politics is too gray, its gray all the way and it causes a lot of confusion. It's ambiguous; it's all these sorts of thing. Where as from the ground up they are saying, 'hey, look all our kuias are dying', [so the goals should be] clear'.* Once again, the importance placed upon designing health promotion programmes based on community input, and community needs was viewed as essential.

2.3.6 Maori Health Promotion

The opportunity to explore concepts contributing to Maori health promotion as opposed to health promotion for Maori was provided during the workshop. Participants in the workshop were involved in an interactive session to develop concepts they viewed as contributing to Maori health promotion. Those concepts were then contrasted with Mason Durie's Maori health promotion called *Te Pae Mahutonga*. The kaikorero presented the following comments. Firstly, the session was viewed as quite revealing, *'I think everyone in that room would have agreed with that if we could have all sat back and looked at it again and thought true, everything*

belonged in everything. And that's a common ground for all of us, it displays the general part of us as Maori.' There were two key observations that can be made in terms of this excerpt. The first is that there was a degree of consensus with the concepts that were derived from the workshop, which was an important outcome. Secondly, the fact that those same concepts were consistent with the Te Pae Mahutonga model, despite the participants not being exposed to that model prior to the workshop was also important.

It was also reiterated that *'the workshop was good for us as it supported a lot of our natural practices but it was also a bit difficult. You know like Pakeha who don't understand wairua they just deal with health, because they still view a lot of public health not of the broader concepts of what we are in. For example, what does the water level in the river mean to health? How can that make you unhealthy?* This excerpt outlays another way of looking at health and well-being, which reinforces a broader environmental view. For instance, the well-being of Maori did not only relate to the quality of the water in a river, but also the total appearance of the river as well. Another kaikorero felt that although Mason Durie put the model together, the ideas belonged to everyone and already existed.

An issue that emerged during the discussions about Maori health promotion was the extent to which prior models have over-emphasised the importance of overseas models being utilised in New Zealand. For instance, *'we went through how it is more important for this country to adopt overseas models [such as the Ottawa Charter] than it is for them to acknowledge, recognise and support those models that have been developed locally or within this country, particularly if those models have been developed by Maori then they really are not interested in them...'* In the kaikorero's view, it exposed health as a contradiction. Secondly, the issue of holism was raised in the context of health promotion modelling. The kaikorero highlighted that, *'the naturopaths [were not too] different than our kuia's who used to prepare leaves to get rid of our boils that was all seen as heebeegeebee'.* The contradiction exposed here is that Maori already practice holistic approaches to health. As well, the recognition of foreign experts over and above existing Maori practices appeared to be a common practice that diminished the value of Maori knowledge systems. The

development of and use of a Maori health promotion model goes some way to alleviating those concerns by validating the use of Maori health models. The kaikorero also highlighted the differences associated with Maori health promotion and health promotion for Maori in that the two phrases are different.

2.3.7 Health Promotion Practices

A further set of questions focused upon the extent to which concepts or kaupapa influenced the actual practice of health promotion. A number of issues were highlighted in the excerpts. Firstly, the actual provision of health programmes on a day to day basis can interfere with the emphasis placed upon kaupapa based health promotion. For instance one of the kaikorero said, *'I am more inclined to think that the day to day programmes try to interfere unless you are confident in Maori and how these two interpret what is defined as a programme and undertake the practice with your people'.* This excerpt suggests that acting Maori is first based on ones ability to be a confident Maori. Secondly, there is a contradiction between what communities need in terms of health services and what the Ministry of Health prioritises, as health needs. Thirdly, many of the health promoters *do health promotion*; they are not obliged to *think health promotion.* As a result, there appears to be an inconsistency between the concept of health promotion and the practice of health promotion.

The following excerpt identifies one key issue related to the difficulty associated with implementing approaches to health promotion that are kaupapa based. It was believed that, *'...there is a huge significant shift from where we used to practice in Toi te Ora. When Mana Manaaki were full on and moved away from Western Bay and came into Toi te Ora even in the initial stages. Toi te Ora was a lot more flexible and cooperative in enabling the Maori work force to effectively deliver to our people, now it has totally changed there are no resources to actually meet that need. There is an acknowledgement of it but there is no flexibility in ensuring that those needs are met. For those people that were out there before in the past are no longer getting out there like they used to, to talk with the communities to do the mobilisation. Now it is totally different and we are not even just talking about ourselves, the whole of our workforce.'* The kaikorero has identified a significant shift in the culture of the organisation away from providing resources on a flexible basis to other health providers. What is also not apparent in the excerpt is to what extent that shift has

occurred as a result of external factors, such as changes in health reforms and constant restructuring.

2.3.8 Social Marketing

The assessment of social marketing as a potential tool for Maori health promotion was tabled as an issue in this research. An important part of the workshop and also the post-workshop conversations was the active critical exploration of the model by participants. One kaikorero said, *'I think it is a lot more of an honest approach, when people say I got the latest profit out of this and I can accept that. I find it very difficult for people to say things like the alternative 'this is going to help our people, we are going to improve'.* Secondly, it was viewed as another tool of many that are currently available; *'I see it as being a useful tool'.* And last, the concern about profit was alleviated, *'the notion that profit is about money or a substitute for money or some other value then yeah.... I mean you could change profit to social profit'.* The excerpts above suggest that the social marketing model was more honest about its expectations. Profit could be changed to social profit and on the whole it was one of many tools that health promoters could use.

2.3.9 Potential Appeal of Social Marketing

The conversations about social marketing and its possible benefits were tempered by influences of the external environment, which made it difficult to bring about significant social change. This excerpt demonstrates, *'I think its just me fighting against Pakeha, we're fighting against these marketing strategies, we are fighting against Tobacco companies and then Lion Red, so to me the only way to market it is to out market them... '* This excerpt highlights the difficult task health promoters are faced with in respect to the increasingly exploitative environment that permits the use of large-scale tobacco and alcohol marketing campaigns. A suggested response by kaikorero was to become more familiar with marketing tools and to use them as a combative approach in the arena of health promotion.

2.3.10 Social Marketing Concepts - Markets and Marketing

The social marketing model is founded upon a set of assumptions and concepts that construct health differently to other approaches. To illustrate, health is viewed as a set of behaviours and even a commodity. The question posed in this section was

concerned with clarifying terminologies used in marketing and whether those terms could be applied to Maori health promotion. In the first excerpt, it is perceived that Hapu can be seen as a market despite kaikorero being uncomfortable with the use of the term. For instance, *'I agree that [Hapu can be seen as a market] but I don't know whether I would use it'*. It was further elaborated that those types of terms already exist within their contracts, '*They are certainly in the contracts, you have got targets, they don't use that word officially, but they say that's your market. But they haven't broken it down to that target group'*.

Whilst social marketing terms were being used, it was also clear by the following excerpt that there were several implications associated with its use. For example, '*what* happens *is that in breaking it down that way and servicing it that way, it further disempowers or disables our opportunities as Maori workers to work with the people at the kainga so you know when we in the past have been able to work with a lot more flexibility, that whole target group is Maori and we would only take delivery of our programmes to Maori, not just to the tamariki and not just the rangatahi and all that. The whole motivation is quite deliberately identified as targets that clearly we need to market.'* As the comment suggests, the ability of Maori health workers to work with people through the vehicle of Whanau and Hapu is severely compromised. The consequence being, that the existing Maori approaches to enhancing Maori health promotion are undermined. This set of responses is concerning, as on the one hand, the kaikorero are receptive to the idea of exploring the use of social marketing, although they are also aware of the implications associated with its use. This particular excerpt expands upon the discussion above. For instance, the question raised in this section referred to the likelihood of creating segments within markets and then prioritising the segments based on the notion of who are *most at risk*. The logic applied to this query was founded on the proposition that Maori are the most health deprived and on that basis they should receive more resources to combat ailments. For example; *'You know that your argument in this organisation is to capture that market, otherwise why haven't they given in to the demands if Maori had said deliver the services to the people, why haven't they given that money back?'* The reality as highlighted in these questions is quite the opposite. There appears to be an inherent contradiction with the semi-receptiveness to marketing, but only to a certain

extent. For instance, Maori should be receiving more resources to focus upon Maori health needs on the basis that Maori possess the most detrimental health statistics.

2.3.11 The Marketing Mix

The marketing mix is another social marketing concept. A question posed here related to the possibility of using the concept or modifying it instead. The outcome from this approach suggested that there were no expectations in terms of the models adopted by the funding agencies, *'there is no big expectation that we would outline the type of approach we would adopt in terms of practices or that we actually align with communities'*. Once again, whilst there is receptiveness towards the use of the model, it appeared unlikely that it would occupy any significant position with the organisation unless it was based on a convincing argument. For instance, *'I think it is another extra tool to come on board, I would be quite happy to undertake the whole exercise. In terms of developing the social marketing approach further and applying it, to see how it would go. Whether we could actually implement it internally? I can't guarantee... [that we would].'*

2.3.12 Organisational Receptiveness

Toi te Ora was a much bigger organisation then the other case groups involved in this study. As a result, the likelihood of gaining approval to explore, design and implement alternative models of practice were dependent on seeking approval from Management. The excerpt below provides an insight into that particular discussion. Firstly, there was an amount of investment time required to convince Management that the model was useful, *'I think you would have to spend a lot of time convincing them to believe it'*. Secondly, there are other issues that would impact upon its receptiveness by Management, the following comment explains, *'If the marketing approach is going to be useful to take to the PHO and say look, this is an approach that would really suit you and the things you have got. I am not saying this is where our work will go, I am saying that is an approach that PHO will be able to look at and they understand what our business is. It is another mechanism in the game for an organisation like this to fully appreciate and understand the dynamics of the environment....'*. And thirdly, despite those reservations the kaikorero still believed that, *'the environment is conducive to looking for that sort of thing.'* As a result

despite the need to negotiate the models use with senior management, their enthusiasm to explore the use of social marketing within the organisation was also influenced by events taking place within the health environment.

2.3.13 Kaupapa Approach Revisited

As a result of the in-depth discussions above, further clarification was sought at the end of the korero about the importance of kaupapa as a guiding principle in Maori health promotion. The excerpt below suggests that there are organisational dynamics that impact upon kaupapa in terms of its conceptual transition into practice. As highlighted, *'More often than not, I find that with tauiwi, the whole thing has been taken out of context with kaupapa such as Mana Manaaki. I find that tauiwi are quite ignorant or arrogant and start trying to mould and shift and create something that they can accept rather than have or interpret that which social marketing is about per se, it can become a detrimental tool as a result'.* Despite the existence of foundational concepts guiding a tool such as Maori health promotion or social marketing, at the end of the day there is a degree of modification that takes place within the organisation that transforms its meaning, suggesting that a tool (irrespective of which one) can manifest into something that it is not as a result.

2.4 Other Kaitautoko Responses

This section explores a number of issues raised in conversations with kaitautoko that did not emerge during the post-workshop interviews. They relate primarily to two core issues about health services in general, and then about the wider context of Whanau, Hapu and Iwi development.

2.4.1 Manaakitanga – Concept of Health

The concept of Mana Manaaki and manaakitanga was brought up constantly throughout the discussions. In the earlier interviews, the concept of Mana Manaaki was associated with alcohol related problems as highlighted. However Mana Manaaki meant much more and it changed to represent a philosophy of practice for Maori health promotion. The following comments provide an insight, *'...concepts*

like manaaki and awhina. I guess the whanaungatanga you know and just the knowledge of who we are. Yeah, so I suppose I promote ideas, which seem to have kept us, well before. When we talk about – where a programme has got sun smart in there.' Another comment focused on care, *'...it was about how we look after each other, how we take care of each other – sure they were really needed to do that mostly because of the stats around – alcohol – that was then, but that's actually real kaupapa.'* And lastly, *'...see, one of the things we are looking at now is trying to promote smokefree marae and to me the way to promote it is not to promote smoke free marae, but by promoting manaaki for your manuhiri at your marae.'*

The quote below highlights suggestions that the concept could have expanded into other areas with the use of different Maori forums such as waka ama. For instance, *'...Mana Manaaki should have continued to develop some other type of relationship with [whoever] was involved with waka ama, to support waka ama activities.'* However, with the explosion of Maori health providers throughout the district, the collaborative fashion in which people worked together steadily demised whilst Hapu and Marae established their various health activities. Mana Manaaki as a concept also influenced the way in which groups interrelated with each other. Events such as the Mataatua Kapa Haka competitions were seen as essential whakawhanaungatanga hui. For example, *'...well what are we getting for our money. We are getting the opportunity to stand by Mataatua in rejoicing who they are, what they are - what makes them well. So we are supporting them to promote their wellness in their Hapu, that's right we are health promoters – not ill health promoters.'*

Over the last five years, there has been a growing interest in recapturing the essence of Mana Manaaki and moves to re-launch the programme have been canvassed. However, what has emerged during those discussions is the realisation that Mana Manaaki no longer exists as it was. It is now a constant kaupapa about the way that health promotion services should be delivered. It also encapsulated the way in which Maori staff within Toi Te Ora may choose to treat themselves and each other. One idea was to share the concept of Mana Manaaki in a number of other health areas. For example, *'...I want it to be an integral part of the way that we practice, the work that we do and I want it to be seen, rather than just a concept. I think that Mana*

Manaaki is part and parcel of who we are as Maori and it is how we take care of our own well-being, we are now wanting to push it more towards the practical stuff, by using it as a philosophy.' And also, *'...certainly there is a good opportunity now to develop practical ways, so that it is something that is in the past, but that is something that governs the whole range of Maori providers and now take that and expand it into something. It is more about Mana Manaaki being the direction ahead on behalf of the collective.'* And lastly, *'...all our work is about Mana Manaaki, you know it is about us getting together, as well as us providers to see how we can support and help each other. Maybe that is really the concept, but we need to broaden the way that we practice that concept and recognise that, that is what they are all doing. It is all about caring for each other.'* These responses suggest that Mana Manaaki is a concept that has re-emerged as an appropriate foundation for all health promotional work being performed by some of its Maori staff members at Toi te Ora in Tauranga Moana.

2.4.2 Compartmentalisation of Health

A concern raised by one of the kaitautoko was the *taken for granted* way in which the terms Hapu and Iwi were used today. In her view, those terms were not only new, but they were not readily used when she was first involved in the provision of health promotion. Her comments clearly highlight the importance of not taking terms and their meanings for granted. For instance, *'You can't compartmentalise it like that. If you are strong with inter-marae sports and inter-marae sports people were very much marae-based people, so it goes without saying that it would therefore had been strong....'* Another comment suggested the use of terms such as Hapu and Iwi were politically motivated, for instance, *'I would be very careful about that type of marketing because everything comes in like what is vogue and when I first became involved in health, marae were not even being used that much and we say that in our stuff at Whaioranga, but there was a resurgence in the 80's, so then you could say, that you could work with marae, and then the politics changed. While we were an Iwi, Iwi are not being recognised by the Government, so suddenly you have this resurgence of Iwi and people saying, we're actually Ngati Pukenga and we're actually Ngaiterangi. So then you have to kind of go with that and then it was 'but we're not Ngaiterangi, we are getting left out, so we operate from the Hapu base'.*

2.4.3 People as Champions of Health

The involvement of people who championed the cause of Maori health was a pre-requisite to achieving Maori health gains. The excerpt below highlights that those types of people are not as readily available in the area of Maori health promotion. For example, *'...the people who could take on that responsibility for drink driving aren't the same. They don't have the same sort of thinking behind it – those philosophies. With Mana Manaaki initially, the intent with Orewa and them was around the drink driving and the host responsibility. People like Ani and Lorraine they added in the other factors, the Manaaki factors that weren't written down as part of contracts, it was just an understanding that this is what we actually needed to happen.'*

Also highlighted was the extent to which Toi te Ora staff members rely upon the Maori staff to assist with the development and delivery of health promotion programmes to Maori, *'Consciously or unconsciously, they really rely on Maori staff to take things out to those tribes in their programme work but in a way that's going to fit with Maori and without actually offering extra.'*

2.4.4 Contracting Nature of Hauora

An issue that arose was the way in which health services are contracted and also the impact that contracting has upon the delivery of those services. The excerpt below highlights that it was a normal expectation for Maori staff members in particular to go beyond their contracted obligations. For example, *'...it has to be with the commitment to Maori health. I guess there are some areas where you have a job description that says we do this, this and this, when in actual fact you do all of it, but as well as that – you know it doesn't stop. And there are certain areas that we make it our business to be our business.'*

2.4.5 Community – Hard to Reach Community

One kaitautoko said it was essential to provide people with a choice to decide whether to utilise a health service or a health promotional activity or not. The excerpt

explains, *'...I don't believe in taking away peoples choices, so as a promoter I would hope they do provide choices. But if they don't I don't care and I don't go backwards, because my job to you as a promoter is to promote all the options within that thing but then it's up to people to choose and hopefully I can see it well enough to motivate a change of thinking, but the realities are that some people just don't want to change.'*

2.4.6 Concerns about Hapu and Iwi

Two further issues were raised about Hapu and Iwi. The first excerpt highlighted the benefits associated with working in a mainstream health promotion unit as opposed to a Hapu or Iwi organisation, *'...I think one of the benefits of working inside a mainstream organisation dedicated towards Maori health is that you don't get stuck within the Tauranga politics.'*

However, that same person saw the importance of linking health goals, directly to a sense of Hapu status of health, *'Probably the picture that I strive towards is like - what makes Tukairangi good at being Tukairangi, it's important what it is. Because if Tukairangi is going ok, then everyone is happy and they are essentially capable of practicing being Tukairangi then that's the picture of health for them. What more could they want? And so, I mean, it's about looking at what those Hapu are striving for and the freedom to express and be who they are.'*

2.4.7 Outputs Based Health Promotion

One respondent was concerned with the emphasis placed on outputs based health promotion. The kaitautoko said that *'we don't throw health at people'*. Although that comment reflected the person's sentiments, the following discussions tell a contrasting story, *'...that's alarming too because some of our own people at the marae, they want to [impose policies] and actually approve that – that's scary because that immediately starts shifting our people out of the marae.'* But outputs based health promotion is becoming the norm as the following excerpt suggests, *'... Its bloody hard because if I was asked, how the work you are doing now is improving*

Maori health gains, what would you say? I would say its not and they would say well what are we paying you for then if the work you are doing isn't achieving the Maori health gains? One of the things for me is because everything I do I could never be that presumptuous or arrogant to say 'I am improving Maori health by this much,' but I have been advertising how this can show where the gains are. I think you can do that. In our custom we deal with alcohol, tobacco, drugs, sex and teenage pregnancy and other things like that. Everything I see comes from either more problems with alcohol or teenage pregnancy and more of our young people are taking up cigarettes and how can I say that I am improving health gains?'

2.4.8 Marae Hui as Research

Another comment highlighted the importance of Marae in terms of research. She noted that Marae provide a forum for information collection and dissemination. For example, *'We have to find ways that are easier for our research to be put together, so I am a fan of marae, because this other stuff takes too long and sometimes we need to just get out there and too bad if it is not the greatest bit of interviewing etc, and just keep a few [records] and korero about it.'*

2.4.9 Te Whakaoho Mauri – Embrace Manaakitanga

Despite the challenges posed for maintaining a platform for Maori health within a mainstream organisation, there were two key areas that could be explored to enhance change and development. The first issue sought to rebuild the concept of Mana Manaaki so it became a driving philosophy for Maori health within Toi te Ora, at least in the Western Bay of Plenty region, *'... it needs to be rebuilt Mana Manaaki – I have just made it my job to do all my work under that banner and that's the philosophy for everything I do. It's not smokefree, not sun smart, not anything – it's about manaaki and how we in my community support each other. It's all about families and how we build each other up and how we strengthen each other. It's all about motivation for the work that I do.'*

The second issue that provided respondents with much hope in the future concerned a suggestion to develop a Maori public health unit. The following comment provides

an overview, '*...A Maori Public Health Unit that is supported by the Maori Public Health Advisory Team. That would be great. That would be a think tank unit as well. The Maori focus would come out from there too. They would do research for improving health and so forth. In that way, some staff would not have to go out on a limb, because it would be the responsibility of this unit to make a difference.*'

2.5 Conclusion

Mana Manaaki was originally formed as a response to the negative alcohol and drink driving related health statistics prevalent in the Western Bay of Plenty region. In its original formation, it utilised Marae sports clubs as a vehicle to promote the message and philosophy of *manaakitanga*. At that time, there were a limited number of Maori health providers in the field and the relationships formed by Toi te Ora kaimahi with others was constantly reinforced through activities such as the Inter-Marae sports. However, as more Maori health providers emerged in the district, the collaborative nature of health provision momentarily diminished as the wider Bay of Plenty region was divided into smaller hauora specific regions. At the same time however, some of the health promoters involved with Mana Manaaki resigned, leaving a temporary vacuum in skills, programme knowledge, networks, collaborative spirit and people energy. More significant however was the impact that the national ALAC Manaaki Tangata programme had upon Mana Manaaki. This case narrative has sought to outline the history of Mana Manaaki by identifying the concerns related to instilling a philosophy for Maori health promotion practice within a mainstream community health organisation. As a result, some of the organisational issues that Toi te Ora kaimahi deal with, are different to the other case groups which participated in this research project. The conclusions drawn from the research undertaken in this case narrative are highlighted below.

Mana Manaaki is no longer operating as a health promotion programme focused upon alcohol drugs and drink driving. The Mana Manaaki that is being spoken about today is a conceptual framework or kaupapa base from which to forge Maori health promotion activities across the board within Toi te Ora at Tauranga. The new goal for Mana Manaaki *'is then to build on positive cultural concepts such as*

manaakitanga, kotahitanga and partnerships as a constant set of guiding principles for Maori health promotion'. The emphasis for this case narrative has been to review the historical information and context of Mana Manaaki, and then query social marketing in light of the information that has emerged throughout the case narrative.

This case narrative indicated that Toi te Ora has an established long term position in the provision of health promotion and health protection services within Tauranga. That position has been maintained through the long-term provision of government funded health promotion and community health services. That traditional foundation has ensured that Toi Te Ora is in an established position compared to emerging Maori Hauora with regards to accessing health resources. As a result, issues that face Maori Hauora are not as prevalent within Toi te Ora.

Toi te Ora kaimahi have also been exposed to a small number of emerging trends within the health services environment. One of those trends relates to the nature of health service contracting. Within the increasingly business oriented environment, relationships with other hauora are established through sub-contracting. This relationship foundation is not always conducive to forming or maintaining alliances for the provision of Maori health development on the whole and the actual delivery of health promotion services and activities can be diminished. Health promotion within this context can be perceived as a series of conversations, dialogues and negotiations between Toi te Ora and other hauora kaimahi. The role that health promoters have with people is less obvious, which may draw some criticism in regards to the lack of transparency for development and change with the people in the community.

The health environment is also becoming very competitive. As a result, Hauora territories have been established to correspond with different Iwi and Hapu regions. These zoning practices are contributing to the increasingly competitive way in which Hauora are being required to operate. That is seen as a contradiction to the Maori health strategic goals espoused in Government policy documents related to Maori health development. There is also a concern with the emphasis placed upon health promoters to achieve measurable gains in Maori health development. The obsession

with achieving health gains, within a system that does not deal directly with the structural issues impacting upon health such as education, crime, violence and even environmental concerns is alarming. As such, it is difficult to expect long-term sustainable behaviour change when the health services contract requests a different set of health outputs. Health outputs are sometimes seen as the distribution of pamphlets and posters and the number of hui held which is contrary to the aspirations for a model of health based on well-being. This is a serious concern as it erodes the ability of Maori health promoters to bring about change under the banner of 'kauapa led health promotion'. For instance, *'....they constantly look at illness and Maori are under attack all of the time. Yes they are unwell and there are alcoholics and smokers. I want a big mind shift to wellness, which is what I think, is important. And contracts in public health emphasise illness.'*

Another concern relates to the way that communities were not provided with opportunities to highlight the health needs in their regions by being able to influence the types of health promotion programmes developed to meet those needs. National health strategies are influencing the types of health promotion programmes implemented within communities instead of the communities developing their own sets of health needs. For instance, *'...sometimes we are given a direction so some of our workers directive is quite descriptive and for me on the ground sometimes I think it should come from the need identified within the community and this should be able to influence what they end up purchasing...'*. Health is therefore reconfigured as a prescribed set of tasks and activities that form part of the checklist for improved health gains.

The ongoing subjugation of Maori health within a business framework compromises the ability of Maori health promoters to achieve aspirations for Maori within a framework that is consistent with Mana Manaaki. For instance, the ability of Maori health promoters to utilise Hapu and Iwi systems instead of markets and target groups is diminished. As well, business approaches to health do not support culturally derived approaches to health. The possible outcome from such a scenario is the

subtle form of neo-colonialism, which slowly over time erodes and compromises the very pillars of existence upon which Maori people are based.

The research findings indicate that Toi te Ora has maintained a consistently high ratio of Maori staff within its ranks throughout the three regions. This has contributed to the ability of Maori to initiate new approaches at the grassroots level. In saying that, Toi te Ora is subjugated by hierarchical layers of control that exist within any medium sized organisation and creative ideas for health promotion can be stifled at those higher levels. Within the organisation itself, there were also concerns about the retention of Maori health promoters within Toi te Ora despite having a higher ratio of Maori staff per total staff than any other public health unit in the country. This is something that the Management should consider looking into in further detail. It was not something that was looked into in much depth within this case narrative.

The initial purpose of this study was to inquire into the extent to which social marketing might be usefully applied as a model for the attainment of Maori health development. The responses provided by kaikorero in this research project confirmed three points. Firstly, kaimahi were aware of the conceptual implications of adopting social marketing and they were able to articulate those concerns within the research. The kaikorero were already utilising some ideas they saw as social marketing related and it was their view that the implementation of social marketing would be consistent with the current trends of development for Toi te Ora. Secondly, Toi te Ora kaimahi were prone to accept the social marketing model as it was viewed as a *more honest* approach to health promotion in light of the competitive health environment that currently influenced their approaches to practice. The kaikorero believed that it was more appropriate to be direct with the approaches they adopted, instead of suggesting that their organisation operated holistically, when sometimes it did not. The kaikorero saw the issue of making promises that could not be delivered as a contradiction that currently existed within the health sector at this time. Kaikorero were also willing to take social marketing to the implementation stage, in order to gauge whether direct benefits could be derived as a result. However, it was mentioned that the approval of Management would be required for that to occur.

There were four aspirations articulated within this case narrative. In terms of health promotion activities, there was an emphasis placed upon encouraging the adoption of Mana Manaaki as a philosophy of practice for all Maori kaimahi first, and then all kaimahi within Toi te Ora second. As such, kaupapa led health promotion were seen as important and valued. Secondly, the kaikorero suggested that the establishment of a Maori health unit or an advisory group within Toi te Ora could address the concerns raised in the case narrative. The unit might be responsible for ensuring that Maori methodologies and models of practice were consistently utilised across the various forms of activities and services provided by Toi te Ora. Thirdly, the kaikorero emphasised the importance of providing opportunities for people to reclaim their cultural identity as part and parcel of the responsibilities of Maori health promoters. The last aspiration was that people from other Maori health organisations work more closely together and that Mana Manaaki form the foundation upon which the Hauora build and maintain working relationships.

To conclude, the case narrative sought to critically explore whether social marketing would be beneficial for the enhancement of Maori health. As an isolated research inquiry, it would be possible to conclude from the responses that social marketing would provide the kaimahi with a set of tools to advance their current work related performance. In the view of one of the kaikorero, social marketing offered them the ability to be *more honest.* However, part of the research involved the exploration of wider issues concerning Maori health promotion and Maori health development. When the scope of the research included those issues, it was no longer possible to validate the use of social marketing without highlighting some critical observations. One such criticism is that social marketing is a different conceptual tool that threatens or diminishes any kaupapa led health promotion model that may be adopted. For instance, the recognition of Maori health founded on principles of manaakitanga is not the way that health is articulated within the social marketing model. Within a social marketing model, health is reconfigured as a commodity.

Secondly, the research identified the importance placed upon Hapu or culturally derived notions of well-being and that current models do not emphasise a role for identity building with Maori people. One respondent said that a pathway forward for

Maori health development involved the reclamation of things Maori drawn from a foundation of Te Ao Maori. Whilst there were aspirations to achieve those ends, work is required to be done within Toi te Ora to ensure that the organisation is able to accommodate and facilitate those aspirations. One of the kaikorero said that there is a genuine willingness by Toi te Ora to address those concerns.

2.6 Recommendations

There are six recommendations that have been identified as part of this case narrative. They are provided for the benefit of Toi te Ora particularly the Maori health promotion staff members within the Tauranga office referred to below as Toi te Ora kaimahi. The recommendations are also directed towards Toi te Ora Management, in the hope that serious critical thought is made to look further into some of the issues that are being raised.

That Toi te Ora allow Maori staff members in Tauranga to develop a process where Mana Manaaki is the foundation for providing health related services, activities, messages and ideas by Maori staff members and that health promotion practices are established on the basis of that recommended process. From that foundation, a core network of Maori health promoters should be re-established as a broader support system for Maori health promoters out in the field. An approach to Maori health promotion founded on Mana Manaaki provides a dual emphasis for caring for people which also allows kaimahi to work within the boundaries of the Maori health development model.

That Toi te Ora allow Maori staff members of Tauranga to develop a regional strategy for Maori health with the intention of determining whether some of the suggestions highlighted in this report are feasible. Some of the suggestions include the development of a Maori advisory team and the development of a Maori public health unit, which might be responsible for developing Maori health strategies and policies that support Maori methodologies of Maori health promotion.

That Toi te Ora kaimahi emphasise the importance of identity reclamation in their Maori health related activities and that strategies are implemented to reflect a commitment to Hapu and Iwi development in the Tauranga region.

That Toi te Ora kaimahi work in collaboration with its funders to re-examine the way in which contracts are prepared. The goal would be to ensure that an emphasis is placed on developing kaupapa led health promotional activities such as Mana Manaaki and that the terminologies in the health services contract are consistent with those goals. Toi te Ora Management should also be mindful of the concerns related to sub-contracting kaupapa led health promotional activities out to other groups, such as Maori health organisations.

That Toi te Ora kaimahi work in collaboration with Iwi and Hapu to continually re-examine Toi te Ora strategies to ensure that goals and strategies put in place to enhance Maori health development are being achieved and that those goals are consistent with the health needs of Iwi and Hapu.

That Toi te Ora kaimahi create, assert and comply with accountability measures that meet their service requirements whilst acknowledging that Toi te Ora Management needs assurance that the resources provided as part of the contract are used and managed appropriately. It is also important that the contract reflects the values based approach to health promotion that is founded upon Te Ao Maori and that that type of approach to Maori health promotion is valued within the organisation.

Case Narrative Three: Pirirakau Hauora – Tu Pou Tahi

3.1 Introduction

The aim of this research project is to critically examine the extent to which social marketing is able to contribute to Maori health advancement. The aim of this case narrative is to explore the implications of adopting social marketing within Pirirakau Hauora. Pirirakau Hauora is one of the four case groups involved in this research report. This case narrative however focuses mainly upon the health promotional activities of one of its health programmes called Tu Pou Tahi. Tu Pou Tahi was originally one of two national pilot programmes focusing upon the health concerns for rangatahi. The original programme was referred to as Rangatahi Health and Well-being Suicide Prevention and Rangatahi Sexual Health. This case narrative is presented in six sections. Section 3.1 is the introduction and Section 3.2 provides an historical overview of Pirirakau Hauora and Tu Pou Tahi. Section 3.3 provides an overview of the post-workshop conversations with kaikorero and Section 3.4 provides an overview of discussions with kaitautoko. Section 3.5 and 3.6 present the conclusions and recommendations.

3.2 Historical Overview

The initial driving energy to establish Pirirakau Hauora was instigated by a small group of kohanga reo mothers. In 1994 under the umbrella of Pirirakau Incorporated Society, the Hauora was contracted through the Midland Health Funding Authority (Midland Health) to provide a range of health services. Those services were consolidated and expanded in 1995 to include mirimiri and home based support services. In 1996, Midland Health granted capital venture funding to Pirirakau Hauora to construct a new building on previously Church owned land[36]. The new

[36] Members of the health committee looked for land to establish the health centre. The Catholic Church owned one area of land that was not being used. Church administrators agreed to give back a portion of the land that was not being used as a site for the health clinic. The Trust established to administer those land interests is called the Te Huhunu Trust, named after the puna waiora that is located near the Hauora.

facility was officially opened on 27 February 1997. The Hauora is currently part of a complex that includes a kohanga reo, kaumatua and kuia flats, Hapu administration and an environmental centre. Since those earlier days, the Hauora has extended its health services to provide extended general practitioner services during the week and more health promotion activities. The range of health services provided by Pirirakau Hauora include; general practitioner services, tamariki ora services, rangatahi health and well-being services (now called Tu Pou Tahi), mirimiri, home based care services and a number of health education and screening services such as diabetes checks.

There were other factors that contributed to the development of Pirirakau Hauora. The Te Huhunu stream for instance is said to represent a tradition related to health and well-being that influenced the proposed location of the facility, *'...there is a tradition here that deals with health and well-being, it is an ideal location'* and *'...they say that there were some minerals in that water that used to have healing properties, so they called [the administrative entity] the Te Huhunu Trust after that stream. When the Hauora was brought here they decided to name the building after that stream as well, so that's why that says the healing waters of Te Huhunu.'* The stream is a communal resource from which all Whanau of Pirirakau draw inspiration (Pirirakau Hauora, 2002).

The Hauora has become a focal centre for many Hapu matters. For instance, *'this hauora and the land on which it sits has become a focal point for the Hapu for many things, not just health. Even for our old people, we get our old people coming here and just having a cup of tea with us, and that is all to do with their health and well-being'*. The long-term commitment and dedication of health committee members has formed the foundational support for the Hauora, which in turn has contributed to supporting the Hapu.

3.2.1 Pirirakau Hauora Kaupapa

The kaupapa of the Hauora is *'to enhance the health and well-being of the Pirirakau Community by providing a range of health care and other services that are founded on the four cornerstones of Maori health; taha wairua, taha hinengaro, taha whanau*

and taha tinana' . One of the respondents explains, *'I suppose what we strive for is improvement in the health status of our people, making sure that people are well, hoping that we can ensure that people do have good health and that their well-being is catered for. That all their needs are met because health is not just about being sick or well you know, health is holistic. I believe that Pirirakau Hauora doesn't want to be the ambulance at the bottom of the hill'.* Another kaitautoko said, *'you know the focus here is Hapu. That's not to ignore the whole Iwi but it's about the well-being of the Hapu first and by association with Iwi and the Moana, that is the focus for everything, it is really Hapu driven'.*

Although the vision and mission of the Hauora are interconnected to the kaupapa highlighted above, there are other objectives that impact upon that vision. For instance, one respondent commented that, *'One of the dreams of the trustees is [for] this to become a full time service, that we have five day doctors and we have a nurse all year and that it'll evolve in that capacity to a full time service'.* There are not only organisational service goals being sought after, but also specific cultural objectives that relate to the overall well-being of the Hapu. Pirirakau Hauora is regarded today as one of the better established Maori health providers operating within the wider Western Bay of Plenty region.

3.2.2 Services Region

The services region for Pirirakau Hauora covers the area from the Wairoa River to the Waipapa Stream and across to the Kaimai Ranges in *Figure 4.* However, Tu Pou Tahi services the wider Western Bay of Plenty region, which includes the Kaimai's, Omokoroa, Katikati, Waihi Beach, Tauranga, Mt Maunganui, Te Puke, Maketu, Paengaroa, Pukehina and Matakana Island as highlighted in *Figure 5.*

Pirirakau Hauora is situated within a rural community on the outskirts of Tauranga. Statistics from the 2001 Census and Populations and Dwelling provide an indication of the number of recorded Maori located in the Western Bay of Plenty region as

24333[37]. In *Table 3* the number of Maori located within the Te Puna region is 561. There are no statistics available for the Pirirakau Hapu, however the number of Ngati Ranginui Iwi to which Pirirakau primarily affiliates living within the Western Bay of Plenty region is 3009. The total recorded number of Ngati Ranginui nationally is 6120 (Statistics New Zealand, 2001). In *Table 4* the number of Maori rangatahi aged between fifteen and twenty-four living in the Western Bay of Plenty region in total is 3384.

Table 3: Maori in Te Puna and Western Bay Region

	All	Maori	Non-Maori	Other
Te Puna	2526	561	1719	246
WBOP	129129	24333	89286	15510

Source: NZ Statistics 2001

Table 4: Rangatahi 15-24 Years in Western Bay Region

	All	Maori	Non-Maori	% Maori Popn
Western Bay	3696	948	2748	17.5%
Tauranga	10401	2436	7965	16.1%
Total	14097	3384	10713	N/A

Source: Bay of Plenty District Health Board (2002)

[37] This figure indicates that the person has Maori ancestry, but they may not necessarily be included in the Maori ethnicity category. The actual figures for people who define their primary identity group as Maori was approximately 20,500.

Figure 5: Pirirakau Services Region

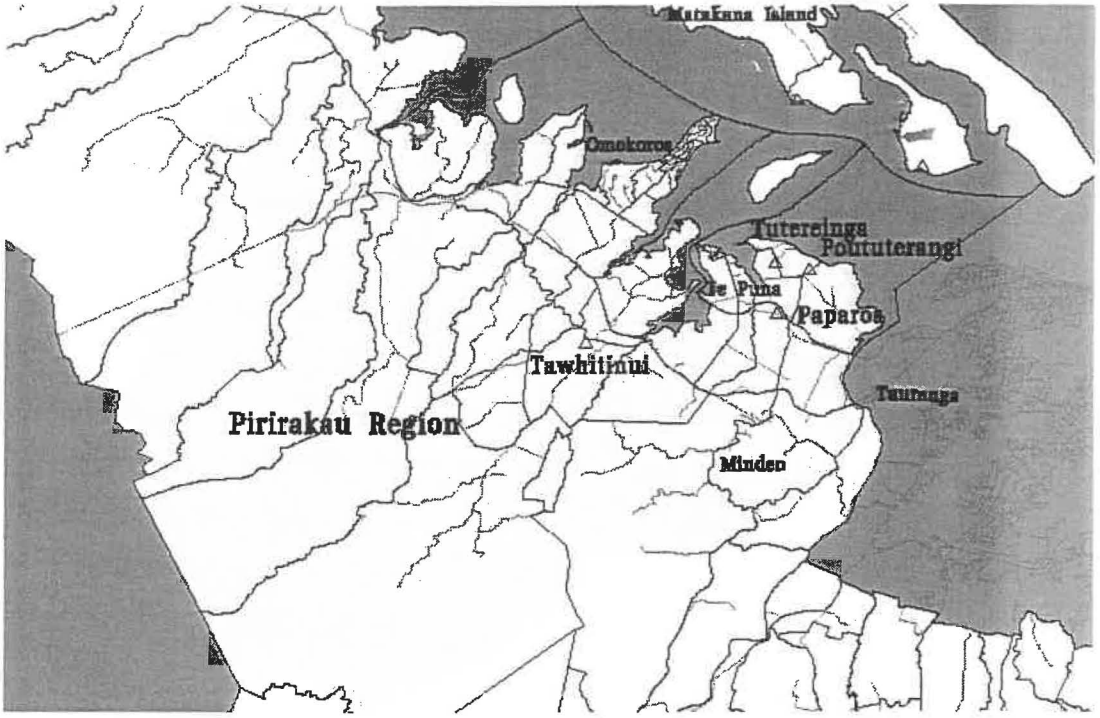
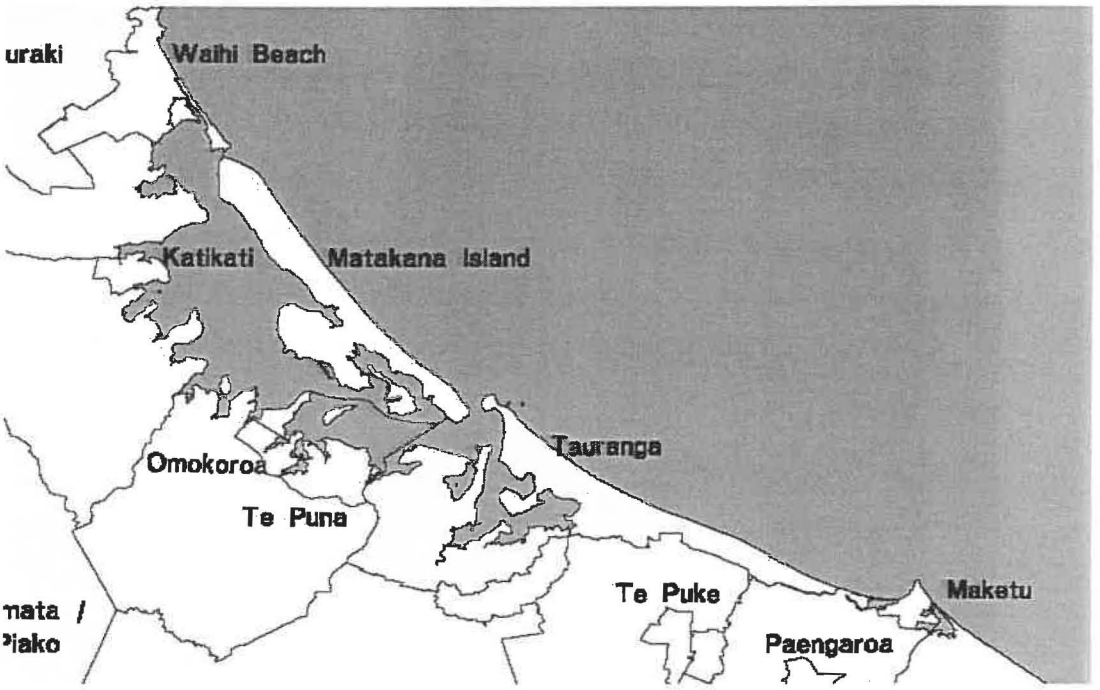


Figure 6: Western Bay of Plenty Region



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3.2.3 Tu Pou Tahi Programme

The case narrative focused upon the health promotional activities performed with Tu Pou Tahi. Tu Pou Tahi is a programme provided by Pirirakau Hauora and sub-contracted through Te Manu Toroa. Tu Pou Tahi represents an amalgamation of two separate service contracts that were grouped under the Rangatahi Health and Well-being Programme name. The Rangatahi Health and Well-being Programme name was changed to provide an identity for the programme. A logo competition organised by the Tu Pou Tahi team provided rangatahi with the opportunity to become part of the programme. One of the kaimahi said, *'first we needed the programme to have its own identity, it needed to tautoko its own kaupapa. The Health and Well-being programme wasn't a suitable [name] for us, and we asked some of the rangatahi and they didn't think it was too user friendly, it sounded like you were going in as a client and we didn't want that'*. Tu Pou Tahi literally means, *'stand together as one'* (Coupe, 2001).

The service specifications of Tu Pou Tahi combine two separate service contracts into one; rangatahi well-being and youth suicide prevention programme and also rangatahi sexual health programme. The primary service objectives of the rangatahi sexual health component are:

- to promote and enhance the need of safe sex to rangatahi through marae, schools, youth groups and other service providers (Western Iwi Health, 2000).
- To reduce rates of unintended pregnancy by improving access to contraceptive information.
- To design and run programmes that focus on sexual health and well-being for rangatahi.

The primary service objectives of the rangatahi well-being youth suicide prevention programme are:

- To promote and enhance the general well being of rangatahi through marae, schools and rangatahi groups.

- To maintain relationships with key stakeholders to plan and coordinate services to assist rangatahi.
- To coordinate activities and events to enhance the well-being and self-esteem of rangatahi (Te Manu Toroa, 2001).

One kaitautoko thought; *'the desired outcomes were basically to decrease suicide for young Maori, specifically in the Tauranga/Te Puke area and also to decrease statistics based around sexual and reproductive health'.* The development of a district wide strategic plan for rangatahi health and well-being was also an objective. The overall mission is part of a joint venture arrangement between Te Manu Toroa and Pirirakau Hauora was, *'to provide and develop a model of care to be an effective model for the rangatahi of Tauranga Moana and the Western Bay of Plenty'*(Western Iwi Health Board and Pirirakau Hauora, 2000). A number of strategies are included in the document. One of those strategies involves the establishment of an infrastructure of support groups for rangatahi health and well-being. One of the other strategies aims to directly impact upon the health of rangatahi themselves.

3.2.4 Tu Pou Tahi Past and Current Activities

The past and current activities undertaken by Tu Pou Tahi kaimahi involved a range of promotional and educational events and programmes, as well as one to one advice sessions. Some of the events were aimed at enhancing a number of rangatahi specific issues. For instance, the Rangatahi Culture Day aimed to, '*increase cultural awareness in rangatahi by facilitating a day of cultural learning and experiences'* (Western Iwi Health Board and Pirirakau Hauora, 2000). The Tu Pou Tahi team were also extensively involved in up to six region wide events during the year. Each event took between six weeks to three months to plan, organise and complete. The kaimahi were involved in developing strategic documents and policies, as well as being involved in the establishment of the Tauranga Youth Council. These activities were time intensive for the health promoters involved with the programme. The emphasis placed on working in partnership with other groups was an essential component of their support network. The following excerpt shows, *'...The formula itself was of course whether to go into areas and work with a team of people from that area and*

give assistance with their programmes. We didn't actually go in there and run the programmes, we would run it along side them. So there's a lot of empowerment that went on and with empowerment came a lot of trust but then it built up the workload quite immensely. Because once you've got a name and trust, then you're going to get a lot of work. And basically, we got a lot of work'.

The promotion of positive messages about sexual education and suicide prevention was a very difficult issue to communicate to rangatahi, as a result the Tu Pou Tahi team advanced rangatahi development with the use of Maori cultural concepts such as whanaungatanga, *'... We didn't like the programme to have an image of being just for at risk youth, because we had the whole vision of helping each other - whanaungatanga. If we're going to start labelling at risk, then we're going to start getting people that need to be on the programme going, nah, I'm not at risk, I don't need to be there or the healthy ones not wanting to be there because we needed everyone so we had to take that sort of element away'.* Kaimahi also emphasised that Tu Pou Tahi focused upon enhancing the identity of the rangatahi, *'...It was cultural awareness, cultural significance, individual identity and our own roles within our own Whanau, our Hapu and our Iwi. And also going into our communities and seeing what's available in those communities to help people, because even though we were based at Te Puna and I'm from Te Puna, the programme itself was for all people of Tauranga Moana – aged between 15 and 24'.*

The kaimahi were also aware that whilst their activities ensured that rangatahi health issues were being promoted and awareness throughout the community was increasing, it was difficult to determine whether the activities were having a direct impact upon sexual health and suicide related statistics. What made it even more challenging is that they were discouraged from promoting suicide prevention as their primary focus. Despite these challenges, representatives from the Health Funding Authority in 2000 remained anxious to see how the programme and the related activities panned out. For instance, *'activities only create awareness. And once the activity is over, people forget. A plan to bring about cohesiveness via collaboration with each other in that rohe, will surely ingrain that community in the knowledge that*

something must be done (Health Funding Authority, 2000)'. One comment emphasised that youth should be deciding what is best for themselves in terms of the programmes that are delivered, for instance, *'The main thing for me was that I was really trying to push health promotion in terms of special health, smoke free, drugs and alcohol and youth gambling, those were the main focus, they are hard work, it is becoming a real bad thing you know with experiences with my friends and my peers and all that, so the way I went about that was, I put up an expo, I had posters all over the hall wall and resources all over tables to actually push that kaupapa. I didn't want anybody to actually facilitate or present at that expo it was more about letting the youth make their own choice and actually go towards the information provided for them in their own way'.*

3.2.5 Evaluation of Services and Programmes

Tu Pou Tahi has a robust evaluation system in place. Besides the need for external evaluations as part of its service contract, kaimahi also undertake a series of internal evaluations as well. Some of those evaluations include; workshop questionnaires, reviews during post-event meetings, event surveys, personal communication with other health providers, focus groups and written reports.

Tu Pou Tahi kaimahi submit quarterly reports to both Te Manu Toroa and the Ministry of Health in order to demonstrate that performance outcomes as per the service contracts are being met. As well they are subject to on site evaluations by Ministry of Health representatives. Reflective practices through evaluations and surveys were common features of the way the Hauora obtained feedback from participants of its services and programmes in general. Kaimahi were asked about the way that evaluations were conducted during the interviews. Some of the responses include a discussion about the focus of the evaluation, *'I did hear a lot of rangatahi say, "you know G there's heaps of stuff about sex and relationships", so they checked it out and when they were filling out the evaluation, one of the questions was "what are we trying to promote?" Then I heard a lot of rangatahi say "sexual health and STD's" all those vital points that I was hoping would get across and actually might have touched a few people, so I thought yeah, even if they do touch a*

couple of young rangatahi that might be sexually active and don't know about these things'. The provision of evaluation forms and questionnaires appeared to be an established practice within the Hauora, *'we always have evaluation forms on all of those types of things, events and programmes. I suppose feedback was also done through our video footage and things like that, doing interviews, taking photos – asking a lot of people what they felt. But generally I just looked at the way their attitudes were on the day and if the attitudes were good, then my perception was that they [were happy]'*. Another kaimahi said that a programme was effective if rangatahi asked for resources, *'you know that you are effective through evaluations. There is a programme that we put on and we always have evaluations to keep us on target. I know it is effective because I hear feedback from the community, I know it is effective because the rangatahi come and ask me for resources'*.

3.2.6 Organisational Structure, People Resources and Responsibilities

Pirirakau Hauora is a Charitable Trust governed by a group of trustees, some of who were the original health committee members. A full time manager is responsible for all staff employed by the Hauora on a day-to-day basis. Tu Pou Tahi has two full time health promoters that are guided in their daily routines by the Hauora Manager. Other kaimahi of the Hauora also provide additional support in terms of administration, reception and catering for manuhiri during meetings.

The Hauora is also guided by relationships that go beyond the legal requirements set out in the Trust Deed. These relationships include the Whanau of four marae: *Poututerangi, Tutereinga, Tawhitinui and Paparoa.* The Hauora also works closely with, the two kohanga reo and the two local kura.

3.2.7 Partnerships

Tu Pou Tahi is founded upon principles of partnership and close working relationships with other groups and people. Tu Pou Tahi works in partnership with several other providers and community based groups, particularly during the bigger events such as with the *Ra Whakawhanaungatanga.* Tu Pou Tahi kaimahi are active

members of the Tauranga Youth Council, which provides an essential networking and support system for the type of activities for which they are involved. Tu Pou Tahi relies heavily upon sponsorship to hold its one-day events and those relationships require ongoing maintenance. Tu Pou Tahi kaimahi also interact with youth groups and secondary schools as part of its contractual obligations. Tu Pou Tahi has a relationship with funding agencies such as Te Manu Toroa and the Ministry of Health.

3.2.8 Issues of Control and Ownership

There are two broad themes concerning control and ownership within Pirirakau Hauora. One theme involves the Hapu related activities and aspirations about identity. One of the difficulties associated with improving control and ownership of Hapu identity is the sheer challenge and bigness of the tasks. This excerpt highlights the challenges, *'that is an observation that I had about what is happening [in regards to the Hapu] and it's a protective measure and in many ways was born out of fear, fear of the unknown, fear of being challenged, fear of making mistakes and all those sorts of fears so I believe it is healthy to challenge everything'.*

Another issue related to the personal notion of self-esteem and confidence within oneself as an important consideration for Tu Pou Tahi, which is a personal concept of control. For example, Tu Pou Tahi kaimahi were always encouraged to explore innovative ideas as part of their programme planning. The following example is what occurred at one of the events, '*When they spray painted the wall over at Maungatapu and they painted one down here, spray painting originally comes from black America and America. But we didn't do any of their art we did Maori art, the kowhaiwhai, Maori patterns and things that signify us as being Maori and we are proud of it, being rangatahi and that is how we would use those two aspects to get a result'.* This comment suggests that rangatahi are interested in the same things as other teenagers worldwide such as Hip Hop American culture. However, they were also interested in tikanga Maori and where possible the best approaches for including rangatahi involved the fusion of two different non-related areas. This issue also highlighted

that cultural symbols of one's personal identity provide a set of codes for enhancing one's own self-confidence.

3.2.9 Current Organisational Issues

In June 2001, an impact evaluation report about the Rangatahi Health and Well-being Programme (as it was known then) highlighted a number of broad issues concerning organisational and contract related issues. One issue was concerned with the threat of employee burn out, for example, *'we get burnt out because we don't say no....we find it hard to say no to other things, but then if it's part of our passion and it's going to help us to actually achieve some of our outcomes....'* Coupe (2001) said kaimahi were encouraged to take annual leave breaks to recoup. They are also encouraged to hold debriefing sessions to reflect on ideas for programme improvements. Another issue related to difficulties with accessing secondary schools within the community. Coupe (2001) recommended that a Tu Pou Tahi package was put together and that schools be re-approached again. The Pirirakau Hauora strategic plan also highlighted that limited funding and mixed community support impacted upon the ability of the Hauora and therefore Tu Pou Tahi to achieve all of its programme goals.

3.2.10 Current Health Issues

The contract expectations that were integrated into Tu Pou Tahi were quite specific about the health issues to be addressed. The rangatahi age group ranged from 15 to 24 and the health issues related to sexual health education and well-being, and youth suicide prevention. Some of the respondents elaborated upon core health issues that related to those identified health needs. The first excerpt highlights the difficulties associated with suicide prevention, '*My understanding of suicide is pressures, its all about pressures and that is why I know with pregnancy, relationships, drugs and alcohol all of these are all added pressures to a teenager, just to keep them informed of what is going on, like this and that sort of thinking'*. Another excerpt highlights that you are dealing with a group of people who have lost their connection with their marae, *'...when we are engaging with rangatahi it is really hard because some of them have never been bought up in a marae or some of them have never ever talked*

to Maori, some of them don't even know their whakapapa, so you cannot be pushing that all the time, there is a point where you have to cut off'.

The issues related to preventing suicide are extremely difficult, the following comment explains, *'...so far I haven't found anything that says, "here's ten people that have committed suicide" and of those ten people three of them had relationship problems, one of them whose father beat him up from a young age and he had just had enough or he was bullied at school, there is nothing that gives any ideas as to why these kids are doing it. Lots of people are saying yes it goes back to an identity base. You're dealing with urbanised Maori and I am as big an urbanised Maori as anybody else and they don't know where they are from. All I can really do with that is provide different ideas... '.* Another area of concern relates to the place of men in the family and their roles in society, *'...Men have no idea what a man is and if that's the case, they have no idea how to be a dad. The parents who are also at risk of suicide aren't seeing the male side of the discipline and there are lots of solo parent situations. So without a male figure with any decent standing, everybody loses'.*

The final comment seems to suggest that the pressures impacting upon rangatahi, families, parents, men and women are related directly to the financial resources available within a household, '... *people cant afford to live these days, so they worry about feeding their kids and the nurturing and all the rest of it becomes irrelevant and then they have got nothing. Society is complaining that kids are off the rails and all the rest of it, because we can't afford to do any other things, you have to be very good to know where your kids are every minute of the day when you are working your ass off to feed them and to send them to school, to pay for their school uniforms, nothing is cheap and in New Zealand wages aren't going up to match inflation'.* The comments demonstrate that issues related to preventing suicide and improving the health related issues involved with rangatahi sexual activity were very complex and include many facets of the rangatahi's life. In a recent report by the Bay of Plenty District Health Board, the identified health concerns for youth aged between 15 and 24 years of age were injury and poisoning, especially youth suicide, violence and motor vehicle accidents, sexually transmitted diseases, unplanned pregnancies and

drug and alcohol related abuse and illness (Bay of Plenty District Health Board, 2002).

3.2.11 Aspirations Articulated by Kaikorero and Kaitautoko

The people interviewed for this section of the case narrative were quietly confident that the future aspirations for Pirirakau Hauora were achievable. Along with the potential for a full time health service, there were goals that included the reclamation of tikanga-based practices such as rongoa Maori and also forming an alliance with a Maori Public Health Organisation. One respondent commented that there will always be aspirations for tino rangatiratanga, they never go away, but alongside those goals comes the need to articulate strategies for how tino rangatiratanga can be obtained. Another respondent commented on the future possibilities of direct funding to Maori health providers and saw that realisation in the near future.

3.2.12 Research Focus of Case Narratives

The research issues that will be considered in this case narrative relate to the health promotion and educational activities of Tu Pou Tahi. The first area of investigation will focus upon the health promotion activities, the principles and concepts of health promotion that are practiced by kaimahi, why and how those practices are performed and the way in which Maori health promotion is articulated within the broader range of activities of the Hauora. Related to those areas of investigation is the need to explore the broader principles of Maori health, Maori health development and Maori health promotion to see if those activities might underpin the work of the kaimahi responsible for Tu Pou Tahi. The second aspect of the research critically examines the social marketing model and the extent to which representatives of Tu Pou Tahi might consider employing the framework for their health promotion activities.

3.3 Reflective Conversations

This section presents a series of reflective conversations about Maori health promotion and social marketing within the context of Tu Pou Tahi. The content is obtained principally from post-workshop conversations and other conversations held

with kaitautoko. There are three characters in the post-workshop discussions and seven kaitautoko in total involved in the development of this case narrative. The conversations have been organised into themes, which emerged during those discussions. The quotes in italics are a sample chosen to represent the overall concerns. Space constraints did not allow for all comments to be included.

3.3.1 Kaupapa Based Health Promotion

A central aim in the research process was to determine whether Tu Pou Tahi kaimahi were guided by concepts or kaupapa that were different to other health providers. The first interpretation associated kaupapa to improving health status through a Hauora that was Hapu owned, *'I think what we are driven by is the health status of our people to be Hapu based and Hapu owned and answerable to the Hapu and to specifically meet the needs of the Hapu'*. One comment linked kaupapa to identity, *'I think with my job that I do, identity building is a big part of what should be happening. Lots and lots of different aspects of Maori kaupapa should be part of my job'*. A further excerpt related kaupapa to rangatahi and tikanga, *'a lot of rangatahi actually find themselves gaining confidence when they do learn those things [reo, tikanga]. And its about identity and just knowing those simple processes, when you go onto marae, they feel like they belong'*.

Another excerpt highlighted the holistic focus of Maori health promotion, *'I think looking at the whole picture especially now that I am getting involved with learning rongoa, the whole picture is real its not just a fairy story, hippy way naturopath out there thing'*. The responses suggest that kaupapa did not necessarily correlate to one meaning, instead there were several meanings; health status, identity, who you are, who your people are and how cultural learning can be seen as a means to liberating rangatahi.

3.3.2 Maori Health Development in Tauranga

An important component of the workshop and the post-workshop conversations was the opportunity to reflect upon the developments that have occurred in health for Maori in Tauranga. A kaikorero said, *'I think it is important to see how Tauranga fitted into the bigger picture. It looked like to get the big picture of Tauranga health; there was a lot of leadership in the health field'*. One kaikorero said there were also a

number of really strong people involved in Maori health development in Tauranga, *'we still have some really, really strong people that are involved in all those changes and people that have really believed in the kaupapa, because they fought some real big battles to achieve what they achieved and to get us to where we are today'.* She also said that those same people continue, *'to keep us all on track to say this is the kaupapa that we have fought for all these years and with all the changes that the Government has [brought about] in health, we are not prepared to compromise, [we continue] to uphold our motto... '.*

One kaikorero spoke about the number of providers in Tauranga, *'we had grown and developed and that now we have more than ten [hauora]. It is important because it's about having those [hauora] in each area available to the people and for me, if I meet people in those areas, then its best to refer them to their own Hauora'.* The comments reiterate that Maori health development in Tauranga was led by a number of committed leaders, who continue to this day to mind the kaupapa from within the health field and at a distance. And secondly, that Maori health development in Tauranga has meant an increased number of Hapu and Marae health providers.

3.3.3 Maori Health Promotion Model

The opportunity to discuss concepts that contribute to Maori health promotion, as opposed to health promotion for Maori was provided during the workshop and the post-workshop conversations. During the workshop participants were actively involved in a process to develop concepts for Maori health promotion that emerged from earlier interviews. Those concepts were then contrasted with Mason Durie's *Te Pae Mahutonga* – Maori health promotion model. One kaikorero discussed the process, as well as the different interpretations that arose through that process, *'I thought it was quite interesting seeing how we dissected what was said and some of those dissections we could have [changed] the whole meaning of what that person was trying to say or their interpretation, but I saw there that a few of us were interpreting different things differently. I suppose a lot of it is to do with interpretation and it was really quite interesting that exercise'.* One kaikorero was present at the presentation of the Te Pae Mahutonga model by Mason Durie and commented, *'I think being Maori you can make all those connections because when [Mason] presented it he went right back into the history of New Zealand and our*

culture and it made you think. He talked about health in the days of Peter Buck and all those guys and it was easy to make a connection'. Another kaikorero who was prompted during the conversation reflected upon the importance of the six points of the Te Mahutonga model and how the concepts developed in the workshop were very similar to that model. The six points of the Te Pae Mahutonga model include

- Mauri Ora - Access to Te Ao Maori.
- Waiora – Environmental Synergy.
- Toi Ora – Healthy Lifestyle.
- Te Oranga – Participation in Society.
- Nga Manukura – Leadership and;
- Te Mana Whakahaere – Autonomy (Durie, 1999).

One kaikorero discussed the interactive process to discuss those concepts as well as what the points meant. For instance, *'its kind of scary because I can get more on a one on one basis than I can share in front of the group, because I've still got that respect thing and I don't like to speak out in front of older people'.* The kaikorero also said that, *'there are certain things in there that I totally agree with like leadership, autonomy, healthy lifestyles and linking that with [our] promotional hui. So we are sort of practicing that model, or trying to...so, I can relate back to at least two of those points in every event that I'm actually doing whatever the project'.* Three observations can be made as a result of those discussions. Firstly, the interactive process enabled input from participants that would not otherwise have occurred. Secondly, all kaikorero had an affinity with the concepts as Maori and thirdly, the Te Pae Mahutonga concepts were not only important they were also similar to the concepts developed by participants at the workshop.

3.3.4 Tu Pou Tahi Focus verses Hapu Focus

Whilst Pirirakau Hauora emphasised the importance of improving the health status of the Pirirakau Hapu, Tu Pou Tahi was concerned with rangatahi. One kaikorero highlighted the difficulty with being perceived as working only for Pirirakau, *'sometimes that's our downfall because people think that we are only there for the Pirirakau people and we're not, so when I go to hui, I always introduce myself as Western Bay, not as Pirirakau Hauora'.* Another kaikorero emphasised the need to

connect the rangatahi to who they were, *'to connect all you have to say to them, to get them to open up to us, to tell me your name and where you are from, 'oh, Ngati Ranginui', oh yeah, I'm related to them and who is your mother and then they feel like, oh she is from there too. Because all of them have been educated in the mainstream system and they've forgotten, they've forgotten their Maori side'.* It was also emphasised that rangatahi have potential, *'they are really bright kids, so that's what I like about the lifeskills programme, it is tough if it is a bad school, but we get all the ones that aren't motivated and are looking for guidance really and our programme is about changing behaviour'.* The responses suggest that well-being of rangatahi is very important.

3.3.5 Social Marketing

The assessment of the value of social marketing by kaikorero was an essential component of this research. An important part of the post workshop conversations was the active critical review of the tool from the perspective of the participants. Some of the excerpts emphasised that the implementation of new models as a management responsibility, *'it's more professional for management, you know to be able to do all of those things and for us to organise the programme'.* Other comments emphasised the tools merits, tempered by a need to retain a Maori way of thinking, *'I think that management should at least have a look at social marketing, [along with] all the relevant stuff, but not to forget that we are Maori and that we have our own way of thinking'.* And also, *'I don't know, I would have to have a really good look at it and make it a bit more kaupapa Maori and a bit more acceptable to the situation that we are working with'.*

One kaikorero discussed some concerns, *'it looks a lot like how I approach my job anyway, but if we were to take it on as a model we would risk having the Government tell us who the target is, and how to do it, like 'we want you to work with this age group of kids and for this we would really like you to look at kids that were expelled from school or drug addicts instead of just saying like our contract at the moment is targeted to those aged between 15 and 24 for the whole Western Bay of Plenty. If you took on this structured [approach], then it opens up the Government to really have input, because we report back to the Ministry... '.* That same kaikorero was not

opposed to the idea of segmenting the target group; the concern related to the imposing stature of the Government under the proposed social marketing regime. In spite of the concerns, kaikorero were still receptive to its use, *'I actually like it. I do like it, because I am into studying and I like to have everything organised and right there to the point and to be clear'*. The responses indicate that whilst there was an encouraging reception to the idea of using social marketing, it was tempered by the need to consider things Maori and the implications it might bring with increased Governmental surveillance.

3.3.6 Social Marketing Concepts and Assumptions

The social marketing model is founded on a set of assumptions and concepts, which are derived predominantly from the discipline of marketing. During the post-workshop conversations, kaikorero were given the opportunity to explore some of the concepts in more depth. A kaikorero responded, *'I [have] never looked at health promotion and marketing together before, I have never considered it at all really, but when you look at it I can see how it could fit'*. Kaikorero were also asked whether it was possible to replace their existing models for health promotion with social marketing. One kaikorero said, *'I think I can see social marketing fitting into what we are doing'*. An apprehensive kaikorero suggested, *'it's hard to take that model there away from our people, it would be such a mission, because that's basically who they are. We are different'*.

Kaikorero considered the concept profit adopted in the social marketing model. He commented, '*A lot of people were jumping up about the money side of things, but you can easily do away with the profit thing, you can say rather than getting paid you are getting knowledge or whatever. There are [also] other ways of getting around that...*'. To another kaikorero, the word profit related to, *'Money. They think because it is all that they want to make is some bucks. People will ask what you want to make bucks for? You're just trying on some of those other technical words, they'll get mixed up'*, and also, *'I knew we were talking about people so it wasn't a problem whereas the others sounded like they were talking about money'*. The concept of voluntary behaviour change was also viewed positively, *'well that is all we could ever hope for is voluntary behavioural changes, we could sit somebody down in a chair and brain wash them but at the end of the day when they leave it is still up to them*

whether they take on that brain washing. So, everything revolves around that comment [voluntary behaviour change] really'.

Someone highlighted a further threat, *'say someone from America came in and tried to give us that model it could quite possibly be social marketing, it may become a really money oriented thing just like any other business. I think if this was to come into Maori health, it would have to be run by Maori, but even then you would have to find the right person so that they are not money grabbing politicians like they have had in the past that were pro-Maori apparently'.* The responses seem to indicate that whilst there were concerns about social marketing concepts such as profit and that it was a model from overseas, those concerns could be alleviated.

3.3.7 Social Marketing Terms and Language

All three kaikorero were apprehensive about the terms adopted in the social marketing model. Some of the terms include; market, marketing, customers, clients, price, promotion and the marketing mix. One of the kaikorero thought the terms could be changed. He said, *'I think the terms could be changed, I was fine with the concept [that] people are a market but if you found a word to match that then the rest of us might be quite happy with it'.* Another kaikorero was more specific and said that you could change the words to relate to rangatahi, *'instead of saying product you'd say its 'the goods'. It's just switching the words to something that they can adapt to. Anything can happen from just doing that'.* One kaikorero was concerned with the predominate use of commercial words. *'...The words you used for that whole part of the workshop were business type words, they were commercial words and commercialism and business means profit and I don't know what it is like working for the University, but the rest of us aren't there for profit....'* One kaikorero also commented that, *'it would be freaky alright if you turned around and said Pirirakau market'.* The responses advocate for a more in-depth analysis of the social marketing terms, words, and phrases. In spite of the concerns raised, kaikorero suggested that the phrases could simply be changed and in changing the terms the meaning would also be changed.

3.3.8 Social Marketing Appeal

Whilst there were concerns raised about the social marketing model, two kaikorero thought the model had some appealing features. One comment related to its clear set of processes, *'it's clear and its processes have a goal, you know right there what you're trying to achieve and how you're going to do it and what you need'.* The second excerpt highlighted that aspects of the model were already being performed, *'now that I have looked at social marketing, I am pretty much social marketing the programme. I have picked the target group, I have worked on how to try and help that target group, I haven't really gone through costs and pricing and that part of it, but I am sure if I sat down I would probably have to'.* These responses suggest that social marketing could be useful.

Kaitautoko Responses

One kaitautoko not involved in the workshop commented on the use of marketing in the area of Hapu matters. The following excerpt highlights that the goals of the Hapu, do not necessitate the use of the marketing model and in his view he is suspicious about marketing. He explains with the use of obtaining information from kaumatua and kuia,' *...If you go to them – talking about marketing and this is in some way marketing because you're marketing the concept of the claim. And it never worked and since then my experience too – I mean I have a resource consent application that comes in and it's for Omokoroa, so I go to the koroua and he spent a lot of time there and so on and so I put him in the car and we go for a ride. And so, there was an opportunity to take these old fullas out for some fish and chips and go down to Plummers Point and you know – we'd spend most of the day, but in the process we'd go and do the job. And the korero that came – would come out from them was amazing. When you put things before them they can't answer you – or won't answer you, so I'm a little bit suspicious of something called marketing. I think you can achieve what it is that you want – I'm not sure about the other Hapu but you can achieve, but you need to think about how you encourage them to pass on information'.* The responses suggest that kaumatua would be suspicious of a marketing type model.

3.3.9 Emphasis on Behaviour Change

An additional point raised in the conversations related to the purpose of health promotion and the role of the kaikorero in assisting the achievement of those goals. Two key points were raised. The first point emphasised the overall goal of health promotion, *'I mean we are talking about Auahi Kore and we want these people to change their behaviour. We are talking about immunisation and we want the parents to change their behaviour with diabetes. Ideally we want people to change their lifestyles, that is what health promotion is about. That is what I see as being the message behind health promotion'*. This excerpt clearly highlights the role of health promotion in facilitating behavioural change. Another excerpt suggests that there was limited time in the working role of health promoters to explore meaning in the concepts and models that were used. *'When we are out there doing health promotion, we don't think 'what does health promotion mean? I mean it is good to know the definition of health promotion or social marketing. But when you are doing your work, we don't get time to think about that'*.

3.4 Other Kaitautoko Responses

This section explores a number of themes and concerns raised in conversations with kaitautoko that did not emerge during the post-workshop interviews and which do not relate exclusively to Tu Pou Tahi but are important nonetheless. The themes provide information about the context of Maori health promotion and Maori health development that impacts all areas of Pirirakau Hauora, Tu Pou Tahi included.

3.4.1 Concepts of Maori Health

A few comments revealed what people thought contributed to concepts of Maori health. The first excerpt for instance, emphasised the political nature of health, *'I have a very political view of health and our health – because we've got a whole lot of hauora relying on how things have happened to you and what won't happen to you or they hope you can mitigate against certain things. [For instance], good health is about stopping the exploitation of the little bit of land that you have left, good health is about my urupa, it's [filling up] and where are we going to go? That worries me,*

that is health for me. It's about our kukuroa, they are disappearing and it's also about the pollution, we can't swim in our waters at the moment, because they are so polluted...we can't swim and we can't control these things and that is actually a huge thing for me – exploitation and the development that is coming and to me it is always about us having a lack of control over ourselves...that is about good health to me'. A political view of health as the excerpt suggests includes concerns about land, water, development, identity, pollution and access to taken for granted resources such as swimming in the local estuary. Another excerpt argued that Maori health is more than physical health, for instance, *'...Physical health is important but that is only one part'.* Another response emphasised the notion of caring or manaakitanga, *'...I think attitudes towards health from different individuals comes down to caring and I think that for our people. It is important to be an integral part of the community, so that sharing can occur'.* The notion of manaakitanga extended to include Whanau who were not tangata whenua, *'... I am a strong believer in supporting non tangata whenua with general health services and I keep thinking my mokopuna might go to Auckland and I don't want them to be excluded – because they are not from there'.* One kaitautoko accentuated the inherent differences between Maori health and other models of health, *'....I believe that Maori health is different and that Maori health should be provided by Maori, because its only Maori that understand what it is to be a Maori and sometimes if you don't, if you haven't got that understanding of being Maori [health] can be discriminatory'.*

One comment stressed the importance of tikanga Maori in Maori health, *'...to facilitate Maoritanga we always had karakia, [our programmes] always have Maori elements in there like carvings and stuff like that, anything that we thought would help us hands on was another important thing. But it had to have the wairua and that's why we looked to the marae as a base. We always had powhiri, so we always sticked to tikanga and that kaupapa of doing it properly. But once we covered those areas, we were pretty flexible, they didn't have to speak Maori all the time and they didn't have to have a huge knowledge of [tikanga Maori]'.* One further comment suggested that whilst Maori health was about Maori ways of doing things, diverse approaches from different Hapu and or Iwi were prevalent, *'...it's really about Maori ways of doing things. We do our best, but it has to be brought back. It has to be*

brought back to our worldview of things – and even from when we have different perceptions of different levels; you've got to be careful. What is important to Matapihi could be different to another group in Tauranga, such as Pirirakau and then you might have a collective view of Tauranga'. The responses suggest that Maori health was not only concerned with physical ailments, it was also concerned with broader indicators of Maori health and well-being such as land retention, reo vitalisation and the adoption of Maori ways of doing things. However, in highlighting Maori approaches to Maori health, it was also important to be mindful of Hapu and Iwi diversity.

3.4.2 Taha Wairua

Taha wairua emerged as both an integral part of Maori health, as well as a component of ones cultural identity during the kaitautoko discussions. Three themes surfaced during the discussions, the first issue highlighted how our grandparents had a closer affinity to nature than we currently do and that affinity facilitated a closer connection between taha wairua and our health and well-being. For instance, *'...They lived with nature – and they lived with people and they knew far [more] than we'd understand ourselves. And they had this undying faith that there was – there is a greater being – that there is a purpose to be here. All of those things, I mean they didn't have to go to church but they all believed that. And so when we talk about self-belief now we are talking about people. And that sort of emotional thing that we are talking about today, in those days it was part and parcel of who they were'.* This comment suggests that the connection with nature is something that is being lost, or is less natural to us today than in the times of our grandparents. Another comment demonstrates how that relationship with nature, facilitated the use of other means of communicating with the land and with others, *'...So, we had those people who were gifted and they had on some occasion, they had – they were matekite. They knew things in the environment that were signs and so on like they all view the calendar for planting and so on and so it was a way of life. There was this observation of nature and things to do with the wairua that were natural to them and whilst they suffered their own health like any one else in different parts of their lives, I think they were probably more adjusted, not better off but more adjusted to that.*

The second theme discussed the components of wairua, as intangible aspects of ones being, *'...you see here what I am talking about is the things of the wairua – things that are not physical and we are affected by our traditions within our family and the bias that our families feel, you know about other people.'* Added further to that theme, is the impact upon a person when an event such as *raupatu* occurred. For instance, *'...I suppose of feeling that loss and feeling the impact and this was 1918 onwards. And these are the areas, as you say we puzzle over social impacts, in fact what they are talking about is the spiritual impact and it is not a matter of quantifying the loss in economic terms, it's quantifying the loss in how and what was taken away from us and that is our spiritual well-being'.* Health and wairua were interconnected, *'Health has a lot to do with your wairua, who you are, your identity, where you're from, stuff like that.'*

The final theme highlighted how the taha wairua can be affected even today and that that feeling is not easily articulated into words, *'...its almost like saying that is my example of impact on the wairua. You know, because you can't explain that – I can't tell you how that feels. But none the less we feel it you know and so that's in me and because you can't describe those things it remains there'.* There are two significant observations that can be made as a result of these observations. Firstly, Maori health includes a metaphysical component, which is termed taha wairua. And Secondly, when events occur that impact the broader notions of Maori health as mentioned above, the wairua of a person can be impacted upon negatively. The responses seem to indicate that the spiritual side of a person is an important component of a person's state of health.

3.4.3 Contracting Nature of Hauora

Other issues arose during the discussions that focused upon the way that health services or service contracts are facilitated. One comment focused on the narrow and confining definition of service provision. This feature of service contracting impacted upon Hauora as a whole, for instance, *'...the contract basically tells you this is the service you are going to provide but it doesn't say, if your service is to look after diabetics in your area, it doesn't say it is your responsibility to make sure that*

they've got home help, or to make sure that they've got a way up the stairs and stuff like that. They just basically look after the clinical needs...'

One set of responses highlighted a concern with under bidding for contracts and the impact that competitive bidding had on the staff members involved with the programmes. For instance, *'...you know when we're bidding for contracts, we put in the lowest price so that we can get the contract, instead of putting in a price that we feel is going to give a quality service, so we are really just trying to grab out and you know that we're undercutting ourselves'.*

The following comments highlight the flow on effects that occur with limited resources. For example, *'When you're put on a project, you had to find the money to put it on – you know, there was never the money there allowed for the actual methodology. There was enough to cover rental, resources, wages and stuff like that, but if we wanted to put something on, we had to find the money. That in itself, burnt up a lot of time'.* Another comment suggests that the Hauora on the whole covered the shortfall, *'the Hauora probably spent money out of their overall budget a lot of the time for Tu Pou Tahi, because we never were able to actually have access to the full amount we needed. So using some of the other jobs within the Hauora were compensated for out of their budget. If we struck gold, we were able to give them something back'.*

Despite those challenges, Tu Pou Tahi had scope for adaptation and development as long as, *'we resource it properly, as long as we've got the right people in there, but most of all as long as that's what the youth want, because I forgot to mention this, we do too many things for our youth that they're not asking for and one of the big things that we have built in was getting a voice from the youth and that was the youth council. We wanted them to tell us what types of things they needed'.* The responses highlight that the activity of bidding for health contracts is competitive and in being competitive there were flow on constraints that impacted upon the organisation. As well, part and parcel of the contract was ensuring that the voice of the youth was heard.

3.4.4 People Development – Whakapakari Tangata

The concern with developing a foundation of skilled and available people emerged as an issue during the discussions, '*...the biggest difference in resources is human resources. We put so many briefs on our Maori people to cover and we don't really give them the option to do it properly. In mainstream centres, they'll give you one brief and you're able to do it properly. In Maori organisations you have four or five briefs and that is seen as the same job'*. The threat for Maori organisations involved potential employee burn out, *'I'll be straight with you now, I'm working on five projects at the moment, you know, Tauranga Moana, Tauranga Tangata festival, I'm part of waka ama and then we've got the Mataatua kapa haka festival coming up next year that we're starting to get into. We find it hard to say no to other things, but then if it's part of our passion and it's going to help us to actually achieve some of our outcomes. We get burnt out'*.

The concern raised about overloading staff was apparent throughout the Tauranga Moana region according to this comment, '*I've visited a few [hauora], they are out there, they're really trying to achieve, up to the point where you might be trying to go a bit too quickly – they're trying to be too much at once and they're going to find that they're going to put more briefs on people and you know I had a lot of briefs when I was with the Hauora. So you need to just be careful. And treat our people like - equally like the mainstream do, so that's why they don't get burnt out'*.

The final comment suggested that there was one consolation and that was related to the involvement of Hapu members in further tertiary training, *'I suppose I'm encouraged by progress that some of our rangatahi are making in regards to their education and some of the directions that some of them have taken in – like tertiary study and so on. But like all other Hapu and Iwi we are going to lose those ones for a period of time at least and it may be 20 years, they'll go off and do what they want to do and so on before really thinking about coming home'*.

The comments raised above seem to suggest that there are resourcing concerns related to the number of people that can be employed at any one time and the impact that the

lack of resources has upon the existing Maori health workforce. The risks associated with under-resourcing translated into the workforce being burnt out. However, a closer examination of those concerns suggests that some of the stressed load was attributable to other external activities, although all under the banner of Hapu health development.

3.4.5 Health Promotion

There were some concerns with the activities of health promotion. One comment focused on the role of communication in health promotion, *'as a Maori you can deliver health promotion and it doesn't necessarily have to be as [the textbook] says, you learnt when you did in all the health promotion training that things don't have to be in writing and sometimes it's the way you communicate with people.'* Health promotion could also be seen as an innovative way of interacting with people, *'I encourage my staff in health promotion, rather than give people a bunch of books, piles of paper that you know they're not going to read, talk to them and give them [things], show them [things], make it more interesting and hands on'.*

Another comment emphasised the challenges related to suicide prevention and the importance placed upon building self-esteem, *'...we run programmes and activities and we don't talk about suicide. Even though it's suicide prevention, we run programmes and activities that build up their self esteem, because we know that the reason kids are [not coping] is because they've got low self esteem, they don't care about themselves, they think the world hates them. So we do things that build their self-confidence up and self-esteem, which makes them feel proud of whom they are. A lot of the kids problem is that they haven't got that identity to use, so working with Maori kids is giving them some knowledge about their history and korero about who they are and where they're from'.*

One kaitautoko even suggested that the use of Maori methodologies of communication were under utilised, *'I think a lot of the whakatauki could be used in health promotion and you know, we had our tauparapara and a lot of things I think are unexplored yet. With whakatauki and tauparapara, if you looked at it, you will discover the value and you will find the people in them'.* The comments suggest that

Pirirakau Hauora is willing to adopt innovative approaches to achieve its goals and that the type of programmes they provide required innovative thinking and ideas.

3.4.6 Rangatiratanga – Ownership and Control

There were also comments that related to ownership and control or rangatiratanga. One comment related to the need for people to assert their own sense of control of themselves, even as Hapu or Whanau. The failure to do so led to increased dependency, which was not viewed positively. For instance, *'You have to take control of yourself, even if from a Hapu or from a little whanau you are going to say well I got it, and because it is free now. People have just got to go out and get their own contract. But you can see too much dependence and that is not good. It is not good for our people'*. One comment referred to the loss of control and the impact that had upon the Hapu, *'we can't control these things and that is actually a huge thing to me – exploitation and development that is coming and to me it is about always having a lack of control over ourselves - that is good health to me. Holding on to what bit of land we have got for our future, encroachment among our rural areas, you would understand – we're all under siege'*. One kaitautoko elaborated further into the way that the Government was able to circumvent the ability of people to achieve their aspirations, *'...but I'm hoping that if we come up with a model, then it's going to start working, that the Government doesn't look at it and try and twist it so that it doesn't work. Because sometimes I look at that and they let things go that will work and it's only because I feel they don't want it to work sometimes, otherwise they lose control over it'*.

One person also reiterated the importance of long term thinking and planning to the ability of people to have control over the future destiny, *'...there is still very few of us and the experience of having too many of us is that a lot of people come in and go out so there is no consistency long term. I am a long-term planner and I think of the people – I want us to have a Maori health system at the end of the day that is controlled by our people. It has to be quality too you know no hum bug half pie outfit'*. The comments highlight that rangatiratanga was a constant concern for health

leaders and all activities undertaken by the Hauora related directly to enhancing the ability of Hapu to improve control over the future.

3.4.7 Whanau, Hapu, Iwi

There were many comments raised that related to the broad themes of Whanau, Hapu and Iwi. One comment emphasised the relationship that Pirirakau Hauora had with the other Marae, *'all marae, all the people from all of the marae utilise this place...'* and in terms of services provided by the Hauora *'... we just make sure that all our services link into their structures like Kohanga reo, or their Marae committee and to their kaumatua and so it's not as formal – it's not formal but as long as they know that everyone is there they're beginning to think, it is that kind of situation'.*

Another set of comments highlighted the interconnectedness that people felt with regards to their Hapu identity, as if it was a collective consciousness. For example, *'I sit on a lot of health organisations so at the end of the day your Hapu is the one that is always going to be there to hold your heart, to hold your heart and I owe my heart to Pirirakau. I owe my Hapu, so they get the benefits of any knowledge that I gain...'* One respondent suggested that the deep connection with Hapu came after knowledge, experience, and also commitment, *'... It's a conscious thing but the conscious thing comes probably with knowledge and experience and I think that with our people - you're only as influential as our people can trust you – because I could be at a lot of levels but if people don't trust me, then you make no impact – so it's about me being very clear of where my politics lie and I try to be kind of pono about anything, so it is clear...'* The focus of the Hauora then was predominately related to the health needs of Hapu, *'you know the focus here is Hapu. That's not to ignore the whole Iwi but it's about the well being of the Hapu first and by association with Iwi and the Moana, that is the focus for everything is really Hapu, Hapu driven'.*

One respondent was fortunate to see in person the impact of that collective spirit during the Treaty of Waitangi Tribunal hearing for the Pirirakau Hapu, *'...and on the day before everyone did this big hikoi from Whakamarama and I tried to do so many things all on the same bloody day and so I never actually took part in that, but when*

they finally got to Tutereinga, that little marae – when they finally got to Tutereinga I couldn't believe the size of their bloody ope. Incredible! So, yeah it was – it was an amazing thing and we'll probably not experience that again – in our lifetime'. Another characteristic of the Pirirakau Hapu identity involved the fusion between the Hapu identity and Catholicism, *'For us in Pirirakau it seems to be a cross between Catholicism and some of the old kinds of practices, so it is a kind of mixture of that – those two things come together and you get the kind of, different type of, well you've got wairua or whatever you know just kind of spiritual kind of dimension of health... '*

But, the notion of Hapu is not always a liberating experience. As one kaitautoko said, the impact of politics infiltrated the psychology of Hapu creating negative results. For example, being Hapu did not always translate into positive development, *'it's hard for me – because I see in some ways we're going shit, I wanna be straight with you. In some ways, I feel sometimes we are tokenistic too many times – saying we're doing things for our people and we're not. We can't even sort out issues within our own Hapu sometimes and we're expected to go out there and support the wider community – until we really start becoming happy within ourselves, we're always going to struggle. You know I can't stop reiterating that'.* And also, *'if we can sort out a lot of our in house fighting and our inter Hapu and inter Iwi and those differences, then we can work together a lot more as one, then we're going to have a better, stronger base to work to improve our own health standards. I know that our kaumatua are out there trying, but for every good deed that's done, there seems to be two things that will come into the community that will blow that. You know, and that's forever exhausting our energies – fighting ourselves'.*

Another issue was concerned with the way that society had given children rights. In the view of the kaitautoko, this had not always been a good thing, *'...The one thing that is happening in society is the kids have got rights and they show that, mum and dad can't touch them, they can't smack them, because if you smack them then that's assault, same with at school, so they have got rights, they are given everything, they have got Play station which is instant gratification and other tools of instant gratification, everything is given to youth on a plate, absolutely everything, so coming here from my history when I was a kid at the age of about 12, I have worked for everything that I have, mum and dad have helped me with half of it, but if you want it,*

go and get a job, that proves to us that you can earn what you want and we will give it to you'. Another concern related to the growing dependency that some Hapu members were having upon the Hauora. This was highlighted in people not wishing to contribute to the costs of the activities by way of koha. The reasons for this were unclear, for instance, *'...To come to a place where even $5.00 is a koha towards the programme is too much, these parents are smoking drugs and drinking alcohol, there is money out there, why are we giving it, all we are doing is encouraging the parents to keep doing what they are doing. I can see that we are working with the low-income bracket, which is negative in the first place; I don't know how to fix it'*

The comments portray a contradictory, and conflicting picture of community development and community upheaval. The task of continually uniting the energies of all Hapu members, as suggested is both an energy sapping exercise on the one hand and an enlightening process on the other. The added difficulties with changing expectations in society where children have more rights and where the tikanga of koha was being eroded were also proving to impact upon the work of the kaimahi.

3.4.8 Te Whakaoho Mauri – Rangatiratanga

There were comments that signalled that a positive future existed for Pirirakau Hauora in terms of health development. For instance, *'[I have] great hope for our people – we have a great future. When I look around, even though in some ways, I see terrible examples of our ill health, but then I go out to the Hauora and I see the most wonderful work that is being done with our people...'*

There was also an understanding by those involved with Tu Pou Tahi that the future for rangatahi lay in enhancing their identity and self-esteem. This excerpt demonstrates, *'...We are promoting our people in having their identity – first we needed the programme to have it's own identity, it needed to tautoko it own's kaupapa. Health and Well-being programme wasn't a suitable programme for us. So we asked some of the rangatahi and they didn't think it was too user friendly, it sounded like you were going in as a client and we didn't want that. We needed all*

rangatahi to come up, the 'at risk', the ones that are well off, we needed to come in and come together and be together to help each other'. The model to work from in the future involves a deep conscious understanding of who you are and where you are from. It also needs to be linked to the kaupapa of rangatiratanga, *'....The ideal for that – I suppose it's being able to do that sub consciously without having to think about it, with that particular model and discipline'.*

3.5 Conclusion

Pirirakau Hauora is a Hapu based health organisation that provides a range of health services primarily to the Pirirakau community. Pirirakau Hauora also provides the Tu Pou Tahi programme, a rangatahi health and well-being programme which aims to improve the health related statistics of suicide prevention and sexually related illnesses for rangatahi in the Western Bay of Plenty region. This case narrative looked at Pirirakau Hauora in general and Tu Pou Tahi specifically. In Section 3.2, I provided an historical overview of first Pirirakau Hauora and then Tu Pou Tahi. The purpose of doing so was to ensure that the foundation of the Hauora was emphasised at the beginning of the case narrative. Sections 3.3 and 3.4 were concerned with exploring aspects of the post-workshop conversations with kaikorero and kaitautoko. The focus of which was to report on the critical examination of social marketing within the parameters of Tu Pou Tahi and then to examine any further concerns that also arose. The key conclusions drawn from those conversations are presented below.

The research conversations provided as part of this case narrative indicate that Pirirakau Hauora is currently in a strong position to be engaged with various opportunities that present themselves in the health services environment. Tu Pou Tahi for instance, is an innovative approach to the provision of health promotional services in the wider Western Bay of Plenty region. The approach adopted by Pirirakau Hauora has assisted the kaimahi to maintain a sense of passion in their work. For instance, *'Pirirakau Hauora doesn't want to be the ambulance at the bottom of the hill. We want to prevent a lot of ill health happening to our people. That's why a lot of our emphasis is on health promotion in our mahi. Of course we've got the clinical services, but we do health promotion and the doctors service*

works hand in hand.' As a result, the vision that encapsulates who Pirirakau Hauora is and where Pirirakau Hauora wants to be in the future is therefore being accommodated. A concern that should be considered is whether it is time to revisit the vision, in light of the region serviced by Tu Pou Tahi, which at this time goes beyond the scope of the Pirirakau community.

The research findings also indicated that Pirirakau benefited from the involvement of very strong leaders in its midst. A comment raised by one of the kaimahi, highlighted that not only were people actively involved in forging a future for Pirirakau Hauora in the past, but some of those people still remained within the Hauora, guiding its direction within the committee and in other related positions. One of the people involved in this case narrative for instance highlighted how important occupying roles of influence in other health related areas could be to assisting Pirirakau Hauora. Pirirakau Hauora therefore can be seen as an icon of the innovative approaches to health that have contributed to Maori health development in Tauranga, which are articulated throughout the case.

A small number of emerging trends within the health services environment have had an impact upon Pirirakau Hauora. One of those trends relates to the nature of contracting health services. Within this environment, Pirirakau Hauora through Tu Pou Tahi is expected to be accountable to Te Manu Toroa in terms of delivering measurable outcomes as per the services contract. A stark observation however, is that with respect to the issues that Tu Pou Tahi deals with, for instance, rangatahi suicide prevention and sexually related illness reduction is a particularly sensitive area in which to operate. There is very limited direction provided by the Ministry of Health as to possible strategies for improving the current health related statistics in this area. As a result, Pirirakau Hauora may need to exercise a degree of caution in how the programme actually aligns with the improvement of health related statistics in rangatahi suicide and sexual related illnesses.

Concerns about the increasing subjugation of health services to business related practices and methodologies were demonstrated by the familiarity of kaitautoko to

business related terminologies. At the same time however, there was an emerging contradiction with the acceptability of those terms on the one hand and a commitment to the Pirirakau Hauora kaupapa on the other. The reconfiguration of Hapu as a market or a group of clients is one such example. Concerns about the holistic care for others that is presumed with Maori health advancement is minimised with the use of these types of business models of which social marketing is one.

Tu Pou Tahi kaimahi provided responses to indicate that there was a desire to assist people to make lifestyle behaviour changes. This is an area of Tu Pou Tahi's operations that requires more training and investigation. As highlighted by one of the Ministry of Health correspondents, one-off events encourage awareness, however they do not encourage behavioural change. There are concerns then that the efforts put into the programme and the related outcomes may be viewed as ineffective despite all meaningful intentions primarily because of the complex health issues involved with teenage suicide prevention and sexual health. There is also limited evidence available to show what works well in this area and the pathway for future development may be one of the unexpressed expectations of the services contract, that is placed upon Tu Pou Tahi.

Another concern relates to people skills and people workload. The type of activities involved in designing programmes, messages, health promotional materials and resources within the rangatahi programme were extensive. As a result, the current programme may be currently understaffed. This is something for Pirirakau Hauora to consider, as it poses a threat to maintaining long-term staff retention in the future.

The purpose of this study was to inquire into the extent to which social marketing might be usefully applied as a model for the achievement of Maori health development. The responses obtained in regards to integrating social marketing as a model for use within Tu Pou Tahi highlighted three points. Firstly, the kaimahi were inclined to accept the use of social marketing. In their view, they were already utilising some of the ideas and it would therefore be an improvement in what they are currently doing. Secondly, when probed further it was highlighted that whilst it may be an appealing model, there was a need to adapt the terminologies, or change them

completely. If those alterations could be accommodated, then any concerns raised with the model would be overcome. In contrast, only one respondent raised concerns about the use of marketing, particularly from a conceptual point of view. It was highlighted that marketing did not promise anything significantly beneficial, particularly when working with kaumatua and kuia. If anything, they would be suspicious of the model. This issue directly related to the importance of Taha Wairua in Maori health and how health development from a Hapu perspective involved much more than just paying attention to physical ailments. It is something that social marketing models did not deal sufficiently with in this case narrative.

There were four aspirations articulated within this case narrative. In terms of health promotion activities, there was an emphasis placed upon encouraging lifestyle behavioural changes. Pirirakau Hauora kaimahi were in a position as a result of the current support mechanisms to articulate this desire as part of their programmes. However, there is some work required for the kaimahi to evaluate whether those changes are being made. These tasks require a specific set of skills that the staff may currently not possess. Secondly, there is an aspiration for Pirirakau Hauora to emphasise kaupapa led approaches to health promotion, which encapsulate the threat of Taha Wairua loss and the need to enhance the development of cultural identity growth. Therefore, there is an emerging contradiction between this desire to reclaim Taha Wairua and the pressure it may pose upon rangatahi where they are not so comfortable with their Taha Maori. Thirdly, there was a desire within Pirirakau Hauora to go beyond the scope of its current vision. The delivery of Tu Pou Tahi by the Hauora is an example of what can be done, but careful thought needs to be made about the challenges that may arise with the desire to expand. Finally, Pirirakau Hauora has a desire to provide a full time general practice service to complement the other health services that it provides.

To conclude, the case narrative sought to critically explore whether social marketing would be beneficial for the enhancement of Maori health. As an isolated research inquiry, it would be possible to conclude from the responses that social marketing would provide the kaimahi of Tu Pou Tahi with an added value model for the types of activities that they perform as part of the programme. However, part of the research

involved the exploration of wider issues concerning Maori health promotion and Maori health development. When the parameters of the research included those issues, it was no longer possible to validate the use of social marketing without highlighting some critical observations. One such criticism is that it poses a threat to any kaupapa led health promotion model that may be adopted. For instance, the recognition of Maori health as a holistic framework does not complement the social marketing model. Within a social marketing model, health is a commodity or a product. And secondly, the threats posed to who controls who is targeted and why that may compromise the public health goals is a reality. For instance, the opportunity for the Government to continually survey the kaimahi of Tu Pou Tahi is a possibility that restricts the possibility of providing health within a holistic framework. The biggest threat however, was concerned with reclaiming Taha Wairua as a means for further Maori health development. It is not possible therefore for Taha Wairua and Social Marketing to be concurrently utilised as conceptual frameworks for Maori health promotion initiatives as both models are founded upon different conceptual foundations.

In sum, an excerpt from the responses highlights where one of the kaitautoko positioned Pirirakau Hauora in terms of the future with broader issues that might impact Maori health, *'the difficulty is being able to talk about solutions. I mean – anyone can pick holes in things – we've picked holes in lots of things but you know if you don't have a solution well then that's where it stays'.*

3.6 Recommendations

There are four key recommendations that have been identified as part of this case narrative. They are provided for the benefit of Pirirakau Hauora as a whole and Tu Pou Tahi kaimahi in particular. The recommendations are also directed towards Te Manu Toroa; in the hope that serious critical thought is made to look further into some of the issues that are being raised as a result of the research.

That Pirirakau Hauora in collaboration with Te Manu Toroa re-examine the way in which evidence, feedback, and research is encapsulated to inform the approaches to facilitating behavioural lifestyle change. Currently, the types of health promotional

activities that were provided by Tu Pou Tahi have often focused upon one-day events. Whilst one-day events are usual forums for communicating messages, it is not clear whether those forums can be utilised as a means to facilitate behavioural lifestyle change. Pirirakau Hauora should ensure that the costs of preparing or being up skilled in research is reflected in the resources made available as part of the health services contract.

That Pirirakau Hauora in collaboration with Te Manu Toroa re-examine whether the full costs of resourcing Tu Pou Tahi staff, resources and administration are being accounted for in the funding made available through the services contract. The responses, particularly relating to *'employee burn out'*, suggest that the resources being made available are currently insufficient for an emphasis to be placed upon forging long term behavioural change.

That Pirirakau Hauora in collaboration with Te Manu Toroa re-examine the way in which contracts are prepared to ensure that the desire to emphasise kaupapa led health promotional initiatives is reflected in the terminologies used. This kaupapa should emphasise the loss of Taha Wairua that was highlighted in the case narrative.

That Pirirakau Hauora in collaboration with the Pirirakau community re-examine the vision of the Hauora, in light of the future organisational aspirations that may go beyond what is currently being articulated within the strategic documents of the Hauora.

Case Narrative Four: Waipu Hauora

4.1 Introduction

In this research project, I critically examine whether social marketing may be useful for enhancing Maori health. Waipu Hauora is one of the case narratives included in this research report. It was established in 1994 as the health services delivery arm of the Hungahungatoroa Marae (Fisher, 2000). It began with weekly general practitioner visits and gradually expanded its services to include health education and promotion activities. Waipu Hauora is currently contracted to provide a broad range of promotional activities, as part of a Whanau Ora programme. The contractual relationship exists between the Poutiri Trust (the funder) and the Hungahungatoroa Marae and the health services arm of the Marae is Waipu Hauora. The Waipu Hauora case narrative is presented in six sections. Section 4.1 introduces the case narrative and Section 4.2 provides an historical overview. Sections 4.3 and 4.4 explore the themes highlighted in the reflective conservations with kaikorero and kaitautoko. Section 4.5 and 4.6 present the conclusions and recommendations.

4.2 Historical Overview

Waipu Hauora was originally established in 1994 and operated for a short time from the Hungahungatoroa Sports and Recreational Clubrooms at Matapihi, Mount Maunganui. It initially provided free general practitioner services to the Matapihi community. One of the original people involved with its development explains what he saw as the health needs of the community at that time, *'...Putting it together was really about better health. And that was the goal. I had nothing else to think about because I saw kids with cold sores, snotty noses and so forth. These were some of the issues and we had a lot of tough [debates] about these things. [We] went from 27 [health goals] to 17 [health goals] after talking with the marae'.*

In those initial development stages, a whanau member voluntarily supported the general practitioner and where possible provided health educational seminars and hui.

As a passionate advocate for improving health in the community she said, *'Because I was at the coalface, I knew the availability of services to Maori and communities. Especially the older ones [who were affected by] the intimidation of going away from the home base, you know what I mean? I have never seen so many kaumatua being attended by a GP until it was introduced to the marae. It was quite mind blowing for me [and] to have our own GP was quite significant'.*

Later that year, members from the Marae Committee secured a contract with the Midlands Regional Health Authority[38] to provide Whanau based holistic health services (Midlands Regional Health Authority, 1994). In 1996, the Hauora purchased a building, as the designated facility for health services and promotional activities. In that same year, a part time Health Coordinator was employed to ensure that the Waipu Hauora met its contractual obligations. In 1999 as a result of increased work expectations placed upon the Whanau from the Marae and the health funder, the Health Coordinators role expanded. Waipu Hauora is now seen as a Marae based Maori health provider situated within the Hungahungatoroa Marae complex.

4.2.1 Waipu Hauora Kaupapa

The original kaupapa of Waipu Hauora was *to deliver health promotional activities to the Matapihi community.* The most recent articulation of the kaupapa however is to improve the health and well-being of the whanau of the three marae; Waikari, Hungahungatoroa and Whareroa which are located within the wider Matapihi Whareroa region (Fisher, 2000). However, there is an explicit contractual requirement that the services provided are available to both Maori and non-Maori in the community, despite the fact that the composition of the community is mainly Maori and that Waipu Hauora is required to design services that meet the health needs of that community.

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[38] The Ministry of Health required Regional Health Authorities to facilitate the purchasing and contracting arrangements that emerged from the health reforms after the dissolution of the Area Health Boards. These organisations were originally Regional Health Authorities, but they have also been Transitional Health Authorities and Health Funding Authorities. In 2001, those types of regional authorities were disbanded and the contracting responsibilities were transferred to the District Health Boards.

4.2.2 Vision and Strategic Goals

As outlined in the Strategic Plan 2000-2005, the vision for Waipu Hauora is *to be a key contributor in the development of a strong, vibrant, culturally rich and health community in Matapihi Whareroa.* There are three strategic goals articulated within that document which are as follows:

- To improve the health status of our community through the provision of targeted health promotion and service delivery programmes.
- To develop within our community, people with skills and knowledge in the delivery of health promotion and service delivery programmes.
- To implement best practice in the development and delivery of health services to our community (Fisher, 2000).

The Marae Committee and its delegated authority the Health Committee is responsible for ensuring that those goals are achieved. The Health Coordinator is responsible on a day to day basis for the operations and delivery of health promotion and health services.

4.2.3 Services Region

Waipu Hauora services primarily the Matapihi Whareroa area, although all people living within the Tauranga area are welcome to utilise the services. The region includes three marae; Waikari, Hungahungatoroa and Whareroa and two Hapu of Ngaiterangi Iwi; Ngai Tukairangi and Ngati Tapu, a primary school and two-kohanga reo. The current Health Coordinator encourages input in the development of services from the community by hand delivering notices to all members of the community.

The Matapihi Whareroa region is located on the shores of Waipu Bay and is predominantly multiply-owned Maori land. The Matapihi area remains a rural region, surrounded by kiwifruit and avocado orchards. The Whareroa Marae community is a small hamlet located next to Waipu Bay and enclosed within a semi-industrial park near the Port of Tauranga. Both areas are heavily impacted upon by the encroaching urban sprawl in Mount Maunganui and Tauranga city. Current

demographic information for the Matapihi and Whareroa is not available. However, statistics from the 2001 Census of Populations and Dwelling provide an idea of the composition of the community. The total population for Matapihi increased from 585 in 1996 to 615 in 2001. Of that 615, 480 were Maori and 135 were non-Maori (Satistics New Zealand, 2002).[39] The Whareroa community consists of approximately 30-40 people who reside in either the kaumatua flats or the separate dwellings taking the Matapihi Whareroa population up to between 510 and 520 people. Although these figures represent the number of Maori people living in that community, there are many Whanau members who live within Tauranga, that are regularly involved in many of the community's activities who have not been included in these figures.

Table 1: Maori in Matapihi Whareroa Region

	All	Maori	Non-Maori	Other
Matapihi	615	480	90	45
Whareroa[40]	40	35	5	0
Total	655	515	95	45

Source: NZ Statistics 2001

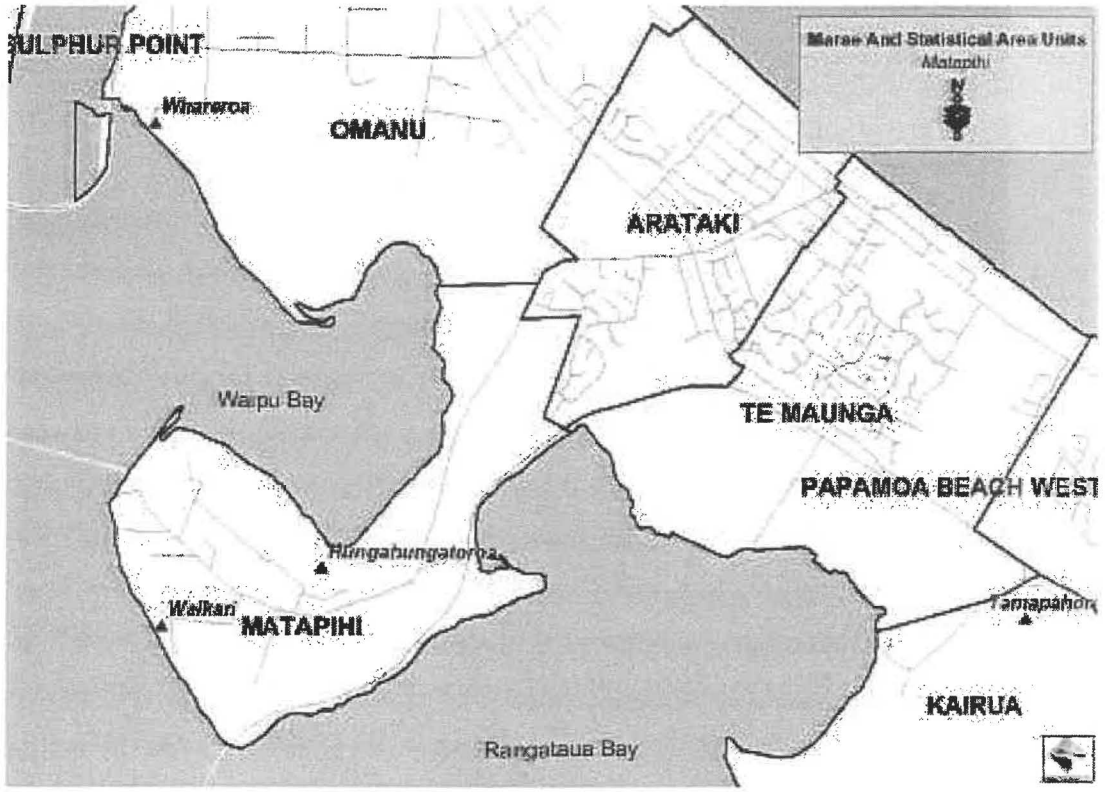
There are no statistics available for Hapu, but Ngaiterangi statistics indicate there are 3339 Iwi descendents living within Tauranga and 9561 descendents nationally[41].

[39] Of the 135, 90 were non-Maori and 45 were either another ethnicity or they did not provide a classification.

[40] The figure is estimated.

[41] Although there are 9561 Ngaiterangi descendants nationally, only 9009 that indicated that they were Ngaiterangi also identified their ethnicity as Maori. The remaining 552 identified as non-Maori, but had Ngaiterangi ancestry.

Figure 7: Matapihi Whareroa Services Region



Courtesy of Tauranga District Council

4.2.4 Nature of Services and Programmes

Waipu Hauora has provided a range of health promotional activities in the past, and still currently provides many of those services. The range of activities have included the following:

- General practitioner services.
- Nursing assistance.
- Mirimiri.
- Kaumatua and kuia excursions.
- Rangatahi programmes.
- Holiday programmes.
- After-school programmes.
- Aerobics & Taebo.
- Walking Groups.
- Ante natal services.
- Drug and alcohol education.
- Smoking awareness.
- Asthma education.
- Diabetes education.

- Nutrition and;
- Inter-marae sports.

4.2.5 Evaluation of Services and Programmes

The evaluation of services and programmes provided by Waipu Hauora is undertaken using the following methods. With regards to the general practitioner services, the number of attendants and the health related issues they present are monitored and tallied weekly. With the various health promotional activities, the Health Coordinator provides a written report to the Marae Committee discussing recent events and activities. Quarterly reports are prepared for the Poutiri Trust relating to the ongoing progress of Waipu Hauora against the stipulated requirements of the services contract. Included in that contract are specific performance targets that Waipu Hauora must meet in terms of both how many people are contacted each month, the number of hui provided and the number of Whanau activities provided. Although the community views the services and health promotional activities as valuable, a methodology to collate performance outcomes for highlighting the relationship between the delivery of health services and health status of the community is yet to be established. This is an area that the Health Coordinator would like to improve in the future, yet the enthusiasm to make improvements may need to be tempered by the experience of people within the Hauora. The ability to analyse health status through health services is an area that the Poutiri Trust is also attempting to improve. The current Health Coordinator was recently informed by the Poutiri Trust representative that, *'...[Improving measurability] is something that should be looked at and that is what is going to come into the reporting. There is actually going to be more paperwork and more expectations and more in-depth one on one approaches to targeting people'.*

4.2.6 Organisational Structure and People Resources

Waipu Hauora is directly responsible and accountable to the Hungahungatoroa Marae Incorporated Society through the Health Committee. The Health Committee in turn monitors progress related to achieving objectives outlined in the contract and as stipulated in the strategic plan. The positions on the Marae Committee are voluntary

except for the Treasurer and Secretary roles. Currently one employee is hired in the full time role as the Health Coordinator to provide the health services.

The Marae is currently involved in three different sets of activities. The Marae operates a sports and recreational facility which holds events and opens as a tavern and bistro six days of the week. As well as catering to the cultural needs of Whanau members, the Marae hires out the complex to various groups. The Wharekai and the clubrooms are regularly used as venues for special purpose dinners and conferences.

4.2.7 Partnerships

Waipu Hauora is not involved formally with any group in a capacity of dual-delivery of health promotion activities. However, they have several informal relationships that ensure that health specialists and educationalists are regularly available. Waipu Hauora works closely with the Hapu, Marae, the primary school and the kohanga reo in terms of providing forums to promote health activities and services. Waipu Hauora recently considered formalising those relationships in the interests of ensuring that the delivery of services was performed collaboratively. There is a possibility that a closer working relationship may develop with the newly constituted Matapihi Sports and Cultural Association.

The Poutiri Trust also provides opportunities for Waipu Hauora to network with other Hauora in the community as a formal contractual arrangement between these two parties. Waipu Hauora is part of the Ngaiterangi Health Committee and network meetings are held to facilitate opportunities for information sharing and enhancing service delivery. Waipu Hauora was also involved directly with Te Whanau Poutiri Rangiora a Papa, prior to the inception of the Poutiri Trust.

4.2.8 Issues of Control and Ownership

Waipu Hauora is one of the smaller case groups involved in this research project. Despite its size, issues related to control and ownership within the context of Whanau

and Hapu development remain paramount. Waipu Hauora for instance, is the only case group that is governed directly by a Marae Committee. The Marae Committee draws volunteers onto the committee from the pool of whanau members in the community. In the past, the types of skills sought to be in the committee included; knowledge of the community, availability, participation in hui, knowledge of tikanga, possession of marae skills and an interest in pursuing opportunities for development of the Marae. The breadth of skills within the committee ensured that at any time, the wider community of Matapihi was mobilised at a moments notice for matters concerning the welfare of Whanau and Hapu. Familiarity that comes with being part of the community ensures that the Marae Committee understands many of the community's needs. However, it also means that members are open to pressures that are different to those experienced by other voluntary type committees. As well, committee members do not have specific professional skills, including those of the formal organisational governance in a context characterised by contracts, legal requirements and health expertise. This has proven challenging to the Marae Committee for various reasons. This comment provides insight into some of the issues, *'...we had a small suite of programmes and then we added things on that we thought were relevant to our community and I was always careful at the time to think well, because we didn't have health professionals or health specialists. We didn't have a health professional background or health services background. I had to make sure that we were able to get contracts that provided services that were relevant to our community and that we could deliver to our community so we've got capability issues that we haven't been able to address'.*

Waipu Hauora has an opportunity to make improvements in the health status of the community despite the challenges associated with the dearth of formal expertise and the voluntary nature of a committee often under specific community pressures and the increasing complexity of health service contracting. Whilst other groups have already been engaged in the delivery of multiple services covering rangatahi, kaumatua, tamariki and specific health related areas, Waipu Hauora has not extensively explored those prospects.

4.2.9 Current Organisational Issues

Waipu Hauora has been in operation for just over nine years. During that time, the number of activities performed by the Health Coordinator has increased significantly. This has occurred particularly within the last two years as administrative duties related to quality compliance have increased and the requirement for sub-contractors to become ISO 9000 accredited was becoming a standard. This added expectation for quality compliance from the Poutiri Trust, who themselves are under pressure from the Ministry of Health has created capability concerns with the Hauora.

The Marae Committee has found it difficult to fulfil the increased requirements involved with delivering health services and decision-making processes are under new pressures. The growing expectations that the Health Committee should provide advice in areas such as employment relations, contracting matters, quality management and health services performance as well as assist with performing the health promotional activities has demonstrated the vulnerability of skills within the Marae Committee. A recent decision to disband the Health Committee of the Marae and then to re-establish it again has also caused problems. The recent resignation of two Health Coordinators within a short period of time has been compounded by the recent resignation of two of its newly re-established Health Committee members. The Marae Committee, the Health Committee and the new Health Coordinator in concert are re-evaluating how to overcome these issues.

The process of funding various ventures is affected by the relationship of the entities within the marae. A concern raised by one of the kaitautoko was related to funding, *'one of the obstacles with the hauora under the marae, is that when you apply for funding, you are not your own entity, you have to go under the marae and then they might be going for things as well. They might go for a grant as well, so there is a conflict or clash. It has its advantages and disadvantages'.* The Marae Committee has become aware of these concerns along with others such as the impact of increased paperwork, *'...[the increased documentation] has a big impact on the whole of the marae – I mean the marae is now like a million dollar business. I think we have to*

look at the quality of the people that we elect to run the marae and that's including the health, that's part of it as well. I don't think [some people] really understand'.

4.2.10 Current Health Issues

The health services and promotional activities provided by the Marae are based on a series of priorities for Maori health articulated within Ministry of Health documentation. The ability to provide services based purely on identified community needs is not as simple as it first appears and attempts have been made to highlight those issues. For instance, *'the range of services were primarily determined by the Government, or the Ministry of Health priorities, so their priorities are cancer and things like that and sometimes when we had our Marae meetings here, one of the Whanau said, how come you know, we got asthmas as a priority? We've only got half a dozen people who've got asthma, but asthma – Maori asthma is a priority for [them]. Well, I don't know if it still is, but [cancer] was a priority area for health funders'.*

During the process of this research, those people involved in the interviews identified a series of unmet health needs and concerns within the community. Here are some priority health concerns highlighted by the kaitautoko, *'I look around and see our kuia and kaumatua here and I think they sit in their homes and half the time nobody knows if [they] are ok. We need somebody to go and support them and I don't know whether this crosses into social services.'* Concerns about the older people were matched with concerns about tamariki, *'it is really to do with kids. There is just nothing here for them and we are trying to focus on tamariki programmes [through health] as well'.*

One comment related directly to how difficult it is to reach certain groups of people. For example, *'I like to get the educators in and get Te Hotu Manawa down again because of heart disease. And even obesity, you see it in the paper about healthy living, changing our lifestyle and all that sort of stuff. But the thing is when it comes to young people, I've found that unless you dangle a carrot at the end, they won't come.'*

The kaitautoko also highlighted that in spite of the contractual arrangements relating to the provision of health services, allowances were always made to accommodate unmet health needs by providing extra services to the Matapihi community as part of the responsibilities performed by Waipu Hauora. For instance, *'you know the contracting arrangement is that you get contracted to provide A, B and C and that's what your contract is for and that is what you report on. Now our community may have wanted A, B, C, X, Y, Z but X, Y, Z and H, J, K whatever, we'd do those ourselves and we would try and run the health operations, irrespective of the contracts. We were quite transparent about that as well'.*

4.2.11 Aspirations Articulated by Kaikorero and Kaitautoko

The aspirations articulated by kaikorero and kaitautoko in the interviews varied. Whilst the goals for Waipu Hauora are articulated formally within its documentation, one of the kaitautoko considered the goal of the Hauora to be, *'Our vision was to get the Provider of the Year [from] Poutiri Trust – but we have a long way to go'.* Further responses included a better understanding of health in general, *'general well-being, for our kids to have better knowledge and a better understanding of health and what it can do for their well-being'.* One kaitautoko was also concerned about the tamariki, *'I want my kids to know exactly what is out there in health and I want them to be able to make choices, with whatever they want to do and I want them to be able to understand that once they do that, and keep doing that, that they know what is going to happen to them. That is why I am working so hard for them'.* A further collective vision for the community was suggested as, *'I think that would be the ultimate vision. Three [marae] coming together.'*

4.2.12 Research Focus of Case Narrative

There are two key research issues considered in this case narrative. The first issue explores the health promotion activities and concepts that are practiced by Waipu Hauora kaimahi, why and how those practices are performed and the way in which people articulate Maori health promotion within the Hauora. Related to those areas of investigation is the need to articulate the broader principles of Maori health, Maori health promotion and Maori health development, and how those activities might

underpin the work of the Hauora. The second issue explores social marketing concepts and critically examines the extent to which social marketing may be considered an appropriate model for Maori health promotion.

4.3 Reflective Conversations

This section presents a series of reflective conversations about Maori health promotion and social marketing within the context of Waipu Hauora. The content is obtained principally from the post-workshop conversation and other kaitautoko conversations. There was one kaikorero involved in the post-workshop conversation and eight kaitautoko involved in the development of the entire case narrative. The conversations have been organised into themes, which emerged during those discussions. Each conversation is contextualised into a theme and then critically analysed. The quotes in italics are a sample chosen to represent the overall concerns. Space constraints did not allow for all comments to be included.

4.3.1 Kaupapa Maori Health Promotion

An important aspect of the research process was to determine whether Maori health organisations such as Waipu Hauora were guided by concepts of health different to other health providers. Kaupapa in this conversation is interpreted to mean *purpose*. For instance, the purpose for Waipu Hauora is *'to improve our health, our knowledge in the health to educate the whole Matapihi Whanau and the wider community'*. The excerpt places an emphasis on the community Waipu Hauora is involved with. A further excerpt provides a vision of what that might look like, *'there could be a few more people involved in it and then it could get up there, more people would come here and knock on the door, not even knock on the door the door is already open'*. The responses suggest that purpose or kaupapa appear to relate directly to the type of activities that are provided by Waipu Hauora.

4.3.2 Vision and Passion

Another theme related to the vision of Waipu Hauora and where it might go in the future and whether the work performed by the kaikorero was connected to that vision.

The following excerpt highlights an interest in *'the kids, I wanted something for our teenagers, there was never [anything] here for us when we grew up'*. Whilst previous health coordinators had been able to focus on *'the whole Whanau'*, the kaikorero said, *'my main drive was the kids, but I have seen the youth that were young when I came in and now they are 18 and we missed them. We are still missing them the ones that are going through, we are lucky enough that some of them have jobs'*. The following comment provides an overview of why it had been difficult to concentrate on the kids and their needs. It clearly demonstrates that working with all Whanau health needs was difficult. For instance, *'...I think if I was solely looking at the youth which is even kids, I mean you can't really join them up with teenagers, they would have benefited more from me.'* The comments suggest that the needs of youth are not being met and that an emphasis placed upon their needs, could provide for a future vision.

4.3.3 Maori Health Development in Tauranga

An important component of the workshop and also the post-workshop interviews was the opportunity to provide feedback about the state of Maori health development in Tauranga. This exercise sought first to obtain comparative responses by participants which were bundled together into a collective overview. The comments suggest that the opportunity to reflect upon the picture of Maori health development in Tauranga was welcome, and the feedback signalled that it was progressive and innovative, *'I thought that was awesome the development that Tauranga has done'*. But the response was tempered by a realisation of the size of Waipu Hauora in comparison to other Hauora, for instance, *'but in saying that Waipu Hauora is only little really'*. A further excerpt brought back memories about a particular whanau member who had been involved in the provision of health promotion services at the Marae. The kaikorero relates those memories to specific health related activities, *'I know she was always pushing for low alcohol drinks, always different drinks with no alcohol in... '*. The comments seem to indicate that Tauranga Moana as a community of Maori health providers has adopted innovative and progressive approaches to health services development and Waipu Hauora was seen as part of that development.

4.3.4 Maori Health Promotion Model

The opportunity to analyse concepts contributing to Maori health promotion, as opposed to health promotion for Maori was provided during the research process. In the workshop participants were actively involved in a process to develop concepts for Maori health promotion that emerged from earlier interviews. The concepts were then contrasted with Mason Durie's Maori health promotion model called Te Pae Mahutonga. The initial response from a kaikorero was, *'a lot of them were similar too'*. When further prompted to discuss the issue in more detail, the following comments were provided, '*I tell you what, I was blown away because being in here and I have heard of Mason Durie but I have never actually read it until this [workshop]...and when I read his stuff it is all to do really with well-being so everything is balanced and I think that is where he was coming from. The next person that comes in here the first thing I will be getting them to do is read Mason Durie. I think reading it helped me'*. There are three points that can be raised from this comment. Firstly, the workshop and the material in the workshop manual exposed the kaikorero to new information. The session was therefore a learning opportunity. Secondly, the concepts focused upon health as well-being and balance. Thirdly, it appeared that the kaikorero wanted to ensure that anyone involved with Waipu Hauora in the future has access to that information. The Waipu Hauora representative at the workshop was one of the youngest in attendance.

4.3.5 Tikanga Maori

A question raised in the conversation attempted to determine whether Tikanga Maori directly influenced the services and activities provided by Waipu Hauora. The first response was, *'Not how I would have liked them to be, they have not really. I mean Aunty Mabel was the one who stressed that. We had a karakia before we started and at the end of the day. I started doing that but I get [one of the koroua] here and get him to do it'*. The kaikorero was aware that there is an expectation to be able to provide services in a way that are consistent with tikanga Maori and she encouraged that with karakia and by getting one of the koroua in to help.

Another excerpt provides a better understanding of all the issues related to the difficulty associated with ensuring that tikanga Maori is adhered to. One of those

issues concerned the burden placed upon koroua and kuia to perform these duties, *'they get hoha with doing it aye? If they don't have to and if we can get out of it we won't do it.* She also reiterated that people who are involved with Waipu Hauora expect tikanga Maori to be adhered to, *'I think they expect it, coming to a marae with a Maori organisation, we should have a powhiri anyway a cup of tea I mean we do it when we hire out the Marae'.* A key issue here is related to the skills base of the person and also the expectations placed upon that person in his or her role. It is one issue to be an effective health promoter, but it is another issue for a health promoter to also be proficient in tikanga Maori and at such a young age.

4.3.6 People Development

Another important issue that arose concerned people, particularly the skills base that they possessed in relationship to the changing environment for the provision of health services. In the following excerpt, the kaikorero explained, *'times are changing now and you have to get up there and be moving with the rest of them'.* When further prompted as to whether it, [meaning the social marketing terms and terminologies] could just be designed and then implemented, the kaikorero responded, *'it wouldn't work in that way'*, and further *'here if you had a set committee for a year that was committed it could be awesome'.* This excerpt suggests that the voluntary nature of the Health Committee impacts upon the potential of Waipu Hauora. The ideal scenario as suggested above is that willing and able people who are prepared to remain part of committee long term are an important pre-requisite to Waipu Hauora's future.

4.3.7 Social Marketing

The evaluation of the usefulness of social marketing as a tool or framework in the area of Maori health promotion is a core issue in this research. An important part of the post-workshop interviews was the active critical review of the model from the viewpoint of the participants. This first excerpt highlights that the model had similar features to the ISO 9000 model, with which the kaikorero was familiar, *'It reminded me a lot of ISO, the planning and satisfying your clients and customers and how do you do that. It had to be measured to analyse your improvements. I think it is a good thing'.* In this excerpt she also thought that it would useful, as it *'would integrate ISO*

into it'. These responses indicate that the kaikorero was familiar with the terminologies and therefore could see value in its adoption and use.

4.3.8 Social Marketing Concepts and Terms

The social marketing model is founded upon a set of assumptions and concepts that describe health differently to what is articulated within the areas of public health and also Maori health. Another question raised in the post-workshop conversation was concerned with obtaining some insight into what the kaikorero thought of these concepts and assumptions. The kaikorero reiterated that it is possible to see whanau as a market, *'well they are [a market] in a way, well this place wouldn't hold a contract if it wasn't for our Whanau or Hapu they are our clientele'*. However, the kaikorero was concerned that, *'it doesn't sound good'*.

The inter-changing of terms used within Waipu Hauora was an issue that arose during the discussion. In regards to social marketing, the types of terms used are derived from the marketing discipline and include; market, marketing, target markets, customers, clients, price and so forth. The kaikorero related the use of marketing terms such as client and customer to be, *'just terminology in the Pakeha sense'* and that some explanation of that needed to take place for others to understand that. It was clarified that *'client or customer means whanau and the same [applies] for the whole meaning to social marketing and we were already changing words aye?'* It was suggested that the terminologies used, were not a great concern and that to overcome any concerns the terms were just changed by, *' taking words out and that was just so it was easier for us to understand'*. These responses suggest that the people of the Marae have in place a language or set of codes that already describe who people are, how they interact with each other, and that the use of social marketing terms whilst occurring is not automatically accepted, or viewed positively. The suggestions to overcome those concerns involved the process of removing particular words or replacing them.

4.3.9 The Marketing Mix

The marketing mix is a marketing concept that includes four elements; price, promotion, place and product. When adopting a social marketing framework, the use

of the marketing mix is a pre-requisite. This area of questioning was concerned with exploring what the kaikorero thought about the adoption of that tool. The kaikorero responded that it would be, *'an improvement, especially the promotion side of things'*. It was also explained that these types of tools are already being adopted, *'we are using it in a way, the venue, the budget, who we were targeting and our target age group'*. The responses suggest that as there are already steps being taken now to utilise the specific terms, it would be an improvement upon the existing methods of health promotion utilised by Waipu Hauora to fully implement the model.

4.3.10 Social Marketer or Health Promoter

Another aspect of inquiry in the research examined social marketing labels, particularly the terminologies used to describe his or her role in Waipu Hauora. The first excerpt is concerned with the position held by a person. The kaikorero thought the name of the position should be accurately reflected in the types of roles and responsibilities that he or she is performing within the organisation. As a result, she felt that, *'[she] never liked health promoter and that coordinator was better than promoter or facilitator'*. But, she also felt that the use of social marketer was also inappropriate. In her response she says, *'social marketer sounds flash and it doesn't really sound like 'health''*. The use of the word social marketer conjured up different images of the activities that would be performed. For instance, *'you couldn't really think the two people are the same thing or that the two names were the same, 'social marketer' and 'health coordinator'*. The kaikorero thought, *'[social marketing] sounds like they are out there advertising and promoting, advertising kind of like what the health promoter wants....'*. The response indicates a degree of apprehensiveness towards the use of the term social marketer.

Kaitautoko Responses

Another kaitautoko provided specific feedback about the use of social marketing within the area of Maori health that was not part of the post workshop review. The following excerpt indicated that the kaitautoko had learnt about marketing principles and as a result the use of marketing was viewed as appropriate. For instance, *'I think it is good to market. I feel like I am marketing when I put out my flyers. I feel I am*

marketing in some way, when I try to get people involved in whatever I am doing, I feel it is right.' When prompted to explore those thoughts further, the following response was provided, *'my thinking about marketing is you go out there and market your organisation and promote and tell them what it is about... '.* A further prompt was explored related to the expectation that concepts such as taha wairua and taha hinengaro were also included in the health promotion contracts of groups such as Waipu Hauora alongside the use of social marketing models. The intermingling of the two different sets of concepts appeared to present difficulties as the following excerpt suggests, *'I think that is hard, because we are based on the marae and whenever we hold a hui, we use our tikanga Maori...that is where we are at and we are on a marae and a lot of hauora are not on a marae.*

4.4 Other Kaitautoko Responses

This section explores a number of issues raised in conversations with kaitautoko that did not emerge during the post-workshop interviews. They relate primarily to two core issues about health services in general and then about the wider context of Whanau, Hapu and Iwi development.

4.4.1 Contracting Nature of Hauora – Whakapapa Connections

An issue raised by one of the kaitautoko in the earlier start up period of Waipu Hauora, was the need to ensure that links by the Marae and Hapu to the Iwi were acknowledged and maintained, *'I had to go to the Iwi, to Ngaiterangi and the Marae nominated me to Ngaiterangi and this was sort of done on a spiritual basis, because I knew that without Iwi input, we would not get support'.* This excerpt highlights that the Marae Committee was required to consider aspects of relationship building that were different from other voluntary organisations and based on tikanga Maori.

4.4.2 Competitive Environment of Hauora

It was also highlighted that the environment for the provision of health services to Maori, by Maori has become competitive. The following response provides insight into that environment, *'as the providers worked through the issues, then it became a lot tighter because, I think the potential of what could be provided – the size of the*

contracts, the requirements of accountability from the funding organisations and it is almost what I term as quite competitive and competitive in a sense that you had to be really organised to be able to get contracts to deliver health services so I think it was a question of, well you had to do it or you were going to fall by the wayside'. The excerpt suggests that if Maori health providers were not organised in a way to ensure accountability measures were in place to do the contract right, they would not be in a position to tender for any further contracts. Issues about competitiveness and tendering conjure up the idea that health is a business enterprise.

4.4.3 Accountability

An important issue was related to the accountability measures that Waipu Hauora had in place. The concept of accountability was interpreted to mean the ability to measure whether the public funds provided as part of the services contract were accounted for through contractual obligations and annual audited accounts. Alongside those sets of accountabilities, was the emphasis placed upon demonstrating 'evidence based' measures of success in increasing the number of people quitting smoking, or the number of people taking up exercise for the first time. These second lot of accountabilities appeared to be a secondary consideration as the following comment suggests, *'...everything has to be measurable, they just said that the paperwork is not going to decrease, it is going to increase and everybody needs to be more accountable in how you are going to demonstrate how many people you had this year giving up smoking and that is a hard one because there are people that are auahi kore. I spoke with a colleague and he said, that he offers all of the information but it is up to [them] to give up and to make that decision and what he does is that he records the contacts'.*

4.4.4 Innovative Spirit

Comments provided by kaitautoko highlighted the innovative spirit that influenced the way some health services were delivered. There are two examples that demonstrate that creativity in the design of services and programmes was encouraged. The first example related to the introduction of Whanau health plans. At the time that the plans were suggested, Waipu Hauora was one of the first in Tauranga to

implement them, *'the philosophy to develop the Whanau health plan is in that you identify the health needs of that Whanau and then target, you know, the services that you are providing out here align with those needs you are providing. For example an asthma service for Whanau A, they've got two people who have asthma, but they actually don't participate so we'll target them and get information to them specifically about that programme. So, what happened when the requirement – or the opportunity to provide Whanau health services came up, Poutiri Trust negotiated with us and its providers, to say well we want you to provide Whanau health plans and that's where the target for us was made and what we did for the other providers – so that was a hell of a change'.*

A second example related to the recent hui held at the Hungahungatoroa Marae about the drug P. The problems associated with the use of the drug P within the community have surfaced as a serious problem. The hui was well attended by the community, *'We had a hui on the drug P, and it was actually fantastic and that was at the marae and that is what we did. If people request a service from me, I try to do my best. So, that will be coming in my plan this year, so this week I am going to be taking some of the ideas that [the previous health coordinator] has, and I want to change some things that she has done'*. There are still avenues for the exploration of new ideas and new approaches within Waipu Hauora. This point was raised in the excerpt below, *'I need help with the ideas and things like that. I need help with the ideas especially with the rangatahi. You have to try and think of new ideas and sometimes it is hard for me. And that is where the Matapihi Sports is the way to go. Putting out flyers is just not enough and you have to have people coming out too, professionals eh'.*

4.4.5 Community – Hard to Reach

Despite the range of health services provided to the community, there still remained an element within the community that were characterised as hard to reach. One kaitautoko for instance explained, *'you see that is also the thing with our people eh, it's like they are whakama and then they're just too bloody lazy you know'*. The impact of this realisation with Waipu Hauora is that some of the more contentious

services like drug and alcohol education were not necessarily attended by those who were defined as those who would benefit the most.

4.4.6 Taha Wairua – Concept of Maori Health

In contrast to most of the responses about health and whether Waipu Hauora adopted a Maori concept of health or not, one kaitautoko articulated a holistic concept of Maori health derived from Taha Wairua. The kaitautoko highlighted that Taha Wairua encompasses the cultural values that underpin Whanau and Hapu identity and that this concept should underpin any Maori health promotion model, *'so we've got the health stream out here, you know, I'll just refer to it as Taha Maori, that Taha Wairua side, which we've lost and we need to sort of grab that and try and – I mean, just going back to the marketing and Maori model, in that you would think that if we were absolutely strong about – you know about our values and about what underpins who we are and about you know the value of Whanau, Hapu and the way of holding on to those sorts of values and practicing – if we held – if we understood them and we held them we'd be able to practice them. Essentially that's the model and that's the marketing thing, but we are sort of not able to market it at the moment, we're not able to market that because we haven't got it and we somehow sense that we've got to grab some of the stuff back somehow – and get it to underpin the way we operate, we need our community to do that, but in the meantime we've sort of got to keep going along this pakeha stream if you like, adapt it to Maori health delivery because we've got no choice'*. The excerpt shows that the kaitautoko was deeply concerned that the community might be inclined to utilise marketing as a model for health promotion, on the basis that we currently have no other choice.

4.4.7 Community as a Contradiction

One comment focused upon the contradiction that exists within the Matapihi community. In the view of a kaitautoko, although the community is a strong network of Whanau, the energy behind those strong Whanau is not utilised to bring about enormous change in the area of health, for example, *'I say that we are a contradiction because our Whanau here is really strong, they're a really strong close Whanau, but when it comes to some of those things like that, you know that they enjoy [such as the*

use of marijuana], that's the part I think you would think that we could achieve enormous things here [such as eliminating the use of drugs]'. The response suggests that the community can be mobilised with respect to Whanau and Hapu matters, as long as it does not disrupt what they come to see as normal.

4.4.8 Deep Concerns about Iwi, Hapu, Whanau Identity

A series of comments were raised about identity and how as Maori the community is different and that that difference should be cherished. The comments were articulated as a conversation resembling deep concerns about the potential loss of Whanau, Hapu and Iwi identity. One of the excerpts related to those comments is highlighted, *'...I mean we are different and you know, we can even talk about being colonised and integrated and all that stuff, but fundamentally we're different – we're absolutely different and I think that if we stop acknowledging that we're different and if we lose sight of why it is that we are different and the things that underpin those differences, then you know, we'd be lost – a lost people. So the connections are really strong with me and yeah they do start with the Whanau and then whakapapa and Whanau in the wider sense but it starts with the initial immediate Whanau but you know, your Whanau in terms of your marae and Hapu and those links are really really strong. I mean and I think in Matapihi, like at times I despair, I get frustrated because we're just well placed as a community as a Hapu and a Whanau, but this section of Tukairangi is not isolated, but contained, we're in a confined geographical area, we've got our land around us, we all live together, we socialise together and so we're still able to on a daily basis, just keep those really close ties and bonds, but it seems to me that we have a generation of us which is the generation at risk because we don't – we've almost sort of take that stuff for granted and don't have an understanding or a framework of our wider self – there's an element I think that's missing in our community – and I talk about it periodically, around our Ngai Tukairangitanga and that's about who we are and the people and you go over to Ngati Awa on the other side of Mataatua and they're really strong about their connections.'*

The concerns that surfaced by the kaitautoko about loss of identity as a Whanau, Hapu and Iwi is contextualised within the possibility of Matapihi being urbanised and

the threats posed to the community as a result. It is his belief that as a community, things are taken for granted, *'I think it's a huge issue for us. It might not happen in ten or fifteen years, but eventually you can see the pressure coming on this area so much, that we are going to succumb eventually and then I think that once that happens we're going to become urbanised. I can't even bear to think what this place would be like. We need to organise ourselves to wake out of our lethargy because I don't think we actually are asleep, it's just that we take things for granted.'*

4.4.9 Te Whakaoho Mauri - Hope

Despite the deep concerns raised about the loss of identity and the emerging threats to the Matapihi way of life, there is always a glimmer of hope. The excerpt below provides a glimpse of how the reclamation of Te Ao Maori could play a role in awakening the community. *'My hope is that we can organise ourselves and we can strengthen our identity and I think we need to do that, I was going to say, its not selfish, we have to be selfish, absolutely selfish about protecting our identity of who we are. This whole thing is around your opportunities, this is the value thing around your obligation to protect things for the next generation'.* Another positive point that emerged related to the mass of talented people within the community. For instance, *'one of the real positives for me is that, like you were saying before, absolutely true – we've got a lot of talented people'.*

4.5 Conclusion

Waipu Hauora is a marae based, marae run health organisation that provides health promotional services to the Matapihi Whareroa community in Tauranga Moana. In Section 8.2 of the case narrative I provided an historical overview of Waipu Hauora with the view of setting the scene for a critical inquiry into the extent to which social marketing might be adopted to enhance Maori health. Sections 8.3 and 8.4 were concerned with presenting aspects of the reflective conversations that arose during the research process. The major findings that have been drawn from those conversations are outlined below.

The research conversations indicate that there is a genuine desire by kaitautoko of Waipu Hauora to provide a range of health promotional activities and general

practitioner services that meet the needs of the community. That vision has remained constant throughout the nine-year history of the Hauora and it is articulated as a sense of responsibility to care for tamariki, kaumatua and kuia; the most cherished groups within any Maori community.

A number of emerging trends within the health services environment have exposed kaimahi and the Marae Committee to a series of organisational vulnerabilities. One of those trends is the increasing expectation that Waipu Hauora is accountable in terms of measurable expectations specified by the new forms of contracts through which their work is now resourced. This is a shift from the historical focus upon attempting to match health services with the specific needs of the community in ways appropriate to and understood by the community. The new set of expectations has created a mismatch of expertise in the ranks of the Marae Committee. What is desired by the contract and what is required for the community are now calling on differing skill sets. These new pressures have exposed a contradictory expectation by health funding authorities that Marae Committee, which are largely voluntary community based groups, should provide the skills base that meets the contractors preferred operational requirements in ways recognised by the contractor.

Concerns about the increasing subjugation of health services to business related practices and methodologies was demonstrated not only by the increasing familiarity of kaitautoko to business related terminologies but also by a considered resistance to the translation of human need in their communities into a market model. The reconfiguration of people into clients or consumers is one such example. The reconfiguration of services into products is another. Concerns that the holistic care for others that they associate with Maori health enhancement is diminished in this model sits at the heart of this concern.

The provision of health services is changing so extensively that Whanau of Marae and Hapu are constantly under pressure to comply with new employment, health and quality regulations. Two findings emerged as a result of the research conversations associated with this study. The first observation was that different conceptual

approaches to health provision are infiltrating the way that Whanau think about health, for instance health was in threat of being seen as one business arm of the Marae. A second observation was the emerging domestication of Whanau to serve the contract and its specifications rather than the needs of the people. There is therefore a threat that Whanau are being driven by the expectations of the contract and not the desire to address the health needs of the community. Risks of losing badly needed resources provided through the contracts and the desire to provide for the real and urgent needs of the community are generating increased levels of stress.

The ability of Whanau to articulate a series of health aspirations based on Taha Wairua within the confines of a services contract is being minimised. Kaimahi are so busy *'doing'* health, that there is limited time available to ensure that what is being provided is what the community actually wants and needs. There is also a need to align the future foundation of health services offered by Waipu Hauora within the conceptual frameworks of Hapu and Iwi health development.

The initial purpose of this study was to inquire into the extent to which social marketing might be usefully adapted and harnessed to the achievement of Maori health enhancement. The exploration of prominent social marketing models and concepts with the community provided insightful discussions. On the one hand, kaikorero suggested that the model would be beneficial. In their view, marketing involved everything from promotion to advertising. Even conceptually, for some the idea that Whanau could be likened to a market was seen as reasonable and a familiarity with the terms already existed. Others were concerned about the limitations of the glossary of terms and its implications. There was one kaitautoko who was very critical of the adoption of marketing based practices and suggested that the only reason why it might be adopted was because there was currently no Taha Wairua based model that presently existed. For instance, '*...we've got to grab some of the stuff back and somehow – and get it [taha wairua] to underpin the way we operate, we need our community to do that, but in the meantime we've sort of got to keep going along this pakeha stream if you like, adopt it to Maori health delivery because we've got no choice'.*

However, there were three key aspirations articulated within this case narrative. Firstly, the loss of identity within the Matapihi Whareroa community is a major threat to the very existence of community. There is a dire need to proactively liberate the community to heed the warnings that are being signalled as part of this report. As such, the desire to have a Taha Wairua approach to health was seen as an aspiration by the kaitautoko. Secondly, it was highlighted that kaumatua, kuia and tamariki are groups within Matapihi Whareroa that possess specific health related needs and those needs should be emphasised as part of any future health promotion contracts that Waipu Hauora is involved with. Finally, there is a vision expressed by kaitautoko to unite the three marae and work in the interests of them all in terms of delivering health services in the future. These visionary goals provide an enormous scope for community led health development in the future for Waipu Hauora.

To conclude, the case narrative had sought to critically examine the extent to which social marketing may be useful to Maori health development. As an isolated research inquiry, it would have been possible to conclude that social marketing is an improvement to the methodologies currently adopted by Waipu Hauora. However, during the research process it became imperative to examine many facets of Waipu Hauora and the current conditions in which it operates. When those broader issues within the health environment for Maori health providers were revealed, it was clearer that whilst social marketing may have provided temporary improvements to the way that health promotion is delivered by Waipu Hauora kaimahi, in the long term the risk that it might serve an assimilist project that contradicts any Taha Wairua approaches to the enhancement of Maori health in the future must be noted.

4.6 Recommendations

There are four recommendations that have been identified as part of this case narrative. They are provided for the benefit of the Hungahungatoroa Marae Committee, the Health Committee and the Health Coordinator. The recommendations are also directed towards the Poutiri Trust; in the hope that serious critical thought is made to address some of the concerns raised in this case narrative.

That the Hungahungatoroa Marae Committee in collaboration with the Poutiri Trust re-examine the way in which health service contracts such as Whanau Ora are formed. It is recommended that the health goals identified in the contract are decided in collaboration with representatives of the Hungahungatoroa Marae Committee and that those health goals are based upon the identified health needs of the community and the concerns raised about loss of *Taha Wairua* in this case narrative.

That the Hungahungatoroa Marae Committee in collaboration with the Matapihi Whareroa community reclaim and reinstate a holistic approach to Maori health development founded upon *Te Ao Maori* that emphasises and addresses the concerns raised about identity loss by kaitautoko in this case narrative. It is recommended that regular kaupapa hui are held to identify what the community identifies as kaupapa and that those suggested activities become the foundation of the way in which health services are provided to the community by Waipu Hauora.

That the Hungahungatoroa Marae Committee consider enhancing the skills set of the Health Committee by including some Whanau members that currently are not on the Marae Committee and that this change is viewed positively.

That the Hungahungatoroa Marae Committee create, assert and comply with accountability measures that meet their service requirements whilst acknowledging that the Poutiri Trust needs assurance that the resources provided as part of the contract are used and managed appropriately. It is also important that the contract language be simplified to reflect an agreed understanding between the two partners.

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