The Treaty of Waitangi Principles in

He Korowai Oranga – Māori Health Strategy:

An Effective Partnership?

A Critique from the Perspective of TB Care

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Abstract

The three Treaty principles - partnership, participation and protection now frame policy actions in *He Korowai Oranga - Māori Health Strategy (2002),* for the purpose of engaging Māori in the health sector. However, the effectiveness of the Treaty of Waitangi principles in legislation is frequently disputed. Treaty clauses are often vaguely worded and rarely give the reader explicit direction as to the actions required. Given the lack of definitional clarity and the normally indeterminate manner in which Treaty principles are applied in legislation, the recent use of Treaty principles in Māori health policy raises the question. What do the Treaty principles mean in He Korowai Oranga – Māori Health Strategy?

How Treaty principles have influenced the shape and effectiveness of health services, is investigated from the perspective of health service users who are Māori. Information was gathered from interviews with Māori participants (n=10) who were diagnosed with tuberculosis (TB) within the Auckland Public Health Region from 2002 to 2005. Participants have considerable experience within the public health sector, as treatment for TB often requires hospitalisation and a lengthy period of drug therapy. An analysis of the Treaty principles using Deborah Stone's policy paradox theory identified key attributes of each Treaty principles, which was then comparatively evaluated with the experiences of study participants.

The findings of this research are that Treaty principles have influenced He Korowai Oranga - Māori health strategy only to the extent of supplying a framework for enabling Maori involvement within the health sector. The intersection of economic changes, international trends, Māori development and fiscal imperatives in the health sector has served as more significant influences. Māori providers are at the nexus of these changes. Further research is recommended into the Māori health service user preferences and usages of Māori Health providers.

Acknowledgements

Table of Contents

List of Tables

Māori English Glossary of Terms

Hapu	Sub-tribe
Hauora	Lifebreath, health
Hinengaro	Thoughts, feelings, mental
Hongi	Press noses, greeting
Iwi	Tribe
Kaiawhina	Helper, assistance
Kanohi ki te kanohi	Face to face
Karakia	Prayer
Kaitiaki	Guardian
Kaupapa	Purpose
Kaumatua	Male elder
Matauranga	Information, knowledge, education
Mihi	Greeting
Mirimiri	Massage
Mokopuna	Grandchild
Rangatahi	Youth
Rongoa	Herbal remedies
Tangata whenua	Local people
Taniwha	Mythical creature, water monster
Taonga	Treasures or anything highly prized
Tapu	Sacred
Te o Māori	Māori world/perspective
Tikanga	Protocols and practises
Tinana	The body, physical
(tino) rangatiratanga	Sovereignty
Tohunga	Expert, specialist, priest
Wairua	Spiritual, faith
Whakapapa	Genealogy, cultural identity
Whanau	Extended family
Whanau ora	Healthy families
Whare tapa wha	A four sided house

Abbreviations

ARPHS	Auckland Regional Public Health Service
DOT	Directly Observed Therapy
MAPO	Māori Co-Purchasing Organisation
MDO	Māori Development Organisation
NZPHD	New Zealand Public Health and Disability (Act)
PHN	Public Health Nurse
PHCS	Primary Health Care Strategy
SAT	Self-directed Therapy
TUHANZ	a Treaty Understanding of Hauora in Aotearoa-New Zealand
WHO	World Health Organisation

CHAPTER ONE

Introduction

In this thesis I investigate the meaning of Treaty of Waitangi principles in Māori health policy and whether the Treaty principles have influenced the shape and effectiveness of health services from the perspective of health service users who are Māori. Despite the effectiveness of the Treaty of Waitangi principles in legislation being frequently disputed, the Treaty principles - partnership, participation and protection now frame policy actions in *He Korowai Oranga - Māori Health Strategy (2002),* for the purpose of engaging Māori in the health sector.[1] Treaty clauses are often vaguely worded and rarely give the reader explicit direction as to the actions required. Given the lack of definitional clarity and the normally indeterminate manner in which Treaty principles are applied in legislation, the recent use of Treaty principles in Māori health policy raises the question. What do the Treaty principles mean in He Korowai Oranga – Māori Health Strategy?

This research is part of a larger Tuberculosis (TB) study - the University of Auckland Anthropology Department, *Political Ecology of Tuberculosis in New Zealand Research Project*, investigating TB across five different ethnic groups. Information was gathered for the Political Ecology of TB Research Project and for this study from interviews with Māori participants who had been diagnosed with TB within the Auckland Public Health Region from 2002 to 2005.

Participants have considerable experience within the health sector, as TB treatment involves a lengthy period of drug therapy and hospitalisation. An analogy can be drawn between the continuing relationship participants have with the health sector and expectations derived from understandings of Treaty principles. An assumption is made that in most interactions with the health sector, individuals will anticipate reasonable consultation, a duty of care of health professionals and the ability to access health services. These expectations

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[1] *Ministry of Health*, He Korowai Oranga – Māori health policy. Ministry of Health Website, (2002a). Accessed 12/12/04, http://www.moh.govt.nz.

reflect meanings attributed to the Treaty principles, partnership, participation and protection. In this study, the key issue is whether these interpretations in health policy are derived from the Treaty meanings or from other more potent influences.

Tuberculosis has been a significant killer of Māori people. While data was not collected on the incidence of TB among Māori until the 1930s, where rates were shown to be ten times greater than Pakeha, anecdotal reports indicate that Māori communities were ravaged by the disease throughout the nineteenth and early twentieth century prior to the collecting of statistical data.[2] Although, the incidence of TB amongst Māori has improved significantly, every participant in this study except one could name a relative who had died from TB. Even a number of my relatives have died from the disease. Currently, rates of TB among Māori remain twelve times higher than those of Pakeha.

TB is most often associated with overcrowding, migration and poverty. Poverty remains the single most important determinant of ill health, determining life expectancy and morbidity.[3] A key determinant of poverty amongst Maori was the lack of recognition of property rights following the Treaty of Waitangi. Settler control of the mechanisms which distribute property rights greatly determined the economic impact of colonisation on Maori.[4] Māori have remained on the economic fringes with most located in the lower stratum of employment, education and income. In 2001, the average income was $24,000 p.a., yet 56 percent of Māori adults had an income of less than 15,000p.a.[5]

The interplay between TB, poverty and the Treaty of Waitangi has relevance for this study. The manner in which the Treaty of Waitangi was originally interpreted rendered many Māori impoverished and susceptible to infectious diseases like TB. Similarly, how the Treaty principles will be applied

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[2] L. Bryder, 'If preventable, why not prevented?': The New Zealand response to tuberculosis, 1901-1940, in L. Bryder (ed.), *A healthy country, essays on the social history of medicine in New Zealand,* Wellington, Bridget Williams Books, (1991), p.109.

[3] Hofrichter, R. (2003). The politics of health inequalities: contested terrain, in Hofrichter, R. (ed.). *Health and social justice – politics ideology and inequity in the distribution of disease.* San Francisco, John Wiley & Sons, pp.1-3.

[4] S. Liebcap, *Contracting for property rights.* New York, Cambridge, (1989), p.1.
[5] *Te Puni Kokiri*, Maori in New Zealand – Maori work and income statistics, Te Puni Kokiri Website, (2001). Accessed 8/12/04, http://www.tpk.govt.nz/maori/work/default.asp

and interpreted within the health sector, will have a direct bearing on health outcomes and experiences of health service users who are Maori.

Interpretations of Treaty principles are informed by many influences. Changes such as Treaty claims, Māori demands for greater self-determination, Waitangi Tribunal reports, Iwi development, high profile Court cases and apparent Government response to Māori issues have been construed in the wider electorate as being predicated on the Treaty. Consequently, interpretations of the Treaty are often contentious, informed by perceptions of inequitable distribution of economic benefits and rights. Such notions form the basis upon which the Treaty principles are generally understood.

In order to determine which of these interpretations might inform the use of Treaty principles in He Korowai Oranga, Deborah Stone's *Policy paradox (2002)* theory is applied. Identifying the underlying attributes of each of the Treaty principles, may give clarity to their use in the context of Māori health policy.[6] This theory is more fully discussed in Chapter Three.

This analysis begins with a discussion of the influence of Treaty of Waitangi perceptions to general understandings of Treaty principles in Chapter two. I argue that public perception of Treaty principles reflect Government responses to Treaty related issues. In Chapter three, Deborah Stones Paradox theory is applied to the Treaty principles, to distinguish attributes, commonalities and expectations that might be derived from using Treaty principles in Māori health policy. Chapter four, outlines the research methods and analysis, and discusses issues confronted by the researcher in applying a Kaupapa Māori approach to research. In Chapter five, the themes determined in participant narratives are categorised according to the Treaty principles.

In Chapter six the influence of the Treaty principles in He Korowai Oranga is discussed in three key areas: the intersection of devolution with international trends and domestic social and political changes, the present and future role of Māori health providers in He Korowai Oranga and the issue of Māori identity, as relevant to this research, is also discussed briefly.

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[6] D. Stone, *Policy paradox, the art of political decision making- Revised Edition*, New York, W. W. Norton, (2002), pp.8-14.

The research results indicate that the Treaty principles have been applied only as an enabling framework in He Korowai Oranga to engage Māori in and with the health sector.

CHAPTER TWO

The Treaty of Waitangi:

the origin of Treaty Principles

Introduction

This chapter outlines some of the more contentious interpretations that influence current perceptions of the Treaty of Waitangi. It is argued that these shifting interpretations associated with the Treaty, have allowed successive Governments to strategically avoid clarifying the official status or meanings of the Treaty. More importantly, the effect of the Governments inaction has negatively influenced perceptions associated with the Treaty and increasingly obscured the original intention of Treaty principles.

Until recently, the Treaty of Waitangi was relatively unknown. The rapid shift from obscurity to prominence has been the result of a confluence of factors. Māori activism, the Treaty settlement process, Iwi development and the Waitangi Tribunal have each contributed to the shifting meanings associated with the Treaty of Waitangi. As such, the Treaty has come to represent many understandings, beliefs and expectations. Consequently, the value, meaning and relevance of the Treaty in contemporary New Zealand society is frequently contested.

Perhaps the most contentious aspect of the current Treaty debate centres on the use of Treaty of Waitangi principles in policy. Treaty principles are derived from the underlying tenets of the Treaty and are assumed to bridge the literal differences between the Māori and English Treaty texts. Principles are not intended to supplant the Treaty, but rather to inform its application in contemporary circumstances. Yet, there is no universal agreement as to the exact meaning of the principles and it is not known if all possible interpretations of the Treaty have been identified. Experts agree that the evolution of principles is dynamic, on-going and, therefore, the compilation of a

complete and comprehensive list of principles may never be possible.[7] This apparent indeterminate aspect of the principles has generated a great deal of disputation.

At the second reading in Parliament of the Treaty of Waitangi Bill (1975), the now late Venn Young (Member of Parliament for Mount Egmont) predicted that without clear definition, the principles 'would lead to debate, dissension and even divisiveness within the community'.[8] In part this was reflected through past surveys where respondents declared they neither understood nor cared about Treaty principles. Subsequently, they believed the Treaty principles should not be included in legislation.[9]

In 2005, the lack of clarity accompanying the phrase 'Principles of the Treaty of Waitangi' in legislation resulted in the tabling of the *Treaty of Waitangi Principles Bill*.[10] Within current legislation Treaty clauses are often vaguely worded without any accompanying clarification as to how the clause should be practically implemented. Some illustrative examples include, 'to give effect to' (Conservation Act 1987) and 'all persons exercising powers under this Act shall take into account the principles of the Treaty of Waitangi' (Hazardous Substances and New Organisms Act 1996).[11] Because definitions of Treaty principles are wide-ranging, application of such clauses require detailed knowledge about the principles, the specific context in which the clause is implemented and Māori cultural practices, protocols and beliefs.[12] Winston Peters, a Māori who has had a long career as a Member of Parliament and who has served as a Minister in both national-led and Labour-led coalition Governments, has been a long standing critic of the Treaty clauses in legislation. In Peters' view, all references to the Treaty principles in New Zealand statutes should be eliminated.

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[7] J. Hayward, (1997) quoting Professor Orr, p. 30.

[8] J. Hayward, Flowing from the Treaty's words, in J. Hayward & N. R. Wheen, *The Waitangi Tribunal, Te Roopu Whakamaa I te Tiriti o Waitangi*, Wellington, Bridget Williams Books, (2004), pp.29-30).

[9] National Business Review poll, 15 August 1989 cited in J. Kelsey, *Rolling back the State*, Wellington, Bridget Williams Books, (1993), p.236. NBR is considered a right-wing publications.

[10] R. McVeagh, Treaty of Waitangi Principles Bill [Member's Bill - Rodney Hide], in *Public Law and Policy Newsletter*, (19 December 2005). Accessed internet December 27/12/05: http://www.russellmcveagh.com/Newsletters/PublicLaw/PublicLawNews-Dec05.htm

[11] *National Party Website*, Examples of the principles in legislation. Accessed internet 21/11/05 http://www.national.org.nz

[12] B. Smythe, *Treaty principles ill-disposed to health delivery*, National Business Review, 5 March (2004).

Earlier in 2005 he introduced an unsuccessful member's bill, the *Principles of the Treaty of Waitangi Deletion* Bill (2005) calling for the removal of all Treaty clauses.[13]

Another significant factor in the Treaty debate is that the status of the Treaty of Waitangi is ambiguous. The Treaty dominates this country's intellectual landscape,[14] yet it has relatively little legal and constitutional power. Further confusing perceptions of the actual status of the Treaty are political rhetoric, media reports, inconsistent policy measures and Māori interpretations and expectations of a Crown duty to honour the agreement.

Although the Privy Council (1941) acknowledged the Treaty of Waitangi as a valid Treaty of cession, an agreement between sovereign peoples, the Treaty sits outside domestic law and internal governance, except where given effect in statute.[15] While over sixty statutes mention the Treaty of Waitangi, relatively few actually create legally binding obligations on the Crown.[16] Currently, the Privy Council ruling on the Treaty's legal status appears to stand, despite a number of past Court cases potentially capable of challenging the orthodoxy of that decision.[17]

The Treaty is accorded 'constitutional-like' status as our founding document - a sacred pact by Government, Māori and public agencies. However, the extent of constitutional recognition afforded the Treaty, is more symbolic than real, according to Boast et al. (2004), often amounting to 'little more than pious platitudes'.[18]

Currently, New Zealand's constitution is unwritten having evolved through different laws and conventions, rather than relying on any one document, as in other countries. A 2005 Parliamentary Select Committee considered the possibility of a written constitution. While the Treaty was acknowledged as a critical component in the

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[13] *W. Peters*, The principles of the Treaty of Waitangi Deletion bill, Members Bill 2005, No 247-1. Accessed internet 10/01/06 http://www.brookers.co.nz/bills/defeated/b052471.pdf

[14] A. Sharp, The trajectory of the Waitangi Tribunal, in J. Hayward & N.R. Wheen, *The Waitangi Tribunal, Te Roopu Whakamana i te tiriti o Waitangi*, Wellington, Bridget Williams Books, (2004), pp. 195-206.

[15] *Te Heu Heu Tukino v Aotea District Māori Land Board, (1941).*

[16] For some examples of statutes refer Barrett & Connolly stone, (1998); National party website.

[17] See Boast et al discussion of the 1987 New Zealand Māori Council v Attorney General, Attorney General v New Zealand Māori Council 1991 and New Zealand Māori Council v Attorney General 1992, p.4-5.

[18] R. Boast, A. Erueti, D. McPhail, N.F. Smith, *Māori land law, second edition*. Wellington, Lexisnexis, (2004) p.3.

development of a constitution, it was deemed unlikely to be the foundation of such a document.[19]

The recent rise in the Treaty's prominence was, in part, initiated by Māori protest action. Despite the infamous Chief Justice Prendergast's 1877 dismissal of the Treaty as a 'simple nullity,'[20] for many Māori, the Treaty then and still continues to remain salient, a source of considerable social and economic injustice. Māori discontent regarding the extent to which the Treaty had been implemented simmered, almost since the Treaty was signed. During the 1960's a number of Māori leaders evaluated the Treaty's power in terms of delivering rights anticipated by Māori, as 'little more than a piece of paper.'[21] Although Māori had pursued legal action many times since the Treaty signing, few if any of these cases were successful. One of the few remaining strategies left for raising awareness of the importance of the Treaty to Māori, was public protest.

Until this time, many New Zealanders believed that their country was a shining example of race relations. A pervasive welfare mentality sustained a national belief that New Zealand was a raceless, classless society that cared for Māori and Pakeha alike, without significant extremes in attitude or possession.[22] The idiom of 'one law for all' prevailed. A study by David Ausubel (1960) found that in fact there were high levels of Pakeha prejudice and intolerance, with Māori experiencing considerable discrimination as hotel patrons and workers. He concluded New Zealand's excellent race relations reputation was the result of limited contact between Māori and Pakeha and was as yet an untested assumption.[23]

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[19] E. Durie, *The Treaty of Waitangi in New Zealand's constitutional structure,* a paper presented to 22nd Australasian and Pacific Ombudsmen Regional Conference, Wellington, 10 February 2005. Accessed internet 1/02/06, http://www.ombudsmen.govt.nz/APOR%20docs/Judge%20Eddie%20Durie.pdf
Stuff Website, Government responds to constitution committee, (3 February 2006), Accessed internet 4/02/06, internet http://www.stuff.co.nz/stuff/0,2106,3559902a11,00.html
New Zealand Herald, An interview with Peter Dunne, (April 1 2005).

[20] *Wi Parata vs the Bishop of Wellington 1872.*
[21] Rui Barclary, (1960), declared the Treaty had done little for Māori and was 'little more than a scrap of paper'; Iriaka Ratana – Member of Parliament (1960), agreed saying the Treaty was 'little more than a scrap of paper'. Accessed internet "Made in New Zealand Website, 20/01/06 http://www.Treatyofwaitangi.govt.nz/quotes/1960.php

[22] J. Kelsey, Aotearoa/New Zealand: the anatomy of a state in crisis, in A. Sharp, (ed.), *Leap into the dark*, Auckland, Auckland University Press, (1994), pp. 178-206.
[23] D. Ausubel, *The fern and the tiki*, USA, Holt, Rinehart and Winston, (1960) p. 183.

From the 1980s, many Māori and Pakeha considered that the Treaty was the cause of rising racial tension.[24] While that impression of the Treaty may still hold, somewhat ironically, recent interpretations in the wider electorate have focused more on issues of equity.[25]

Treaty settlements and apparent growing political deference to things Māori have reinforced a perception of the Treaty as unfairly benefiting Māori over others. Evidence of this was notable in the response to Don Brash, leader of the National political party, and his 2004 Orewa speech, and 2005 electoral campaign, which pledged 'one law for all' - again. Over the past decade, media headlines have reflected wider resentment, suggesting the property rights of other New Zealanders were being sacrificed in order to settle Māori claims,[26] or reports that suggested "unless you are one of the big boys or Māori, forget forestry,"[27] or even "halt the Treaty gravy train".[28] Such statements support the assumption that some non-Māori now believe the Treaty is a basis for unfair allocation of rights and economic benefits.

The effect of three decades of Treaty claims and increasing Treaty awareness is that any strategy or policy directed at Māori is perceived as distributing benefits derived from the Treaty. One such strategy, *Closing the Gaps (1999)*, was designed to target social inequalities, of which Māori were acknowledged as experiencing to a significant percentage. The policy attracted considerable critical scrutiny.[29] As the Prime Minister, Helen Clark (2000) explains, "it never occurred to us that anyone would seriously have maintained that any Government would give preferential access to health treatment to any particular ethnic group."[30] The policy was subsequently re-branded and launched as a social equity policy for the benefit of all New Zealanders.[31]

Government have since been careful to statutorily declare their position on social equity issues. While section 4 of the *New Zealand Public Health and Disability Act*

[24] National Business Review poll, 15 August 1989 cited in J. Kelsey, *Rolling back the State*, Wellington, Bridget Williams Books, (1993), p.236.
[25] A. Fleras & P. Spoonley, *Recalling Aotearoa, indigenous politics and ethnic relations in New Zealand,* (2002), Melbourne, Oxford University Press, p.123-149.
[26] *New Zealand Farmer*, Wrong way on this land issue, (July 1995), p 13.
[27] *National Business Review*, Unless you are one of the big boys or Māori, forget forestry, (29 September 1995).
[28] M. Bassett, *Halt the Treaty gravy Train*, The Dominion, (6 February 2002), p.12.
[29] S. Chapple, *Māori socio-economic disparity, paper for the Ministry of Social Policy*, September 2000, Accessed 12/12/04, www.msd.govt.nz. The ACT party launched an attack on the policy based on Chapple's report.
[30] *New Zealand Herald*, Big no Treaty clauses, (28 November, 2000).
[31] K. Baehler, Ethnicity-based research and politics: snapshots from the United States and New Zealand, *Social Policy Journal of New Zealand*, (June 2002), p.18.

(2000) states that the Treaty principles will be 'recognised and respected' to improve Māori health, there is also the following caveat in another clause "to avoid any doubt, nothing in this Act entitles a person to preferential access to services on the basis of race".[32]

Such changes indicate that the Government remains mindful of negative reactions to policy perceived as inequitable by the general electorate. Theorists observe that policy development depends on the salient norms, beliefs and prevalent ideas underpinning popular knowledge at a particular time. Political feasibility will depend on the political context in which a given decision is formulated, and major policy changes may only occur if public opinion is conditioned to accept new ideas and concepts.[33]

Government responses to Māori activism initially reflected electorate sentiments toward Māori (and the Treaty). Strategies ranged from blunt coercion - the heavy handed eviction of protestors at Bastion Point in 1978, to a (slightly) more conciliatory approach with the formation of the Waitangi Tribunal. The Tribunal was established under the Treaty of Waitangi Act (1975) to consider Māori Treaty grievances. The Tribunal's jurisdiction was initially limited to those claims arising from the date the statute was enacted; this was extended in 1984 to the date of the Treaty signing.[34]

The Waitangi Tribunal has been an influential purveyor of Treaty meanings. As the main conduit of Treaty interpretations, the Tribunal's 'findings and recommendations [are] expressed in the currency of Treaty principles'. The Tribunal evaluates historical Crown action or inaction as anticipated by the Treaty signatories, determining its findings according to existing or new principles and whether such principles were breached by the Crown in the context or case to which they are applied.[35] Tribunal procedure differs from civil proceedings. Hearings are located on Marae, Māori protocols are observed and in line with Māori custom, space is given at

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[32] *Ministry of Health*, New Zealand Public Health and Disability Act 2000, Part 1 Section 3, Sub clause 3, (2000c). Accessed University database 6/01/06 http://www.legislation.govt.nz

[33] K. Coates, International perspectives on Relations with Indigenous peoples, in K. S. Coates & P. McHugh, *Living relationships, Kōkiri ngātahi,* Wellington, Victoria University Press, (1999), pp.19-103.
G. Majone, *Evidence, argument and persuasion in the policy process*, Yale University Press, New Haven, (1986), pp.145-149.
H. Heclo, The political foundations of antipoverty policy, in S. H. Danziger & D. H. Weinberg (ed.), *Fighting poverty: What works and what doesn't*, Harvard University Press, Cambridge, (1986), pp.312-340

[34] P. McHugh, *The Maori Magna Carta*, Auckland, Oxford University Press, (1991), pp.309-15.

[35] P. McHugh, (1991), pp.309-15; J. Hayward, (2004), p.29.

the beginning of proceedings for individuals to vent their frustrations. Oral evidence is accepted and adversarial cross examination is limited.

However, despite such adaptations, the Tribunal has many of the characteristics of court process. Claimants must make their case, like any other forum of enquiry. In deliberating, Tribunal members must take account of laws, rules, authoritive judgements, as well as 'past acts and present possibilities.' And although their recommendations are not binding upon the Government, they have, Sharp (2001) concludes, 'acted very much like a court'.[36]

This raises questions regarding the exact status of the Tribunal. Like the Treaty, the Tribunal's status seems somewhat ambiguous. Empowered to deliberate on Treaty-related matters, increasingly the recommendations handed down, feel indeed like those of a court. Tribunal findings carry considerable weight, delivered by a Tribunal panel of authoritive experts, their findings influencing Treaty jurisprudence. Indeed, the Courts have acknowledged that 'the opinions of the Waitangi Tribunal are of great value to the Courts'.[37] The preponderance of claims indicates Māori rely very much on the power of the Tribunal as a final avenue for settlement of Treaty grievances.[38] Yet, legally, the Tribunal is a creature of statute, essentially a quasi-court, a commission of enquiry.

Given the apparent influence of the Tribunal, critics have scrutinized the robustness of Tribunal procedure. Because strict legalistic process is avoided with laws used to justify a particular interpretation whenever findings sit outside the literal words of the Treaty,[39] Smith (2000) believes that the Tribunal steps beyond statute limitations, compromising credibility of recommendations.[40] Oliver (2001) charges that in the absence of the usual academic conventions, the Tribunal is engaging in a reconstructive process of history to align with contemporary political aspirations,[41] as opposed to Durie (1998) who suggests that the Tribunal is finally revealing all of New

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[36] A. Sharp, Recent juridical and constitutional histories of Māori, in A. Sharp & P. McHugh, *Histories, power and loss,* Wellington, Bridget Williams ,(2001), pp.31-33.
[37] Judgement of Cooke, P, in the *New Zealand Māori Council vs Attorney General (1987)*.
[38] Sharp, (2004), 195-206.
[39] P. McHugh, (1991), pp. 309-15.
[40] N. Smith, Treaty would be folly in education, *Dominion*, 25 September, (2000).
[41] W.H Oliver, The future behind us, in A. Sharp & P. McHugh, *Histories of power and loss*, Wellington, Bridget Williams, (2001), pp.9-30.

Zealand's history.[42] Winston Peters (1990) believes the Tribunal is a 'quasi-legal' entity, lacking proper Court systems and defective for such a role.[43]

The Courts have played an equally influential role in directing recent interpretations of the Treaty and Treaty principles. The most significant decision has been that of the Court of Appeal in *New Zealand Māori Council vs. Attorney General (1987),* also known as the *Lands* case. The claimants initiated litigation after Crown assets under claim to the Waitangi Tribunal were being privatised, potentially placing them beyond the Crown's retrieval. Section 9 of the State-owned Enterprises Act (1986), declared "nothing in this act shall permit the Crown to act in a manner that is inconsistent with the principles of the Treaty of Waitangi." The clause was interpreted by the Court as creating responsibilities analogous to fiduciary duties, where one party had an obligation to protect the interests of the other party as the more powerful in the agreement. The decision initiated the process of redefining the boundaries of Crown duty to Māori.[44]

Until this case there had been relatively little discussion regarding exactly what the principles of the Treaty were. The Court of Appeal identified Treaty principles for evaluating future Government actions. The principle of protection of rangitiratanga refers to recognition of Māori self-determination in exchange for recognising British sovereignty. The duty to act reasonably and in good faith encompasses the principle of reciprocity and is inherent to the concept of partnership. The principle of kawanatanga is an acknowledgement of the right of the duly elected Government to govern. The principle of active protection refers to the Crown's duty to protect Māori taonga, is not passive. The principle of redress refers to Government duty to remedy past breaches where the Tribunal investigates and finds merit in a Treaty claim. The Court stopped short of recognizing a principle of consultation, referring instead to a requirement for the Crown to be sufficiently informed to fulfil fiduciary responsibilities.[45] In the absence of any clear directive from parliament, the Court's response was effectively an attempt to statutorily clarify the meaning of Section 9.[46]

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[42] M. Durie, *Te Mana, Te Kawanatanga, The politics of Maori self-determination.* Melbourne, Oxford University Press, (1998a), p. 175.
[43] The Evening Post, (1990), quoted in Wheen & Hayward, (2004), p.7.
[44] New Zealand Court of Appeal, *The Treaty of Waitangi in the Court of Appeal: the full judgements of the Court in the New Zealand Māori Council's case*, Wellington, (1987).
[45] *ibid*.
[46] McHugh, (1991), pp.247-250.

The Government has periodically attempted to develop a framework from which to apply the Treaty principles in statutes. A proposal in 1986 to incorporate Treaty principles in all future legislation was initially strongly worded to include the Treaty of Waitangi. The final version was modified to refer merely to the principles and was little more than a directive for the processes to be used in formulating policy.[47] In 1989 the Government released *Principles for Crown action on the Treaty of Waitangi.* Described as a 'selective refinement'[48] of the Treaty principles developed by the Court of Appeal (1987) and Waitangi Tribunal, the proposal attempted to establish a Treaty principles framework for Government engagement with Treaty issues.

In 1995 National released a set of Treaty principles, *Crown proposals for the Settlement of Treaty of Waitangi Claims.* Commonly known as the fiscal envelope, the proposal was a framework for Government actions regarding Treaty settlements. It received a mixed response and was eventually abandoned some years later.[49] Apart from these minor dalliances, interpretations and applications of Treaty principles have been left mostly to the Tribunal and the Courts.

There have been other, less obvious, attempts to identify the place of the Treaty and Treaty principles within the policy process. The Government established a Royal Commission on Social Policy (1984-7) to consider 'all policy instruments, administration, institutions and systems that were relevant to the needs of New Zealanders'. As part of that task the Commission identified three Treaty principles partnership, participation and protection relevant to the future development of social policy.[50] Since then the meanings of these principles have evolved beyond any overt influence from Government, deriving many agreed upon characteristics from the Courts and Tribunal.

The principle of partnership has been conceptualised differently by the Courts and the Tribunal. Both generally agree on the attributes of partnership, such as good faith, reasonableness, consultation and reciprocity. However, with regard to the status of the partners, the Tribunal considers the partners equal, whereas the Courts do not. The principle of participation refers to Government supported initiatives which

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[47] Fleras & Spoonley, (2002), p. 121.
[48] J. Kelsey, *Rolling back the state*, Wellington, Bridget Williams, (1993), pp.255-6.
[49] M. Henare, Sustainable social policy, in J. Boston, P. Dalziel, S. St John, (ed.), *Redesigning the welfare state in New Zealand,* Auckland, Oxford University Press, (1999).
[50] Royal Commission on Social Policy, *The April Report Volume II,* Wellington, (1988), pp.47-49.
C. Cheyne, M. O'Brien, M. Belgrave, *Social Policy in Aotearoa in New Zealand, a critical introduction, 2nd Edition*, Auckland, Oxford University Press(1997), p.11-16.

increase or facilitate Māori involvement across all sectors - as determined by Māori. The principle of protection refers to the responsibility of the Crown to actively safeguard Māori interests as was anticipated by Māori signatories to the Treaty.[51] In social policy, this requirement translates to a facilitation role for Government, one which accepts diversity, supports relevant service development and encourages independence.

One of the central Treaty demands for Māori has been rangatiratanga, the right of self-determination. The concept of rangatiratanga is derived from the fundamental exchange that occurred because of the Treaty. Māori signatories anticipated their continued mana and right of tribal self-determination in exchange for acknowledging British sovereignty and acceptance of British citizenship. In 1984 Hui Taumata (Māori Economic Summit) focused the importance of basing Māori economic, social and cultural development on tino rangatiratanga to achieve positive Māori development.[52] Māori calls for rangatiratanga coincided with Government economic reforms.

The fourth Labour Government's devolution strategy was viewed (by Government and some Māori) as an appropriate mechanism for meeting Māori calls for greater autonomy from the state.[53] The market model would be applied to the provision of social services thereby increasing competition and efficiency. Competition would be generated by transferring responsibility to an elected body or approved Iwi, under the (since repealed) *Runanga Iwi Act (1990)*, effectively bringing the decision making closer to the people directly affected.[54]

However, the control of social services represents a substantial source of political and economic influence, creating rivalry amongst potential providers. Territorial boundaries and what happens for urbanised Māori were also an issue.[55] Māori became responsible for the delivery of Government programmes within a tight regulatory framework, at a lower cost, and funding was often inadequate for the high health need encountered. Furthermore, the responsibility for welfare was effectively relocated back

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[51] M. Durie, The Treaty of Waitangi perspectives for social policy in I.H. Kawharu, (ed.), *Waitangi. Māori and Pakeha perspectives of the Treaty of Waitangi,* Auckland, Oxford University Press, (1989), pp.291.
Ministry of Health, (2002), p.2. See also Te Puni Kokiri, (2001a), pp.73-93; The April Report (1988), pp.47-69.
[52] Durie, (1998a), pp.10-12.
[53] Fleras & Spoonley, (2002), p.122.
[54] Henare, (1999), p.54.
[55] S. Kunitz, The history and politics of healthcare for Native Americans, in J. Healy & M. Mckee, (ed.), *Accessing healthcare*, Oxford, Oxford University Press (2004), p.316.

in the very communities from which the social needs arose.[56] In reality, devolution may have answered Māori calls for self-determination, but it was within a limited interpretation of the word.

The range of contemporary interpretations of rangatiratanga does not help to clarify perceptions nor clearly direct applications of the term either. Claims range from radical, absolute Māori ownership and political control to an acknowledgement of the transfer of sovereignty, with Māori resources and taonga remaining within Māori control.[57] The Tribunal has commented extensively on rangatiratanga, noting that interpretations are dependent upon the context in which self-determination is claimed.[58]

In responding to Māori assertions of rangatiratanga, the Government has focused on Iwi as the expression of rangatiratanga,[59] resurrecting and legitimating Iwi over other forms of Māori social organisation.[60] Because of this, Government has been accused of ignoring the diverse forms of Māori social organisation and the possibility those connections to hapu or urban organisations are more salient than those which are tribally based.[61] Tribunal reports have interpreted rangatiratanga as an attribute of all groups that comprise Māori communities.[62] In pre-contact Māori communities, hapu and whanau were the main units of political and social organisation and are believed to be the collectives that signatories to the Treaty represented: not Iwi.[63]

Government approval of Iwi has also facilitated the rise of a class of tribal elite, variously described as ethnicity entrepreneurs,[64] comprador bourgeoisie or brokering elite.[65] While good leadership is acknowledged as a critical component in successful development, critics charge that this 'elite' group of Government bureaucrats and self-

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[56] C. Kiro, *Māori Health Policy and Practice*, Ph.d Thesis Massey University Albany, Auckland (2000), p. 122.
[57] Fleras & Spoonley, (2002), pp.24-27.
[58] For example; Wananga Capital Establishment Report (1999), Te whanau o Waipareira Report (1998), Taranaki Report Kaupapa Tuatahi (1996), Muriwhenua Fishing Claim (1988), Orakei Claim (1987), Manukau Claim(1985).
J. Hayward & N. R. Wheen, (ed.), *The Waitangi Tribunal, te roopu whakamana i te Tiriti o Waitangi*, Wellington, Bridget Williams Books, (2004).
[59] Fleras & Spoonley, (2002), pp.22-26.
[60] R. Walker, *Ngā Pepa a Ranginui, The Walker papers,* Auckland, Penguin, (1996), pp.120-121.
[61] *ibid.,* p.125.

[62] J. Hayward, (2004), p.35.
[63] Waitangi Tribunal Report (1998) cited in C. Kiro, (2000), p.52.
[64] S. Chapple, (2000), p.2.
[65] E. Rata, *The Treaty and neotribal capitalism,* (August 2003). Accessed internet 27/12/05
http://www.ace.ac.nz/doclibrary/pdf/postgraduate/staff/erata/TreatyNeotribalCapitalism.pdf

appointed experts now control the criteria that determine what constitutes an Iwi, who are members and consequently who are Māori.[66]

A strong cultural identity is acknowledged as fundamental to successful indigenous endeavour and improved health and wellbeing. However, the Treaty settlements' empowerment of an elite group influential enough to determine criteria of ethnicity authenticity, is potentially excluding. As Poata-Smith (2004) observes "the Treaty settlement process has entrenched a view of Māori identity that draws on a mythic sense of primordial authenticity and a set of static cultural social and political assumptions that ignore the dynamism and diversity of contemporary society".[67] By continuing an Iwi-centric focus for Māori development, the Government increases the potential political and economic influence of this elite group, endorsing a general impression that the Treaty has served the interests of a few.

Economic reforms have continued to intersect with Māori aspirations and expectations of the Treaty. The contractual mechanisms introduced with the *Health and Disability Act (1993)*, although limited, provided more opportunity for Māori service providers - Iwi, hapu, whanau based, or other community or urban based organisations, to establish. The development of 'by Māori for Māori,' providers, delivered health services based on Kaupapa Māori, Māori perspectives (te ao Māori) and Māori models of health - delivered predominantly by Māori health professionals. As a result of these initiatives, provider numbers grew rapidly.[68]

But again, there were implementation challenges. Two reports, *Māori primary care services (1999)* and *Improving Māori health policy (2002)* noted that contract specifications were inconsistent with Māori health models and Māori approaches to service delivery, funding was inadequate, there was a lack of trained Māori health professionals, limited implementation of the Treaty of Waitangi and considerable geographical variations in services.[69]

This inconsistent policy approach to Māori and Treaty issues has characterised the responses of successive Governments. In 1988, the Parliamentary Commissioner

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[66] See E. S. T. Poata-Smith, The changing contours of Māori identity and the Treaty settlement process, in Haywood, J. Wheen, N.R. (ed.), *The Waitangi Tribunal, Te Roopu Whakamana I te Tiriti o Waitangi,* Wellington, Bridget Williams, (2004). P.183., Rata, (2003), Kelsey, (1996), p.193-4
[67] Poata-Smith, (2004), p.183.
[68] Kiro, (2000), p.311.
[69] Crengle, S. (1999). *Maori Primary care service*. Paper prepared for the National Health Committee. Accessed 3/10/05 http://www.nhc.govt.nz
National Health Committee, Improving Māori Health Policy, Wellington, (2002). Accessed NHC website 06/08/05, http://www.nhc.govt.nz

noted a lack of political will and institutional commitment to Treaty policy, reflecting the waning tolerance of the general electorate.[70] Sharp (1997) believes confusion around Treaty issues is indicative of the Government's inability to control policy formulation and execution in relation to the Treaty.[71] In fact, the ongoing uncertainty and confusion has enabled the Government to avoid taking a clear position (legal or constitutional) regarding the Treaty, a theory supported by a statement of Jenny Shipley when she was Minister of Health in the mid nineties. When queried regarding the Crown's obligation to a particular Treaty issue, she remarked, "the Crown's Treaty duties in respect of health and disability services have yet to be determined by the Courts or the Waitangi Tribunal".[72]

Māori initiatives have enhanced the overall awareness of the Treaty and have facilitated the integration of some Māori cultural practices into contemporary New Zealand culture. The integration and acknowledgement of Māori beliefs and perspectives has occurred in many social services, with the inclusions of Treaty clauses in some public policy and the use of Māori protocols in Government departments. However, these have not always been interpreted positively.

The recent saga of Corrections Department officer Josie Bullock provides an illustrative example. Bullock was censured, after refusing to "go along with official gender discrimination because it was part of Māori custom".[73] In another incident, a stretch of Waikato highway was rerouted following consultation with local Iwi, regarding the existence of a taniwha. In this instance compensation was paid, stimulating considerable debate regarding the public interest of acknowledging Māori beliefs.[74]

In 1987, Justice Chilwell suggested that the 'Treaty is part of the fabric of New Zealand society' and that Māori cultural and spiritual values should be considered

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[70] J. Kelsey, From flagpoles to pine trees: tino rangatiratanga and Treaty policy today, in Spoonley, P., Macpherson, C. Pearson. D. (ed.) *Nga Patai, Racism and ethnic relations in Aotearoa/New Zealand.* Palmerston North, Dunmore Press,(1996), p.183.
[71] A. Sharp, Civil rights, amelioration, and reparation in New Zealand, in M. E. Brown & S. Ganguly, *Government policies and ethnic relations in Asia and the Pacific,* Cambridge, MIT Press, (1997), pp.421-456.
[72] M. Aggett, *Cultural identity is a big factor in health,* New Zealand Doctor, (24 July 1996).
[73] S. Franks, *Where is Mr Swain on Corrections Racism*, (25 June 2005). Accessed internet, http://www.scoop.co.nz/stories/PA0506/S00722.htm

[74] J. Corbett, *Transit and the taniwha,* New Zealand Herald, (9 November 2002). Accessed Herald Website, 31/01/06, http://www.nzherald.co.nz/section/story.cfm?c_id=1&objectid=3003401

when determining the general interests of the public.[75] In the absence of Government decisiveness, public interest will continue to be difficult to determine when the public remains uncertain which piece of the cloth represents the Treaty of Waitangi.

Conclusion

The Treaty of Waitangi is a contemporary symbol of the complexity of modern-day New Zealand society. Interpretations and meanings determined by competing beliefs and values have imbued the Treaty with a highly political and divisive reputation. In part this is the consequence of intolerance and ignorance, but it is also due to perceptions of inequitable distribution of economic benefits, Māori development, and the increasing prevalence of Māori cultural practices in many previously monocultural institutions.

While successive Governments have implemented many changes in the name of the Treaty, for example Treaty settlements, Government apologies for past Treaty grievances and recognition of Māori cultural practices; the lack of legal or constitutional power afforded the Treaty indicates the impetus for change has been driven by other influences rather than the Treaty alone. Government continues to have considerable latitude in responding to the Treaty while it has minimal legal recognition and no official constitutional authority. In many respects the Treaty has been the perennial victim of political expediency, its worth deliberated over by the Tribunal and Courts whose findings can be easily diluted or dissolved in parliament.

While the uncertain status of the Treaty of Waitangi is a key influence in the perceptions and interpretations of Treaty principles, the Treaty remains a significant symbol for Māori. Because of this, Treaty principles now frame health policy for Māori.

A clearer picture is needed to determine the utility of Treaty principles as components of policy, particularly as these are the anticipated mechanisms of change in the health sector. This might also provide a clearer framework for evaluating the health service experiences of participants with TB in this study. In the next chapter, Deborah Stones paradox theory is applied to each Treaty principle to distinguish the characteristics and attributes of value to the policy objectives of He Korowai Oranga.

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[75] Durie, (1998a), p.182.

CHAPTER THREE

The Meaning of Treaty Principles

in He Korowai Oranga

Introduction

Like the Treaty of Waitangi, Treaty principles are imbued with meanings from many sources. Few of these interpretations give clarity to the value or purpose of using Treaty principles in policy development. This ambiguity causes considerable dissension.

As a component of public policy, the Treaty principles provide a moral framework for policy action but they are rarely the determinant or motivator for public policy action. Instead the Treaty principles are used in *He Korowai Oranga – Māori Health Strategy (2002)* to frame policy for the purpose of engaging Māori in, and with, the health sector.

In this chapter, the meaning of the Treaty principles, partnership, participation and protection, as applied in *He Korowai Oranga – Māori Health Strategy (2002)* are explored separately using *Deborah Stone's Policy Paradox (2002)* theory. Through deconstruction, the possible interpretations taken by Māori and the probable intention of policy makers are identifiable. Included in this analysis are relevant sections of the companion document to He Korowai Oranga, *Whakatataka - Māori Health Action Plan (2002-2005).*[76] Other Ministry of Health documents, which have since assessed the implementation of these strategies, have also been referenced. In order to conduct an analysis of the Treaty principles in He Korowai Oranga, common definitional features of the principles were categorised separately. This has resulted in some minor differences in classifications of components between the policy and this analysis.

The chapter begins with a brief outline of Stone's theory, followed by the analysis of the three Treaty principles.

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[76] Ministry of Health, *Whakatakaka – Māori health action plan,* (2002-2005), Ministry of Health Website, (2002b). Accessed 12/12/04, http://www.moh.govt.nz.

The Policy Paradox

Deborah Stone's (2002) theory of policy paradox is a practical guide for distinguishing amongst the multiple meanings which inform the use of Treaty principles in policy. According to Stone, the struggle for control of criteria, classifications and boundaries which ultimately determine the framework of public policy, is the essence of policy making. Stone believes that this struggle to control the discursive framework of policy making, results in political decisions which reflect the alliances and interactions involved in the policy process as well as wider societal values.[77]

Stone describes three standard features of public policy making – a model of policy reasoning, a policymaking model and a model of society. She argues that the model of reasoning, - described as a rational decision making model produced through a series of well-defined steps, and policy making - a rational production-like process, both ignore the multiple barriers to any rational policy-making process.[78] The model of reasoning is, however, useful in this analysis because it may explain the rationale underpinning the use of Treaty principles in He Korowai Oranga.

The model of society envisaged in the policy process, will depend on the intended outcome of a policy decision. In most industrial countries, the values of the market direct policy decisions, although this influence is not necessarily, made explicit.

Societies are also political communities, in which policy action is a product of collective will and effort. Because ideas and objectives often compete, this process is usually characterised by conflicting interpretations of community values, ambiguous motivations for policy change and contested prioritization of societal ideals.[79]

Political and cultural groups form according to formal and informal rules in a society. Political group members are individuals who live under the same political rules and governance as citizens, while cultural communities are defined as people who share the same culture, language, traditions and history.[80] Political communities have traditionally operated with an idealized model of the polis that asserted one

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[77] D. Stone, pp.8-14.
[78] *ibid*., p.9.
[79] *ibid.,* pp. 9-11.
[80] *ibid.,*

common descent, language and culture be referenced for all.[81] Alliances will form within and between these groups around commonly held notions of public interest, sustained through influence, cooperation, power and the strategic use of information.[82] Membership in these societies and to some extent, alliances, will often determine access to social, economic and political rights.[83]

The purpose of public policy is the distribution of costs and benefits. While Government motivations may vary, Stone contends there are four common policy objectives - equity, efficiency, security and liberty.[84] These determine the policy response to perceived problems, as well as the solutions chosen. Problems will always be strategically represented (language, numbers, symbols and stories) to illustrate a particular causal pathway and persuade an audience toward the preferred policy decision.[85]

Solutions are 'ongoing strategies' to achieve a collective purpose, at any given time. The use of inducements, rules, powers, decisions and facts, are all just a means of exerting power over others, to do something they might not otherwise do.[86] How the policy is defined and which solution is chosen, will ultimately, be determined not by rational and value-free policy-making processes, but by the prevailing societal values operating at any given time.

The Paradox theory provides a useful guide for thinking about the way the expectations of both the policymakers' and policy targets might be achieved in policy areas of contested meanings. Stone's theory highlights the importance of shaping policy solutions according to the values, beliefs and culture of the intended policy target. In this respect, the utility of the Paradox Theory may be its ability to clarify the complexity of Treaty principle meanings applied in He Korowai Oranga.

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[81] W. Kymlicka, *Multicultural citizenship*, New York, Oxford University Press, (1995).
[82] Stone, pp.23-27.
[83] *ibid.,* pp.9-11.
[84] *ibid.,*
[85] Stone, p.133.
[86] Stone, p.263.

<u>Principle of Partnership</u>

The principle of partnership is defined in He Korowai Oranga as a collaborative relationship, one of 'working together.' The parties in a relationship with the Government are identified as Iwi, hapū, whānau and Māori communities. However, other organisations have potential influence in this relationship. Te Puni Kokiri, a Government agency, monitors programs delivered by Māori, as well as Māori development. Māori Co-purchasing Organisations (MAPO) is responsible for planning and purchasing of health and disability services in their respective regions. Māori Development Organisations (MDO) was established to assist the Māori health and disability sector.

The term partnership is used to describe relationships between District Health Boards (DHB) and Māori. The term Māori is used to refer to local Iwi, Māori communities and Māori providers.[87] The policy does at times discuss Māori as a homogeneous group, not distinguishing between provider and user. There is no discussion of the relative status of each party and while the DHB maintains overall control of the partnership process,[88] the requirement to enable and facilitate Māori participation in the partnership is analogous to a fiduciary duty.

The model of society under which the principle of partnership operates is bicultural. The policy affirms the importance of te ao Māori[89] to Māori cultural identity and health, but acknowledges the context of Māori existence within the wider New Zealand society. A bicultural model symbolically links into the idea of partnership between Māori and the Ministry of Health, the expectation of rangatiratanga of each party as well as acknowledging the Government's right of governance. Both parties are identified as critical participants in the process of improving Māori health.

The members of this society can be part of two groups, political and cultural. The political group comprises Ministry of Health, DHBs, Primary Health Care

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[87] MOH, (2002b), p.17.
[88] MOH, (2002a), p.5.
[89] Te ao Maori refers to the Maori world and being connected rather than separate to things Maori, that is Maori language, tikanga, marae – the community focal point, waahi tapu – sites of importance, and access to whānau, hapu and Iwi.
Auckland Regional Public Health Service, *He pūrongo Hauora o ngā Iwi Māori I te rohe o Tamaki Makaurau, A report on Māori Public Health in the Auckland Region,* (2005), p. 25. Accessed 3/08/05, http://www.arphs.govt.nz/publications/MaoriPHReport05/Mauri%20Ora.pdf

Organisations (PHO), Māori Co-Purchasing Organisations (MAPO), Māori Development Organisations (MDO), community service providers, Māori health providers, Iwi, and all forms of Māori community. Essentially all organisations, groups and individuals involved in health services, as providers or consumers. The cultural community members are Māori, iwi, hapu, whanau, Māori health providers and organisations that operate with a Māori kaupapa.

Alliances are anticipated between partners and amongst providers.[90] A major challenge noted internationally to community based health initiatives, is that in order to succeed there needs to be a degree of interdependence among separate organisations. This can result in a loss of autonomy. Competitiveness and political tension may undermine the robustness of such alliances. For example, Ngati Porou Hauora, an East Coast Māori health provider encountered tensions because smaller providers within the PHO felt their interests were marginalised by the interests of the larger more powerful providers.[91]

The policy focuses the majority of the activities of the Māori partner toward Māori provider development. He Korowai Oranga looks to providers as representative of Māori communities because Māori providers 'developed within hapu, Iwi and Māori communities and [are] well placed to meet the needs of whanau.'[92] The policy also appears to perceive Māori providers as representative of the interests of health service users who are Māori.

Consultation is a key attribute of this partnership. DHBs are statutorily required to involve Māori in governance level decisions regarding Māori health priorities and the nature of health service delivery to Māori.[93] Determining health priorities requires making value judgements, often attracting considerable public scrutiny, and as such, public involvement is believed to be necessary if support is to be gained.[94]

The political nature of the consultation process has resulted in many Government agencies establishing formalised guidelines for consulting with the public. Guidelines

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[90] MOH, (2004a), p.13-15.
[91] S. Abel, D. Gibson, T. Ehau, D. T. Leach, Implementing the Primary Health Care Strategy: a Maori health provider perspective, *Social Policy Journal of New Zealand*, (26 July 2005), pp. 70-87.
[92] MOH, (2002a), p.16.
[93] *Ministry of Health*, Ko Tātou, Building and maintaining relationships with Maori a guide for District Health Boards, Ministry of Health Website, (December 2004a). Accessed 12/06/05
http://www.moh.govt.nz
MOH, (2002a), p.5-6.
[94] T. Tenbensel, Interpreting public input into priority-setting: the role of mediating institutions, *Health Policy*, (2002), 62, p.174.

facilitate a positive engagement and ensure that the process is perceived as legitimate and fair. Māori, like many other public groups, expect timely and reasonable consultation. Ko Tatou (2004) outlines guidelines for DHB for effective and meaningful consultation with Māori. The criterion includes early information sharing, negotiation, clear simple understandable documentation and the importance of negotiating cultural differences.[95]

He Korowai Oranga does acknowledge the importance of community wide consultation, but there do not appear to be any strategies directing this in the action plan.

A goal of this partnership is efficiency. Stone (2000) believes that the pursuit of maximum value for any given resources by comparing the merits of different ways of doing things, guides communities to obtain the most value from scarce resources.[96] He Korowai Oranga seeks to achieve efficiency through redistribution of resources at primary health care level. DHBs must work within the existing population funding formula, prioritising and reallocating money in order to meet MOH objectives for Māori health.[97] A targeted delivery of health care services to Māori requires Māori involvement to develop appropriate initiatives and to determine the utility of various health interventions. Utility is a key criteria used to assess the rationality of resource allocation decisions.[98] To that end, a monitoring framework for He Korowai Oranga is currently being developed.[99]

The successive restructuring of the New Zealand health system during the nineties has resulted in health services now being delivered by a mix of public and private providers. From this, the establishment of Independent Practitioner Associations and Primary Health Organisations (PHO) has created choice for the health consumer and a competitive environment into which new Māori health providers must establish. The MOH has a number of schemes, the Whanau Ora

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[95] MOH, (2004b), pp.17-21.
[96] Stone, pp.64-66.
[97] MOH, (2000b), p.7.
[98] Tenbensel, (2002), p.176.
[99] *Ministry of Health*, Developing a monitoring framework and strategic research agenda for He Korowai Oranga, summary of submissions, (May 2005). Ministry of Health Website, Accessed 12/12/04, http://www.moh.govt.nz.

Awards and the Māori Provider Development Scheme (MPDS), as incentives to support Māori providers in the health market.[100]

To be eligible for development funding, Māori providers must be led by Māori governance and management structure, express Māori Kaupapa, and hold or be in the process of negotiating a contract to deliver health and disability services targeting Māori.[101] Another method for securing provider status is to seek accreditation for establishing quality assurance processes in management and services delivery.[102]

While MOH support is obtainable, viability is not guaranteed. A report for the MOH (2004) pragmatically notes that economic uncertainties and risks are such that 'providers will adjust their behaviour accordingly and there will be winners and losers'.[103] There are anecdotal reports that some Māori health service users have left Māori health providers for a PHO 'across the road', perceiving the services offered are of a better quality or based on a preferred care model. Data on Māori preferences for health services appears scarce, the only current indicator of preference, is the market.[104]

A key theory sustaining this partnership is that Māori will develop the most appropriate strategies, given political recognition of rangatiratanga and economic opportunity. The policy defines rangatiratanga as 'building Māori capacity to control the 'direction and shape of Māori institutions and communities'.[105] In order to achieve rangatiratanga, He Korowai Oranga intends to bolster Māori provider capacity and capability, although, He Korowai Oranga does appear to direct this development

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[100] The Whanau Ora Awards promote successful models of service delivery or initiatives that increase whanau health and well-being, by building on the strengths and assets of whanau and Maori communities. Accessed Maori Health Directorate Website, 2/02/06, http://www.moarihealth.govt.nz/2004/awards.php
The Māori Provider Development Scheme (MPDS) is a MOH funding scheme to assist Māori providers establish. Accessed Ministry of Health Website 2/02/06, http://www.moh.govt.nz/moh.nsf/wpg_index/News+and+Issues-Maori+Provider+Development+Scheme+2004-2005

[101] *Ministry of Health*, Māori Provider Development Scheme Application form, MPDS 2005/2006. Accessed Māori Health Directorate Website, 6/02/06, http://www.maorihealth.govt.nz/2004/0,204,1767c60,400368.php

[102] MOH, (2000a), p.22.
[103] New Zealand Institute of Economic Research, (NZIER), *PHOs and Maori health, Implications of PHO policy for Maori health policy objectives*, A report to Maori Health Directorate, Ministry of Health, (August 2003), p.20. Accessed internet 12/06/05 http://www.moh.govt.nz/moh.nsf/0/971716d1ff320a27cc256da60007233e/$FILE/PHOsMaoriHealth.pdf
[104] *ibid.,* p.17.
[105] MOH, (2002a), p.7.

predominantly toward tribal structures, appearing at times to privilege Iwi over other forms of Māori organisation.

The expression 'by Māori for Māori' symbolises rangatiratanga in health. Stone argues that symbols are devices that highlight an issue, directing an audience toward a favoured conclusion or response.[106] Until recently, Māori have had relatively little control of the shape of health services delivered to Māori. In recognising rangatiratanga, He Korowai Oranga delivers a degree of control to Māori health providers.

Sustaining independence may well be a challenge for Māori providers, given that many are small and experience funding and resourcing difficulties with meeting compliance and administrative requirements.[107] There is a current dearth of Māori medical professionals. Despite programmes such as the university medical school admission systems, e.g. Māori and Pacific Admissions Scheme (MAPAS)[108] and targeted nursing recruitment and scholarships, Māori medical professional numbers remain low.[109] This may challenge Māori provider qualifying criteria under this principle.

Māori providers' ability to function autonomously and successively will depend on whether some of these issues can be resolved. Developing a successful partnership with Māori providers is a central strategy in He Korowai Oranga, for improving Māori health and increasing Māori health service users' involvement in the health sector.

The Principle of Participation

He Korowai Oranga defines the principle of participation as creating pathways of access which enable Māori to participate across the health sector. As such, the policy has a two pronged approach, Māori provider development and the enablement of Māori health service users.[110]

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[106] Stone, pp.137-162.
[107] NZIER, (2003), p.13.
[108] University of Auckland Website, MAPAS application, Accessed 3/02/06, http://www.health.auckland.ac.nz/study/undergrad/medicine/entry.html#mapas
[109] N. North, F. Hughes, M. Finlayson, E. Rasmussen, T. Ashton, T. Campbell, S. Tomkins, *The cost of nursing turnover and its impact on nurse and patient outcome: a longitudinal New Zealand study,* College of Nurses, Aotearoa New Zealand Website, (February 2006). Accessed 23/02/06 http://www.nurse.org.nz/leadership/ls_cost_study.htm
[110] MOH, (2002a), pp.19-26.

The model of society envisaged under this principle is egalitarian. In this society assumptions are made that all people enjoy equal social, political, economic rights and opportunities. Based on this vision, health services are distributed according to need, as stated in *New Zealand Public Health and Disability Act (2000)*. Every individual has specific healthcare rights, as outlined in the Health and *Disability Commissioner Act (1994),* including basic human rights as well as rights more relevant to healthcare. These are the right to receive services of an appropriate standard, the importance of effective communication and individual rights to dignity and independence.[111]

He Korowai Oranga identifies health inequalities as the key problem affecting Māori rates of participation. A complex interaction of determinants, shorten Māori lives and cause poorer health at all educational, occupational and income levels.[112] Many countries now recognise that the principal determinants of health inequalities are macro-environmental factors and the nature of physical and social environments.[113]

For Māori, the Treaty of Waitangi, colonisation and the deregulatory policies of the eighties and nineties have been the cause of significant structural barriers to good health.[114] Institutional barriers arise when the dominant group in a society ignores the different cultural perspectives of minorities. Monocultural health care and perceived racism have been found to have negative health outcomes for minorities.[115]

The goal of participation is equity. According to Stone (2000) assumptions about equity generally hold that the same benefits, costs, services and risks will be distributed to all recipients.[116] The underlying rationale of equity is social justice. Social justice refers to the overall fairness of a society in its divisions and distributions of rewards and burdens. Under social justice all persons are entitled equally to fundamental social goods such as healthcare, education and a minimum income.[117] However, equity issues may be compromised when efficiency objectives underpin

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[111] MOH, (2000a), p.22.

[112] MOH, (2000a), p.3.

[113] I. Crombie, L. Irvine, L. Elliot, H. Wallace, *Closing the health inequalities gap: an international perspective,* Copenhagen, World Health Organisation, (2005), p.4.

[114] *Ministry of Health*, Decades of disparity II, socio-economic mortality trends in New Zealand 1981-1999, (2005), p.XV. Accessed Ministry of Health Website 12/12-04, http://www.wnmeds.ac.nz/academic/dph/research/nzcms/decadesofdisparity2.pdf

[115] Kwate, NOA, H.B. Validmarsdottir, J.S. Guevarra, D.H. Bovbjerg, Experiences of racist events have negative health consequences for African American women, *Journal of Medical Association*, (2003), 95, pp.450-460.

[116] Stone, pp.28-29.

[117] D. E. Beauchamp, Public health as social justice, in R. Hofrichter, (ed.), *Health and social justice, politics, ideology and inequity in the distribution of disease,* San Francisco, Jossey-Bass, (2003), pp.267-276.

policy decisions. By addressing some of the issues identified in supply side mechanisms, He Korowai Oranga seeks to provide Māori the opportunity for both development and whanau access to healthcare. There are four key areas.

The first action encourages mainstream services to work with Māori providers and Māori communities to improve the effectiveness of mainstream services. Strategies include identifying barriers still experienced by Māori in the mainstream services, developing needs assessment processes with criteria appropriate to Māori.

The second action outlines the need for high-quality, accessible, effective and timely health services for Māori.[118] Evidence indicates the quality of service for Māori patients still needs to significantly improve. For example, in New Zealand Māori have the poorest cardiovascular health outcomes. Intervention rates for coronary artery bypass grafting and angioplasty have, for many years, been consistently lower than would be anticipated of high cardiovascular disease prevalence.[119] He Korowai Oranga proposes adopting best practice protocols and standards for improving the quality of care in order to reduce the incidences of preventable harm.[120]

The third action promotes the co-ordination of intersectoral initiatives to mediate the effects of policy decisions in other sectors. Poor housing, low educational achievement, unemployment, inadequate incomes, are known to correlate with a range of lifestyles that predispose to disease and injury. He Korowai Oranga advocates a 'whole of Government' approach to raise awareness of the potential health effects from policy decisions.[121]

The last action encourages mainstream services to be more responsive to the different needs of Māori health service users - now a contractual requirement for publicly funded organisations. Cultural alienation has been recognised as an important consideration for effective health care. He Korowai encourages the integration of Māori health models into models of care across the health sector and many hospitals now operate Māori and whanau units.[122] Engaging Māori in the health system according to Māori beliefs and customs is the basis of the third principle, protection.

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[118] MOH, (2000a), pp.16-23.
[119] D. Bramley, T. Riddell, S. Crengle, E. Curtis, M. Harwood, D. Nehua, P. Reid, A call to action on Maori cardiovascular health, *New Zealand Medical Journal,* (09 July 2004), Vol 117, No. 1197.
[120] MOH, (2000a), p.19.
[121] MOH, (2000b), pp.29-31.
[122] MOH, (2000a), p.20.

<u>The Principle of Protection</u>

The principle of protection is applied in He Korowai Oranga as a duty of health services to recognise and respond to Māori cultural beliefs, values and practises. To that end, the policy focuses on supply side mechanisms in health, in order to assure Māori culturally appropriate health services.

The goal of this principle is liberty. Here, liberty is applied as a freedom or choice to do or be as one chooses, unless that choice causes harm to others. Stone (2000) suggests that sometimes curtailing the liberty of others is necessary to preserve a community in which individuals can thrive and exercise free choice.[123] However, expressions will still be within a range of activities defined by Government. To that end, the strategies in He Korowai Oranga focus on reorienting health services to Māori perceptions of identity, models of health and service expectations.[124]

The model of society under the protection principle is te ao Māori. In this society the only model of reasoning is Māori. A Māori world view determines norms, practices, societal organisation, health and well-being. In this society the right of 'Māori to be Māori' is protected.[125]

Members of this society are Māori or Māori providers. Within this society, whakapapa binds the groups (whanau and hapu) who together seek to promote the social economic and cultural well-being of their respective groups. Māori identity is based on the Māori concepts of tikanga, te reo, whakapapa and whanau. These measures are used to gauge ones connectedness to others. He Korowai Oranga identifies the strength of cultural identity and community as 'essential to the advancement of whanau ora'.[126]

Generally alliances will work toward developing a strong sense of Māori identity in order to strengthen communities and support whanau. As such, alliances in this society are important, based on trust and honour, judged harshly if disrespected. Local Iwi communities share kinship or whakapapa ties, have recognised landmarks within their region and as such are recognised as mana whenua of that area.[127] Because

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[123] D. Stone, (2002), p.108.
[124] MOH, (2000a), pp.9-13.
[125] MOH, (2000a), p.7.
[126] MOH, (2000a), p.11.
[127] MOH, (2004a), pp.7-8

providers are often tribally based, the rules of membership in this society will be controlled by local Iwi.

In a Māori society the predominant models of reasoning for understanding health, well-being and illness, are Māori.[128] To recognise and support development of Māori communities, Māori models of health and knowledge are incorporated into training and assessment of all health practitioners. He Korowai Oranga encourages the integration and implementation of Māori health models across the health sector.[129]

Mason Durie's Whare tapa wha model conception is one of many which may be applied. Durie's model conceptualises Māori health as that of four walls of a house, each representing a different dimension of individual well-being. Taha wairua, the spiritual side, is considered by many Māori the most essential component of health. Wairua refers to the capacity for faith and wider communion and acknowledges that health is often influenced by intangible energies. Taha hinengaro, the mental or emotional side, refers to our capacity to communicate think and feel in a way that can affect our physical health. Taha tinana, the physical side, refers to physical health and taha whanau, the family side, refers to our capacity to belong, to care and to share with those with whom we have a familial connection.[130] The acceptance of holistic health models at policy level may reflect wider societal trends toward the use of alternative health care and other holistic approaches to health.

He Korowai Oranga anticipates that Māori providers will apply Māori solutions to Māori health issues. Treatment might include a referral to tohunga or traditional Māori healer, and the use of mirimiri, karakia, and rongoa, anticipated to alleviate physical and spiritual distress. This may also involve a 'green' prescription – the use of an option other than medication.[131]

Health promotion is another strategy for improving Māori health.[132] Health promotion is the process of supporting individuals and communities to increase control over the factors which influence their health and quality of life. The Ottawa Charter (1986) highlights the centrality of social determinants in individual health status

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[128] MOH, (2000a), p.7
[129] MOH, (2000a), p.12.
[130] M. Durie, *Whairoa: Māori health development, (2nd edition),* Auckland, Oxford University Press, (1998b), pp.69-73.
[131] Kiro, (2000), p.322.
[132] MOH, (2000a), p.20.

outlining five strategies that are prerequisites for promoting health and well-being.[133] A local health promotion model, developed by Mason Durie, is used by Māori providers to promote Māori health.

Te Pae Mahutonga, (1999) - the Southern Cross, is a symbolic map for bringing together significant factors of health promotion as they apply to Māori health. These are a secure Māori identity, healthy environment, healthy lifestyle, good leadership and community based health promotional programmes. [134] The tenets of the Ottawa Charter and Te Pae Mahutonga are conceptually threaded throughout He Korowai Oranga, acknowledging the importance of using Māori approaches to health for Māori.

Conclusion

The application of the Paradox theory has been useful for making sense of the different values and meanings associated with the Treaty of Waitangi principles. There are a number of areas of mutual benefit as well as some areas of future potential tension.

The focus of He Korowai Oranga on Māori provider development provides a degree of control in developing Māori health services. The symbolic use of the term 'partnership' delivers a participative role to Māori while avoiding any symbolic threat to Government sovereignty. However, Māori rangatiratanga rights remain within a defined range of activities, determined largely still by Government.

The use of more participatory health models in He Korowai Oranga acknowledges Māori perspectives of health, and recognises Māori expectations to be

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[133] These are the need for healthy public policy, the importance of having a healthy environment to live in, the need for a strong supportive community, the requirement for appropriate and understandable health education and the need to re-orient health services to be more responsive to the health needs of the communities they serve.
Health promotion forum of New Zealand, What is health promotion? Accessed internet 1/07/05, http://www.hpforum.org.nz/page.php?7

[134] Access to te ao Māori rests on a secure Māori identity, in which Māori have increased opportunities for cultural expression and cultural endorsement within society's institutions. Environmental protection, waiora, refers to the need for health promotion to take account of the nature and quality of interaction between people and the surrounding environment. Toiora, or healthy lifestyles is about shifting individual behaviour from high risk patterns to safer healthier practises with targeted interventions that focus on the management of risks, minimisation of harm, cultural relevance and positive development. Te Oranga focuses on increasing Māori participation in society. Ngi Maunkura, leadership refers to the need for good community leadership, the importance of alliances with a range of community and professional leaders and the need to relate to communities in terms which make sense to them are all important if health promotion is to be successful. Te mana whakahaere refers to the need for health promotional programmes to be owned by the community.
M. Durie, Te Pae Mahutonga: a model for Maori health promotion, *Health Promotion Forum of New Zealand Newsletter 49*, (2-5 December 1999).

consulted. As a mechanism for enablement, Māori providers appear to be strategically located.

However, the different policy goals identified under each principle may prove to be incompatible in the distribution process. Efficiency is often sacrificed to achieve equity, and similarly, equity is always at the expense of efficiency. This presents a problem for the MOH. Overriding equity for the sake of efficiency is always an unpopular and sometimes resisted decision.

Similarly, liberty may be curtailed to achieve equity. While Māori anticipate equity, curtailing their choices of process by which health equity is achieved, may be viewed as limiting rangatiratanga.

Lastly, while a society in which Māori norms, beliefs and practises prevail is an expression of rangatiratanga. The perception of a separate Māori society may be challenged in the future if the attitudes of dominant groups change or other minority groups seek similar recognition. Within Māoridom, forming of alliances may also generate internal challenges.

Māori desire to determine Māori experiences from a Māori perspective is the topic of the next chapter. A Kaupapa Māori approach to research prioritises Māori epistemology and Māori expectations to determine the appropriateness of research in Māori communities. Because a key determinant in this process is the researcher, firm guidelines outline the researcher's engagement with Māori communities. The next chapter argues that overly rigid application of such criteria may serve to distort the reality of the communities we seek to enhance.

CHAPTER FOUR

Researching Other Māori: The Politics of Research

Introduction

There is an expectation that as a Māori researcher working with a Māori community, a Kaupapa Māori Research approach will be used. A Kaupapa Māori approach to research anticipates that the researcher has competency in Māori cultural practises and that both the researcher and the research participant will be comfortable with and conversant in, Māori customary practises. This assumption is potentially limiting when not all Māori are accustomed to the practises now associated with claiming Māori ethnicity. In my childhood for instance, we learnt tikanga, some whakapapa and a sprinkling of te reo. Raised in a predominantly Pakeha city, my formative years were strongly influenced by non-Māori cultural norms. Despite the lack of exposure to things Māori outside of my family, my childhood remains the primary source and basis of my Māori identity. Research indicates other Māori have similar grounding as a basis for their Māori identity.

This chapter considers the definitional boundaries of identity used in Kaupapa Māori Research for Māori researchers and members of the Māori community engaged with research. The diverse Māori identities encountered during this study indicate some Māori identify strongly as Māori, without necessarily subscribing to all the traditional notions of Māori identity. The differences encountered as well as the context of this research, influenced the manner in which Kaupapa Māori Research approach was applied in this study.

A Kaupapa Māori Research (KMR) methodology is premised on traditional Māori cultural beliefs, values and social practices. Linda Smith (1995) describes Kaupapa Māori research as, "research by Māori, for Māori and with Māori".[135] Smith argues for a standard of researcher who is both academically qualified and culturally competent in Māori Kaupapa.

The key principles of KMR approach are tikanga Māori, te reo (Māori language), whānau (family) and whakapapa (genealogy). Tikanga refers to the customary practices of social interaction. It is about doing what is right, interpreting accurately what is observed and acknowledging Māori etiquette. As the subtleties of culture are embedded in language, the researcher must have, at least, a basic level of proficiency in te reo.[136]

Within Māori Kaupapa, the whānau is seen as the mainframe of the individual. Each person has a responsibility and obligation to that structure grounded in the common connections through whakapapa.[137] These principles frame the way a Māori researcher is expected to engage with a Māori community.

Ethics for research with Māori

Over the last ten years, research institutions have developed ethics guidelines for conducting research with Māori.[138] The guidelines serve to instruct non-Māori in appropriate Māori cultural conventions, whilst reminding Māori researchers of their obligations to their people.[139] In this research, the guidelines have been adapted to respond to the limitations and circumstances within research relationships. A discussion of the guidelines and modifications follows.

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[135] Smith, L.T. Toward Kaupapa Māori research. Paper presented at Matawhanui Conference (Māori University Teachers Conference), Massey University, (1995), cited in M. Glover, *Kaupapa Māori health research: A Developing discipline,* paper presented at Hui Whakatipu, Whaiora Marae, Otara, Auckland, (1997). Accessed HRC Website 5/09/05, http://www.hrc.govt.nz/assets/pdfs/publications/huiwhakatipu1997.pdf

[136] L. T. Smith, (2000), pp.225-247.

[137] *ibid*., p.241-2

[138] N. Te Awekotuku, (1991), K. Powick (2002), HRC (1998), MSD (2004), F. Cram, (2001).

[139] L.T.T. Mead, *Ngā aho o te kakahu matauranga: The multiple layers of struggle by Māori in education.* Thesis (PhD – Education), University of Auckland, (1996), p. 221; 212.

<u>Aroha ki te tangata (a respect for people)</u>

Having a respect for people begins by allowing individuals to define their own spaces and to meet on their own terms.[140] For Māori, this process includes connecting to other Māori through whakapapa. Nearly half of the participants in this study asked where my people were from. Kathy Irwin (1994) refers to these 'rituals of first encounters' as giving the research participant the power to determine the manner in which the research relationship evolves. In most other forms of research, the researcher controls that process. The people being visited therefore define how the researcher should conduct themselves within their area. During first encounters the differences which separate the two groups are acknowledged, mediated and moved past with the intention of forming one group.[141]

The development of this united, non-hierarchical research whānau is another way of showing respect for other Māori. However, the gap between researcher and participant is characterised by multiple similarities and differences, creating distance outside the control of the researcher. In this research for example, although I am Māori, an insider, my role as a researcher, my gender, different Iwi, different socio-economic circumstances and education levels all identify me as an outsider.[142] Such factors impact the research relationship at different times and in different ways and need to be recognised and acknowledged.

<u>He Kanohi kitea (the seen face, that is present yourself to people face to face)</u>

For Māori, meeting face-to-face builds trust. According to KMR, the research relationship is initiated through consultation with the relevant

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[140] F. Cram, Rangahau Māori: Tona tika, tona pono – The validity and integrity of Māori research, in Tolich, M. *Research Ethics in Aotearoa New Zealand.* Longman, Auckland, (2001), p. 42.

[141] K. Irwin, Māori research methods and processes: An exploration. *Sites*, (1994), Issue 28, pp.36-38
[142] This point is made by Linda Smith in (1996, 1999, 2000).

community/Iwi leaders. In this study TB fractured whānau relationships, with disclosure of TB diagnosis outside immediate family members often only occurring if contact tracing was implemented. Therefore it was not appropriate to initiate consultation through community leaders.

Some interviews were preceded with initial meetings, providing an opportunity for participants to question my research objectives, research methods and to assess whether or not they would consent to participate in my study. There was an opportunity to conduct a telephone interview. However, given participant sensitivity about having TB, only opportunities for face-to-face informant interviews were pursued.

Continuing contact after data collection is completed reinforces the confidence placed in the researcher. To this end, all participants' transcripts were returned to them for approval, along with a research progress report.[143]

Titiro, whakarongo…korero (look, listen…speak)

The first role of the researcher is one of observing, listening, learning and waiting until it is appropriate to speak.[144] The significant impact of TB on most of the informant's lives made recounting their stories an emotional experience. Respecting their distress meant remaining silent, listening, observing and when appropriate, prompting the discussion.

In such circumstances, it is important that the intended meaning of participant words is reflected rather than just the literalness of their words. For example, in this study one person declared they were "ashamed of being Māori". What I believe, the person meant was that sometimes they perceived others rejected them because they were Māori.

Manaaki k ite tangata (share and host people, be generous)

Research is a collaborative process. Knowledge flows both ways and as Cram (2001) notes "participants and researchers both have something meaningful to contribute". Here the concept of utu, the notion of reciprocity,

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[143] Cram, (2001), pp.43-44.
[144] L. Smith, (1997), p.212.

requires that researchers acknowledge the 'time, effort, information and aroha' given by participants.[145] Acknowledgement, in the form of reporting back and sharing research results as well as some other small koha, should be given.

Kia tupato (be cautious)

This concept refers to being politically astute, culturally safe and aware, as a Māori researcher, of our insider/outsider status. While we are part of the community we seek to study, our different roles within the research relationship signal our outsider status.

Cultural safety is about respecting values, history and social practices of another culture. This applies to Māori visiting the rohe of other Māori. While being in the company of other Māori is familiar, connecting and comfortable, during this study, I needed to be mindful of different protocols. For Māori researchers, this dual insider/outsider status must be negotiated carefully. Not only during interaction with research communities, but when detailing research findings; discussion of other Māori, should not be from an outsider perspective.[146]

Kaua e takahia te mana o te tangata (do not trample over the mana of people)

The views and knowledge of participants should be valued and respected. A critical element in respecting participants and preventing harm is the core research principle of informed consent. This means providing information in a "manner that most easily and effectively permits the would-be participant to understand and voluntarily commit to participate".[147] Information about the

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[145] J. Bevan-Brown, By Māori , for Māori , about Māori - Is that enough? Paper delivered to Te Oru Rangahau Māori Research and Development Conference, 7-9 July, (1998), Massey University, cited F. Cram, Rangahau Māori: Tona tika, tona pono – The validity and integrity of Māori research, in Tolich, M. *Research Ethics in Aotearoa New Zealand*. Longman, Auckland, (2001), p.46.

[146] Cram, (2001), p.47.

[147] University of Auckland, University of Auckland Human Participants Ethics Committee: Guidelines, 2003, p. 5. Accessed University of Auckland Website: http://www.auckland.ac.nz/docs/research/UAHPEC%20Guidelines%20approved%20by%20Council%20Dec%202003.doc

research is usually presented in written form, on the letterhead of the research institution, which supports the particular study. This can be a deterrent for Māori to participate. In this study most interviewees seemed to make their decision to participate in the study based on our first meeting. Few participants appeared to have read the information sheet. Those who did were still more interested in what my 'spoken' motivations for doing this research were. Uncertain of my ground at times, I offered a complete explanation of my study before and after each interview.

Kaua e mahaki (don't fault your knowledge)

This concept refers to the need for the researcher to remain humble. Cram (2001) believes some critical self-scrutiny is necessary to ensure, we as researchers, place the interests of those we engage in research above our own self-interest. She suggests honouring our communities, by supporting access to knowledge gained from the research relationship. This is not to suggest the researcher should belittle themselves or their knowledge. Sharing knowledge and using one's qualifications for the benefit of the research community is, I believe, an integral part of the research relationship, particularly when access to research participants for this study was granted, not because of my qualifications, but because of the fact I was Māori.[148] This point was starkly illustrated, when a potential participant refused to be interviewed because she thought I was *not* Māori.

Kaupapa Māori Approach to Research

The development of a Kaupapa Māori approach to research was a response to past research which perpetuated negative stereotypes and 'problematised and pathologised Māori culture, social structure, beliefs, parenting and attitudes'.[149] Māori resented participating in research over which they had no control, from which the community did not benefit and for which the

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[148] Cram, (2001), pp.48-49.
[149] L. Smith, (1997).

objective was research for knowledge sake.[150] In 1985 Evelyn Stokes articulated Māori resentment when she asserted, there was a need for the development of a research approach which not only reflects Māori realities, but 'arise[s] out of the aspirations and needs of Māori people'.[151] In a Department of Health report, Kilgour & Keefe (1992) echoed Stokes, reporting Māori aspired to do "their own research and to generate their own statistics".[152] During this period, Māori academics had also begun advocating a research epistemology premised on a 'traditional' Māori world view, as the means for accurately interpreting the views and aspirations of *all* Māori.

To ensure Māori experiences are portrayed through a Māori world view, proponents of Kaupapa Māori advocate strict researcher eligibility criteria. Knowledge of one's whakapapa is asserted, by respected Māori scholars and tribal leaders and other proponents of KMR, as indicative of the depth of understanding one holds of Māori society.[153]

What criteria defines a Māori community was challenged by the te Whānau o Waipareira Trust. The trust attempted to gain Crown recognition, as a non-Iwi based Māori community, in which kinship was not the common link for drawing individuals together.[154] Many urban-based Māori encountered by Waipareira Trust were estranged from kinship ties with no knowledge of whakapapa. Waipareira roopu kaumatua was established to assist such individuals to trace their whakapapa.[155] Despite the basis for association being geographical, rather than genealogical, the Trust considers traditional cultural practices primary.

Advocates argue that Māori are better equipped to conduct research with Māori. Unless a non-Māori researcher has a strong grounding in Māori Kaupapa, I would tend to agree. Jahnke & Taiapa (2003) disagree. They argue that there must also be a consideration of tribal affiliations, age, gender and knowledge of

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[150] E. Stokes, *Māori research and development,* National Research Advisory Council, Wellington, (1985), p.3-6.
[151] *ibid.*
[152] R. Kilgour, V. Keefe, *Kia piki te ora : the collection of Māori health statistics,* Wellington, New Zealand, Department of Health, Health Research Services, (1992), p.68.
[153] See H.M. Mead (2003), L. Smith (2000, 1999, 1997), Durie (1998a).
[154] *Waitangi Tribunal*, Te Whanau o Waipareira Report, Wai 414, Wellington, GP Publications, (1998).
[155] Ibid.

tikanga.[156] However, the critical criterion is really the researcher's willingness to 'abide by a Māori system of ethics and accountability'. Arohia Durie (1992) believes researchers who conduct research this way are more likely to be Māori.[157]

Accountability is also the key tenet of Bishop and Glynn's (1990) argument. They deny the call for researchers with Māori ancestry is 'biological essentialism'. The authors believe a minimum level of cross-cultural competence, which includes, conducting appropriate mihi with Kaumatua, meetings with the appropriate kaitiaki in the proposed research communities and respect of Māori world views, ensures the research process is empowering for both Māori and researchers. This is the only way, they argue, of ensuring accountability to the researched.[158]

Unsurprisingly, post-graduate Pakeha students have increasingly avoided including a Māori sample in cultural research, because they feel intimidated or they claim to have been warned off researching Māori. Even Martin Tolich (2002), co-editor of *Social Science Research in New Zealand (2003)*, admits to a degree of 'Pakeha paralysis' when discussing inter-ethnic research.[159] Although Smith (1999) explains non-Māori can be included in different parts of KMR, provided Māori maintain control of the research,[160] Tolich (2002) believes the boundaries for non-Māori researchers need to be more clearly defined. Where the boundaries are for Māori researchers also remain unclear.

Smith (1999) warns there is no place in Kaupapa Māori Research for Māori researchers who are 'anti-Māori' or those who are merely 'a researcher who happens to be Māori'.[161] The problem is, as Jahnke & Taiapa (2003) note, the effects of colonisation have resulted in relatively few Māori researchers being

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[156] H. Jahnke & J. Taiapa, Māori research, in Davidson, C., Tolich, M. in *Social Science research in New Zealand*, Auckland, Pearson Education, (2003), pp.39-50.

[157] A. Durie, "*Whaia te ara tika: research methodologies and Maori*", (1992) cited in H. Jahnke & J. Taiapa, Māori research, in Davidson, C., Tolich, M. in *Social Science research in New Zealand*, Auckland, Pearson Education, (2003), pp.39-50.

[158] R. Bishop & T. Glynn, "He kanohi kitea: conducting and evaluating educational research', *New Zealand Journal of Educational Studies,* (1992), Issue 27(2), pp.128-135.

[159] M. Tolich, Pakeha Paralysis, cultural safety for those researching the general population of Aotearoa, *Social Policy Journal of New Zealand,* (December 2002), 19, pp.164-179

[160] L.T.Smith, *Decolonizing methodologies,* Dunedin, Zed Books, (1999), pp.184-5.L. Smith, (1999), pp.184-5

[161] L.T.Smith, (1999), pp.184-5.

eligible to undertake research with Māori. Should Māori communities refuse all research overtures unless researchers conform rigidly to KMR criteria? Do all Māori communities anticipate a process of research informed by Kaupapa Māori? Are Māori researchers like me fortuitously exploiting my ethnicity? Under what definition is one classified as an 'anti-Māori' Māori researcher? For this researcher, answering such questions raises issues of ethnic membership legitimacy and challenges to individual identity. The criterion was certainly intimidating and caused considerable personal disquiet regarding my own eligibility to do this research.

Despite protestations to the contrary, the debate over who is suitably qualified to research Māori has, to some extent, created an 'us and them' divide. Rata (2004a) and Dannette (1999) agree. The authors argue Kaupapa Māori avoids critical scrutiny of alleged intellectual and scientific flaws by invoking an 'us and them' dichotomy.[162] Even as a Māori researcher, my status remains unclear as to whether I am part of 'them' or one of 'us'.

Ultimately, my responsibilities as a (Māori) researcher are to engage appropriately with participants involved in my research endeavours, regardless of whether they are Māori or non-Māori.[163] As Peter Mataira (2003) muses, "whether one is an 'insider or an 'outsider' [it] is fundamentally a matter of perspective".[164] Perhaps Mataira (2003) and Stokes (1985) are correct, when they suggest "a researcher who is comfortable in both cultures, regardless of racial or biological origin or skin colour is more likely to produce better outcomes for Māori".[165]

A Kaupapa Māori approach to research anticipates that Māori research participants hold 'traditional' notions of Māori identity. Diverse notions of Māori identity encountered in this study indicate not all Māori construct their Māori identity based on such factors. Tracey McIntosh (2005) believes contemporary

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[162] E. Rata, *Ethnic ideologies in New Zealand Education: What's wrong with Kaupapa Māori*. Auckland College of Education, (2004a). Accessed 12/08/05 http://www.ace.ac.nz/doclibrary/pdf/postgraduate/staff/erata/RataTefanzFinal1June04.pdf
M. Dannette, *Engaging culture and science: A scientific realist perspective of Māori mental health.* Unpublished doctoral dissertation, University of Canterbury, Christchurch, (1999).
[163] L.T. Mead, (1996), p.212.
[164] P. Mataira, *Māori evaluation research, theory and practice: Lessons for Native Hawaiian evaluation studies*, presented at Evaluation Hui, Hawaii, June 2003. Accessed 4/08/05 www.ksbe.edu/pase/pdf/EvaluationHui/Mataira.pdf

[165] Stokes, 1985, p.9; Mataira, 2003, pp.11-12

Māori identity is not rigid, but is shaped and informed by the 'socio-political reality in which they, [Māori], are embedded'. As a result, she argues, three groups of Māori identity, fixed, fluid and forced, are now discernable.[166]

Individuals' claiming a fixed identity, have individual knowledge of whakapapa, matauranga Māori, proficiency in te reo and tikanga. This identity is articulated by influential spokespeople such as scholars and tribal leaders, who are better positioned to positively promote and empower Māori, whilst challenging negative stereotypes.[167] Indeed, other studies have found ethnic affiliation is linked to higher self-esteem.[168] However, Toon van Meijl (2002) argues, this 'traditional orientation' is a limited conception of culture which results in some Māori (he refers to rangatahi) viewing Māori culture as the 'traditions of others, not themselves".[169]

In 1996 survey results for the Auckland region, (the largest regional population of Māori) found one in four Māori were unable to name their Iwi. Similarly, 2001 national census results showed 58% of Māori could speak no more than a few words in te reo. When these statistics were divided by region, Auckland, had a below national average for te reo competency.[170] As McIntosh (2005) laments, for some Māori, lack of proficiency in whakapapa, tikanga and te reo, is often deeply shaming and may be used to challenge one's authenticity as a Māori, by both Pakeha and Māori.[171]

Unsurprisingly, some Māori prefer to construct their identity by mediating some of the traditional elements of Māori identity and fusing these adaptations with social and material influences, to form a more 'fluid' identity. As a result, fluid identity tends to be more inclusive, embracing geographical settings in preference to tribal ones; often as a result of mixed culture, ancestry

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[166] T. McIntosh, Māori identities: Fixed, fluid, forced, in J. Liu, T. McCreanor, T. McIntosh, T. Teaiwa (eds.), *New Zealand identities: Departures and destinations*, University of Victoria Press, Wellington, (2005a), pp.1-16.

[167] *ibid.,*
Mason Durie (1998a) also discusses 4 distinct groups of Māori identity, pp.57-9.

[168] M. Song, *Choosing ethnic identity,* Polity Press, Cambridge, (2003), p.9.

[169] T. Van Meijl, Culture and crisis in Māori society: the tradition of other and the displacement of self, in E. Kolig, H. Mückler, (eds.), *Politics of Indigeneity in the South Pacific*, Transaction Publishers, Hamburg, (2002), p.55.

[170] *Te Puni Kokiri*, Te Māori i Ngā Rohe Māori Regional Diversity, (October 2001). Accessed Te Puni Kokiri Website, 29/08/05, http://www.tpk.govt.nz/maori/population/default.asp

[171] McIntosh, (2005a), p.6.

and intermarriage.[172] This complex mix was found in a study of problems confronting ethnicity based social policy, to produce 'ethnic fluidity' around notions of identity.[173] As Sharp (1995) observes, "cultures are actually leaky vessels, created, renewed and transformed in endless contact with others".[174] However, Kukutai (2003) believes, Māori most likely to moderate or reject a 'fixed' Māori identity tend to have a higher socio-economic living standard.[175]

Economic and social circumstances form the basis of McIntosh's third identity. Forced identity is a response to structural forces often formed under conditions of deprivation and is externally imposed, being based predominantly on the perceptions of outsiders, although economic, social and stigmatising factors (such as disability, mental illness and sexual orientation) tend to contribute to a marginalised status,[176] Kukutai (2003) believes this group often affiliates strongly with a fixed Māori identity.[177] However, her claim raises questions as to why statistical data show a large percentage of Māori have low income, yet the census results indicate knowledge of traditional cultural concepts is not correspondingly high. In this study for example, the majority of participants had minimal incomes. While most valued their Māori identity, a significant proportion was distanced from whānau and the majority admitted to a lack of proficiency in te reo. Ironically, those participants with higher income levels appeared to claim a fixed identity, being conversant in tikanga, with strong whānau support and fluency in te reo.

If the objective of KMR approach is to use methods of enquiry which enhance and advance Māori communities then a number of issues should be reconsidered. Currently the researcher criterion for non-Māori researchers is exclusionary. Researchers avoid including Māori in their sample, but their findings may then be applied to the general population. For Māori researchers

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[172] McIntosh, (2005a), p.8.
[173] P. Callister, Ethnicity measures, intermarriage and social policy, *Social Policy Journal of New Zealand,* (December 2004), i23, p.12.
[174] A. Sharp, Why be bicultural? In M Wilson & A Yeatman (eds.), *Justice and Identity: Antipodean practices,* Bridget Williams Books, Wellington, (1995).p.118
[175] T. Kukutai, *The dynamics of ethnicity reporting: Māori in New Zealand,* (2003), p.9. Accessed Te Puni Kokiri Website, 03/09/05 http://www.tpk.govt.nz/
[176] T. McIntosh, (2005a).
[177] T. Kukutai, The problem of defining an ethnic group for Public policy: Who is Māori and why does it matter? *Ministry of Social Development Website*, (2004). Accessed 2/03/05 http://www.msd.govt.nz/

the criteria feels intensely political and vulnerable to subjective application. This could serve to discourage appropriately qualified Māori from considering a career in research. Neither outcomes advance Māori interests.

There is also a risk that in asserting the current KMR theory as the only lens to interpret contemporary Māori realities, all Māori will be represented according to the perspectives of the researcher, as determined by KMR criteria. In doing this, we risk confirming the charges of KMR critics. Indeed, McIntosh's (2005) observation that 'there is no single Māori experience…we do not all suffer the same burdens or enjoy the same privileges',[178] illustrates the diversity of Māori and the need for KMR to interpret such diversity honestly. What is needed is to extend the range of research methods premised on Māori Kaupapa, whilst avoiding the essentialist trap.[179]

Methods

This section outlines the sampling method, the types of data collection used – interviews, participant observation, document analysis and the data analysis approach applied in the coding, thematic and content analysis, of the interview transcripts and documents.

Sample

Within the Auckland Regional Public Health Service (ARPHS) area, based on 2001 census results, it is estimated approximately 146,700 people claim Māori ethnicity. The geographical area covered by the ARPHS extends from Rodney District in the North to Franklin District in the South and includes Waitemata, Auckland, and Counties Manukau District Health Board boundaries, as well as the seven Auckland Territorial Authorities.[180]

Rates of TB amongst Māori (1994-2004) indicate approximately 20 cases per 100,000 population, in Auckland, with approximately 60% of TB cases

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[178] T. McIntosh, Waihi I te toipoto, kaua i te toiroa: Intersections of race gender and social policy in Aotearoa/New Zealand, in Bangura, Y., Stavenhagen, R. (eds.). *Racism and public policy.* London, Belgrave McMillan, (2005b).p. 271.
[179] Mataira, (2003), p.11-12.
[180] *Auckland Regional Public Health Service,* (2005), p.8.

occurring in those aged 15-40 years. Reactivation of infection is more common amongst older Māori (over 40yrs) with a low incidence rate amongst children (0-3 cases p.a since 2001). There is no gender based data.[181]

Potential participants were those who self-identified as Māori in the ARPHS notifications database with a recent TB diagnosis (2002-2005). This period coincides with the operational period of He Korowai Oranga, Māori Health policy (2002). The total population for this period is 45, of which three patients are now deceased. The sample total for this study was ten - seven from the notifications list, one case was a relative of one of the initial group of informants with dormant TB – these cases are not included on the notifications list, one case was categorised a TB reactivation, therefore assumed to be previously registered on the notifications list and one other case was outside of the ARPHS region, for reasons explained shortly. The gender make-up and age range of this study sample is four males and six females, aged from 22months to 72 years. The majority of participants (eight) are outside the 15-40yr age bracket. (See Table 1.)

The TB treatment regime is predominantly administered and/or supervised by Public Health Nurses (PHN). Contact with all study participants was initiated through Auckland Public Health Nurses. There was considerable difficulty gathering a sample for this study. Many of the cases on the notifications database were no longer contactable. For those approached who declined study participation, reasons included the stress of on-going health problems arising from multiple diagnoses, incarceration, feelings of being over-researched[182] and non-disclosure.[183] Consequently, it is my belief that consent to participate in this research was in no small way due to the advocacy of the PHNs and in one particular instance, a Māori Health promotion staff member.

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[181] *Auckland Regional Public Health Service,* (2005), pp. 82-3.

[182] There is considerable discussion in Kaupapa Māori literature regarding Māori reluctance to participate in research. For example: In 2001 the Waikato District Health Board investigated diabetes service delivery preferences of Māori. Results indicated considerable scepticism as to the value of participation, when a similar investigation had yielded minimal service improvement for the community. Waikato District Health Board, 2001, He Whakawhaititanga o Nga Ratonga Mate Huka, Integrated Diabetes Project, Waikato, p.7.

[183] One individual, who refused to participate in this study, had not disclosed their TB diagnosis to friends or acquaintances. The PHN would meet with the individual at a central city fast-food outlet store and surreptitiously slipped the drugs to the person under a napkin on a plate or with a coffee or juice, ensuring other diners were unaware of the transaction. (Personal communication)

Interviewees were geographically widely dispersed, throughout the Auckland region; rather than predominantly concentrated in South Auckland where rates of TB among Māori are high.[184] Although ethics approval for the research project related only to the Auckland DHB region, permission was granted to interview one participant living outside the region. An inappropriate treatment regimen prescribed outside of Auckland, had resulted in debilitating medication side affects. Timely treatment reassessment in Auckland reversed a rapidly deteriorating health status and facilitated the person returning home with a more optimistic prognosis than the one they arrived with.

With participant consent, relatives and Public Health nurses were interviewed, and medical records examined to clarify confusion regarding some details of participant accounts of their illness narrative and timeline. (Only one participant refused access to medical records). Diverse versions of the same event gave insight to the way those associated with the interviewee understood or made sense of their TB and medical treatment. This is particularly relevant when considering participant experiences of health services and perceptions of the attitudes of other people.[185] Māori Health professionals were interviewed providing professional accounts of the health environment that Māori with TB encounter, how some Māori might respond to a TB diagnosis, health services and some of the common issues confronting Māori requiring prophylactic healthcare.

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[184] *Auckland Regional Public Health Service,* (2005), p. 83.
[185] R.M. Emerson, R.I. Fretz, L.L. Shaw, *Writing ethnographic fieldnotes,* Chicago, The University of Chicago Press, (1995), p.116.

Table 1. Participant Demographic Characteristics and TB Information

Categories / Names	Age	Gender	Spouse	Children	Income or working	Car? During TB Treatment	Car licence	Rural or Urban?
Reka	54	F	N	Y	invalid benefit	N	N	R
Pita	45	M	?	?	invalid benefit	N	Y	U
Kowhai	24	F	Y	Y	Income support	N	N	R
Omaka	62	F	Y	Y	employed	Y	Y	U
Hemi	58	M	N	Y	employed	Y	Y	U
Rangi	37	M	N	N	employed	N	Disq	R
Ngaire	72	F	Y	Y	pension	N	N	U
Mahina/Pania	22 mths	F	Y	N/A	child	Y	N/A	R
Maata	49	F	Y	Y	working	Y	Y	R
Hone	57	M	Y	Y	invalid benefit	Y	Y	R/U

Categories / Names	TB Type	TB detected by?	How TB Diagnosed?	Delayed Diagnosis?	Cause of Diagnosis Delay?	DOT/SAT	Treatment Compliance?	Why not?	Smoker During Treatment?
Reka	Pulmonary	acute hospital admission	lab test	yes	Patient delay	D	N	Forgot pills	N
Pita	Pulmonary	hospital admission	lab test	yes	Doctor delay	D	N	Hosp escape	Y
Kowhai	Pulmonary	GP referral	lab test	yes	Patient/ in hospital doctor delay	D	N	Hosp escape	Y
Omaka	X-Pulmonary (Reactivation)	GP referral	lab test	no	N/A	D	N	Pill side effects	Y
Hemi	Pulmonary	chest x-ray	lab test	no	N/A	S	N	Forgot one dose only	Y
Rangi	Pulmonary	GP referral	lab test	no	N/A	SAT/DOT	N	Forgot pills	Y
Ngaire	Pulmonary	chest x-ray	lab test	no	N/A	D	Y	DOT	N
Mahina/Pania	TB Meningitis	acute hospital admission	lab test	yes	Lab/ doctor delay	D	Y/N	Forgot appointments DOT	N
Maata	Dormant TB	contact tracing	Not known	no	N/A	S	Y	SAT	N
Hone	X-Pulmonary	GP referral	lab test	yes	Patient delay	S	Y	SAT	Y/N

Data Collection

In this study, I used semi-structured interview, participant observation, content/thematic analysis – transcripts, medical records and literature review, to gather data.

Semi-structured Interviews

Interviews were conducted from April 2005 to July 2005. Kanohi ki te kanohi, face-to-face interviews were conducted following a semi-structured open-ended format. Māori ethics research guidelines propose an initial period of consultation occur with the intended research group and their whānau, prior to interviewing. However this was not appropriate given the dislocated whānau circumstances of most participants, the geographical distance between individuals and their whānau and the prevalence of non-disclosure outside of immediate family members.

Interview questions (see Appendix A) guided the discussion. However, informants usually provided much of the information of interest merely by recounting their experiences. Interviews were conducted at the participant's home, place of work or other agreed locations. Not withstanding technology failure, most interviews were recorded and transcribed verbatim. All interviews were followed by subsequent telephone conversations, emails or meetings with participants (if contactable), before and after interview transcription and during initial data analysis. A copy of the transcript was then returned to participants. All participants have been given pseudonyms, and possible identifying markers have been omitted or masked to preserve confidentiality.

The interview focused on four general areas of discussion:

- Health experiences relating to TB illness and treatment;
- Whānau and community responses to TB;
- Cultural identity;
- Political beliefs, relevance of the Treaty of Waitangi for individuals.

<u>Participant observation</u>

"Human behaviour is not random, but socially structured." Observation of human beings can facilitate the discovery of the mechanisms most likely to shape social behaviour. Recording and detailing what is going on, who is included and the setting activity occurs in all provide a framework through which individual behaviour and responses might be understood.[186]

Throughout fieldwork, a record of observation details was kept to give context to each interview. To try and avoid assumptions, when recall failed a general overview of each interview was documented. Details included the general disposition and physicality of the interviewee, the place where the interview occurred, unrecorded relevant remarks, and the presence of other whānau or friends. A log of all contacts with interviewees and conversations details was kept to ensure an accurate time line was maintained during interview analysis.

Opportunities for clinic-based participant observation were rare. Most participants had already completed their treatment; some declined preferring solitude when undergoing uncomfortable diagnostic tests. Due to considerable geographical distances offers of transport assistance to clinical appointments were unworkable or totally impractical. Only one opportunity presented to accompany a participant to a seemingly routine clinical appointment.

<u>Document analysis</u>

Documents provide a source of information, a record of an event, an account of the perspective of one person or group and a record by which details of the accounts of participants might be correlated. Diverse versions of an event, written and verbal, can provide insight into the ways different members construct and make meaning of the same event.[187]

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[186] J. Green., N. Thorogood, *Qualitative methods for health research,* London, Sage Publications, (2004), p.144.
[187] Emerson, et al., (1995), p.118.

Permission to examine medical records of all but one of the participants was obtained. A record of why the document is significant, subject matter, the tone, word choice and any other distinguishing linguistic features was kept.[188] Because reports are not value-neutral accounts, any discernable assumptions in the reporting or recording observations, such as those found in ward notes, was also noted.

The Researcher

Semi-structured interviews are a product of social interaction between the participant and the researcher.[189] Factors shaping that interaction here were a KMR approach, the researcher being Māori and female, as well as the age of some of the research participants.

The shared cultural norms and practices influenced the type of data collected. For example, when questioning kuia or kaumatua my approach would be more deferential than perhaps to someone of my own age. Anderson & Jack (1991) suggest where the interviewer and participant share similar backgrounds of shared norms for interaction; interview strategies should be made more explicit to avoid interference.[190] Their suggestion ignores the power dynamics underpinning social and cultural traditions and customs. Adopting such an approach with kuia or kaumatua would most likely result in no interview.

However, the role of the researcher is not passive. The interviewer is a social actor, a conversation contributor, posing questions, choosing which points to explore and responding in verbal/non-verbal ways to the participant narrative.[191] The researcher can also shape the participant's narrative by focusing on aspects of their story which fit into an existing schema of what the researcher

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[188] M. B. Miles, A. M. Huberman, *Qualitative data analysis, 2nd ed.*, USA, Sage Publications, (1994), p.54.

[189] D. Hammer, A. Wildavsky, The open-ended, semistructured interview: An (almost) operational guide, in A. Wildavsky, *Craftsway: On the organization of scholarly work*, Transaction Publishers, New Jersey, (1993), pp.57-101.

[190] K. Anderson, D. Jack, Learning to listen: interview techniques and analyses in S.B. Gluck & D. Patai, (ed.), *Women's words, the feminist practise of oral history*, London, Routledge, (1991), p.11-14.

[191] E. Georgaca, Analysing the interviewer: the joint construction of accounts of psychotic experience, in L. Finlay, B. Gough, *Reflexivity, a practical guide for researchers in health and social sciences*, London, Blackwell, (2003), pp.120-132.

already knows. [192] Gerring (2001) suggests that it is inevitable that researchers are implicated in the subjects whom they study, he muses, "it is our blessing and our curse". [193]

Analysis

An inductive interpretive analysis of the data was used in this study. The interviews were first scrutinised using the TB Research project GIS (Geographic Information System)[194] coding categories, to identify areas of missing or thin information. The transcripts were imported into the QSR N6 software program and coded descriptively, topically and according to common themes. A coding scheme was developed using the three Treaty principles, TB and 'Other' headings. Data was recoded, as far as possible under the Treaty principles. The process of transcribing, categorising, and coding data, provided considerable opportunity to reflect on and identify common themes and concepts, within or between participant narratives. An interpretive analysis of the transcripts identified linguistic features, narrative structure themes and narrative style.

Coding Scheme

Codes are tags or labels for assigning units of meaning to the descriptive or inferential information gathered during research. These can be a straight forward category, referring to the topic or literal content of the information being coded or a more complex and conceptual interpretation of the particular data.[195]

A provisional list of coding was developed under five main categories: the three Treaty principles – partnership, protection and participation, TB and other. The source material for the starting list included, the conceptual framework, GIS coding categories and recurring topics across participant interviews. Because of the interconnectedness of the three principles, a typology

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[192] Anderson & Jack, (1991), p.19.
[193] J. Gerring, *Social science methodology, a criterial framework*, Cambridge, Cambridge University Press, (2001), p. xix.
[194] Views and analyses data from a geographical perspective - links location to information to provide an understanding of how it all interrelates.
[195] Miles & Huberman, (2001), p. 56.

of definitional attributes was created to provide clear differentiating coding criteria for each principle.

If the objective is to simplify terms and meanings so that a general level of definitional agreement is achieved and understood, then Gerring (2001) believes it matters "how we define not merely that we define". [196] For example, consider what the definition of partnership means generally and what it should mean within this study. Here, partnership is problematic to define because in the context of Treaty debates, the meaning of partnership is contested. Māori view partnership with the Crown as one of equals, whereas the Court of Appeal refers to the relationship as one '*akin* to partnership'. [197] To avoid semantic difficulties Gerring (2001) suggests sampling representative usages and definitions. These included usages in ordinary language – with particular attention to context, and a review of the definitional attributes from a variety of sources. [198] A list of universal attributes, specific to each of the principles was collated, and then reduced to a list of minimal and ideal-type definitions. [199] (See Appendix B) From this process coding categories and a concept definition for the three principles was developed:

> *Protection*: Health highly prized resource; Maintain/support/promote access to cultural, social, spiritual, economic mechanisms necessary to health, maintain health through TB knowledge through HCP support/provision, health promotion, active health intervention/services by the MOH or not, the health behaviour of participants – health history, family health knowledge. Participant health seeking/keeping behaviours – are there resources to facilitate change?

> *Participation:* The ability of participants to engage with - the activities of daily living, their whānau , their community, employment, work environment – colleagues, other communities, education, housing, decision-making relating to themselves - i.e. autonomy, representation. Activities of HCP - engage Māori, culturally appropriate service delivery,

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[196] Gerring, p.65-69.

[197] *Te Puni Kokiri*, He Tirohanga ō Kawa kit e Tiriti o Waitangi, A guide to the principles of the Treaty of Waitangi as expressed by the Courts and the Waitangi Tribunal. Te Puni Kokiri Website. Accessed 05/03/05,
http://www.tpk.govt.nz/publications/docs/tpk_Treaty/Treaty_principles.pdf.

[198] Health policy - NZ Health & Disability Act 2000, He Korowai Oranga Māori Health Policy 2002, Whakatakaka 2002; The Royal Commission, April Report 1988; Waitangi Tribunal Reports – Wai 1071, 692, 8,; Durie, (1989); Haywood, (2004), (1997); Te Puni Kokiri's discussion of the Courts and the Waitangi Tribunal's application of the three principles.

[199] Gerring, p.71.

compulsion, patient decision making in treatment? Effects of stigma. Independence.

Partnership: About collaboration, corroboration, power, equity, and empowerment. Interaction of HCP with participants: supporting treatment, treatment complications, treatment enforcement, perceived attitudes of HCP, best interests of patients? Relationships with whānau before/during after TB. Emotions.

Coding was adjusted or redefined throughout the coding process as different themes and concepts were revealed. A complete summary of coding categories are included in Appendix C.

Narrative analysis

Here, narrative refers to a story with a beginning, middle, and end. Within each narrative there are mini-narratives, distinguishable by the development of a plot. Each is constructed to convey a meaningful story and often there is one overarching moral within each narrative or mini-narrative.[200] There is also, usually, an underlying reason for telling these stories.[201] For example, one participant with dormant TB struggled with feelings of guilt. Her granddaughter contracted TB meningitis and initially she was believed to be the source of her granddaughter's infection. Even though she could not have been the source of infection, guilt pervaded her story, structuring her account according to the different events which implicated her. In telling her story, I believe, she sought to relinquish some of that guilt.

In narrative analysis, the story as a whole is considered, as well as the context of the story and the reason for telling a story a particular way. The importance of listening to patient narratives, in order to guide medical professionals toward appropriate measures of care, has received increasing academic scrutiny. Kleinmann (1988) has argued for physician education which centralises illness narratives in treatment response to the chronically ill.[202] As a result, lay perspectives of health and illness are less likely to be discarded as

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[200] J. Park, C. Banwell, *On analysing in-depth interviews*, Unpublished manuscript, (1999), pp.1-6.
[201] Miles & Huberman, (1994), pp.54-56
[202] A. Kleinman, *The illness narratives,* New York, Basic Books, (1988).
J. Macdonald, J. Park, The culture of health and illness, in Dew, K. & Davis, P., *Health and society in Aotearoa New Zealand,* Melbourne, Oxford University Press, (2005), pp.86-98.

purely subjective. Instead, patient discourses are viewed as a way for the individual to make sense of an experience, give opportunity to an audience to understand what it might feel like to have that particular experience and allow the narrator to communicate what is important in their lives.[203] Building upon the work of other theorists, Mike Bury (2001) applies theoretical frames to these three factors motivating patient discourse, which he refers to as contingent, moral and core narrative frames.

A contingent narrative refers to the beliefs of the origins of disease an individual has and the effects of illness in everyday life. Chronic or long term treatment builds familiarity with medically based ideas, which informants will often incorporate into their stories. Often a normalisation of illness within everyday life occurs, where illness is part of 'normal' life. Bury suggests under these conditions people are likely to disclose their illness, rather than concealing it.[204] For example, one participant continued to work throughout his treatment and was proud of his ability to continue a 'normal' life despite having TB.

> …they praise me for, you know, for a sickly guy, they reckon, they are very amazed at the ability of my arr work ability, you know. They think a bloke with all that arr sickness, you would think he be nearly dead, ya know.   (Hemi, 57yrs)

Moral narratives are evaluative. The underlying intent of the narrative is to account or justify, in a way which portrays the self favourably, in accordance with personal beliefs, cultural and societal values. Anderson & Jack (1991) believe, 'moral self-evaluative statements allow us to examine the relationship between self-concept and cultural norms'.[205] As such, strategies used to portray the moral qualities of illness are likely to include the maintenance of normal appearances (in the face of illness), virtuous self presentation and the presenting of oneself as living 'successively' with illness.[206] For example, Hemi's belief in continuing a normal life structured his attitudes about illness.

> …you know how some people just give up on arr on all types of things like working, oh, virtually living some people do…some of me mates had arr, various

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[203] L. C. Garro & C. Mattingly, Narratives as construct and construction in C. Mattingly & L.C. Garro, *Narrative and the cultural construction of illness and healing,* Berkley, University of California Press, (2000), pp.1-32.

[204] M. Bury, Illness narratives: fact or fiction? *Sociology of Health & Illness*, Vol. 23, No. 3, (2001), pp.263-273.

[205] Anderson & Jack, p.20.

[206] Bury, pp.274-277.

diseases and they've just given up…You've got to stick with it…hold your head up high and keep going and you'll get there. I don't get down just because I got TB and think oh arr I'm gonna die.   (Hemi, 57yrs)

Core narratives refer to the elements of the narrative revealed, consciously or not, by the individual's language, clichés, motifs, and other linguistic elements which influence how and what is expressed in relation to suffering and illness. These connections relate to a person's experiences and the deeper cultural meanings attached to illness. These accounts are often complex, ambiguous and contradictory at times.[207] For example, Kowhai was uncooperative and non-compliant during treatment. Despite not wanting family members to catch TB from her, she ran away from the hospital and returned home to the support of her family.

Really I just didn't give a shit. I didn't. I just wanted to get out of there. I didn't wanna be in hospital. Wanted to be at home. That's how I felt, I didn't wanna know…I was scared, yeah, I was crying, but I didn't give a shit. I just wanted to be out of there.
                                                    (Kowhai, 24yrs)

A mix of narrative frames is evident throughout participant stories, as their plot, focus and intention shift to the construction of other mini-narratives within their overall discussion.

Thematic Analysis

Thematic analysis focuses on identifiable themes, common ideas, patterns of living and behaviour within a data set. It is useful for revealing messages within text which is difficult to see with casual observation. It is a process of reading between the lines. Linguistic features such as repeated metaphor usage, colloquial or formal speech and shifts from first to second person can also identify a theme or signal a shift to a new theme.[208]

Conclusion

Māori desire to control research, is not merely an expression of rangatiratanga, but a desire to ensure that the benefits derived from such

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[207] Bury, pp.277-280.
[208] Park & Banwell, (1999), pp.7-9

endeavours accrue to Māori. However, the qualifying criteria for researchers may serve to undermine this process as both Pakeha and Māori researchers avoid engaging with Māori communities because of such requirements. Furthermore, in some instances, this criterion has the potential of distorting the realities of Māori communities if the only frames of reference are those of the researcher. It is also important that as Māori researchers, we do not engage in the process for which the non-Māori research fraternity has been accused.

From this analysis eight areas of common participant experience were identified. These are now categorised in the following chapter under the three Treaty of Waitangi principles - partnership, participation and protection.

CHAPTER FIVE

The Treaty Principles in the Health Experiences

of Māori: a case study of TB

In this chapter the key themes identified in the interview transcripts are categorized according to the three Treaty of Waitangi principles – partnership, participation and protection. In general usages, interpretation of the meanings of Treaty principles are diverse with understandings often determined by the case or context to which the principle is applied.[209] Here too, I have referenced particular interpretations of Treaty principles which relate to my interest in the use of the principles in public policy. For this reason explanations accompany each section to guide the reader to the particular perspective used. It is also important to note that the interconnectedness of the Treaty principles mean that some themes could be categorized under more than one principle. The key themes identified were treatment compliance, patient-doctor communication, trust, independence, stigma, and culture.

The Partnership principle in health

In nearly any context, the term partnership is conceived of as a collaborative process. That is, a formal relationship established between organisations or individuals, who co-operate in a shared activity toward a common purpose. Each group is assumed (by the other) to be acting in 'good faith', for the mutual benefit of both groups with an acknowledgement of a duty to consult each other regarding activities which influence their common goal. He Korowai Oranga - Māori health policy envisages a partnership between Māori communities and the Government for the purpose of achieving whānau ora.

Health agencies and providers assume responsibility on behalf of the Ministry of Health as the 'partner' in the process of achieving whānau ora. In TB,

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[209] Te Puni Kokiri, (2001a), p.78.

the case managers (the Public Health Nurse and clinician) are the Government representatives in partnership with the person diagnosed with TB. From the first meeting, the PHN seeks to build a positive relationship with the patient, taking time to learn about their health history, beliefs and attitudes about TB, as well as sources of social support and potential barriers to treatment. Effective communication is crucial for establishing trust and rapport in order to build a good relationship with patients.[210]

The idea that a patient-health practitioner relationship could operate like a partnership was one introduced by medical physician, Timothy Quill (1983). Quill (1983) describes a partnership model, in which both parties consent to the relationship, have unique responsibilities, are willing to negotiate and benefit from the encounter.[211] This process has the effect of empowering patients, by engaging them in their treatment in a manner which ensures that their individual autonomy and choices are not threatened.

However, medical responses to notifiable infectious diseases, such as TB, have multiple imperatives driving treatment decisions. Aside from the treatment of an individual there is also the fundamental issue of protecting the population from perceived public health threats. Consequently, opportunities for patients to exercise any independence can only occur within a limited range of choices. Any patient deviation from treatment is likely to be deemed a threat to population health objectives.

In New Zealand, adherence to TB treatment focuses mostly, but not exclusively, on individuals taking their anti-TB medication, as prescribed. Whether the treatment process is inclusive of whānau or not, is a decision made by the individual. Because of the lengthy medication period, patients are assigned one of three medication supervisory methods - self-administered treatment (SAT), close supervision or Directly Observed Therapy (DOT).[212] The Public Health Service closely monitor medication adherence regularly counting pills and

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[210] M. McLean, Chapter 4: Adherence to treatment in *Guidelines for Tuberculosis Control in New Zealand 2003*, Ministry of Health, (December 2002). Accessed Ministry of Health Website 15/08/04
http://www.moh.govt.nz/moh.nsf/49ba80c00757b8804c256673001d47d0/4760df3580a6f5b5cc256c86006ed394?OpenDocument
[211] T.E. Quills, Partnerships in patient care: a contractual approach, *Annals of internal medicine,* (1983), 98, 2, pp. 228-234.
[212] SAT refers to self-administered treatment – the PHN's deliver medication in blister packs.

keeping track of the physical location of patients, particularly those on DOT. A failure to complete the course of medication as prescribed will usually result in a longer period of treatment and much closer monitoring of the individual. If necessary, incentives or contracts to encourage individuals to continue treatment are used. However, if a person adamantly refuses treatment whilst infectious, a Medical Officer of Health can apply to a District Court Judge under Section 16 of the Tuberculosis Act 1948, for a court order to detain and isolate that person.[213] The use of detention is rare. Threatening to detain individuals is also uncommon.[214]

In this study, treatment compliance ranged from absolute adherence to absconding from the hospital whilst still infectious. The extent of individual adherence to treatment was influenced by TB knowledge, comprehension of TB treatment, medication side effects and the relationship established by case managers with participants.

A treatment partnership?

There were mixed reviews from participants regarding their relationship with medical and healthcare professionals. PHNs were viewed the most positively followed by clinicians. This is unsurprising as these are the two health professionals participants engaged with the most. Other health professionals, hospital staff and community service providers were only mentioned if participant experience was very positive or rather negative.

The health professionals who attracted the least negative comments were the PHNs. The PHNs also provided emotional support, obtained information for participants about their treatment, discussed health-keeping practices, particularly tobacco use and translated clinical explanations in lay terms.
Participants expressed genuine affection for their PHN. Comments included, 'a terrific bird', 'a great woman', and 'I love her, aye'. Participants acknowledged the nurses as significant factors in helping them cope with their treatment.

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[213] *Ministry of Health,* A guide to Section 16 of the Tuberculosis Act 1948, Wellington, Public health policy and regulation section, (1996).
[214] Personal communication 27/10/05, Craig Thornley, Medical Officer of Health, ARPHS.

> …if it wasn't for [PHN] I would have been locked down. But she had so much patience with me. She did, she had a lot of patience I was just a real bitch. I was that stubborn, that she would wait and wait and wait for me to calm down….I just love her really, I must say, to take me on…   (Kowhai, 24yrs)

By comparison, other nursing professionals received more moderate reviews. Often other nurses were only mentioned if participants were unhappy with the care received or the nurse's perceived attitudes. One participant believed a staff nurse was like herself, from the 'old school' and that is why they clashed. The term 'old school' appeared to mean a more traditional expectation of unquestioning compliance to medical treatment. Another participant said a staff nurse 'gave him the feeling' it was his fault he was sick. The same participant's partner also mentioned the different approaches of District Health Nurses.

> …one of the district nurses that came to change his thing [dressing], it was sort of like, straight in, do her thing, never mind having a talk to see how he actually is. You know, change his dressing and off. Whereas another one, use to come in and have a cup of tea and shall we get your dressing changed now, you know, making him, comfortable in his own place, whereas the other one, hmm…   (Manaia, Hone's partner)

While the doctors also received mixed reviews, generally participants considered their doctors professional and good. The clinicians were described the most positively. Descriptions included having a 'good manner', professional, empathetic and a 'hell of a nice guy'. Often, a doctor's ethnicity was included in the description given by participants. For example, 'a Pakeha', Hindu, 'is part Māori ', Indian and 'Scotsman or Irish, he's got a funny accent.' Only when participants perceived the attitude of a doctor was unhelpful, did they differentiate the status of the doctor, i.e. clinician, house surgeon, registrar or General Practitioner. Negative comments were rarely directed at the perceived skill level of doctors.

Reports indicate Māori underutilize general practitioner services.[215] This concurs with the findings in this study. A number of participants admitted delay (patient delay) in consulting a medical professional even though symptoms were significant and debilitating.

> …the walking, oh I found that a struggle…if I did get up I had to crawl, I crawled to the toilet.   (Reka, 54yrs)

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[215] S. Crengle, (1999).

However, once participants in this study consulted a medical physician, they expected a rapid diagnosis. Kowhai had symptoms for a month before finally seeking medical attention. After five days in hospital, doctors were still unable to confirm a diagnosis.

> …they're telling her it was one thing, then end up telling her it's another thing. All she wanted to know really was, you know, what's the sickness I've got and what can yous do about it…   (Rau, Kowhai's partner)

Previous studies indicate doctor delay is a significant component of the total delay in diagnosing TB. Calder et al. (2000) found that often patients have pre-existing lung conditions, multiple consultations with different doctors, or the physician failed to inquire about past exposure to TB or request a chest X-ray.[216]

Two participants approached other health services for support, the Māori Health Unit based at North Shore Hospital and He Korowai Aroha, operated by Ngati Whatua. Both participants commented on the importance of the people running these services being Māori. Both organizations facilitated access to other social services, alternative health services as well as providing emotional support. Rangi described He Korowai Aroha as giving genuine, caring support, something he felt was 'rare these days'.

Good faith?

In Treaty jurisprudence, good faith is understood as a duty to act reasonably, honorably, respecting each others respective interests or views and acknowledging some degree of accountability between partners.[217] An analogy can be drawn between the good faith expectations of Treaty partners and that of patient expectations for a duty of care of their health professionals. A duty of care means there is an expectation that health professionals will exercise a reasonable standard of care while performing any act that could forseeably harm patients.[218] That is, complete and comprehensible information about intended treatments, as well as timely and appropriate care. In this study, inadequate explanations from

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[216] L. Calder, W., Gao, G. Simmons, Tuberculosis: reasons for diagnostic delay in Auckland, in *New Zealand Medical Journal*, (2000), Vol. 113, pp.483-5.
[217] Wai 414, (1998).
[218] *Wikipedia Website*, Accessed 10/12/05, http://en.wikipedia.org/wiki/Duty_of_care

clinicians or doctors were common and for three participants, inappropriate treatment and doctor delayed diagnosis of their TB had significant impact on their lives.

Mahina, the youngest participant in this study developed TB meningitis at the age of eleven months, after the laboratory results were not sent to her general practitioner. For two months her condition continued to deteriorate, despite her doctor conducting investigative tests and prescribing various medications. Eventually her grandmother urged Mahina's parents to take her to the hospital again.

> So I looked at her, and it just seemed something, just something different about her. Her face, her expression on her face while she was sleeping. So I picked her up and went to wake her up and when she opened her eyes, it was like one eye opened first and then the other eye opened afterwards and it was like her eyes were just bulging out of her face. And I got a fright and it just bought back memories of arr, um her Aunt being in the same sort of a situation, semi-comatose state before actually passing. So that was when I said to Pania, get her into the car you got to get her to the hospital, get her to the doctor, um, this is not normal. (Maata, 49yrs)

The consequences of diagnostic delay for Mahina are significant. Due to meningitis she has life-long endocrinological issues, delayed speech development, some hearing problems and is currently underweight for her age. Her parents have struggled to come to terms with what happened to their baby.

> …it was just s'pose to be TB, not TB meningitis, where she nearly died.
> (Pania, Mahina's mother)

Another participant visited his family doctor, after night sweats, chills and weight loss and was prescribed an influenza vaccination. He claims the vaccine triggered psychotic symptoms.

> … it just boom, blew me out…I was like out there, you know I mean like I was hearing voices and started to get all of this sort of disorientations and stuff…
> (Pita, 44yrs)

After approaching his family for help, a sister offered to care for Pita, giving him unprescribed medications, which he believes caused an acute psychotic episode. He was arrested for assaulting his sister and was eventually committed to a psychiatric unit with a diagnosis of mental instability. Shortly afterwards, he was transferred to North Shore hospital, when a blood test indicated other health issues. Pita believes if he had been diagnosed correctly, he

would not have been committed to a psychiatric unit with a mental illness. Pita feels that his psychiatric diagnosis was the reason he received poor treatment from medical professionals and hospital staff during his hospital stay. He is now on an invalid's benefit and has recently been diagnosed with lung cancer, the cause of which he also blames on the delay to diagnose his TB.

Patient expectations of timely diagnosis and treatment are also matched by an expectation that doctors will prescribe the appropriate treatment. Reka was diagnosed with TB outside of the Auckland region. Despite being described as highly mobile with multiple social issues, she was discharged from hospital still infectious, (with community support and home services) without DOT and with twice the recommended medication dose.

As a consequence, Reka suffered debilitating medication side effects. Generally, low-level side effects from medication are accepted by most participants as part of the treatment. Indications of serious side effects such as rashes, hepatic or retinal toxicity are monitored closely by case managers. Participants who experienced serious symptoms are prescribed alternative drugs. Nearly all participants reported low level symptoms like tiredness, mood changes or nausea. These are usually managed more passively, with B6 supplements or anti-emetics.

However, Reka's treatment side effects were not discovered. Unable to cope living alone, she went to live with a daughter in Auckland. By this stage she was thin, frail, moving only with assistance, suffering from constant diarrhea and wearing adult diapers.

> … they were ugly, the, the side affects I had…From the first ones...getting bad headaches and my stomach was tight, yeah, oh everything, I felt horrible…in my stomach, and then everything came out… out of my bowels and it was ooh…

Following intervention by an Auckland based PHN and clinical reassessment by an Auckland based clinician, Reka's medication was changed and community support services mobilised. Reka was unable to recall whether she mentioned her side effects during routine PHN visits or TB clinical consultations or not.

The general level of communication experienced by participants often undermined the patient-doctor relationship. Complaints ranged from frequent use of medical jargon and incomprehensible explanations (to a lay person).

Participants perceived a general lack of willingness on the part of their doctors to take time to explain procedures.

Omaka has tertiary level qualifications, yet she had difficulty understanding her doctors. She observed they "appeared incapable of explaining what they meant" and while in hospital, there was one instance where two of her doctors gave conflicting instructions.

Research indicates TB treatment compliance relies on key health professionals establishing good communication with each other and their patient.[219] This means, providing information to patients in a manner, form and language understandable to that person. This is, after all, what informed consent implies.

> …they weren't even breaking their big words down for me. As much as I asked them, arr look, can you explain that better? I can't understand your medical terms. They couldn't do that.   (Kowhai, 24yrs)

While there is some debate about the efficacy of verbal and written information when explaining clinical treatment to patients,[220] patient education is still considered the most effective tool for ensuring TB treatment is completed.[221] How much information a patient might absorb will depend on a variety of factors. The communication skills of key healthcare providers and their patient caseload, the patient's age, educational status and cultural beliefs, all of these influence individual uptake of information. Differences in understanding of common medical terms between doctors and their patients all can play a role in the level of patient knowledge about their medical treatment.[222]

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[219] K. Currie, M. Rajendran, M. Spink, M. Carter, J. Anderson, Consumer health information: what the research is telling us, *Australian Family Physician,* (2001), Vol. 30, No. 11, pp. 1108-1112. Accessed Internet 27/10/05 http://www.racgp.org.au/document.asp?id=4897
McLean, (2002), p.11.

[220] J. Collett, Remember to communicate and communicate to remember, *New Zealand Medical Journal*, (October 2002), No. 115, Vol. 1164. Accessed University of Auckland Database 26/10/05 http://www.nzma.org.nz.ezproxy.auckland.ac.nz/journal/115-1164/218/
P. Turner, C. Williams, Informed consent: patients listen and read, but what information do they retain? *New Zealand Medical Journal*, (October 2002), No. 115, Vol. 1164. Accessed University of Auckland Database 26/10/05 http://www.nzma.org.nz.ezproxy.auckland.ac.nz/journal/115-1164/217/

[221] Oest, C van der., Chenhall, R., Hood, D., Kelly, P., Talking about TB: multicultural diversity and tuberculosis services in Waikato. New Zealand, *New Zealand Medical Journal*, (2005), No. 118, Vol. 1216. Accessed University of Auckland Database 26/10/05, http://www.nzma.org.nz.ezproxy.auckland.ac.nz/journal/118-1216/1496/.

[222] J. Hadlow, M. Pitts, The understanding of common health terms by doctors, nurse and patients, (Abstract), *Social Science & Medicine,* Jan 15, 1991, Vol. 32, No. 2, pp.193-195.

A language barrier between patients and doctors has the effect of disempowering individuals. In the absence of a comprehensible explanation, participants felt uncertain about what was going to happen to them.

> …the major doctor that I had, I just had a real problem with him, simply because he would not sit down with me and explain to me everything that they were putting me through, it was like, we're gonna do this, and I'd say why? And he would just say, we're gonna do it, ok. (Pita, 44yrs)

In this study, a general lack of understanding of medical terms and procedures accompanied with instances of insufficient or inconsistent medical advice influenced the relationship with various healthcare professionals and at times, the degree of participant willingness to adhere to treatment.[223]

Rangatiratanga

In He Korowai Oranga, rangatiratanga is conceptualised as a process whereby Māori aspirations determine the shape and direction of their own institutions, communities and development.[224] Accepting that rangatiratanga has generally applied to leaders of Iwi and the collective they represent, for the purposes of this analysis, that idea is utilised at the level of the individual. Participants (and whānau if included) are viewed as holding autonomous and independent health objectives, which may not necessarily differ from those held by their case managers. Consultation with participants regarding treatment decisions acknowledges the mana and right of the individual to control what happens to their bodies. This means in the consultative process, participant input is recognised and responded to by their partners - the case managers. If autonomy is threatened, individuals may resist, withdraw from the relationship and reassert their independence by modifying their co-operation.

In this study, although participants generally co-operated with their treatment, most felt they had few choices and relatively little control over the process. One participant commented that while Māori may not question the treatment, they will resist by choosing when to co-operate. An example of this was a person on DOT, who declined to participate in this study. Evidently this

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[223] These factors also found to influence compliance in C. van der Oest et al. (2005).
[224] MOH, (2002a), p.11.

person would regularly disappear on fishing or hunting trips seemingly unconcerned about the continuity of their treatment.

Most participants did not like taking the medication and more than half missed dosages for various reasons. Participants complained about the large quantity and size of tablets, variously describing the pills as 'humongous', 'the size of ten cent pieces', 'big tablets, hard to swallow' and 'ugly'.

Any attempts by participants to claim greater control over what was happening to them were deemed acts of non-compliance. After three days on a particular medication, Omaka adamantly refused to take the 'grey' pill.

> Dizzy, I was dizzy, and I was arr, vomiting and I was, couldn't walk oh yeah, and they trialed me on these for about a fortnight, I told em, you know where you can go mate. So I biffed em, you know, er, they're, they're standing there giving me the pills, oh poor old [PHN], nah, get out of here with your stuff, I'll take these but I aint taking that.
> (Omaka, 62yrs)

From a clinical perspective, Omaka's symptoms may have been assessed as low risk and therefore manageable with other medication. Because she was unable to persuade her clinicians or nurses to change her medication, Omaka threatened to leave the hospital.

> …I just told her straight, you don't own me mate. I own myself, I make the decisions, what I put in my body and what I don't, you either take that away or I'm outta here, simple. I don't have to, me, I'm here because you fullas say I got TB.

Although she had repeatedly asked for a different drug, the medication was not changed until she threatened complete withdrawal of her co-operation. Thereafter, Omaka took her tablets without incident.

A stronger claim for independence was made by two participants, who absconded from hospital while still infectious. After being transferred from a psychiatric unit to a general hospital, Pita, found he was confined to his room, with a guard stationed outside his door. Feeling like he was losing control of his life he took matters into his own hands.

> … I thought oh, this is my chance, so I just ran, I just ran out of that hospital, I ran down stairs, I blocked off the lift, all the doctors and that are chasing after me, and, I get to the door, I opened it up, chucked the nurses out and jumped in the lift and the doctor comes and jumps in I says you jump in here I'm gonna whack ya, the door shut, I got down to the lobby, I got to as far as the car park and I asked this guy, bro give me a ride home, you know, and I, I still had my pyjamas on…   (Pita, 44yrs)

Pita was not the only participant to abscond during treatment. Initially, refusing to believe she had TB, Kowhai left hospital and returned home to her whānau.

> I felt like if, really I didn't feel like I was, I had tuberculosis…You know, and my partner, was the closest one to me, slept in the same bed, kiss me, you know, did all that stuff with me. Why didn't Rau have it? … So I really felt like, really I didn't care; I didn't have it… if I had it for that long. Why hasn't anybody else caught it?
>
> (Kowhai, 24yrs)

Even though she did not want anyone else to catch TB, Kowhai left hospital whilst still infectious and returned home to her whānau. She was eventually 'persuaded' to return to hospital.

> …I got threatened by the PHN. Well it wasn't a threat it was just the truth. Um, I didn't want to be locked up in hospital, I didn't want to have to stay in one room all day for a year. And it scared me, cos it meant I didn't get any visitors, my partner couldn't be there next to me.

A contract was drawn up by her PHN and agreed to by Kowhai to ensure her continued co-operation with her treatment.

The Participation principle

He Korowai Oranga - Māori health strategy (2002) targets health inequalities which contribute to low levels of health service usage by Māori. The policy anticipates that addressing these factors will enable Māori to access health services.[225]

Access to healthcare is defined by Andersen et al. (2001) as 'actual use and everything that facilitates or impedes use', that is, those existing conditions which predispose people to use or not use services. These include demographic factors (income, education and employment), knowledge of services and their function, proximity to those services and cultural beliefs of health and illness.[226] The Geneva Declaration on the health and survival of indigenous peoples also includes the consequences of colonization.[227] Andersen (1995) refers to these

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[225] MOH, (2002a), p.2.

[226] R. M. Andersen, T. H. Rice, G. F Kominski, (ed.), *Changing the U.S. health care system, Key issues in health services, policy and management,* San Francisco, Jossey-Bass, (2001), pp.3-30.

[227] *United Nations Economic and Social Council Permanent Forum on Indigenous Issue (1949),* The Geneva declaration on the health and survival of indigenous peoples. Accessed United Nations Website, 12/04/05, http://www.dialoguebetweennations.com/N2N/PF11/English/HealthAnnex1.htm

factors, which shape the manner in which individuals' access medical care, as enabling resources.[228] In this study, the presence or absence of enabling factors determined the manner in which individuals participated in their TB treatment with health services.

<u>Getting to clinic</u>

Most participants relied on the intervention or support of another person to get to the three monthly clinical appointments at either Greenlane or North Shore Hospital. The Public Health Service closely monitors attendance at clinical appointments, with any missed visits promptly investigated by PHNs. Non-attendance is considered to be an indication that a patient requires closer supervision or more support getting to clinical appointments.[229] In this study, participants used a variety of resources and strategies to overcome transport barriers to attending the outpatient clinics.

Half of the informants lived in outer Auckland suburbs or in rural communities, resulting in considerable geographical distance from home to hospital. Of those living in rural communities, three did not own vehicles or hold a current drivers' licence. Using public transport was not a practical option, as services to rural areas are often limited or unavailable. Of the remaining six holding a valid licence, four owned a vehicle, although one car was unregistered and without a warrant.

Car-less participants used various resources to get to their clinical appointments. One rural participant hitchhiked to work each day and had attempted, unsuccessfully, to hitchhike to his clinical appointments, ninety kilometers away. Another urban participant used volunteer driver services as his whānau were unavailable to assist with transport.

Other participants were able to rely on whānau with a vehicle and the time available to transport them to appointments.

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[228] R. Andersen, Revisiting the behavioural model and access to medical care: Does it Matter? *Journal of Health and social behavior*, Vol. 36, No.1, (Mar 1995), pp.1-5.
[229] M. McLean, (2002).
http://www.moh.govt.nz/moh.nsf/49ba80c00757b8804c256673001d47d0/4760df3580a6f5b5cc2 56c86006ed394?OpenDocument
Auckland Regional Public Health Service, Protocol for management of tuberculosis cases, (February 2003), Auckland District Health Board.

… I'd get sent out a notice when I'd have to go in and I pre-book it, pre-book my drivers… I had to use, I had to, if it wasn't a sister, it had to be a brother…

(Kowhai, 24yrs)

However, this arrangement did not guarantee attendance as relatives sometimes forget or more urgent appointments happen at short notice. In one rural participant's clinical notes, the clinician and the PHN 'explored' the possibility of the person moving into the local township so as to be 'more accessible'. Who the shift was to benefit, the service provider or the patient, is unclear. What is clear is that the young woman chose to live rurally with her whānau, because they supported her during her illness, providing transport, childcare, financial assistance and aroha. Moving closer to town might improve access issues, but shifting away from her family, would also create other problems not so easily resolved.

For another participant, the ability to juggle family responsibilities with getting to clinical appointments relied heavily on whanau support. Close clinical monitoring of Mahina following her TB meningitis has resulted in numerous clinical and hospital appointments. To cope with Mahina's treatment schedule, Pania and her five children moved in with her parents and sister, who live in a rural community. Her mother, who works full-time, often cares for her children when Pania is attending appointments with Mahina. She also lends her car, as Pania's vehicle is un-road worthy.

[seven different specialists that you're seeing?]
…it's quite hectic. Its arr, I have to, I have to like, get my mum's vehicle to get me to these, um appointments and I just don't have much to do at home. Because I have to go in and make sure Mahina gets to these appointments. Which I've missed a few on the way here. But I still get around to getting to, getting them rescheduled and doing them.
(Pania, Mahina's mother)

Sometimes Public Health Nurses transported participants to appointments. For example, the eldest participant in this study was taken to her appointments by her PHN. However, she lived in the central city. In the case of rural patients this was not always practical unless the PHN lived in a nearby community.

When participants have transport difficulties the Auckland Regional Public Health Service provides assistance.

Somehow we really make sure they get to those appointments. We make sure we're there…We either pay for that via the service, like taxi chits, or, um petrol

vouchers. For the person who may or may not be, maybe taking them in, or we pick them
up ourselves.   (Marama, Public Health Nurse)

Difficulties getting to treatment seemed to be something which participants accepted. Perhaps this was because transport challenges were a fact of their lives, regardless of whether or not individuals had TB. The PHNs were more concerned about patients and their transport challenges, aware of the importance of monitoring treatment response and the potential consequences of not completing treatment.

Barriers to Treatment – the stigma of TB

In this study, all participants indicated they were aware of a stigma associated with having TB. Some participants believed they experienced different treatment purely because of their illness, others did not. Goffman (1992) describes stigma as anything that publicly discredits us. Such things threaten our presentation of self and are often morally discrediting too. Unsurprisingly, individuals with TB strategize in order to manage the circulation of potentially damaging information by carefully concealing or strategically disclosing their diagnosis.[230] Sometimes, the amount of social stigma experienced by individuals can influence treatment adherence or even abandonment of TB treatment.[231]

High levels of stigma are not uncommon in Māori families, particularly amongst our older Māori who can remember when TB was common.[232] In this study, the range of responses used to cope with the attitudes of other people toward participants with TB, varied. Some felt ashamed, embarrassed and reluctant to admit to having, what one participant described as, 'a dirty disease'. Others had more pragmatic attitudes, choosing to be open about their illness.

Next I discuss five areas in which participants' encountered stigma.

Whānau

For half of the informants in this study, TB fractured or strained whānau relationships. Fear, stigma and misinformation impacted the extent to which

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[230] E. Goffman, *Stigma,* New Jersey, Prentice-Hall, (1964).
[231] A. J. Rubel, L. C. Garro, Social and cultural factors in the successful control of tuberculosis, *Public Health reports*, (Nov-Dec 1992), v:107, no: 6, pp.631-2.
[232] Oest et al. (2005).

participants and their whānau admitted the presence of TB within their families. In this discussion, the term whānau is inclusive of partners and their families too.

There was a clear disclosure boundary within participant whānau.

> Yeah well most Māori that I've worked with have, they have really wanted it to be kept within their family. And if its talked about outside of that family, then they do it. We don't. (Marama, PHN)

For different reasons, disclosure was usually restricted to participant partners/spouses and their children. When disclosure did occur, it was often because of contact tracing. The response from whānau was sometimes negative. One participant reported her son-in-law was angry with her. It was not clear whether the anger was for exposing his children to an infectious disease or not advising him prior to contact tracing. The partner of a participant experienced a more ostracising response from a sibling.

> … my own brother…I went back one time and he said to me don't touch my kids, you know, you might have TB. I said but I've been tested, you know, and then he started saying to me, oh, well Kowhai's got TB. So you must have TB, don't touch my kids. And that really bummed me out… (Rau, Kowhai's partner)

Not wishing to be identified as the carrier of disease was a common fear expressed by participants. A TB carrier was variously constructed as being the 'other', with unsanitary discriminatory connotations – 'a dirty disease you Pakeha brought'. Whilst for another participant, being identified as a TB 'carrier' was to be the cause of a life-threatening illness for a younger member of her whānau and the source of considerable guilt.

> …I was frightened I was the carrier. It's not a really…a good feeling, because, oh, how should I put this, arr, being the probable cause for any child…even your own…can break you. (Maata, 49yrs)

In this study, there were two participants from a family with four cases of TB. The youngest member, Mahina, contracted TB meningitis, and subsequent contact tracing reveal three adult cases - two with dormant TB and one with infectious TB. The severity of the illness of the child increased anxiety over the identity of the carrier, as children generally catch the disease from an adult. Initially, one of the three infected adults was assumed to have infected the child.

Prior to the test results coming back, um I really thought I was, I could have been the carrier. You know I could have been the one to give it to my granddaughter…The rest, the rest of the family were that I was the one to put Mahina in her position…so he [father of Mahina] was blaming me, for passing it on to Mahina, but I let that slide, because I didn't know he had it. And then when I found out he had it, I thought to myself, now it can't be me. (Maata, 49yrs)

Identifying the carrier of Mahina's illness was the cause of considerable tension between Mahina's parents. While, the child's father blamed Maata, the child's mother, Pania, blamed the father's sister.

I just wanted to find the person that had TB and I was quite angry and looking for that person. When I shouldn't be, cos they didn't know that they had it…And when they explained to say that she…oh, that this person, whoever, passed it on to her, didn't know that they had it…I was quite alright about it…It wasn't anybody's fault that she had got it…it's just something that I got over, that I can handle, that it can happen to anybody… (Pania, mother of Mahina)

Both the Aunt and the grandmother had non-infectious TB. Therefore the only case capable of infecting the child was the father. The father and child did not have the same strain of TB.

Members of this family did not tolerate discussion of their diagnosis by whānau beyond the non-disclosure boundary. Maata's anxiety over possibly being the carrier turned to anger when she learned her father and siblings had been advised of her TB by another relative.

She was going around telling my Dad and my family, my brothers and sisters. That I, I could be the carrier of the TB. Now if you get that kind of talk from your own, your own sister, ya big sister…I was, I was really angry with her. (Maata, 49yrs)

Sometimes non-disclosure occurred between couples. For one participant the source of his infection was his partner who initially refused to admit to having had TB.

Well she's funny medical wise. She keeps things to herself; you know… she keeps it under wraps. She's arr, a bit reluctant to let anyone know, that she, her family's got it… Arr she'll think, ooh, they know I got TB. They'll, you know, they'll think oh keep away from that lot. (Hemi, 57yrs)

Health and Medical Services

Participants reported that medical and hospital based staff sometimes increased feelings of isolation and stigma. One participant reported perceiving her

doctor was reluctant to examine her after recently spraining an ankle. She believed the doctor's reaction occurred after she disclosed her TB history.

Two participants, who required periodic hospitalization for other health conditions, commented on the response of hospital admittance staff since having had TB.

> …so like every time he goes into hospital now…attitudes change as soon as they find out he's had TB, he goes straight into isolation.   (Pania – partner of Hone)

> …right across my file, TB…so of course, straight into isolation…and on the outside of the door, TB…   (Omaka, 62yrs)

For Hone and Omaka there was greater concern directed toward their history of TB, than the health problem for which they were hospitalised. Two years after having TB, Omaka had this experience,

> …the staff nurse that was on, didn't read my records, so she made it known to staff that were going to be dealing with me, that when they came in or if I had visitors, this is the [isolation] process, before you come in the door…

> …a nurse came in … she came to ask me a questions, and it was about TB. And I was like aye? So I said, why are you asking me questions about this and not about this? What the hell's that got to do with this?

> …the staff nurse finally came and she was full of apologies…you know, and she openly said we didn't read the records, yeah, and I thought how bad is that?

Omaka wondered whether her treatment by medical staff was due to her being Māori or having TB. She also questioned whether Pakeha with TB experienced the same treatment.

Participants perceived some non-medical hospital staff treated them differently. One participant claimed the cleaning staff would often avoid cleaning his room, while he was in isolation. Another informant had this experience,

> …oh, the tea lady she was the worst of all, she hated my guts. I don't know why, but she was the worse of the lot, I couldn't get nothing out of her, couldn't get a cup of tea, drink of water, had to go get it myself and I couldn't go out of my room, cos I had TB.   (Pita, 44yrs)

Both of these stories seem to indicate participants were sensitive to the responses of others in relation to their having TB. It is quite feasible the cleaning staff were simply less than thorough in their attitudes to their work. Similarly, Pita's attempt to escape hospital, threatening physical harm and his psychiatric diagnosis were the more probable reasons for the tea lady's attitude toward him.

However, he believed the attitudes of all the hospital staff was a response to his mental illness diagnosis.

> While I was in there, they locked me up again in the room um, and by that time all the hospital staff had seen my behaviour, so to speak, and had made up on their little minds, this guys lost it. And so I was, after that I was pretty much treated like dirt.

A suspected TB diagnosis has considerable impact on older Māori with previous experience of the disease. For example the elderly mother of a PHN was isolated after the doctor suspected her respiratory condition could be TB. Apparently no tests were conducted to confirm the doctor's assumptions and the patient claimed no explanation was given for her isolation. The woman spent a sleepless night worrying about whether she had infected her mokopuna, other whānau and people with whom she had recent contact with at her local marae.

At work

Employed participants experienced a range of responses from work colleagues following disclosure of their TB diagnosis. Of the four participants with full-time work, two said they were well supported by work colleagues. One participant felt let down by her colleagues, whom she believed she had always supported during their personal crises.

Returning from sick leave, she noticed some changes.

> I felt, that people were staying clear of me…it was like danger, stay away… [So no hongi?]…no coming in, no, no, you know, cos we always kissed.
> (Omaka, 62yrs)

These changes may have been due to a number of employees questioning why they had not been advised, given the disease was infectious and notifiable. Concerned that her colleague's attitudes were based on a belief that she was the 'carrier', she requested health agencies to come in to her work environment to explain the situation.

Community

Generally, most participants encountered very little discrimination in their community. This is probably due to the high prevalence of non-disclosure and in one instance a partial disclosure. When Mahina returned to normal activities, such

as attending pre-school, her mother advised that Mahina had been sick. By the questions that were asked, it would appear, the discussion focused on meningitis rather than TB. It is possible that this conversation coincided with the public campaign for meningococcal meningitis earlier this year.

Three participants received community services. In the case of one participant who was suspected of still being infectious after hospital discharge, support services were reluctant to provide home help, such as cleaning and meals on wheels. Another participant was asked to leave his boarding house accommodation after being discharged from hospital, because other occupants had also been diagnosed with TB. He was viewed as the carrier.

Social networks

Most participants seemed more comfortable disclosing to friends and acquaintances, rather than relatives, although one participant admitted delaying telling his friends about his TB diagnosis because he was uncertain of the reception he would get.

Participants reported a range of responses from friends and social contacts. One participant reported some friends distanced themselves from him after hearing he had TB. Sometimes participants were not avoided, but were aware of subtle changes in the behaviour of others.

> … just the funny looks that I got. I mean, they'd still share a cigarette. It's just the looks I got, but they'd still share the cigarette.   (Kowhai, 24yrs)

Generally though, most participants received positive support when disclosing their TB illness to friends.

The Principle of Protection

The offer of protection featured prominently throughout the preamble to and content of the Treaty of Waitangi. Protection at the time of the Treaty was understood as applying to property or taonga, chiefly mana, self-determination and those rights acquired with British citizenship. Historically, the principle of protection has been limited to upholding Māori property rights, although somewhat intermittently and rarely (if ever), when those rights challenged public

or Government interests. As a result, the exact nature of Crown protection and what it applies to has shifted frequently in response to legislative changes.[233]

The extent of the Crown's responsibility for protecting Māori interests was clearly outlined in the 1987 Lands Case, *New Zealand Māori Council vs. Attorney General*. The Court of Appeal ruled that 'the duty of the Crown is not merely passive, but extends to active protection in the use of their lands and waters…'[234] The Court held that such responsibility was akin to a fiduciary duty where one party had an obligation to protect the interests of the other party as the more powerful in the agreement. The decision initiated the process of redefining the boundaries of Crown duty to Māori. In exploring Crown responsibility, the Tribunal concluded that 'the principle of protection encompassed the Crown's obligation to take positive steps to ensure that Māori interests are protected. Exactly what 'interests' or taonga the Crown has a duty to protect has been the cause of some discussion.

The Waitangi Tribunal held that the concept of taonga or 'valuable possessions' extended to things intangible as well as tangible.[235] Doug Graham, former Minister in Charge of Treaty of Waitangi Negotiations, argued that the Treaty did not guarantee entitlement to intangible resources such as social services. These types of privileges were drawn from citizenship not the Treaty.[236] Smythe (2004) wondered whether enlarging the scope of Treaty principles causes unnecessary confusion and complications, with no certainty of benefits to Māori.[237] Smith (2000) charged that such shifts in Treaty interpretation moved the Waitangi Tribunal outside the original brief, undermining credibility.[238] Even the Treasury has commented that there are areas where the Treaty is considered 'silent.'[239] Despite the criticisms, Tribunal reports have continued to place

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[233] Waitangi Tribunal Report, *The Napier Hospital and Health Services Report #Wai 692,* Legislation Direct, Wellington, (2001), p.54. Waitangi Tribunal Website. Accessed, (17 March 2005) www.waitangi-tribunal.govt.nz.
[234] New Zealand Māori Council v AG [1987] 1 NZLR 641, 664, per Cooke P cited in TPK (2001) report.
[235] Wai 692, p.49.
[236] D. Graham, Taking the Treaty too far, *Dominion*, (30 August, 2000).
[237] B. Smythe, (2004), 36-01.
[238] N. Smith, (2000).
[239] *New Zealand Treasury*, Government management: Brief to incoming Government, Wellington, Treasury, (1987), p.348.

emphasis on the need to protect intangible assets. That is, our culture and Māori as a people should be considered taonga.[240]

Safeguarding Māori culture, values and belief, as well as improving Māori health status are key objectives of He Korowai Oranga (2002). For indigenous people, health policy which provides access to health services, health promotion and prevention programmes, has historically been limited, inadequate and culturally inappropriate.[241] Achieving equitable health outcomes for Māori requires reorienting health services which serve Māori from a Māori perspective of health and wellness.[242]

In this study, participant notions of identity and culture were a mix of traditional and modern influences. Participant's health keeping and health seeking practices were determined by income and individual attitudes, habit or fear. Some participants used alternative health treatments, but most chose not to deviate from the prescribed treatment. These were sometimes connected to ideas of health keeping practices, but not always.

Taonga

An accepted translation of taonga is 'treasures' or 'anything highly prized.' As already noted, Māori consider intangible valuables taonga too. Language, cultural knowledge and the mauri of a river are some examples. The Courts have ruled that preservation of taonga does not lie solely with the Crown. Māori as Treaty partners must share in that responsibility.[243]

Most participants valued their Māori identity. Individual notions of being Māori were determined by factors such as regular contact with their marae, proficiency in te reo, age and childhood grounding in tikanga. Older participants held stronger Māori values, whilst younger participants identified as Māori, but mediated this identity with other contemporary influences. Generally, however, participants were proud to be Māori.

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[240] For example Te Reo Maori (1986), Mokai School Report, (2000), Te Ika Whenua Rivers Report (1993), Waiheke (1987), Napier Hospital and Health Services (2001).
[241] *World Health Organisation*, International decade of the world's indigenous people, provisional agenda item 8, (December 1998).
[242] MOH, (2000a), p.15-23.
[243] Te Puni Kokiri (2001a), pp.60-64.

Māori are…they're just strong.   (Pania, mother of Mahina)

Put it this way, I was born into it and I'm stuck with it. So I, arr, you can't help but love it, you know.   (Hemi, 57yrs)

…we got so much kaha…in us, aye, our wairua…   (Reka, 54yrs)

For some participants, their Māori identity was not necessarily based on cultural knowledge or language proficiency.

I only know the basics. I think that's all I probably will learn to do...I'm like Māori hard but not in the language. Not even in Māori culture. I don't think I would adapt to it very good.   (Pania, mother of Mahina)

Language competency was one of the most commonly raised issues when participants spoke about their Māori identity. Te reo competency among participants ranged from fluent speakers to only knowing commonly used Māori words. A number of participants believed their lack of competency was due to prohibitions against speaking Māori in schools during the first half of the twentieth century. One participant's parents enforced opposite rules at home, when he was a child.

See when I was small…we use to come back from school. If I got caught talking Pakeha in the house, I get a clip across the ears. Yeah, that's how I think I picked it up.   (Hemi, 57yrs)

The loss of language was believed, by participants, to be one of the contributing factors in the development of the 'modern Māori'. Other factors included, lack of whānau interest in 'things Māori', assimilation, the education model, and urbanisation. The evolution of a modern Māori identity was not viewed positively by the older participants, who implied being Māori was connected to a childhood that was 'hard' or had 'old values', or was a 'traditional Māori upbringing'.

But see most of my learning has come from my father, from my whole whānau. And that learning was mainly about things Māori. You know you couldn't call it a wananga, but that's what they term it today. Because they were the learnings of the marae of the environment, on health or everything…   (Omaka, 62yrs)

Studies on identity formation and development have found that identity is shaped in early childhood, with people such as parents, family and peers, having a

significant influence.[244] Whilst older participants identified their childhood as the key determinant in developing their Māori identity, younger participants did not usually discuss a specific source or cause for their identifying as Māori.

Te ao Māori was evident in some areas of participant discussion. Most participants spoke about themselves in relation to their whānau, mentioning their children, siblings, parents, aunts, uncles and grandparents. One participant spoke of traditional practices for disposal of tuberculous body fluids when she was a child.

> …Our grandmother taught us well, about being hygienic… at home, because everything wasn't inside, we knew where to go. And we all had to carry bottles, because it belongs to us and we had to get rid of it in the appropriate place.   (Omaka, 62yrs)

A few participants mentioned their whakapapa. One participant had pictures of her tūpuna on her lounge wall. Another informant spoke of a korero with her Uncle about whether the cause of her contracting TB for a second time was a warning from her tūpuna. She also mentioned knowing about the local tohunga when she was a child and hearing her mother following the tohunga's instructions.

Even participants with relatively modern attitudes would occasionally indicate that tikanga, (the expectation that younger whanau respect older whanau members), still underpinned some of their attitudes.

> …and that to a Māori, is a big slap in the face, how dare you ever tell me what to do, you young, you know, who do you think you are?   (Pita, 44yrs)

For many Māori, the Treaty of Waitangi is considered taonga, a tapu document. Discussions of the Treaty indicated most participants had limited understanding of the Treaty, with comprehensive knowledge rare. This result concurs with the findings of a recent study on Treaty of Waitangi awareness amongst the public.[245] Most participants held quite strong views about the Treaty of Waitangi.

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[244] T. Moeke-Pickering. *Maori identity within whanau: A review of literature.* Hamilton, University of Waikato, (1996). Accessed 09/08/05
http://psychology.waikato.ac.nz/mpru/pubs/paps-sums/moeke-pickering-2.html
[245] *State Services Commission*, Treaty of Waitangi awareness research, March 2004. Accessed 9/09/05 http://www.ssc.govt.nz/display/document.asp?docid=3858

…a piece of paper saying one thing, but their actions say another. (Pita, 44yrs)

Māori have been ripped off. The Treaty, what has it done? Nothing...It hasn't done jack, the Treaty was written by the Pakeha, for the Māori to put a mark on…
(Reka, 54yrs)

…it's all crap, its all bumpkin…   (Hone, 57yrs)

Despite the depth of emotion expressed, most participants admitted to having very little knowledge about the Treaty. When pressed for an explanation of the purpose of the Treaty, most participants suggested it was about a 'partnership', 'equal roles', '50/50', 'riding parallel', 'equal Stevens' and one participant's suggested it was for 'helping the Māori out…to get their land back'. Of the two participants that knew of the principles, only one had a comprehensive understanding, having worked previously in a Government agency. This person believed there could be no partnership without equitable distribution of resources.

There were diverse opinions about the meaning of the Treaty, mostly negative. One participant was scathing of the way the Treaty had been implemented suggesting 'Māori don't know the trickery behind it'. One participant believed the Treaty was being 'used and abused', for the benefit of only a few Māori. While another had this to say;

…as far as I'm concerned the Treaty was written down and we just obey by what's arr, what's there. A lot of us take it for granted some of the things are in there…they think it's personal, for their own Iwi. And they grab whatever the Government allocated...   (Hemi, 57yrs)

Hemi also expressed concern about the management of financial opportunities arising from policy changes and Treaty settlements.

I think each Iwi had the same conception, when they get the money, yeah we'll share it, and away we go. Then next minute…some how or other it goes croak upstairs. Okay don't, let's make it straight and spread it, you know.   (Hemi, 57yrs)

Generally, participants stated the Treaty had provided few benefits to Māori. Participants felt being tangata whenua had resulted in Māori being treated poorly or as 'second class citizens'.

Active Protection

Active protection refers to the duty of the Crown to take proactive measures to protect Māori interests. Here, Māori interests are defined as Māori health, culture, values and beliefs. In protecting such interests, there is an expectation the strategies used will match the vulnerability of the taonga in question. Proactive measures in the treatment of TB include health promoting strategies, acknowledging different cultural health models and enhancing participant knowledge of TB disease and treatment

In this study, the TB ward at Greenlane Hospital and the PHN appeared to be the main sources of TB information to participants.

As one nurse explains,

…we have visual pictures and things that we can show them, you know. The signs and symptoms, and usually they may have had one or two of them. If they've been admitted into hospital, they've usually had sweats and the loss of weight and you know, the coughing up of blood etc.   (Marama, PHN)

Other information sources for TB included personal enquiries and previous experiences of TB. Most participants were aware of the disease, having previously experienced or observed family members with TB, although knowledge based on personal observations or deductions was not always in line with current bio-medical explanations of disease causation. Two participants and some of their family members appeared to conclude that TB was a familial disease.

… they looked at our father…oh I know he had it…my sisters [said] aye, how come we haven't got it?   (Reka, 54yrs)

I couldn't understand how on earth I cop'd it, and the rest haven't. You know there's eight of us in my family and I'm the youngest … I couldn't figure that out.
(Hemi, 57yrs)

Given the high rates of TB across our Māori communities in the past, this assumption is unsurprising. In this study, almost every participant named a family member/s from the previous generation who had contracted TB or died from it.

When stigma is an obstacle to providing effective treatment or ensuring whanau support, a hui will often be called with the all whanau members invited to be involved. Māori elders, key health providers and professionals attend,

explaining their experiences, their role, educating the whanau about the disease and TB treatment.

> … when I have called the hui of the family it's very interesting, because when you get um, the older family members in the room. Or in a bigger hui, like kaumatua and kuia they, they always remember TB from the '50s' and what it did to their families.

> And so I find my job is, is a lot easier. Because they get up and they talk about it...they start to see it from a different light…I just think that it helps, a lot.
> (Marama, Public Health Nurse)

From this study, it appears the PHS strategy to inform patients about their TB has been effective, despite most participants claiming to not have a clear understanding of the disease. For example, a number of participants used terms from the PHS educational resources, such as 'sleeping' - which refers to dormant TB. Some informants mentioned commonly known or observed symptoms like 'coughing up blood'. Others discussed physiological conditions in which TB is more likely to be contracted or activated, such as being depressed, inadequate nutrition and lowered immunity. A number of participants professed to not knowing anything about TB prior to becoming ill. This would seem to indicate participants had absorbed the information, but most seemed unaware of it.

Health keeping strategies are an important component in safeguarding public health and containment of TB disease. Most participants did understand TB was infectious and described measures and strategies to prevent infection spreading to others.

For some participants health keeping strategies were based on cultural practices and beliefs.

> …my father was there, he was, him and I saying our karakia together felt good, it felt really, you know, and when he left, I felt better. And he said, arr, we love you and this and that and you're gonna be better. (Reka, 54yrs)

Reka was not the only participant to seek comfort in karakia. One participant consulted a Māori spiritual healer, while another participant admitted using rongoa during her TB treatment. Traditional Māori medicines are considered by some doctors to have limited efficacy and are therefore unlikely to have been discouraged by TB clinicians.[246]

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[246] T. McCreanor, R. Nairn, Tauiwi general practitioners' talk about Maori health: interpretative repertoires, *New Zealand Medical Journal*, December 2002, Vol. 115, No. 1167, Accessed 26/10/05 http://www.nzma.org.nz/journal/115-1167/272/

<u>Conclusion</u>

The experiences of participants relating specifically to the principle of partnership could not be directly compared with the strategies outlined in He Korowai Oranga. He Korowai Oranga applies the term partnership to the relationship between Māori providers and DHBs rather than between health services and health service users. The policy does 'encourage' a reorientation of mainstream health services toward the cultural perspectives of Māori health service users. Few participants raised concerns about the manner of their treatment because of cultural reasons. From the transcript themes it is clear that a 'partnership' analogy would not be an accurate description of participant's experiences of treatment by some health professionals.

Participants engaged in their treatment process, predominantly because they wanted to get better. However, the potential for Public Health officials (although refuted by the ARPHS) to enforce compliance, was a persuasive 'stick' for even the most reluctant participant. While the majority of participants faced significant challenges with transport, childcare and finances when accessing clinical appointments, the most significant barrier to treatment, in this study, was the social stigma of TB.

Although He Korowai Oranga affirms Māori identity, culture and beliefs, whether the policy is able to deliver these objectives to mainstream health service users who are Māori is still not known. This small case study has indicated that there are still significant challenges with regard to minimizing preventable harm to patients and reorienting health services to a user perspective as well as from a Māori perspective.

Given the diversity of Māori identities expressed and the increased awareness and respect for cultural differences in many areas of the health sector, I am optimistic these policy objectives will eventually be achieved, incrementally. Whether or not such an outcome occurs specifically because of the Treaty principles in He Korowai Oranga, is the focus of the discussion in the next chapter.

CHAPTER SIX

The Purpose of Treaty Principles

in He Korowai Oranga

<u>Introduction</u>

The Treaty of Waitangi principles provide a framework for *He Korowai Oranga– Māori Health Strategy (2000).* The Treaty is used to engage Māori in the health sector and it could be said that the Treaty and the Treaty principles are enabling mechanisms for Māori.

It has proven methodologically challenging to draw comparisons between the theoretical analysis of He Korowai Oranga and the themes identified across participant interviews. He Korowai Oranga applies the Treaty principles in an interrelated and overlapping manner. This made direct and consistent comparisons difficult. Despite these difficulties, conclusions about the associations between policy decisions, study participant experiences and the Treaty principles can still be drawn.

This chapter discusses the research conclusions in three areas: the influence of Treaty principles in He Korowai Oranga, the role of Māori providers and the issue of Māori identity.

<u>The Influence of Treaty Principles</u>

In 2000, a Treaty clause within the *New Zealand Public Health and Disability Act* recognised the right of Māori to 'contribute' to decision making and to 'participate' in the delivery of health services.[247] Where the use of Treaty principles in legislation is normally criticised as producing 'vague laws, which

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[247] *Ministry of Health*, New Zealand Public Health & Disability Act, Ministry of Health Website, (2000c). Accessed 12/12/04, http://www.moh.govt.nz.

are bad laws,'[248] the intention of this statute was patently clear. The Government would work with Māori, recognising Māori rights derived from the Treaty and the Treaty principles would guide the formation of such a relationship for the delivery of health services to Māori.

If, as research indicates, few people understand the Treaty, it is highly probable even fewer comprehend the meaning of Treaty principles or their relevance to public policy. In this research, few participants understood the Treaty and most had never heard of Treaty principles. While Treaty principles frame Māori health policy, may influence health services and consequently the experiences of health service users, few recipients would be able to determine what it is the presence of the Treaty principles might deliver in terms of health services. Indeed I found it difficult to distinguish what it was the Treaty principles might deliver once other influences had been discounted. While the Treaty is a very important document, tapu for many Māori, the Treaty is neither a determinant of, nor the motivation for, *He Korowai Oranga – Māori Health Strategy (2002)*.

In developing a Māori health strategy, policy makers draw on many sources of information, experience and practices. They consider the experiences of other countries, and jurisdictions, make comparative evaluations, consider relevant research and existing resources and implement whatever is deemed the most appropriate action.[249] In consideration of these policymaking practices, it is evident that the policy framework of He Korowai Oranga has been strongly influenced by internal trends toward a contracting environment in health, Government policy to decentralise health services and directives from the World Health Organisation (WHO).

As one of a number of primary health care strategies, He Korowai Oranga seeks to improve Māori health through better access to primary health

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[248] *Scoop Website*, MP's urged to support Treaty principles Bill, Press Release New Zealand First Party, (10 May 2005). Accessed 18/02/06, http://www.scoop.co.nz/stories/PA0505/S00233.htm

[249] These articles refer to policy learning, policy transfer, lesson drawing.
R. Gauld, One country, four systems: comparing changing health policies in New Zealand, *International Political Science Review,* (2003), Vol 24, No.2, pp.200-01.
K. Jacobs, P. Barnett, Policy transfer and policy learning: a study of the 1991 New Zealand health services taskforce, *Governance: an International Journal of Policy and Administration*, Vol 13, No. 2, (April 2000), pp.185-213.

services.[250] Based on the *Primary Health Care Strategy (PHCS) (2001)* and *the New Zealand Public Health and Disability Act (2000)*, primary health care strategies aim to develop local community initiatives, reduce structural and institutional barriers and affirm the importance of culture to health and well-being.[251] While these strategies are framed in terms of the three Treaty principles,[252] a more significant influence has been the World Health Organisation Declaration of Alma-Ata (1978) on primary health care.[253]

An equally influential WHO directive is the Ottawa Charter (1986). The Charter calls for health promotion, healthy public policy, health environments, strong communities, (culturally) appropriate and understandable health information and health services oriented toward the health needs of the communities they serve.[254]

The Ottawa Charter also advocates the use of holistic models of health and considers these widely applicable in health care, recommending their use in palliative, reproductive and communicable disease management. The Ottawa Charter (1986) refers to 'holistic needs' as 'more than just medical or clinical needs, and like the Māori health model, Whare Tapa Wha, the whanau and community is the mainframe of support around the individual.[255]

Because documents like the Ottawa Charter are derived from a wide range of empirical sources they have considerable legitimacy and influence - although Māori consider the Ottawa Charter consistent with, but secondary to the Treaty of Waitangi. As far back as 1986, the Department of Health, while acknowledging the importance of the Treaty to Māori and the need for Māori health services, acknowledged that the Department's approach was in accord

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[250] MOH, (2001a), p.2.
[251] MOH, (2002a).
[252] April Report, (1988), pp.46-69.
[253] 'Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.'
WHO Regional Office for Europe Website, Declaration of Alma-Ata (12 September 1978). Accessed 13/02/06, http://www.who.dk/AboutWHO/Policy/20010827_1
[254] Health promotion forum of New Zealand.
[255] WHO Website, Accessed 15/02/06, http://www.who.int/en/

with 'the WHO principles set out in the Alma-Ata Declaration'.[256] In an interview with a health worker for this thesis, the comment was made that "a lot of our policies and the way we work come from that World Health Organisation…they make [the] decisions for your future direction".

Community control of primary care health services has been a cornerstone of WHO strategies. In many industrial countries community control has manifested as devolution or decentralisation of social services.

The 'rolling back' or decentralising of the welfare state enjoys the support of free-market proponents, Governments, and community organisations.[257] For Governments there are economic benefits in decentralising health services. For community based and voluntary organisations it gives greater control of their local health services, the ability to deliver more locally appropriate healthcare and to some extent it legitimises the role of these organisations in their respective communities. In New Zealand, the decentralising of health care provision has facilitated an important role for the third sector.[258]

The third sector refers to the non-Governmental, non-profit sector of a country's organisational system and in New Zealand comprises voluntary, community and Māori organisations. Since the 1980's, the third sector has delivered comprehensive primary health care services to vulnerable populations in low income areas - a market that neither the state nor the private sector adequately service.[259] Māori are a significant percentage of the population served by the third sector.

The coinciding of decentralisation with Māori calls for rangatiratanga was no less than a windfall for Government. The reconfiguration of health services has delivered to Māori organisations a crucial health care role for vulnerable Māori populations, but it has also facilitated a transfer of the responsibility for low rates of Māori participation in the health sector.[260] Thus

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[256] Durie, (1998b), p.85.
[257] Kelsey, (1993).

[258] P. Crampton, A. Dowell, A. Woodward, Third sector care for vulnerable populations, *Social Science & Medicine,* (2001), 53, p.1491.
[259] P. Crampton, A. Woodward, A. Dowell, The role of the third sector in providing primary care services – theoretical and policy issues, *Social Policy Journal of New Zealand*, (December 2001), p.16.
[260] Larner & Craig, (2002), p.13.

far, the Ministry of Health strategies have proved relatively ineffectual in successfully engaging Māori with population health issues, particularly screening programmes. If the coinciding of decentralisation with rangatiratanga improves Māori participation population health objectives, then for Government, the change has, as Brown and Crampton (1997) suggest, 'killed two birds with one stone.'[261]

The shift in emphasis to community based health initiatives has been accompanied by an increasing acceptance of public participation in policy processes. For some, public involvement is viewed as legitimising policy decisions.[262] For others, the location of policy activity at community level is an inclusive process, highlighting the importance of territory or place to the network of relationships (common identity, interest or purpose) which comprise people's lives.[263]

However, public involvement generates expectations of choice and negotiation in local policy decisions; stemming from the belief that opinions will be heard, communities empowered and power shared.[264] Anything less, observes Arnstein (1969) is 'manipulation of public opinion'.[265] A manifestation of the idea of power sharing with the public is the use of 'local partnerships'.

Local partnerships, according to Larner and Craig (2002), are ubiquitous, diverse and include 'a kind of 'everything and nothing' polysemy'. Formed for the purpose of developing community based initiatives, local partnerships provide access to social services and are an 'attractive strategy for drawing disaffected groups back to the political mainstream'.[266] As such local partnerships are a new form of social governance, as Governments realise social

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[261] M. C. Brown, P. Crampton, New Zealand policy strategies concerning the funding general practitioner care, *Health Policy*, (1997) 41, p.99.

[262] J. Dryzek, *Discursive democracy,* Cambridge, University Press, (1990).

[263] *ibid.*, p.13.

[264] P. Bishop, Introduction: community consultation and the policy process, *Australian Journal of Public Administration,* Vol 61, No. 1, (March 2002), p.13.
P. Bishop, G. Davis, Mapping public participation in policy choices, *Australian Journal of Public Administration,* Vol 61, No 1, (March 2002), pp.14-17.

[265] S. Arnstein, A Ladder of citizen participation in the USA, Journal of the American Institute of Planners, Vol 35, No 4, (1969), p.217, cited P. Bishop, G. Davis, Mapping public participation in policy choices, *Australian Journal of Public Administration,* Vol 61, No 1, (March 2002), pp.14-17.

[266] Bishop & Glynn, (2002), p.13.

problems cannot be resolved by economic or authoritarian measures.[267] Local partnerships are now a key strategy in primary health services, with partnerships established between DHBs and Māori health providers.

Māori providers represent a convergence of factors. For Government Māori providers are part of the process of decentralising health services. Providers establish in communities with high Māori health need, have distinctly holistic approaches to primary health and most importantly, their presence is a further reflection of the primary health directions envisaged by the WHO. For Māori, Māori providers are a political expression of rangatiratanga and symbolically connect Māori with the Treaty.

<u>Māori providers</u>

Māori health providers have been a presence in the health sector for some time.[268] Operating under various guises, wherever funding was available, it was not until the introduction of contractual mechanisms that more Māori organisations entered the health market. There is now a diverse range of community and tribally based primary care initiatives, reflecting the extent of current need. Geographically spread, with higher numbers generally reflecting greater concentrations of Māori population,[269] providers are a strategic community based resource.

Only one of the participants in this study used the services of a Māori provider. It is not known whether he was referred by the ARPHS to the provider or whether he self-presented. Normally TB patients receive their primary care from PHN and other allied mainstream medical professionals. Given that non-adherence to TB treatment is an ongoing issue with Māori patients; it would seem that there is a role for Māori providers to participate in aspects of TB treatment for Māori.

The causes of Māori non-adherence to TB treatment are numerous. The more commonly cited problems are cultural differences in treatment, lack of

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[267] Larner & Craig, (2002), pp.2-12.

[268] Kiro, (2000), p.310.

[269] Māori Health Directorate Website, http://www.Māori health.govt.nz/2004/about.php

comprehensible treatment explanations, miscommunication and difficulties accessing treatment.[270] These were reflected in the interview themes of this study and indicate a different approach is needed.

In line with WHO directives, but not because of them, Māori providers apply Māori models of health according to Māori cultural beliefs and that difference is noted by their service users.[271] Māori providers also tend to challenge entrenched clinical behaviours – short clinical consultation, detailed clinical explanations and routine prescription of drugs, by considering alternative non-medical solutions e.g. green prescriptions.[272] Providers often live in the communities in which they work, and are therefore aware of the context of people's lives in regard to their illness. Furthermore, the ARPHS do use 'laypeople' to provide community based care to patients on DOT and it has proved a cost effective and reliable method of gaining compliance.[273]

Whether Māori providers remain viable will depend on the extent to which their services are integrated into and across the health sector in areas like public health. (Some providers already hold public health contracts). The use of Māori providers to resolve problems resulting from apparent cultural differences is logical and it could be argued, would increase efficacy of other health services facing similar issues with Māori patients. However, whether Māori providers are able to continue to provide such services will depend on the current operating conditions in the health sector remaining the same or improving.

Currently providers are dependent on contracts funded by DHB, as many charge low co-payments or no fee at all.[274] Funding is an on-going issue, particularly for providers delivering services in high health need areas. Hudson (1998) observed that the financial risk carried by Māori health providers was often greater than other non-Māori health providers.[275] Few have the financial resources or current skill base to diversify services further, thereby restricting the options for increased revenue streams.

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[270] McLean, (2002), p.2.
[271] Kiro, (2000), p.290.
[272] Green prescriptions refer to non-pharmaceutically based treatments, Kiro, (2000), p.322.
[273] C. Bullen, G. Simmons, K. Pritchard, Tackling the communicable disease challenge, *New Zealand, Healthcare and Informatics Review online*, (1 May 2000), Vol 4, No.5, p.5. Accessed 11/04/05, http://www.enigma.co.nz/

[274] NZIER, (2003), p.16.
[275] Cited in Kiro, (2000), p.318.

Māori providers deliver a range of services to their clients. In rural Māori communities it would be inconceivable to visit a home and not be prepared to attend to the health of other household residents.[276] The comprehensiveness of the service approach is value for money for the DHB; however it stretches the resources of smaller providers, with funding gaps filled by the 'sweat equity' of Māori staff. Maintaining staffing levels and increasing the depth of professional skill bases are a current and future challenge. Māori providers lack clinical clout to attract Māori health professionals, who are scarce and increasingly sought after.[277]

The potential for compliance costs to undermine viability remains ever present. A recent NZIER (2003) report noted a lack of a comprehensive national database on Māori health provider development.[278] Developing these types of data, although highly relevant, is frequently inadequately funded. For example, Ngati Porou Hauora (NPH) highlighted the difficulty of juggling MOH data requirements and more pressing clinical demands, when the funding was only two dollars per person.[279]

Lastly, if recent electioneering is to be believed, a change of Government poses a threat to Māori providers. Given the propensity in recent decades of newly incumbent Governments to reform the health sector, it is possible this sector is vulnerable to future 'fiscally inspired restructuring'.[280]

Māori Identity

Māori identity is now implicitly linked to the Treaty of Waitangi. Many of the Government concessions to Māori have been as a result of processes which recognised past Treaty grievances. Because the criteria which determines who are Māori and who are not, seems increasingly determined by those at the

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[276] Abel et al., (2005), p.76.
[277] Kiro, (2000), p.319.
[278] NZIER, (2003), p.8.
[279] Abel et al. (2005), p. 77.
[280] D. Craig, Reterritorialising health: inclusive partnerships, joined-up governance and common accountability platforms in Third Way New Zealand, *Policy and Politics*, Bristol, The Policy Press, (3 July 2003), vol 31, no. 3, pp.335-52.

centre of the redistribution and management of Treaty settlements,[281] the issue of who is Māori has assumed much of the ambiguity associated with Treaty interpretations.

Like the Treaty, there are definite criteria underneath the uncertainty. Authenticating criteria of Māori identity has shifted from primordial notions of blood quantum and skin colour, to whanau, te reo, whakapapa, and tikanga. Confusion occurs though, when these new qualifying mechanisms or fixed notions are not reflected in the current realities of a significant percentage of Māori lives.

Participant perceptions of identity in this study, were acknowledged as being Māori, but were not necessarily predicated on the above criteria. Some participants claimed and demonstrated proficiency in Māori protocol, while others admitted to minimum competency. Despite this wide variation encountered, the criterion to engage with and interpret Māori experiences in research is fixed to the above conception of Māori identity.

Similarly, health services for Māori are in the process of being reoriented to the cultural differences of whom and how Māori are Māori. These changes are shaped to reflect the Treaty principles, thereby connecting to the Treaty, a contemporary talisman of Māori identity. Within this process, Māori providers are the nexus between a Māori identity linked to the Treaty and health service users. But even Māori providers have grappled with the issue of Māori identity. Kiro (2000) reported that many admitted an initial lack of cultural competency and had to improve their knowledge, in order to claim 'by Māori for Māori' status.[282]

Clearly the state has played a role in perpetuating a fixed notion of Māori identity. He Korowai Oranga and similar documents reflect the fixed notions of Māori identity, directing health policy at Māori, the generic. While Māori who identify as Māori in non-tribal terms can still access health care, the point of such policies is to reduce social barriers not create them. While I do not believe any Māori provider would distinguish between Māori clients based on these criteria,

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[281] Rata, (2003).
[282] Kiro (2000), 316.

it has been used to disenfranchise Māori not affiliated with iwi in Treaty settlements.[283]

There is a real sense that the issue of Māori identity tends to draw a line in the sand between what is Māori and what is not. The propensity to do this can be defended as ensuring the continuing vitality of Māori culture and society. However, the increasing use of these criteria in Government documents is not about reflecting all contemporary conceptions of Māori identity, but rather the practice serves to place a defining line between and among Māori. Whether that line is a clarifying mechanism or a divisive one, is likely to be a matter of perspective.

Conclusion

He Korowai Oranga - Māori health strategy is the result of intersecting economic changes, international trends, Māori development and fiscal imperatives in the health sector. Māori providers are at the nexus of these changes.

The capacity building of these providers, while answering Māori calls for self-determination, may be compromised by the extent to which provider services are prioritised within the health sector. Rangatiratanga anticipates freedom from the control of others. Inadequate funding is itself a form of coercion.

The attributes of Māori identity will continue to be contested and connected to the Treaty of Waitangi and to any policy perceived as distributing to Māori, more rights and benefits, than costs. The current Government propensity toward a more fixed form of Māori identity is a consequence of the manner in which the Treaty of Waitangi is referenced in policy. This practice may further marginalise the groups that such policies seek to assist.

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[283] Poata-Smith, (2004), p.178.

CHAPTER SEVEN

Conclusion

The Treaty of Waitangi principles in Māori Health policy have been influential only to the extent of supplying a framework in He Korowai Oranga enabling Māori engagement in the health sector. More significant influences have been international trends, domestic policy changes, existing resources and fiscal limitations. These factors intersected with Māori demands for greater self-determination.

While Māori demands for rangatiratanga are related to the Treaty of Waitangi, I believe these claims are not recognised by Government because of any connection with health policy. Rather rangatiratanga coincided with the trends in health policy and Government devolution strategies and was a useful resource in the process of decentralisation.

The Treaty principles do provide a useful framework for enabling Māori to participate in some areas of the health sector. Either as health service providers or service users. Māori health providers are a central strategy in the development of health services that enable Māori access to Māori provider, provided health services. However, the cultural responsiveness of mainstream health services to Māori is less predictable or controllable at the point of implementation. This is evidenced in participant experiences in different parts of the health sector, presented in this research.

Māori health issues are highlighted in the name of the Treaty, but whether or not they have been recognised because of the Treaty remains questionable. Māori access to health care is a citizenship right as well as a Treaty based one. The intertwining of the Treaty principles in He Korowai Oranga may obscure this fact. Cultural responsiveness to Māori health needs, while an expectation of Māori is motivated more by Government realisation that such changes will yield more efficient resource utilisation.

There are multiple factors that influence how the Treaty of Waitangi is interpreted and consequently the manner in which Treaty principles are applied in statutes. The use of Deborah Stone's Paradox theory identified the different

attributes that characterise each principle and the differing objectives underpinning each Treaty principle in He Korowai Oranga. These differences may cause future tension. The principle of partnership presupposes a mutual purpose, while the goal of efficiency appears the dominant objective of health policy change for Māori. These are rarely compatible with equity objectives.

As is always the case in any distributive process, who qualifies as a member of the recipient group, is a key component of discussion, particularly if eligibility is perceived to be based on the Treaty. This perception is often associated with Māori issues regardless of whether they are related to the Treaty. Because Māori identity is now closely aligned to Treaty interpretations, the issue of who is Māori is often in close attendance. This is in part because of a lack of agreement around the Treaty, but more so a result of the lack of agreement about the definitions and relations within and between Māori and non-Māori.

The conclusions of this research are that Māori providers should be a more central part of the health sector; they currently appear to be classified as an alternative option located on the fringes of the health sector. Future research into the preferences of Māori health service users, particularly those using Māori health providers may strengthen the case for a wider role in the health sector for these providers.

The issue of the Treaty and what it means should be actively addressed. The lack of awareness regarding the Treaty amongst participants in this study indicates there is still a need to incorporate more Treaty knowledge based courses into our education curriculum. Until this happens, the Treaty of Waitangi and Treaty principles will continue to be viewed disparagingly, predominantly because of ignorance.

With regard to the use of Treaty principles in legislation, Winston Peters is right. Treaty clauses are vaguely worded and should either be reworded to convey explicit intention or removed altogether.

This research has only focused on the three Treaty principles, partnership, participation and protection, used in He Korowai Oranga. There are many more that are potentially relevant to obtaining better health outcomes for Māori.

The number of participants in this study was small. However, the research sample represented almost 25% of surviving people who had TB in the last four years. The high number of medically mismanaged cases may be an

unfortunate characteristic of this sample, which given the opportunity to enlarge, would not have detected any further such cases.

The experiences of the participants provided a useful lens to examine the correlation between policy content and implementation. For example, a central policy action of He Korowai Oranga is reducing the barriers created by health determinants. The experiences of participants provides a measure for evaluating policy effectiveness, because people with TB have long term interaction with health providers and their diagnosis and treatment requires effective communication and access.

Finally, my perspective, experiences and values are a product of my being Māori, urban based and a political studies student with a background in nursing. Much like the Treaty principles, many influences inform my understandings of interpretations of the Treaty principles in He Korowai Oranga and the health sector.

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Appendices

Appendix A

Interview Questions Guidelines:

An exploration of 4 Themes in participant's lives and experiences of TB

1.   Health experiences

        a. Tuberculosis

What do you know/understand about TB?
-        What do you think causes TB?
-        How do you think TB infection is spread?
-        What problems, do you think, people face when they have TB?
How do you think TB affects a whānau ?

        b. Individual experiences of TB

Tell me about when you found out that you had TB.
-        Do you know/recall how you knew you had TB?
-        What type of TB have you got/had?
-        How do you think you came to have TB?
-        What do you think caused your TB?
-        When did you notice changes in your health?
-        What have been the main problems of living with TB, for you?
-        How did your whānau respond to your having TB?
-        How has it affected your whānau ?
-        Have you told people outside of your whānau ? Reaction?
-        How has TB made you feel?
-        How are you feeling at the moment or how is your health now?

        c. Experiences of Health services

Can you tell me about the treatment you have had for TB?
-        What type of treatment have you been having?
-        How long?
-        What side-effects have the drugs had on you?
-        Where do you usually have your treatment?
-        Is that close to where you live?
-        How did you get to medical appointments/treatments?
-        Were you hospitalised? How was that?
-        Who are the main people involved in your treatment?
-        What do you think of the medical people that have cared for you?
-        How often to you visit them (doctors, nurses, others)

- Did you consider alternatives forms of treatment? (herbal, Chinese, Māori)
- Did you discuss your treatment choices with people other than medical staff?

2.　Cultural identity

Can you tell me about how you feel/identify with being Māori ?
- Your Iwi? Regular contact with your tribal grounds/marae?
- Are/Have you been involved in Māori cultural activities e.g. *Kapa Haka*?
- Do you speak Māori ? When do you speak Māori most often? How did you learn?
- *How responsive do you think health services have been to your being Māori ?*
- When you hospitalised did you prefer whānau to come in and care for?
- Did the hospital staff accommodate this?
- Traditional Māori healers/medicines
- Why did you choose to use a Māori service provider?

3.　Political identity

What is your understanding of the Treaty of Waitangi?
What is your understanding of the Treaty?
What do you think the Treaty means?
Do you think the Treaty has much influence in policy or political decisions?
Have you heard of the principles of the Treaty?
Do you know what the principles mean?
Do you think Māori can influence what is happening politically in our country?

4.　Demographic/socio-economic factors

How would you describe your economic circumstances?
- Age?
- How many people in your immediate family?
- How many people live here?
- How do you get income?
- Are you working?
- Before you were ill, how did you earn a living?
- How did you come to be on a benefit?

Appendix B

Example of Typology and General Definitions for 'Principle of Protection':[284]

Location	*Function*	*Minimal Definition*
Thought	Safeguard	Thought (attitudes, Behaviour
Protect		values, beliefs)
Language	Provide	Rights/access
Law/justice	Guarantee	Human
	Exchange	Vulnerability
	Encompass	Duty
	Empower	Compliance
	Compliance	

Subject Matter	*Motivation*
Care	Treaty rights
Politics	Interests - economic
Health	Human rights
Property rights	Economic restraints
Knowledge	
Power	
Taonga	

Subject	*Cognitive/affective*	*Ideal Type Definition*
Human		Taonga - treasures
Māori	Care	Treaty rights (health,
Pakeha	Structure	language, knowledge,
Victim	Tikanga	culture)
Aggressor	On-going duty	About politics (power
Defender	Dependency	relationships)
Honour	Control	Law and justice
	Compliance	Empowerment
	Obligation	Interests
	Inconsistency	Constraining
Position		Tikanga
Dominant		Obligation
Subordinate		Safeguard
Powerful		
Vulnerable		

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[284] J. Gerring, *Social Science Methodology, A criterial framework*, Cambridge, Cambridge University Press, (2002), pp.74-81.

Appendix C

<u>Coding Categories:</u>

(*HCP = Health care providers - refers to Public Health Nurses, District Nurses, Hospital Nurses, GP's, hospital doctors, clinicians, community service providers, Iwi/hospital/community support groups)

Principle of Protection:

Health highly prized resource; Maintain/support/promote access to cultural, social, spiritual, economic mechanisms necessary to health, maintain health through TB knowledge through HCP support/provision, health promotion, active health intervention/services by the MOH or not, the health behaviour of participants – health history, family health knowledge. Participant health seeking/keeping behaviours – are there resources to facilitate change?

1. TB knowledge:
>> Pre-diagnosis information/awareness of TB; post diagnosis knowledge to safeguard future health, information access, myths/ assumptions

2. Maintaining cultural knowledge:
>> Te reo competency/usage;
>> Tikanga and reference to whakapapa; Treaty/principles knowledge/understanding, notions of Māori identity.

3. Existential connections:
>> The right to practise culturally based beliefs i.e. god, Jesus, te ao Māori, tohunga; spiritual experiences enhancing health outcomes.

4. Health keeping/seeking behaviour:
>> Health & wellness history, smoking, drinking; behaviours to maintain/improve health or not; resources to facilitate changes? Family health knowledge.

5. Aspirations:
>> Looking to the future to aspire to having things, events, experiences.

6. Death:
>> Possibility from illness, Fear of, experiences of other deaths - TB or not, tangis, attitudes to death.

7. Active protection:
>> Belief of individual in health system to protect;
>> Actions of health system to protect or not.

Principle of Participation

The ability of participants to engage with the activities of daily living, their whānau , their community, employment, work environment – colleagues, other communities, education, housing, decision-making relating to themselves - i.e. autonomy, representation. Activities of HCP - engage Māori , culturally appropriate service delivery, compulsion/decision making in treatment? Effects of stigma and independence.

1. Disclosure and stigma:
> Barrier to participating in day-to-day life?
> Consequences of telling others.
> Feared consequences of disclosing diagnosis.

2. Impact and effect of TB:
> How it affected ability to participate in ADL
> Effects on life economic, emotional, physical, social, cultural.

3. Individual choice and responsibility:
> About health, self- the body, identity and illness.

4. Political perceptions:
> Perception of the political place, role and activity of Māori
> Māori politicians
> Political situations in everyday life related to being Māori

5. Socialising (after TB diagnosis):
> Engaging in social events, community outings, in hospital setting, friends keeping in contact, visiting.

6. Decision-making:
> Involved in decisions about treatment.
> Control over decisions about their daily activities and life.

7. Hobbies & Interests (after TB Diagnosis):
> Activities still able to do, things want to do but illness preventing them.
> Interests which get people into social environments.

8. Economics, work, income:
> Employment, other income sources, volunteer worker.

9. Independence (before and after TB diagnosis):
> Not asking or accepting help, managing alone, deciding to act alone.

10. Isolating:
> Feeling unconnected, being left alone.

Principle of Partnership

About collaboration, corroboration, power, equity, empowerment. Interaction of HCP with participants: supporting treatment, treatment complications, treatment enforcement, perceived attitudes of HCP, best interests of patients? Relationships with whānau before/during after TB. Emotions.

1. Public Health Nurse (PHN):
The PHN role, patient relationship with, impact of PHN to the illness and treatment experience, other influences of the PHN.

2. Good faith:
Trusting the HCP to act in the best interests of the patient, not acting as pt expects, a duty of care.

4. Treatment: (Descriptive - what kind of treatment)
i. Medication side effects: Problems associated with taking the medications. Some anticipated, some not.
ii. Medication: Taking the TB medications, DOT or SAT, difficulties adjusting daily routine to take TB medicine, adjusting to taking the medication, issues with taking any medication, issues with TB medication.
iii. Hospital: Past hospital experiences – fear of, to do with TB, effect of isolation routine and hospital routines, attitudes toward being in hospital, hospital accommodate non-medical requirements?,.

5. Treatment compliance:
Modifying health behaviours, refraining from behaviour which impacts treatment e.g. smoking, drinking, taking the tablets, not missing clinical appointments, following health/discharge advice.

6. Healthcare providers (HCP): (General perceptions, descriptions of relationships with doctors, nurses, general hospital staff)

i. Don't go to the doctor:
Accounts of delays before seeking treatment for illness.

ii. Perceived attitudes of the HCP:
Feelings about the HCP's attitudes.

7. Support of Whānau :
Whanau make-up, ostracised from? Tensions? Whānau attitudes about TB diagnosis, response to diagnosis, whānau support or not during TB.

8. Emotions:

Feelings about life, TB treatment, TB illness, meds side affects, how feelings about the behaviour of others connected to illness experience - not HCP, impacts on the individual ability to cope i.e. anger, guilt.

Tuberculosis

1. Own story:

Individual's story.

2. Source of:

How/why they caught TB, includes beliefs, myths, questions individual may have about the way they believe they contracted TB.

i. Family history of TB: Accounts of family members, includes tupuna, who have had TB.

ii. Contact tracing: Results of, extent of, reactions to.

3. Diagnosis:

How TB was diagnosed. Other diagnosis made at the same time.

4. Infectivity Threat:

Response of pt and whānau to isolation rules, illness a threat/barrier to relationships or interactions, TB history and subsequent hospital admissions, response of all staff to infectivity threat.

Other

1. Family history:

About family dynamics.