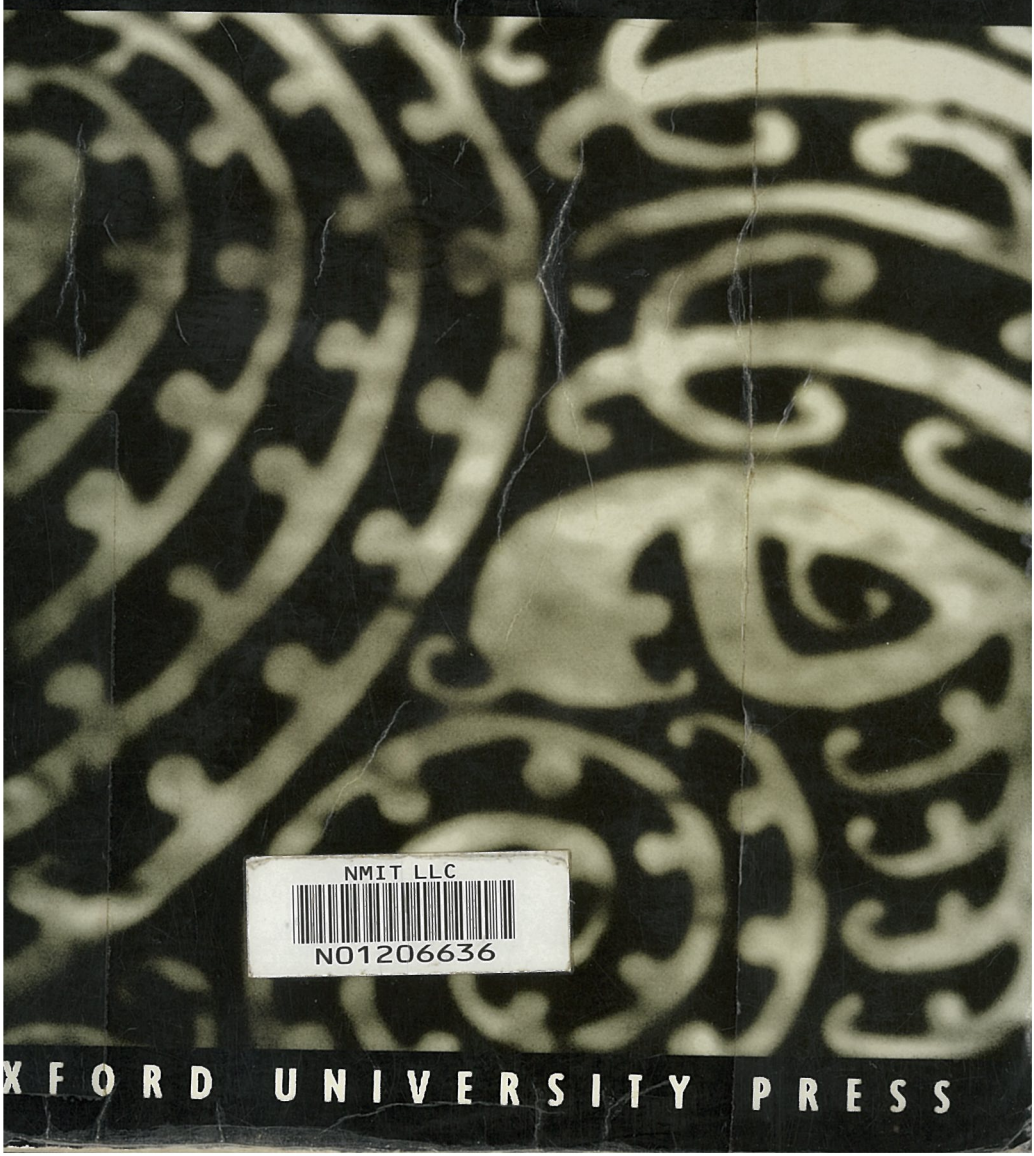
WHAIORA

MĀORI HEALTH DEVELOPMENT

MASON DURIE

Second Edition



XFORD UNIVERSITY PRESS

OXFORD
UNIVERSITY PRESS
253 Normanby Road, South Melbourne, Victoria 3205, Australia
Oxford University Press is a department of the University of Oxford.
It furthers the University's objective of excellence in research, scholarship,
and education by publishing worldwide in
Oxford New York
Athens Auckland Bangkok Bogotá Buenos Aires Cape Town Chennai
Dar es Salaam Delhi Florence Hong Kong Istanbul Karachi Kolkata
Kuala Lumpur Madrid Melbourne Mexico City Mumbai Nairobi Paris
Port Moresby São Paulo Shanghai Singapore Taipei Tokyo Toronto Warsaw
with associated companies in Berlin Ibadan
OXFORD is a trade mark of Oxford University Press
in the UK and in certain other countries

First published 1994
Reprinted 1995, 1996 (twice), and 1997
Second edition first published in 1998
Reprinted 1999, 2000, 2001

National Library of Australia
Cataloguing-in-Publication data:

Durie, Mason
WHAIORA MĀORI HEALTH DEVELOPMENT

ISBN 019 558403 1

Text designed by Anitra Blackford
Cover designed by Christine Hansen
Typeset by Archetype, Wellington
Printed through Bookpac Production Services, Singapore

Chapter Five

TIROHANGA MĀORI

MĀORI HEALTH PERSPECTIVES

At the opening of the Hui Whakaoranga, a national Māori health conference held on the Hoani Waititi Marae, Auckland, in 1984, the Hon Ben Couch, Minister of Māori Affairs in the National Government, declared, '. . . there is no such thing as Māori health or Pākehā health; there is only people health'. He went on to ascribe differences in health standards to self-inflicted lifestyle choices, '. . . most people who enjoy good health have earned it. The rules are the same for people of all races; good eating, plenty of sleep and exercise, and moderation in all things'.[1] His views were not atypical of the era but they were out of step with Māori thinking in two respects. First, they ignored Māori experience and the growing body of evidence which linked culture and health; and, second, they disregarded socio-economic status as a significant determinant of good health, quite apart from individual motivation.

Over the succeeding two days the Hui Whakaoranga rejected the notion that cultural factors were irrelevant to health and concluded on quite a different note, recommending that 'health and educational institutions recognise culture as a positive resource' and that 'the feasibility of including Māori spirituality in health education programmes in schools and in tertiary educational institutions be investigated'.[2]

ILLNESS AND TREATMENT

Prior to 1976, professional and academic interest in Māori perspectives on health and sickness tended to confine discussion to particular clinical syndromes which were unique to Māori and of anthropological as much as medical interest. Mākutu and mate Māori, for example, attracted considerable comment from Western-trained psychiatrists, though tended to be reinterpreted as superstitious phenomena and of doubtful diagnostic significance.[3,4] Māori concepts of illness

were increasingly reinterpreted by the medical anthropologists in mental and psychic realms, scarcely relevant to the vast majority of human illnesses and hardly applicable to contemporary times. It was left to Māori writers to point out the continuing relevance of culture to illness and treatment, and to provide some balance for the more esoteric ideas which had appeared in the earlier medical and scientific literature.

The process started with an examination of medical practice and hospital procedures to determine the significance of culture to Māori patients in everyday situations. Durie concluded that, although Māori were more often than not Westernized, or at least appeared to be, cultural heritage continued to shape ideas, attitudes, and reactions, particularly at times of illness. 'The concepts of tapu and the perception of illness as an infringement against tapu are central to much of the anxiety and depression which surround the Māori patient while in hospital. Family involvement at times of illness is likewise a very traditional and culturally necessary attitude which must be recognised in the management of the whole patient and not just his impaired organ.'[5]

The relationship between tapu and noa, and explanations of illness based on a postulated breach of tapu, continued to have meaning for Māori and therefore had implications for doctors in the management of Māori patients as well as the care of the deceased as long as they were still in hospital custody. Because early retrieval of a relative's body was critical to uphold the mana of the family and the individual, mourning Māori families were grossly offended if the body were not released within twenty-four hours of death. Post-mortem delays, or simple administrative inefficiencies, could add immeasurably to the grief of an already distressed family.[6]

Tipene-Leach, writing about aspects of the doctor–patient relationship, described a number of sensitivities and behaviours relevant to communication during a clinical examination.[7] For instance, immediately asking patients to reveal their names, without any preliminary remarks, could lead some Māori to feel threatened even before the examination had commenced. Similarly, expecting a Māori patient to engage in direct eye-to-eye contact could be interpreted as an invitation to demonstrate bad manners since looking an older person in the eye was a sign of haughtiness or disrespect. Various parts of the body were also described as having special significance, though not necessarily at a conscious level. Medical or nursing interventions involving the head, sexual organs, hair, and nail clippings, required a measure of caution and a greater degree of circumspection than was customary in busy hospital wards.

The gradual introduction of Māori concepts into medical routines was not entirely welcomed, but nor was it dismissed outright. By the mid-1970s there was some tentative recognition that ethnicity and culture had implications for health. Māori views, though not always understood, were often taken on board at face

value, even though they could not be rationalized in medical terms. Moreover, discussions of similarities between tohunga and doctor in the *New Zealand Medical Journal* had generated sympathetic interest.[8] Both, it seemed, were experts in history-taking as a prelude to making a diagnosis; both took extensive family histories (tohunga more than doctor); both employed specific treatment methods; and both recommended periods of rehabilitation. By removing Māori concepts from the realms of the supernatural, and emphasizing their continuing importance even when a patient did not profess to subscribe to them, Western-trained health professionals were more able to appreciate their significance and respect them.

HEALTH AND WELL-BEING

Having shown the relevance of culture to health and sickness, Māori interest then turned to the wider contexts of health and community. For some years it had been acknowledged that there were many dimensions to health. In its 1947 definition, the World Health Organization concluded that health was greatly influenced by social and cultural factors: 'Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity'.[9] The definition was a reminder to the world that there was more to health than biological dysfunction and that it went well beyond the province of the health sector. Neither was it the exclusive province of the medically trained doctor or nurse, although they had a particular interest in some aspects of it having made spectacular advances in the treatment of physical illnesses, especially infections, from the 1940s onwards. The problem was, or at least was perceived as being, that medical interest in physical disease greatly outweighed an interest in the person as a whole within a sociological and ecological environment. A cellular focus no longer seemed adequate for understanding the complexities of health even though it had been a useful step in the past.

During the 1970s Māori were beginning to insist that a narrow focus on micro-organisms or even on physical illness created a distorted framework within which to consider health and to plan for the future. Interest moved towards a view of health that made sense to Māori in Māori terms, and outside hospital. As Māori participation in the health debate escalated, a number of Māori perspectives were advanced. All emphasized the value of traditional belief systems to health, though not necessarily at the expense of Western medical practice. Indeed, seldom did debate move towards an exclusively Māori system. Greater balance was the goal.

Several views emerged, but one which subsequently gained wide acceptance as 'the Māori health perspective' was a four-sided health construct, later known as whare tapa whā (a four-sided house).[10] Though often described as a traditional

Māori approach to health, more correctly it was a view of health which accorded with contemporary Māori thinking. Its ready acceptance by Māori was to some extent proof of that. The characteristics of whare tapa whā are shown in Table 12.

Table 12: The whare tapa whā model

	Taha Wairua	*Taha Hinengaro*	*Taha Tinana*	*Taha Whānau*
Focus	Spiritual	Mental	Physical	Extended family
Key Aspects	The capacity for faith and wider communion	The capacity to communicate, to think, and to feel	The capacity for physical growth and development	The capacity to belong, to care, and to share
Themes	Health is related to unseen and unspoken energies	Mind and body are inseparable	Good physical health is necessary for optimal development	Individuals are part of wider social systems

Whare Tapa Whā

Briefly, the whare tapa whā model compared health to the four walls of a house, all four being necessary to ensure strength and symmetry, though each representing a different dimension: taha wairua (the spiritual side), taha hinengaro (thoughts and feelings), taha tinana (the physical side), taha whānau (family). The concept of health as an interaction of wairua, hinengaro, tinana, and whānau was first presented at the Rahui Tane Hostel in Hamilton in August 1982 during a training session for fieldworkers in the Māori Women's Welfare League research project, Rapuora.[11] During the welcome , kaumātua Tupana te Hira had emphasized in Māori the importance of wairua as a starting-point for health. It was a view that many kaumātua shared and which was frequently heard on marae throughout the country. Later that evening, psychiatrist Henry Bennett spoke about mental illness and mental health, while Dr Jim Hodge of the Medical Research Council described some of the common disorders such as kidney failure which affected Māori disproportionately. Dr Mason Durie, also a psychiatrist, drew these themes together, calling them taha wairua, taha hinengaro, taha tinana, and taha whānau and leaving League members with a broadly based view of health which seemed to combine the four basic ingredients for good health. Importantly, a notion of balance between them was also introduced. The model later appeared in the Rapuora report: 'To say that a person is a psychosomatic unity, a personality formed jointly by physical and mental processes, only partly embraces the Māori concept. A study of Māori health must follow more than two

strands. Tinana is the physical element of the individual and hinengaro the mental state, but these do not make up the whole. Wairua, the spirit and whanau the wider family, complete the shimmering depths of the health pounamu, the precious touchstone of Māoridom'.[12]

The four-part framework was again presented by Durie at a health hui held at the Palmerston North Hospital in December 1982[13] and further developed for the 10th Young People's Hui held at the Raukawa marae in May 1983.[14] The four dimensions of health were originally portrayed as a set of interacting variables, not dissimilar from a holistic view, nor for that matter from the World Health Organisation 1947 definition but, unlike them, firmly anchored on a spiritual rather than a somatic base.

Taha wairua is generally felt by Māori to be the most essential requirement for health. It implies a capacity to have faith and to be able to understand the links between the human situation and the environment, Without a spiritual awareness and a mauri (spirit or vitality, sometimes called the life-force) an individual cannot be healthy and is more prone to illness or misfortune. A spiritual dimension encompasses religious beliefs and practices but is not synonymous with regular churchgoing or strong adherence to a particular denomination. Belief in God is one reflection of wairua, but it is also evident in relationships with the environment. Land, lakes, mountains, reefs have a spiritual significance, quite apart from economic or agricultural considerations, and all are regularly commemorated in song, tribal history, and formal oratory.[15] A lack of access to tribal lands or territories is regarded by tribal elders as a sure sign of poor health since the natural environment is considered integral to identity and fundamental to a sense of well-being.[16]

Spiritually, the hours immediately following death are particularly significant. As the deceased person's spirit hovers tentatively between the visible world and the world of spirits, mourners themselves are able to feel a spiritual presence and to experience a renewed sense of continuity with their own ancestors, their history, and their future. For that reason a rapid retrieval of a deceased relative from hospital becomes a matter of urgency.

Taha hinengaro is about the expression of thoughts and feelings. In Māori nomenclature, thoughts and feelings derive from the same source, located within the individual. The notion that they are vital to health is a well-recognized concept among Māori. Western authorities have reached similar conclusions though through circuitous routes that have traversed psychological and psychiatric observations, a path that other cultures have not needed in order to finish up at the same point. Māori thinking can be described as holistic. Understanding occurs less by division into smaller and smaller parts, the analytical approach, than by synthesis into wider contextual systems so that any recognition of similarities is based on comparisons at a higher level of organization.

Consistent with this style of thinking, health is viewed as an interrelated phenomenon rather than an intra-personal one. Healthy thinking from a Māori perspective is integrative not analytical; explanations are sought from searching outwards rather than inwards; and poor health is typically regarded as a manifestation of a breakdown in harmony between the individual and the wider environment. There are several words and expressions which bind the individual to the outside world. Whenua, for example, can mean both placenta and the land, rae is either the forehead or a land promontory, iwi refers equally to a bone (kō-iwi) or to a nation of people, while hapū can denote pregnancy and a section of a large tribe. The word for birth is whānau, the same term used to describe a family, and wairua, spirituality, can also be used to refer to an insect, just as kāpō can mean blind or a species of eel. Whakapo is to darken (as in approaching night) and, as well, to grieve, waimate is a hereditary disease but also polluted water, kauae can be the jawbone or a major supporting beam in a building, and tāhuhu refers both to the vertebral column and the ridge pole of a meeting-house.

A further distinctive feature of taha hinengaro is its relevance to both thoughts and feelings. While Western thinking distinguishes between the spoken word and emotions (and generally encourages the word more than the feeling), Māori do not draw such a sharp distinction. Communication, especially face-to-face, depends on more than overt messages. Māori may be more impressed by the unspoken signals conveyed through subtle gesture, eye movement, or bland expression, and in some situations regard words as superfluous, even demeaning. Emotional communication can assume an importance which is as meaningful as an exchange of words and valued just as much. Condolences, for example, are frequently conveyed with tears; infrequently with words. So, when Māori children who are chided by their teachers for showing what they feel, instead of talking about their feelings, they are not only made to feel unworthy (of their feelings) but must also contend with a sense of frustrated expression.

Taha tinana (bodily health) is a more familiar health dimension, though the Māori emphasis is different in that there is the clear separation of tapu and noa. Certain parts of the body, and the head in particular, are regarded as special (tapu), and bodily functions such as sleeping, eating, drinking, and defecating are imbued with their own significance, reflecting various levels of importance and requiring quite different rituals. Food, for example, is a leveller which removes any vestige of sacredness or distance (as between people). Because cleaning the body and eating are polar opposites, separation of food from toileting functions is regarded as necessary to maintain good health, a condition severely tested in hospital wards where all functions are frequently conducted in the same confined space.

Body image may be regarded differently by Māori. Slender body forms are not necessarily prized more than well-rounded shapes, nor does obesity provoke the same sense of disapproval encountered in society generally. Perhaps because of this, anorexia nervosa remains relatively infrequent among Māori girls. By the same token, however, health workers report difficulties in trying to convince Māori patients that they should lose weight. Their efforts might be better spent in appealing to health risks, especially for future generations, rather than to personal vanity.

The fourth dimension of health, taha whānau, acknowledges the relevance of the extended family to health. There are at least two important considerations. The first is that the family is the prime support system for Māori, providing care and nurturance, not only in physical terms but culturally and emotionally. Reported rises in the prevalence of family dysfunction, including signs of abuse, do not lessen the point but underline its significance. Māori still maintain that ill health in an individual is a reflection on the family and may well blame a family for allowing a person to become ill or to die, even when there is no direct causal link. The practice of muru is still observed in some areas. When there is evidence that a lack of quality care by the family has contributed to death, neighbours and more distant relatives may seek retribution by removing family property or personal belongings, especially when the deceased is a community leader. Similarly, in cases of child abuse or neglect the extended family may take it upon themselves to remove the boy or girl from parental custody and take over the caring role. Parental rights often tend to be seen as secondary to the interests of the whānau or even the tribe to ensure that future generations are protected.

A second consideration of taha whānau relates to identity and sense of purpose. The much-lauded state of self-sufficiency or self-realization does not convey a sense of health to Māori. Quite the reverse, since an insistence on being overly independent suggests a defensive attitude, while a failure to turn to the family when the occasion demands is regarded as immaturity, not strength. Interdependence rather than independence is the healthier goal.[17] Sometimes this goal clashes with the European regard for independence in teenagers as 'one of critical developmental tasks of adolescence, . . . a fundamental building block of health'.[18]

Even in modern times a sense of personal identity derives as much if not more from family characteristics than from occupation or place of residence. Interest in family and tribal background rivals personal qualifications or achievements so that credibility, certainly in Māori settings, depends on an individual being able to make the links and demonstrate that there is active whānau and tribal support. On that basis, it has become a common occurrence for family members to accompany job-seeking applicants to an interview. Their role is a dual one: to convince the interview panel that their relative is the best person

for the job, but also to ensure that the job itself is suitable and not likely to lead to exploitation, unfulfilled expectations, or disrespect. There have been instances when an applicant has been successful but the family, unhappy about the interview, has counselled against accepting the position. Similarly, there are numerous anecdotal accounts of candidates being passed over because of the family's confronting attitude during the interview.

Underlying the whare tapa whā model is the consistent theme of integration. Individual health is built into a wider system, the boundary between personal and family identity being frequently blurred. Similarly the divisions between temporal and spiritual, thoughts and feelings, mental and physical are not as clear-cut as they are have been in Western thinking since the advent of Cartesian dualism.[19]

Māori interest in redefining health in their own terms and reclaiming a positive role in shaping health services was accelerated when the whare tapa whā model was introduced. It was simple, even simplistic, but that was also its appeal. In addition, it appeared at a time when Māori were debating the general direction which health services were taking. Widespread concern had focused on three issues.

First, Māori were not impressed by the overemphasis on physical aspects of health with its biological constructs and increasing preoccupation with cellular phenomena. Nor for that matter were a number of other New Zealanders. At a national conference to consider the role of the doctor, holistic care was emphasized to balance a perception that many doctors had acquired too narrow a focus, their work often lacking ecological and caring dimensions. 'Because the scientific and technical aspects of practice cannot be separated from human concerns and social skills, particular attitudes are required: the readiness to treat people as equals; empathy; willingness to share information two ways; and a recognition that patients have a responsibility for their own health.'[20]

Second, many Māori felt that their relationship with health professionals, and with the health system generally, had become strained. Rightly or wrongly a feeling of alienation had arisen, not necessarily because of poor access or even inadequate care, but mainly because there was a lack of shared decision-making and limited recognition of Māori views. The more professionals acted as if they knew best, the less tolerant Māori became. Surely, they argued, Māori health belonged to Māori people. Māori health perspectives such as whare tapa whā were welcomed because they provided the necessary framework within which a semblance of ownership over health could be entertained.

Third, despite a century and a half of colonization, Māori remained convinced that good health could not be gauged by simple measures such as weight, blood pressure, or visual acuity. Spiritual and emotional factors, though more difficult to measure, were equally important.

TE WHEKE

There were other Māori health perspectives which gained acceptance in the 1980s. One of these, te wheke (the octopus), was discussed by Pere at the Hui Whakaoranga in 1984. In order to illustrate the main features of health from a Māori family perspective, she compared health to an octopus.[21] Each of the eight tentacles of the octopus symbolized a particular dimension of health while the body and head represented the whole family unit. The intertwining of the tentacles indicated the close relationships between each dimension.

Like te whare tapa whā, the model included wairuatanga (spirituality), taha tinana (the physical side), hinengaro (the mind), and whanaungatanga (the extended family, similar to taha whānau). The other dimensions were: mana ake, the uniqueness of the individual and each family and the positive identity based on those unique qualities; mauri, the life-sustaining principle resident in people and objects, including language; hā a Koro mā a Kui mā, literally the breath of life that comes from forebears and an acknowledgment that good health is closely linked to a positive awareness of ancestors and their role in shaping the family; whatumanawa, the open and healthy expression of emotion, necessary for healthy human development; and waiora, total well-being for the individual and the family, represented in the model by the eyes of the octopus.

NGĀ POU MANA

In 1988 the Royal Commission on Social Policy described another set of values and beliefs—four supports, ngā pou mana—as pre-requisites for health and well-being.[22] As with the other models a set of interacting variables was proposed, the combination leading to individual and group well-being manifest by the retention of mana, cultural integrity, a sound economic base, and a sense of confidence and continuity. This model, unlike the other two, placed greater stress on the external environment and the significance of oral tradition as a stabilizing influence. Though prepared primarily to examine foundations for social policies and social well-being, nonetheless it has relevance for health and has similarities with Durie's three 'institutions of health'—land, language, and family.[23]

The four supports—family (whanaungatanga), cultural heritage (taonga tuku iho), the physical environment (te ao tūroa), and an indisputable land base (turangawaewae)—brought together social, cultural, and economic dimensions in a way which could be readily appreciated by Māori and which demonstrated the links between the three. Particular reference to the environment (te ao tūroa) was perhaps influenced by the Waitangi Tribunal's landmark decisions in respect of claims made by tribes against the Crown and on the basis of pollution of tribal waterways.[24] These claims had all recognized the significance of a clean environ-

ment for good health and drew attention to the overlap between physical and cultural pollution. Quite apart from the effects of effluent on seafood and the consequent risks of hepatitis or other alimentary diseases, Māori claimants also described a type of pollution which debased spiritual and cultural values. Disposal of human waste, treated or not, onto potential food sites or into wāhi tapu (historical sites declared tapu) offended Māori just as the depletion of traditional foods through pollution created embarrassment when families were unable to meet customary hospitality obligations when visitors arrived.

Turangawaewae is a pou mana with cultural, social, and economic significance. Not only does it refer to land rights and access to an economic base, it also includes the marae, an institution, perhaps like no other, where Māori customs and tradition, including language, have priority. A measure of Māori identity, and indirectly a health measure, is the level of access, as of right, which an individual has to a marae. Since the marae is the epitome of a collective identity and one of the few remaining opportunities for social relationships to be strengthened in a manner which is mutually supportive, it enables Māori to redress some of the imbalance between individual and group pursuits inevitably created by life in suburbia.

Taonga tuku iho, cultural heritages upon which intellectual and philosophical traditions are based, are also valued by Māori because they suggest a continuity with past wisdom and consolidate a Māori identity. Increasing recognition of language as a taonga (treasure), important for cultural and health reasons, has resulted in extensive revitalization strategies locally and nationally. After considering a claim brought by Ngā Kaiwhakapumau i te Reo (the Wellington Māori Language Board), the Waitangi Tribunal described language as a taonga, categorizing it along with physical resources such as land.[25] The Tribunal report made it very clear that there was a Treaty of Waitangi obligation on the Crown to ensure that Māori language was strengthened before it was lost altogether, and the point was made on several occasions that without language any sense of pride or cultural integrity is seriously undermined.

Cultural heritage, as a basis for well-being if not health, also concerns the ownership of intellectual and cultural property. Cultural erosion has come about not only because of assimilation but also because history, traditions, art forms, healing methods, and poetry have often been appropriated by others and in the process Māori have been denied a guardian or custodial role, or have lost access to their own material altogether.

The Draft Declaration on the Rights of Indigenous Peoples recognizes both the significance of intellectual property to indigenous peoples as well as indigenous forms of health care, based on traditions passed down over the generations.[26]Article 22 of the Draft Declaration states that 'Indigenous peoples have the right to their traditional medicines and health practices,

including the right to the protection of vital medicinal plants, animals and materials'. Article 27 is more specific: 'Indigenous peoples have the right to special measures to protect, as intellectual property, their sciences, technologies and cultural manifestations, including genetic resources, seeds, medicines, knowledge of the properties of fauna and flora, oral traditions, literatures, designs and visual performing arts'.

Table 13 summarizes the main features of the three perspectives.

Table 13: Māori health perspectives–three models

	Whare Tapa Whā	*Te Wheke*	*Ngā Pou Mana*
Components	Wairua Hinengaro Tinana Whānau	Wairuatanga Hinengaro Tinana Whanaungatanga Mana ake Mauri Hā a Koro mā a Kui mā Whatumanawa	Whanaungatanga Taonga tuku iho Te ao tūroa Turangawaewae
Features	Spirituality Mental health Physical Family	Spirituality Mental health Physical Family Uniqueness Vitality Cultural heritage Emotions	Family Cultural heritage Environment Land base
Symbolism	A strong house	The octopus	Supporting structures

GAINING PERSPECTIVE

Other Māori health perspectives were advocated on various occasions. Te Roopu Awhina ō Tokanui, a group of Māori health professionals at a psychiatric hospital, became active in promoting Māori health, particularly mental health, and were instrumental in establishing a Māori unit, Whaiora, within Tokanui Hospital. At the Australian Congress of Mental Health Nurses held at Adelaide in 1986, they presented a nine-part framework to guide psychiatric nursing: taha wairua (spirituality), taha whānau (family), taha hinengaro (well-being), taha tinana (physiology), taha whenua (environment), taha tikanga (compliance), Māoritanga (old world), Pākehātanga (new world), taha tangata (self).[27]

All Māori health perspectives had similar themes. Essentially they sought to widen understandings of health, to translate health into terms which were culturally significant, and to balance physical and biological approaches with cultural

and sociological views. The Department of Health agreed that, 'Māori people in general believe that their current health status is ultimately linked to their historical, social, cultural, economic, political and environmental circumstances. In order to achieve any improvement in health status, health initiatives must incorporate a holistic definition and approach and be part of a developmental strategy to improve the overall status and wellbeing of a Māori community, tribal or family group. In doing so Māori people would like to define health for themselves; identify their own specific health concerns; . . . take responsibility for their own health; be involved in their own health care'.[28]

The appearance of the Māori health perspectives in the early part of the 1980s was not altogether surprising, given the strong moves towards positive Māori development and a rejection of assimilationist ideals. In education, housing, social welfare, and political representation Māori were intent on injecting a genuine Māori point of view as a prelude to reclaiming some degree of ownership and autonomy over social as well as economic arenas. Health was no exception.

But the perspectives also reflected a more general re-examination of New Zealand's health goals and its health services. Māori often articulated issues which had worried a wide cross-section of New Zealanders but which had not otherwise been able to find expression. The S-Factor for example was a concept used to encompass spirit, spirituality, or even 'something which represents that which defies being placed into the categories of ethics, psychology, medicine, and sociology'.[29] It was seen to be similar to taha wairua, but more relevant to Western than Māori culture, and it was introduced to balance a preoccupation with measurable and quantifiable health outcomes. Once Māori began to talk about spirituality, thoughts, feelings, and family in connection with health, others followed.

However, not everyone was impressed by the Māori health perspectives. To sceptics, they were based on romantic visions of the past, devoid of practical application, and likely to discourage Māori patients from seeking appropriate health care. At a time when scientific and technological advances were enabling organ transplants and new hopes for the disabled, Māori, it seemed, were longing for the quiet life and a return to a world now recognizable only in the history books. Further, because whare tapa whā extended the focus for health well beyond the individual, a sense of futility often developed among health workers. How could a diabetic regain health if the land injustices of the past century were ignored? By taking the debate to the widest possible levels, health programmes ran the risk of being so general and indistinguishable from welfare programmes that they would have no significant impact. Worse, if cultural factors were so important, sometimes it seemed pointless to treat a diabetic unless steps were also taken to provide parallel cultural enrichment; and health workers sometimes felt that they should take the initiative.

Far from improving treatment opportunities, it was argued that the new perspectives would displace clinical priorities and resources with sociological, economic, or political agendas. A further issue concerned the difficulty in measuring concepts as diffuse as taha wairua. While measurements of physical illness and subsequent medical interventions lacked accuracy, they were improving and at least there was some agreement about the desirable indicators. Not so in mental health (taha hinengaro) and even less so in spiritual matters. Was taha wairua of any practical value if it could not be measured? The critics felt not.

Generally, however, Māori health perspectives were consistent with new orientations and global trends: general systems theory, family psychotherapy, the community health movement, health promotion, primary health care, and calls for de-medicalization of the human life cycle. New Zealand was moving in the same direction and, in recommending a national health policy in 1988, the New Zealand Board of Health advocated five principles: holism, empowerment, social and cultural determination, equity of access and devolution, and equitable and effective resource use.[30] The Board had borrowed extensively from Māori views and writings.

By 1990, Māori views on health had made a significant impact on New Zealand health services generally, but more importantly they had given Māori people the necessary confidence, based on their own understandings of health, to challenge the system and reclaim a more active participatory role in society and within the health sector.

ENDNOTES

1 Komiti Whakahaere, (1984), *Hui Whakaoranga: Māori Health Planning Workshop*, Department of Health, Wellington.

2 Ibid.

3 G. Blake-Palmer, (1954), 'Tohungaism and Makutu', *Journal of the Polynesian Society* 63 (2): 147–63.

4 L. K. Gluckman, (1976), *Tangiwai: A Medical History of 19th Century New Zealand* Whitcoulls, Christchurch, pp. 232–60.

5 The psychoananalyst Carl Jung used the term 'collective unconscious' to describe the continuing influence of cultural beliefs even when they were beyond conscious appreciation.

6 M. H. Durie, (1977), 'Māori Attitudes to Sickness, Doctors and Hospitals', *New Zealand Medical Journal* 86: 483–5.

7 D. Tipene-Leach, (1978), 'Māoris: Their Feelings About the Medical Profession', *Community Forum*, Auckland.

8 Durie, (1977), *op cit.*

9 World Health Organization, (1947), 'Constitution of the World Health Organization', *Chronicles of the World Health Organization* 1: 12.

10 M. H. Durie, (1985), 'A Maori Perspective of Health', *Journal of Social Sciences and Medicine* 20 (5): 483–6.

11 E. Murchie, (1984), *Rapuora: Health and Māori Women*, Māori Women's Welfare League, Wellington, p. 112.

12 Ibid., p. 81.

13 The 1982 Hui Ora was arranged by a Māori health interest group, made up mainly of Māori professional staff from the Palmerston North Hospital. It was attended by representatives of major Māori organizations in the area. The keynote speakers were Drs David Yates, Paratene Ngata, and Mason Durie.

14 W. Winiata, (1984), 'The Raukawa Tribal Planning Experience and Health', in *Hui Whakaoranga, op cit.*

15 D. S. Sinclair, (1975), 'Land: Māori Views and European Response', in M. King (ed.), *Te Ao Hurihuri*, Hicks Smith, Wellington.

16 M. H. Durie, (1979), 'Land and Mental Health', unpublished paper presented at the the RANZCP Conference, Queenstown.

17 M. H. Durie, (1987), 'Implications of Policy and Management Decisions on Maori Health: Contemporary Issues and Responses', *International Journal of Health Planning and Management* 2, Special: 201–13.

18 C. Maskill, (1991), *A Health Profile of New Zealand Adolescents*, Discussion Paper 14, Health Research Services, Department of Health, Wellington.

19 M. H. Durie, (1986), 'Te Taha Hinengaro: An Integrated Approach to Mental Health', *Community Mental Health in New Zealand* 1 (1): 4–11.

20 C. J. Heath (ed.), (1985), *Summary Report—National Conference on the Role of the Doctor in New Zealand: Implications for Medical Education*, University of Otago Medical School, Dunedin, p. 8.

21 R. R. Pere, (1984), 'Te Oranga o te Whānau: The Health of the Family', in *Hui Whakaoranga, op cit.*

22 M. Henare, (1988), 'Nga Tikanga me nga Ritenga o te Ao Māori: Standards and Foundations of Māori Society', in *The April Report*, III, part 1, Royal Commission on Social Policy, Wellington, pp. 24–232.

23 M. H. Durie, (1985), 'Māori Health Institutions', *Community Mental Health in New Zealand* 2 (1) 63–9.

24 W. H. Oliver, (1991), *Claims to the Waitangi Tribunal*, Department of Justice/Daphne Brasell Associates, Wellington. The major claims were brought by Te Ātiawa (the Motunui claim), Ngāti Pikiao (Kaituna River), Ngāti Te Ata (Manukau Harbour), and Ngāti Kahu (Mangonui Inlet).

25 Waitangi Tribunal, (1986), *Te Reo Māori Report*, Department of Justice, Wellington.

26 Working Group on Indigenous Populations, (1993), *Draft Declaration on the Rights of Indigenous Peoples: Report on the Eleventh Session of the United Nations Working Group*

on Indigenous Populations, United Nations, Geneva.

27 Te Roopu Awhina ō Tokanui, (1987), 'Cultural Perspectives in Psychiatric Nursing: A Maori Viewpoint', *Nursing Praxis in New Zealand* 2 (3): 3–11.

28 P. Ngata and L. Dyall, (1984), 'Health: A Māori View', *Health* 36: 2.

29 C. Benland, (1988), 'The S-Factor: Taha Wairua', in *The April Report, op cit.*, pp. 450–68.

30 New Zealand Board of Health, (1988), *Priorities for the New Zealand Health Services,* New Zealand Board of Health, Wellington, p. 6.