*The Journal of Primary Prevention, Vol. 25, No. 1, September 2004 (© 2004)*

# Whare Tapa Wha: A Mäori Model of a Unified Theory of Health

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*Mäori, the indigenous people of New Zealand, have suffered social and economic deprivation as a result of colonisation. Mäori suffer worse health then their Päkehä (non-Mäori) cohort. Mäori are using their traditional worldview to develop a model of health that can be used as a holistic or unified theory of health. The model, Whare Tapa Wha, can be used as clinical assessment tool. The model is part of Mäori seeking to regain control over our health services. It has supported the development of a Mäori health sector, which has led to gains in both health and community development.*

**KEY WORDS:**

Ko Aora_k_i te mauka
Ko Ma_k_aawhio te awa
Ko Uruao te waka
Ko Te Koeti te takata
Ko Poutini te whenua
Ko Kati Mahaki te hapü
Ko Mamoe Kai Tahu te iwi
Tënä koutou katoa

(Greetings to you all, Aora_k_i is my mountain, Ma_k_aawhio is my river, the Uruao is my ancestral canoe, Poutini is my homeland and Te Koeti the ancestor who links me to these things. My tribe is _K_ati Maha_k_i of the Mamoe _K_ai Tahu people of the South Island of New Zealand.)

This is a greeting that places me as a Mäori of the Mamoe _K_ai Tahu confederation of tribes of the South Island of New Zealand. More specifically, it links me to my ancestral home at the mouth of the Ma_k_aawhio

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0278-095X/04/0900-0041/0 © 2004 Springer Science+Business Media, Inc.

river on the southwestern coast of that island. These links form my identity and give me knowledge of my place in the world and the responsibility to pass that knowledge on to my children. In my professional life, I am a lecturer in Mäori health at the Wellington School of Medicine of the University of Otago.

The purpose of this paper is to describe culturally specific frameworks developed by Mäori to respond to our health needs. The framework can operate at high level policy setting, as templates for designing prevention strategies, as a clinical assessment tool, or to set outcome indicators for assessing appropriate treatment for Mäori.

This framework can be useful for understanding any kind of health issue and forms a unified approach to health services. While the universality of the frameworks is significant, it is essential for Mäori that the cultural specific nature of the framework is emphasized.

For this reason, I will use Mäori words to describe the framework with translations provided in brackets. A glossary will also be provided. The dialect I will use is of my own Iwi (tribal confederation or nation) the Mamoe *K*ai Tahu people of Te Wai Pounamu (South Island).

I will discuss theoretical models; I will then attempt to illustrate these with concrete examples that express the underlying principles.

## SOCIOHISTORICAL BACKGROUND OF MÄORI

Mäori are the ta*k*ata whenua or indigenous people of New Zealand. We make up just under 15% of the population and are a young people with a median age of 21.6 years (Te Puni Kökiri, 1999).

Like most indigenous peoples, Mäori were colonized and suffered from loss of land that sustained traditional lifestyles. The loss of an economic base has resulted in Mäori being forced to abandon those lifestyles, and we have been marginalized in our own homeland (Awatere, 1984; Bellich, 1986; Crosby, 1986).

Each iwi (and there are more than forty) has its own history of colonization, and as a result Mäori live in diverse reality often alienated from both Mäori and Päkehä worlds with loss of language and cultural institutions as well as economic loss.

This is reflected in Mäori being over represented in almost every negative social statistic, such as prisons, poverty unemployment, poor housing, and low educational status (Te Puni Kokiri, 1998, 2000).

This is particularly true for health. Päkehä can expect to live 8.1 years longer for males and 9 years longer for females than their Mäori cohort does. Precise disparities are often hard to define, as ethnicity data in New Zealand are poor, the gap is greatest in chronic illnesses most associated with social deprivation, such as type 2 diabetes (as described in detail below) (Ministry of Health, 1999).

We (Mäori) are more likely to suffer from cancers, heart disease, diabetes, infectious diseases, mental illness, drug dependence, suicides, and injuries both intentional and unintentional. Many of these illnesses manifest themselves earlier in Mäori then their non-Mäori cohort and the outcome is almost always more severe (Ministry of Health, 1999).

In addition, Mäori will present to the health sector later in the course of their disease and with significantly more severe conditions. This suggests that improving the access to health services with a primary prevention focus will be important in improving Mäori health status (Ministry of Health, 1998a; Pömare et al., 1995).

The response to these disparities is both in health and social indicators and a framework for managing these, needs to combine health and more general political perspective. I will begin with the politics of colonisation and describe traditional Mäori society (Te Ao Mäori) prior to the arrival of Päkehä.

## MÄORI SOCIETY

Traditional Mäori society was organized around whänau (extended family), hapü (tribe), and iwi. These were descent groups, based around an ancestor. The iwi—the largest grouping—was usually based around the ancestor who established mana whenua (guardianship and ownership of land) of a large area. Each iwi contained several hapü that divided up territory between them (Te Rangi Hiroa, 1949).

Each hapü was made up of a number of whänau who would be positioned according to their relationship to the founding ancestors of the hapü and iwi. Their place would determine the access each whänau had to mahika kai (food gathering places). Whakapapa (genealogy) was an extremely important and complex body of knowledge. Because of this, each whänau, hapü and iwi had tohuka (experts) responsible for the preservation and passing on of this knowledge (Metge, 1995).

Whakapapa also linked the whänau, hapü, and iwi to creation. Tohuka would trace descent lines from the primeval founding parents, Rakinui (sky father) and Papatuanuku (earth mother), and from their various children who were gods and had responsibility for different aspects of the world. It is their descendants who are all things in the environment both animate and inanimate (Teone, 1939).

This emphasis on the common descent ensures that the relationships with both with both people and the environment are based on reciprocity and balance. The relationship is also a reflection of the belief that all things imbued with a physical aspect as well as a spiritual aspect, with all things possessing a *mauri,* or life force, reflecting its spiritual aspect (Marsden, 1989).

Marsden (1989) discusses how this life force is the unifying principle and suggests the problems in the physical world are also reflections of a disturbance in the spiritual world. Mäori did not distinguish between the mental and physical aspects of health with individuals, communities, and the environment.

Mäori based their social and cultural structures around concepts of interconnectedness and interdependence. This collective lifestyle resulted in an effective form of social organisation in which “a public health system evolved which was based on a set of values that reflected the close and intimate relationship between people and the natural environment” (Durie, 1994).

## COLONIZATION

The impact of the arrival of the Päkehä (mainly from Britain) and the subsequent colonization of New Zealand is a long and complex story that would take many books to tell. From the very first meeting, the contrast between the individualist, materialist culture of the explorers, traders, and missionaries, and the collectivist and spiritual culture of the Mäori led to clashes that often resulted in warfare and death (Awatere, 1984).

The newcomers were instrumental in introducing muskets and diseases, both of which wreaked havoc through the first half of the nineteenth century and beyond (Crosby, 1986). Concern over this havoc and a need to achieve legal recognition for their trading ships led Mäori rakatira (chiefs) to make a Declaration of Independence in 1835, and then, in 1840, to sign the Treaty of Waitangi (Orange, 1987).

## TREATY OF WAITANGI

The Treaty of Waitangi was a Treaty between over 500 rakatira representing Mäori and the British Empire which was signed in 1840 and formed the foundation document of New Zealand. The Treaty contains three articles:

- In the first article, Mäori were to recognize the kawanataka (governance) of the Crown (Queen Victoria),
- In the second article, the Crown were to recognize the rakatirataka (chieftanship) over their own peoples and possessions,
- In the third article, Mäori were to be treated in the same manner as British Citizens.

The Treaty was written in English and translated into Mäori; however, the translation is significantly different, and this has resulted in a myriad of books and legal debates that will no doubt continue for years to come (Orange, 1987).

Despite these ambiguities, for Mäori, the Treaty of Waitangi is the document that defines the relationship between iwi Mäori and the Government. Only through the Treaty can the policy development reflect the rights and responsibilities of the Treaty partners and therefore hope to achieve conflation of both partners’ interests (Durie, 1998).

The Treaty is a unique document that set out in 1840 the prospect of genuine recognition of two distinct peoples of different cultures living together in equality. It was, unfortunately, beyond the capacity of the British officials, who negotiated the document, to see outside their paradigm of British superiority.

Even today, 160 years later, we as a nation struggle with the idea that two cultures can be given equal respect, and many disputes around the world show the difficulty of achieving this dream. In my view, the Treaty of Waitangi should be a model of the basis of cultural tolerance from which we can all learn.

The failure of successive New Zealand Governments to honor the Treaty has been the dominant theme of Mäori politics for 160 years. Its relevance to health is that it places a responsibility on the Government to recognize the rights of Mäori to determine the shape and nature of their health services.

In 2000 the newly elected Labour Government of Helen Clark restructured the health sector and inserted a reference to the Treaty of Waitangi in the health legislation. That clause was watered down in response to objections that such a clause would privilege Mäori in accessing services. Mäori, like most indigenous peoples, have significantly less access to effective health services than their Päkehä cohort, despite a higher need. The reaction appears to be a result of an irrational fear of increasing Mäori rights.

The negative reaction was well orchestrated and led by conservative politicians, senior public servants, and the media and suggests that there are still many obstacles in the path ahead to a honorable relationship between Mäori and the Government.

## OTTAWA CHARTER

The Treaty of Waitangi does provide a model for cultural autonomy, and it is one that is consistent with the Ottawa Charter of the World Health Organization (WHO) and its model of health promotion and community development. The Ottawa Charter is based on the principle that the health of a community is dependent on the overall development of that community (World Health Organization, 1986).

In a subsequent declaration at Sundsvall in 1991, the World Health Organization (WHO) acknowledged "the unique spiritual and cultural relationship between indigenous peoples and the physical environment and believes that this relationship provides valuable lessons for the rest of the world. The right of indigenous peoples to preserve their cultural heritage is fundamental to their health development, according to the World Health Organization" (World Health Organization, 1991).

Mäori models are consistent with these positions and can provide models for other indigenous peoples who are facing the same problems.

## Mäori Perceptions of Health

Mäori defined their own health needs at Hui (conference) Te Ara Ahu Whakamua (the path forward) held in Rotorua in March 1994 (Te Puni Kökiri, 1994). Over one thousand Mäori health, community, and tribal leaders met to assess the state of Mäori health, to measure the progress, and to set a strategic direction for Mäori health over the coming decade.

The hui was organized by Te Puni Kökiri (the Ministry of Mäori Development) and provided an opportunity for Mäori health leaders to meet with mainstream health leaders (including Cabinet ministers). It came at a time when the Treaty had begun to achieve legal status and Mäori communities had begun to exercise their raḵatirataḵa (autonomy).

The hui was mainly a series of presentations by key speakers but did include many workshops which enabled a wide variety of participants to formulate a remarkable consensus around the common view that Mäori needed to control the future direction of health services to their communities.

The hui focused on some key questions:

- What constitutes a healthy Mäori?
  *Participants considered that a healthy Mäori had a strong sense of identity; self esteem, confidence and pride, control of his/her own destiny, leadership, intellectual, physical, spiritual, and whänau (extended family) awareness, personal responsibility, respect for others, knowledge of te reo (the Mäori language) and tikaḵa (custom), economic security, and solid whänau support.*
- How should Mäori health be measured?
  *It was accepted that Mäori health could be measured best in terms of the number of Mäori in positions of influence, the value of resources in Mäori ownership, life expectancy, reduced crime rates, increased educational and business achievement, and te reo usage.*
- What policies should be put in place to achieve health for Mäori?
  *Policies that should be put in place include those that are developed by Mäori for Mäori, are based on consultation and good information, raise the status of te reo and tikaḵa, ensure access on an equal basis, promote the unique qualities and talents of Mäori, and encompass a range of social services such as broadcasting, education, justice, and welfare.*

Te Ara Ahu Whakamua was subtitled the Mäori health decade hui, as it reflected on ten years of progress in which there had been a remarkable development in Mäori health and other social services (Ministry of Health, 1998a). These were the result of two intersecting forces. One was a reflection of the growing political strength of Mäori that included recognition of the Treaty in legislation, the beginning of the settlements of past grievances, and a resurgence in Mäori language and culture (Fleras & Spoonley, 1999).

The second force was more negative as New Zealand had experienced a painful restructuring of the country towards a more market economy, which marginalised poorer communities, including Mäori. The period from 1984 to the present saw a rapid increase in social and economic disparities between Mäori and Päkeha and a failure of the state institutions to adequately respond to Mäori need (Keefe, Ormsby, Reid, Robson, Cram, Purdie, Ngati Kahungunu Iwi Authority, 1999; Kiro, 1998; Ministerial Advisory Committee, 1988).

In health, Mäori saw that failure of mainstream health services as a clear indication that health services for Mäori needed to reflect Mäori need and to take into account the Mäori social position. Health for Mäori needed to be more holistic, and the result was the development of health models that more completely reflected Mäori reality than the western bio-medical paradigm.

## WHARE TAPA WHA

Whare Tapa Wha was developed from a hui of Mäori health workers in 1982 as described by Dr. Mason Durie (1994). Mäori believe that most health services follow a biomedical model based on a reductionist worldview, which does not recognize things that cannot be measured. As a result, the service is able only to respond to the physical (or tinana) needs of Mäori.

Mäori usually use a holistic model of health called Whare Tapa Wha (four cornerstones of health), the four realms being:

**taha tinana** (physical); **taha hinekaro** (emotion);
**taha whänau** (social); and **taha wairua** (spiritual)

Whare Tapa Wha can be seen as a unified theory of health, and in fact, in 1993 Robert Lafaille built a model of a unified theory of health that is almost identical to the Whare Tapa Wha. To Lafaille, the health views can be broken to four main paradigms, which are:

1. Biomedical—which equates with taha tinana;
2. Existential anthropological or psychosocial–which equates with taha hinekaro;
3. Culturological or socio-economic—which equates with taha whänau; and
4. Systemic or environmental seeing human health as part of the wider web of life, interconnected and interdependent—which equates with taha wairua.

Whare Tapa Wha is a model that enables one to tease out two major dichotomies in health: the tension between seeing health at an individual or population level (macro–micro) and the tension between mind and body (substance–form). This can be shown diagrammatically as in Fig. 2.

The substance/form dichotomy reflects the tension between a reductionist materialist worldview and one that recognizes that there are patterns and symmetries

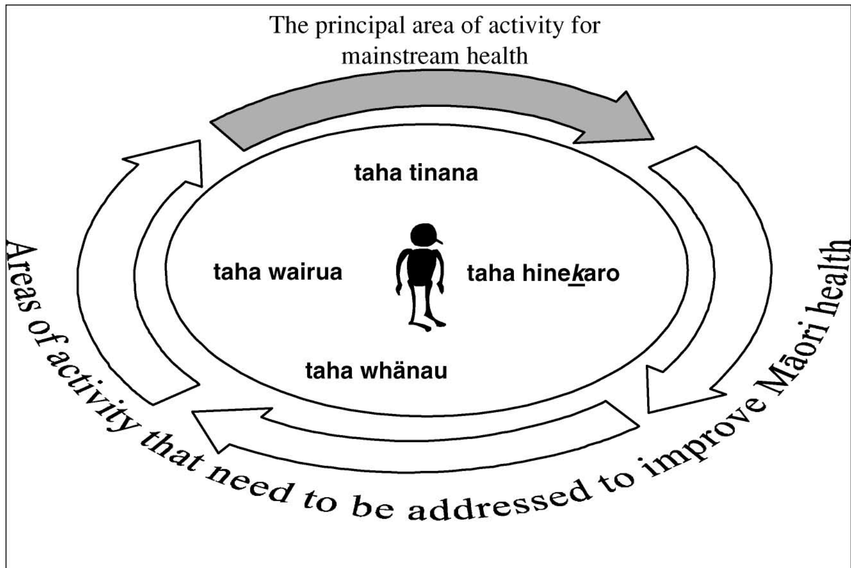


**Fig. 1.** Source: Ministry of Health (1998b).

that are emergent. At a macro level these patterns can be seen in the complex web of life (Cohen and Stewart, 1994; Capra, 1982, 1996). The symbiotic nature of life suggests some organizing principles, and this can be equated with the Mäori view that the material world reflects an underlying spiritual world (Marsden, 1989).

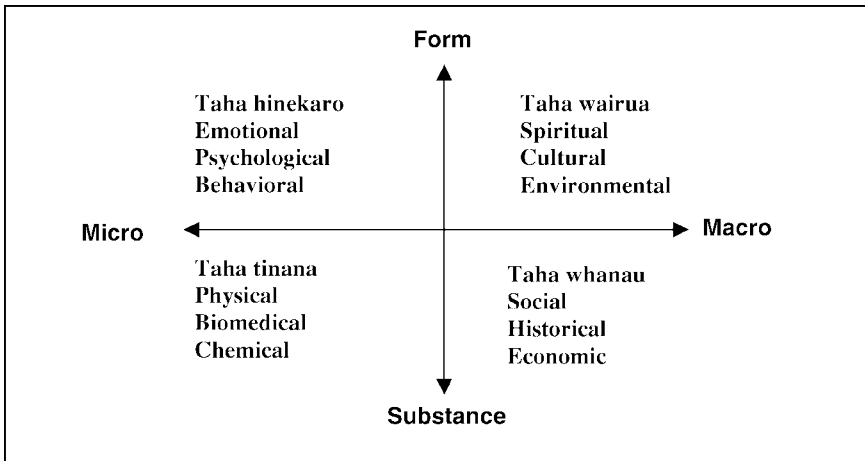


**Fig. 2.** Source: author.

Whare Tapa Wha is universal in its application but also reflects the unified view of the universe, which is fundamental to the Mäori worldview. Its unique Mäori character enables Mäori to take greater ownership of the insights the model can bring and, therefore, in this ownership begin to reverse the impact of colonisation.

In addition to a unified theory of health (and therefore emphasizing its power as an analytical tool), Whare Tapa Wha can be used to design a response to a complex disease such as type 2 diabetes, as shown below.

## DIABETES

Type 2 diabetes (also known as adult onset diabetes or non-insulin dependent diabetes mellitus, NIDDM) is characterized by raised blood glucose (hyperglycemia) and is caused by a combination of resistance to insulin and a relative insulin deficit (Ministry of Health, 1997).

Type 2 diabetes has been characterized as an age related illness, where insulin resistance increases over a lifetime. In addition to the well-documented effects of a high fat diet and lack of exercise, there is evidence that long-term chronic stress can lead to insulin deficit. Stress produces cortisols that are known to suppress insulin and when stress becomes chronic this is thought to result in permanent damage (Ministry of Health, 1997).

Some researchers have begun to develop a theory that minorities who suffer from the premature manifestations of age-related illness may be suffering from accelerated aging caused by the stresses of being alienated from the mainstream. It is suggested that this accelerated aging is a reflection of the racism they face (Camara-Jones, 1999).

Mäori carry a higher burden of type 2 diabetes; they are reported to suffer 4–5 times the prevalence, have 3 times higher hospitalization rates, 9 times the mortality rate (the difference between these rates reflects differences in access to health services), and they are diagnosed at a earlier age, with the median age of diabetes diagnosis for Mäori being 43 compared with 55 years for their Pakeha cohort (Ministry of Health, 1997).

As a result of poor access to primary health, many Mäori only become aware of their diabetes when microvascular complications start to manifest themselves. These include loss of sight, impotence, kidney disease and diabetic foot, which can lead to amputation (Ministry of Health, 1997). Treatment and support for these complications is the realm of *taha tinana* and is the principal response of the health sector to type 2 diabetes among Mäori.

In addition to the physical response, diabetics need emotional support. To manage their condition, a diabetic needs to change their lifestyle, which is often the lifestyle of their whänau and others around them. This is in addition to managing the pressures of having a life-threatening condition. Managing these pressures is working in the realm of mental strength or *taha hinekaro*.

It is well accepted that effective management of type 2 diabetes, however, comes from prevention, rather than medical management. The risk factors are lifestyle and are to a certain extent heritable (either genetic or prenatal) (Ministry of Health, 1997). The whänau of those who have type 2 diabetes are therefore also at high risk for developing the disease. Healthy lifestyles of whänau would be a major contributor to type 2 diabetes prevention, and this is in the realm of *taha whänau*. Whanau well-being also requires some economic independence.

Diabetes clusters around ethnic minorities (particularly indigenous peoples) and poverty in developed nations (Ministry of Health, 1997). Economic development would reduce chronic stress in Mäori and therefore reduce type 2 diabetes amongst Mäori. This involves supporting Mäori development. When Mäori communities are well, then Mäori are well.

Development needs to be tied to cultural development for two reasons. Firstly, in addition to poverty, Mäori suffer from the stress associated with the loss of land, language, and socio-cultural structure. These losses compound the loss of economic capacity with the destruction of the cultural institutions that sustain them (Reid, 1999).

Mäori are then educated to believe that they have benefited from the process of colonization. They are taught that Mäori have been not been the victims of invasion and theft but that their rights have been swept away by natural selection, by the tides of history. This view holds both Mäori and their culture as being inferior and replaced by a better culture (Simon & Smith (Eds.), 2001).

These attitudes, while declining, are still held by significant sections of society, including in the power elite. These racist attitudes are often internalized by ethnic minorities (Camara-Jones, 2000). Cultural recovery by Mäori is essential in promoting self esteem and healthy lifestyles, and these are thought to be essential in reducing type 2 diabetes.

In summary, Mäori need to have a cultural identity that reflects our spiritual place in the world. To be well, Mäori require knowledge of their culture, their identity, and their heritage. Only then can one understand their place in the world. Mäori call this their tikak̲a (customs) and whakapapa (genealogy and history). This is the realm of *taha wairua*. Only by developing the spiritual, cultural, economic and psychological aspects can Mäori achieve well-being (Durie, 2001).

This can be shown in Fig. 3 where the natural course of type 2 diabetes is described in the central column while the determinants and response is shown as appropriate to each of the domains of Whare Tapa Wha.

## DETERMINANTS NATURAL COURSE OF DISEASE, RESPONSE BY DOMAIN FOR TYPE 2 DIABETES MELLITUS FOR MÄORI

The broader focus of Whare Tapa Wha ensures that the health sector considers the wider socioeconomic conditions that, to a large extent, are the cause of poor

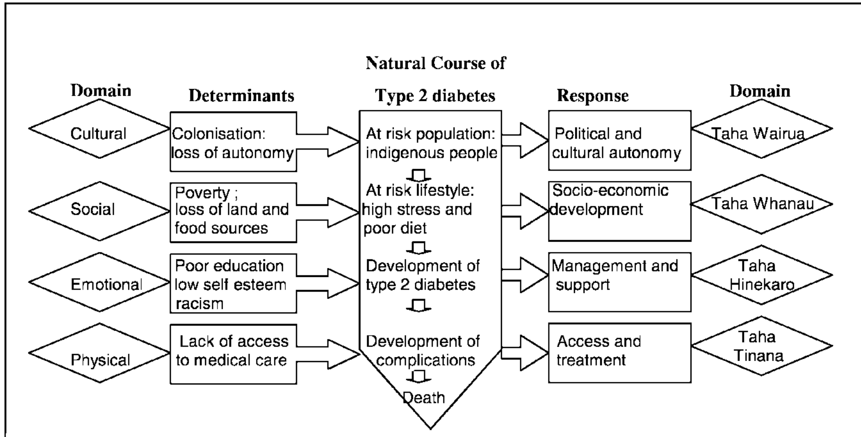


**Fig. 3.** Source: author.

Mäori health status. In addition, these indicators would provide a clearer picture of the confidence of Mäori, including the levels of self-esteem of individuals, whänau, hapü, and iwi.

## MENTAL HEALTH

Whare Tapa Wha can also be seen as a direct clinical tool. A pioneer Maori mental health provider, Te Whare Marie, was set up using Mäori kaupapa (procedure and custom) after mainstream mental health services failed to provide adequate care to Mäori (Te Puni Kokiri, 1996). Te Whare Marie developed the following clinical assessment tool based on Whare Tapa Wha (Dr. J. Baxter, personal communication, 2000).

If a mental health consumer presents to mainstream mental health providers, the clinician principal diagnostic and treatment algorithms will be based on the chemical balance (or lack of). Treatment will be drug based and hopefully will enable the consumer to stabilise their life (Dyall, 1997). This reflects the *taha tinana* of the consumer.

The consumer will have already developed coping strategies for their illness. These could include introversion, drug abuse, aggression, and crime. To go beyond simple management of mental illness would require therapy that replaces negative coping strategies with positive ones (Hirini, 1997). This is the realm of *taha hinekaro*.

The consumer's illnesses will be entangled in their life history and will likely involve their family. Family members, through their actions or absence, may have directly contributed to the consumer's illness. In addition to the impact of the

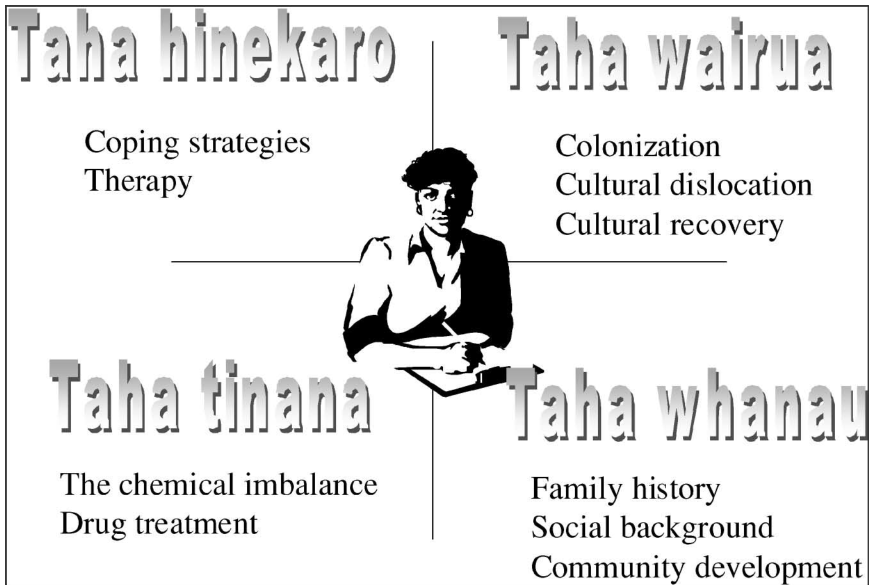


**Fig. 4.** Source: author.

family, any mental illness will certainly be shaped by the socioeconomic and cultural environment in which the consumer and their family were raised (Durie, 2001). This is the realm of *taha whänau*.

For Mäori, as the indigenous people of New Zealand, the deconstruction and reconstruction of our culture place huge pressures on individual Mäori. Confusion over identity, loss of land and other resources that have provided spiritual sustenance to our tipuna (ancestors), and the loss of self-esteem are all the result of colonization and are significant contributors to mental illness. Mäori also suffer from poor diagnosis from cultural misunderstanding by Päkehä clinicians, resulting in inappropriate treatment (Durie, 2001). These are all aspects of *taha wairua*.

Mäori are beginning to develop therapies that reflect these complex determinants of mental illness. One such model, Paiheretia (relational therapy) utilizes therapeutic tasks from the domains of Whare Tapa Wha as set by kaumatua (elders) to encourage mental health consumers to develop reciprocity in their relationships (Durie, 2001).

Whare Tapa Wha enables a diagnosis and treatment path that reflects the historical, social and psychological aspects of mental illness, as opposed to being confined to managing only the chemical imbalances, as is the case for so many Mäori consumers.

## POLICY IMPLICATIONS

It is now well accepted that cultural and socioeconomic conditions are principal determinants of our health status. The health sector cannot be held accountable for the socioeconomic status of Mäori, but it can be asked to report on how it responds to health needs created by poverty (National Health Committee, 1998).

The sector should be able to identify health needs and shifting resources to meet those needs. Specifically, this includes improving mainstream responsiveness to Mäori and investing in the development of Mäori health providers.

Investment in community-based Mäori health services will also contribute to the development of Mäori communities' economic base. An increase in training for Mäori health and community workers will contribute to the growth of the social capital of Mäori communities. This means the networks of social engagement, cooperation and reciprocity (Putnam, 1995).

Successful Mäori health development links initiatives to improve Mäori health with overall Mäori development. This approach requires the health sector to coordinate their programmes with both Government and Mäori initiatives in other sectors such as housing, employment and education. This is consistent with the holistic approach of the framework Whare Tapa Wha.

The centre of traditional Mäori communities is the marae. It usually consists of a wharenui (large meetinghouse), marae atea (courtyard), and whare kai (dining hall), as food is not admitted in the wharenui (Te Rangi Hiroa, 1949). The marae remains the cultural centre of Mäori communities and is increasingly used as a base for the resurgence in the iwi, hapu and whänau activities.

Below is a possible model of a comprehensive, marae based, community development program.

## INTERVENTIONS—MÄORI HEALTH DEVELOPMENT

A key to improving Mäori health is reducing the lifestyle risks such as smoking, alcohol consumption, and poor nutrition that can be identified as causing major

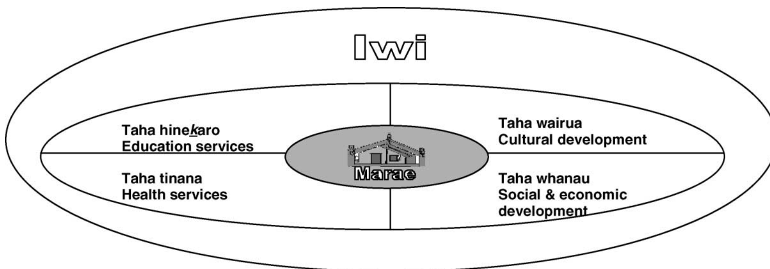


**Fig. 5.** A model of a comprehensive, marae based community development program.

health problems for Mäori. This requires changing often long-established lifestyle patterns (Pomare, 1995).

To encourage these changes and respond to existing illnesses, it is essential that Mäori access quality health services. There is evidence that many illnesses, disabilities and early deaths amongst Mäori are preventable. They can be prevented by early identification of the problem, appropriate health promotion, and early access to primary healthcare service (Labonte, 1997; Ministry of Health, 1998a; Pomare, 1995).

There is good evidence that effective Mäori providers have improved the access of health services to Mäori. Experience has shown that local solutions are likely to solve local problems. Generally, Mäori providers are in the best position to understand the communities they serve and to respond to their needs (Crengle, 1998; Ruakere, 1998; Te Puni Kökiri, 1993, 1994, 1995).

An acceleration of Mäori provider development contributes to Mäori economic development and creates opportunities to improve the collective and individual self-esteem of Mäori. This will lead to improved lifestyle management. In doing this, the development of effective Mäori health providers responds to the principle cause (determinant) and risk factors of Mäori ill-health and, therefore, is more likely to lead improved health outcomes.

In addition to accelerating Mäori provider development, the health sector also needs to ensure mainstream providers take responsibility for Mäori health. To do this, they must work in partnership with Mäori to reduce barriers and improve the access Mäori have to health services. Innovative Mäori health services have been successful in responding to Mäori health need (Rochford, 1997; Te Puni Kokiri, 1994; Voyle & Simmonds, 1999).

## CONCLUSION

Mäori have long called for health services that reflect Mäori health needs. Now Mäori are developing our own services and reflecting our worldview. In the past, health services have failed Mäori. Now they are being delivered in a culturally safe manner, they are consistent with our cultural beliefs and they have succeeded when no one has before them.

## GLOSSARY

Mäori—the indigenous people of New Zealand
Päkehä—non-Mäori
Iwi—(tribal confederation)
Mamoe Kai Tahu—name of my own tribe
Te Wai Pounamu—South Island
Takata whenua—indigenous people

Te Ao Mäori—traditional Mäori society
Whänau—extended family
Hapü—tribe
Mana whenua—guardianship and ownership of land
Mahika kai—food gathering places
Whakapapa—genealogy
Tohuka—expert
Rakinui—sky father
Papatuanuku—earth mother
Mauri—life force
Marae—centre of traditional Mäori community
Rakatira—chiefs
Kawanataka—governance
Rakatirataka—chieftanship, autonomy
Hui—conference
Te Ara Ahu Whakamua—the path forward
Te reo—Mäori language
Tikaka—custom, correct way of behaving.
Kaupapa—procedure and custom
Tipuna—ancestors
Paiheretia—relational therapy
Kaumatua—elders
Wharenui—large meetinghouse
Marae atea—courtyard
Whare kai—dining hall

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