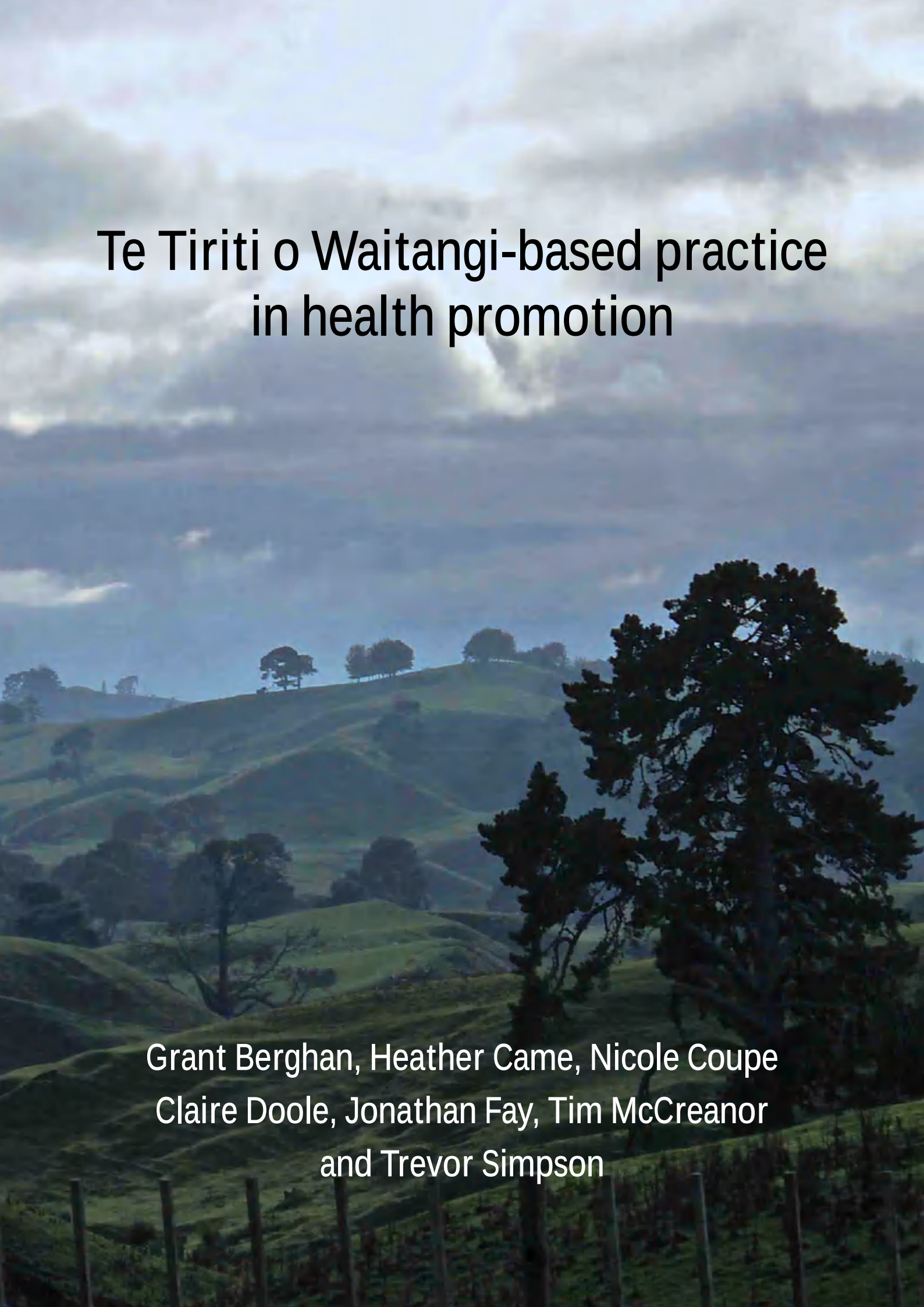
Te Tiriti o Waitangi-based practice in health promotion



Grant Berghan, Heather Came, Nicole Coupe
Claire Doole, Jonathan Fay, Tim McCreanor
and Trevor Simpson

DEDICATION

To Dr Irihapeti Ramsden for her staunch championship of the relationship between te Tiriti o Waitangi and health.

The legacy of your work continues on in nursing and beyond.

ACKNOWLEDGEMENTS

Thank you to the senior practitioners and to STIR: Stop Institutional Racism, for your contributions to this work, and to Emma Rawson additionally for her data collection.

Thanks to the Faculty of Health & Environmental Sciences, Auckland University of Technology (AUT) and to the Auckland branch of the Public Health Association for financially supporting this project, and to the School of Public Health and Psychosocial Studies at AUT for part funding the costs of the print version of this resource.

Thanks to Dominic O'Sullivan, Amy Zander, Rose Black, Maria Humphries, Susan da Silva and Maria Rameka for your comments and feedback on drafts of sections of this resource, to Keith Tudor, the grammar king, and to Susan Healy, Fiona Cram and Moana Jackson for their academic peer review.

Thanks to Jenny Rankine, of Words & Pictures for editing, design and layout.

Cover photo of a Matamata landscape by Tobias Keller from Unsplash.

CITATION

Berghan, G., Came, H., Coupe, N., Doole, C., Fay, J., McCreanor, T., & Simpson, T. (2017). *Te Tiriti o Waitangi-based practice in health promotion*. Auckland, Aotearoa New Zealand: STIR: Stop Institutional Racism. Accessed from: https://trc.org.nz/treaty-waitangi-based-practice-health-promotion

[***Note**: This electronic version has different pagination from print copies.*]

Hauora - Everyone's Right

Runanga Whakapiki Ake i te Hauora o Aotearoa
Health Promotion Forum of New Zealand

STIR

Tāmaki Treaty Workers

Public Health Association of New Zealand
Kaihui Hauora Tūmatanui

AUT
TE WĀNANGA ARONUI O TĀMAKI MAKAU RAU

Te Tiriti o Wāitangi-based practice in health promotion

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and Trevor Simpson

Published by STIR: Stop Institutional Racism
Auckland, Aotearoa/New Zealand
2017
ISBN 978-0-473-41439-9

CONTENTS

GLOSSARY

Aroha ki te tangata – expression of love to other people

Hapū – sub-tribe

He kanohi kitea – a face seen

Hinengaro – emotional and mental wellbeing

Hui – large gathering

Iwi – tribe

Kai – food

Kaimahi – worker

Kaitiaki – guardian

Kaiārahi – guide

Kawa whakaruruhau – cultural safety

Karakia – prayer

Kaupapa Māori – Māori approach

Kāwana – governance

Kāwantanga – governance

Koha – reciprocity

Komiti – committee

Kōrero – conversation

Kuia/kaumātua – elders

Mana – prestige and authority

Manāki – nurture

Mana whenua – territorial land right holders

Marae – courtyard meeting place

Mātāwaka – Māori living outside their tribal areas

Mātauranga Māori – traditional Māori knowledge

Mauri – life force

Noa – something safe or normal

Ōritetanga – equity

Pākehā – New Zealanders of European descent

Pou – pillar

Pōwhiri – welcome on marae

Rāhui – restrictions

Rangatahi – youth

Rangatira – chief

Rite – the same or alike

Taiao – the natural environment

Taonga – treasures

Tapu – sacred or prohibited

Tauiwi – non-Maori

Tautoko – support

Te ao Māori – the Māori world

Tēnā koutou – formal greeting to a group

Te Puni Kōkiri – Ministry of Māori development

Te Tiriti o Waitangi – Māori text of the Treaty of Waitangi

Tikanga – Māori system of customs and traditions

Tinana – Physical body

Tino rangatiratanga – sovereignty

Te reo Māori – Māori language

Wairua/Wairuatanga – spiritual strength and practice

Whakapapa – genealogy or lineage

Whakatau – welcome

Whānau – extended family

Whanaungatanga – active relationship building

Whenua – land

1.0 FOREWORD

It is appropriate this resource is dedicated to Irihapeti Ramsden. As a nurse and deep-thinking philosopher, she was committed to finding practical ways to give effect to *te Tiriti o Waitangi*, especially in health. Her promotion of the concept of cultural safety in nursing recognised the power dynamics at play in any relationship between health professionals and those in their care. In a very real sense it was based in *te Tiriti o Waitangi* and was thus a recognition that the *Tiriti*–Treaty relationship is also about power.

This resource builds upon that recognition and in a carefully considered and practical way it offers guidance for all who work in the health sector to manage and develop their Treaty based practice in ways that recognise the power relationships it enshrines. It acknowledges, as did the original philosophical underpinnings of cultural safety that those relationships are not merely therapeutic or health-centred but are also historical, political, and economic.

The resource's emphasis on the Māori words in *te Tiriti* is especially important too as it recognises the often-ignored reality that all of the iwi and hapū discussions about the Treaty in 1840 were in te reo Māori. Of course, that is not surprising as it was the language of this land at that time and an important exercise of mana or rangatiratanga such that treating between polities would naturally be conducted in Māori.

It is equally unsurprising that the rangatira signed the words of *te Tiriti* only in te reo Māori, apart from the few rangatira at Waikato Heads who were shown only the English text. In that regard Māori have long said that the rangatira did not sign the English words because they were neither discussed nor read and thus were irrelevant.

In recognising the importance of *te Tiriti*, this resource helps correct the erroneous Crown emphasis on the "English Version" of the Treaty, which ignores the linguistic and cultural facts of Māori life in 1840 in favour of privileging an alleged cession of Māori sovereignty to the Crown. It therefore also reaffirms the iwi and hapū reality that no rangatira had the right or authority to cede or give away the sovereignty or mana which they were entrusted with exercising. Even to contemplate doing that would have been spiritually and culturally incomprehensible, as well as legally impossible.

The resource is particularly timely too as it reflects the evolving understanding of *te Tiriti* that has occurred since the 1970s when the so-called radical Māori groups such as Ngā Tamatoa took it off the marae and thrust it into the wider social consciousness. In doing so, they were simply making available a Treaty discourse which iwi and hapū had consistently maintained even through the darkest and

most despairing days of colonisation in the 19th century. It was a discourse based on *te Tiriti* and the long-standing denial of cession as well as a restatement of the authority of self-determination encapsulated in the concepts of mana and tino rangatiratanga.

Although many Pākehā were unaware of that discourse the resource acknowledges it as well as the various Crown responses to it which were initially sourced in the 19th century presumption that the Treaty was a "simple nullity" as Māori supposedly lacked the capacity to treat. However, later refinements have seen the Treaty characterised as the "founding document of the nation" and the legitimating source of Crown power. Within that paradigm, successive governments and court decisions have created a whole new Treaty vocabulary including the notions of "partnership" and "participation" which, nevertheless, continue to be predicated upon a cession of Māori authority.

In contextualising Tiriti-based health practice in this way the authors of the resource acknowledge that while progress is being made in understanding the *Tiriti* relationship, there is still some way to go. Perhaps in that sense their most important contribution is the recognition that, ultimately, any Treaty relationship is a constitutional one. It was indeed heartening to see acknowledgement of the recent work done in that area including that undertaken by the Independent Iwi Working Group on Constitutional Transformation, Matike Mai.

I am grateful for the work done by all of those involved in compiling and editing this resource and commend it not just to people involved in the health professions but to everyone who chooses to live in this land. After all, good health and good health practice come from a shared interest in the just-ness of a society. Perhaps more than anything else it is the hope and promise of such just-ness that *te Tiriti* most enshrines.

Moana Jackson

2.0 INTRODUCTION

Te Tiriti o Waitangi (*te Tiriti*) legitimises settler presence in Aotearoa New Zealand and governance by the British Crown. Therefore, *te Tiriti* must lie at the heart of ethical health promotion in this country. This resource, inspired by activist scholarship, explores the ways in which senior health promoters work with the articles of *te Tiriti* and its aspirations. The research question was: How do senior health promoters apply the articles of *te Tiriti* to practice? This question emerged out of dialogue with members of the health activist network STIR – Stop Institutional Racism. STIR (Came, McCreanor, & Simpson, 2016) is a group of senior public health practitioners and activist researchers who aim to end racism in the public health sector. The promotion of *te Tiriti*-based practice is a promising pathway to counter institutional racism in Aotearoa (Came & McCreanor, 2015). The resource aims to refresh and extend the important work of the Health Promotion Forum (2000) in the development of *Treaty Understanding of Hauora in Aotearoa-New Zealand* (TUHA-NZ) – the pioneering *Tiriti*-based practice guidelines.

We start by outlining the importance of *te Tiriti* to health promotion practice in Aotearoa.

The Treaty, then, was not just a political and legal covenant but also a spiritual one ... Because of the Treaty, Māori believe right to this day that they are equal partners and yet they know from experience that is not so.
James Henare, 1987

Then we set out the research method on which this resource is based, and from which we advocate deeper engagement with *Tiriti*-based practice, anti-racism and decolonisation. We locate *te Tiriti* as a sequel to *He Wakaputanga o Te Rangatiratanga o Nū Tīreni* (the Declaration of Independence). We next orient readers to each of the articles of the Māori text of *te Tiriti* as it relates to health promotion in Aotearoa. Specifically, we look at the concepts of kāwanatanga, tino rangatiratanga, ōritetanga and wairuatanga. Under each article of *te Tiriti* we introduce relevant research, information from this study, and insights from the authors' experiences related to *te Tiriti*. The final section draws out the core elements of Tiriti-based practice. The appendices introduce the senior practitioners who participated in this research, the authors, and the peer reviewers of this resource.

3.0 HEALTH PROMOTION AND *TE TIRITI O WAITANGI*

Health promotion is a distinct professional discipline and a process of enabling people to take control over their health (WHO, 1986). It can involve community work, policy development, advocacy, and empowerment as well as working in settings where people live, work and play. It is different from other public health approaches, such as immunisation or health literacy, as it is overtly driven by values, and is often political in its attempts to transfer power to communities and strengthen social justice.

In an era plagued with inequities between and within countries (WHO, 2013), health promotion is one of the fundamental public health approaches available to redress entrenched health inequities. Health promotion at its radical best can be the systematic practice of addressing the determinants of health by dealing with the 'causes of the causes' of ill health. Early life influences, stress, employment, support, social inclusion, food and addictions are all recognised contextual factors that influence health outcomes (Wilkinson & Marmot, 2003).

The absence of material on indigenous health promotion in academic databases suggests that indigenous communities have, historically, been underserved by the health promotion community or that academics have struggled to have such material published in academic journals. Alternatively, it may reflect indigenous peoples' decisions not to share indigenous knowledge for fear it will be commercialised, or someone will claim ownership of their intellectual property rights.

We, as authors, aim to elevate indigenous knowledge and work with a holistic definition of health outcomes. In line with Māori health practitioners, we look beyond the biomedical realm, recognising the interconnections of whānau, wairua, hinengaro, and tinana (Durie, 1998a).

From a human rights standpoint, the United Nations (2007) affirmed indigenous peoples' rights to both sovereignty (Article 46) and health (Articles 17, 21, 23, 24 and 29) in the *Declaration on the Rights of Indigenous Peoples*. New Zealand ratified this declaration

Health promotion at its radical best can be the systematic practice of addressing the determinants of health by dealing with the 'causes of the causes' of ill health.

in 2010. The *Universal Declaration of Human Rights* (UN, 1948) also details the right to health (Article 25). Globally, indigenous people (Anderson et al., 2016), including Māori, carry a disproportionate burden of preventable disease (Marriott & Sim, 2014). These persistent disparities suggest that an equal right to health, particularly life expectancy, is being denied to Māori and other indigenous peoples.

In addition to widely accepted determinants of health (Wilkinson & Marmot, 2003) such as income and socio-economic status, Mowbray (2007) argued that indigenous people have further cultural and historical determinants of health. These include negative experiences of colonisation and destructive institutional racism, alienation of land and thus identity, and historical trauma. These determinants are rarely successfully addressed through conventional health promotion activities. Indigenous sovereignty and self-determination are also considered determinants of health. There is also little research with indigenous analysis or evidence in policy.

Colonisation, and the resulting transfer of power, money and resources from indigenous peoples to the colonisers, impacted not only the immediate colonised generation but also later generations. Whānau often had no land, house or money to transfer to the next generations. O'Sullivan (2015) explained that inequitable access to education and employment intensify for many indigenous peoples, and is expressed as complex inter-generational challenges for some families and communities.

The global health promotion community has given scant attention to indigenous health.

Marmot (2016) attributes indigenous disparities in health to basic inequities in access to power, money and resources, which were transferred to the colonisers. Chino and DeBruyn (2006) argued that such inequities represent the failure of Western institutional systems, policies and practices, rather than poor choices by indigenous people. Gregg and O'Hara (2007) suggest that these causes of disparities could provide fertile opportunities for advocacy, grounded in the core health promotion values of social justice and equity. Māori also have the right to health and the right to live 'as Māori', which is central to processes of decolonisation. It seems the global health promotion community has given scant attention to indigenous health (Carter, 2011) or decolonisation. The milestone *Ottawa Charter* (WHO, 1986), the landmark *The Social Determinants of Health: The Solid Facts* (Wilkinson & Marmot, 2003), and the *Sustainability Development Goals* (UN, 2015) were all silent on indigenous health.

Te Tiriti o Waitangi sets out the terms and conditions of Tauiwi (non-Māori) settlement in Aotearoa. *Te Tiriti* reaffirms Māori sovereignty and positions Māori aspirations at the heart of ethical practice. It is widely interpreted as a partnership relationship between Māori and

the settler government, and in practice is enacted at multiple levels. Despite challenges to its validity by successive settler governments, we argue that *te Tiriti* is a potentially health-promoting agreement that can be honoured. *Te Tiriti* provides an ethical imperative (Health Promotion Forum, 2011; Public Health Association, 2012) for prioritising investment in health promotion that improves holistic indigenous health outcomes. Likewise, from a social justice standpoint, the higher health needs of Māori reinforce the importance of interventions that improve Māori health and reduce health inequities.

The Aotearoa New Zealand health promotion community has a longstanding commitment to working with *te Tiriti* (Durie, 1989; Health Promotion Forum, 2000; Ratima, Durie, & Hond, 2015). This view is reinforced by competency documents articulating practice aligned with *te Tiriti* (Health Promotion Forum, 2011). Hicks (2015) argues that the New Zealand health promotion competencies are unique in their emphasis on Māori health. Through the competencies, health promoters are expected to be conversant with *te Tiriti o Waitangi* and its application, our colonial history, Māori models of health and how to engage with Māori communities (Health Promotion Forum, 2011). These competencies are a voluntary code, applicable to all who practice health promotion in New Zealand and set some useful minimum benchmarks that enable deeper conversations about indigenous health. This research aims to refresh such understanding of *Tiriti*-based practice.

New Zealand health promotion competencies are unique in their emphasis on Māori health.

Ngā Kaiakatanga Hauora mō Aotearoa / Health Promotion Competencies for Aotearoa New Zealand, Health Promotion Forum, 2012

4.0 METHOD

Our research was influenced by activist scholarship and research that translates to action. Activist scholarship comes from the critical paradigm and uses the political process of knowledge-making to generate evidence to advance social justice agendas in dialogue with activists (Came, MacDonald, & Humphries, 2015). The purpose of activist scholarship is to provide evidence to promote social change, social justice and reduce inequities. Within activist scholarship *what* research is undertaken is important, as is *how* it is conducted and the *outcomes* it aims for.

Translational research (Ogilvie, Craig, Griffin, Macintyre, & Wareham, 2009) is applied research, made through dialogue between researchers and practitioners, aiming to transfer knowledge and insights to strengthen practice and ultimately improve health outcomes. Health promotion is a values-based practice. Translational research in this context refers to drawing together practice and practice-based research (Woolf, 2008). These methods dovetail to advance the goal of decolonisation.

In addition, this resource weaves in relevant research and has an auto-ethnographic component (Have, 2005), drawing on the authors' own experiences and insights into *Tiriti*-based practice over decades.

Translational research generates knowledge through dialogue between researchers and practitioners, to strengthen practice and ultimately improve outcomes.

The researchers share a body of knowledge from practice and assume these understandings are shared by the participants. Both researchers and participants agree that ethical health promotion practice in Aotearoa is firmly based on implementing *te Tiriti* in action.

The next stage of this project is to disseminate the findings proactively, and develop and deliver training to strengthen engagement with *Tiriti*-based practice. Our intention is to maintain dialogue about *Tiriti*-based practice and ideally refresh the resource every five years through additional contributions from senior health practitioners and the co-authors. Understandings about *te Tiriti* will continue to unfold.

There has been much debate about the importance of *te Tiriti* within the health promotion sector. There has been steadfast resistance to its implementation, which has worn down its champions. Despite the development of *TUHA-NZ* (Health Promotion Forum, 2000), colleagues in STIR have found that some in the sector are uncertain about how to apply the articles of *te Tiriti*. This project aims to demystify *Tiriti*-based practice by engaging with a purposeful (small and experienced) sample (Palinkas et al., 2015) of senior practitioners. We interviewed practitioners with considerable expertise working with *te Tiriti*, rather than those disengaged. This research collates their insights and ideas about what they view as effective *Tiriti*-based practice.

STIR: Stop Institutional Racism core collective and friends at the Inaugural STIR symposium, 2017.
Photo: Denis Came-Friar

Interviews for this project were carried out between December 2015 and January 2016 with senior practitioners across the country. We engaged ten senior health promotion practitioners as key informants. Their work settings spanned district health boards, the primary health sector, non-government organisations, local government and a university. Seven of the ten participants were women, of Māori (4), Pākehā (4), Pacific (1) and/or Asian (1) whakapapa, who had worked in the sector for more than ten years. All but one participant used their names (Kiterangi Cameron, Lucy D'Aeth, Ciarán Fox, Tipene (Steve) Kenny, Ngaire Rae, Sandra Skipwith, Soraya (Pseudonym), Prudence Stone, Sione Tu'itahi and Grace Wong – Appendix 2). We have bolded their names when their comments appear in the text, and used their first names to distinguish them from researchers we mention.

We developed a standardised interview schedule, and pre-tested it with public health colleagues. To avoid generalities about "partnership", the interview questions were framed about the specific articles of *te Tiriti*. Our research questions (Appendix 1) focused on how practitioners interpreted and applied the articles of *te Tiriti* in their practice. In taking that focus the authors appreciated that *te Tiriti* must be taken as a whole and the spirit of *te Tiriti*

transcends the sum of its constituent written words and tight legalistic interpretations (E. Durie, Willis, & Latimer, 1983).

Practitioners were recruited by phone and email through STIR professional networks. Selection was based on recommendation by STIR members, and centred on practitioners' understanding of and experience in *Tiriti* application. Collectively, STIR members have extensive health promotion experience and a wide range of networks. Interviews were taped, transcribed as said, then coded and stored in NVivo qualitative research software. Data were independently analysed by two of the authors using the pre-determined questions and then compared to identify themes, as recommended by Braun and Clarke (2006).

The research focused on *Tiriti*-based practice experiences of Māori and Tauiwi practitioners working in general population services; no one was working for a Māori organisation when interviewed, which is a limitation of the research. The story of how Māori work with *te Tiriti o Waitangi* in Māori organisations is yet to be told.

The term 'general population' services refers to organisations and agencies that are not kaupapa Māori in their philosophical orientation or identity, or are not established under hapū authority or located on the Māori side of the *Tiriti* relationship. The term is not intended to detract from the social, cultural, political normality of Māori in Aotearoa.

We chose to work with the Māori text of *te Tiriti*, as this was the text the majority of rangatira signed and is the text signed by Hobson at Waitangi. We choose the English translation by Margaret Mutu (2010).

The Auckland University of Technology Ethics Committee (No. 15/259) approved the research, and it was funded by the Auckland University of Technology Faculty of Health & Environmental Sciences (CGHS 15/15).

This romanticised reconstruction of the signing of Te Tiriti was painted by Marcus King nearly 100 years afterwards.

The Signing of the Treaty of Waitangi, February 6th, 1840 (1938) Marcus King, 1891-1983. G-821-2. Alexander Turnbull Library, Wellington, New Zealand.

5.0 TE TIRITI O WAITANGI

Northern rangatira began meeting around 1807 in a collective strategic confederation, formed by Bay of Islands chief Te Pahi. The collective of hapū was known as Te Whakaminenga o te Hapū o Nu Tireni and was formed in response to the gathering tide of settlers. From this base, in 1835, rangatira declared sovereignty to international countries through *He Wakaputanga o Te Rangatiratanga o Nū Tīreni*, to advance Māori economic interests and consolidate international recognition of the mana of Māori. The declaration was formally recognised by King William IV, leading other nations to acknowledge Aotearoa as an independent Māori state (Kingsbury, 1989)

Several factors led the English to *te Tiriti o Waitangi* in 1840. With increasing numbers of Pākehā coming to Aotearoa, there were growing tensions over land and the behaviour of some of the immigrants. The New Zealand Company was claiming they had secured large tracts of land and were in the process of sending settlers to New Zealand. At the urging of the British Resident, James Busby, and the British missionaries, the British Crown decided in 1839 to send Captain William Hobson to New Zealand with a view to negotiate a treaty with Māori.

By 1840, a sizable group of rangatira were open to the proposal that a British-appointed governor would have authority over the Queen's people. The rangatira in the North had already asked British monarchs to take more responsibility for their subjects in Aotearoa.

Trade with Britain and other nations was flourishing. Hugh Rihari (cited in Healy, 2012, p. 152) described Māori as politically dominant, well-travelled and commercially savvy. "We [Māori] had the numbers – we [Māori] determined the rules". The rangatira expected *te Tiriti* to foster ongoing, mutually beneficial relationships, and ensure their mana was respected by the Queen's people.

Māori were politically dominant, well-travelled and commercially savvy.

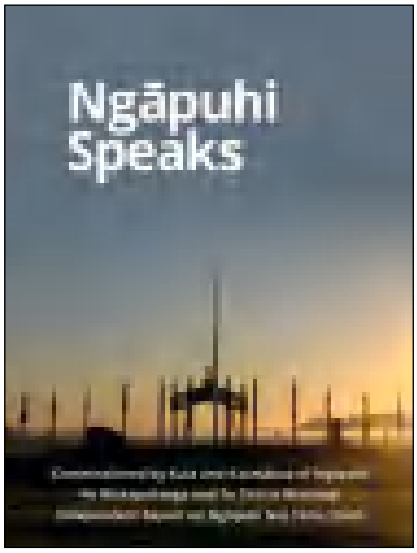
They wanted to strengthen the alliance with the British monarchy, with whom their leaders had friendly ties, especially since the 1820 visit to England of rangatira Hongi Hika and Waikato. Since then, Māori had given protection and provided food to British settlements in Aotearoa and New South Wales, while King William had ordered the British navy to offer protection to Māori ships when sailing in international waters.

In 1840, when there were approximately 100,000 Māori and 2,000 settlers in Aotearoa, *te Tiriti o Waitangi* was signed by over 500 rangatira representing their hapū, and by Hobson representing the British Crown. *Te Tiriti* was negotiated in a time of peace, and critically was not a treaty giving up sovereignty, but rather, as Lyall (cited in Healy, 2012) argued, an important political alliance. It outlined the terms and conditions of Tauiwi settlement and

reaffirmed the Māori sovereignty previously recognised through *He Wakaputanga*. *Te Tiriti* enabled a British governor to take responsibility for British people in Aotearoa. It guaranteed the British would uphold Māori authority, ensured protection of Māori land and taonga including their health, assured equity with British subjects and religious freedom.

Te Tiriti is the closest document New Zealand has to a written constitution. The significance of *te Tiriti* and its interpretation remain the subject of strong disagreement (Came & Zander, 2015; Healy., 2012; O'Malley, Stirling, & Penetito, 2013; Tawhai & Gray-Sharp, 2011).

Despite this, *te Tiriti* remains a foundation, articulating rights and responsibilities between the Treaty parties. In 2001, the Court of Appeal described it as a living document (Te Puni Kōkiri, 2001). The meaning of *te Tiriti* continues to unfold with developments such as *Te Paparahi o Te Raki* (Northland -WAI 1040) (Waitangi Tribunal, 2014), as discussed below.



Although the Treaty of Waitangi Act 1975 requires the Waitangi Tribunal to recognise both the Māori text and the English version of the Treaty, the authors assert the Māori text of *te Tiriti* is the tika or correct text. Henare (cited in Healy, 2012) explains the significance of the Māori text:

> *From our Māori perspective, there is only Te Tiriti o Waitangi. That is what was signed here [at Waitangi], it is to that Tiriti that our ancestral tūpuna tohu tapu [the sacred seals of our ancestors] were signed... They signed only what they understood (p. 155).*

The Māori text is the text recognised by international law through the convention of *contra proferentem* (Fletcher, 2014). In international treaty law, *contra proferentem* provides that, in situations of conflict about treaty interpretation, the treaty (contract) is interpreted *against* those who proposed or drafted the treaty. In this instance, the Māori text is recognised. Furthermore, Williams, cited in Healy (2012), confirmed there are eight known English texts with minor differences, dated February 5 or 6. None of these were signed at Waitangi nor are their origins certain. Additionally, the English version which stated that Māori ceded their sovereignty to the British Crown has now been discredited (Waitangi Tribunal, 2014).

Our interpretations are guided by the evidence presented at the WAI 1040 (Waitangi Tribunal, 2014) tribunal hearings in Northland. Its conclusions arose from primary historical sources in English and te reo Māori, and tribal and oral history from Ngāpuhi elders that had not previously been made public. These primary sources were interpreted by an array

of respected historians and linguists. This rich evidence has been published in the parallel independent report (Healy, 2012) commissioned by the kuia and kaumātua of Ngāpuhi, and in the subsequent Waitangi Tribunal report (2014).

Critically, the 2014 Tribunal report confirmed that in signing *te Tiriti*, Ngāpuhi did not cede their sovereignty. Having heard the evidence from the Crown and Ngāpuhi Nui Tonu, the Waitangi Tribunal concluded (p. 526-7):

> ***The rangatira did not cede their sovereignty in February 1840; that is, they did not cede their authority to make and enforce law over their people and within their territories.***
>
> ***Rather, they agreed to share power and authority with the Governor.***
>
> ***They and Hobson were to be equal, although of course they had different roles and different spheres of influence.***
>
> ***The detail of how this relationship would work in practice, especially where the Māori and European populations intermingled, remained to be negotiated over time on a case-by-case basis.***

The complex and far-reaching implications of this finding remain unclear. However, at the time, Treaty Negotiations Minister Dr Chris Finlayson quickly minimised the significance of the Tribunal's findings, maintaining that "the report did not change the fact the Crown has sovereignty in New Zealand" (Newshub Archive, 2014).

This situation reinforces the value of discussions initiated by the Constitutional Advisory Panel (2013) and the importance of the Matike Mai *Aotearoa Report* (2016), which argued persuasively for a process of constitutional transformation. The following sections examine the preamble and each article of the Māori text of *te Tiriti*.

Rangatira did not cede their sovereignty in February 1840; rather they agreed to share power and authority with the government.

5.1 HE KUPU WHAKATAHI – PREAMBLE TO TE TIRITI O WAITANGI

The preamble of a treaty, like a preamble in a contract, denotes its purpose. Table 1 shows the Māori text of the preamble to *te Tiriti o Waitangi* and the English translation by Mutu (2010, pp. 21, 23), a noted Māori leader and scholar.

Table 1: The Preamble text

Māori text	Ko Wikitōria te Kuini o Ingarani, i tana [sic] mahara atawai ki ngā rangatira me ngā hapū o Nū Tīrani i tana hiahia hoki kia tohungia ki a rātou o rātou rangatiratanga, me tō rātou wenu,ā ā kia mau tonu hoki te Rongo ki a rātou me te Atanoho hoki kua wakaaro rā he mea tika kia tukua mai tētahi rangatira hei kai wakarite ki ngā Tāngata Māori o Nū Tīrani – kia wakaaetia e ngā rangatira Māori te Kāwanatanga o te Kuini ki ngā wāhi katoa o te wenua nei me ngā motu – nā te mea hoki he tokomaha kē ngā tāngata o tōna iwi kua noho ki tēnei wenua, ā e haere mai nei. Nā ko te Kuini e hiahia ana kia wakarite te kāwanatanga kia kaua ai ngā kino e puta mai ki te tangata Māori ki te Pākehā e noho ture kore ana. Nā, kua pai te Kuini kia tukua ahau a Wiremu Hopihona he Kapitana I te Roiara Nāwi he kāwana mō ngā wāhi katoa o Nū Tīrani e tukua āianei, āmua atua ki te Kuini e mea atu ana ia ki ngā Rangatira o te wakaminenga o ngā hapū o Nū Tīrani me ērā Rangatira atu ēnei ture ka kōrerotia nei.
Translation	Now, Victoria, the Queen of England, in her well-meaning thoughts for the heads of the tribal groupings and the tribal groupings of New Zealand, and out of her desire also to signal to them their paramount authority and their lands, and so as to maintain peace with them and peaceful habitation also, has thought that it is a right thing to send a head of a tribal grouping as an arranger with the Māori people of New Zealand – so that the kāwanatanga of the Queen to all places of this land and the islands will be agreed by the heads of the tribal groupings of the Māori because indeed of the many of her people who are already living on this land, and are coming. Now the Queen desires to arrange the kāwanatanga so that no evil will come to Māori, and to Europeans living in a state of lawlessness. So the Queen is agreeable to send me, Wiremu Hopihana, a Captain in the Royal Navy, to be Governor for all parts of New Zealand (both those) being allocated now and in the future to the Queen and says to the leaders of the tribal groupings of the Confederation of the tribal groupings of New Zealand and other chiefs these laws spoken of here.

Te Tiriti affirmed the existing relationship between Māori and the British and established a more formal partnership between hapū and the Crown. The Waitangi Tribunal (2014) maintains the partnership was a useful strategic political alliance for both parties. The New Zealand Human Rights Commission (2011) and Fletcher (2014) accept that the purpose of *te Tiriti* was to protect Māori rights and property, keep peace and order and establish spheres of influence. It also enabled later migration to New Zealand for future settlers who were bound by *te Tiriti*. Edwards (cited in Healy, 2012) interpreted the Preamble as "she [the Queen] will not trample their [Māori] authority nor their [Māori] lands" (p.204).

He Kupu Whakatahi (preamble) is of critical importance to the interpretation of *te Tiriti*. It sets the tone of the articles that follow, providing an understanding of the intent and rationale of the parties. It envisages relationships of care and protection as well as autonomy and self-determination for hapū and limited authority for the Crown, which are directly relevant and important to guiding relations between Māori and the Crown now. The key points articulated in the Preamble reflect such core values within health promotion they were not explicitly described in the practitioner interviews.

WORKING WITH THE PREAMBLE

5.1 a) Whanaungatanga

Whanaungatanga, is the active process of building relationships though shared experiences and connections, critical to *Tiriti*-based practice and a prerequisite of authentic engagement. It sets the tone for all relationships with Māori.

Health promoters will have informal, longstanding relationships and formal organisational relationships with Māori through their workplaces. Health-related *Tiriti*-based relationships might be with hapū, a mana whenua entity, a mātāwaka network, Māori urban authorities, Māori health and/or iwi health providers. The relationship may be between individuals or a matrix of associations, such as where two or more organisations collaborate to a mutual advantage.

Within these *Tiriti*-based relationships, the ability of Tauiwi to listen and act on advice and input from Māori is central at all levels. It is not simply about building any relationship, it is about the pursuit of the "right relationship" (Huygens 2006, p. 370). Such a relationship recognises each party's sphere of influence, and each party works towards learning about the practice of relating to each other. Hall and Morice (2015) emphasised the importance

It is not simply about building any relationship, it is about the pursuit of the right relationships.

of investing in meaningful and balanced relationships. Hoskins, Martin & Humphries (2011) stress the need for ongoing consideration of relationship and responsibility. Verbos and Humphries (2014; 2015) amplify this exploration.

Tiriti-based relationships should

> *promote power sharing, understanding, mutual respect for language, life-styles, and beliefs which could lead to beneficial interaction between the two major and inter-dependent cultures (National Action Group, cited in Cooper, 1998, p. 9).*

Cooper later explained the relationships needed to model accountability, responsibility and transparency.

Jackson (2010) warns we still live in a colonising society – where institutional racism and culturally unsafe practices are the normal way to do things. In such a context, all Māori will almost certainly have experienced institutional and personal racism (Human Rights Commmision, 2014). A pre-requisite to a functional *Tiriti* relationship is therefore to first, do no harm. This requires non-Māori to engage in self-reflection, decolonisation education and to strengthen political and cultural competencies to be an effective partner (Came & da Silva, 2011). This critical, preliminary personal and professional development work is usually done with other non-Māori.

Margaret (2016, p. 8) explained that engaging deeply with a Treaty relationship for Tauiwi is about being open to the unknown. It can be both exciting and scary. It requires courage, reflection on one's own practice, and reflection with others to help negotiate the complex relationship. A Pākehā participant in her book about how organisations work with *te Tiriti* said:

> *This is about thinking differently, not always having the answers, and being okay to admit you don't know. Being honest that we don't know how it is going to work but we respect both parties ... this isn't the same as going off to a hui and following a tikanga process (Margaret 2016 p. 8).*

Other participants note that Tauiwi practitioners need to really listen to Māori and avoid the temptation of speaking *for* Māori. **Grace** described her experience:

> *It's a bit like if you listen to the piano and it's a piece of Bach and it has four tunes all running along together. If you listen to the bass, you have to listen carefully to the bottom tune, cos the top tune would always be in your ear.*

McGloin (2015) emphasised the need to pursue effective listening and hearing practices with indigenous partner(s). She used the term "listening to hear" (p. 267), and said it is critical for allies to consider, imagine and engage with experiences and worldviews other than their own. She said listening to colonial truths and contemporary

Institutional racism and culturally unsafe practices are still the normal way to do things.

racism can be uncomfortable and distressing but provides a knowledge base for authentic relationships.

There are divergent standpoints for viewing the world and implications of whanaungatanga between Māori and Pākehā. Individualism is common among Pākehā, while collectivism is widespread amongst Māori. These have implications for health promotion practice.

Action points for practice

- Engage in whanaungatanga with Māori
- Listen and read to learn Māori aspirations
- Commit to act in the utmost good faith – consistently over time
- Recognise the strengths, expertise, skills and experience of Māori
- Be respectful and practice cultural humility by not speaking for Māori
- Develop your cultural and political competencies
- Understand the difference between individualistic and collective world views
- Do no harm.

5.2 KO TE TUATAHI – ARTICLE ONE: KĀWANATANGA

Table 2 shows the Māori text and the Mutu (2010) translation.

Table 2: Text of Article One

Māori text	Ko ngā rangatira o te wakaminenga me ngā rangatira katoa hoki kihai i uri ki taua wakaminenga ka tuku rawa atu ki te kuini o Ingarani ake tonu atu – te kāwanatanga katoa o ō rātou wenua.
Translation	The heads of the tribal groupings of the Confederation and all the leaders of the tribal groupings who have not entered that confederation allow the Queen of England all the kāwanatanga [control of her subjects] of their lands.

From *Te Paparahi o Te Raki* (Waitangi Tribunal, 2014) evidence, Article One confirms that rangatira agreed to the British having a governor, to exercise kāwanatanga over British people. This interpretation aligns with contemporary understandings that Māori did not cede sovereignty to the British. Sadler (cited in Healy, 2012) maintained that rangatira:

> *sent for the governor to come and help, to help them. They allowed the governor to come. But in that agreement, it was not to govern them, but a governor for their own [Pākehā] people that were arriving to this island (p. 151).*

In 1840, kāwanatanga was a word familiar to Māori from the Bible, where 'kāwana' was a transliteration of governor. It had been used five years previously in the text of *He Wakaputanga*. Paul (1994) argued that kāwana was a Western-based notion that highlighted the rights of the individual and was hierarchical in nature. This is sharply contrasted with the collective rangatiratanga of many rangatira.

In unravelling the application of the concept of kāwanatanga in the wider context of *te Tiriti*, Margaret (2016, p. 10) makes the distinction that

> *the power granted to the British Crown to govern their people (kāwanatanga) sits beneath the power affirmed for hapū (tino rangatiratanga).*

This is the defined meaning of kāwanatanga in *He Wakaputanga* (1835 Declaration of Independence) and the meaning understood by the rangatira who signed *te Tiriti o Waitangi* (Healy, 2012, pp. 194–195).

Sandra, in her interview for this research, illustrated the distinction between kāwanatanga and tino rangatiratanga using the metaphor of a rental house. She said the tenant has kāwanatanga, while Māori, the landlord, has tino rangatiratanga. However, when the New Zealand government imposed sovereignty in 1852, it massively undermined Māori authority.

Since the 1980s, major reports have recognised institutional racism as entrenched in the government's kāwanatanga of the public sector (Berridge, 1984; Jackson, 1988; Ministerial Advisory Committee, 1988). This institutional racism disadvantages Māori, embeds Pākehā world views, and enhances Pākehā social and health status. Given these political impediments, the Kāwanatanga Network (1996) maintains that to achieve honourable kāwanatanga, land and resources must be returned to Māori and racism (and other systemic discriminations) within government systems must be identified and remedied.

The Health Promotion Forum (HPF, 2000) interpreted Article One as an articulation of the Crown's obligations and responsibilities to govern and protect all New Zealanders. All New Zealanders – in the context of *te Tiriti* as constitutional – means protecting Māori interests as much as all other legitimate interests. They argue that *te Tiriti* is a legitimate (or social) responsibility for all agencies that draw their authority from the Crown or receive public money. In *TUHA-NZ*, the HPF (2000) established health promotion goals for each of the articles of *te Tiriti* as pathways to enable *Tiriti*-based practice:

> *Achieve Māori participation in all aspects of health promotion. Kia pā te ringa Māori ki ngā āhuatanga whakapiki hauora katoa (p. 13).*

HPF argued to achieve this goal required meaningful Māori involvement at all levels of health promotion, from funding, decision-making and planning to implementation and evaluation. They recommended as critical actions – establishing and maintaining relationships with Māori, specifically monitoring service delivery to Māori, addressing equity issues and maintaining a focus on evaluation.

Te Tiriti is a legitimate responsibility for all agencies that draw their authority from the Crown or receive public money.

WORKING WITH ARTICLE ONE

5.2 a) Decision-making

As kāwanatanga occurs at a decision-making level, many health promoters will have limited scope and mandate to act in this realm. While the appointment of Māori operational staff may strengthen the Māori capacity of an organisation and provide benefits, it does not necessarily address the requirements of kāwanatanga. Māori participants in this study argued that kāwanatanga is about Māori input into the highest levels of decision-making, rather than operational participation. This includes representation on governance boards, on steering and advisory committees, and/or being part of senior management teams.

To apply kāwanatanga, **Tipene** described setting up a steering group with a Māori representative from each marae and Māori health provider in his district. This group helped guide the work plan of his division and the executive team of his workplace. Through this network he could leverage strong Māori participation onto his board, which he believed strengthened the position of Māori.

Grace described her engagement with a Māori partner as being co-directors of a project. She explains:

> *We don't make decisions without talking to her about anything, not just about things to do with Māori nurses but about anything.*

This free sharing of information and decision-making enables Māori control and input on Māori terms.

A nationwide survey by Came, McCreanor, Doole and Simpson (2016) identified that Public Health Units, as Crown agencies, prioritised Māori health to fulfil their *Tiriti* obligations. They also deliberately built relationships with Māori both externally and internally within their district health boards (DHBs) to enable this work. But it was unclear whether this input occurred at a governance/kāwanatanga level.

The Health Funding Authority (1988, p. 13) championed an indigenous matrix management system to respond proactively to Māori health issues. This included i) vertical and horizontal integration of Māori health issues and staff; ii) Māori-specific key performance indicators in all staff contracts, iii) a Māori workforce development policy and dedicated resource allocation to Māori health.

Action points for practice

- Advocate and/or ensure *Tiriti* partner input within strategic decisions
- Tautoko (support) Māori public health leadership
- Tautoko Māori public health leadership programmes, post-graduate, graduate and training opportunities
- Establish steering, advisory and reference groups where Māori input is not tokenistic
- Re-orientate consultation processes to ensure Māori voices are heard
- Re-orientate strategies and plans to prioritise Māori aspirations
- Work with, value and enable kaumātua and kuia engagement and participation at all levels.

5.2 b) Māori representation and kaitiakitanga

Across our study there was widespread agreement of the importance of Māori representation at all levels of decision making in health promotion – from needs assessment to concept development, planning, delivery and evaluation. Māori participants in this study were often pragmatic about representation and were open to Māori representation from government agencies, Māori health providers, mana whenua, mātāwaka or those with technical expertise.

The Mental Health Foundation consulted with and held a hui with the local iwi authority and Māori groups to determine Māori aspirations and to feedback information (Tankersley, 2004). It provided active support to Māori initiatives recognising "they didn't need to know everything about an issue to support Māori on it" (p. 9).

Working in a Crown agency, **Kiterangi** explained her role as a Māori practitioner being that of a kaitiaki over cultural processes, relationships and taonga. She managed processes as a means of protection and provided critical analysis of policy, strategic planning and decision-making. She cited examples of working on iwi-driven initiatives where her role was to share time, skills and build capacity, without the demands of ownership.

Sandra noted there are different layers of engagement:

> *You can consult by telling your whānau what's going on and what your intentions are or you can engage them in consultation by asking them what they want.*

She has frequently seen organisations using the former approach. **Lucy** deliberately engaged with the local tribal authority and Te Puni Kōkiri throughout her work to ensure representation. She sought to include mātāwaka living within her district. She reported finding herself at high-level professional health promotion meetings without any Māori representation. In situations, such as these she would question:

> *Why aren't there Māori at the table? Who should be here? What might they be saying if they were here? Can we suspend the conversation till they are?*

Action points for practice

- Ensure Māori are involved in all decision making
- Ensure recruitment processes reflect and value cultural competencies
- Encourage the active retention of Māori staff
- Open professional development opportunities to Māori partners
- Work with existing governance teams to promote understanding, value the necessity of such appointments and resource appropriately
- Commit resources to prepare Māori for leadership roles.

Many community sector organisations use a two house or waka hourua (double-hulled) power sharing approach to governance.

5.2 c) Structural mechanisms

Came (2014) and O'Sullivan (2015) see Western-style majority decision-making as a site of racism and a barrier to a Māori voice in decision-making. Māori involvement can require significant interventions, such as transforming organisational constitutions and changing organisational policies and practices. The structural protection of Māori interests, through mechanisms such as Māori-designated parliamentary seats and the appointment of Māori to district health board governance, are pathways to deal with these concerns. Some participants referred to their organisation's constitutional commitment to Māori health and working with *te Tiriti*. Participants in some agencies developed a policy on *te Tiriti o Waitangi*.

The effectiveness of these mechanisms varies. A study by Boulton (2004) of indigenous participation in health policy found governance arrangements varied across DHBs. They found evidence of communication and collaboration with Māori, but observed that Māori governance

Young activist hui, Whangarei Heads. Photo: Denis Came-Friar

mechanisms were not always well resourced. Structural mechanisms do provide a clear point of accountability to an often-public declaration of intent.

Tauiwi participants, shared strategies to ensure Māori input into governance. For instance, **Sione** said his organisation had embedded *te Tiriti* within their constitution as a mechanism to enable kāwanatanga. They had rules relating to a minimum of 50 percent Māori membership of the governance board, maintained a Māori standing committee, had a nominated kaumātua (elder) and his deputy executive director was Māori. **Prudence** ensured there were Māori delegates on every strategic committee to ensure joint decision-making.

Margaret (2016) noted many community sector organisations use a two house or waka hourua (double-hulled) approach to governance, also described by Martin, Humphries, and Te Rangiita (2003). Waka hourua is an internal power sharing that enables the development of external relationships with Māori. Margaret (2016) argued that most community organisations in New Zealand are constituted under Pākehā law and

fit within these structures. She says that despite these constraints, organisational values and culture when aligned with strong political will, can ensure honourable kāwanatanga. As an alternative to making a single big decision to become a *Tiriti*-based organisation, she noted that such an aspiration may be achieved over time through an iterative process with smaller, less dramatic steps.

Organisations such as Rape Crisis and Women's Refuge have long embraced kāwanatanga commitments through processes of parallel development – where organisations have dual (Māori and Tauiwi) leadership structures and explicitly divide resources (Huygens, 2001).

Action points for practice

- Strengthen constitutions to embed and ensure Māori participation into governance structures
- Ensure Māori representatives have adequate structural and pastoral support
- Consider embracing a waka hourua or parallel development structure. There are pros and cons to this approach, so careful consideration needed.
- Develop a *te Tiriti o Waitangi* policy and/or a *te Tiriti* clause in your constitution.

5.3 KO TE TUARUA – ARTICLE TWO: TINO RANGATIRATANGA

Table 3 shows the Māori text of Article Two of *te Tiriti o Waitangi* and the Mutu (2010, p. 25) translation.

Table 3: Text of Article Two

Māori text	Ko te Kuini o Ingarani ka wakarite ka wakaae ki ngā rangatira – ki ngā hapū – ki nga tangata katoa o nū tīrani te tino rangatiratanga o ō rātou wenua o rātou kāinga me ō rātou taonga katoa. Otiia ko ngā rangatira o te wakaminenga me ngā rangatira katoa atu ka tuku ki te Kuini te hokonga o ērā wāhi wenua e pai ai te tangata nōna te wenua– ki te ritenga o te utu e wakaritea ai e rātou ko te kai hoko e meatia nei e te Kuini hei kai hoko mōna.
Translation	The Queen of England agrees and arranges for the heads of the tribal groupings, for the tribal groupings and all the people of New Zealand, their paramount and ultimate power and authority over their lands, their villages and all their treasured possessions. However, the Chiefs of the Confederation and all the Chiefs will allow the Queen to trade for [the use of] those parts of their land to which those whose land it is consent to, and at an equivalence of price as arranged by them and by the person trading for it (the latter being) appointed by the Queen as her trading agent.

At WAI 1040 hearings, Hohepa and Henare (cited in Healy, 2012) maintained that in Article Two the Queen of England affirmed the tino rangatiratanga of Māori. This is understood to mean absolute authority over lands, settlements, and all that was and is valuable to Māori (taonga).

According to Wihongi (2010) the meaning of tino rangatiratanga is "complex, fluid, multi-faceted and context related" (p. i). In their constitutional aspirations report, Matike Mai Aotearoa (2016), stated that "the right for Māori to make decisions for Māori" (p. 8) is the very essence of tino rangatiratanga. Jones (2010) interpreted tino rangatiratanga as being about Māori control, and achieving it requires a high degree of autonomy. Harwood (2010) interpreted rangatiratanga to be "the desire by indigenous people to 'take charge' over the direction and shape of their own organisations, communities and development" (p. 975).

Reinforcing the distinction between kāwanatanga and tino rangatiratanga, Jackson (1995) clarified that in te ao Māori, rangatiratanga is a power subordinate to no other. Therefore, it could not be ceded through a treaty. "Rangatiratanga", Jackson (1995, p. 7) explained:

> *was entrusted to the living to nurture and hand on to the generations yet to be. As a gift from the ancestors, it was both spiritually incomprehensible and legally impossible to even contemplate giving it away.*

The Waitangi Tribunal (2014) agreed with Jackson when they ruled that Ngāpuhi (and therefore potentially other iwi) never ceded sovereignty. This landmark ruling from an independent commission of inquiry has intensified the quest to understand and incorporate tino rangatiratanga. Certainly, Gregory (cited in Healy, 2012, p. 149) maintained *te Tiriti* articulated the Crown's responsibility to protect tino rangatiratanga.

The relationship between *te Tiriti* and health has been discussed extensively elsewhere (see Bryder & Dow, 2001; Dow, 1995; Durie, 2012; Lange, 1999). Using health legislation (New Zealand Public Health and Disability Act 2000) and the *Declaration of the Rights of Indigenous Peoples* (2007), health professionals have a mandate to engage with *te Tiriti* and Māori sovereignty. Whitinui (2011) argues that honouring *te Tiriti* is a cultural necessity to maintain, sustain and promote a healthy society in Aotearoa, and critical for improved Māori health outcomes.

Barrett and Connolly-Stone (1998) and Durie (1994) confirmed that under Article Two, health is considered a protected taonga. This assessment is affirmed in the WAI 2575 kaupapa claim (Isaac, 2016) – a compilation of over 100 health-related claims logged with the Waitangi Tribunal. These range from concerns about lower life expectancy and disparities for Māori across a wide spectrum of health conditions, to concerns about institutional racism in the public health system. They include historic claims around colonisation and assimilation policies, and contemporary issues around access to appropriate services.

In their *Tiriti*-based practice guidelines, *TUHA-NZ*, the HPF (2000, p. 14) has developed a health promotion goal to capture Article Two:

Māori providers have a strong track record of effective delivery to Māori communities traditionally described as 'hard to reach'.

Achieve the advancement of Māori health aspirations. Te whakatūtuki haere i ngā wawata Māori mō te hauora.

TUHA-NZ emphasised that Māori aspirations needed to be determined and tailored to hapū and whānau. To communicate aspirations, trusting relationships needed to be formed, information gathered, plans formulated and enacted. The authors emphasised that power-sharing was essential and involved prioritising investment in Māori. It is likely to entail clearing the way for Māori development by removing obstructive policies and/or practices.

Māori aspirations can be determined through dialogue with Māori partners and/or through engagement with Māori health research. Through the 1980s, a series of important Māori health hui were held to discuss Māori aspirations in relation to health (Durie, 1998b). Among those was Te Ara Ahu Whakamua (the path forward) hosted by Te Puni Kōkiri (March 1994). This hui focussed on three questions; What constituted a healthy Māori? How should Māori health be

measured? What policies should be put in place to achieve Māori health? The proceedings of these hui and other similar documents are a rich resource articulating many Māori aspirations.

WORKING WITH ARTICLE TWO

5.3 a) Māori providers

Māori have consistently recognised the need for health services delivered, designed and administered by Māori for Māori (Boulton, 2004; Rochford, 2004). Māori health providers developed in the 1990s and are a distinctive feature of the New Zealand health sector.

They are diverse, autonomous organisations delivering integrated health services primarily to Māori. They operate from Māori cultural values, beliefs and practices to support whānau in exercising control over the determinants of their health (Makowharemahihi, 2016; Mauriora ki te Ao, 2009). Māori providers often have formal governance arrangements with local hapū, iwi or mātāwaka and pursue a holistic agenda that encompasses, social, economic and cultural development.

Māori providers have a strong track record of effective delivery to Māori communities traditionally described as 'hard to reach' (Cram & Pipi, 2001; Crengle, 1998; Rochford, 1997; 2004; Ruakere, 1998; Wilson, 2008). In health promotion, Māori providers represent a strong expression of tino rangatiratanga. Despite working on government contracts, Kiro (2000) argued Māori providers have enjoyed unprecedented levels of control and resources. Ratima, Durie and Hond (2015) say control over Māori health promotion should stay with

Māori organisations. *Tiriti*-based practice can therefore involve re-allocation of resources (Rochford, 2004). Investing in Māori providers becomes a pathway to enable tino rangatiratanga.

Soraya[1] advanced tino rangatiratanga through administering pockets of money with carefully crafted criteria, and advising non-Māori colleagues on using their budgets to address ōritetanga. According to Soraya, this enabled the funding of "projects that are definitely strongly kaupapa Māori [in] focus". This in turn "enabled [communities] to do [projects] their way and build on their customs and practices". Kaupapa Māori programmes come from a Māori philosophical approach incorporating the knowledge, skills, attitudes and values of Māori society.

Action points for practice

- Reallocate resources with Māori health providers
- Advocate for investment in Māori health providers – so the level of resourcing is sufficient to reduce health inequities
- Promote, champion and refer to Māori providers
- Work in partnership with Māori providers.

5.3 b) Māori health promotion

The central place of tino rangatiratanga in Māori health promotion is well documented (Durie, 1998a; Gifford, 2003; Ratima, 2001; Ratima, Durie & Hond, 2015). In *Te Pae Mahutonga*, Durie (1999) presents a holistic Māori health framework grounded in Māori cosmology. It articulates tino rangatiratanga through integrated concepts of cultural vitality, healthy lifestyles, environmental integrity and social inclusion, along with the critical determinants of leadership and autonomy. Durie (1999) has consistently argued for health promotion to embrace the two prerequisites of indigenous health: ngā manukura (leadership) and te mana whakahaere (autonomy). Although *te Tiriti* is presented within a holistic framework, the authors argue that Durie is explicitly asking for tino rangatiratanga, for Māori control, as guaranteed particularly by Article Two of *te Tiriti*.

Ramsden and Erihe (1988) consistently argued for the centrality of culture to successful indigenous health outcomes. Chino and DeBruyn (2006) said that Western frameworks are often regimented and linear, while tribal people aspire for balance in nature and life. Chino and DeBruyn advocated for programmes based on traditional indigenous values that recognise indigenous people can only engage fully in health promotion when:

> *the wounds caused by colonization, historic trauma, racism and disparities in health education and living conditions [are] acknowledged, treated and healed (p. 598).*

Gould (2013) and Angell and colleagues (2014) provided evidence that strengths-based and culturally targeted interventions which involve communities are amongst the most effective in engaging indigenous peoples for positive outcomes. Researchers (Abel and Tipene-Leach, 2013; Boulton, Gifford, Kauika, & Parata, 2011; Ratima, 2010; and Ratima, Durie & Hond 2015) confirmed that indigenous control and authority are important to successful interventions.

1 Soraya links to Ngā Iwi o Te Tairawhiti, and chose not to be identified in this research.

As a practitioner, **Kiterangi** saw her role as "igniting the inner active citizen in the community". She saw herself as a catalyst "incubating ideas and creativity, encouraging and challenging people and organisations to walk their [*Tiriti*] talk and do their [*Tiriti*]". She had encountered resistance to Māori engagement, but strove to provide opportunities for meaningful Māori engagement in her work. Rather than big dramatic wins, Kiterangi reported "small wins over time". Buoyed by Māori groups she worked with, Kiterangi explained:

> *If my work doesn't advance tino rangatiratanga immediately, it does eventually. I would have been told by now, by my people, if I was pushing in the wrong direction.*

Tipene saw Māori health promotion as an expression of tino rangatiratanga. He explains "it's about me taking the initiative to plug the right cords into the right phone to make those connections happen". To enable this he explained *te Tiriti*:

> *It's like pulling out a light-sabre; it's like a special weapon from the past, it's kind of the bee's knees where everybody has these other tools and stuff but nothing is as cool as a lightsabre.*

Action points for practice

- Prioritise investment in Māori health promotion
- Engage in and tautoko Māori-led health promotion endeavours
- Actively manāaki Māori colleagues, particularly in institutional settings.

5.3 c) Anti-racism praxis

Institutional racism is systemic in public health sector administration, built on a legacy of mono-cultural colonial policies and practices (Came, 2012; Kearns, Moewaka Barnes, & McCreanor, 2009). Research by Came, Doole, McKenna and McCreanor (2017) confirms Māori providers' experiences of institutional racism from their government funders. The authors' nationwide survey of public health providers showed statistically significant variation between Māori and general services in the length of public health contracts, the intensity of monitoring, perceived compliance costs and frequency of auditing. The qualitative material documented inconsistent treatment by Crown portfolio managers.

Transforming racism entails detecting, confronting and preventing racist policies, practices and attitudes. It mean acknowledging that entrenched Pākehā privilege breaches the equality affirmed by New Zealand in formal commitments to United Nations conventions. Work by Came & Griffith (2017) and Came & McCreanor (2015) argued anti-racism (and thereby health equity) are best pursued from multiple co-ordinated directions, reflecting a system change approach. This requires political will, organisational and sector commitment and courageous leadership.

Came, McCreanor and Simpson (2016) advocated for collective action to transform racism. Stop Institutional Racism (STIR) is a boutique, growing, grass roots social movement,

attempting to end racism within the public health sector, and enable tino rangatiratanga. This network has re-energised conversations about racism, and strengthened the capacity and evidence base around sites of racism and anti-racism praxis. Partnership between Māori and Tauiwi practitioners and academics, underpinned by a commitment to *te Tiriti*, is central. Aligned to this, Came and McCreanor (2015) have developed a blueprint for a national plan to end institutional and everyday racism, with a planned system change approach, which is strongly aligned to health promotion values and principles. The plan recognises *Tiriti*-based practice as a pathway to address institutional racism.

Until transformation is achieved, the challenge for health promoters is to trust indigenous solutions and identify what action we can pursue within our spheres of influence (Covey, 2004). The success of these interventions will depend on the technical, cultural and political capacity of practitioners, and their access to resources, networks and influence as well as the political context in which the work takes place.

Prudence continues to push to get the "best outcomes for Māori in everything and anything we do". For her this involved "getting behind the Māori leadership in the sector", working in partnership and using her influence to remove barriers.

Action points for practice

- Engage in collective planned action to end racism
- Identify, name and challenge institutional racism
- Attend, and mobilise others to attend anti-racism training
- Nurture skills of reflective practice
- Support Māori health promotion leadership.

5.4 KO TE TUATORU – ARTICLE THREE: ŌRITETANGA

Table 4 shows the Māori text of *te Tiriti o Waitangi* and the Mutu (2010, pp. 26-27) translation.

Table 4: Text of Article Three

Māori text	Hei wakaritenga mai hoki tēnei mō te wakaaetanga ki te kāwanatanga o te Kuini. Ka tiakina e te Kuini o Ingarani ngā tāngata Māori katoa o Nū Tīrani. Ka tukua ki a rātou ngā tikanga katoa rite tahi ki ana mea ki ngā tāngata o Ingarani.
Translation	This is also the arrangements for the agreements to the kāwanatanga [control of her subjects] of the Queen – the Queen of England will care for all the Māori people of New Zealand and will allow them all the same customs as the people of England.

In te reo Māori, *rite* is the root word for ōritetanga. Rite means same or alike; however, ōritetanga in this context extends the meaning to equity or equality. In English, equality is about the same treatment, whereas equity is a more complex term that includes history, access versus opportunity, and structural disadvantage. This distinction has important implications for investment decisions. Durie (1998b) and Kingi (2007) both argued that Article Three refers to equity, working towards Māori enjoying the same levels of health and well-being as Tauiwi.

This explanation mirrors the government's commitments to reducing health disparities as outlined in section 3(1)b of the New Zealand Public Health and Disability Act 2000. The legislation drives policy and investment decisions in the New Zealand health system. Despite efforts by successive governments, there is compelling evidence that health and social outcome inequities persist (Anderson et al., 2016; Marriott & Sim, 2014; Robson & Harris, 2007). Sheridan (2011) argued, achieving health equity requires a political commitment to health equity, at all levels of the health system, enabled through evidence-informed action. All parts of the health sector, the government and society are responsible for health equity

Whitehead (1992) defined health inequities as disparities in health that are:

- Avoidable
- Unnecessary
- Unjust.

Braveman (2014) argued health equity means that no-one is denied the possibility to be healthy by being part of an economically or socially disadvantaged group. She defined health equity as:

> *a commitment to reduce—and, ultimately, eliminate—disparities in health and in its determinants (p. 6).*

Implicit in Braveman's definition is recognition of everyone's right to the highest attainable standard of health (Hunt et al., 2009).

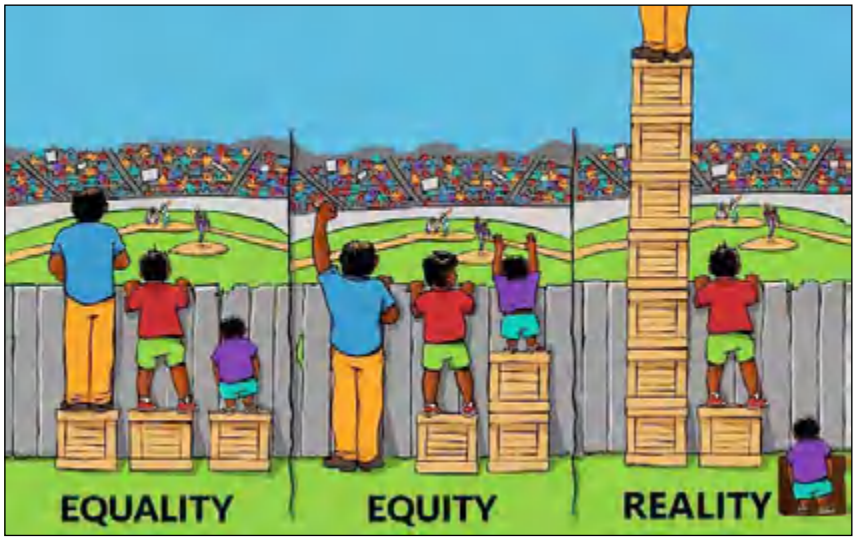
Under international human rights law, countries are obliged to demonstrate "progressive realisation" of these rights by systematically removing impediments to their promotion and protection. Starfield (2011) argued inequity has become normalised and built into health systems. To address inequities, she said organisations need to embed equity within organisational culture, practice, policies and systems in a sustainable way.

In TUHA-NZ, the HPF (2000) developed a goal in relation to Article Three:

> *Undertake health promotion action which improves Māori health outcomes. Te mahi whakapiki hauora kia pai ai ōna hua..*

Implicit in this goal is a steady improvement in the equity of health outcomes. Improving Māori health involves ensuring Māori have access to the prerequisites of health (WHO, 1986) and engaging with the historical, cultural, economic and social determinants of indigenous health (Kiro, 2000; O'Sullivan, 2015). The HPF says this will involve working with those

Despite efforts by successive governments, health and social inequities persist.



Source: Andrew, Facebook user in Canada, http://interactioninstitute.org/the-4th-box-sparks-imagination/

outside the health sector. Robust formative evaluation is also critical to define the intervention, and to enable its efficiency and effectiveness to be assessed.

WORKING WITH ARTICLE THREE

5.4 a) Normalising ethical practice

A commitment to both health equity and social justice is central to ethical and competent health promotion practice (Health Promotion Forum, 2011; Labonte, 2016). Whitehead and Dahlgren (2009) argued that achieving health equity requires improvement in the health of those most economically and socially disadvantaged. Globally, and within New Zealand indigenous people carry a disproportionate burden of disease (Anderson, 2016). Ethical practice in Aotearoa therefore requires prioritising work to improve Māori health.

The Ministry of Health commissioned the Health Equity Assessment Tool (Signal, Martin, Cram, & Robson, 2008) to help practitioners and decision-makers determine whether an initiative or policy might increase or decrease inequities. It is most useful in planning, and works at both strategic and operational levels, but users need a level of political and cultural competence to ensure that analysis is robust.

Participants in the research took great ethical care in considering what projects they prioritised and how they framed or contributed to a project. This care was evident in who was invited to partner on a project, or in what and how objectives were set. Participants were pragmatic about how they framed the justification for a project to decision makers, but made ethical choices that protected their integrity and mana.

Soraya, working within a Crown agency, noted that within the current political environment it was more acceptable to justify involvement in a project because of equity concerns than *te Tiriti* responsibilities or obligations. As a Māori practitioner, she led the project, was supported by colleagues with technical expertise and they partnered with a Māori group. These elements together produced positive health outcomes, contributing to equity.

Ethical practice in a New Zealand context, requires prioritising work that improves Māori health.

Ciarán recognised that an ethical equity focus was essential in his work. To him it was an everyday thing, embedded in the planning and design of interventions. His work was informed by international evidence, mātauranga Māori and market research – which examined the reach and impact of programmes and included an ethnic analysis. This three-tiered process ensured that interventions were targeted and relevant to Māori communities.

Sione was very clear that his core values personally and as a professional were closely aligned with *te Tiriti*. He explains

> *I know if my practice is aligned with the articles of te Tiriti o Waitangi I know that me and my fellow human beings will lead a healthier life. The whenua will lead a healthier life as well, and we achieve our life given purposes we will divide up our resources fairly, we won't fight, we will actually enhance each other and we will achieve a lot more.*

Within his organisation "the Māori culture is a very positively prevailing culture ... and we thrive because of that and also our ability to include Pākehā knowledge, Pākehā culture, you know, Moananui a Kiwa cultures and other cultures".

His work was informed by international evidence, mātauranga Māori and market research – which examined the reach and impact of programmes.

Action points for practice

- Normalise ethical practice; ie, do it right
- Engage in ethical discussions about the investment of health promotion resources
- Consistently apply the *Health Equity Assessment Tool* or similar in planning.

5.4 b) Equity-centric evaluation

Evaluation is an everyday practice in health promotion. It is an invaluable mechanism to track progress towards health equity, as championed by the United Nations. A robust evaluation needs ethnic-specific baseline data to track and monitor an intervention. To enable an ethnic-specific analysis requires quality Māori data that is equal to that for non-Māori. This concept is called equal explanatory power (Te Rōpū Rangahau Hauora o Eru Pōmare, 2002), and requires Māori populations to be oversampled so there is enough data for equal analysis. Sadly, despite guidelines to the contrary (Health Research Council, 2010; Hudson, Milne, Reynolds, Russell, & Smith, 2010) much research in New Zealand without an ethnic or cultural analysis.

The health sector has a rich treasure-trove of cultural and equity audit tools that have been developed, influenced by cultural safety work led by Ramsden (1988). For instance, The CHI Model: Culturally Appropriate Auditing Model (Durie, 1993) enables services to be audited against Māori development, health gain, cultural beliefs and values. He Taura Tieke (Cunningham, 1995) is a checklist to assess effectiveness of service delivery to Māori, addressing technical and clinical competence, structural and system responsiveness and consumer

satisfaction. More recently, Cram (2014a, 2014b) developed the evidence-based Māori Health Equity Framework, which provides guidance for funding and planning staff and senior managers about addressing inequities. It uses the domains of i) leadership, ii) knowledge and iii) commitment. It is unclear whether these frameworks have been evaluated for their contribution to health equity.

The Health Funding Authority (1988), a former health funder, warned that setting goals about general Māori health status has historically not achieved results. They instead argued for specifying the desired outcome, which results in an ordered and useful process of performance analysis. Without top-down funder leadership, this responsibility lies with providers and practitioners. Ideally the motivation to be accountable should come from a professional commitment to integrity and health promotion values, rather than an external compulsion.

Sandra uses a purpose-built, comprehensive evaluation rubric (Skipwith, 2014), and reviews the evaluation annually to ensure an equity focus is maintained and refined within her work. She reinforced the importance of having reliable, ethnic-specific baseline data to assess health and social outcomes. Sandra's rubric has 18 elements, with three levels, transition steps and sub-steps. She explained: "We talk about ... policies and priorities and it's all very much talking about how equitable it is and who's getting left behind and invariably in many cases it's Māori".

Tipene was adamant that reducing inequities was a cornerstone of health promotion practice. He ensured that work plans in his influence focused on reducing inequities, and prioritised collaborating with Māori. His team had developed their own evaluation matrix which they applied and reviewed annually to ensure an equity focus was embedded in their work. They tracked selected equity measures such as Māori participation at events, whether programmes were marae-based, and Māori leadership.

Action points for practice

- Ensure you evaluate health promotion using ethnic specific tools
- Re-orient practice to centre Māori health outcomes
- Review outcomes of health plans for equity and tailor interventions for Māori
- Identify the gap between the rhetoric of equity and the reality
- Continually improve the robustness of evaluation of health promotion to build a supportive and informative body of evidence.

5.4 c) Determinants of health

Research is increasingly documenting the cultural, social, economic and historical determinants of health (Kiro, 2000; Marmot, 2005; Mowbray, 2007; National Advisory Committee on Health and Disability, 1998; Wilkinson & Marmot, 2003). In spite of rhetoric about the importance of determinants in health policy, much of current funded health promotion work in New Zealand continues to focus on healthy lifestyles. This

She reinforced the importance of having reliable, ethnic-specific baseline data to assess health and social outcomes.

approach is championed in the neo-liberal oriented New Zealand Health Strategy (NZHS, Ministry of Health, 2016). Although there is a place for individual responsibility (Hamerton, Mercer, Riini, McPherson, & Morrison, 2012), Came, McCreanor, Doole and Rawson (2016) argued that the NZHS directs health practitioners to focus on 'motivating' people, to take individual responsibility for their health, rather than address the causes of the causes of ill health.

The evidence suggests that working with the causes of the causes of ill health creates greater health gain than generic healthy lifestyle programmes (Farrer, Marinetti, Cavaco, & Costongs, 2015; Kickbusch, 2015). The introduction of clauses prohibiting lobbying in government contracts in the early 2000s profoundly compromised the ability of health promoters to contribute politically to address the determinants of health (Grey & Sedgewick, 2013). The sector works on housing (Howden-Chapman, 2015) and food insecurity (Carter, Lanumata, Kruse, & Gorton, 2010) but does little on income (Regan, 2009) or racism (Paradies et al., 2015), which are key determinants of health.

The NZHS directs health promoters to focus on 'motivating' people to take individual responsibility for their health, rather than address the causes of the causes of ill health.

Ngaire is part of a collaborative healthy housing project which identifies and supports whānau (extended families) living in sub-standard accommodation. It secured funding to insulate houses and organise curtains and bedding for residents. Māori providers were sub-contracted to undertake assessments and broker relevant support. Equity outcomes were then monitored. In an experimental intervention including insulating houses, 50 percent of the participant households were Māori. The health of householders in homes that were insulated improved, with fewer hospitalisations, sick days off work and school and respiratory infections; they also felt better (Howden-Chapman, 2007).

Lucy commented about determinants of health: "we think it's hard to modify housing [but] actually social and economic policy is what determines Māori health outcomes". Lucy said that it is easy to get caught up in healthy public policy initiatives that make quite a few people better off, but Māori worse off. This happens because populations able to make changes are often those with higher health status. Further improvement in the health of those already comparatively well off further increases disparities.

Action points for practice

- Tailor initiatives to address the causes of the causes of health inequities
- Invest in areas outside the scope of health through inter sectoral partnerships to improve housing, education, employment, income and neighbourhoods
- Work with communities on community priorities
- Advocate for equitable distribution of power and resources.

5.5 KO TE TUAWHA – ARTICLE FOUR: WAIRUATANGA

Under international law and tikanga, both oral and written assurances given when a treaty is signed are important (Phillipson, 2006). At the first Titiri signing at Waitangi, William Colenso recorded a discussion between Lieutenant-Governor Hobson and Bishop Pompallier about religious freedom (Ward, 2011). Hobson and the rangatira agreed to the statement in Table 5, which was not included in the *Tiriti* parchment but discussed on the morning of February 6 1840, and is recognised as the oral clause in *te Tiriti*.

Table 5: Text of Article Four

Māori text	E mea ana te Kāwana ko ngā whakapono katoa o Ingarani, o ngā Wēteriana, o Roma, me te ritenga Māori hoki e tiakina ngātahitia e ia.
Translation Henare (cited in Healy, 2012, p. 202)	The Governor says that the several faiths (whakapono) of England and of the Wesleyans and Rome and also Māori custom shall alike be protected by him.

In te Reo Māori, whakapono is the verb to believe or have faith, while wairuatanga is the noun for spirituality. As Marsden (2003) explained in a collection of essays, *The Woven Universe*, Māori spirituality is like many other indigenous worldviews in holding the sacred unfolding of creation to be at the core of everyday life, embedding the basic concerns of human existence within the larger order of the natural and cosmic world. Marsden has consistently maintained, from a Māori worldview, all life is sacred and everything has a mauri, so therefore all things are related and interconnected. Morice (2003) likewise maintains that "the Earth is our mother, and all her animals and plants are our ancestors and our brothers and sisters" (p. 40). Durie (1994) suggests that Māori cultural and social structures are based around reciprocity, interconnectedness and interdependence; collectively these elements are critical to sustaining life and relationships. Problems in the physical world are related to and can reflect disruptions in the spiritual world.

The interconnected concepts of whakapapa, whenua and whānau (family or kinship) are central to Māori models of health, including both Te Wheke (Pere, 1991) and Durie's (2004) Te Whare Tapa Whā. Te Wheke – a model based on the integrative functioning of the octopus – acknowledges waiora or total health and wellbeing as the product of integrated and seamless links between mind, spirit and human connections with whānau or extended family relationships. The model also incorporates the physical world, mauri or life force, mana ake or unique individual identity, koro and kui ma, the ancestral breath of life, and whatumanawa, open and healthy expression of emotions. Wairuatanga is one of the eight tentacles. Te Whare Tapa Whā, widely cited

Failure to engage with spirituality in health promotion work risks ignoring some of the most central values and concerns of many Māori.

Karakia and waiata occur before every significant meeting in their building. This, alongside whanaungatanga, helped provide space for spirit.

in health policy, is based on the structure of the four walls of a meeting house. Durie asserted to be healthy there needs to be a balance between taha wairua (the spiritual), taha tinana (the physical), taha whānau (extended family) and taha hinengaro (intellect and emotions). Threats to health, such as the intergenerational impacts of colonisation, and loss of land and language, can unbalance and sever the connections between these dimensions, losing the connection essential to health and wholeness.

Durie (1985) clearly identified the spiritual dimension of health as "the most basic and essential requirement for health" (p. 483).

Māori spirituality is a holistic, embodied spirituality that values and promotes links to ancestry, ancestral land, culture and close kinship ties to extended family and the wider Māori world. Failure to engage with spirituality in health promotion work risks ignoring some of the most central values and concerns of many Māori. Failure to engage with spirituality also represents a potential breach of *te Tiriti*, which guarantees religious freedom in the broad sense - requiring our recognition and respect for indigenous principles, and willingness to uphold and support those indigenous practices that reflect adherence to spiritual principles.

Western research disagrees about the meaning of spirituality, but dominant Pākehā meanings often equate it with formal religion. Writing in New Zealand, Egan (2011) developed a useful working definition:

> *It may include (a search for): one's ultimate beliefs and values; a sense of meaning and purpose in life; a sense of connectedness; identity and awareness; and for some people, religion. It may be understood at an individual or population level (p. 321).*

Frankl (1984) described a spiritual vacuum within contemporary Western society, driven by what he described as meaninglessness. Eckersley (2004) argued that this spiritual malaise may contribute to high rates of suicide, self-harm, individualism and rampant consumerism. McSherry (2007) said that engaged spirituality has been connected to a range of positive health outcomes. This has led to its recognition in a range of healthcare policy, guidelines and curricula. She advocates a reorientation of health interventions from traditional bio-medical to inclusive bio-psycho-social-spiritual approaches.

WORKING WITH ARTICLE FOUR

5.5 a) Normalising wairuatanga

Research on spirituality and health promotion in New Zealand is sparse, with notable exceptions in faith-based programmes popular with Pacific communities (Rowland & Chappel-Aiken, 2012), work championed by Raeburn and Rootman (1988) and emerging

research on spirituality and evaluation (Kennedy, Cram, Paipa, Pipi, & Baker, 2015; Kennedy et al., 2015). Egan (2010) advocates the explicit inclusion of spirituality in all aspects of health promotion planning, implementation and evaluation. He has identified a series of questions to enable this:

> *Do we have a sense of our own spirituality? How is spirituality promoted in our public health/health promotion organisations? What are the core values and beliefs of health promotion and how do they reflect spiritual aspects of health? How do we understand the spirituality of those we work with? How might our programmes promote spiritual well-being? And how might we measure effectiveness in this domain? (p. iii).*

From the standpoint of a Māori practitioner, **Kiterangi** maintained wairuatanga as a non-negotiable and significant point of difference in her work. Her spiritual orientation is something that she hopes will have a legacy, and continue to flow through the corridors after she is gone. She explains wairuatanga through a quote from her tupuna kuia (female ancestor):

> *Ki runga, ki raro, ki roto, ki waho – Hau Paimārire. We are a spiritual and heavenly peoples and we must conduct ourselves in this manner for all time.*

Ciarán embraced wairuatanga through actively celebrating customary practice and identity in his work. Rather than "wrapping it in cotton wool" he advocated celebrating it and giving it a high profile. He aligned himself to the concept of "culture as cure"; foregrounding the importance of culturally-targeted initiatives to foster and maintain wellbeing. He advocates wairuatanga being made visible, relevant and recognised as precious within health promotion work.

Sandra specifically incorporated wairua within a supervision framework she developed (Skipwith, 2014). She described it as a central pou. Through engagement with her kaumātua and kuia, she secured support for her working with wairua. Like Kiterangi, she could not separate wairua from her work. For her, it was important to be inclusive and to acknowledge the specific beliefs and values of different cultures and their contribution to the work.

Action points for practice

- Engage respectfully and proactively with spiritual beliefs and values in one's practice
- Develop familiarity with Māori spiritual principles and practices and their importance in te ao Māori
- Incorporate a spiritual dimension in planning and everyday practice
- Avoid 'lip service' or superficial ritual observances
- Reflect on one's own values and beliefs, and understand the impact of these on oneself and others.

Te reo Māori and Māori culture are both critical health promotion pathways to communicate with Māori communities.

5.5 b) Te Reo me ōna tikanga

Te reo is a unique taonga of Aotearoa and is a crucial origin and medium of Māori thinking and knowledge (Jackson, 1993). The worldview and cosmology embedded in te reo Māori make it an essential means for transferring cultural knowledge. Robertson and Neville (2008) argued that te reo Māori and Māori culture are both critical health promotion pathways to communicate with Māori communities.

Tikanga is the Māori-defined system of customs and traditions that have been handed down through generations. Jones, Crengle, and McCreanor (2006) identified several principles of tikanga; mana, tapu, he kanohi kitea, whanaungatanga, manaakitanga, koha, and aroha ki te tangata. Collectively understanding and valuing these principles can guide an endeavour to work safely, with Māori communities and maintain cultural safety. By cultural safety we mean:

1. Reflecting on one's behaviour and understanding oneself as cultural bearer

2. Understanding the socio-political context and the impact of inter-generational trauma and colonisation

3. Working to develop trust

4. Implementing *te Tiriti* in practice.

Tipene always involved a kaumātua for cultural support when his team had a big gathering. His team learnt waiata and a phrase or kupu Māori (word) every week to extend their vocabulary and build confidence. He was mindful as the champion of this cultural development to share only a little at a time, to avoid overwhelming people.

Soraya said that in previous Māori workplaces, her team would gather for karakia and korero followed by kai at 9am each morning. Her current team is engaged with Te Rito programme (Kia Māia Bicultural Communications, 2016) to strengthen their understanding of tikanga, values and the context of karakia.

Acknowledging her Chinese heritage, **Grace** saw her role as being respectful and willing to do what she was told about tikanga and follow the lead of those who held cultural knowledge, rather attempting to initiate this herself.

Action points for practice

▷ Advocate for the use, development and retention of te reo Māori as a determinant of health and wellbeing for Māori
▷ Strengthen your knowledge and expertise in te reo me ōna tikanga Māori including:
→ Strengthen pronunciation
→ Learn waiata, introductions and understand common Māori words
→ Remove any impediments to the use of te reo.

5.5 c) Tapu and noa

At the heart of tikanga is the recognition and management of tapu (the sacred). All things tapu potentially involve the risk of transgression. Tapu can be contrasted with noa, in which something was made safe or normal and the restrictions related to tapu status relaxed or lifted. Historically, the traditional world of Māori included physical and spiritual realms and many social norms were influenced by the relationship between tapu and noa (Durie, 1998a).

Codes of behaviour, governed by tapu, noa and rāhui, were used to ensure survival using tikanga that protected water supplies, food sources and the safety of whānau (Ratima & Ratima, 2003). In the absence of written laws, making something tapu was a public sanction with the power to limit personal and community activities. Durie (1994) explains:

> *The balance between tapu and noa was a dynamic one, moving to accommodate seasonal, human and physical needs within a value system that was sufficiently holistic to accommodate health interests (p. 10).*

Most of the participants described their efforts to create safe environments for collaboration. **Lucy** said that her team initiates processes which allow people to connect, engage and then depart. Within her team, karakia and waiata occur before every significant meeting in their building. This, alongside whanaungatanga, helped provide space for spirit. She saw her role as a host, as helping to protecting the mauri (life-force) of the work and for her this has become cultural good manners. Similarly, **Ngaire**'s process involved always taking time to acknowledge everyone in the room. For her this set a welcoming and friendly atmosphere and nurtured a real sense of connection.

Participants used whakatau and pōwhiri in their work to engage with external stakeholders. For **Sione**, the pōwhiri process was a pathway to enhance the wairua dimension of life. He expressed this poetically:

> *Pōwhiri is not just about the meeting of the minds and bodies, ... it's about meeting of the wairua. It's about meeting of the souls. As you know that's why we say tēnā koutou (hello) three times. It's for those that have gone to the spirit world and for those who are now here and for those who will come in the future.*

Action points for practice

▷ Become aware of the application of tapu and noa to health promotion
▷ Respect tikanga and elders to promote understanding, cooperation and effective action
▷ Understand and reflect on oneself as culture bearer and the impact one has on others
▷ Provide space, time and resources for tikanga
▷ Value difference and take your lead from Māori.

6.0 PATHWAYS FORWARD: TAKING ACTION

Health promotion is political work (Signal, 1998) and *Tiriti*-based practice requires strong analysis, relationship building and resourcefulness. Māori and Tauiwi in this study were aware of and brought a strong *te Tiriti* analysis to their mahi (work). They recognised *te Tiriti* as the bedrock of ethical and competent health promotion practice in New Zealand. Their diversity of engagement with *te Tiriti* was heartening and suggests there is flexibility and lack of orthodoxy in *Tiriti*-based practice. This resource highlights a range of *Tiriti*-based approaches and specific actions that could be implemented in negotiation or in solidarity with tangata whenua.

Across the study, relevant research and through dialogue between the authors, three main themes emerged as the core elements of *Tiriti*-based practice:

- Whanaungatanga, (outlined earlier)
- Taking action and being an ally
- Decolonisation and power-sharing.

6.1 TAKING ACTION – BEING AN ALLY

McPhail-Bell, MacLaren, Isihanua, and Maclaren (2007) warned that health promotion has colonial tendencies to tell indigenous communities what to do, rather than embrace progressive traditions of empowerment. The process of being an ally is the opposite of a colonial approach and is about assuming an active role of solidarity to advance a social justice issue with a group experiencing injustice (Margaret, 2013). The challenge of being an effective ally or Treaty partner has been likened to the metaphor of a dance – critically, the ally follows rather than leads the dance. Came and Tudor (2016) describe it as standing in solidarity and supporting indigenous-led solutions.

Whatever may have happened in the past and whatever the future may bring, it remains the sacred duty of the Crown today as in 1840 to stand by the Treaty of Waitangi, to ensure that the trust of the Māori people is never betrayed *(Queen Elizabeth II, cited in Paul, 1994)*.

After recognising and learning about injustice comes the responsibility of taking action. Practitioners in this research identified a range of resourceful strategies to be allies within their spheres of influence - the strength of their professional networks, their access to decision-makers, resources and information, and their ability to shape policy, practices and strategic plans.

Ciarán, for instance, was an ally by identifying Māori aspirations through research. He conducted his practice so it enhanced Māori mana. To him this involved acknowledging peoples' right to set their own goals and focussing on what Māori wanted to achieve, what was important to Māori. He said that it is not about accepting what "our government says is going to be good for you, what's good enough for Pākehā is good enough for you". It is about working with "what is identified as being enriching and empowering for Māori".

Tipene embraced a role as a translator for the Māori community. He strove to strengthen the capacity of his workplace to improve its engagement and services to Māori. He explained to Tauiwi that they were guests in that district and needed to learn about the local marae, as well as some local history, genealogy and stories of the indigenous people's pain. He found this enabled more authentic bicultural engagement.

Sione's workplace has a longstanding commitment to *Tiriti*-based practice. He said the health promotion sector is currently facing a "challenging economic, social, and cultural environment". He argued that in tough times it is important to maintain one's resolve and not allow external pressures to influence one's thinking and practice. His organisation has trained over 1,000 Māori practitioners, a significant contribution. His workplace has also provided platforms for Māori leaders at events and in publications.

Ngaire reported raising indigenous issues on a global stage as an extension of being an ally with Māori. Ngaire described working on a UNICEF project which led her workplace to make their accreditation criteria more inclusive of indigenous worldviews. By valuing and developing bicultural competencies, Tauiwi health promoters can become trustworthy allies and reposition power and resources to reduce health disparities.

Action points for practice

- Develop partnerships with Māori, by following not leading
- Spend time doing ordinary things together, build trust, value reliability, long-term working goals and relationships
- Identify unfairness, racism, and oppressive practice
- Value openness, address mistakes and misjudgements
- Develop an understanding of, embody and practice the role of the ally.

6.2 DECOLONISATION AND POWER-SHARING

During the annexation of New Zealand, Mutu (2015) says colonisers engaged in genocide, land theft, social and cultural dislocation, incarceration, takeover of Māori authority, denial of te reo Māori, and devaluation of Māori institutions and intellect. Decolonisation is about removing oppression and marginalisation and repairing the damage, focusing on honouring, upholding and implanting *te Tiriti*. She notes that progress towards decolonisation has been slow, with an average of less than one percent of land being recovered. Pākehā have fought to retain unilateral power and privilege.

Came (2012) describes decolonisation as an individual and collective process of revealing and analysing the historic and contemporary impact of colonisation, monoculturalism and institutional racism, combined with political movement towards the recognition of sovereignty. Came, McCreanor and Simpson (2016) describe decolonisation as a process in which education is critical to mobilise allies to transfer power.

The authors maintain that the core goal of health promotion is to support communities to take control over the determinants of their health. The work of decolonisation, and the systematic disinvestment of colonial power, fits comfortably within the scope of health promotion (Smith, 2012, p. 98). Decolonisation is about shifting power and resources to enable indigenous control. It is a domain led by Māori, working to enable tino rangatiratanga. As Freire (2000) said, this approach acknowledges the different roles of the descendants of the colonisers and the colonised in the journey towards equity and decolonisation.

Margaret (2016) argued that to engage in decolonisation and become an effective *Tiriti* partner requires a basic set of competencies traditionally found through formal Treaty education programmes. *Tiriti* partners need to be equipped to engage critically with negative messages about Māori in the mass media (Nairn et al., 2012), and often need to unlearn misleading colonial history (Huygens, 2007). To complement the cultural safety work led by Ramsden (2002) and others, Came and da Silva (2011) have compiled a set of political competencies to strengthen anti-racism work. These include a familiarity with colonial history and a commitment to share power and resources,

using structural analysis and self-reflection to guide practice.

Sandra noted in her mahi that it was difficult to get schools with low Māori enrolment engaged. She explained "there's some resistance from them to be doing too much because they feel, well, we don't have a whole lot of Māori. Sometimes their eyes glaze over. The challenge is to keep the relationship, keep the dialogue going so they can move."

Action points for practice

- Become informed, develop political competencies, analyse colonisation and *Tiriti* rights
- Look for the collective in preference to the individual
- Address Māori health priorities, use Māori processes and re-orientate resources
- Integrate decolonisation and anti-racism work into health promotion.

7.0 CONCLUDING THOUGHTS

Pivotal *Tiriti*-based practice includes concepts of agency, authority and the ability of Māori to make decisions for themselves and take control of their destiny. This requires the development of an effective voice, as well as determination and confidence, supported by evidence, resources and technical skills. For those coming from a settler heritage, this entails a willingness to work with Māori for institutional change that is positive and life giving for all. If the core business of health promotion is enabling communities to take control over their health, then enabling indigenous sovereignty is central to the ethical promotion of health practices in all corners of the world.

The size and scope of the problems is daunting, but health promoters in New Zealand and around the global can promote health equity and put indigenous health and health justice at the heart of our practice. This study has shown how, galvanised by a commitment to *te Tiriti o Waitangi* and indigenous health and wellbeing, some New Zealand practitioners engage innovatively with *Tiriti*-based practice.

APPENDIX 1 INTERVIEW QUESTIONS

Indicative interview questions for senior practitioners about health promotion and Tiriti-based practice

1. How long have you worked in health promotion?

☐ 1– 5 years ☐ 6– 10 years ☐ 11– 15 years ☐ 16– 20 years ☐ 21 plus

2. What ethnic group(s) do you identify with?

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3. How important is te Tiriti o Waitangi to your practice? Can you explain further?

4. Think of a time when you were working with te Tiriti on a particular project or initiative and it worked really well and shifted in a positive way. Tell us about it...

To delve a little deeper:

- What do you think were the critical success factors, from the outset?
- What do you think made success more likely; such as social support, positive incentives
- What outside resources or practical support made a difference?

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5. Can you describe how you apply article one of te Tiriti in your work

a. How are Māori involved in decision-making and governance of projects you are involved in? Can you share an example

6. Can you describe how you apply article two of te Tiriti in your work

a. How do you know whether your work advances Māori tino rangatiratanga? Can you share an example

7. Can you describe how you apply article three of te Tiriti in your work

a. How do you know your work increases health equity? Can you share an example

8. Can you describe how you apply article four of te Tiriti in your work

a. How do you integrate wairuatanga in your work? Can you share an example

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9. For you, what are the rewards of working with te Tiriti?

10. What words of advice would you offer a new health promotion practitioner as they start their journey to working with te Tiriti?

APPENDIX 2

2.1 THE SENIOR PRACTITIONERS

Kiterangi Cameron, front, with her mother Ngaropi, has links to Ngāti Mutunga, Ngāti Kahungunu, Te Ātiawa and Taranaki iwi. She has more than fifteen years' experience within the health and community sector working within Māori and non-Māori providers, most recently in community partnership development. She has participated in a range of regional and national reference and advisory groups advocating for indigenous rights. Kiterangi is a Board member for Tū Tama Wahine o Taranaki, a Tangata Whenua Development and Liberation group, servicing whānau across Taranaki. She is a founding member of the Taranaki Māori Women's Network and the Peaceful Province Initiative, co-ordinators of the Peace Walk to Parihaka and Peace for Pekapeka, focused on highlighting the need for local government to engage appropriately and fairly with tangata whenua.

Lucy D'Aeth is an English-born New Zealander. She has worked in health promotion and community development for over 30 years and since the Canterbury earthquakes of 2010– 11, much of her work has focused on population wellbeing and recovery. As a Public Health Specialist with the public health unit of the Canterbury District Health Board, she continues to find the process of learning what it means to be Tangata Tiriti joyful, fascinating, challenging, painful and enriching.

Ciarán Fox has worked for over 20 years in public health promotion, community development, youth health, arts, advocacy and events. He has been with the Mental Health Foundation of New Zealand since 2008 and specialises in the areas of positive mental health, wellbeing, social marketing and health promotion. He is the co-inventor of The Wellbeing Game, a world-first, online tool utilising the sciences of gamification, positive psychology and health promotion. He has served as a trustee on several boards for charitable organisations including the original 198 Youth Health Centre in

Christchurch. He is the board chair of Christchurch city-making initiative Gap Filler and is fascinated with the role of the arts, community activism and activating urban environments for community wellbeing. He is the mental health promotion strategist for the award-winning All Right? campaign promoting the psychosocial recovery and future flourishing of people in Canterbury following the earthquakes of 2010–2011 and 2016.

Tipene (Steve) Kenny
Tipene is from Wellington and is Ngāti Toa Rangatira, Te Atiawa, Ngāti Raukawa as well as whakapapa links to Te Tai Tokerau, Taranaki whānui and Ngāi Tahu. He has extensive experience in various services in both Māori and mainstream organisations including mental health, alcohol and drugs, rangatahi services, public health and cancer control. Tipene has an interest in cancer prevention, healthy housing and men's health in particular with his role in developing the "Get the Tools" programme for Cancer Society. Always looking for solutions, Tipene created "Junk Free June" with the aim of reaching a global audience to raise awareness and fundraise to fight cancer. Tipene is a director of Tiaki Housing Solutions Ltd and is currently a serving member of Mana Tane Ora O Aotearoa.

Ngaire Rae is the Health Promotion Manager for Northland PHOs (a shared service entity that spans Te Tai Tokerau PHO and Manaia Health PHO and covers the geographic boundary of Whangarei, Kaipara and the Far North District Councils). She has held this role for the last 13 years. Ngaire manages a team of health promoters whose work spans a diverse range of projects including smoking cessation, healthy housing and Oranga Kai. Ngaire has a Master's in Public Health with a major in health promotion. Ngaire has a passion for child health and reducing inequities in health status. Ngaire is a member of several collaborative community groups including Chairperson for Healthy Homes Tai Tokerau Governance Group. Ngaire also provides health promotion advice at a regional and national level.

Sandra Skipwith has links with Ngāti Whātua, Ngāti Wai, Waikato and Ngāti Maniapoto. Having been trained in the education sector, Sandra moved into the health sector in a health promotion role as kaiārahi for health promoting schools. She has initiated frameworks to support Māori within mainstream organisations as well as kaimahi Māori groups to support and encourage Māori staff to bring with them their indigenous skills and knowledge and normalise these within their practice. Sandra is also a komiti member of Te Rūnanga o Ngā Toa Āwhina, the Māori representation of

the Public Service Association union. Sandra currently works as a health promotion team leader in a bowel screening programme.

Soraya (pseudonym) links to Ngā Iwi o Te Tairawhiti. Has over 20 years' experience working in public health – including research, planning and funding, workforce development and strategy. This includes work in research and academic Institutions, Māori health providers, district health boards, public health units, and government and national Crown health providers.

Prudence Stone is the youngest of seven and was raised in Rangiora, South Island. She studied Feminist Studies at Canterbury University, then completed her Masters and PhD at the New School for Social Research in New York, specializing in media, cultural reproduction and political economy. She received a Post-Doctoral Research Fellowship from the Stout Research Centre for New Zealand Studies to study the colour black and its cultural significance for New Zealand's national identity. Her book Black Inc. One nation's identity, a cultural politic was published in 2013. Prudence has eight years' professional experience in advocacy and public health leadership. She directed the Smokefree Coalition and is currently the Children's Rights Advocate for UNICEF NZ. She has two teenage children and lives in Island Bay, Wellington.

Sione Tu'itahi is a writer, teacher and health promoter. Human rights – including indigenous, women's and children's rights – are among his major areas of professional interest. He is the Executive Director of the Health Promotion Forum of NZ, taught at a number of educational institutions, and is a member of several national and international advisory boards and groups in health, education, and community development. In his spare time, he writes children's stories, mainly for his grandchildren, and dabbles with poetry and music.

Grace Wong is a fourth generation New Zealander of Chinese heritage. Each decade from the 1980s she has worked to ground *te Tiriti o Waitangi* in nursing practice. In February 1984, she and two others represented the Auckland public health nurses at the Rotorua Regional Health Hui for public health nurses (PHNs) at Tūnohopū Marae, Ōhinemutu. The theme was Māoritanga in relationship to public health nursing. After a 7 year break Grace returned to work in South Auckland where she facilitated the PHN Treaty of Waitangi Monitoring Group. As a nurse lecturer in the 2000s, she supported *te Tiriti* workshops for nursing and other health studies students. Her ten-year leadership of Smokefree Nurses Aotearoa, alongside Evelyn Hikuroa, is based on Treaty principles.

2.2 THE REVIEWERS

Dr Fiona Cram
Ko Mohaka te awa. Ko Tawhirirangi te maunga. Ko Ngāti Pahauwera te iwi. Fiona's tribal affiliations are to Ngāti Pahauwera on the east coast of Aotearoa. Fiona is the mother of one son. Fiona has a PhD in social and developmental psychology from the University of Otago. She has lectured in Social Psychology and has also been a Senior Research Fellow within the International Research Institute of Māori and Indigenous Education, at the University of Auckland. In the middle of 2003 Fiona established Katoa Ltd. Fiona's research interests are wide-ranging including Māori health, justice, and education. The over-riding theme of Fiona's work is kaupapa Māori (by Māori, for Māori). Fiona is Editor-in-Chief of the Aotearoa New Zealand Evaluation Association new evaluation journal, Evaluation Matters – He Take Tō Te Aromatawai.

Moana Jackson
is a well-known and respected Māori activist and lawyer from Ngāti Kahungunu and Ngāti Porou specialising in Treaty and constitutional issues. He has worked internationally on indigenous issues, particularly drafting the *UN Declaration on the Rights of Indigenous Peoples* and as a judge on the International Tribunal of Indigenous Rights in Hawaii in 1993. Moana was the principle researcher and author of *He whaipaanga hou: Maori and the criminal justice system*, published in 1988. This report was, and remains, the only significant, empirical exploration of Maori engagement with the New Zealand criminal justice system. Most recently, Moana Jackson was a vocal critic of the government's foreshore and seabed legislation in 2004, and of the October 2007 police 'terror' raids perpetrated against the Tuhoe iwi (tribe) of the Bay of Plenty.

Dr Susan Healy
is of Irish, British and Cornish ancestry, and has been involved in research and teaching on Treaty-related issues since 1984. She has a doctorate in Māori Studies from the University of Auckland, her dissertation being The nature of the relationship of the Crown in New Zealand with Iwi Māori (2006). Susan is co-author of *Ngāpuhi Speaks: He Wakaputanga and te Tiriti o Waitangi: Independent Report on the Ngāpuhi Nui Tonu Claim* (2012).

2.3 THE AUTHORS

Grant Berghan
MBA (Distinction). Grant is from Te Tai Tokerau with links to Ngāpuhi, Ngātiwai and Te Rarawa Iwi. He is a Māori development consultant. He has extensive experience in the heath and labour market sectors. He has held leadership roles with Ngāti Kahu Social and

Health Services Trust, Hauora.Com, Taranaki DHB, Te Hau Ora o te Tai Tokerau. He has worked in policy development, funding, advocacy, facilitation and evaluation, public health, auditing probation, social work and a freelance journalist. He enjoys healthy living, travel and endurance sports. He is the co-chair of STIR.

Dr Heather Came is a seventh generation Pākehā New Zealander who grew up on Ngātiwai land. She has worked for nearly 25 years in health promotion, public health and Māori health and has a long involvement in social justice activism. Heather is a founding member and co-chair of STIR, a fellow of the Health Promotion Forum, co-chair of the Auckland branch of the Public Health Association and an active member of Tāmaki Tiriti Workers. She currently embraces life as an activist scholar. She is a Senior Lecturer based in the Taupua Waiora Māori Health Research Centre in Auckland University of Technology.

Dr Nicole Coupe is from Te Tai Tokerau with whakapapa to Kai Tahu, Te Atiawa, Ngāti Toa, Rangitane, Raukawa iwi. Nicole has developed innovative research techniques to support Māori suicide prevention. The findings have been implemented across a number of DHBs to support cultural assessment among people who present to emergency departments through powhiri based processes and problem solving therapy. This work has contributed to her leadership and management roles in community, primary and secondary mental health sector. Currently she is taking time to watch the tides and support the very important work of STIR.

Claire Doole, as a Pākehā, has been grappling with the meaning of *te Tiriti* in her personal life since the 1980s when the slogan was 'The Treaty is a fraud'. As Aotearoa developed an understanding of tino rangatiratanga the slogan became 'Honour the Treaty'. Claire is the Pākehā partner and co-lecturer in the Māori Health paper in the nursing department at Auckland University of Technology. Claire has spent most of her career working as a community nurse and was privileged to learn her foundational understanding of *te Tiriti* from kuia in the community. Claire is passionate about exploring and understanding the meaning of *te Tiriti* in nursing practice for Crown partners. Claire is a founding member of STIR.

Dr Jonathan Fay is a clinical psychologist with 40 years' experience in clinical and academic settings in Aotearoa and the USA, practising, supervising, training and teaching psychotherapy. He is married to Margaret Poutu Morice, a Ngāti Porou kaiwhakaruruhau and psychotherapy practitioner. They have three adult children. Jonathan is a member of STIR.

Dr Tim McCreanor is a senior researcher at SHORE and Whāriki Research Centre, at Massey University in Auckland. His broad public health orientation and interest in the social determinants of health and wellbeing, provide a platform for social science projects that support and stimulate social change. In particular, his research seeks to foreground, critique and redress the mechanisms of talk, text and other forms of communication that operate to produce, maintain and naturalise the disparities, exclusions and inequities so evident in our society. Discourse analysis and other qualitative methods have been a central theme in Tim's approach to research domains around ethnicity and culture, inclusion and exclusion and health inequalities. Key topics include racial discrimination, youth wellbeing, alcohol marketing, media representations and social cohesion. Tim is a founding member of STIR and Tāmaki Tiriti Workers.

Trevor Simpson – Te kotahi a Tuhoe ka kata te po. Trevor joined the Health Promotion Forum in 2010 to manage the Māori portfolio. He is married to Vanessa with two grown children and has worked in the health promotion field since 2006. Prior to this he worked in a number of vocations including Crown Land administration, Treaty Settlements and special youth projects. His interests are in raising the profile of Māori issues particularly in the areas of health and matters of social importance. Trevor is committed to health promotion as a fundamental approach to improving Māori health status and believes that strong Māori leadership in this field is an essential facet if we are to contemplate success. Trevor Simpson is a White Ribbon Ambassador and member of STIR.

REFERENCES

Abel, S., & Tipene-Leach, D. (2013). SUDI prevention: A review of Māori safe sleep innovations for infants. *New Zealand Medical Journal, 126*(1379), 86–89.

Anderson, I., Robson, B., Connolly, M., Al-Yaman, F., Bjertness, E., King, A., . . . Yap, L. (2016). Indigenous and tribal peoples' health (The Lancet–Lowitja Institute Global Collaboration): A population study. *The Lancet, 338*(10040), 131–157. doi:10.1016/S0140-6736(16)00345-7

Angell, B., Muhunthan, J., Irving, M., Eades, S., & Jan, S. (2014). Global systemic review of the cost-effectiveness of indigenous health interventions. *PloS One, 9*(11), e111249. doi:10.0.1371/journal.pone.0111249

Barrett, M., & Connolly-Stone, K. (1998). The Treaty of Waitangi and social policy. *Social Policy Journal of New Zealand*(11).

Berridge, D., Cowan, L., Cumberland, T., Davys, A., McDowell, H., Morgan, J., . . . Wallis, P. (1984). *Institutional racism in the Department of Social Welfare*. Auckland, New Zealand: Department of Social Welfare.

Boulton, A., Gifford, H., Kauika, A., & Parata, K. (2011). Maori health promotion: Challenges for best practice. *AlterNative: An International Journal of Indigenous Peoples, 7*(1), 26.

Boulton, A., Simonsen, K., Walker, T., Cumming, J., & Cunningham, C. (2004). Indigenous participation in the 'new' New Zealand health structure. *Journal of Health Services Research and Policy, 9*(S2), 35–40. doi:10.1258/1355819042349853

Braun, V., & Clarke, V. (2006). What can 'thematic analysis' offer health and wellbeing researchers? *International Journal of Qualitative Studies on Health & Wellbeing, 9*. doi:10.3402/qhw.v9.26152

Braveman, P. (2014). What are health disparities and health equity? We need to be clear. *Public Health Reports, 129*(Suppl 2), 5–8.

Bryder, L., & Dow, D. (2001). Introduction: Maori health, history, past, present and future. *Health and History, 3*, 3–12.

Came, H. (2012). *Institutional racism and the dynamics of privilege in public health.* (Unpublished doctorate), Waikato University, Hamilton, New Zealand.

Came, H. (2014). Sites of institutional racism in public health policy making in New Zealand. *Social Science and Medicine, 106*(0), 214–220. doi:10.1016/j.socscimed.2014.01.055

Came, H., & da Silva, S. (2011). Building political competencies for the transformation of racism in Aotearoa. *Kotuitui, 6*(1–2), 113–123. doi:10.1080/1177083X.2011.615332

Came, H., Doole, C., McKenna, B., & McCreanor, T. (2017). Institutional racism in public health contracting: Findings of a nationwide survey from New Zealand. *Social Science & Medicine*. doi: 10.1016/j.socscimed.2017.06.002

Came, H., & Griffith, D. M. (2017). Tackling institutional racism as a wicked public health problem: The case for anti-racism praxis. *Social Science and Medicine*. doi: 10.1016/j.socscimed.2017.03.028

Came, H., MacDonald, J., & Humphries, M. (2015). Enhancing activist scholarship in New Zealand and beyond. *Contention: The Multidisciplinary Journal of Social Protest, 3*(1), 37–53.

Came, H., & McCreanor, T. (2015). Pathways to transform institutional (and everyday) racism in New Zealand. *Sites: Journal of Social Anthropology & Cultural Studies, 12*(2), 24–48. doi:10.11157/sites-vol12isss2id290

Came, H., McCreanor, T., Doole, C., & Rawson, E. (2016). The New Zealand health strategy: Whither health equity? *New Zealand Medical Journal, 129*(1447), 72–77.

Came, H., McCreanor, T., Doole, C., & Simpson, T. (2016). Realising the rhetoric: Refreshing public health providers' efforts to honour Te Tiriti o Waitangi in New Zealand. *Ethnicity and Health*, 1–14. doi:10.1080/13557858.2016.1196651

Came, H., McCreanor, T., & Simpson, T. (2016). Utilising health activism to remove barriers to indigenous health in Aotearoa New Zealand. *Critical Public Health*, 1–7. doi:10.1080/009581596.2016.1239816

Came, H., & Tudor, K. (2016). Bicultural praxis: the relevance of Te Tiriti o Waitangi to health promotion internationally. *International Journal of Health Promotion & Education*, 1–9. doi:10.1080/14635240.2016.1156009

Came, H., & Zander, A. (2015). *State of the Pākehā nation: Collected Waitangi day speeches and essays 2006–2015*. Retrieved from https://nwwhangarei.files.wordpress.com/2012/11/sotn2015.pdf

Carter, K., Lanumata, T., Kruse, K., & Gorton, D. (2010). What are the determinants of food insecurity in New Zealand and does this differ for males and females? *Australian & New Zealand Journal of Public Health, 34*(5). doi:10.1111/j.1753–6405.2010.00615.x

Carter, S. M., Rychetnik, L., Lloyd, B., Kerridge, I. H., Baur, L., Bauman, A., . . . Zask, A. (2011). Evidence, ethics, and values: A framework for health promotion. *American Journal of Public Health, 101*(3), 465–472. doi:10.2105/AJPH.2010.195545

Chino, M., & DeBruyn, L. (2006). Commentary. Building true capacity: Indigenous models for indigenous communities. *American Journal of Public Health, 96*(4), 596–599 doi:10.2105/AJPH.2004.053801

Constitutional Advisory Panel. (2013). *New Zealand constitution: A report on a conversation He Kōtuinga Kōrero mō Te Kaupapa Ture o Aotearoa*. Wellington, New Zealand: New Zealand Government.

Cooper, R. (1998). *National strategic plan for Maori health: 1998–2001*. Auckland, New Zealand: Health Funding Authority.

Covey, S. (2004). *The 7 habits of highly effective people: Powerful lessons in personal change*. New York, NY: Free Press.

Cram, F. (2014a). *Equity of healthcare for Māori: A framework*. Wellington, New Zealand: Ministry of Health.

Cram, F. (2014b). *Improving Māori access to healthcare: Research report*. Wellington, New Zealand: Ministry of Health.

Cram, F., & Pipi, K. (2001). *Determinants of Maori provider success: Provider interviews summary report* (Report No.4). Wellington, New Zealand: Te Puni Kokiri.

Crengle, S. (1998). *Ma papatuanuku, ka tipu nga rakau: Proceedings of Te Oru Rangahau: Maori research and development conference*. Palmerston North, New Zealand: Massey University.

Cunningham, C. (1995). *He taura tieke: Measuring effective health services for Maori*. Wellington, New Zealand: Ministry of Health.

Dow, D. (1995). *Safeguarding the public health: A history of the New Zealand Department of Public Health*. Wellington, New Zealand: Victoria University Press.

Durie, E., Willis, W., & Latimer, G. (1983). *Report of the Waitangi Tribunal on the Motunui–Waitara Claim [WAI 6]*. Wellington, New Zealand: Waitangi Tribunal.

Durie, M. (1985). A Māori perspective of health. *Social Sciences and Medicine, 20*(5), 483–486.

Durie, M. (1989). The Treaty of Waitangi and health care. *New Zealand Medical Journal, 102,* 283-285.

Durie, M. (1993). *The CHI model: A culturally appropriate auditing model: Guidelines for public health services*. Wellington, New Zealand: Public Health Commission.

Durie, M. (1994). Te kawenata o Waitangi: The application of the Treaty of Waitangi to health. In M. Durie (Ed.), *Whaiora: Maori health development* (pp. 82–98). Auckland, New Zealand: Oxford University Press.

Durie, M. (1998a). *Te mana, te kāwanatanga: The politics of Māori self–determination*. Auckland, New Zealand: Oxford University Press.

Durie, M. (1998b). *Whaiora: Māori health development* (2nd ed.). Auckland, New Zealand: Oxford University Press.

Durie, M. (1999). Te pae mahutonga: A model for Māori health promotion. *Health Promotion Forum Newsletter, 49*, 2–5.

Durie, M. (2004). An indigenous model of health promotion. *Proceedings of 18th World Conference on Health Promotion and Health Education* (pp. 1–21). Melbourne, Australia.

Durie, M. (2012). Indigenous health: New Zealand experience. *Medical Journal of Australia, 197*(1), 10. doi:10.5694/mja12.10719

Eckersley, R. (2004). *Well and good: Morality, meaning and happiness*. Melbourne, Australia: The Text Publishing Company.

Egan, R. (2010). Health promotion and spirituality: Making the implicit explicit. *Keeping Up to Date, 34*, i–iv.

Egan, R., McGee, R., MacLeod, R., Jaye, C., Baxter, J., & Herbison, P. (2011). What is spirituality? Evidence from a New Zealand hospice study. *Mortality, 16*(4), 307–324. doi:10.1080/13576275.2011.613267

Farrer, L., Marinetti, C., Cavaco, Y. K., & Costongs, C. (2015). Advocacy for health equity: A synthesis review. *Milbank Quarterly, 93*(2), 392–437. doi:10.1111/1468– 0009.12112

Fletcher, N. (2014). *A praiseworthy devise for amusing and pacifying savages? What the framers meant by the English text of the Treaty of Waitangi*. (Unpublished Doctoral thesis), Auckland University, Auckland, New Zealand. Retrieved from https://researchspace.auckland.ac.nz/handle/2292/24098

Frankl, V. (1984). *Man's search for meaning* (3rd Ed.). New York, NY: Pocket Books.

Freire, P. (2000). *Pedagogy of the oppressed*. New York, NY: Continuum.

Gifford, H. (2003). *He arorangi whakamua: Reducing the uptake of tobacco in Ngāti Hauiti rangatahi*. (Unpublished Doctoral thesis), Massey University, Palmerston North, New Zealand.

Gould, G., McEwen, A., Watters, T., Clough, A. R., & van der Zwan, R. (2013). Should anti–tobacco media messages be culturally targeted for indigenous populations? A systematic review and narrative synthesis. *Tobacco Control, 22*(4), 1–10. doi:10.1136/tobaccocontrol–2012–050436

Gregg, J., & O'Hara, L. (2007). Values and principles evident in current health promotion practice. *Health Promotion Journal of Australia, 18*(1), 7–11.

Grey, S., & Sedgwick, C. (2013). *Fears, constraints, and contracts: The democratic reality for New Zealand's community and voluntary sector*. Wellington: Community and Voluntary Sector Forum.

Hall, A., & Poutu Morice, M. (2015). Shifting ground: Reflecting on a journey of bicultural partnership. *Ata: Journal of psychotherapy Aotearoa New Zealand, 19*(22), 117–127. doi:10.9791/ajpanz.2015.11

Hamerton, H., Mercer, C., Riini, D., McPherson, B., & Morrison, L. (2014). Evaluating Māori community initiatives to promote Healthy Eating, Healthy Action. *Health Promotion International, 29*(1), 60–69.

Harwood, M. (2010). Rehabilitation and indigenous peoples: the Māori experience. *Disability and Rehabilitation, 32*(12), 972–977.

Have, P. (2005). The notion of member is the heart of the matter: On the role of membership knowledge in ethnomethodological inquiry. *Historical Social Research*, 28–53. Retrieved from http://www.jstor.org/stable/20762011

Health Funding Authority. (1988). *Waitangi Treaty policy development*. Auckland, New Zealand: Author.

Health Promotion Forum. (2000). *TUHA–NZ: Treaty Understanding of Hauora in Aotearoa New Zealand*. Auckland, New Zealand: Author.

Health Promotion Forum. (2011). *Ngā kaiakatanga hauora mō Aotearoa: Health promotion competencies for Aotearoa–New Zealand*. Auckland, New Zealand: Author.

Health Research Council. (2010). *Guidelines for researchers on health research involving Maori* [*Version 2*]. Auckland, New Zealand: Author.

Healy, S., Huygens, I., & Murphy, T. (2012). *Ngāpuhi speaks.* Whangarei, New Zealand: Network Waitangi Whangarei, Te Kawariki.

Henare, J. (1987). *Address to David Lange's cabinet*. Wellington, New Zealand.

Hicks, K. (2015). *The uniqueness of the Aotearoa 2012 health promotion competency framework: Māori inclusivity as an essential prerequisite.* (Masters of Public Health), Auckland University, Auckland, New Zealand.

Hoskins, T. K., Martin, B., & Humphries, M. (2011). The power of relational responsibility. *Electronic Journal of Business Ethics & Organization Studies,* 16(2), 22-27.

Howden–Chapman, P. (2015). *Home truths: Confronting New Zealand's housing crisis*. Wellington, New Zealand: Bridget Williams Books.

Howden–Chapman, P., Matheson, A., Crane, J., Viggers, H., Cunningham, M., & Blakely, T. (2007). Effect of insulating existing houses on health inequality: Cluster randomised study in the community. *British Medical Journal, 334*. doi:10.1136/bmj.39070.573032.80

Hudson, M., Milne, M., Reynolds, P., Russell, K., & Smith, B. (2010). *Te ara tika guidelines for Māori research ethics: A framework for researchers and ethics committee members*. Retrieved from Wellington, New Zealand: Health Research Council website: http://www.hrc.govt.nz/sites/default/files/TeAraTikaGuidelinesforMaoriResearchEthics.pdf

Human Rights Commission. (2011). *Te mana i Waitangi: Human rights and the Treaty of Waitangi*. Auckland, New Zealand: Author.

Human Rights Commmision. (2014). *Tūi tūi tuituiā Race relations in 2013*. Retrieved from Auckland, New Zealand: http://www.hrc.co.nz/files/2114/2389/2938/Race-Relations-in-2013-for-website.doc

Hunt, P., Backman, G., Bueno de Mesquita, L., Finer, L., Khosla, R., Korljan, D., & Oldring, L. (2009). The right to the highest attainable standard of health. In R. Detels, R. Beaglehole, M. Lansang, & M. Gulliford (Eds.), *Oxford textbook of public health* (pp. 335–350). Oxford, NY: Oxford University Press.

Huygens, I. (2001). Feminist attempts at power sharing in Aotearoa: Embarrassing herstory or significant learning towards Treaty–based structures? *Feminism and Psychology, 11*(3), 393–400. doi:10.1177/0959353501011003010

Huygens, I. (2006). Discourses for decolonization: Affirming Maori authority in New Zealand workplaces. *Journal of Community & Applied Social Psychology, 16*, 363–378. doi:10.1002/casp.881

Huygens, I. (2007). *Process of Pakeha change in response to the Treaty of Waitangi*. (Doctoral dissertation), Waikato University, Hamilton, New Zealand.

Isaac, W. (2016). *Memorandum – Directions of the chairperson commencing a kaupapa inquiry into health services and outcomes WAI 2575, #2.5.1*. Wellington, New Zealand: Waitangi Tribunal.

Jackson, M. (1988). *He whaipānga hou: The Māori and the criminal justice system* [*Part 1*]. Wellington, New Zealand: Department of Justice.

Jackson, M. (1995). *Maori, Pakeha and politics: the Treaty of Waitangi sovereignty as culture, culture as sovereignty: Maori politics and the Treaty of Waitangi*. Paper presented at the Global Cultural Diversity Conference, Sydney Australia. http://www.immi.gov.au/media/publications/multicultural/confer/13/speech56a.htm

Jackson, M. (2010). Restoring the nation: Removing the constancy of terror. *Proceedings of traditional knowledge conference June 2008 Te tatau pounamu: The geenstone door traditional knowledge and gateways to balanced relationships*. Auckland, New Zealand: Nga Pae o te Maramatanga

Jackson, S. (1993). The first language. In W. Ihimaera (Ed.), *Te ao marama: Regaining Aotearoa: Maori writers speak out* (Vol. 2, pp. 215–218). Auckland, New Zealand: Reed.

Jones, B., Ingham, T., Davies, C., & Cram, F. (2010). Whānau tuatahi: Māori community partnership research using a Kaupapa Māori methodology. *MAI Review*(3), 1–14.

Jones, R., Crengle, S., & McCreanor, T. (2006). How tikanga guides and protects the research process: Insights from the Hauora Tane project. *Social Policy Journal of New Zealand,* (29), 60– 77. Retrieved from https://www.msd.govt.nz/documents/about–msd–and–our–work/publications–resources/journals–and–magazines/social–policy–journal/spj29/29–pages–60–77.pdf

Kāwanatanga Network. (1996). Pakeha/Tauiwi discussion paper on future constitution. In J. Margaret (Ed.), *Pakeha Treaty work: Unpublished material* (pp. 156–164). Auckland, New Zealand: Manukau Institute of Technology, Treaty Resource Centre.

Kearns, R., Moewaka Barnes, H., & McCreanor, T. (2009). Placing racism in public health: A perspective from Aotearoa/New Zealand. *GeoJournal, 74*(123–129). doi:10.1007/s10708–009–9261–1

Kennedy, V., Cram, F., Paipa, K., Pipi, K., & Baker, M. (2015). Wairua and cultural values in evaluation. *Evaluation Matters: He Take to te Aromatawai, 1*, 83–111.

Kennedy, V., Cram, F., Paipa, K., Pipi, K., Baker, M., Porima, L., . . . Tuagalu, C. (2015). Beginning a conversation about spirituality in Māori and Pasifika evaluation. In S. Hood, R. Hopson, & H. Frierson (Eds.), *Continuing the journey to reposition culture and cultural context in evaluation theory and practice*. (pp. 151–178). Charlotte, NC: Information Age Publishing.

Kia Māia Bicultural Communications. (2016). *Te Rito*. Retrieved from http://www.kiamaia.org.nz/te-rito.html

Kickbusch, I. (2015). The political determinants of health – 10 years on. *British Medical Journal, 350*(h81). doi:10.1136/bmh.h81

Kingsbury, B. (1989). The Treaty of Waitangi: Some international law aspects. In I. H. Kawharu (Ed.), *Waitangi: Maori and Pakeha perspectives of the Treaty of Waitangi* (pp. 121–157). Auckland: Oxford University Press.

Kiro, C. (2000). *Kimihia mo te hauora Maori: Maori health policy and practice*. (Doctoral dissertation), Massey University, Auckland, New Zealand.

Labonte, R. (2016). Health promotion in an age of normative equity and rampant inequality. *International Journal of Health Policy and Management, 5*, 1–8. doi:10.15171/ijhpm.2016.95

Lange, R. (1999). *May the people live: A history of Maori health development 1900–1920*. Auckland, New Zealand: Auckland University Press.

Makowharemahihi, C., Wall, J., Keay, G., Britton, C., McGibbon, M., LeGeyt, P., . . . Signal, V. (2016). Quality improvement: Indigenous influence in oral health policy, process, and practice. *Journal of Health Care for the Poor & Underserved, 27*, 54. doi:10.1353/hpu.2016.0035

Margaret, J. (2013). *Working as allies: Supporters of indigenous justice reflect*. Auckland, New Zealand: Auckland Workers Educational Association.

Margaret, J. (2016). *Ngā rerenga o te Tiriti: Community organisations engaging with the Treaty of Waitangi*. Auckland, New Zealand: Treaty Resource Centre.

Marmot, M. G. (2016). Empowering communities. *American Journal of Public Health, 106*(2), 230–231. doi:10.2105/AJPH.2015.302991

Marmot, M. (2005). Social determinants of health inequalities. *The Lancet, 36*, 1099–1104.

Marriott, L., & Sim, D. (2014). *Indicators of inequality for Māori and Pacific people* [*Working paper 09/2014*]. Wellington, New Zealand: Victoria University.

Marsden, M. (2003). *The woven universe: Selected writings of Rev Maori Marsden*. New Zealand: Estate of Rev. Maori Marsden.

Martin, B., Humphries, M., & Te Rangiita, R. (2003). A two hulled waka: Managing diversity in a Pacific mode. *International Journal of Diversity in Organisation, Communities & Nations, 3B*, 99–111.

Matike Mai Aotearoa. (2016). *He whakaaro here whakaumu mō Aotearoa*. New Zealand: Author.

Mauriora ki te Ao. (2009). *Te toi hauora–nui: Achieving excellence through innovative Maori health service delivery*. Retrieved from http://www.moh.govt.nz/moh.nsf/pagesmh/9815/$File/te-toi-hauora-nui.pdf

McGloin, C. (2015). Listening to hear: Critical allies in Indigenous Studies. *Australian Journal of Adult Learning, 55*(2), 267–282.

McPhail–Bell, K., MacLaren, D., Isihanua, A., & Maclaren, M. (2007). From 'what' to 'how' – capacity building in health promotion for HIV/AIDS prevention in the Solomon Islands. *Pacific Health Dialog, 14*(2), 125–131.

McSherry, W. (2007). *The meaning of spirituality and spiritual care within nursing and health care practice*. London, England: Quay Books.

Ministerial Advisory Committee. (1988). *Puao te ata tu* (*Day break*). Wellington, New Zealand: Department of Social Welfare.

Ministry of Health. (2016). *New Zealand health strategy: Future direction*. Wellington, New Zealand: Author.

Morice, M. P. (2003). *Towards a Māori psychotherapy: The therapeutic relationship and Māori concepts of relationships. A systematic literature review with case illustrations.* (Masters of Health Sciences), Auckland University of Technology, Auckland, New Zealand.

Mowbray, M. (2007). *Social determinants and indigenous health: The international experience and its policy implications: Report on specially prepared documents, presentations and discussion on the International Symposium on the Social Determinants of Indigenous Health*. Adelaide, Australia: Commission on Social Determinants of Health.

Mutu, M. (2015). Māori issues. *Contemporary Pacific, 27*(1), 273–281.

Mutu, M. (2010). Constitutional intentions: The Treaty of Waitangi texts. In M. Mulholland & V. Tawhai (Eds.), *Weeping waters: The Treaty of Waitangi and constitutional change* (pp. 13–40). Wellington, New Zealand: Huia.

Nairn, R., McCreanor, T., Moewaka Barnes, A., Borell, B., Rankine, J., & Gregory, A. (2012). "Maori news is bad news": That's certainly so on television. *MAI Journal, 1*(1), 38–49.

National Action Group. (1991). *Bicultural development in nursing: Guidelines*. Wellington, New Zealand: RPIEN.

National Advisory Committee on Health and Disability. (1998). *The social, cultural and economic determinants of health in New Zealand: Action to improve health.* Wellington, New Zealand:

Newshub Archive (2014, November 14). *Waitangi Tribunal: Northland Maori didn't cede sovereignty.* Retrieved from http://www.newshub.co.nz/nznews/waitangi-tribunal-northland-maori-didnt-cede-sovereignty-2014111413

New Zealand Public Health and Disability Act 2000 (S.N.Z. No.91.), 2000 S.N.Z. No. 91.

O'Malley, V., Stirling, B., & Penetito, W. (2013). *The Treaty of Waitangi companion*. Auckland, New Zealand: Auckland University Press.

O'Sullivan, D. (2015). *Indigenous health: Power politics and citizenship*. Melbourne, Australia: Australia Scholarly Press.

Ogilvie, D., Craig, P., Griffin, S., Macintyre, S., & Wareham, N. (2009). A translational framework for public health research. *BMC Public Health, 9*, 116. doi:10.1186/1471-2458-9-116

Palinkas, L., Horwitz, S., Green, C., Wisdom, J., Duan, N., & Hoagwood, K. (2015). Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. *Administration & Policy in Mental Health, 42*(5), 533–544. doi:10.1007/s10488-013-0528-y

Paradies, Y., Ben, J., Denson, N., Elias, A., Priest, N., & Pieterse, A. (2015). Racism as a determinant of health: A systematic review and meta-analysis. *PloS One, 10*(9), e0138511. doi:10.1371/journal.pone.0138511

Paul, G. (1994). Kawanatanga. *Network Waitangi Newsletter*, December, 1– 13.

Pere, R. (1991). *Te Wheke: A celebration of infinite wisdom*. Gisborne, New Zealand: Ao Ako.

Phillipson, G. (2006). *Bay of Islands Maori and the Crown, 1793–1853: An exploratory overview for the CFRT (Wai 1040, Doc#4.1.3)*. Wellington, New Zealand: Waitangi Tribunal.

Public Health Association. (2012). *Te ture whakaruruhau: Code of ethical principles for public health in Aotearoa New Zealand*. Wellington, New Zealand: Author.

Raeburn, J., & Rootman, I. (1988). Towards an expanded health field concept: Conceptual and research issues in a new era of health promotion. *Health Promotion International, 3*(4), 383–392.

Ramsden, I. (2002). *Cultural safety and nursing education in Aotearoa and Te Waipounamu*. (Doctoral dissertation), Massey University, Palmerston North, New Zealand.

Ramsden, I., & Erihe, L. (1988). Our culture is our health. *New Zealand Nursing Journal, 82*(4), 3–6.

Ratima, M. (2001). *Kia urūru mai a hauora: Being healthy, being Maori: Conceptualising Maori health promotion*. (Unpublished Doctoral dissertation), Otago University, Dunedin, New Zealand.

Ratima, M. (2010). *Maori health promotion – a comprehensive definition and strategic considerations*. Auckland, New Zealand: Health Promotion Forum.

Ratima, M., Durie, M., & Hond, R. (2015). *Māori health promotion Promoting health in Aotearoa New Zealand* (pp. 42–63). Dunedin, New Zealand: Otago University Press.

Ratima, M., & Ratima, K. (2003). *Māori public health action: A role for all public health professionals*. Auckland, New Zealand: Auckland University of Technology.

Regan, T. (2009). *A dirty determinant of health: What is the role of public health units in reducing the inequitable effects of inadequate income on health and wellbeing?* (Unpublished Masters thesis), University of Otago, Wellington, New Zealand.

Robertson, H. R., & Neville, S. (2008). Health promotion impact evaluation: Healthy Messages Calendar (Te Maramataka Korero Hauora). *Nursing Praxis in New Zealand, 24*(1), 24–35.

Robson, B., & Harris, R. (Eds.). (2007). *Hauora: Māori standards of health IV. A study of the years 2000–2005*. Wellington, New Zealand: Te Rōpū Rangahau Hauora a Eru Pōmare, University of Otago.

Rochford, T. (1997). Successful Maori public health initiatives in Aotearoa/New Zealand. *Promotion Education, 4*(3), 19–21.

Rochford, T. (2004). Whare tapa wha: A Māori model of a unified theory of health. *The Journal of Primary Prevention, 25*(1), 1573–6547. doi:10.1023/b:jopp.0000039938.39574.9e

Rowland, M. L., & Chappel–Aiken, L. (2012). Faith–based partnerships promoting health. *New Directions for Adult & Continuing Education, 2012*(133), 23–33. doi:10.1002/ace.20004

Ruakere, T. (1998). A comparative study of Maori use of an iwi general practice and mainstream general practice. *Ma papatuanuku, ka tipu nga rakau: Proceedings of Te Oru Rangahau: Maori research and development conference*. Palmerston North, New Zealand: Massey University.

Sheridan, N., Kenealy, T., Connolly, M., Mahony, F., Barber, A., Boyd, M. A., . . . Moffitt, A. (2011). Health equity in the New Zealand health system: A national survey. *International Journal for Equity in Health, 10*(45), 1–14. doi:10.1186/1475–9276–10–45

Signal, L. (1998). The politics of health promotion: Insights from political theory. *Health Promotion International, 13*(3), 257–263. doi:10.1093/heapro/13.3.257

Signal, L., Martin, J., Cram, F., & Robson, B. (2008). *Health equity assessment tool: A users guide*. Wellington, New Zealand: Ministry of Health.

Skipwith, S. (2014). *Te pou: A framework for supervision in a bicultural context*. Paper presented at the Population Health Congress, Auckland, New Zealand.

Smith, L. T. (2012). *Decolonizing methodologies: Research and indigenous peoples*. London: Zed Books.

Starfield, B. (2011). The hidden inequity in healthcare. *International Journal for Equity in Health, 1*, 15. doi:10.1186/1475–9276–10–15

Tankersley, M. (2004). Te Tiriti o Waitangi and community development. *Big day in: Community Develoopent Conference* (pp. 1–10).

Tawhai, V., & Gray–Sharp, K. (Eds.). (2011). *Always speaking: The Treaty of Waitangi and public policy*. Wellington, New Zealand: Huia.

Te Puni Kōkiri. (2001). *He tirohanga ō kawa ki te Tiriti o Waitangi*. Wellington, New Zealand: Author.

Te Puni Kōkiri. (March 1994). *Te ara ahu whakamua: Proceedings of the Maori health decade*. Wellington, New Zealand: Author.

Te Rōpū Rangahau Hauora o Eru Pōmare. (2002). *Mana whakamārama – Equal explanatory power: Māori and non–Māori sample size in national health surveys*. Wellington, New Zealand:

UN. (1948). *Universal Declaration of Human Rights*. Geneva, Switzerland: Author.

UN. (2007). *Declaration on the Rights of Indigenous Peoples*. New York, NY: Author.

UN. (2015). *Sustainable development goals*. Retrieved from http://www.un.org/sustainabledevelopment/sustainable–development–goals/

Verbos, A., & Humphries, M. (2014). A Native American relational ethic: An Indigenous perspective on teaching human responsibility. *Journal of Business Ethics, 123*(1), 1–9. doi:10.1007/s10551–013–1790–3

Verbos, A. K., & Humphries, M. (2015). Amplifying a relational ethic: A contribution to PRME praxis. *Business & Society Review, 120*(1), 23–56. doi:10.1111/basr.12047

Waitangi Tribunal. (2014). *Te paparahi o te raki* (*Wai 1040*). Wellington, New Zealand: Author.

Ward, J. (2011). *William Colenso's authentic and genuine history of the signing of the Treaty of Waitangi*. (Doctoral Dissertation), Massey University, Auckland, New Zealand.

Whitehead, M. (1992). The concepts and principles of equity in health. *International Journal of Health Services, 22*, 429–445. doi:10,1093/heapro/6.3.217

Whitehead, M., & Dahlgren, G. (2009). *Concepts and principles for tackling social inequities in health: Leveling up part 1*. Copenhagen, Denmark: World Health Organization.

Whitinui, P. (2011). The teaty and "treating" Maori health. *AlterNative: An International Journal of Indigenous Peoples, 7*(2), 138–151.

WHO. (1986). Ottawa Charter for health promotion *Proceedings of the 1st International Conference on Health Promotion.* Ottawa, Canada: World Health Organization.

WHO. (2013). *The economics of social determinants of health and health inequities: A resource book*. Author: Luxembourg.

Wihongi, H. (2010). *Tino rangatiratanga in health policies and practices: A kaupapa Māori analysis of the 1996 National Cervical Screening programme's policy document – the years 1990 to 2000*. (Doctoral dissertation), Waikato University: Hamilton, New Zealand.

Wilkinson, R., & Marmot, M. (2003). *Social determinants of health: The solid facts* (2nd ed.). Geneva, Switzerland: World Health Organization.

Wilson, D. (2008). The significance of a culturally appropriate health service for indigenous Māori women. *Contemporary Nurse: A Journal for the Australian Nursing Profession, 28*(1–2), 173–188. doi:10.5172/conu.673.28.1–2.173

Woolf, S. H. (2008). The meaning of translational research and why it matters. *Journal of the American Medical Association*, 299(2), 211–213.

ISBN 978-0-473-41439-9