

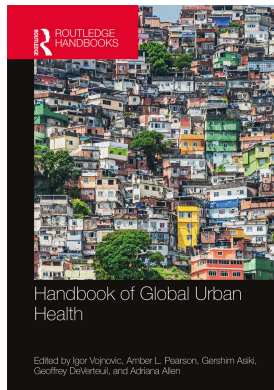
This article was downloaded by: 10.2.97.136

On: 30 Mar 2023

Access details: *subscription number*

Publisher: *Routledge*

Informa Ltd Registered in England and Wales Registered Number: 1072954 Registered office: 5 Howick Place, London SW1P 1WG, UK



## Handbook of Global Urban Health

Igor Vojnovic, Amber L. Pearson, Gershim Asiki, Geoffrey DeVerteuil,  
Adriana Allen

### Cities and Indigenous Communities

Publication details

<https://test.routledgehandbooks.com/doi/10.4324/9781315465456-18>

John Ryks, Naomi Simmonds, Jesse Whitehead

**Published online on: 20 May 2019**

**How to cite :-** John Ryks, Naomi Simmonds, Jesse Whitehead. 20 May 2019, *Cities and Indigenous Communities from: Handbook of Global Urban Health* Routledge

Accessed on: 30 Mar 2023

<https://test.routledgehandbooks.com/doi/10.4324/9781315465456-18>

**PLEASE SCROLL DOWN FOR DOCUMENT**

Full terms and conditions of use: <https://test.routledgehandbooks.com/legal-notices/terms>

This Document PDF may be used for research, teaching and private study purposes. Any substantial or systematic reproductions, re-distribution, re-selling, loan or sub-licensing, systematic supply or distribution in any form to anyone is expressly forbidden.

The publisher does not give any warranty express or implied or make any representation that the contents will be complete or accurate or up to date. The publisher shall not be liable for an loss, actions, claims, proceedings, demand or costs or damages whatsoever or howsoever caused arising directly or indirectly in connection with or arising out of the use of this material.

## 16

CITIES AND INDIGENOUS  
COMMUNITIESThe Health and Wellbeing of Urban Māori in  
Aotearoa New Zealand*John Ryks, Naomi Simmonds and Jesse Whitehead***Introduction**

The health and wellbeing of indigenous communities in urban environments presents complex challenges, particularly for those communities that have experienced the harmful and marginalising effects of colonisation. Historically, the rapid development of modern cities often overwhelmed existing indigenous settlements, resulting in the displacement and invisibility of the original inhabitants. In Aotearoa New Zealand,<sup>1</sup> the migration of Māori<sup>2</sup> from rural to urban areas has been recognised as one of the most rapid internal migrations by a population globally (Barcham 1998; Kukutai 2011, 2014). At the start of the 20th century, 85% of the Māori population lived in rural locations and 15% in urban locations. By the start of the 21st century, this had reversed, with 85% living in urban settings (Kukutai 2014; Statistics New Zealand 2006). This migration peaked following the Second World War as the New Zealand government encouraged Māori to move to major urban areas as a way of accelerating post-war industry. Incentives included offers of employment, accommodation and additional social assistance (Barcham 1998; Kukutai 2014; Meredith 2000), but, as Ryks et al. (2016, p. 28) state:

these incentives were offset by government policies that had the effect of dispersing Māori families among other urban migrants and further discouraging Māori from speaking their own language in schools and workplaces. Such policies also resulted in the atrophy of traditional Māori social structures such as whānau (extended family)<sup>3</sup> and led to a profound degradation of cultural, social and physical living environments.

Urban Māori now disproportionately feel the effects of economic recession, experience poorer health outcomes compared to other New Zealanders, receive poorer education, and are less able to access quality housing (Barcham 1998; Bargh 2012; Howden-Chapman et al. 2013; Kukutai 2004; Robson and Harris 2007).

In this chapter, we contend that the historical and ongoing effects of colonialism, combined with the failure of contemporary mainstream policies and services to respond to the health and cultural needs of Māori, are creating and widening health inequities in urban Aotearoa New Zealand. Despite these inequities and the challenges they present, a continuously evolving urban Māori identity is manifested both socially and spatially. We suggest that culturally responsive health and

wellbeing models and services are one way in which the diverse health needs of urban Māori can be more appropriately considered. It is imperative that measures and analyses of Māori health inequities in Aotearoa New Zealand engage with diverse Māori realities and that responses are defined, measured and implemented to enable Māori self-determination and enhance Māori health and wellbeing.

### **Urban Māori Identity and the Spatial Distribution of Urban Māori**

In contemporary Aotearoa New Zealand, the urban Māori population is composed partly of those descendants of iwi (tribes) and hapū (sub-tribes) who were already established in places where cities were built and typically prior to the signing of the Treaty of Waitangi.<sup>4</sup> This group is known as mana whenua, meaning those descendants who hold mana (authority) over the whenua (land). It is also composed of mātāwaka, meaning those descended from iwi and hapū whose ancestral links lie outside the region. Ryks et al. (2016) explored the heterogeneity of Māori in urban areas by looking at the spatial distribution of different Māori sub-populations, including both mana whenua and mātāwaka. Specifically, they sought to understand how the spatial distribution of urban Māori across four urban centres in Aotearoa New Zealand could inform and enrich a discussion about the rights and interests of urban Māori in the planning and development of cities, and subsequent policy responses from central and local government.

In their analysis Ryks et al. (2016) conceptualised urban Māori identity as being composed of mana whenua and mātāwaka inhabitants. Using this framework and 2013 New Zealand Census data they showed how the distribution of the urban Māori population varies spatially across Aotearoa New Zealand's cities and towns and demonstrates the heterogeneity of the urban Māori population. Kukutai (2014) also analysed the spatial distribution of urban Māori and intra-Māori heterogeneity by looking at reported iwi affiliation by urban area. Importantly, Kukutai noted how urbanisation and urban migration over time have intersected with a period of re-tribalisation (where Māori are re-connecting with their iwi), resulting in iwi becoming the key political and corporate entities for reparations for historical injustices. Kukutai goes on to state that the benefits of reparations may not be realised for Māori who have shifted from historical lands and no longer identify with iwi. Furthermore, tribal corporate entities and service providers continue to negotiate ways to reach, and distribute benefits to, iwi members who live away from their tribal lands through such mechanisms as education grants, language courses, online communication platforms and cultural events such as performing arts festivals and tribal sports competitions.

The notion of a heterogeneous urban Māori population parallels international research about indigenous populations who share a similar history of colonisation and urbanisation (for example, see Frideres 2014; Kukutai 2014; Peters 2002; Peters et al. 2014; Voyageur and Calliou 2000; White et al. 2003). Ryks et al. (2016, p. 29) emphasise that, 'contrary to colonial and post-colonial discourses that assume(d) or support(ed) a unified and homogenous indigenous identity, the heterogeneity of indigenous groups is complex and expressed in many different forms socially and spatially'. Kukutai (2004, p. 87) states 'indigenous peoples such as Māori exemplify the problem that policy makers face in dealing with heterogeneity . . . yet, for reasons of history and contemporary politics, public policy tends to treat them as homogenous'. This failure to understand the heterogeneity of the urban Māori population continues to influence how Māori access and receive health services and underpins the persistence of health inequities.

### **Health Inequities and Māori**

Health inequities are systematic differences in health that are unjust and avoidable by reasonable action (Commission on Social Determinants of Health 2008). While most New Zealanders identify

themselves as being in good health, there are many ways in which Māori experience worse health outcomes in both rural and urban contexts (Pearce et al. 2006).

Poorer outcomes have been linked to the ongoing effects of colonisation and the failure of mainstream policies and services to cater to the needs of Māori. P. Reid (2015, p. 152) states that health is ‘shaped by historical events that are embodied in or impact on the way our bodies grow, develop and age’. The colonisation of Aotearoa New Zealand has impacted Māori through land confiscation, the marginalisation of Māori knowledge and language, loss and degradation of resources, racism, and repeated breaches of the Treaty of Waitangi (Theodore et al. 2015), the effects of which are still felt and negotiated by Māori today. Furthermore, Māori have been burdened with Eurocentric legislation and policies that aim (implicitly and sometimes explicitly) to further disadvantage Māori (Wepa 2015). For example, within midwifery, as a subset of healthcare in Aotearoa New Zealand, there have been a number of changes over recent decades that see maternity policy and legislation take account of the principles of the Treaty and reference Māori values. However, as Kenney points out (2009, p. 63), ‘if midwifery is inherently a European dominated middleclass profession then it is extremely unlikely that the profession will comprehend the nuances of mātauranga Māori and this appears to be reflected in the governance language of the profession’. In other words, while there are legislative references to the principles of the Treaty of Waitangi, or policy frameworks that reference Māori values, for the most part legislation and policy related to health and urban communities continue to be grounded in Western ideologies which ‘Other’ Māori understandings of the world. The historical and ongoing contemporary trauma of colonisation contributes to health disparities between Māori and non-Māori, despite Māori being guaranteed rights to protection under Article 3 of the Treaty of Waitangi, including access to the same quality of health and standard of living as Pākehā citizens (Wepa 2015).<sup>5</sup>

Further, the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) states that ‘indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health’ (United Nations 2008). Cram (2014, p. 20) argues that the ability for Māori to meet these standards and positively move beyond them, utilising Māori institutions, customs and practices, would demonstrate ‘progress towards the realisation of Māori rights as embodied in the 1840 Treaty of Waitangi and the more recent Declaration’.

Krieger (2001) argues that the social environment, including racism, can influence health. Jones (2000) differentiates between interpersonal (prejudice and discrimination), institutional (differential access to goods, services and opportunities) and internal (when stigmatised groups accept negative messages about them) racism and suggests that racism can lead to ethnic inequities in health through differential access to the social, economic and environmental factors that influence health, differential access to healthcare, and differences in the quality of care received.

### **Urban Māori Health**

Housing, transport, socioeconomic deprivation, racism, differential access to healthcare, and differential quality of care have been recognised as some of the key social determinants of health for urban Māori (Robson et al. 2007). Others include education, employment, income, living standards, justice, cultural practices and language. Below, we expand on some of these key determinants as an example of how they operate to create health inequities.

#### ***Housing***

Housing is recognised as an important determinant of health for urban Māori. In New Zealand, urban areas have the highest levels of severe housing deprivation, and severe housing deprivation

is five times higher among Māori than European/Other New Zealanders (Amore 2016). Urban crowding is strongly related to low income for Māori families, and the highest levels of household crowding among Māori are found in the greater Auckland region (Aotearoa New Zealand's largest urban area), with 35% of Māori in the Counties Manukau District Health Board (DHB) region and 27% of Māori in the Auckland DHB region living in crowded conditions (Ministry of Health 2014). Household crowding is associated with several poor health outcomes, including infectious disease, rheumatic fever, meningococcal disease and respiratory infections (Ministry of Health 2014). Māori and Pacific people experience a greater burden of infectious diseases where household crowding plays a role, and, while 10% of infectious disease hospitalisations in New Zealand have been attributed to household crowding, this rate is higher for Māori (17%) and Pacific people (25%) (Baker et al. 2013). For meningococcal disease, household crowding accounts for 9% of the disease burden in European/Other children compared to 23% and 34% in Māori and Pacific children respectively (Baker et al. 2013).

### ***Transport***

Māori are less likely to live in a house with motor vehicle access than non-Māori, and a lack of transport has been identified as a barrier to Māori accessing general practitioner (GP) services (Ministry of Health 2015b). Māori adults are twice as likely to be unable to access GP services, and three times more likely to be unable to access after-hours services owing to a lack of transport than non-Māori. Transport inequities are greater for children, with a lack of transport three times more likely to be a barrier to accessing GP services and five times more likely to act as a barrier to after-hours care for Māori children compared to non-Māori children (Ministry of Health 2015b).

### ***Socioeconomic Deprivation***

Socioeconomic deprivation, which is associated with poor health in New Zealand (Ministry of Health 2015a), disproportionately affects Māori. In 2013, 23.5% of Māori lived in the most deprived areas of Aotearoa New Zealand compared to 6.8% of non-Māori (Ministry of Health 2015b). Furthermore, Māori were more likely to be unemployed, have a personal income less than \$10,000, receive income support or live in rental accommodation, and less likely to have completed school (Ministry of Health 2015a). People living in areas of high deprivation are more likely to develop cancer, have their cancer detected later and have a lower chance of survival (Robson et al. 2010). Deprivation appears to have a greater impact on cancer outcomes for Māori, since 50% of Māori cancer registrations were in the most deprived neighbourhoods (compared to 18% for non-Māori) and differences between Māori and non-Māori were greatest for people living in the most deprived areas (Robson et al. 2010). Inequities in ischaemic heart disease (IHD) incidence are also related to socioeconomic deprivation, and Curtis et al. (2010, p. 317) argue that 'the differential distribution of deprivation within Aotearoa New Zealand increases the likelihood of Māori developing conditions that are risk factors for IHD'. Although deprivation is an important determinant of health, Blakely et al. (2007) found that less than half of the difference in mortality rates between Māori and European/Other New Zealanders is due to unequal socioeconomic position. In other words, higher levels of Māori deprivation do not explain the mortality gap, and other factors such as racism and differential access to and quality of healthcare are likely to contribute to higher mortality rates for Māori across all age groups.

### ***Racism***

Racial discrimination has been shown to contribute to health inequities (Harris et al. 2006, 2013; Panelli and Tipa 2007) and influence physical health and wellbeing, as 'it shapes what we know,

how we understand the world and relate to it, the level of access we have to societal resources and opportunities, as well as our ability to navigate our way through social systems' (Reid, P. and Robson 2007, p. 6). In their qualitative study with urban Māori, Cram et al. (2003) reported that participants were sceptical of mainstream health services and that often persistence and assertiveness were required on their part in order to access good-quality healthcare.

The ethnic density of neighbourhoods appears to be a protective factor against racial discrimination and poor health for Māori, since Māori living in neighbourhoods with higher proportions of Māori residents were less likely to report poor self-rated health, doctor-diagnosed common mental disorders, and experiences of racial discrimination (Bécares et al. 2013). When area-level deprivation was controlled for, this association strengthened, and analysis revealed that Māori living in the most socioeconomically deprived neighbourhoods were twice as likely to report poor self-rated health and unfair treatment as Māori living in the least deprived neighbourhoods (Bécares et al. 2013). Furthermore, racism affects other determinants of health such as housing, where Māori were 13 times more likely to experience discrimination than non-Māori in terms of renting or buying a house (Harris et al. 2006), and employment, where discrimination has been estimated to account for up to 48% of the difference in wages between Māori and Pākehā (Sutherland and Alexander 2002). Education is another determinant of health (Commission on Social Determinants of Health 2008) where Māori are affected by institutional racism. Māori were historically excluded from higher education and taught a non-academic, technical curriculum (Theodore et al. 2015), and a study has found that teacher expectations, which are a strong determinant of student success, were lower for Māori students (Rubie-Davies and Peterson 2016).

### ***Differential Access to Healthcare***

Certain barriers to accessing healthcare affect Māori more than non-Māori. Transport has been mentioned as one barrier that has a greater impact on Māori, and it appears that the cost of healthcare is an additional barrier. Māori are more likely to have an unmet need for GP services owing to cost, with Māori boys twice as likely to have an unmet need as non-Māori boys (Ministry of Health 2016). Māori are also more likely than New Zealand Europeans to put off buying prescription medicine owing to cost (Jatrana et al. 2011), and in 2015/16 Māori children were almost three times more likely than New Zealand European children to have an unmet prescription owing to cost (Ministry of Health 2016).

Systemic issues also act as a barrier to accessing healthcare for Māori, who receive relatively low access to appropriate IHD care, and are less likely to receive IHD interventions that address IHD risk factors (Curtis et al. 2010). Māori also report being less likely to be seen on time or offered a choice of appointment times when accessing general practice care despite being more likely to report urgently needing to see a GP (Jansen et al. 2011). Young Māori women have higher rates of teenage pregnancy than New Zealand European women as a result of systemic barriers to accessing contraception (Lawton et al. 2016), and young pregnant Māori women, despite engaging with GP services early in their pregnancies, have lower access to maternity care owing to systems-level barriers (Makowharemahihi et al. 2014). Areas with the highest densities of Māori and Pacific people were found to have the fewest dental clinics per capita (Kruger et al. 2012). J. Reid et al. (2016a, p. 121) argue that '(neo) colonial relations continue to condition equitable Māori access to primary health care'.

### ***Differential Quality of Care***

The health system is a determinant of health (Commission on Social Determinants of Health 2008), and Scott (2014) argues that ethnic and socioeconomic inequities often represent poor-quality, non-standardised care within a healthcare system. Tobias and Yeh (2007) provide evidence that the New

Zealand health system is associated with inequitable health outcomes. Amenable mortality rates examine ‘unnecessary and untimely deaths’ that can be prevented and treated, to give an idea of deaths that should not have occurred given the available healthcare services (Tobias and Yeh 2007). It was found that amenable causes of death accounted for 27% and 34% of the total mortality disparity between Māori and non-Māori males, and Māori and non-Māori females respectively, which suggests that differential access to healthcare and the quality of care provided contribute to inequitable health outcomes (Tobias and Yeh 2007). Data from 2010 to 2012 shows that amenable mortality rates are almost two and a half times higher among Māori than non-Māori, while ambulatory-sensitive-hospitalisation (ASH) rates, which represent hospitalisations that are treatable in primary care, were 1.6 times higher among Māori than non-Māori from 2012 to 2014 (Ministry of Health 2015a).

Hill et al. (2010) have shown that Māori receive inferior-quality cancer care, and Seneviratne et al. (2015) have proposed that differences in barriers to accessing care, healthcare structure, delivery of health services and possible institutional racism have contributed to inferior breast cancer treatment being delivered to Māori compared to New Zealand European patients. A multivariate analysis was carried out to determine the relative contribution of several variables to the survival disparity between Māori and New Zealand European women (Seneviratne et al. 2015). The stage of cancer at diagnosis contributed to approximately 25% of the survival disparity, while healthcare access factors contributed approximately 20%, and screening, treatment and patient factors contributed approximately 15% each. Only 7% could be attributed to cancer biological characteristics, suggesting that the major factors in survival disparity are related to the healthcare system and patients’ access to the determinants of health, and together contribute up to 70% to the survival differences between Māori and New Zealand European women (Seneviratne et al. 2015).

Harris et al. (2013) found that Māori who were identified as European-only had lower experiences of racial discrimination than Māori who were identified as non-European. Moreover, being identified as European-only was associated with health advantage compared to being identified as non-European, suggesting that ethnic appearance is an important determinant of health (Harris et al. 2013). Furthermore, being identified as Māori is perceived as a barrier to accessing quality, non-discriminatory healthcare from non-Māori service providers (Reid, J. et al. 2016b). It has been argued that ‘monocultural hospitals and health systems do not . . . allow Māori to be Māori’ (Dew et al. 2015, p. 149), while a lack of continuity of care and access to a preferred GP was identified by a sample of urban Māori adults as a barrier to receiving quality and non-discriminatory care from non-Māori clinicians (Reid, J. et al. 2016a).

Scott (2014) suggests that having culturally safe and non-racist health professionals and equity-focused policies aiming to improve Māori health and achieving equity at every level of healthcare could combat institutionalised racism (Scott 2014). P. Reid and Robson (2007, p. 3) go further, stating that such inequities are ‘derived from the consistent, comprehensive and compelling disparities in health outcomes, exposure to the determinants of ill-health, the lack of health system responsiveness and the underrepresentation of Māori in the health workforce’. Transformation of all of these things is, therefore, necessary in order to address the complex and intersecting factors leading to health inequities for urban Māori. The next section discusses some of the policy and service responses attempting to address such inequities.

### **Policy and Service Responses to Urban Māori**

Bécares et al. (2013, p. 78) state that ‘adequately redressing Māori losses, and addressing poverty and the inequitable distribution of socioeconomic resources by ethnicity and place in New Zealand is vital to improving health and reducing inequalities’ and would require a strong commitment to eliminating racism, since access to goods, services and opportunities within New Zealand society is racialised. P. Reid and Robson (2007, p. 5) therefore argue that, rather than discuss

the increased health needs of Māori, as is often the case in dominant health discourse, ‘it is more appropriate for us to frame Māori health needs as arising as a consequence of our indigenous rights being breached’.

A lack of an equity focus at a health system level is also likely to be contributing to health inequities between Māori and non-Māori. Sheridan et al. (2011) conducted a national survey of New Zealand’s healthcare system and found that many chronic care programmes were Eurocentric and poorly adapted to the needs of Māori and Pacific peoples. In order to address culturally deficient programmes, inferior quality care and institutional racism (Harris et al. 2013; Hill et al. 2010; Sheridan et al. 2011), P. Reid (2015) advocates that equity must be central to health promotion planning. Resources should be distributed according to people’s needs, and groups with higher needs should receive access to higher levels of resources to allow all groups to enjoy similar outcomes (Reid, P. 2015). P. Reid (2015) criticises a ‘one-size-fits-all’ approach to health promotion as benefiting those who already have a privileged position in society and are more easily able to take up mainstream health ideas and information. To ensure that ethnic inequalities do not widen through health promotion, Sheridan et al. (2011) recommend that all programmes are developed on an equity basis and state that cultural competency is required to ensure quality healthcare for all.

Eurocentric policy responses and initiatives that have not resulted in any improvement in Māori health outcomes have often led to a deficit approach whereby Māori, or particular sub-groups of Māori, are said to be ‘lacking’ and where failure of an intervention is said to lie with the ‘inability’ or ‘unwillingness’ of Māori to engage or change behaviours. Discourses of this nature ignore structural and systemic biases and ensure that, by focusing on Māori as the ‘problem’, the dominant ideologies about health and wellbeing in Aotearoa New Zealand remain intact and health inequities are not addressed. They also do not appropriately acknowledge the rights and resources granted to Māori in the Treaty and the UNDRIP.

Measuring and understanding health inequities is a key aspect of effective action on the social determinants of health (Commission on Social Determinants of Health 2008). A lack of data often means little recognition of problems, while monitoring levels of health, the social determinants of health, the effects of interventions and overall progress can make action on health inequities more effective (Commission on Social Determinants of Health 2008). Theodore et al. (2015, p. 510) point out that ‘research is pointless unless interventions based on that research are implemented’. Knowing that interventions are likely to be effective is the first step, but support and resourcing from the government are essential to allow long-term initiatives to succeed (Theodore et al. 2015).

Ratima et al. (2015) assert that generic health promotion is inadequate for Māori, since it comes from a Western worldview that does not recognise Māori concepts of community and wellbeing. A Māori approach to health promotion builds from a Māori foundation with a Māori worldview that acknowledges that identity and cultural integrity are key components of Māori wellbeing (Ratima et al. 2015). A kaupapa Māori approach that allows Māori more autonomy to design and deliver health services will better meet the needs of Māori (Theodore et al. 2015). Wepa (2015) supports a whānau ora approach that focuses on wellness and health, addressing what is important to specific whānau, and building on the strengths of whānau members, as opposed to current mainstream strategies that emphasise individual diseases and deficits. Wepa (2015) also asserts that interpersonal connections are vital to improving whānau health and wellbeing, and that the Māori health-related workforce must be strengthened, since it brings essential insights and understanding of cultural and socioeconomic issues impacting Māori.

Central to a kaupapa Māori approach are the opportunities for self-determination—within the context of understanding health inequities it is important that different Māori communities (iwi, hapu, LGBTQ, urban, rural) are enabled to determine their own needs, service responses and accountability measures. There is a need for further research on kaupapa Māori models and both objective and subjective measures of wellbeing within theory and practice (Cram 2014), and in



particular in relation to urban Māori communities.<sup>6</sup> The next section turns to highlight some of the more well-known models of Māori health and wellbeing and to highlight the opportunities for culturally responsive and relational health services for urban Māori.

### **Models of Māori Health and Culturally Responsive Health Services for Urban Māori**

There is a wide range of literature on Māori health that has involved analyses of health statistics, subjective experiences of health interventions and systems, and best practice across different health sectors, as well as the creation of health and wellbeing models to address Māori health inequities. Such models have become an important feature of Māori health policy and practice, informing both sector-specific practice guidelines (for example, the Tūranga Kaupapa Cultural Framework for the New Zealand College of Midwives) and wider national health strategies such as He Korowai Oranga—The Māori Health Action Plan of 2002.

A range of existing models of Māori health and wellbeing have been developed, evolved and adopted within the health sector in New Zealand (see Durie 1994 and Pere 1987). These models incorporate the spiritual, physical and emotional aspects of wellness with culture, language, land and water, and communities (Kara et al. 2011). There are three specific models that dominate the health literature—Te Whare Tapa Whā, Te Wheke and Te Pae Mahutonga. Te Whare Tapa Whā (a four-sided house) is a model of Māori health developed by Durie (1994) and utilised by a range of health, social and education providers. This model describes the four cornerstones of Māori health as te taha tinana (physical), te taha wairua (spiritual), te taha hinengaro (mental) and te taha whānau (family). These four walls of the house, when strong, provide a solid frame for wellbeing. Another model, developed by Pere (1987), is represented by a wheke (octopus), with the head of the octopus representing whānau and the tentacles various aspects of Māori health—wairuatanga (spiritual), tinana (physical), hinengaro (mental), whanaungatanga (relationships), mana ake (uniqueness), mauri (vitality), hā a koro mā, a kui mā (inspiration from ancestors) and whatumanawa (emotional). Te Pae Mahutonga (the Southern Cross) uses the night sky as a reference for wellbeing, using the stars that make up the Southern Cross constellation as the model. The four stars represent mauriora (access to the Māori world), waiora (environmental protection), toiora (healthy lifestyles) and te oranga (participation in society). The two pointers can be used to represent moving forward through ngā manukura (leadership) and te mana whakahaere (autonomy) (Durie 1999).

Each of these models emphasises the interconnectedness of the individual to the wider collective and the interrelationship between the physical, emotional and spiritual. While there is strength in these frameworks, there is still evidence that cultural concepts and practices imperative to Māori wellbeing are undermined by dominant views and practices that poorly account for the diversity of Māori realities. More recent work on Māori wellbeing is extending these well-known models by providing a more nuanced approach that addresses the complexities of health and wellbeing for the diverse realities of Māori, including urban Māori. Two particularly relevant examples are Panelli and Tipa's (2007) discussion on place-based wellbeing and Waa et al.'s (2017) Ngā Pou Mauriora framework.

Panelli and Tipa (2007) provide a useful analysis of wellbeing which highlights the cultural and spatial specificity of understandings of wellbeing as they are located and experienced in place. They argue that placement of wellbeing within specific physical and socio-political locations 'affects the conditions and opportunities people experience in their lives and environments—including their health and wellbeing' (Panelli and Tipa 2007, p. 446). They note that a focus on place also indicates how people's experiences of wellbeing can be physically and politically placed or mis-/re-placed. For urban Māori this is particularly useful and relevant. For example, the spatial relationships that

mātāwaka may have with both the place where they currently live and also their tribal lands and waters necessitate a more dynamic assessment of place attachment, and its effect on health and well-being outcomes, than what is currently provided in most mainstream health research. Panelli and Tipa (2007, p. 449) make the point that:

In contrast to individualist Western health-science views of wellbeing, Māori culture inspires our reconceptualisation of wellbeing, focusing on culture–environment linkages that are place-specific. Like many indigenous groups, Māori lives and wellbeing are influenced by a complex combination of cultural beliefs, values, and uses; a history of colonisation and alienation from their lands; and a diverse set of contemporary cultural practices and interactions with a non-Māori world that is based primarily on capitalist Western values. As a consequence, there is no single, unified Māori perspective (or critique of Māori experiences) and many complexities and contradictions exist for different Māori peoples.

The development of the Ngā Pou Mauriora framework came about in an attempt to consolidate existing Māori and international wellbeing models and to reframe them to better account for urban environments and experiences. Using five domains (pou)—whanaungatanga (social support and collective belonging), kaitiakitanga (respect for the environment), ūkaipōtanga (cultivating sense of place and identity), wāhi manaakitanga (supportive, safe and healthy living environments) and whairawa (equitable access to, and distribution of, resources)—objective measures are used to better understand how urban environments and governance can better support sustainable and resilient Māori communities. ‘Ngā Pou Mauriora frames wellbeing in terms of conditions that enable communities to be well and how wellbeing is perpetuated over time’ (Waa et al. 2017, p. 51) and demonstrates the resilience of urban Māori communities and their ability to respond to and negotiate changing spatial and socio-political environments.

All of the models of Māori health and wellbeing described engage with collective as well as individual perspectives. There is a powerful politic to reclaiming the collective in understandings and measures of wellbeing for urban Māori, and Māori more generally. The historical policy to disperse Māori when they moved to urban areas was done knowing that there was, and is, strength in the collective. Urban Māori communities have demonstrated resilience in the face of adverse realities and increasing health disparities through collective formations that go beyond traditional genealogical connections and are arranged spatially and/or socially. Reclaiming the collective focus contains a political imperative that policy makers in Aotearoa New Zealand are beginning to recognise through such policy initiatives as *Whānau Ora*. The policy landscape in Aotearoa New Zealand has changed dramatically with the ‘collaborative turn’ through the likes of the *Whānau Ora* policy framework whereby connectedness and collaboration must go beyond individuals and families to include stakeholders and service providers across health, social and educational services (Kara et al. 2011).

### ***Case Study: Whānau Ora—From Philosophy to Practice?***

A focus on the collective needs of whānau and on whānau ora (the health and wellbeing of whānau) has long been an important goal of Māori. Thus ‘whānau ora’ is a term that has been used to describe a philosophy or approach to wellbeing and self-determination, an approach to understanding the health needs of Māori, and the practice of delivering services to Māori through Māori health providers. It is within the latter context that, in 2010, the government-funded Taskforce on Whānau-Centred Initiatives produced a report outlining the need for government to take a new approach to meeting the needs of Māori and achieving whānau ora. The report outlined a framework based on a review of relevant literature, the experiences of health and social service agencies, and extensive

consultation with Māori and recommended that a new model of service delivery be introduced that was ‘whānau-centred’ and that through such an approach whānau would be:

- self-managing;
- living healthy lifestyles;
- participating fully in society;
- participating in te ao Māori (the Māori world);
- economically secure and successfully involved in wealth creation;
- cohesive, resilient and nurturing.

(Taskforce on Whānau-Centred Initiatives 2010)

The New Zealand government approved the recommendations of the report and introduced a new initiative called *Whānau Ora*, led by Te Puni Kōkiri (the Ministry of Māori Development) and supported by the Ministry of Social Development and the Ministry of Health. These agencies were tasked with developing a research and monitoring framework for tracking Māori health and other social outcomes, as well as funding Māori health and social service providers to develop and implement initiatives and services that were focused on whānau collectives, rather than individual clients. Importantly, the equitable allocation of funding across cities and regions, and by population type and density, was not a focus of the design of *Whānau Ora*.

The success of the *Whānau Ora* initiative in its first phase (2010–2013) has been debated. Government evaluations of *Whānau Ora* report that almost two-thirds of whānau clients enrolled in *Whānau Ora* received tailored support from the initiative, this success underpinned by improved access to services (Te Puni Kōkiri 2015). In contrast, criticisms of the initiative have centred on having hard-to-define and impossible-to-measure outputs and funding not being equally distributed across regions. Furthermore, it was argued that the lack of support for centrally coordinated research and evaluation meant that regionally based ‘action researchers’ were unable to consistently and meaningfully report on whānau ora outcomes (*Waatea News* 2016). In its second phase (2013–present) *Whānau Ora* focuses more directly on initiatives designed to build whānau capability using non-government agencies to commission activities to support whānau capability. An independent evaluation of this phase of the initiative found that funding allocation across regions continued to be an issue and that this was an important factor in the total number of whānau that providers could potentially reach. It also found that Te Puni Kōkiri was not being sufficiently supported or resourced to centrally coordinate and analyse provider data (Te Puni Kōkiri 2016).

In the North Island of Aotearoa New Zealand, the National Urban Māori Authority (NUMA) was successful in the bid to become a *Whānau Ora* commissioning agency, and under the proposal a new entity—Te Pou Matakana—was established. NUMA is made up of a number of urban organisations that offer support and services for Māori in urban areas of Aotearoa New Zealand. In the South Island the successful commissioning agency—Te Pūtahitanga o te Waipounamu—is made up of a partnership of nine South Island iwi. There is also a commissioning agency for Pacific families.

*Whānau Ora* is deeply rooted, with a focus on the holistic wellbeing of the collective, not simply the individual. It has grown and developed over years of dissatisfaction with dominant health models and services in an attempt to provide meaningful and transformative change for whānau in Aotearoa New Zealand. *Whānau Ora* is not just for Māori families, but the services can be taken up by other whānau in Aotearoa New Zealand. That being said, *Whānau Ora* does tend to privilege whakapapa (genealogical)-based relationships in terms of understandings of whānau. A broader understanding of whānau is needed for urban Māori communities, where familial-type relationships are not always contingent on genealogical connections but may be arranged in other ways, such as spatially or socially. Whānau-type formations may be arranged spatially around urban marae,

churches, neighbourhoods or schools, or they could be formed through social functions such as sport, gardening and performing arts. This is increasingly the case for many urban Māori who have established connections to urban places, sometimes over generations of their whānau making urban centres their home. What is significant, then, is that urban places, whānau configurations and the relationships between the two are constantly made and remade by urban Māori, and these changing and dynamic relationships to place and people should be considered in understanding wellbeing, health and whānau ora.

*Whānau Ora* itself is characteristic of a new approach to collaborative management and integrated service delivery. As Kara et al. (2011, p. 100) highlight, ‘the use of whānau ora (healthy families) to represent individual health while also encompassing the collective of family means there is a need to address connectedness that goes beyond wider family structures to include health, education and social service providers’. *Whānau Ora* is an evolving case of how an indigenous philosophy and approach to health and wellbeing is translated, interpreted and arguably appropriated, in the attempt to deliver a new model of health services. Ultimately the success of the initiative will be determined by whether or not Māori, including urban Māori, experience improved health outcomes over time and whether any improvements can be attributed to the initiative.

## Conclusion

This chapter has highlighted a range of challenges and opportunities for indigenous urban communities and specifically for urban Māori. This includes the challenge of unpacking the validity of a universal view or approach to understanding the wellbeing and health needs of urban Māori. It also includes the need to adopt models and frameworks of wellbeing that are developed, implemented and assessed by, and for, Māori communities. It is insufficient for Māori-specific measures to be incorporated into existing Eurocentric frameworks. The health and wellbeing of urban Māori is multi-faceted and complex, and a one-size-fits-all approach has been shown to be ineffective. Those who propose simplistic descriptions deny this complexity and deny Māori communities the right to fully resourced and informed solutions. Furthermore, universal approaches to health and wellbeing do not appropriately acknowledge or address the rights granted to Māori in the Treaty of Waitangi and the UNDRIP.

There is a powerful politic to reclaiming the collective in understandings and measures of wellbeing for urban Māori. The historical policy to disperse Māori to urban areas was done knowing that there was, and is, strength in the collective. Urban Māori communities have demonstrated resilience in the face of adverse realities and increasing health disparities. Reclaiming the collective focus contains a political imperative that policy makers are beginning to recognise, but it is important to consider whether collaborative and culturally responsive policy initiatives such as *Whānau Ora* provide sufficient space for the recognition and exercise of tino rangatiratanga.

## Notes

- 1 Aotearoa (land of the long white cloud) is one of the original names for New Zealand. We follow a common practice of using both names.
- 2 Māori are Aotearoa New Zealand’s indigenous people.
- 3 The primary collective or unit of traditional Māori society. Note, the word whānau also means to be born, or give birth.
- 4 Aotearoa New Zealand’s founding document. There were two versions of the Treaty—a version written in Māori and a version written in English. The English version outlined somewhat fewer rights for Māori while extending the right of settler governance to absolute sovereignty. The Māori version guaranteed Māori tino rangatiratanga (self-determination) over their lands, waters, forests, fisheries and other taonga (treasures), only ceding limited governance to the British. The Māori version received the majority of signatures. The Treaty

was intended to establish a partnership between Māori and the British Crown, and it should be noted that both versions of the Treaty, in Article 3, gave Māori the rights of British subjects.

5 Pākehā is the Māori term for a New Zealander of European descent.

6 The Health Research Council goes some way to contributing to this gap through its Rangahau Hauora Māori investment stream, and there are an ever increasing number of Māori health scholars working across a diverse range of areas (see [www.hrc.govt.nz](http://www.hrc.govt.nz)). Given the intergenerational and persistent nature of many of the health disparities in Aotearoa New Zealand, however, there is still a great deal more work to be done.

## References

- Amore, K. 2016. *Severe housing deprivation in Aotearoa/New Zealand: 2001–2013*. Wellington: He Kainga Oranga/Housing and Health Research Programme, University of Otago. Retrieved from [www.healthyhousing.org.nz/wp-content/uploads/2016/08/Severe-housing-deprivation-in-Aotearoa-2001-2013-1.pdf](http://www.healthyhousing.org.nz/wp-content/uploads/2016/08/Severe-housing-deprivation-in-Aotearoa-2001-2013-1.pdf)
- Baker, M., McDonald, A., Zhang, J., and Howden-Chapman, P. 2013. *Infectious diseases attributable to household crowding in New Zealand: A systematic review and burden of disease estimate*. Wellington: He Kainga Oranga/Housing and Health Research Programme, University of Otago. Retrieved from [www.healthyhousing.org.nz/wp-content/uploads/2010/01/HH-Crowding-ID-Burden-25-May-2013.pdf](http://www.healthyhousing.org.nz/wp-content/uploads/2010/01/HH-Crowding-ID-Burden-25-May-2013.pdf)
- Barcham, M. 1998. The challenge of urban Māori: Reconciling conceptions of indigeneity and social change. *Asia Pacific Viewpoint*, 39, 303–314.
- Bargh, M. 2012. The post-settlement world (so far): Impacts for Māori. In N. When and J. Hayward (Eds), *Treaty of Waitangi settlements* (pp. 166–181). Wellington: Bridget Williams Books.
- Bécares, L., Cormack, D., and Harris, R. 2013. Ethnic density and area deprivation: Neighbourhood effects on Māori health and racial discrimination in Aotearoa/New Zealand. *Social Science and Medicine*, 88, 76–82.
- Blakely, T., Tobias, M., Atkinson, J., Yeh, L.C., and Huang, K. 2007. *Tracking disparity: Trends in ethnic and socio-economic inequalities in mortality, 1981–2004*. Wellington: Ministry of Health. Retrieved from [www.health.govt.nz/system/files/documents/publications/tracking-disparity-inequalities-in-mortality-1981-2004.pdf](http://www.health.govt.nz/system/files/documents/publications/tracking-disparity-inequalities-in-mortality-1981-2004.pdf)
- Commission on Social Determinants of Health. 2008. *Closing the gap in a generation: Final report of the Commission on Social Determinants of Health*. Geneva: World Health Organization. Retrieved from [www.who.int/social\\_determinants/final\\_report/csdh\\_finalreport\\_2008.pdf](http://www.who.int/social_determinants/final_report/csdh_finalreport_2008.pdf)
- Cram, F. 2014. Measuring Māori wellbeing: A commentary. *MAI Journal: A New Zealand Journal of Indigenous Scholarship*, 3(1), 18–32.
- Cram, F., Smith, L., and Johnstone, W. 2003. Mapping the themes of Māori talk about health. *New Zealand Medical Journal*, 116(1170), 1–7.
- Curtis, E., Harwood, M., Riddell, T., Robson, B., Harris, R., Mills, C., and Reid, P. 2010. Access and society as determinants of ischaemic heart disease in indigenous populations. *Heart, Lung and Circulation*, 19(5), 316–324.
- Dew, K., Signal, L., Davies, C., Tavite, H., Hooper, C., Sarfati, D., Stairmand, J., and Cunningham, C. 2015. Dissonant roles: The experience of Māori in cancer care. *Social Science and Medicine*, 138, 144–151.
- Durie, M. 1994. *Whaiora: Māori health development*. Auckland: Oxford University Press.
- Durie, M. 1999. Te Pae Mahutonga: A model for Māori health promotion. *Health Promotion Forum of New Zealand Newsletter*, 49, 2–5.
- Frideres, J. 2014. Continuity or disappearance—Aboriginal languages in Canada. In F. Trovato and A. Romaniuk (Eds), *Aboriginal populations: Social, demographic and epidemiological perspectives* (pp. 303–324). Edmonton: University of Alberta Press.
- Harris, R., Tobias, M., Jeffreys, M., Waldegrave, K., Karlsen, S., and Nazroo, J. 2006. Effects of self-reported racial discrimination and deprivation on Māori health and inequalities in New Zealand: Cross-sectional study. *Lancet*, 367(9527), 2005–2009.
- Harris, R.B., Cormack, D.M., and Stanley, J. 2013. The relationship between socially-assigned ethnicity, health and experience of racial discrimination for Māori: Analysis of the 2006/07 New Zealand Health Survey. *BMC Public Health*, 13(1), 844–855.
- Hill, S., Sarfati, D., Blakely, T., Robson, B., Purdie, G., Chen, J., Dennett, E., Cormack, D., Cunningham, R., Dew, K., McCreanor, T., and Kawachi, I. 2010. Survival disparities in indigenous and non-indigenous New Zealanders with colon cancer: The role of patient comorbidity, treatment and health service factors. *Journal of Epidemiology and Community Health*, 64(2), 117–123.
- Howden-Chapman, P., Bierre, S., and Cunningham, C. 2013. Building inequality. In M. Rashbrooke (Ed.), *Inequality: A New Zealand crisis* (pp. 112–123). Wellington: Bridget Williams Books.
- Jansen, P., Bacal, K., and Buetow, S. 2011. A comparison of Māori and non-Māori experiences of general practice. *New Zealand Medical Journal*, 124(1330), 24–29.

- Jatrana, S., Crampton, P., and Norris, P. 2011. Ethnic differences in access to prescription medication because of cost in New Zealand. *Journal of Epidemiology and Community Health*, 65(5), 454–460.
- Jones, C.P. 2000. Levels of racism: A theoretical framework and a gardener's tale. *American Journal of Public Health*, 90(8), 1212–1215.
- Kara, E., Gibbons, V., Kidd, J., Blundell, R., Turner, K., and Johnstone, W. 2011. Developing a kaupapa Māori framework for Whānau Ora. *AlterNative*, 7(2), 100–110.
- Kenney, C. 2009. Me Aro ki te Hā o Hineahuone: Women, miscarriage stories, and midwifery: Towards a contextually relevant research methodology. Unpublished PhD thesis. Massey University.
- Krieger, N. 2001. Theories for social epidemiology in the 21st century: An ecosocial perspective. *International Journal of Epidemiology*, 30(4), 668–677.
- Kruger, E., Whyman, R., and Tennant, M. 2012. High-acuity GIS mapping of private practice dental services in New Zealand: Does service match need? *International Dental Journal*, 62(2), 95–99.
- Kukutai, T. 2004. The problem of defining an ethnic group for public policy: Who is Māori and why does it matter? *Social Policy Journal of New Zealand*, 23, 86–108.
- Kukutai, T. 2011. Māori demography in Aotearoa New Zealand 50 years on. *New Zealand Population Review*, 37, 45–64.
- Kukutai, T. 2014. The structure of urban Māori identities. In E. Peters and C. Andersen (Eds), *Indigenous in the city: Contemporary identities and cultural innovation* (pp. 311–333). Vancouver: UBC Press.
- Lawton, B., Makowharemahihi, C., Cram, F., Robson, B., and Ngata, T. 2016. Pounamu E Hine: Access to contraception for indigenous Māori teenage mothers. *Journal of Primary Health Care*, 8(1), 52–59.
- Makowharemahihi, C., Lawton, B.A., Cram, F., Ngata, T., Brown, S., and Robson, B. 2014. Initiation of maternity care for young Māori women under 20 years of age. *New Zealand Medical Journal*, 127(1393), 52–61.
- Meredith, P. 2000. Urban Māori as 'new citizens': The quest for recognition and resources. In *Revisiting citizenship in New Zealand*. Conference 22–24 February, Hamilton, New Zealand.
- Ministry of Health. 2014. *Analysis of household crowding based on Census 2013 data*. Wellington: Ministry of Health. Retrieved from [www.health.govt.nz/system/files/documents/publications/analysis-of-household-crowding-based-on-census-13-data-dec14-v2.pdf](http://www.health.govt.nz/system/files/documents/publications/analysis-of-household-crowding-based-on-census-13-data-dec14-v2.pdf)
- Ministry of Health. 2015a. *Annual update of key results 2014/15: New Zealand Health Survey*. Wellington: Ministry of Health. Retrieved from [www.health.govt.nz/system/files/documents/publications/annual-update-key-results-2014-15-nzhs-dec15-1.pdf](http://www.health.govt.nz/system/files/documents/publications/annual-update-key-results-2014-15-nzhs-dec15-1.pdf)
- Ministry of Health. 2015b. *Tatau Kahukura: Māori health chart book 2015*, 3rd edn. Wellington: Ministry of Health. Retrieved from [www.health.govt.nz/system/files/documents/publications/tatau-kahukura-maori-health-chart-book-3rd-edition-oct15.pdf](http://www.health.govt.nz/system/files/documents/publications/tatau-kahukura-maori-health-chart-book-3rd-edition-oct15.pdf)
- Ministry of Health. 2016. *Tier 1 statistics 2015/16: New Zealand Health Survey*. Wellington: Ministry of Health. Retrieved from <https://minhealthnz.shinyapps.io/nz-health-survey-2015-16-tier-1/>
- Panelli, R. and Tipa, G. 2007. Placing well-being: A Māori case study of cultural and environmental specificity. *Ecohealth*, 4(4), 445–460.
- Pearce, J., Dorling, D., Wheeler, B., Barnett, R., and Rigby, J. 2006. Geographical inequalities in health in New Zealand, 1980–2001: The gap widens. *Australian and New Zealand Journal of Public Health*, 30(5), 461–466.
- Pere, R. 1987. *Te Wheke: A celebration of infinite wisdom*. Gisborne: Ao Ako Global Learning New Zealand.
- Peters, E. 2002. Aboriginal people in urban areas. In C. Andrew, K. Graham, and S. Phillips (Eds), *Urban affairs: Back on the policy agenda* (pp. 45–70). Montreal: McGill–Queens University Press.
- Peters, E., Maaka, R., and Laliberte, R. 2014. I'm sweating with Cree culture not Saulteaux culture—Urban aboriginal cultural identities. In F. Trovato and A. Romaniuk (Eds), *Aboriginal populations: Social, demographic and epidemiological perspectives* (pp. 285–302). Edmonton: University of Alberta Press.
- Ratima, M., Durie, M., and Hond, R. 2015. Māori health promotion. In L. Signal and M. Ratima (Eds), *Promoting health in Aotearoa New Zealand* (pp. 42–64). Dunedin: Otago University Press.
- Reid, J., Cormack, D., and Crowe, M. 2016a. The significance of relational continuity of care for Māori patient engagement with predominantly non-Māori doctors: Findings from a qualitative study. *Australian and New Zealand Journal of Public Health*, 40(2), 120–125.
- Reid, J., Cormack, D., and Crowe, M. 2016b. The significance of socially-assigned ethnicity for self-identified Māori accessing and engaging with primary healthcare in New Zealand. *Health*, 20(2), 143–160.
- Reid, P. 2015. Promoting health equity. In L. Signal and M. Ratima (Eds), *Promoting health in Aotearoa New Zealand* (pp. 146–162). Dunedin: Otago University Press.
- Reid, P. and Robson, B. 2007. Understanding health inequities. In B. Robson and R. Harris (Eds), *Hauora: Māori standards of health IV. A study of the years 2000–2005* (pp. 3–10). Wellington, New Zealand: Te Rōpū Rangahau Hauora a Eru Pōmare.

- Robson, B. and Harris, R. 2007. *Hauora: Māori standards of health IV. A study of the years 2000–2005*. Wellington: Te Rōpū Rangahau Hauora a Eru Pōmare.
- Robson, B., Cormack, D., and Cram, F. 2007. Social and economic indicators. In B. Robson and R. Harris (Eds), *Hauora: Māori standards of health IV. A study of the years 2000–2005* (pp. 21–32). Wellington: Te Rōpū Rangahau Hauora a Eru Pōmare.
- Robson, B., Purdie, G., and Cormack, D. 2010. *Unequal impact II: Māori and non-Māori cancer statistics by deprivation and rural–urban status, 2002–2006*. Wellington: Ministry of Health. Retrieved from [www.health.govt.nz/system/files/documents/publications/unequal-impact-ii.pdf](http://www.health.govt.nz/system/files/documents/publications/unequal-impact-ii.pdf)
- Rubie-Davies, C.M. and Peterson, E.R. 2016. Relations between teachers' achievement, over- and underestimation, and students' beliefs for Māori and Pākehā students. *Contemporary Educational Psychology*, 47, 72–83.
- Ryks, J.L., Waa, A., and Pearson, A. 2016. Mapping urban Māori—A population-based study of Māori heterogeneity. *New Zealand Geographer*, 72(1), 28–40.
- Scott, N. 2014. A Māori cultural reluctance to present for care, or a systems and quality failure? How we pose the issue, informs our solutions. *New Zealand Medical Journal*, 127(1393), 8–11.
- Seneviratne, S., Campbell, I., Scott, N., Shirley, R., Peni, T., and Lawrenson, R. 2015. Ethnic differences in breast cancer survival in New Zealand: Contributions of differences in screening, treatment, tumor biology, demographics and comorbidities. *Cancer Causes and Control*, 26(12), 1813–1824.
- Sheridan, N., Kenealy, T., Connolly, M., Mahony, F., Barber, P., Boyd, M., Carswell, P., Clinton, J., Devlin, G., Doughty, R., Dyall, L., Kerse, N., Kolbe, J., Lawrenson, R., and Moffitt, A. 2011. Health equity in the New Zealand health care system: A national survey. *International Journal for Equity in Health*, 10(45), 1–14.
- Statistics New Zealand. 2006. *Māori mobility in New Zealand*. Wellington: Statistics New Zealand. Retrieved from [www.stats.govt.nz/browse\\_for\\_stats/population/Migration/internal-migration/Māori-mobility.aspx](http://www.stats.govt.nz/browse_for_stats/population/Migration/internal-migration/Māori-mobility.aspx)
- Sutherland, H. and Alexander, R. 2002. *The occupational distribution of Māori 1997–2000*. Dunedin: Department of Economics, University of Otago. Retrieved from <https://ourarchive.otago.ac.nz/bitstream/handle/10523/966/DP0204.pdf?sequence=3&isAllowed=y>
- Taskforce on Whānau-Centred Initiatives. 2010. *Whānau Ora: Report of the Taskforce on Whānau-Centred Initiatives*. Wellington: Ministry of Social Development. Retrieved from [www.msd.govt.nz/documents/about-msd-and-our-work/publications-resources/planning-strategy/whānau-ora/whānau-ora-taskforce-report.pdf](http://www.msd.govt.nz/documents/about-msd-and-our-work/publications-resources/planning-strategy/whānau-ora/whānau-ora-taskforce-report.pdf)
- Te Puni Kōkiri. 2015. *Understanding whānau-centred approaches: Analysis of Phase One Whānau Ora research and monitoring results*. Wellington: Te Puni Kōkiri. Retrieved from [www.tpk.govt.nz/en/a-matou-mohiotanga/whānau-ora/understanding-whānaucentred-approaches-analysis-of](http://www.tpk.govt.nz/en/a-matou-mohiotanga/whānau-ora/understanding-whānaucentred-approaches-analysis-of)
- Te Puni Kōkiri. 2016. *Formative evaluation of the Whānau Ora commissioning agency model: An independent evaluation report*. Wellington: Te Puni Kōkiri. Retrieved from [www.tpk.govt.nz/en/a-matou-mohiotanga/whānau-ora/formative-evaluation-of-the-whānau-ora-model](http://www.tpk.govt.nz/en/a-matou-mohiotanga/whānau-ora/formative-evaluation-of-the-whānau-ora-model)
- Theodore, R., McLean, R., and TeMorenga, L. 2015. Challenges to addressing obesity for Māori in Aotearoa/New Zealand. *Australian and New Zealand Journal of Public Health*, 39(6), 509–512.
- Tobias, M. and Yeh, L.C. 2007. How much does health care contribute to health inequality in New Zealand? *Australian and New Zealand Journal of Public Health*, 31(3), 207–210.
- United Nations. 2008. *United Nations Declaration on the Rights of Indigenous Peoples*. New York: United Nations. Retrieved from [www.un.org/esa/socdev/unpfii/documents/DRIPS\\_en.pdf](http://www.un.org/esa/socdev/unpfii/documents/DRIPS_en.pdf)
- Voyageur, C. and Calliou, B. 2000. Various shades of red: Diversity within Canada's indigenous community. *London Journal of Canadian Studies*, 16, 109–124.
- Waa, A., Pearson, A., and Ryks, J. 2017. Premature mortality resilience and wellbeing within urban Māori communities. *Health and Place*, 43, 49–56.
- Waatea News. 2016. Whānau Ora critics get it wrong. Media statement. *Waatea News*. Retrieved from [www.waateanews.com/waateanews/x\\_story\\_id/MTM5NjQ=/Whānau-Ora-critics-get-it-wrong](http://www.waateanews.com/waateanews/x_story_id/MTM5NjQ=/Whānau-Ora-critics-get-it-wrong) (11 January 2017).
- Wepa, D. 2015. *Cultural safety in Aotearoa New Zealand*, 2nd edn. Melbourne: Cambridge University Press.
- White, J., Maxim, P., and Beavon, D. 2003. *Aboriginal conditions: Research as a foundation for public policy*. Vancouver: University of British Columbia Press.